

Advancing Early Childhood Mental Health through Evidence-Based Home Visiting



What is early childhood mental health?

Brains are built on a foundation of early experiences. In the first few years of life, more than one million neural connections are formed every second. These neural connections, the brain's architecture, are formed through the interaction of baby and their environment through early enriching experiences. While genes provide a blueprint for brain architecture, neural connections must be formed through repeated use. All children are born with the ability to reach their highest potential, but connections that form early form either a strong or weak foundation for the connections that form later. These critical interactions with adults lay the foundation for all later learning, behavior and health.

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BRAINS ARE BUILT BY EARLY EXPERIENCES.



Babies who engage with responsive, consistent, nurturing caregivers and who live in safe and economically secure environments are more likely to have strong emotional health. ZERO TO THREE defines infant and early childhood mental health (IECMH) as “the developing capacity of the child from birth to 5 years old to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture.”ⁱ As children mature, early childhood mental health supports growth in other essential areas of healthy development including physical health, cognitive skills, language and literacy, social skills and readiness for school.

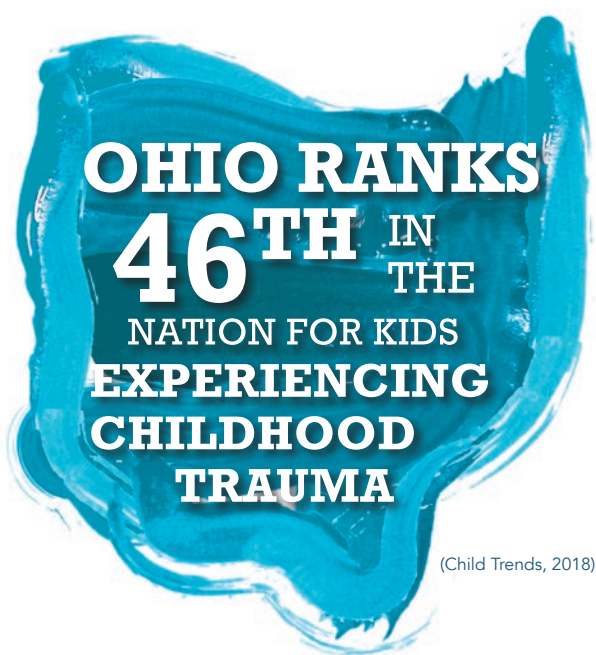
As children mature, early childhood mental health supports growth in essential areas of development.

- Kids who exhibit strong social and emotional skills are **54% more likely to earn a high school diploma.**
- Kids who share or are helpful in kindergarten are **46% more likely to have a full-time job at the age of 25.**
- Children who are overweight or obese as preschoolers are **5X more likely to become obese adults than normal weight children.** ⁱⁱ

When children experience trauma and their emotional health deteriorates, they are subject to poor outcomes in these areas because their ability to form close and secure relationships, manage a full range of emotions and explore their environment is compromised.

What are ACEs?

Adverse Childhood Experiences (ACEs) are traumatic events that have the potential to cause long-lasting negative effects. During the earliest and most critical years of development, children are highly vulnerable to adversity. Almost half of all children in the United States have experienced at least one ACE, but black and Hispanic children are at much higher risk than their white peers—51% of Hispanic children and 61% of black children have had an adverse childhood experience, compared to 40% of their white peers. As the frequency and length of ACEs increase, so do the impacts on physical and mental health, academic achievement, and self-sufficiency. Ohio ranks 46th in the nation for kids having three or more ACEs, putting them at higher risk for long-lasting negative effects. ⁱⁱⁱ



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(Child Trends, 2018)

What Constitutes an ACE?

The Adverse Childhood Experiences Study conducted in 1995 outlined ten ACEs that predict negative outcomes later in life. Today, these have been adapted to create the ACE test—an eight question survey to determine the number of significant adversities a child has experienced.

The commonly accepted questions on the ACE test ask whether a child has ever:

1. Lived with a parent or guardian who became divorced or separated.
2. Lived with a parent or guardian who died.
3. Lived with a parent or guardian who served time in jail or prison.
4. Lived with anyone who was mentally ill or suicidal, or severely depressed for more than a couple of weeks.
5. Lived with anyone who had a problem with alcohol or drugs.
6. Witnessed a parent, guardian, or other adult in the household behaving violently toward another.
7. Been the victim of violence or witnessed any violence in his or her neighborhood.
8. Experienced economic hardship “somewhat often” or “very often” (i.e., the family found it hard to cover costs of food and housing).^{iv}

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The Prevalence of ACEs in Ohio

49% OF OHIO KIDS have had at least **ONE ACE**

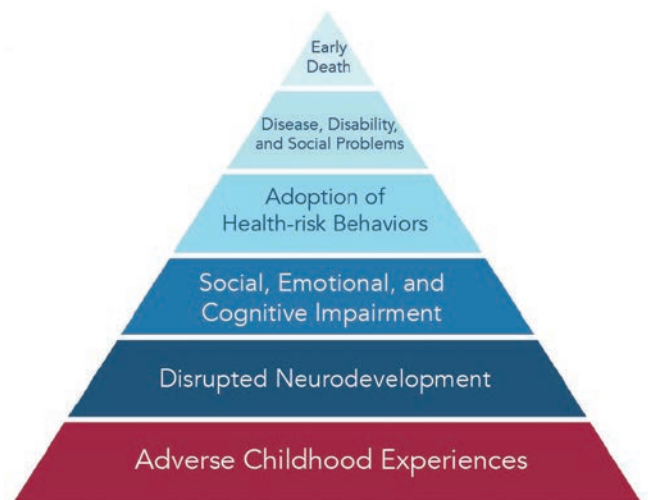
(Child Trends, 2018)

1 IN 7 kids in Ohio had **THREE OR MORE**

ADVERSE CHILDHOOD EXPERIENCES, putting them at much higher risk for long-term negative effects. (Child Trends, 2018)

Long-Term Impacts of ACEs

The experiences a child has during the first several years of life shape who they become. Adverse childhood experiences have the potential to impact long-term mental health, physical health, and behaviors, including smoking, alcoholism, drug use, missed work, depression, suicide attempts, heart disease, diabetes, severe obesity, cancer, and stroke. On average, people with six or more adverse childhood experiences have a life expectancy of 60 years, which is significantly shorter than the 80-year life expectancy for people with no ACEs.





Preventing Adverse Experiences

ACEs have a multi-generational effect—the impact of a parent’s adverse experiences can also influence their child’s development. Studies have shown that the most successful way to prevent the cycle of adverse experiences is to provide interventions for both parents and children.

Successful interventions include:

- Giving parents the tools to be successful caregivers and teachers. Programs that allow parents to cultivate strong, healthy relationships with their children, such as voluntary, evidence-based home visiting, give children the emotional security required for healthy development and provide parents with the knowledge to understand their child’s needs, as well as their own.
- Helping struggling families achieve and maintain consistency and self-sufficiency. In order to provide children with the consistency they need for healthy development in the early years of life, programs like quality publicly funded child care and income assistance allow parents to work toward stable employment and self-sufficiency.
- Creating stable, nurturing environments that ensure healthy physical and emotional development for young children. Access to intimate partner violence prevention programs and mental illness and substance abuse treatment are crucial to ensuring that children are able to grow and thrive without the toxic stress caused by domestic violence and mental illness within the home.^v

There are many opportunities to promote emotional health, prevent trauma and treat mental health problems before they manifest more serious problems later in life and at-risk young children need to be supported by a continuum of services to support their healthy development.

While state policy and investment have lagged behind in making early childhood mental health a priority, the public has embraced this understanding as evidenced by the following poll findings:

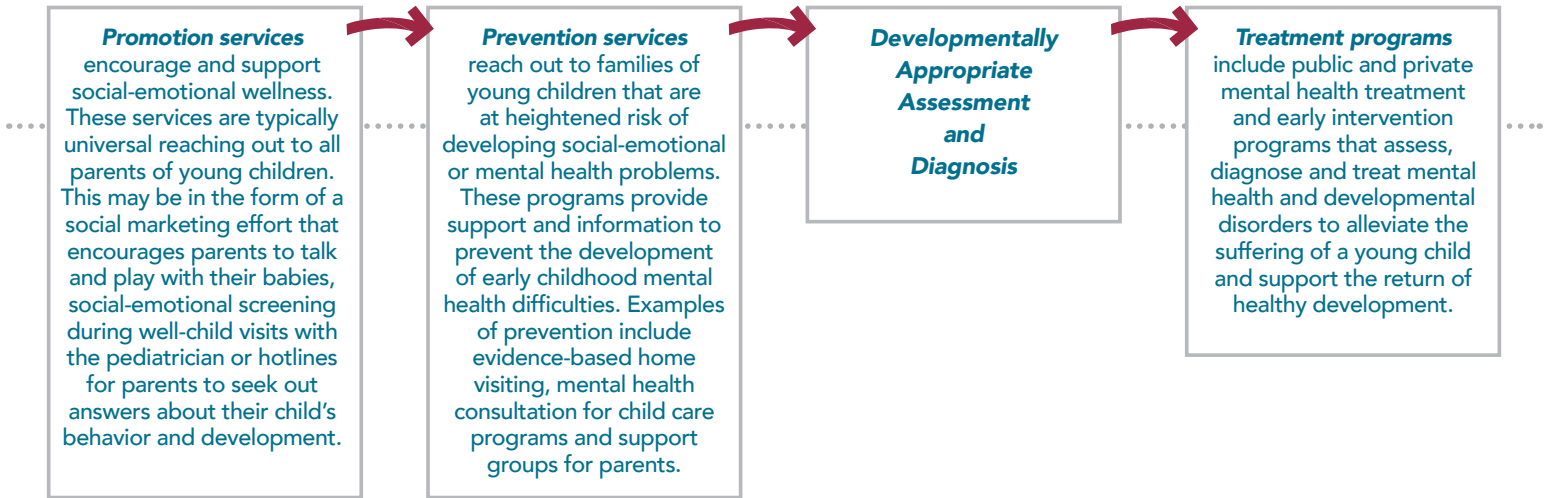
- **More than 9 in 10 voters** say it is important for society to support the healthy emotional development of children ages 3 and younger.
- **Most voters (95%)** feel that emotional milestones are just as important as physical milestones.
- **Most voters (97%)** say it is important for parents to have resources to help them be aware of the emotional development of their children.^{vi}

ACEs have a multi-generational effect—a parent’s adverse experiences can influence their child’s development.



How can we promote social & emotional well-being?

Strategies that support early childhood mental health fall along a continuum of promotion, prevention, developmentally appropriate assessment and diagnosis and treatment. Programs and interventions increase in intensity and specialization of services and supports from promotion to treatment. ^{vii}



Evidence-Based Home Visiting: A Two-Generation Approach to Early Childhood Mental Health

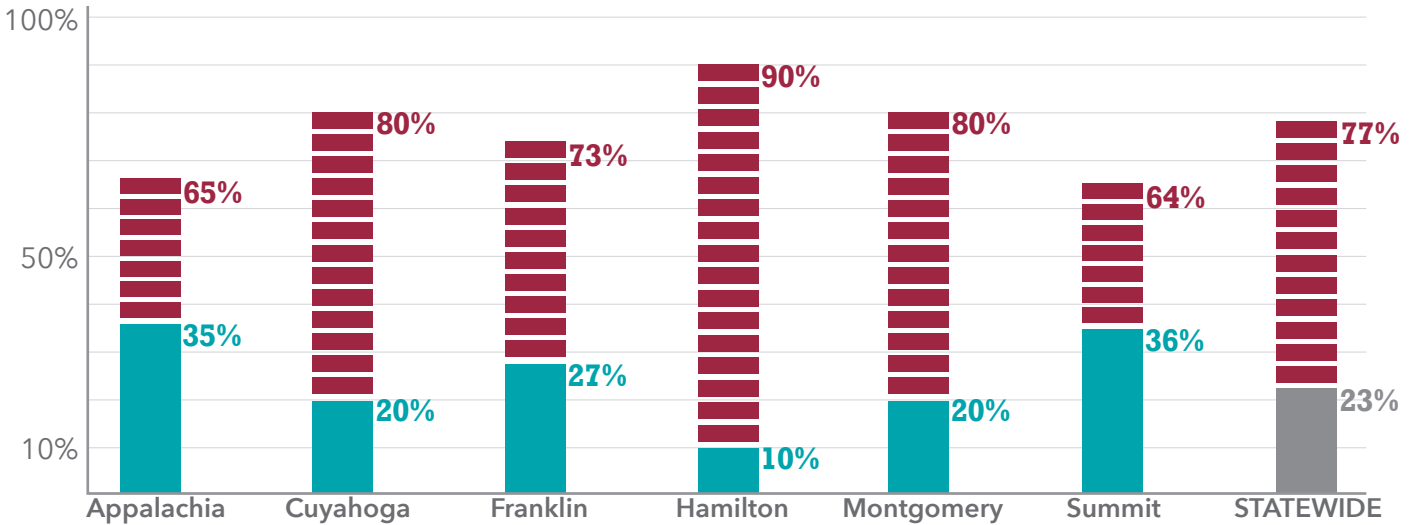
Among the most important investments in a continuum of services to support the emotional development of young children is in evidence-based interventions that prevent the incidence of trauma and support responsive relationships between adult and baby. Evidence-based home visiting is a two-generation approach to child mental health designed to strengthen parent-child bonding, attachments and relationships with direct impacts on both parent and child.

Ohio's voluntary, evidence-based home visiting programs include the federally-funded Maternal Infant and Early Childhood Home Visiting (MIECHV) program and the state-funded Help Me Grow program. Ohio's home visiting programs serve 9,612 families (7,381 by Help Me Grow state GRF funds and 2,231 by federal MIECHV funds).^{viii}



Percentage of 2017 Ohio Home Visiting Families Served in Help Me Grow & MIECHV by Region

Chart 1 ■ Help Me Grow ■ MIECHV



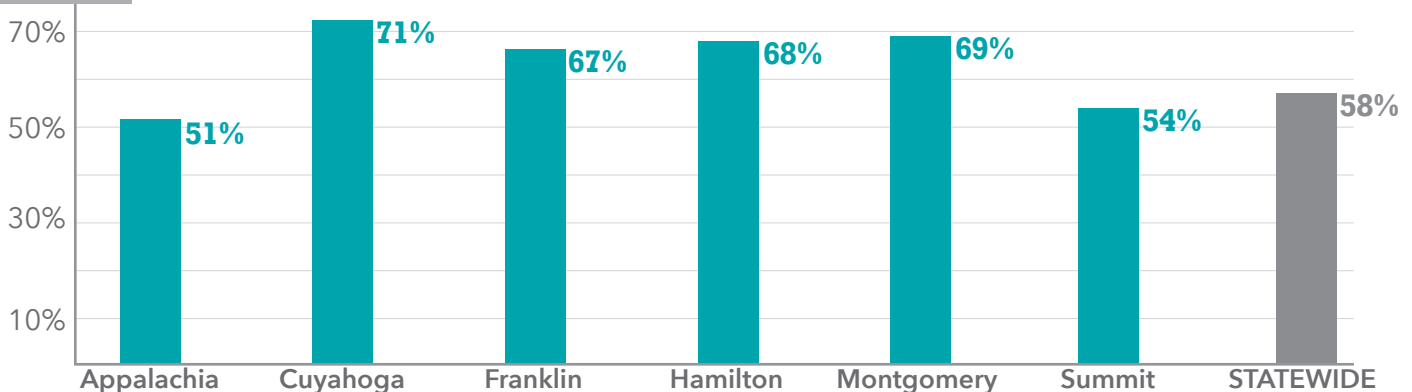
Note: While the majority of home visits are supported by Help Me Grow, MIECHV funding supports Ohio's home visiting infrastructure while also serving a certain percentage of families among 27 communities in Ohio. Data Source: Ohio Department of Health

What do Ohio families served by home visiting look like?

FY17 Percentage of Ohio Families Receiving Home Visits that are Below 50% of the Federal Poverty Level by Region

96% of the families that are served are at or below 200% of the federal poverty level.^{ix}

Chart 2



Data Source: Ohio Department of Health



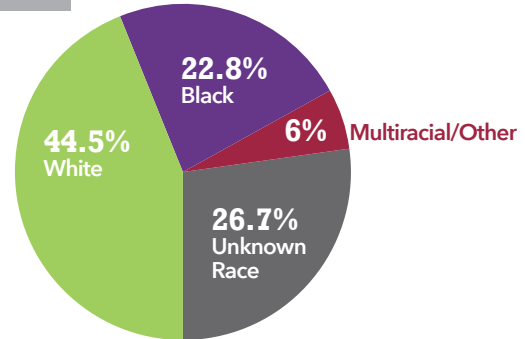
FY17 Home Visiting Families Served by Race/Ethnicity of Parents

* Note that ethnicity was not reported by race so the 492 persons shown as Hispanic/Latino are included in the total of 9,612 persons shown in the breakdown by race.

Table 1

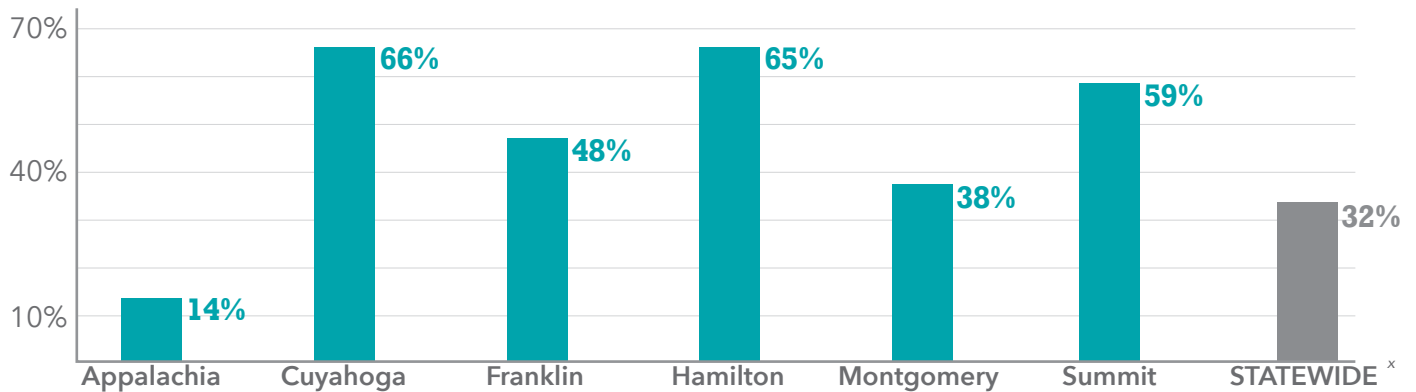
Race & Ethnicity	# of Households Visited	% of Households Visited
White	4275	44.5%
Black	2200	22.8%
Multiracial/Other	574	6.0%
Unknown Race	2563	26.7%
TOTAL	9612	100%
Hispanic	492*	5.1%

Chart 3



FY17 Percentage of Ohio Families Receiving Home Visits That are RACIAL MINORITIES by Region

Chart 4



Data Source: Ohio Department of Health

For those who elect to participate in a home visiting program, providers regularly visit the homes of eligible families (typically once per month) starting while the mother is still pregnant and continuing through the first few years of the child's life. During this critical period of physical, emotional, and cognitive development for young children, parents receive support and guidance on how to create a safe, stimulating environment that promotes growth and learning. Voluntary, evidence-based home visiting programs allow motivated parents to learn how to succeed in their new role and provide children a healthy start with their first and most important teachers—parents. ^{xi}



The Case for Voluntary Evidence-Based Home Visiting

School Readiness:

- Increases scores on 1st-3rd grade math and reading tests by 25% ^{xii}
- Decreases language problems by 68% ^{xiii}

Family Health:

- Decreases instance of low-weight births by 48% ^{xiv}
- Decreases number of major injuries before age 2 by 32.6% ^{xv}

Family Self-Sufficiency:

- Increases the likelihood of mothers to be enrolled in an education or training program by 5 times ^{xvi}
- Decreases Temporary Assistance for Needy Families (TANF) payments by 5.6% for 12 years postpartum ^{xvii}



These benefits, result in an incredible cost savings:

.....

For every \$1.00 invested in evidence-based home visiting, there is a \$5.70 return on investment.

Ohio's Help Me Grow Program

Ohio's state-funded voluntary home visiting program utilizes three evidence-based models:



Although there is variation within each model to provide services catered to individual family needs, the primary goals of all programs are to:

- Cultivate parents' ability to form strong, positive attachments with their children and to keep them safe
- Promote children's healthy physical, cognitive, and social-emotional development by monitoring their progress, guiding parents in recognizing their children's and their own needs, and accessing appropriate services
- Improve maternal and child health ^{xviii}



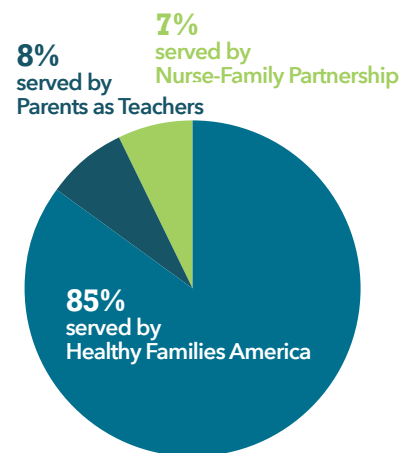
In order to be eligible for services, expectant families or caregivers of a child under the age of two whose family income is not in excess of 200% of the federal poverty level; and possess at least one of the following risk factors:

- A pregnant woman under age 21.
- A previous preterm birth.
- A history of child abuse, neglect, or interactions with child welfare.
- A history of substance use or those that demonstrate a need for substance use treatment.
- A child who has a diagnosed developmental delay.
- Tobacco users.
- An active duty military member.
- A history of unstable housing or homelessness.
- A caregiver who has a history of depression or other diagnosed mental health concerns. (Ohio Administrative Code. "3701-8-02 Home visiting program eligibility." 2019.)

There are currently 106 contracted providers who deploy at least one of the three approved evidence-based models serving families in 82 of Ohio's 88 counties. Most families (85%) are served by Healthy Families America, 8% of families are served by Parents as Teachers and 7% of families are served by Nurse-Family Partnership. ^{xix} Healthy Families America and Parents as Teachers services are supported by state GRF funding and Nurse-Family Partnership services in the Help Me Grow program are supported by federal MIECHV funds only. ^{xx}

While the development of Ohio's home visiting program has required strong state leadership and investment, the state's story is one of local communities. Each county and community have a unique history with adopting and implementing home visiting programs that is told by its program offerings, its diverse array of public and private federal, state and local funding sources and the number of families they are serving.

Chart 5





Local Snapshot: Cuyahoga County

Evidence-Based Home Visiting

While the state-funded home visiting footprint can be very small in many communities, in FY17 nearly 15% (1423/9612) of families served in Help Me Grow were in Hamilton County. Cuyahoga County accounted for the next largest population of families served at 8% (771/9612). Below, you can see the program offerings in Cuyahoga County for evidence-based home visiting programs that are enrolling prenatally to age three (the county also provides opportunities for older children to be enrolled). These programs include those funded by the state, MIECHV, Medicaid, county funds, private philanthropy, the Ohio Children’s Trust Fund and federal Early Head Start dollars. Cuyahoga County has an Early Head Start program serving some of the 8,970 young children served in Early Head Start each year in Ohio.^{xxi} This rich set of offerings is part of a complex system that begins to tell just one local story.

Cuyahoga County Home Visiting Programs—Enrolling Prenatally to Age 3

Table 2

Program Name & Agency Name	Primary Age of Enrollment				Staff	Income Requirements (FPL 0 Federal Poverty Level)	Frequency			Serve Until	Other ^{Refer to} Requirements
	Prenatal	Newborn to 3 months	3 months to 3 years	3 years to 5 years			Weekly	Bi-Weekly	Monthly		
Healthy Families America <ul style="list-style-type: none"> Achievement Centers for Children Catholic Charities Friendly Inn Settlement, Inc. Ohio Guidestone 	√	√			Credentialed Home Visitor	<200% FPL	√	√		Age 3	None
Moms & Babies First <ul style="list-style-type: none"> Northeast Ohio Neighborhood Health 	√				Community Health Worker	<200% FPL		√	√	Age 1	Mom must be 29 years or younger, African American, and reside in East Cleveland, Euclid, Garfield Hts., Maple Hts., or Warrensville Hts.
Nurse-Family Partnership <ul style="list-style-type: none"> MetroHealth Medical Center 	√ Prior to 28 weeks				Registered Nurse	<200% FPL	√	√		Age 2	First-time mothers can re-enroll after birth if previously enrolled prior to 28 weeks of pregnancy
Early Head Start <ul style="list-style-type: none"> The Centers for Families & Children Council for Economic Opportunities 	√	√	√	√	Home Visitor	<100% FPL*	Varies			Age 3	*Exceptions do apply to income requirements.
MomsFirst <ul style="list-style-type: none"> Cleveland Department of Public Health 	√ Prior to 32 weeks				Community Health Worker	<200% FPL		√		Age 18 months	Resides in Cleveland
Parents as Teachers <ul style="list-style-type: none"> Bright Beginnings 	√	√	√		Parent Educator	No Requirement		√		Entry into Kindergarten	None
The Pregnancy Program <ul style="list-style-type: none"> The Centers for Families & Children 	√ Prior to 30 weeks				Community Health Worker	<200% FPL		√			None

Data Source: Bright Beginnings, Cuyahoga County



Leadership for Evidence-Based Home Visiting

Governor Mike DeWine committed to expanding evidence-based home visiting services to help three times as many Ohio families as have previously been served during his campaign for Governor as part of his Opportunity for Every Ohio Kid plan. On his first full day in office, DeWine created and convened the Governor's Advisory Council on Home Visitation and tasked them with developing recommendations for reaching that goal. The advisory committee subsequently reported their findings by March 1, 2019 to inform the state budget process.

The Council's recommendations include:

- Make race and ethnicity foundational elements of the state's infant mortality efforts.
- Expand and streamline eligibility requirements so more at-risk families can be served.
- Create a central point of intake for all home visiting programs.
- Create a central data warehouse for all home visiting programs.
- Promote collaboration among healthcare payers, children's hospitals, birthing hospitals, and other community-based providers.
- Leverage the Medicaid program to reimburse for eligible services in a more cost-effective manner.
- Align Department of Medicaid infant mortality reduction funds to complement the *Help Me Grow* program.
- Increase the frequency of the Ohio Department of Health incentive payments.^{xxii}

In order to begin implementing these recommendations, Governor DeWine asked that the legislature double funding of Ohio's home visiting programs, investing an additional \$50 million over the biennium into evidence-based home visiting programs in his executive budget, bringing the total state funding for home visiting to \$90 million over two years. After the budget negotiations were complete, the state invested an additional \$30 million in state GRF in the Help Me Grow program bringing the total biennial investment to \$70 million, up from \$40 million in the previous biennium.^{xxiii} Additionally, the Ohio Department of Medicaid invested \$47.1 million (\$14.1 million state GRF) in home visiting services as part of a package of investments and policies to support improved health for moms and babies.

With these incredible new investments and utilizing the recommendations of the Advisory Council as a playbook for action, the state team and home visiting stakeholders from across the state will have to work aggressively toward successful implementation of these new dollars to make progress on the Governor's goal of tripling families served by evidence-based home visiting. This is no small task given the state's complex home visiting system. Again, looking at a local snapshot in Cuyahoga County of how implementing the recommendations may look, will allow for a deeper appreciation for the opportunities that the recommendations provide.

Home visiting stakeholders across Ohio need to work aggressively within a complex system to meet the Governor's goal of tripling families served by evidence-based home visiting.

4 Recommendations through a Local Lens

1. Make race & ethnicity foundational elements of Ohio's infant mortality efforts:

- “While statewide infant-mortality reduction efforts have resulted in fewer babies dying before their first birthday, black babies continue to die at nearly three times the rate of their white peers. Accordingly, race, ethnicity, and a strong focus on racial disparities must be central to the state’s ongoing infant-mortality reduction efforts. The state should regularly report on the disparity and impact that social determinants, such as housing, can have on infant mortality. All state agencies that invest in home visiting—including the Ohio Department of Health, the Ohio Department of Medicaid, and the Commission on Minority Health— should use the reports to reevaluate their infant mortality strategy and investments.” ^{xxv}

~ Governor’s Council on Home Visitation

This recommendation encourages all state agencies that invest in home visiting to make program and policy choices in consideration of racial disparities and the social determinants of health. While there are many positive outcomes as a result of participation in evidence-based home visiting, its impact on infant mortality is one that Ohio needs to continue to leverage as the state benchmarks progress and outcomes in the home visiting system. As demonstrated on page 8 of this report, while Ohio is serving many women and families of color, the state must continue to target its marketing and enrollment efforts to reach the most high-risk women and pregnancies, which are disproportionately women of color.

In 2018, Ohio ranked 41st in the nation for infant mortality. ^{xxvi} In 2017, the black infant mortality rate was 15.6 per 1,000 live births, nearly three times the white rate of 5.3 per 1,000 live births. While there is national evidence to affirm the connections between home visiting participation and decreased infant mortality, Ohio specific data also exists to inform this fact. When comparing the risk of infant death among participants in Cincinnati’s Every Child Succeeds program, infants whose families did not receive home visiting were 2.5 times more likely to die in infancy compared with infants whose families received home visiting. Black infants were just as likely to benefit from home visiting as were non-black infants, which means this intervention closed the racial gap in outcomes for families who received the service. The program’s infant mortality rate, with no racial disparity, is currently 4.7 for every 1,000 births, far below the state rate of 7.2 per 1,000 births. ^{xxix}

The infant mortality rate in Cuyahoga County is one of the worst in the nation. Of the 13,871 babies born in the county in 2018, 118 didn’t make it to their first birthday. ^{xxx} 67% percent of these babies were African American from all socioeconomic levels. ^{xxxi} Given the impact of infant mortality on the community, their rich network of home visiting programs is a true asset to the community and some programs are specifically focused on reducing the racial disparity in infant mortality among black babies.



Evidence-based home visiting’s impact on infant mortality needs to continue to be leveraged as Ohio benchmarks progress and outcomes in the home visiting system.



Ohio Moms and Babies First, one of Cleveland’s home visiting programs, works to improve birth outcomes and decrease infant mortality rates with a focus on high-risk pregnant, African American teens and women in two target communities.^{xxxii} This service is provided by the Northeast Ohio Neighborhood Health Services, Inc which also houses complimentary special programs including the Comprehensive Prenatal Care Program (CPCP), Centering Pregnancy Initiative and Moms First which provides perinatal services to high-risk Cleveland pregnant women who are incarcerated, homeless and living in shelters and transitional housing up to the baby’s second birthday.^{xxxiii}

Cleveland is also fortunate to have a collaborative response to the infant mortality epidemic lead by First Year Cleveland. This approach integrates a broad and diverse set of community partners both inside and outside city and county government to implement a multitude of strategies and programs with racial equity at the center of their work alongside a clear understanding of the social determinants of infant mortality. Evidence-based home visiting continues to be a strong part of the solution but is complimented by an array of services and supports that recognize the needs of at-risk families and get to root causes of infant mortality.

Cleveland is also home to a growing community-based doula program that, at its core, is promoting holistic birth equity to change birth outcomes for African American babies and moms. Birthing Beautiful Communities (BBC) “provides social support to pregnant women at highest risk for infant mortality during the perinatal period. It holistically supports pregnant women to deliver full-term healthy babies and achieve equitable birth outcomes. Its free neighborhood-based services include childbirth and parenting education with workshops and classes on breastfeeding, stress relief, bonding with baby, co-parenting and healthy eating. It also offers perinatal support training to provide support for labor, delivery and postpartum health including depression, and family, life and personal goal planning.”^{xxxiv} Since its founding, BBC has trained 26 perinatal support specialists and served over 500 women in total since 2014. Of those who completed all required Sisters Offering Support (SOS) Circle interventions, 92% had full term pregnancies last year, and an overall 99.8% infant survival rate.^{xxxiv}

While it is a sound strategy for home visiting programs and other complimentary services to specifically target black women only, it is also possible to narrow and even eliminate racial disparities by executing existing evidence-based home visiting models to fidelity. Every Child Succeeds, a program without a racial disparity in birth outcomes, is implementing the Healthy Families America model and does not limit or target eligibility for the program beyond the state’s definition. Regardless of the model implemented, it is the ability to deliver the model to *fidelity* that is paramount in driving outcomes. This requires rigorous data collection and timely evaluation so that programs can course-correct where necessary when the outcomes they desire are not achieved. The state can play an integral role in supporting model fidelity and holding evidence-based home visiting and other complimentary programs accountable to a set of priority outcomes including infant mortality.

Regardless of the home visiting model, it is the ability to deliver the model to fidelity that is paramount in driving outcomes.



Additionally, concepts drawn from precision home visiting may allow the state to prioritize outcomes. “Precision home visiting is home visiting that differentiates what works, for whom, and in what contexts to achieve specific outcomes. It focuses on the components of home visiting services rather than on complex models of home visiting that are administered uniformly.”^{xxxv} Successful program implementors in the state already recognize the need to work within a program model to customize the intervention for high-risk families to achieve desired outcomes.

2. Create a central point of intake for all home visiting programs

- “A coordinated state system of home visiting requires a single point of entry for all programs. All home visiting providers—including evidence-based, evidence informed, and promising programs funded by the Ohio Department of Health, the Ohio Department of Medicaid, the Ohio Children’s Trust Fund, and the Commission on Minority Health—should use the state’s central intake system as their primary referral source. The system will connect families to all state-funded models of home visiting, based on eligibility, medical and social risk, and family choice. The system should minimize the of duplication of services. State agencies should work together to share data and ensure home visiting services are provided across systems.”^{xxxvi}
~ Governor’s Council on Home Visitation

The state of Ohio smartly invested in the Help Me Grow central intake and referral system which serves as a single point of entry for access and referral for all home visiting programs and Part C Early Intervention services across the state. On August 1, 2017, central intake transitioned from 83 entities serving 88 counties in various approaches and procedures to a single agency serving all 88 counties. Referrals are made through regional intake contacts who refer women to services available to them in their county.

A statewide system offers the early childhood community a significant opportunity to enhance care by:

- Providing a single point of entry, can promote maximum access and utilization of available family support programs services for each community;
- Assuring that families will be linked to the most appropriate services available based on needs;
- Allowing for uniformity across available programs, a uniform screening process and a uniform mechanism for referral follow-up;
- Promoting collaboration amongst early childhood programs at the state and local levels (shared data, referral across programs/populations);
- Eliminating potential for duplication of services by creating a single point of entry for families.

A coordinated state system of home visiting requires a single point of entry for all programs.





Every county including Cuyahoga has historical context around how local programs serving pregnant women and babies have developed, evolved and been integrated into the early childhood system. The unique footprint of each local community has challenged central intake to map out referrals on a county basis to reflect the priorities of the program and the needs and offerings of each community.

When a referral is made in Cuyahoga County, central intake assesses both eligibility and program capacity first for Nurse-Family Partnership, Health Families America and the Moms and Babies First program. Central intake also ensures the woman isn't already enrolled in a program to prevent duplication of services. If the woman is not eligible or there is no program availability, she is referred to another home visiting program such as Early Head Start. These programs may participate in central intake, even though they are not state-funded, through a memorandum of understanding or a "business associate agreement." In other situations, referrals are made through a warm transfer via phone call directly to the program.

In addition to making referrals to home visiting programs, central intake will also inform women of other complimentary services they may be eligible for that are not a duplication of services including Centering Pregnancy and Birthing Beautiful Communities (BBC) in Cuyahoga County. Resources are also provided to the woman about additional support through the United Way 2-1-1 such as food, clothing, diapers, housing, utilities, mental health services, addiction services and more. The intake staff works with the woman and her family to make the best linkage possible and ultimately client choice prevails among eligible and available options.

Cuyahoga County's experience and robust program offerings have informed central intake, because Bright Beginnings is both the regional contact and the state service provider for central intake. They have worked with these complimentary services or programs to integrate them into the system alongside evidence-based home visiting and understand the commonalities and differences between programs in their purpose, who they serve, and how they work together.

Cuyahoga County is working to integrate the local Pathways Community HUB into the central intake process which, is now required by statute for all HUBs since the state biennial budget for FY20-21 was passed this year (HB 166). The purpose of the Pathways Community HUB is to provide an evidence-based, organized, pay-for-outcomes-focused, network of community-based organizations that hire and train community health workers to reach out to those at greatest risk, identify their risk factors and assure that they connect to medical, social, and behavioral health services to reduce their risk. While the HUB is a complimentary care coordination service to home visiting programs and other perinatal supports, it should also serve as a critical referral source for home visiting services.

Every county has historical context around how local programs serving pregnant women and babies have developed, evolved and been integrated into the early childhood system.



Through the central intake process, counties have also had to map out all referral sources. In Cuyahoga County, the following are the various referral sources for evidence-based home visiting programs:

- Parents and Caregivers
- County Department of Children and Family Services through their Help Me Grow Liaison who educates caseworkers and coordinates referrals.
- University Hospital Rainbow Babies & Children through their child find specialist who educates hospital employees about services and coordinates referrals.
- Neighborhood Leadership Institute through Neighborhood Navigators who do outreach to pregnant women in communities.
- Cuyahoga County Board of Health through their Newborn Home Visit Nurses that conduct one home visit to parents with a newborn and submit referrals. ^{xxxix}
- State agreements and resources including the Ohio Department of Health, Ohio Department of Developmental Disabilities, Ohio Connections for Children with Special Needs and Birth Defects, Ohio Infant Hearing Program, Medicaid and Bold Beginnings.
- Help Me Grow provider agencies that conduct presentations and outreach as-needed while providing services (Early Intervention, Nurse-Family Partnership, Healthy Families America, Moms & Babies First)
- Partner home visiting providers (Moms First, The Centers Pregnancy Program, Parents as Teachers) and collaborative partners such as Early Head Start and Supporting Partnerships to Assure Ready Kids (SPARK).
- Other community referrals including schools, agencies, WIC, child care and physicians.

While the HUB is a complimentary care coordination service to home visiting programs and other perinatal supports, it should also serve as a critical referral source for home visiting services.

The communications and outreach to referral sources is a critical role that central intake plays in each community in addition to processing the referrals. Managing these networks is the gateway to the women and babies who need access to these services the most. The state can build upon these relationships and the role of central intake to meet the state's goal of serving more families and having a bigger footprint in communities.



3. Create a central data warehouse for all home visiting programs.

- “All home visiting providers—including evidence-based, evidence-informed, and promising programs funded by the Ohio Department of Health, the Ohio Department of Medicaid, the Ohio Children’s Trust Fund, and the Commission on Minority Health—should use the state’s home visiting data warehouse, Ohio Comprehensive Home Visiting Integrated Data System (OCHIDS). The director of Children’s Initiatives should work with the Ohio Department of Health and other appropriate state agencies to ensure data is interoperable with existing data management systems and that data is accessible and able to be extracted by providers and relevant state agencies.” ^{xi}

~ Governor’s Council on Home Visitation

There is an urgent need for data to be readily available to improve program and family level outcomes and ensure local programs are meeting desired outcomes set by the state. Quantitative and qualitative data is a key component of evaluating model fidelity. Data also identifies areas where there is need for system infrastructure to support programs in local communities. Additionally, data is required to maintain and grow the home visiting system. It allows the state to account for the return on investment of public dollars, providing an invaluable tool to advocates and stakeholders to continue to bolster the case for increased investments in home visiting.

The state has been steadily building upon the OCHIDS system and the field continues to affirm the potential that exists within this system to function in ways that benefit many stakeholders. The Advisory Council’s recommendation reinforces this belief by encouraging continued growth of the system to accommodate the full range of child-serving systems that are providing evidence-based home visiting and complementary services. Providing a common place for data from all these programs is a critical feedback loop for outcomes at all levels of the home visiting system and provides an opportunity for transparency as the state evaluates performance on priority outcomes.

While the OCHIDS system holds incredible potential, it will require time and steady investment before the infrastructure is built to fully function for all home visiting stakeholders and meet the aspirations of the Council’s recommendation. In the meantime, the state should consider what core set of metrics they would prioritize to which all programs, regardless of model type or funding source, can hold themselves accountable. In a scan of Cuyahoga County home visiting programs, including those currently reporting to OCHIDS and those that are not, we find instructive learnings on the way programs are required to and/or choose to report outcomes. Tracked outcomes are dependent on reporting requirements of various funding streams, applicable measures specific to the program model, and the discretion of individual program evaluators based on priorities set by the programs, their funders and their communities.

All home visiting providers should use the state’s home visiting data warehouse, OCHIDS.





State contracted providers must report on twenty-two outcome metrics and are instructed how to report them in detail with definitions of each metric: ^{xii}

- | | |
|-------------------------------------|--|
| 1. Preterm Birth | 12. Child Maltreatment |
| 2. Low Birth Weight | 13. Parent-Child Interaction |
| 3. Breastfeeding | 14. Early Language & Literacy Activities |
| 4. Depression Screening | 15. Developmental Screening |
| 5. Completed Depression Referrals | 16. Completed Developmental Referrals |
| 6. Well-Child Visit | 17. Behavioral Concerns |
| 7. Postpartum Care | 18. Intimate Partner Violence Screening |
| 8. Substance Abuse/Tobacco Use | 19. Intimate Partner Violence Referrals |
| 9. Substance Abuse/Tobacco Referral | 20. Primary Caregiver Education |
| 10. Safe Sleep | 21. Continuity of Insurance Coverage |
| 11. Child Injury | 22. Inter-Pregnancy Interval |

When you consider the additional programs not receiving state funding in Cuyahoga County that are enrolling from prenatal to three, there are less than ten overlapping metrics that are being tracked and reported for each compared to the state required metrics. Metrics tracked by home visiting programs serving preschool age children and other complimentary services vary substantially from state required metrics because all of their program outcomes are not shared. Even when the reported outcomes are shared, they may be defined differently. Additionally, newer programs and complimentary services may not have undergone an evaluative process to allow them to yet define and set metrics.

To identify a path forward, there first must be a recognition that not all programs are created equal—at-risk families and young children benefit from a robust offering of services with varied outcome metrics because they have varied needs. From a state systems measurement perspective, however, these realities present several challenges to identifying a core set of metrics for which all programs, not just current state funded Help Me Grow providers, could uniformly report into OCHIDS. It requires some thoughtful inquiry and engagement with local programs to understand for which metrics that is possible and instruction on the definition of those metrics. It also requires the state to review the existing metrics and consider whether they should be prioritizing any additional metrics. For example, tracking and reporting infant mortality rates among the population the program serves are not currently required by the state. If progress on this outcome is a shared priority, then it should be added to the reported metrics and considered as a core metric for varying programs to report on where birth outcomes are part of their model.

As the state builds out the OCHIDS system, it should also consider how to take an incremental approach to integrating it with other early childhood data systems, so it can track the utilization of families and young children and their progress and outcomes across the continuum of supports and services offered by the state. Home visiting is a powerful intervention, but it exists in a much larger early childhood landscape.

The state should consider how to take an incremental approach in integrating OCHIDS with other early childhood data systems—so we can track progress and outcomes across the continuum of supports and services offered by the state.



4. Leverage the Medicaid program to reimburse for eligible services in a more cost-effective manner.

- “The Ohio Department of Medicaid, in collaboration with the Ohio Department of Health, should investigate all options for using Medicaid funding to support home visiting services. The Ohio Department of Medicaid should develop its strategy and implement it within a reasonable amount of time.” ^{xlii}

~ Governor’s Council on Home Visitation

With its substantial federal match, ability to reach the most high-risk families, and health benefit alignment, Medicaid provides a powerful tool for scaling up home visiting and sustaining the new state investment over time. In some instances, the Medicaid program is already funding home visiting through managed care grant funds. Deepening that relationship and strategically financing home visiting through Medicaid will allow state funds to go farther in reaching more families. With half of all Ohio births financed by Medicaid already, the program also has unique access to vulnerable populations of women who could benefit from home visiting.

In operationalizing the Council’s recommendation, the state should ensure:

1. Any new benefit that is developed to leverage evidence-based home visiting should be incorporated into new managed care contracts being negotiated through the procurement process.
2. Evidence-based models are supported by strategic financing. This will require a review of rate structures so that they sufficiently reflect the cost of building and sustaining programs given the growth goal.
3. Evidence-based models are delivered to fidelity and have strong accountability to outcomes.
4. Evidence-based home visiting is available to and prioritized for the most at-risk Medicaid populations.

Strategically financing home visiting through Medicaid will allow state funds to go farther in reaching more families.

Medicaid has been used to finance home visiting services for mothers, infants and young children for over twenty years.^{xliii} In addition to being a lever for building capacity, home visiting goals are aligned with the goals of the Medicaid program as it concerns pregnancy, infancy, and early childhood and with the function of the pediatric medical home.^{xliv} “Through referrals, health education, and other direct interventions, home visiting services that achieve their goals can help to achieve the triple aim of improving the experience of health care (including quality and satisfaction), improving population health, and reducing per-capita health care costs.”^{xlv}



Among the 18 home visiting models that meet federal criteria for evidence-based home visiting, the table below is a summary of the primary and secondary favorable effects on maternal and child health outcome domains:

Table 3

Model Name	Maternal Health Primary	Maternal Health Secondary	Child Health Primary	Child Health Secondary
Attachment and Biobehavioral Catch-up (ABC)	Not measured	Not measured	Yes	
ChildFirst	Yes	Yes	Not measured	Not measured
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	Not measured
Family Connects		Yes	Yes	Yes
Family Spirit	Yes	Yes	Not measured	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	Not measured	Not measured
Maternal Early Childhood Sustained Home Visiting Program (MECSH)		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	Not measured	Not measured
SafeCare Augmented	Not measured	Not measured	Not measured	Not measured

Note: Highlighted models are those that are utilized with state and federal funding in Ohio. Ohio also implements Early Head Start through federal funds alone.

Source: Prepared for The Ounce Home Visiting Summit by Johnson Group based on: Sama-Miller, E., Akers, L. Mraz-Esposito, A. et al. Home Visiting Evidence of Effectiveness Review: Executive Summary. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. 2018. Adapted from Table 3. Favorable impacts on primary and secondary measures for home visiting effectiveness, by outcome domain



In review of the chart above, some models give greater emphasis to improving maternal, infant, and early childhood health both in short- and long-term outcomes. Of the three state-funded, evidence-based home visiting programs in Ohio (Health Families America, Nurse-Family Partnership and Parents as Teachers), both Healthy Families America, where we serve most families, and Nurse-Family Partnership emphasize these health outcomes. Accordingly, these programs and Medicaid share desired outcomes including improved birth outcomes, utilization of prenatal and postpartum care, well-child visits, immunizations, developmental screenings and more. While Medicaid's focus may be on these models, Medicaid financing could free up additional state funding in the Department of Health to grow capacity in Early Head Start and Parents as Teachers models across the state.

It comes as no surprise with alignment of outcomes in models, that there is also alignment among select measures for monitoring child health (prenatal to five years of age) across the following: core set of child health measures for Medicaid and CHIP; Health care Effectiveness Data and Information Set (HEDIS); Title V Maternal Child Health Grant National Measures and; Maternal, Infant, and Early Childhood Home Visiting (MIECHV).^{xlvi}

Medicaid, through managed care procurement, can also help to define roles between home visitors and community health workers. As the state held discussions on expanding home visiting, there was a failure to recognize the differences between evidence-based home visitors (currently operating under three state-funded models in Ohio including Health Families America, Nurse-Family Partnership and Parents as Teachers) and other complimentary interventions utilizing community health workers, including how they should work together for optimal efficiency and effectiveness. Both provide needed—but distinct—services.

Community health workers operate in a pay-for-performance care coordination model that identifies and addresses the comprehensive array of interrelated risk factors experienced by targeted populations in a geographic area. Community health workers come from the communities they work in and have a set of core competencies targeted at removing the barriers that prevent mothers from accessing care. While these services are offered in a home setting, they are not offered in the same structure, model and intensity as evidence-based home visiting.

Evidence-based home visiting is a targeted intervention that seeks to cultivate parents' ability to form strong, positive attachments with their children and to keep them safe; promote children's healthy physical, cognitive, and social-emotional development by monitoring their progress; guide parents in recognizing their children's and their own needs, provide access to appropriate services; and improve maternal and child health. Home visiting requires a strong and longer-term commitment from parents and is operated as a voluntary program.

The state has failed to recognize the differences between evidence-based home visitors (currently operating under three state-funded models), and other complimentary interventions utilizing community health workers.



The Departments of Medicaid and Health should take a shared accountability approach using both agencies and the health plans to advance these roles and leverage outcomes for pregnant moms, babies and young children. Medicaid should provide leadership in defining these roles, including through the use of the health plans.

Providing leadership should include conversation around the following:

1. Outlining how to define and view these strategies in a Medicaid context.
2. Creating an incentive in the community health worker structure to screen and refer families to home visiting services.
3. Specifying under what circumstances a mother could receive services from a community health worker and receive home visiting services to improve coordination and avoid duplication of services.
4. Revising the managed care contract to clarify roles and uses for the services provided through each model.

Defining roles and exploring Medicaid’s role in the state evidence-based home visiting system should require a broader vision of health outcomes that include, but are not limited to, birth outcomes. They must reflect the full needs of the family and child beyond the critical indicator of whether or not a child lives to their first birthday. While infant mortality is an absolutely critical measure, we cannot settle on that metric alone—Ohio babies deserve more than a first birthday. We should measure these outcomes and be mindful of the transitions inherent in the choices of programs we provide these families so that vulnerable parents and young children are supported beyond the first year of life.





CONCLUSION

Evidence-based home visiting is an effective method to support healthy child development, increase school readiness, prevent child maltreatment and promote positive parenting. It is a powerful intervention for families and young children that can be an integral part of the response to closing racial gaps in birth outcomes. Equity in birth outcomes and reduced infant mortality rates are among many outcomes achieved by home visiting interventions. While the state should leverage this connection, it also has to be responsive to the fact that the same children and families who it targets to ensure that babies celebrate their first birthday are still our most at-risk families after baby turns one. The state's home visiting system should reflect this fact by considering how to continue to build upon a diverse array of programming across the state and build new capacity in Early Head Start, programs serving toddlers and preschool aged children and programs that prevent families from entering into the child welfare system.

Home visiting exists on a continuum of early childhood and family health and education services that advance early childhood mental health and should be part of a comprehensive and coordinated system of these services.

The state should continue to explore how evidence-based home visiting advances early childhood mental health and how it aligns with a comprehensive system including child care, early intervention, preschool and the child welfare system. As the state implements significant new investments in evidence-based home visiting across agencies, it should continue to utilize the Advisory Council on Home Visitation's recommendations as a playbook. The state should also thoughtfully explore the integration of each recommendation from both a state system lens and a local community lens utilizing external partners early and often to advance shared goals.

Most importantly, the state must continue to provide the strong leadership required to implement the recommendations of the Advisory Council and deliver upon the Governor's goal of tripling the number of families benefiting from evidence-based home visiting in Ohio.

Equity in birth outcomes and reduced infant mortality rates are among many outcomes achieved by home visiting interventions.



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