

TABLE 7

VA Home Visiting Programs Compared by Program Characteristics

Criteria	Resource Mothers	Project Link	Baby Care MICC	Healthy Start	CHIP of Virginia	Early Childhood Special Education	Head Start/Early Head Start	Early Intervention Part C	Healthy Families
Target Population	Pregnant and parenting teenagers 19 years and under	Pregnant parenting and "at risk" substance using women	Medicaid eligible pregnant women or infants up to two years of age.	Pregnant teens and women, interconceptional teens and women, high risk infants living in communities with high infant mortality, poverty, teen pregnancy and fetal deaths	Pregnant woman or family with at least one child under the age of 6 with family below 200% of poverty, residing in a community with CHIP services.	Children age two by Sept. 30 through age five with an identified disability	Children Ages: Early Head Start (EHS): 0 – 3 years old Head Start (HS): 3 – 5 years old	Infants and toddlers, birth through 2 who meet Virginia's Part C definition of eligibility, i.e. diagnosed handicapping condition, or 25 % delay in one or more developmental areas, or a typical development	Pregnant women and new parents with children under 3 months age
Enrollment Criteria (Mother/Parent)	Pregnant Teen living in locality served. Preference given to first-time pregnant teen with little social support	Woman requested/ referred for treatment Requires SA TX or has been affected by family /partners SA	Pregnant woman =identified with at least 1 risk factor as defined by Medicaid Risk Screen criteria	Resident of Norfolk, Petersburg, or Westmoreland County, preference given to medium and high risk applicants (medical, nutritional, lifestyle, economic, environmental and social risks)	Under 200% of poverty and Pregnant or has a child under the age of 6 and Lives in a community with CHIP services	NA	Income eligible	Part C services are voluntary and there are no specific enrollment criteria for parents. Referrals to the Part C system are usually made by physicians, other primary referral sources, family members, relatives, etc.	Assessment process, based on validated survey, determines level of services needed. Parents with few risk factors receive referral and educational materials. Parents with multiple risk factors are offered voluntary home visiting.
Enrollment Criteria (Child)	NA	Child is/has been affected by caregiver's substance use	Infant under age 2 with at least 1 risk identified as defined by Medicaid Risk Screen criteria	Infant born to enrollee and infants with medium to high risk conditions (residency requirement as described in mother/parent)	Child under the age of 6 with family below 200% of poverty (or Pregnant women) in a community with CHIP services.	Child must be found eligible for educational services due to an identified disability (Part B, Section 619, Individuals with Disabilities Education Act – IDEA)	Age appropriate	The child must meet Virginia's Part C definition of eligibility as described above.	Enrollment based on parent criteria and either prenatal stage or under 3 months of age
Families/ Children Served	Annually approximately 2400 teen mothers and their families (includes own parents and partner)	SFY 2004: (8 sites/14 CSBs) 1000 women assessed; 700 enrolled women and 1151 non enrolled women were served 823 children served	Virginia residents who are enrolled in Medicaid and where BabyCare providers are available	500 to 600 program participants (pregnant women/teens, interconceptional women/teens and their infants) and infants/toddlers with high risk conditions	3070 Families; 4330 children; 465 pregnant women served in 2006	Children age two by Sept. 30 through age five with an identified disability Approx. 15,000 per year	HS – 14,448 EHS – 1,648 Pregnant Women – 171	A total of 10,704 infants, toddlers and families received Part C early intervention services in 2006.	Over 4500 families/year – home visiting; 3515 families- assessment service (2006)
Home Agency	17 health districts and 8 private agencies <i>State offices: Virginia Department of Health (VDH)</i>	8 CSBs (see below) <i>State office: Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)</i>	As applicable to health departments and CHIP agencies; managed care organizations provide similar services under Medicaid contract <i>State office: Department of Medical Assistance Services (DMAS)</i>	Local offices: 2 local health districts and one medical school <i>State office: Virginia Department of Health VDH</i>	Local programs: health depts., other child serving non-profits, community health center, independent 501(c)3 <i>State office: CHIP of Virginia (CHIP-VA)</i>	Local school divisions <i>State office: Department. of Education (DOE)</i>	24 Community Action Agencies 41 School System, Private/Public Non-Profit, Gov't Agency	32 of the local lead agencies are Community Services Boards (CSBs); 4 local lead agencies are universities (JMU, VCU, Radford, and Longwood); 2 local lead agencies are local school divisions; 2 are local governments; and 2 are local health departments. <i>State offices: Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)</i>	Health Departments, Community Service Boards, Family and Children Service Agency, Hospitals, Department of Social Services for majority <i>State office: partnership between VA Department of Social Services (VDSS) and Prevent Child Abuse Virginia (PCAV)</i>

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Goals	<p>Improve birth outcomes for the mother and the infant</p> <ol style="list-style-type: none"> Decrease low weight births Decrease infant mortality Early entry into prenatal care Smoking cessation Avoidance of alcohol and drugs Increased breastfeeding rates and length of continuation Screen and refer for perinatal depression Up-to-date immunizations and health care visits for mother Up-to-date immunizations and health care visits for infant Stay in school until graduate from high school or have job Delay repeat pregnancy until adulthood 	<p>Enhance substance abuse treatment services to address the multiple needs of women.</p> <ol style="list-style-type: none"> Provide intensive case management services to assess & link substance-using women of child-bearing age with available community resources. Utilize innovative and creative approaches to overcome barriers to services Enhance community services Provide on-going consultation, technical assistance, and training to providers Educate women re: risks of perinatal substance use & available community resources Provide prevention services, outreach and public education. 	<p>Improve birth outcomes</p>	<p>Through community-driven initiatives, reduce the rate of infant mortality and improve perinatal outcomes in high-risk communities</p>	<p>To ensure that children in low-income families receive consistent, quality health care beginning with prenatal care.</p> <p>To provide a family centered case management system that fosters health, stability, good parenting & self-sufficiency.</p>	<p>Improve functional abilities of the child in a variety of settings. This goal is based on the individual's strengths and needs. It is also comparing the child with same-age, typically developing peers.</p>	<p>The Head Start program provides grants to local public and private non-profit and for-profit agencies to provide comprehensive child development services to economically disadvantaged children and families, with a special focus on helping preschoolers develop the early reading and math skills they need to be successful in school.</p> <p>HS/EHS programs promote school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social and other services to enrolled children and families.</p> <p>They engage parents in their children's learning and help them in making progress toward their educational, literacy and employment goals.</p>	<p>System goals include ensuring that all potentially eligible children are identified and served.</p>	<ol style="list-style-type: none"> Systematically reach out to all parents to offer resources and support based on their strengths and individual circumstances. Cultivate the growth of nurturing, responsive parent child relationships. Promote healthy childhood growth and development Build foundations for strong family functioning Prevent child abuse and neglect
Geography	79 localities (see supplemental list for detail)	30 sites serving 14 CSBs (see below)	60 active providers	(4) Norfolk, Petersburg, Westmoreland County and Richmond City	30 sites serving 30 localities	All school divisions	HS programs-nearly all localities (4 regions) 11 EHS programs	Virginia's Part C program is statewide. There are 40 central points of entry and 40 local early intervention systems.	87 Virginia localities served by 38 programs
Cross Program Partnerships	In some sites, collaborate with HF and CHIP programs to assess for intake into appropriate program, WIC, Family Planning, school system, health care providers	LINK partners with other community based programs to provide comprehensive treatment & support services	BabyCare providers currently include health departments, CHIP agencies and private home health agency. Medicaid Managed Care organizations provide similar services	Healthy Families, CHIP, BabyCare, WIC Program, Family Planning Program, other health department programs, Medicaid, Early Intervention	Depending on locality: Healthy Families, Resource Mothers, Early Intervention, Early Head Start, Head Start, Baby Care, Hospitals	Services may be provided in a community setting (preschool, daycare). Work with Part C to transition eligible children into the school program. Referrals to DSS, CPS, health depts., community preschools and daycares	Some programs collaborate with state-funded pre-k programs (VPI/Title 1) and local child care centers. Head Start has received federal funding to support single-point of entry recruitment/enrollment to assist programs with collaborative efforts. Collaboration also exists between Head Start and local LEAs to provide special needs services. Resource Mothers, CHIP-VA, Healthy Families	Virginia's Part C early intervention program is a statewide system of state and local partnerships of early intervention services to meet the needs of infants and toddlers with disabilities.	Depending on locality: CHIP, Resource Mothers, Early Intervention, Community Service Boards, Baby Care, Early Head Start. "Initiative" concept (active role in collaboration with other agencies) is part of the model
Curriculum Used	<ol style="list-style-type: none"> Florida State Center for Prevention and Early Intervention "Partnering for a Healthy Baby" (4 vol) Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, & Bright Futures Practice Guides on Nutrition, Physical Activity, Oral Health, and Mental Health Project Assist or other smoking cessation curriculum 	No standardized curriculum; consumer driven services are based on individualized treatment plan		<ol style="list-style-type: none"> HRSA- <i>Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents</i>, & Bright Futures Practice Guides on Nutrition, Physical Activity, Oral Health, and Mental Health ACOG/AAP - <i>Guidelines for Perinatal Care</i>, 5th Edition VDH - <i>Maternity Guidelines</i> (2004) IOM - <i>Nutrition during Pregnancy, Nutrition during Lactation</i> VDH - <i>Case Management Manual</i> (2005) Florida State University - <i>Partners for a Healthy Baby</i> 	<i>Bright Futures Guidelines</i> , Parents as Teachers, Some sites use Beginning Guides	Varies from locality to locality Carolina HELP High Scope Creative Curriculum LAP Brigrance Locally developed program	Creative Curriculum/High Scope Curriculum	The Early Intervention system uses a variety of assessment tools to determine eligibility. Assessment of a child's progress is on-going and specific interventions are based on the individualized needs of the child and the family's priorities, concerns, and resources.	Parents as Teachers, Partners for a Healthy Baby, <i>Bright Futures Guidelines</i> , Healthy Families San Angelo (English and Spanish), MotherNet Home Visitors Handbook, Comenzando Bien
Length of Services	Prenatal through infant's first birthday	Pregnancy and as long as mother and child need services	Maternity up to 60 days postpartum. Infants up to age 2.	Pregnancy and through the interconceptional period until the child is 2 years of age	Unlimited as long as 1 child under the age of 6 is in the household; average is 2 years	From time of eligibility to dismissal from special education services or transition to kindergarten	HS – 1 to 2 years EHS – 0 to 3 years	Services are usually provided until the child's second birthday although families may opt to remain in Part C until the child turns three.	Prenatal to age 3-5 for child

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Outcomes Measures	Improved outcomes among program participants compared to local teens on a. LWB b. Infant Mortality c. Participants' repeat pregnancy d. Immunization up-to-date e. Enrolled in WIC and Medicaid f. Mother in school or work by infant's first birthday h. Breastfeeding durations i. referrals completed j. smoking cessation k. Delay repeat pregnancy until able to provide stable home.	*newborns achieve healthy birth wt * postpartum hosp referrals engaged in Tx	Currently being determined	a. Infant mortality b. Low weight births c. Early entry into prenatal care d. Ongoing source of medical care for women e. Medical home for infants and children including up-to-date immunizations f. Cultural competence of health care providers g. Family involvement in program. h. Reduction of risk factors	a. health insurance b. medical home c. dental home d. dental varnish application e. immunizations up to date or on track f. birth spacing g. birth weight h. gestation i. disease mgmt j. family mobility k. parent's education l. parent's employment m. child care enrollment n. literacy/reading encouragement o. developmental assessment/delay	Individual's developmental skills and readiness for school age programs improve compared to themselves. Beginning 2008 – measure children's progress in 3 functional outcome areas (social-emotional skills, skills and knowledge, getting needs and wants met) compared to same age, typically developing peers and/or to themselves. Measures – IEP goal attainment, family input, standardized and criterion based assessments, clinical judgment and observation, input from others that the child interacts with throughout the day. Decided by IEP team and locality.	Children achieve improved language and problem solving skills. Parents receive support and understanding that everyday routines provide the context for learning and development. *Head Start children demonstrate improved emergent, literacy, numeracy and language skills. *Head Start children demonstrate improved general cognitive skills. *Head Start children demonstrate improved gross and fine motor skills. *Head Start children demonstrate improved positive attitudes toward learning. *Head Start children demonstrate improved social behavior and emotional well-being. *Head Start children demonstrate improved physical health.	Child outcomes include measuring progress of infants and toddlers who reach or maintain functioning compared to their peers around positive social emotional skills, acquisition and use of knowledge and skills and use of appropriate behaviors to meet their needs.	<u>Maternal and child health:</u> - prenatal care visits - a primary health care provider within two months of enrollment - Low birth weight - up to date with mmunizations - no subsequent births or have an interval of at least 24 months before subsequent birth <u>Child Development</u> - screened for developmental delay at least semi-annually - appropriate early intervention - monitored for receipt of services <u>Parent Child Interaction</u> - demonstrate an acceptable level of positive parent-child interactions or show improvement - optimal home environment to support child development or will show improvement <u>Abuse and Neglect</u> - founded reports of CAN while enrolled
Staffing	Community health workers supervised by coordinator who is a social worker, nurses, health educator or maternal child health care provider	<u>Varies by site</u> At least 1 Full time MA/MSW/RN/BSW and 1 PT/FT case manager. CSB may provide additional staff.	RN, BSW or MSW with at least one year experience working in community health setting with maternal/child health	Registered Nurse, Registered Dietitian or Nutritionist, Resource Mothers Coordinator, Resource Mothers community health workers	Community Health Worker/ RN teams; some sites have LCSWs on staff; administrative staff varies by site	Licensed Early Childhood Special Education teacher, paraprofessional, related services therapists	HS/EHS Programs: 102 Home Visitors 22 Home-Based Supervisors	Each local early intervention system either provides services directly or contracts with a sufficient number of providers to ensure that services are available to eligible children.	Varies by site. Most teams of home visitors headed by supervisor with social work or nursing degree. 90% of staff have some college and 38% have 4 year degrees; staff hired for combination of personal qualities, knowledge, education and experience

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<p>Services Description</p>	<p>Weekly contacts to provide education on pregnancy and child development, problem-solving, mentoring support and referral to local community services. Screen for perinatal depression</p>	<p>Services vary by site depending on funding & community need. All provide intensive case management (office/ home visit/ phone contact) and support services. Some offer SA treatment, parenting and other psycho-educational groups, emergency housing etc</p>	<p>Minimum face-to-face contact to open and at least one collateral contact per month, more depending on need and face-to-face depending on need.</p>	<p>Outreach and Client Recruitment, Case Management, Health Education, Interconceptional Care, Perinatal Depression Screening and Referral. Staff makes weekly, bimonthly or monthly case management visits to program participants dependent upon their risk level. Screening for risk factors, health education and anticipatory guidance. Nursing case management. Medical Nutrition Therapy. Community health workers provide support.</p>	<p>Screening, Assessment and Planning: Services to assess family and child strengths and needs, leading to the development of family service plans. Assessments include child health, development, and safety; family wellness and stability; parent work experience and employability.</p> <p>Education and Support: Services to assist parents in acquiring parenting skills, learning about growth and development, promoting the health and well-being of their families, and increasing self-sufficiency.</p> <p>Follow-Up: Activities to ensure that necessary services are received by families, and are effective in meeting their needs.</p> <p>Referral and Outreach: Services that link families to available community resources and ensure connection to appropriate community agencies.</p>	<p>Education, speech, occupational therapy, physical therapy services (based on child's individual need) provided in a variety of settings – school based classroom (self-contained classes across programs – Head start, Title I preschool, VPI programs), community settings (preschools, daycares, home child care, home). Home visits/parent education is often in addition to these other services.</p>	<p>HS/EHSGrantees implementing a home-based program option must:</p> <p>Provide one home visit per week per family (a minimum of 32 home visits per year) lasting for a minimum of 1 and ½ hours each. Provide, at a minimum, two group socialization activities per month for each child (a minimum of 16 group socialization activities each year).</p> <p>Collaborate with Medical or social service appointments.</p> <p>Maintain an average caseload of 10 to 12 families per home visitor with a maximum of 12 families for any individual home visitor.</p> <p>Plan and develop with the parents an individualized program for the family and partnership agreement.</p> <p>Work with families to conduct developmental screening, ongoing assessment and evaluation of the children.</p>	<p>Part C Services include assistive technology and services, evaluation and assessment, family training and counseling, home visits, health, nursing, nutrition, occupational therapy, physical therapy, psychology, service coordination, social work, special instruction, speech language pathology services, vision, and audiology</p>	<p>Family needs assessment. Weekly home visits by family support specialist to provide parenting/child development/health information, parent support and goal-setting, community resource referral and follow up, linkage to medical provider, Developmental screening and referral if needed. Ancillary services such as parenting groups, fatherhood services</p>
<p>Fees Charged to Family</p>	<p>None</p>	<p>None</p>	<p>None</p>	<p>None</p>	<p>None</p>	<p>None</p>	<p>None</p>	<p>Most early intervention services are covered by third party payors such as private insurance or Medicaid. Family fees are determined by the family's taxable income and the size of the family and are capped</p>	<p>None</p>
<p>Staff Preparation and Training</p>	<p>Orientation to local agency and local health services; Training on Florida State Curriculum State-sponsored regional trainings on key topics. Bright Futures Guidelines. Smoking Cessation, Edinburgh Screen</p>	<p>The LINK Coordinators are certified/licensed master levels clinicians or have commensurate experience. State sponsored attendance at the Virginia Summer Institute for Addiction Services (VSIA) 2005, 2006 & 2007</p>	<p>None</p>	<p>Orientation to local agency, local health services and community resources. Training on Bright Futures guidelines, Florida State University Curriculum, screening for risk factors including perinatal depression, topics related to prevention of infant mortality and low birth weight. Trainings sponsored by National Healthy Start, the Virginia Healthy Start Initiative, and the Regional Perinatal Councils on key topics.</p>	<p>5 days core training; 3 days prenatal care training; 6 days PAT training, ongoing workshops</p>	<p>College degree and state agency licensing (VDOE, VDH) On-going staff development provided by local school divisions, state training and technical assistance centers (T/TAC) located at universities throughout the state, and VDOE activities around key topics and teacher individual requests</p>	<p>Home visitors must have knowledge and experience in child development and early childhood education; the principles of child health, safety, and nutrition, adult learning principles; and family dynamics. Degree requirements vary among programs. Performance standards require programs to provide ongoing training and professional development.</p>	<p>Each Part provider must meet the highest standard in their discipline and meet Part C requirements for participating in evaluation and assessment, teaming, and plan of care development.</p>	<p>Week long training specific to role; orientation training and wraparound training in first year on over 17 topics; ongoing training requirements</p>
<p>Accreditation</p>	<p>NA Performance standards, but no official accreditation process</p>	<p>NA Performance standards, but no official accreditation process</p>	<p>NA Performance standards, but no official accreditation process</p>	<p>NA Performance standards, but no official accreditation process</p>	<p>NA Performance standards and outcome based funding, but no official accreditation process</p>	<p>NA Performance standards, but no official accreditation process</p>	<p>NA Performance standards, but no official accreditation process</p>	<p>There are no accreditation standards however local early intervention systems must comply with federal and state regulations and requirements</p>	<p>National accreditation process through Healthy Families America or the Council on Accreditation. Sites eligible following 3rd year of service; accreditation renewed every four years.</p>