Vermont's Home Visiting System in Context

Prepared by Johnson Group Consulting, Inc.
For the CHINS (Children in Need of Care and Supervision) Reform Workgroup
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Executive Summary

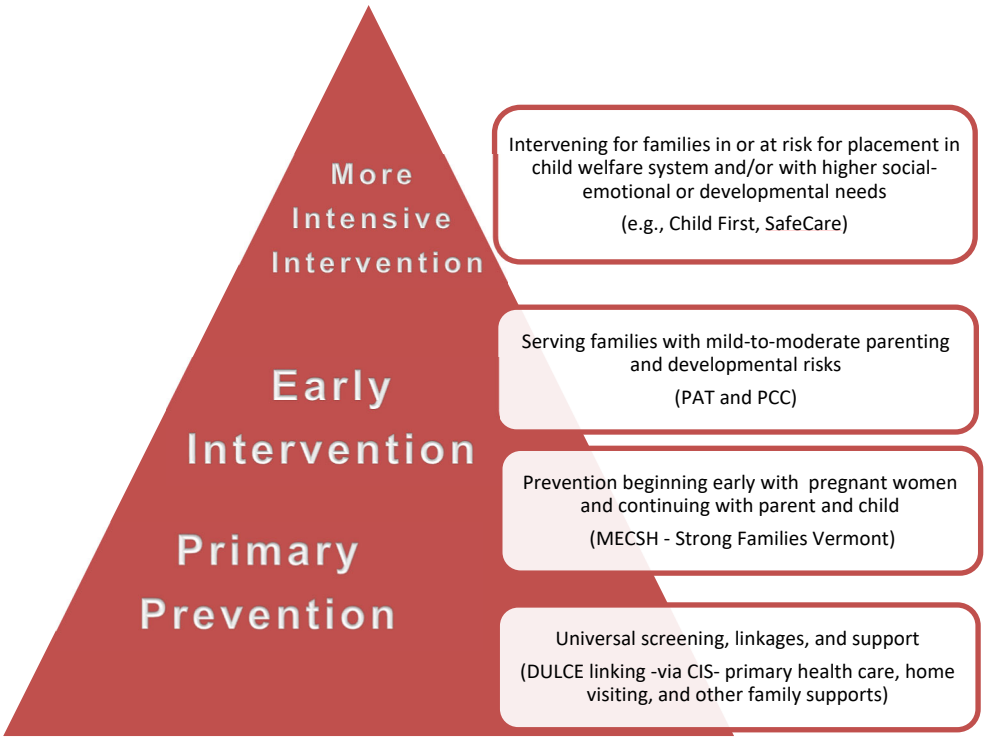
From prenatal to 3 years, safety, stability, and nurturing are foundational to healthy development—physical, social, emotional, and cognitive. Yet by the third birthday, an estimated three in 10 children can be identified to have risks that threaten their likelihood for school readiness, educational achievement, avoidance of justice system involvement, and economic self-sufficiency as adults. In Vermont and elsewhere across the nation, a large share of families struggle to raise their children. State agencies, the legislature, the courts, community leaders, private organizations, and families are all responding to the challenge of keeping young children in safe, stable, and nurturing environments. This report discusses the role of home visiting and other related strategies in the Vermont context. This report on home visiting was prepared for the Child in Need of Care or Supervision (CHINS) Reform Workgroup by Johnson Group Consulting, Inc. working under contract to Vermont DCF.

Key Findings

1. Vermont has a strong home visiting system based on state law, federal and state funding, accountability structures, and public-private partnerships. Without using large amounts of state revenue, it is among the strongest home visiting systems in the nation.
2. Some home visiting models show greater effectiveness in preventing and reducing child maltreatment. This review of the evidence points to variation in impact on this one particular area of risk. Several models, however, show impact across domains of child maltreatment, health, child development, and family security. In particular, six (6) home visiting models have shown through strong research methods that they can have impact on reducing child maltreatment. Vermont is not currently using the strongest models for this purpose.
3. Currently, three evidence-based home visiting models and one evidence-informed approach are in use in Vermont. Those federally approved as evidence-based are: a) Early Head Start-Home-based Option; b) Maternal Early Childhood Sustained Home Visiting (MESCH) which is branded in Vermont as the Strong Families Vermont Home Nursing Program; and c) Parents as Teachers (PAT). In addition, the Parent Child Centers (PCC) have received approval for their evidence-informed model, unique to Vermont. Continuing support for these four approaches anchors a foundation for prevention and early intervention for families with young children at risk.
4. Vermont could benefit from implementation of an additional model with evidence of effectiveness for intervening when families are at risk of child welfare placement or have mental/behavioral health risks. Key evidence-based models include Child First and SafeCare. Implementation of an additional model would require new resources—funding direct services, training, data, and management. Funds might come from federal and/or state allocations.

5. Using and strengthening the Children's Integrated Services (CIS) system, particularly Parent Child Centers, provides a community-based, multi-faceted response when risks and needs are identified. This is a resource unique to Vermont which has adapted to changes in social risk, poverty and employment trends, and emerging evidence about what works in serving families with young children. They form a source of central intake and referral, community-team-based response, and anchor for universal screening as well as home visiting and other responses to family risks. Continuing state investment in CIS and PCC will maintain this family support resource.
6. Vermont has an opportunity to offer "universal" screening and support to families with new babies using DULCE in pediatric primary care practices and clinics across the state. Given that 95% of families with infants have visits with a pediatric primary health provider (e.g., pediatrician, family physician, nurse practitioner in private practice or a publicly funded health center/clinic), using the DULCE program as the "universal" approach to screen for social risks and respond to concrete needs is a sound approach. DULCE, in combination and based in CIS and PCC creates a way to universally identify risks and use community based strategies—including home visiting—to respond.

A Continuum of Support for Vermont Families with Young Children At Risk



(See below for details related to this figure and the titles and acronyms used.)

Vermont's Home Visiting System in Context

Keeping Vermont's Young Children in Safe, Stable, and Nurturing Environments

Our youngest children are those most likely to live in poverty and be affected by social risks. At the same time, the first years in a child's life are critical to lifelong well-being, for setting the trajectory for healthy development—physical, social, emotional, and cognitive. From prenatal to 3 years, safety, stability, and nurturing are foundational to child health and development.[1] [2] Yet by age 3, an estimated three in 10 children can be identified—either based on their own status or their home environment—to have risks that threaten their likelihood for school readiness, educational achievement, avoidance of justice system involvement, and economic self-sufficiency as adults. Public investments in these earliest years should be judged on whether or not they ensure children start life on a successful life trajectory.[3]

In Vermont and elsewhere across the nation, families struggle to raise their children in the face of low wages, long work hours, limited family support, challenges in finding quality child care, unaddressed mental health conditions, the opioid epidemic, inequities in access, and lack of resources in disadvantaged communities.[4] [5] The biggest opportunities for gains in improving young children's health and developmental trajectories are through expanded efforts to improve safety, stability, and nurturing in the home and maintaining family support resources in communities. Giving particular attention to young children and their families with identified individual or community risks but no diagnosis or crisis will require a fundamental shift in thinking and commitment; however, the long-term benefits and the return on investment will accrue to society overall.[6] [7] [8] [9]

This year, the Vermont Department of Children and Families (DCF) reported that child welfare caseloads increased from 2,029 in June 2014 to 2,920 by August 2019. The legislature, the courts, state agencies, community leaders, private organizations, and families are continuing to develop responses to the challenge of keeping Vermont's young children in safe, stable, and nurturing environments. This report discusses the role of home visiting and other related strategies in the Vermont context. This report on home visiting was prepared for the Child in Need of Care or Supervision (CHINS) Reform Workgroup by Johnson Group Consulting, Inc. working under contract to Vermont DCF.

Defining a Home Visiting Program

Home visiting programs embody an effective, evidence-based service approach that has been shown through research to improve family and child outcomes. Numerous studies have documented some of the key common elements of effective home visiting programs.[10] Research and experience tell us that high-quality home visiting programs are: voluntary, family-centered, staffed by well trained and supervised staff, coordinated with other services, and grounded in specific goals with data, quality improvement, and evaluation to document results.

As with terms such as "outreach" or "case management," the term "home visiting" has taken on many meanings. Virtually all home visiting programs that have been shown to be effective are designed to promote positive parenting practices and nurturing parent–child relationships, as well as health, development, safety, family self-sufficiency, and well-being for both child and family. Home visiting programs focus on supporting two-generations, parents and children. These programs generally both

provide direct intervention and link families to other services. Research has shown that the success of home visiting depends on the availability of other early childhood services and supports.[11] While home visitors may be social workers, nurses, early childhood specialists, parent educators, paraprofessionals, or others, having training and supervision related to the specific model or approach they deliver is fundamental to providing effective services.

Not all home-based or in-home services constitute a home visiting program. While other education, health, and human services programs may deliver services in homes, a "home visiting program" is designed intentionally to use trained staff to provide evidence-informed approaches on a voluntary basis at home—generally over a period of years— in order to strengthen families and improve outcomes. The general definition of home visiting services excludes in-home services delivered as part of programs such as: Part C Early Intervention for Infants & Toddlers, child protective services, perinatal case management, and home health for medical conditions. For example, while Part C Early Intervention Programs often deliver physical therapy in the home to infants and toddlers with developmental disabilities. Child protection/child welfare workers often visit homes in cases of suspected child abuse or to deliver interventions. Most states have a perinatal case management program as part of Medicaid, which focus more on health and health care access. Nurses or personal care attendants may serve children with disabilities and special health care needs, providing services and supports in home. These types of in–home services are not called home visiting programs.

State and Federal Roles in Home Visiting Programs

Many states, including Vermont, invested their own resources in home visiting programs between 1985 and 2010. A national survey and case studies of state-based home visiting programs conducted in 1998-99 found that a majority of states had made investments.[12] A second nationwide survey of state-based home visiting conducted in 2009 found that, just prior to creation of a federal program, more than 40 states were funding and/or administering more than 70 programs, with many being hybrids or "home grown" models.[13] Vermont was an outstanding example identified in reports on both of these national surveys.

While some limited federal funding was available, efforts to create a large federal home visiting program during the 1980s were not successful. A small amount of funding was set aside in the Title V Maternal and Child Health Block Grant for home visiting programs in 1989, and Early Head Start was established in 1994 and expanded in 2009. By 2008, Congress funded a pilot program proposed by President GW Bush as part of the Child Abuse Prevention and Treatment Act (CAPTA), designed to support home visiting that would prevent child maltreatment. Some states used Temporary Assistance to Needy Families (TANF) program dollars to encourage family self-sufficiency and well-being through home visiting services and supports.

For more than two decades, states have used Medicaid to finance home visiting services for mothers, infants, and young children. Early adopters in the 1990s included states such as Kentucky, Oklahoma, and Vermont. In the absence of substantial dedicated federal funding for home visiting, states learned how to optimize Medicaid and other various sources of federal funding to finance home visiting services.[14] In 2016, a US HHS Joint Informational Bulletin from the Centers for Medicare and Medicaid Services (CMS) and Health Resources and Services Administration (HRSA) affirmed the flexibility and

options states have to finance home visiting with Medicaid in addition to other funds. By 2019, more than 20 states were using Medicaid federal-state dollars to finance home visiting, with the goal of improving maternal, infant, and young child health and development.[15]

The Family First Prevention Services Act- FFA (P.L.115-123) was signed into law by President Trump in February 2018 to reform federal child welfare finance streams (e.g., Title IV-E and Title IV-B). The FFA added emphasis on providing services to families at risk of entering the child welfare system, offering states the option to use Title IV-E funds—traditionally used for foster care and adoption services—to provide up to 12 months of mental health services, substance abuse treatment, and in-home parenting training to families at risk of entry of the child welfare system. The US HHS Administration on Children and Families (ACF) released guidance in December 2018 with an initial list of programs and services for which FFA funding might be used. The list includes a dozen programs, including: home visiting (in-home parent skill-based), mental health, substance abuse, and kinship navigator programs. Three home visiting models NFP, HFA, and PAT were selected for this initial list. Notably, the home visiting models which focus on children at-risk or with identified conditions related to child welfare and early childhood mental health (e.g., Child First and SafeCare) were not selected in the first round. In addition, in January 2019, the Children's Bureau of ACF informed state child welfare program directors that programs and services will be rated using specific evidence-based standards. This includes models used in the FFA. Notably, the criteria are similar to but not the same as those used for HomVEE to assess the evidence for home visiting programs. State's timelines for implementation of the FFA vary, with one third requesting delayed start. The National Conference of State Legislatures reported in November 2019 that 30 states had enacted or pending legislation related to FFA implementation—ranging from studies to authorizing statutes to appropriations. Vermont has responded in several ways, including undertaking an update of foster care regulations.

Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program

Responding to growing evidence of the effectiveness of certain home visiting programs,[16] bi-partisan Congressional support for creating a federal home visiting program also grew between 2004 and 2009.[17] [18] With enactment of the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV – pronounced "mac-vee") program under the Affordable Care Act,* the use of home visiting programs spread as a result of this new federal investment of $1.5 billion over five years. Subsequently enacted laws extended funding for the program through fiscal year 2022.† The program is administered by the Health Resources and Services Administration (HRSA) in collaboration with ACF within the U.S. Department of Health and Human Services (US HHS).

The MIECHV three purposes are to: 1) strengthen and improve home visiting services and activities, 2) improve coordination of services for at-risk communities, and 3) identify and provide comprehensives services to improve outcomes for families residing in those communities.

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* Section 511 of the Social Security Act (42 U.S.C. § 711).

† Funds for subsequent fiscal years were authorized under Section 209 of the Protecting Access to Medicare Act of 2014, P.L. 113-93 (Federal Fiscal Year-FFY 2015); Section 218 of the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015, P.L. 114-10 (FFY2016-2017); and Section 50601 of the Bipartisan Budget Act of 2018, P.L. 115-123 (FFY 2018-2022).

MIECHV provides grants to states, territories, and tribal governments to expand the availability of home visiting programs for families at risk, particularly those who reside in communities that have concentrations of poor children and other indicators of risk. MIECHV grantees (virtually all are states) are required to give priority to serving eligible families who meet any of the following criteria:

- reside in communities that are in need of home visiting services;
- are low-income;
- include a pregnant woman under the age of 21;
- have a history of child abuse or neglect or have had interactions with child welfare services;
- have a history of substance abuse or need substance abuse treatment;
- have users of tobacco products in the home;
- have children with low student achievement;
- have children with developmental delays or disabilities; or
- individuals who are serving, or formerly served, in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

Key Requirements of MIECHV Grantees

1. Conduct statewide needs assessment to identify communities with concentrations of poverty, poor infant health and mortality, and other negative outcomes for children and families to gauge the availability and use of home visiting services.
2. Establish benchmarks in four out of six areas defined by HHS. Then, demonstrate improvement.
3. Spend no less than 75% of their MIECHV grant funds to conduct a home visiting program using model(s) deemed by HHS to be evidence based.
4. Adhere to the selected model(s), including trained staff, supervision, and monitoring.
5. Collect data, use quality improvement, and conduct evaluation.
6. Ensure "maintenance of effort" – use federal funds to supplement but not supplant previously allocated state funding.

States are permitted to choose among home visiting models whose effectiveness has been demonstrated and who have been approved by HHS through an evidence review.[19] Figure 1 shows the 20 models approved by HHS as of October 2019, out of 50 models reviewed. A majority of states have selected Healthy Families America, Early Head Start-Home-based option, Nurse-Family Partnership, and/or Parents as Teacher. (2019 Home Visiting Yearbook) In some ways, these choices are related to the level evidence of effectiveness; however, states' choices also reflect: prior experience with a model, cost, name recognition, model central office support, and availability of training support.

Figure 1. Evidence-based Home Visiting Models Approved for MIECHV Federal Funding (Effective October 2019)

Prepared by Johnson Group Consulting, Inc. October 2019. Based on Home Visiting Evidence of Effectiveness (HomVEE) https://homvee.acf.hhs.gov/

Home Visiting Impact on Child Maltreatment, Positive Parenting Practices, and Health Outcomes for Mothers and Children

Decades of high-quality research has shown that home visiting can have a positive impact on child and family health and well-being.[20] Using a two-generation approach, home visiting has the potential to improve outcomes across a range of domains, such as maternal and child health, child maltreatment, child development and school readiness, positive parenting practices, and family economic self-sufficiency and well-being.[21] While not all domains have been well studied or have demonstrated improvement for each home visiting model, many positive effects have been reported. To the extent that home visiting

programs improve parent capacity to provide safety, stability, and nurturing in the home, research points to increased chances for optimal development and improved health and well-being through the life course.

Some home visiting models have demonstrated positive impact on prevention or reduction of child maltreatment (i.e., child abuse and neglect).[22] [23] Based on Johnson Group analysis of the US HHS reviews for Home Visiting Evidence of Effectivness (HomVEE), Table 1 shows a summary of the evidence for the impact of home visiting on child maltreatment for 19 federally approved models. [24] [25] (The Community-Based Family Resource and Support (CBFRS) model is not included because implementation support is not currently available.)

Of the 19 MIECHV approved models available, only 6 had primary evidence for positive impact on prevention or reduction of child abuse and neglect. In addition, Early Head Start-Home-Based Option had secondary evidence to support its role in reducing child maltreatment.

Federally Approved Home Visiting Models with Evidence of Positive Impact on Reducing Child Maltreatment (HomVEE)

- Child First®
- Early Head Start Home-Based Option (EHS-HBO)
- Early Start (New Zealand)
- Health Access Nurturing Development Services (HANDS)
- Healthy Families America®
- Nurse-Family Partnership (NFP)®
- Parents as Teachers (PAT)®

For example, research about families participating in Healthy Families America showed lower rates of substantiated child abuse and neglect for up to two years after enrollment, compared to children in a control group. This study used both parent reports and administrative data. Some other studies show small increases in reports of suspected child abuse and neglect; however, many such concerns can be resolved due to more engagement with families by home visitors and prompt preventive action.

Table 1 also shows that 12 of the 19 federally approved models (including MECSH, which is in use in Vermont) have primary or secondary evidence of improving positive parenting practices. This outcome is associated with primary prevention and reduced incidence of child maltreatment by reducing harsh discipline, encouraging parent-child interaction, and increasing parental capacity to promote child development and well-being. Improvement in parenting practices is a particular focus, goal, and success for many home visiting models.

Health is another area of emphasis. Several models give greater emphasis to improving maternal, infant, and young child health, beginning during pregnancy, and some have demonstrated greater impact on both short and long term health outcomes. [26] As shown in Table 2, among the same 19 models approved as evidence-based by the HomVEE process, 14 have demonstrated favorable outcomes in the MIECHV domains of maternal health, child health, or both. The MECSH model has shown evidence of impact on both maternal and young child health outcomes. States seeking to increase utilization of preventive services such as prenatal and postpartum care, well-child visits, immunizations, developmental screening, and maternal depression screening, as well as reduced use of emergency rooms and hospitalizations, may look to home visiting programs that have demonstrated success in increasing use of preventive services related to health and to improving health outcomes.

Table 1. Evidence of Impact on Child Maltreatment and Safety Outcomes, Select Evidence-based Models

Model	Child Maltreatment		Parenting Practices	
Position of outcome in evaluative research (primary or secondary)	Primary	Secondary	Primary	Secondary
Attachment and Biobehavioral Catch-up (ABC)	Not measured		Yes	No
Child First®	Yes		Not measured	
Early Head Start Home-Based Option (EHS-HBO)	No	Yes	Yes	Yes
Early Intervention Program for Adolescent Mothers	Not measured		No	No
Early Start (New Zealand)	Yes	Yes	Yes	
Family Check-Up®	Not measured		Yes	
Family Connects®	Not measured		No	Yes
Family Spirit®	Not measured		No	Yes
Health Access Nurturing Development Services (HANDS)	Yes		Not measured	
Healthy Beginnings	Not measured		No	Yes
Healthy Families America®	Yes	Yes	Yes	Yes
Home Instruction for Parents of Preschool Youngsters (HIPPY)®	Not measured		Yes	Yes
Maternal Early Childhood Sustained Home Visiting Program (MECSH - known as Strong Families in Vermont)	Not measured		Yes	
Maternal Infant Health Program (MIHP)	Not measured		Not measured	
Minding the Baby®	No	No	No	No
Nurse-Family Partnership (NFP)®	Yes		Yes	Yes
Parents as Teachers (PAT)®	Yes		Yes	
Play and Learning Strategies (PALS) Infant	Not measured		No	No
SafeCare Augmented®	No	No	Not measured	

Table 2. Evidence of Impact on Health Outcomes, Select Evidence-based Models

Model	Maternal Health Outcomes		Child Health Outcomes	
Position of outcome in evaluative research (primary or secondary)	Primary	Secondary	Primary	Secondary
Attachment and Biobehavioral Catch-up (ABC)	Not measured		Yes	
Child First®	Yes	Yes	Not measured	
Early Head Start Home-Based Option (EHS-HBO)	No		No	
Early Intervention Program for Adolescent Mothers	No		Yes	
Early Start (New Zealand)	No		Yes	Yes
Family Check-Up®		Yes	Not measured	
Family Connects®		Yes		Yes
Family Spirit®	Yes	Yes	Not measured	
Health Access Nurturing Development Services (HANDS)	Yes		Yes	
Healthy Beginnings		Yes	Yes	Yes
Healthy Families America®		Yes	Yes	Yes
Home Instruction for Parents of Preschool Youngsters (HIPPY)®	Not measured		Not measured	
Maternal Early Childhood Sustained Home Visiting Program (MECSH - known as Strong Families in Vermont)		Yes		Yes
Maternal Infant Health Program (MIHP)	Yes	Yes	Yes	
Minding the Baby®	Yes		Yes	
Nurse-Family Partnership (NFP)®	Yes	Yes	Yes	Yes
Parents as Teachers (PAT)®	No		No	
Play and Learning Strategies (PALS) Infant	Not measured		Not measured	
SafeCare Augmented®	Not measured		Not measured	

Vermont's Home Visiting Law and System

Vermont adopted legislation, regulation, and a manual to standardize the state's approach for administration, delivery, and coordination of home visiting and for monitoring utilization and outcomes. In 2013, Act 66—the Home Visiting Law—was passed, with regulations and a guidance manual subsequently developed. The strength of this policy framework is based upon a strong public-private partnership embodied in the Vermont Home Visiting Alliance.

Under the state's legal framework, Vermont home visiting services are defined as regular, voluntary visits with a pregnant woman or family with a young child for the purpose of providing a continuum of services designed to:

- Improve maternal and child health
- Prevent child injuries, abuse, or maltreatment
- Promote social and emotional health of children and their families
- Improve school readiness
- Reduce crime or domestic violence
- Improve parent education and economic self-sufficiency
- Enhance coordination and referrals among community resources and supports such as food, housing, and transportation

These Vermont home visiting goals align with federal MIECHV goals and benchmark areas: (1) maternal health; (2) child health; (3) child development and school readiness; (4) positive parenting practices; (5) family economic self-sufficiency; (6) reductions in child maltreatment; (7) reductions in juvenile delinquency, family violence, and crime; and (8) coordination, linkages and referrals.

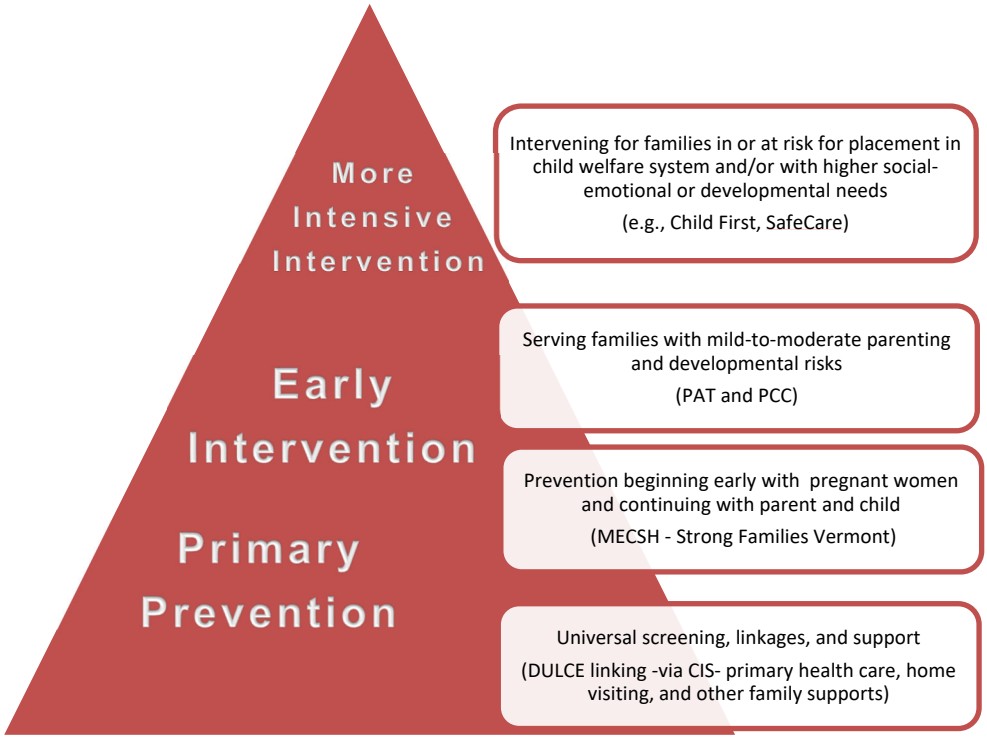
The Vermont home visiting system regulations and manual also define program qualifications. These qualifications are based on research and nationwide best practices in program implementation. Qualified home visiting programs must:

- Meet the core quality elements of home visiting programs as defined;
- Establish written protocols that describe program participation, staff qualifications, and service plans, consistent with the design of its identified home visiting program or model;
- Have experience in serving families during pregnancy and/or the early childhood years (birth to six);
- Document that staff receive training appropriate to their qualifications and the identified home visiting program or model;
- Document clinical and administrative supervision of staff; and
- Comply with reporting requirements, including program, performance, process, and outcome data submitted on an annual schedule determined by the Agency.

Figure 2 provides an illustration of the Vermont home visiting system envisioned through the recommendations of this report. It includes existing models and programs, as well as additional elements to create a fuller continuum of support. The top layer—showing more intensive services for families in or

at risk for placement in child welfare system and/or with higher social-emotional or developmental needs—is missing from the current Vermont home visiting system. While the number of families who need this more intensive intervention is small, the long term costs for taking no action are great in both human and fiscal terms. This section discusses how various models are structured and finances today, as well as how the system might be strengthened.

Figure 2. A Continuum of Support for Vermont Families with Young Children At Risk



Federally Funded Home Visiting in Vermont

Vermont currently supports three evidence-based home visiting models that are federally approved and federally funded. These are MECSH/Strong Families Vermont Nurse Home Visiting Program, Parents as Teachers, and Early Head Start-Home-Based Option.

Vermont initially used federal MIECHV funding to implement the Nurse-Family Partnership (NFP) model. This model is, however, limited to first time pregnant women who enroll early in their pregnancy, and thus is available only to a limited number of women and families. With a substantial number of families who might benefit from home visiting already having children, NFP could not reach many families. In 2018, it served just over 300 families. In addition, NFP is one of the most expensive among federally approved home visiting models on a per family basis. It was clear that another model would better use existing resources.

As a result, key staff guiding home visiting within the Agency for Human Services (i.e., Vermont Department of Health-VDH and DCF) shifted to using the **Maternal Early Childhood Sustained Home**

Visiting (MECSH). Working with the model developer, MESCH has been adapted for Vermont and rebranded as **Strong Families Vermont Home Nursing Program**. Vermont's home health agencies are the primary provider entities used for this model. This model provides access to home visiting for more families (e.g., not only those experiencing a first pregnancy), can better serve Vermont's smaller communities and rural areas, and offers state agencies the flexibility to enhance program design.

The Vermont home visiting system also has used federal funds from the US HHS Substance Abuse and Mental Health Services Administration, Project LAUNCH to support training and delivery of the evidence-based **Parents as Teachers (PAT)** model. PAT particularly promotes the optimal early development, learning, and school readiness. For Vermont, PAT was piloted at three Parent Child Centers in Chittenden County and, starting in 2016, PAT expanded to some additional sites.

The federally funded **Early Head Start-Home-Based Option** is another source of home visiting in Vermont. The program is on the federally-approved list of evidence-based home visiting models. Early Head Start is designed to support low-income families, starting prenatally and focusing on the early years, birth to 3, to promote positive parenting and child development with weekly home visits and structured playgroups.[27] While Head Start funding goes directly to community sites, without passing through state agencies, providers in Vermont have actively participated in system development. The Early Head Start-Home-Based Option home visiting community partners and service areas served are: (1) Capstone Community Action: Lamoille, Orange, and Washington Counties; (2) Champlain Valley Office Economic Opportunity: Addison, Chittenden, Franklin, and Grand Isle Counties; (3) Early Education Services-Brattleboro School District: Windham County; and (4) Northeast Kingdom Community Action: Caledonia, Essex, and Orleans Counties.

Each of these models has individual strengths and is designed to serve a slightly different population and address different risks. The Strong Families/MECSH model is designed to be delivered by nurses, who work with pregnant women and young children birth to age 2. The PAT model is primarily delivered by child development specialists and family support workers. Early Head Start uses various trained staff to serve families prenatal to 3.

Home Visiting in Children's Integrated Services (CIS) sites and Parent Child Centers

Some states, including Vermont, also use other promising, emerging, or evidence-informed models with non-MIECHV sources of funding. Vermont's robust home visiting program of the 1980s and 1990s was incorporated into the work of Children's Integrated Services (CIS) sites, including Parent Child Centers (PCCs) across the state. It continues today.

Vermont has a unique strength in the CIS structure. Developed to increase the coordination, integration and effectiveness of key programs for young children and their families, CIS became a viable approach under the Medicaid Global Commitment Waiver. This makes Vermont one of at least 20 states that are using Medicaid to finance home visiting services in some manner (e.g., waivers, state plan amendments, or under regular child benefits).

The focus of CIS is on prevention of family crises, lagging child development, mental health risks, and other conditions that affect children's health, development, and safety. CIS brought together: a) Part C Early Intervention/Family, Infant, Toddler Program (FITP), b) Healthy Babies, Kids, and Families program which provided home visiting and family support, c) Children's Upstream Services Program (CUPS) which provided community-based mental health services for young children 0-6, including direct treatment and consultation to early care and education sites, d) specialized child care, and e) other prevention and early intervention services for families with young children. CIS uses community-based teams at agencies in each of Vermont's 12 regions, a "one plan" approach, and mechanisms to maximize available funds. CIS sites maintain partnerships with other community partners, such as child welfare agencies, child care resource and referral agencies, health providers, and "designated agencies" (DAs).

Strengthening Families

Vermont has made a commitment to using Strengthening Families™ across all early childhood programs. This is a research-informed approach designed to increase family strengths, enhance child development, and reduce the likelihood of child abuse and neglect. The approach is based on engaging families, programs and communities in building five protective factors:

1. Parental resilience
2. Social connections
3. Knowledge of parenting and child development
4. Concrete support in times of need
5. Social and emotional competence of children

The Child Development Division used the Race to the Top Early Learning Challenge Grant provide Strengthening Families training and initiatives across Vermont in 2018. The approach has been used in other states across the nation as well.

The capacity of CIS to respond to family needs and risks was reduced in recent years with increases in the number of young children entering the child welfare system, increased poverty and related food and housing insecurity, the opioid epidemic, and universal developmental screening that led to identification of more children 0-3 at risk for developmental delay.

Among PCC sites, the core services include: home visiting, early childhood services, parent education, parent support groups, play groups, concrete supports, information and referral, and community development. In most regions, PCCs operate as the CIS hub. Overall PCCs reflects a commitment to family strengths, family-centered services, and family/consumer self-advocacy. With no rigid eligibility criteria, bundled funding, and a non-categorical approach, PCCs offer coordinated and integrated services sufficiently flexible to address an array of family needs. PCCs applied to the Vermont Agency of Human Services in 2018 to become an approved home visiting program under state law, regulations, and guidelines.

The PCC home visiting approach is grounded in several bodies of research related to child and family development, family support, and services to low-income families with risks. For example, the following five areas of research provide evidence to inform the PCC home visiting approach.

- Research on effective elements of home visiting [28] [29] [30]
- Strengthening Families approach[31], including to: focus on protective and promotive factors, recognize and support parents as decision-makers and leaders, value the culture and unique assets of each family, and be mutually responsible for better outcomes.
- Science of resilience and how to enhance it among individuals and communities [32]
- Research on effective interventions to improve parenting in early childhood [33] [34]
- Science on early child and family development [35] [36]
- Research on care coordination and case management for families in Medicaid [37] [38]

The PCC home visiting approach is consistent with what is done under Medicaid case management and targeted case management. Federal regulations define case management services to include four categories: 1) assessment (and periodic reassessment) to determine needs; 2) care plan development (and periodic revision) based on the information collected through the assessment, with specific goals and actions; 3) referrals and related activities to help individuals obtain needed services, which include activities that help link the eligible individual with medical, social, educational providers, or other programs and services that are capable of providing needed services (e.g., making referrals to providers for needed services and scheduling appointments for the individual); and 4) monitoring and follow up activities needed to ensure that the care plan is effectively implemented, which includes contacts with the individual, their family, and other providers as necessary and appropriate. About a dozen states use the Medicaid targeted case management benefit to finance home visiting including select evidence-based models.

Universal Screening and Response related to Social Risks and Needs

A growing number of organizations and experts recommend screening for social determinants of health (SDOH). For young children, this involves assessing the child and family risks and needs and engaging the parents/caregivers in appropriate responses.[39] National and expert recommendations call for SDOH screening in the primary health care settings—particularly in the medical home.[40] [41] [42]

Project DULCE (Developmental Understanding and Legal Collaboration for Everyone) introduces a Strengthening Families approach into the pediatric primary care setting to help build protective factors and mitigate the impact of adverse experiences. DULCE reaches families with infants 0-6 months where they bring their babies for health care. It is "universal" in the sense that all families with a newborn baby in a primary care practice or clinic with DULCE are invited to participate. Using a trained family specialist, the approach bolsters family strengths through structured coaching for parents on infant development and proactively detecting and addressing negative social determinants of health (e.g., inadequate housing, food, transportation, safety).

The model is grounded in a randomized controlled trial conducted at Boston Medical Center. In that study, families received all recommended visits, 75% received them on time, and 95% of those visits were high quality, family-centered experiences. DULCE has achieved high rates of screening for and responses to maternal depression and interpersonal violence. In addition, DULCE accelerates access to concrete supports (e.g., housing, food, employment). The rate of acceptance and participation by families is high – more than 80%. A national study of potential cost impact for Medicaid found that it could achieve savings of at least 3:1 by reducing emergency room visits, improving child health, addressing maternal depression, decreasing unintended pregnancies, and other impacts.

The Lamoille Family Center (a Parent Child Center) is one of six sites nationwide replicating this evidence based approach in Appleseed Pediatrics, Lamoille County. A full-time, trained family specialist at the Lamoille Family Center provides support to families with infants in the pediatric office during routine health care visits. The family specialist also offers home visits, telephone, email and text-messaging support. The annual cost for one clinic site is approximately $110,000 and the service was offered to 150 newborns and their families annually at a cost of $733 per family. The Vermont DULCE Implementation Team includes: Scott Johnson, the former Executive Director of Lamoille Family Center

and current advisor to the DULCE national office, Breena Holmes, MD, Director of Maternal Child Health at VDH, Wendy Davis MD, FAAP, a Professor of Pediatrics at the University of Vermont College of Medicine and Vermont Child Health Improvement (VCHIP), and Floyd Nease, Executive Director of Lamoille Family Center. Together, they are working with other leaders and key stakeholders to expand DULCE across the state of Vermont, reaching at least 25% of the state's newborns across 10 or more pediatric practices in the next three years. With a commitment and resources from OneCare, three new sites are being developed in 2019. With expansion statewide, DULCE could become a universal access point to reach newborns and their families early, which DULCE does by transforming the pediatric home into a space that screens families for social determinants of health, then referring and connecting families to appropriate social services in the community. With 5,700 births statewide annually, serving 1,400 babies would allow them to reach 25% of the state's newborns per year at an approximate cost of $1.5 million. [43]

In addition, Vermont has structured responses to other child development risks. For example, based on a systems model used across the country, Help Me Grow Vermont is a system model for improving access to existing resources and services for expectant parents and families with young children through age eight. Help Me Grow promotes the healthy development of children by supporting families, providers and communities to identify vulnerable children and link families to community-based programs and services. Under the Help Me Grow umbrella, Vermont has developed one of the best approaches for measuring early childhood developmental risks. The Developmental Screening Registry, as part of the Help Me Grow approach, helps to ensure all children get recommended, valid developmental screening, as well as helps to ensure that families receive the follow-up support and services needed. Each of these and others dovetail with CIS and could fit readily with DULCE.

Serving Families at Higher Risk

Vermont has an opportunity to add a home visiting model designed for and studied with families who are at risk of or have confirmed child maltreatment, substance abuse, or other severe family risks. Past studies suggest that families with more severe risks are less likely to continue or complete services under other home visiting models.

Vermont's current system lacks a model that could serve the smaller number of families with higher risks for risks related to child protection and behavioral health. In particular, the state should consider adopting Child First or SafeCare as an additional model to extend the continuum of the home visiting system. Either might be added as a component of CIS, a freestanding approach, or training for existing home visitors. Both have demonstrated positive impact on child and family well-being.

Implementation of an additional model would require new resources—funding direct services, training, data, and management. Additional funds might come from federal and/or state allocations. For example, either of the proposed models could be financed with additional federal funds from: child welfare, TANF, Medicaid, or MIECHV. As with implementation of other models, collaboration between DCF and VDH would help to ensure that a new model would be well integrated into the Vermont home visiting system (e.g., central intake, CIS roles, referral patterns, workforce development, data collection, quality monitoring, and evaluation). (Note that MIECHV requires action across all of these implementation and

system elements). Implementation science in general and studies specifically related to home visiting show that achieving results requires training, supervision, oversight, and systems approaches.[44] [45] [46] [47] [48]

- **Child First** intervenes with vulnerable young children and families at the earliest possible time to prevent and treat the effects of trauma and adversity. The goal is to decrease the incidence of abuse and neglect, emotional and behavioral disturbance, and developmental problems among high-risk young children and their families. Child First is designed to serve pregnant women and families with children from birth through age 5 in which: (a) children have emotional, behavioral, or developmental challenges; or (b) the family faces multiple environmental and psychosocial challenges such as maternal depression, domestic violence, substance abuse, homelessness, or abuse and neglect. A mental health/developmental clinician and a care coordinator work as a team to provide services that include a comprehensive assessment of child and family needs, observation and consultation in early care and education settings, a family and child plan of care, a parent-child mental health intervention, and care coordination. The period of service typically lasts 6 to 12 months, depending on a family's needs. During the first month, the clinician and care coordinator conduct joint home visits twice per week, and thereafter visits occur either separately or jointly and at least weekly. The care coordinator provides intensive support during home visits to connect the family to comprehensive community-based services and supports and addresses barriers to access. The care coordinator generally aims to build parents' capacity for executive functioning through goal setting, planning, prioritizing, and revising; and by connecting families to resources. A randomized controlled trial study showed that Child First significantly reduced the percentage of parents with child protective services involvement at any time from baseline engagement to 3 years later (based on parent reports and child welfare administrative records). [49] [50] [51] Child First is currently studying how the model can be used for in-home support to infants with neonatal abstinence syndrome and their caregivers.
- **SafeCare** aims to prevent and address factors associated with child abuse and neglect among the clients served. SafeCare is a structured parenting intervention that is designed to address the behaviors that can lead to child neglect and abuse. The model is designed for families with a history of child maltreatment or risk factors for child maltreatment, including young parents; parents with multiple children; parents with a history of depression or other mental health problems, substance use, or intellectual disabilities; foster parents; parents being reunified with their children; parents recently released from incarceration; and parents with a history of domestic violence or intimate partner violence. The model also serves parents of children with developmental or physical disabilities, or mental health, emotional, or behavioral issues. SafeCare is intended to complement the more specialized intervention services these families might be receiving from other agencies. SafeCare is an adaptation of Project 12-Ways. SafeCare was developed to offer a more easily disseminated and streamlined intervention to parents at risk for child abuse and neglect, based on three key modules from Project 12-Ways. SafeCare typically provides 18 to 22 weeks of training to parents with children from birth to age 5. Trained home visitors conduct 50- to 90-minute weekly or biweekly home visits. An adaptation of SafeCare, called SafeCare Augmented, meets the criteria established by the US HHS HomVEE for an

evidence-based early childhood home visiting service delivery model under MIECHV. Unlike some models, SafeCare has been studied with rural families.[52] [53] [54]

In addition, home visiting may help Vermont respond to the opioid crisis. The National Institute on Drug Abuse (NIDA NIH HHS) estimates that every 15 minutes, a baby is born suffering from opioid withdrawal.[55] Vermont is one of the states hardest hit by the opioid epidemic. Too many of our families, and particularly young children, are affected by opioid use disorder (OUD). Home visiting programs have a role in the continuum of support, from prevention to treatment. First and foremost, home visitors provide caring relationships, parenting guidance, and connections to the services that many pregnant women and families with newborns need. They also educate women about the effects of substance use during pregnancy, support caregivers in entering treatment programs, help to prevent opioid misuse among other household members, and support mothers in caring for babies who may be experiencing neonatal abstinence syndrome (NAS). Home visitors trained in trauma-informed approaches and supported through reflective supervision are key members of the care team. Connecting mental health and home visiting approaches can also make a difference.[56] [57]

The following examples show how some states are connecting home visiting programs with efforts to combat the opioid epidemic among families, particularly pregnant women and infants.[58]

- In Maine, the Department of Health and Human Services' Office of Children and Family Services, the Maine Center for Disease Control & Prevention, and the Maine Families Home Visiting Program joined forces to extend the Bridging Program statewide. The Bridging Program is designed to increase communication and break down agency silos in order to provide connections to services as early as possible. As part of this effort, home visitors across the state—along with staff from child protective services and maternal and child health nursing—are being trained. In addition, the PAT model has been tailored to better service families with high needs and risks such as substance use.
- An Early Head Start-Home-Based Option site located in New Bedford, Massachusetts provides home visiting services to families, with a primary focus on families of infants born with NAS and families affected by child abuse and neglect. Home visiting program staff will work with the local birthing hospital to meet families of infants born with NAS in the immediate postpartum period and prioritize their entry into the program.
- In West Virginia, a partnership was developed with a behavioral health call center to support home visitors with secondary traumatic stress. Home visitors can call the helpline for an initial 20-minute discussion; resources or referrals are provided as needed for future support. In addition, call center staff provide training on substance misuse and secondary traumatic stress at home visiting staff meetings.

Conclusions and Recommendations

As strong as the Vermont home visiting system design and activities are, more can be done. The National Home Visiting Yearbook estimates unmet need for home visiting for all states, based on Census data related to risks such as families with: parents without a high school diploma, single parents, teen mothers, infants, and/or low income. In Vermont, they estimated that in 2018, more than 29,00 pregnant women and families with children under 6 years old not yet in kindergarten who could benefit from home visiting. These families included 36,100 children.[59]

Based on review of models, the Vermont home visiting system, and existing capacity for improving the safety, stability, and nurturing environments for our youngest children, Johnson Group makes the following conclusions and recommendations.

1. Vermont has designed a strong home visiting system which relies upon a strong policy framework (i.e., statute, rules, and guidance manual), mixed funding, several models, and public-private partnerships. This is a strong basis on which to continue to build and strengthen the home visiting system. The state should continue to convene the Vermont Home Visiting Alliance. Without using large amounts of state revenue, our state has among the strongest home visiting systems in the nation.
2. Some home visiting models show greater effectiveness in preventing and reducing child maltreatment. A review of the evidence points to variation in impact on this one area of risk. Several models, however, show impact across domains of child maltreatment, health, child development, and family security. In particular, six (6) home visiting models have shown through strong research methods that they can have impact on reducing child maltreatment. Vermont is not currently using the strongest models for this purpose.
3. Currently, three evidence-based home visiting models and one evidence-informed approach are in use in Vermont. Those federally approved as evidence-based are: a) Early Head Start-Home-based Option; b) Maternal Early Childhood Sustained Home Visiting (MESCH) which is branded in Vermont as the Strong Families Vermont Home Nursing Program; and c) Parents as Teachers (PAT). In addition, the Parent Child Centers have received approval for their evidence-informed model, unique to Vermont. Continuing support for these four approaches lays a foundation for prevention and early intervention and each plays a role in the continuum of services and supports for families with young children at risk.
4. Vermont could benefit from implementation of an additional model with evidence of effectiveness for intervening when families are at risk of child welfare placement or have mental/behavioral risks. Key evidence-based models include Child First and SafeCare. This could be done using federal funds from: child welfare, ANF, Medicaid, and/or MIECHV. Additional state general funds could support elements outside of federal "siloed" funding. Implementation of an additional model would require new resources—funding direct services, training, data, and management. Funds might come from federal and/or state allocations.
5. Vermont should continue to use and strengthen the Children's Integrated Services (CIS) system, particularly Parent Child Centers, provides a community-based, multi-faceted response when risks and needs are identified. This is a resource unique to Vermont which has adapted to changes in social

risk, poverty, and other demographic trends, as well as the emerging evidence about what works in serving families with young children at risk. CIS local sites form a source of central intake and referral, community-team-based response, and anchor for universal screening as well as home visiting and other responses to family risks. Continuing and increasing state investment in CIS and Parent Child Centers will maintain this family support resource.

6. Vermont has an opportunity to offer "universal" screening and support to families with new babies using DULCE in pediatric primary care practices and clinics across the state. Given that 95% of families with infants visit a pediatric primary health provider (e.g., pediatrician, family physician, nurse practitioner in private practice or a publicly funded health center/clinic), using the DULCE program as the "universal" approach to screen for social risks and respond to concrete needs is a sound approach. DULCE, in combination with CIS and Parent Child Centers creates a way to universally identify risks and use community based strategies—including home visiting—to respond. The planning for statewide expansion is underway and there is an opportunity for a strong public-private partnership at the state and local levels to support this effort.

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