From the President

Reflections on Home Visiting

By Phyllis J. Sloyer, RN, PhD, FAHM, FAAP

The appropriated dollars for home visiting are probably the largest increase the Title V program has received since its inception. It is remarkable that very little attention was given to it as national health reform legislation moved to a final bill for signature by President Obama. While novices may think this is a strong statement about preventive health services and early intervention services for young children, it is in fact another evolution of home visiting since the formation of the United States. I expect that you will learn a lot about this initiative in this issue of Pulse. Therefore, I am not going to reiterate the provisions of the legislation, but rather trace the origins of home visiting so that you recognize the cyclical and incremental nature of public policy. I am especially grateful to the Minnesota Department of Health for an outstanding summary of the history of home visiting legislation.

Home visiting began in the colonial history of the United States to take care of the poor at home and was strongly influenced by our British ancestors and the legacy of providing help to orphaned or neglected children. We can’t forget Florence Nightingale’s legacy of training nurses in home care skills. In the mid 1800s the nurses were known as district or friendly visitors. The Mary Ellen Wilson story in 1874 changed the course of child abuse prevention and intervention services to children. Mary Ellen was an 8-year-old child abused by her adoptive parents. It is also interesting that until 1874, our nation had a Society for the
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Reflections on Home Visiting

Prevention of Cruelty to Animals, but not for children. As we leave the 19th century, we enter the Progressive Era and the beginning of the family support movement stimulated, in part, by immigration, poverty, urbanization and other social and environmental issues.

At the dawn of the 20th century, public policy promoted an increase in a variety of home visitors, representing education, nursing, social services, and churches. President Theodore Roosevelt conducted the First White House Conference on Children and laws were created that recognized the home as the best place for serving families. Now we jump forward to 1935 and the enactment of the Social Security Act, specifically Title V. The federal law created programs for women and children, including handicapped children. Later, we learn that Title V had specific language in it relating to home visiting.

Historians note that the modern home visiting programs began as part of the War on Poverty in the 1960s. Notably, early childhood and child development research provided the evidence that the first five years of life were the formative and critical years of intellectual development. Home visiting was focused on supporting family and child development. These programs continued through the 1960s and 1970s through maternal and child health programs, Head Start and other models that brought family support programs to homes. In the mid 1970s, two landmark pieces of federal legislation offered other opportunities for home visiting: Child Abuse and Prevention Treatment Act and the Education of All Handicapped Children Act. Both of these bills offered funds for home visiting services.

In the latter part of the 20th century, Healthy Start was added to Title V of the Social Security Act in recognition of the need to reduce infant mortality and promote early entry into prenatal care. Many Healthy Start programs offered home visiting as a service approach to meet their objectives. In this issue of Pulse you will read about evidence-based models and best practices used to achieve several objectives relating to the reduction of infant mortality, child abuse or delayed growth and development.

Needless to say, throughout history our nation has used home visiting as a strategy to support families and improve the health and development of young children. Home visiting has had a home in multiple agencies and certain practices have been proven to be effective. At the dawn of the 21st century, we witness landmark national health reform legislation and it should be of no surprise to anyone that home visiting is a part of the legislation, given its origins and emphasis on young children and families. However, it is not a service to be owned by any one agency, but rather a service that begs for collaboration, careful planning, effective strategies and is subject to sound performance measures. At the end of the day, all that matters is how we support and strengthen future generations.
One of my favorite movies of the early 1980s is “Back to the Future.” I think most of you know the story in which Michael J. Fox’s character Marty McFly is transported to the past via an extraordinarily complicated and ridiculously tricked-out DeLorean created by the crazy Dr. Emmett Brown. Hilarious antics follow but the irony of the movie’s title is another key part of the movie. I have been thinking about the notion of “going back to the future” a lot lately. Last month I presented at the inaugural MCH Public Health Leadership Institute in Chapel Hill, N.C. I was asked to speak on the “future of MCH” and had a great time putting that presentation together and talking with a group of talented MCH leaders about the various trends and issues we can anticipate influencing MCH practice in the future. An important part of my presentation had to do with going “back to the future” – meaning the things that were part of MCH practice in the past are things that I think we will carry with us into the future, and in fact, in the future we may need to do more of them.

Take home visitation for example. As Phyllis Sloyer’s column this month aptly describes, home visitation programs have been a core tactic in improving maternal and child health outcomes for many years. The two photos below demonstrate the “back to the future” nature of home visitation. The first photo is of a nurse visiting a Native American family in 1967. The second, more contemporary photo, shows a nurse visiting a family in 2009. With 42 years separating these two scenes we realize the timeless images of an MCH professional, in this case nurses, visiting families and building parenting and child development skills. This truly represents the “back to the future” nature of the new home visitation program established as a new section of Title V. How fitting that in this 75th Anniversary year of Title V we are indeed drawing on the rich legacy of home visitation and investing significant new resources in a tried and true strategy to improve maternal and child health outcomes.

As we look to the future of Title V and the MCH Services Block Grant, the new evidence-based home visitation program is certainly an exciting “back to the future” part of Title V. This issue of Pulse highlights some of the great work being done in the states in the area of home visitation and demonstrates how home visitation improves maternal and child health. As we continue our celebration of Title V’s past, let’s also be sure to acknowledge the future – and look to the new home visitation program and other new investments in maternal and child health as ways for us to look back in time to take what works and use it to improve the health of women, children, fathers and families in our future.
Feature

Title V Partnerships are Key to Implementation

By Kay Johnson
Johnson Group Consulting

Over the past 20 years, the field of home visiting has expanded dramatically. In the absence of a federal program dedicated to home visiting, states and communities have led the way. As of 2008, state-based home visiting programs were reported by 40 states, representing 70 distinct programs. Most states described one or two state-based home visiting programs. Five states had three or more programs. An estimated 3,000 or more local sites exist. At the same time, the home visiting field has been divided due to disagreements over models, tensions between researchers and practitioners, and lack of a federal policy and finance anchor. The challenge of the coming year will be to maximize the existing knowledge, talent and resources, while dramatically expanding both the number and quality of home visiting services.

The Patient Protection and Affordable Care Act (PPAC) established a home visiting grant program for states as a new section of the Title V Maternal and Child Health Services Block Grant program. The Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), as well as the Administration on Children and Families (ACF) and other federal agencies, will have roles to play in the development and administration of this new program. Moreover, both federal and congressional leaders have encouraged state-level interagency planning and development. State MCH program leaders will play a key role in implementation and will have an opportunity to use their partnership skills.

The law provides $1.5 billion over five years for maternal, infant and early childhood home visitation programs. Funds are to be used to supplement, and “not supplant funds from other sources for early childhood home visitation programs or initiatives.” So, now is not a good time to have budget cuts in state-based home visiting programs (including Title V or Medicaid). You may want to advise your governor’s office of the prohibition on supplanting funds.

I propose three key next steps for states. First, form your partnership – build an interagency group and add leaders from community-based home visiting programs. Second, use this partnership to generate a needs assessment that is about more than demographic data on poverty and so forth; it must describe existing home visiting capacity (staff, training, waiting lists, sources of funds, etc.). Third, form a workgroup to study how the state can augment an existing model or adopt a composite home visiting program design that is evidence based. Such a workgroup would consider how your state’s proposed program could help to achieve benchmarks for improvement in maternal and child health, childhood injury prevention, school readiness, crime, domestic violence, family economic self-sufficiency and coordination with community resources.

The policy process and potential competition for new funding has heightened awareness of, interest in and tensions about how to create high quality and effective home visiting programs. But, this is the time to pull together, not apart. Leveraging and sharing knowledge is essential to successful implementation. This begins within your state as described above, but also will involve sharing across states through AMCHP, the Pew Home Visiting Campaign and other national organizations.

Florida’s Home Visiting Coalition

By Annette Phelps, ARNP, MSN
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Florida’s Home Visiting Coalition shares a passion for and commitment to improving the well-being of Florida’s families and their children. The Coalition members recognize home visiting as a critical service delivery strategy and research-based approach for building trusting relationships with parents and other caregivers with the
Florida’s Home Visiting Coalition

knowledge, skills and tools to assist their children in being healthy, safe and ready to succeed in school. The Coalition is committed to maintaining an on-going, direct and honest dialogue and improved communication among programs to ensure collaboration and coordination and an integrated system of care. Family Health Services, Florida Department of Health is a member of the Coalition’s Steering Committee. While each program is uniquely designed and has unique goals, all of the following have a valuable role to play in meeting the complex and diverse needs of families and communities across Florida:

Healthy Start is a maternal and child health program funded with state and federal funds including Title V that has three distinct components: prenatal and infant risk screening, community-based coalitions and direct health-related services to pregnant women, interconception women and children birth to age 3. Through an allocation methodology developed jointly between the Florida Department of Health and the 31 Healthy Start coalitions, funds are distributed to the coalitions to support infrastructure building and the provision of services to the maternal child health population. Since Healthy Start started in 1992, the infant mortality rate has dropped 19 percent, and since 1997, there has been a leveling of infant mortality rates in Florida.

Federal Healthy Start implements community-driven approaches to reduce infant mortality rates by affecting maternal behavioral and medical risk factors and promoting healthy outcomes for women and their families. Florida has six Federal Healthy Start programs across the state. Each community awarded funds assures the availability of a core set of services and activities for the perinatal population in their project area. These services include case management, home visiting and links to health care and other needed services for mothers and their infants. In addition, each Healthy Start project is required to have a community-based consortium composed of individuals and organizations that includes women and families served by their project. Additionally, the consortium is to collaborate with their state Title V (MCH) agency, and to implement a local health system action plan to improve the quality, cultural competence of and access to services and/or to address other problems in the local system of care.

Early Steps serves children (under the age of 36 months) who have a physical or mental condition or have a developmental delay. There are no financial eligibility requirements. In 2009, the Early Steps program provided early intervention services to 37,691 children and their families in their natural environments.

Healthy Families Florida is a child abuse prevention program that provides home visiting services to parents expecting a baby and to parents of newborns. The program delivers home visitation services to children up to age 5 in families who need long term intervention and targets the parent/child interaction to build parenting knowledge and skills. The program attempts to select and train staff that represent the cultural make up of the communities they serve and caseloads are capped. Healthy Families Florida is a uniform national model nationally accredited by Prevent Child Abuse America/Healthy Families America.

Home Instruction for Parents of Preschool Youngsters (HIPPY) program is a home-based, family focused program that assists parents to provide educational enrichment for their preschool child. Because parents play a critical role in their children’s education, the HIPPY program seeks to support those parents who may not feel that they have the skills to help their children prepare for school.

Parents as Teachers program provides support to parents of children from prenatal to 3 years of age. The purpose is to help families prepare their children for school by providing home visitation by parent educators who are certified or meet the requirements of the Born to Learn Institute.

Head Start program promotes school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional and social services to enrolled children and families. Head Start services are available in every county in the state and more than 40,000 children and their families are being served each year. Early Head Start services (birth to 3 years of age) are also available in approximately a third of the state’s counties.

New Parent Support (NPSP) program was established by federal law in order to help build strong healthy military families and is a part of the Family Advocacy Program (FAP). The program benefits military families who are expecting a child, or who have children up to 3 years of age. The program includes home visits, and may also
Florida’s Home Visiting Coalition

include supervised playgroups as well as parenting classes and resources.

Nurse Family Partnership (NFP) is an evidence-based, community health program that partners vulnerable women pregnant with their first child with a registered nurse early in her pregnancy. Ongoing visits continue through the child’s second birthday. The program is administered in one site through the Children’s Services Council (CSC) of Palm Beach County which is a special district of local government that levies property tax dollars to provide funding for programs serving children and families. In the last few years, the pressure for no-nonsense spending has instigated the movement toward ensuring that funds are provided to primary prevention and evidence-based early intervention programs that demonstrate a return on investment. Out of this philosophy, the CSC has incorporated “The Journey to Evidence Based Programming: Changing the face of Social Services” – a focus on using research and data for continuous learning and improvement into its decision-making process for funding service delivery systems and systems of care.

Federal Healthy Start Projects implements community-driven approaches to address infant mortality rates by reducing maternal behavioral and medical risk factors and promoting healthy outcomes for women and their families. Beginning with prenatal care and continuing through the infant’s second year of life, each community awarded funds assures the availability of a core set of services and activities for the perinatal population in their project area. These services include case management, home visiting and links to health care and other needed services for mothers and their infants. In addition, each Healthy Start project is required to have a community-based consortium composed of individuals and organizations and that includes women and families served by their project, to collaborate with their state Title V (MCH) agency, and to implement a local health system action plan to improve the quality, cultural competence of and access to services and/or to address other problems in the local system of care.

Hawaii Healthy Start Program

By Loretta J. Fuddy, ACSW, MPH
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The Hawaii Healthy Start (HHS) home visiting program is administered through the State Department of Health’s Title V program within the Family Health Services Division, (FHSD), Maternal and Child Health Branch (MCHB). HHS began as a demonstration project in 1985 and expanded statewide in 2001. The program included universal screenings and assessments for at risk families in all civilian birthing hospitals. Throughout its 25 year history, HHS has conducted rigorous program evaluations and has made several revisions to the program design to improve child and family outcomes.

HHS home visitors are trained paraprofessionals working with a team which includes a clinical supervisor, clinical specialist, and child development specialist. Home visiting services include screenings for developmental delays and referrals for early intervention services; teaching the caregiver about child development; positive parenting skills and problem solving techniques; linking to community resources; and, when necessary, referring for substance abuse, maternal depression and domestic violence services.

Regrettably, today the program is limited to two sites because of severe budgetary restrictions. Statewide screening and assessment services and inclusion in the Individuals with Disabilities Education Act Part C services for care coordination have been eliminated.

The Title V/MCH Role in Hawaii’s Healthy Start Program

MCHB/FHSD has been the departmental lead for home visitation since 1987. Originally purely a child abuse prevention program, the program was restructured to broaden its intervention to address outcome measures embraced by Title V (e.g. medical home, immunization, age appropriate child development rates). MCHB led
the development of the client tracking data system and partnered with Johns Hopkins University to evaluate program effectiveness.

All violence prevention efforts including child abuse, domestic violence, and sex assault are administered within MCHB and are supported by its statewide network of prevention partners. As part of the current Title V Needs Assessment process, child abuse and neglect (CAN) was ranked as one of Hawaii’s state priority areas.

**Program Impact and Success**

Rigorous evaluation is crucial to program improvement; as such HHS has contributed to the body of knowledge on home visitation. Research highlights include: strategies to prevent child abuse and neglect; and discrete interventions which impact program quality, dosage, assessment, and training issues. Annual variance data indicates consistently that 98 percent of families enrolled in HHS for at least 12 months have no confirmed CAN report. Virtually all the enrolled children have a medical home; and receive timely immunization and developmental assessments.

In response to research findings, professional clinical support for paraprofessional home visitors was added to the model with the inclusion of Clinical and Child Development Specialist positions. HHS has collaborated closely with the author of the evidence-informed “Nurturing Parenting” curriculum to adapt its assessment tools to be culturally responsive to Hawaii’s unique populations.

Through support from the Evidenced Based Home Visitation federal grant, HHS continues its tradition of evaluation and program improvement. Enhancements to its data management system to address continuous quality improvement and the development of program fidelity activities to ensure valid and compelling positive program outcomes are the program’s current priorities.

Due entirely to the community’s overwhelming support for home visitation services, the State Legislature recently increased the appropriation for HHS. This bodes well for the future reinstatement of a statewide home visitation program when the economy recovers. A community voice recognizing the value of early intervention for families is perhaps our proudest organizational achievement. This we believe is a testament to the successful partnership and collaboration between our Title V program, the network of partnering agencies, the consumer and the community.

**Louisiana’s Nurse-Family Partnership Program**

**By Cynthia Suire, MSN, RN**

*Louisiana Nurse-Family Partnership Program Manager*

*Louisiana Office of Public Health Maternal and Child Health Program*

The Nurse-Family Partnership (NFP) program is an evidence-based, nurse home visitation program designed to serve low income, first-time pregnant mothers and their babies. The intervention begins in early pregnancy and continues until the first child reaches two years of age, providing frequent, intensive home visiting services. NFP uses experienced, highly trained registered nurses to guide and educate first time parents to achieve three important goals: (1) healthy pregnancy outcomes, (2) healthy infant/toddler growth and development, and (3) self-sufficient, healthy families. Experienced, registered nurses are critical to the successful delivery of NFP, as women have many questions and concerns about their health and the baby’s health.

Three distinct randomized trials were performed by Dr. David Olds over the last 30 years that study the enduring effects of the NFP on maternal and child health outcomes. The trials occurred in three different areas with demographically different populations in Elmira, New York; Memphis, Tennessee; and Denver, Colorado. The published results of the randomized clinical trials showed that when the program is implemented with fidelity to the NFP model, several health and social improvements can be realized by the clients, families and communities. These improvements are realized through improvement in prenatal health, reduction in child abuse and neglect, reduction in juvenile delinquency and criminal activity, improvement in school readiness for the children and improvement in maternal employment.

The Office of Public Health (OPH) Maternal and Child Health (MCH) Program leadership, in the late 1990’s, recognized that behavioral and psychosocial issues were associated with Louisiana’s persisting poor maternal and
Feature cont.
Louisiana’s NFP Program

child health outcomes. OPH-MCH began implementation of the evidence-based NFP program in 1999 to address those psychosocial issues and as a way to use experienced, skilled public health nurses as home visitors. NFP was chosen as the home visitation model because of its clear protocols, curriculum and intensive training, along with its promised results from rigorous randomized trials. NFP was appealing because it is “relationship based” and it was shown to be effective in nurturing parental competence and child development simultaneously. In addition, NFP National Service Office (NSO) monitored (and continues to monitor) program quality through the collection and distribution of program implementation and outcome information on the mothers enrolled in the program.

Since 1999, Louisiana NFP has grown from two sites to 16 sites in 52 of Louisiana’s 64 parishes and has served over 7,682 families with over 151,035 home visits. In addition, state MCH infrastructure has been formed to guide and support the teams of supervisors and nurses who provide the direct care in the home and areas that they serve. Though Louisiana’s NFP does enjoy diversified funding, Title V/MCH fiscal support is paramount. Families who partake of Louisiana’s NFP program have shown decreases in maternal smoking; increases in maternal workforce participation; decreases in experiences of maternal violence during pregnancy; above normal language development skills in the children and above average immunization rates in the children; clearly demonstrating the positive impact of using evidence-based models of home visiting.

Missouri’s Home Visiting Programs

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Feature cont.
Missouri’s Home Visiting Programs

The Missouri Department of Health and Senior Services offers two types of home visiting programs that serve low-income women both prenatally and post partum, along with their index infant(s), who have been identified as “at-risk” for poor pregnancy and infant health outcomes and/or child abuse and neglect. These women are considered to be “at-risk” due to socioeconomic status, education level, age or prior history. Both programs follow these women and children up to age 2. The programs’ goals are to assist the women improve their health-related behaviors; assist/teach parents to provide more responsible care for their children; and improve the family’s economic self-sufficiency by helping parents develop a vision for their own future.

The Building Blocks of Missouri is an evidence-based nurse home visiting program based on the nationally replicated home visiting program, the Nurse Family Partnership® (NFP). The program has been replicated in Missouri through the Missouri Department of Health and Senior Services since 1999 and is funded through the Title V MCH Block Grant. The department contracts with three providers serving 17 counties in the state and the city of St. Louis to replicate the program. The program follows the Model Elements established by the NFP for the replication of its model. Program enrollment is open to low income, first time mothers who enter the program prior to the 28th week of pregnancy and continues through age 2 of the index child. The Missouri program has had good outcomes including increasing the number of women who enter prenatal care during the first trimester, decreasing smoking in pregnant women, increasing immunization rates, increasing birth spacing, decreasing low birth weight and premature infants, decreasing physical abuse by the partner, and increasing the number of women completing school and gainfully employed.

The Missouri Community Based Home Visiting Program (MCBH) was developed in 1997 by the Missouri Department of Health and Senior Services in collaboration with the University of Missouri, Sinclair School of Nursing as the Families at Risk Model. Some modifications were made to the model in 2000 and the name was changed to the Missouri Community Based Home Visiting Program. The program utilizes registered nurses and family support workers (licensed practical nurses, social workers, or high school graduates with experience in early childhood). Registered nurses are required to do one post partum visit but may do additional visits as the need arises. The target
population is specific for each individual site, but addresses the needs of families in the specific geographic area who are most at-risk of infant mortality or morbidity, and child abuse or neglect. Currently the program is funded to serve 250 women annually through Title V MCH Block Grant funds; however, due to attrition and additional funding obtained by some of the providers, the program served 815 women in 2009. There are currently 10 providers serving 11 counties in Missouri. In 2011, the program will be revised to encourage each site to serve at least 50 percent multiparous women, and to require use of the Partners for a Healthy Baby curriculum, developed by Florida State University, as the standardized curriculum. The program has far reaching effects including increasing first trimester enrollment in prenatal care, decreasing the number of infants born low birth weight and preterm, increasing breastfeeding rates, increasing immunization rates well above the state rate, and increasing the number of women who take folic acid prenatally and interconceptionally.

Real Life Story

Making a Difference: Q & A With a Nurse Home Visitor and a Graduate Client of the Louisiana Nurse-Family Partnership Program

Katherine C. Molbert, RN, known to her clients as Miss Kathy, has been a nurse for more than 25 years and a home visitor with the Nurse Family Partnership (NFP) for 6 and a half years. Lutricia and her daughter Daria from New Iberia, La., participated in the Nurse Family Partnership program from 2005 to 2007. Please read on to learn more about Miss Kathy, Lutricia and Daria and how the NFP program brought them into each other’s lives.

Miss Kathy, please tell us a little bit about yourself.
I was born and raised in New Iberia, La. I have a husband who was also born and raised here and two children. I can’t imagine living anywhere else…we love the culture and opportunities that this area has to offer (my husband is a big fisherman). I’ve been a nurse for more than 25 years and a home visitor with NFP program for 6 and a half years. I love the challenges I am faced with every day and the successes of my clients, no matter how small. I can’t imagine doing anything else.

How did you first learn about the Louisiana NFP program?
Actually, I was talking with the regional nurse consultant at a school function and she mentioned that there was an opening for NFP. I had no idea what the NFP program was at the time so we started talking about it and she explained what it was. It was a time when I was evaluating the job market and looking at different options. I thought seriously about the program and applied for the job.

What made you decide to become a home visitor?
I had worked in home health and pediatrics and loved both fields, especially pediatrics. NFP was a mix of both and I thought what an opportunity to combine two types of nursing that I loved into one job.

What is the best part of your job?
The best part is seeing a client succeed or reach a goal she has set, even if it is a very small accomplishment. Many of our clients don’t have support systems, or anyone who believes in them except the nurses who work with them.

What is the biggest challenge to being a home visitor?
My biggest challenge is motivating my clients to work toward the goals they have set. Sometimes even “baby steps” seem monumental to them because they have never
Real Life Story CONT.
Making a Difference

been challenged to step up to the plate to change anything in their lives for the better.

Lutricia, please tell us a little bit about you and your family.
I was born in New Iberia, La., and although I moved away for awhile, I have lived here for a total of 35 years. Right now, I work as a night manager at a local gas station. I have one child, Daria, who was born at Iberia Medical Center on October 20, 2005.

How did you first learn about the Louisiana NFP program?
I went into the health unit for a Woman, Infants and Children (WIC) appointment and saw a poster on the wall for a home visiting program for first time mothers. Because I had lost my first baby two years prior, I had to call and find out if I was still considered a first time mother and I was. I had an awesome nurse, Miss Kathy and she came once a week starting from when I was two or three months pregnant until Daria turned two.

Because I lost my first child at 21 weeks, having the nurse come in and do tests made me feel better through the pregnancy. Miss Kathy would bring pamphlets on different things – why I should read to my baby and how to keep the house safe once my baby started walking around. I still look at this information that Miss Kathy gave me, especially now that Daria is really active, getting into everything and exploring.

How is Daria doing now?
She’s keeping me busy! Daria is in Head Start and she’ll be starting Pre-K school in August. She is advanced for her age – she could spell her name at three, so once she got to Head Start, she knew everything – she had to be put in an advanced class. She even has a favorite book that she just read to her Grandma all by herself – it’s called “My Little Shopping Bag” – a gift from her teacher. I attribute this to advice from Miss Kathy to read to Daria from the beginning. We still go and see Miss Kathy from time to time.

How did having a home visitor make a difference in your life?
I went back to school three months after having Daria – one semester after I started, I wanted to quit and Miss Kathy encouraged me to go back and wouldn’t take no for an answer. I did go back and I’ll be graduating this July from Louisiana Technical College in Accounting. I want to own a plus sized clothing store – there is a demand for them in New Iberia. Miss Kathy pushed me to go back because she knew what my dreams were.

What would you like other families to know about the Louisiana NFP program?
It’s a good program – they help you know what stages your baby goes through during pregnancy and what stages your child goes through after you have them. Knowing what I went through with my first pregnancy, I wouldn’t have felt as comfortable without Miss Kathy. I had a counselor - Miss Yasmine - come in because I was battling depression and was concerned over carrying my pregnancy. Miss Yasmine stayed on to help me and Daria bond and help with my fear of losing Daria. Miss Kathy would let me hear Daria’s heartbeat once a week to put me at ease. Having both was the best thing that could have happened to me at the time.

Cynthia Suire, DNP, MSN, RN, Nurse-Family Partnership Program Manager, Louisiana Office of Public Health, contributed to this article.

View from Washington

Home Visiting

By Brent Ewig, MHS
Director of Policy & Government Affairs, AMCHP

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act. As we’ve reported what seems like constantly over the past two years, this law creates a Maternal, Infant, and Early Childhood Home Visiting Programs that will for the first time provide a dedicated federal funding stream to support the expansion of home visiting programs. Created as a new section in the Title V statute, this provision represents one of the most exciting and
View from Washington CONT.  
Home Visiting

significant changes to the program – and just in time to coincide with our 75th Anniversary of Title V. With a strong focus on expanding evidence-based models, the law will provide $1.5 billion in mandatory funding to states over the next five years. Now the action turns to the states to begin the crucial work on implementation.

We are all now anxiously awaiting the federal guidance to support that implementation. No official U.S. Department of Health and Human Services (HHS) guidance has been released as this column is being written - but is reportedly coming soon [Editor’s note: HHS guidance was released on June 10]. So while we wait, we thought it would be worthwhile to take a brief look at some of the highlights in the history of home visiting. As the Minnesota Department of Health points out in a fascinating timeline included in a training manual for home visitors in their state, there were elements of home visiting in the United States going back to colonial times. In the 19th century, Florence Nightingale – considered the pioneer of the nursing profession – stressed the importance of home care skills and home visiting in the training of nurses, and nurses were assigned to specific districts across England.

Home visiting also was a key element in the work done in Settlement Houses by our foremothers in the maternal and child health field, and many public health and child welfare agencies continued to expand utilization of home visiting throughout the past century. It was certainly an important strategy employed by programs like Head Start growing out of the Great Society era as well as national efforts focused on preventing child abuse and neglect.

In 1991, the U.S. Advisory Board on Child Abuse and Neglect actually recommended that the “federal government immediately begin phasing in a national universal home visiting program for all children beginning in the neonatal period.” However, without adequate federal leadership or resources the expansion of home visiting in the past two decades has proceeded on an uneven basis, with state leaders and advocates doing their best to implement programs using a patchwork quilt of resources and no dedicated source of federal funding.

Despite these obstacles, Kay Johnson reported last year that at least 40 states and territories are currently implementing a range of home visitation models through various state programs. Her study entitled State-based Home Visiting Strengthening Programs Through State Leadership serves as one of the best resources on the current state of home visiting programs.

A turning point occurred in July 2007 when presidential candidate Barack Obama perhaps ushered in modern era of home visiting when he called for an expansion of home visiting as part of his platform to address poverty in the United States. Building on this momentum, AMCHP’s board of directors passed a policy statement in April 2009 reiterating our support of home visiting as a strategy that works and calling for federal efforts to sustain and increase investments. This policy supported our subsequent advocacy for home visiting to be included in national health reform legislation, and to build the program upon the strong foundation represented by the federal state partnership inherent in the the Title V MCH program.

As action on health reform got underway on Capitol Hill, AMCHP joined a number of partners in this advocacy, and in the end – despite a rocky path and several tribulations - the final health reform package delivered the new program.

So, what happens next? In a perhaps unprecedented move, the law actually directs the Secretary of HHS to “ensure that the Maternal and Child Health Bureau and the Administration for Children and Families collaborate” in carrying out many of the components of the law. By most indications, these two branches of HHS are working together expeditiously to provide states with the necessary guidance to complete the required needs assessment by the September deadline.

In the meantime, in a May 7 memorandum to interested stakeholders, HHS has asked states to 1) familiarize themselves with the legislative provisions, 2) begin collecting the specified information needed to support a needs assessment, and 3) begin connecting key state agencies to discuss how to coordinate, particularly with existing needs assessments.

So that is where things stand as of late May 2010. We are certain that imminent federal guidance will accelerate planning and implementation action in the states, and look forward to supporting the next chapter in the history of home visiting.
Who’s New
New MCH Leaders

HRSA National Program
Director Audrey M. Yowell

Audrey M. Yowell, Ph.D., MSSS, currently serves as the national program director for the Maternal, Infant and Early Childhood Home Visiting Program at the Health Resources and Services Administration (HRSA). Previously, she was the Project Officer for the Alliance for Information on MCH (AIM) Program, and took the lead on MCHB Initiatives including Partners in Program Planning for Adolescent Health (PiPPAH), the health of children in foster care, family health, and women’s Health. She played a primary role in developing and implementing the National Institute on Drug Abuse (NIDA) technology transfer program.

Dr. Yowell has served in a variety of other health and social service program and policy positions in State and local government and in the private sector, building on her earlier experience in direct services to adolescents in health, mental health and juvenile justice settings. She has served as Instructor of Psychology and as a graduate-level Field Instructor in Administration, Policy Planning and Community Organization. Dr. Yowell received her BA from Wellesley College, her MSSS from the Boston University School of Social Work, and her Ph.D. from the Heller School, Brandeis University.

Special Assistant to the Deputy Assistant Secretary
Moushumi Beltangady

Moushumi Beltangady is Special Assistant to the Deputy Assistant Secretary and Inter-Departmental Liaison for Early Childhood Development at the Administration for Children and Families (ACF) at the U.S. Department of Health and Human Services. In this role, she works across federal agencies on a wide variety of early childhood development issues, including coordinating the interagency aspects of the planning and implementation of the Maternal, Infant, and Early Childhood Home Visiting Program and overseeing the Tribal Maternal, Infant, and Early Childhood Home Visiting Program.

Prior to this position, Moushumi was a program analyst at the Office of Refugee Resettlement at ACF, where she performed budget formulation, policy, and data analysis for programs serving vulnerable populations, including the U.S. refugee resettlement program and programs for trafficking victims, unaccompanied refugee minors, and unaccompanied alien children. She also worked for three years as a Presidential Management Fellow in ACF’s Office of Planning, Research, and Evaluation, where she participated in child and family research and evaluation projects and oversaw agency-wide performance management efforts. While a PMF, Moushumi completed a detail to the Senate Health, Education, Labor, and Pensions Committee, Subcommittee on Children and Families.

She has also worked in a variety of other settings in the United States and abroad, including at an immigrant and refugee rights agency, a child care center for immigrant families with children aged 0-5, a poverty research center, and a women’s rights organization in India.

The following are new MCH Leaders:

Arkansas

Bradley Planey
Interim Title V Director
Associate Branch Chief, Family Health
Arkansas Department of Health

Connecticut

Rosa Biaggi
Title V Director
Connecticut Department of Public Health
Who’s New CONT.  New MCH Leaders

New Mexico

Susan Chacon
Interim Children With Special Health Care Needs Director
Children’s Medical Services
New Mexico Department of Health

If you know of a new or retiring MCH leader, please contact Librada Estrada, Associate Director, Workforce & Leadership Development, Family Involvement, AMCHP.

Get Involved

AMCHP to Host a Two-Part Webinar on How to Collaborate to Improve School-Based Health in Youth

The webinar, “Leveraging the Expertise and Experience of Health and Education Departments to Collaboratively Improve School-Based Sexual Health Programs for Youth,” to convene on June 23 from 2 to 3:30 p.m. (EDT), will focus on national and state-level experiences and perspectives related to how state health and education departments have effectively worked together to improve programs and policies for youth. The esteemed speakers will share their experiences and lessons learned from working with the public health and education communities and provide strategies and tools for helping to build more effective partnerships to improve school-based sexual health programs for youth. To register for Part I click here. A follow up webinar will convene on June 29 from 2 to 3:30 p.m. (EDT). To register for Part II click here. If you have any questions, please contact Lissa Pressfield.

Call for Proposals

The Association of University Centers on Disabilities (AUCD) is seeking concurrent sessions, poster presentations, and films for the media room for its 2010 AUCD Annual Meeting and Conference. Proposals will be accepted through June 28 on a wide variety of topics, including Systems-level Implementation, Demonstration and Evaluation. To submit a proposal, visit here.

Get Involved CONT.

MCHB’s Customer Satisfaction Survey of its Resource Centers

The Health Resources and Services Administration’s Maternal and Child Health Bureau (MCHB) is conducting a Customer Satisfaction Survey of its Resource Centers. MCHB provides funding for the Maternal and Child Health Library. The goal is to use the feedback to help improve the quality of their Resource Centers’ services and learn how they can serve you better. The survey will take approximately 10 minutes to complete. CFI Group, an independent research and consulting firm, is conducting this survey for MCHB. The survey is hosted via a secure server and your participation will remain anonymous. If you have any technical questions or issues while taking the survey, please contact MCHBsurvey@mail.cfigroup.com. To complete the survey, visit here.

SAVE THE DATE!

AMCHP’S 2011 ANNUAL CONFERENCE

February 12-15, 2011
Omni Shoreham Hotel
Washington, D.C.

The 2010 AMCHP Conference will bring together leaders in maternal and child health, public health practitioners and family advocates. Join us for sessions led by researchers, federal officials, advocates, families, healthcare providers and directors of state programs.
State-based Home Visiting Programs

Resources

State-based Home Visiting: Strengthening Programs through State Leadership: This report, written by Kay Johnson, The National Center for Children in Poverty (NCCP), Mailman School of Public Health, Columbia University, discusses the nature of home visiting programs; highlights the results of a survey on how state-based home visiting programs are structured and financed and respond to diverse family needs; describes how states are strengthening home visiting programs; and includes recommendations for national and state-level leadership.

The Case for Home Visiting: Strong Families Start With a Solid Foundation: This brief published by the Pew Foundation – Center of the States, highlights the benefits of voluntary home visiting programs on women, infants and families. The Pew Home Visiting Campaign partners with policy makers and advocates to promote smart state investments in quality, voluntary home-based programs for new and expectant families.

MCH Library at Georgetown University - Home Visiting Resource Brief: This resource brief has been updated to reflect information on home visiting in the Patient Protection and Affordable Care Act passed in March 2010. It provides summaries and links to websites, model and promising programs and databases for further research. A bibliography of recent publications is also included.

Realizing the Promise of Home Visitation: Addressing Domestic Violence and Child Maltreatment: This brief, published by the Family Violence Prevention Fund (FVPF) in partnership with the National Child Abuse Coalition and Safe Start Center, with sponsorship from the Avon Foundation for Women, is designed as a resource to help policymakers enhance the effectiveness and reach of home visitation programs by outlining best practices and offering recommendations for integrating domestic violence into existing programs. The brief recommends funding research to determine the most effective methods for integration and collecting additional data, especially in updating the Pregnancy Risk Assessment Monitoring System, to measure the ways violence impacts families.
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Vanessa A. White, MPH, Associate Director, Women’s & Infant Health

Darlisha Williams, MPH, Program Manager, Best Practices

Calendar

AMCHP SPECIAL EVENTS

MCHB 75th Anniversary of Title V Commemoration
October 20
Washington, DC

Looking to the Future: What are the Opportunities and Challenges of Health Reform for Improving Maternal and Child Health?
October 21
Washington, DC

More MCH Events

Advisory Committee on Immunization Practices (ACIP) Meeting
June 23-24
Atlanta, GA

18th Annual Health Forum and American Hospital Association Leadership Summit
July 22-24
San Diego, CA

Fourth Annual National Conference on Health Communication, Marketing, and Media
August 17-19
Atlanta, GA

CityMatCH Urban MCH Leadership Conference
September 11–14
Chicago, IL

AHRQ’s 2010 Annual Conference
September 27-29
Bethesda, MD

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