



Universal Prenatal/Postpartum Care and Home Visitation: The Plan for an Ideal System in New York State

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Executive Summary

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Every family with a newborn baby deserves comprehensive supports from the prenatal period to pre-school. While the birth of a baby should be a joyous event and the first few years of a child’s life should be filled with hope and promise, parents usually find childbirth and child-rearing to be challenging experiences. They are not experiences that any family should go through alone.

This paper will describe a system of services that supports new families by providing three components: universal prenatal care, postpartum screening, and comprehensive home visiting.

All new families in New York State should receive assistance from a model-neutral system of support and services that promotes optimal health, mental health, family functioning and self-sufficiency. Such a system would serve all pregnant

women, infants, and new families (including first-time parents and existing families with new babies). This system of services would include universal contact/screening of all pregnant women and new families; assessments for parent, child and family health, mental health, developmental, social, literacy and other service needs; early intervention and referrals to an array of coordinated supports and services; and home visiting services of varying duration and intensity as needed. In addition, it would reflect a pyramid-type structure (*see diagram on page 3*) wherein all pregnant women and new mothers/families receive general services, those with identified needs receive more targeted services, and those at high-risk receive very specific, intensive services. Finally, the system would utilize proven practices and, in high-risk or high-need situations, evidence-based practices.¹

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Background

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Home visiting for families with new babies, as it currently exists in New York State, is characterized as a number of programs that provide quality services but that are too narrowly defined to be considered a true system. The current models are limited in scope by their own eligibility requirements, lack of financing, and geographic issues. Inconsistent integration between programs means that needy families may not qualify for services. And a lack of funding means that too few programs exist in the state to meet even the needs of those who do qualify.

The Home Visiting Philosophy

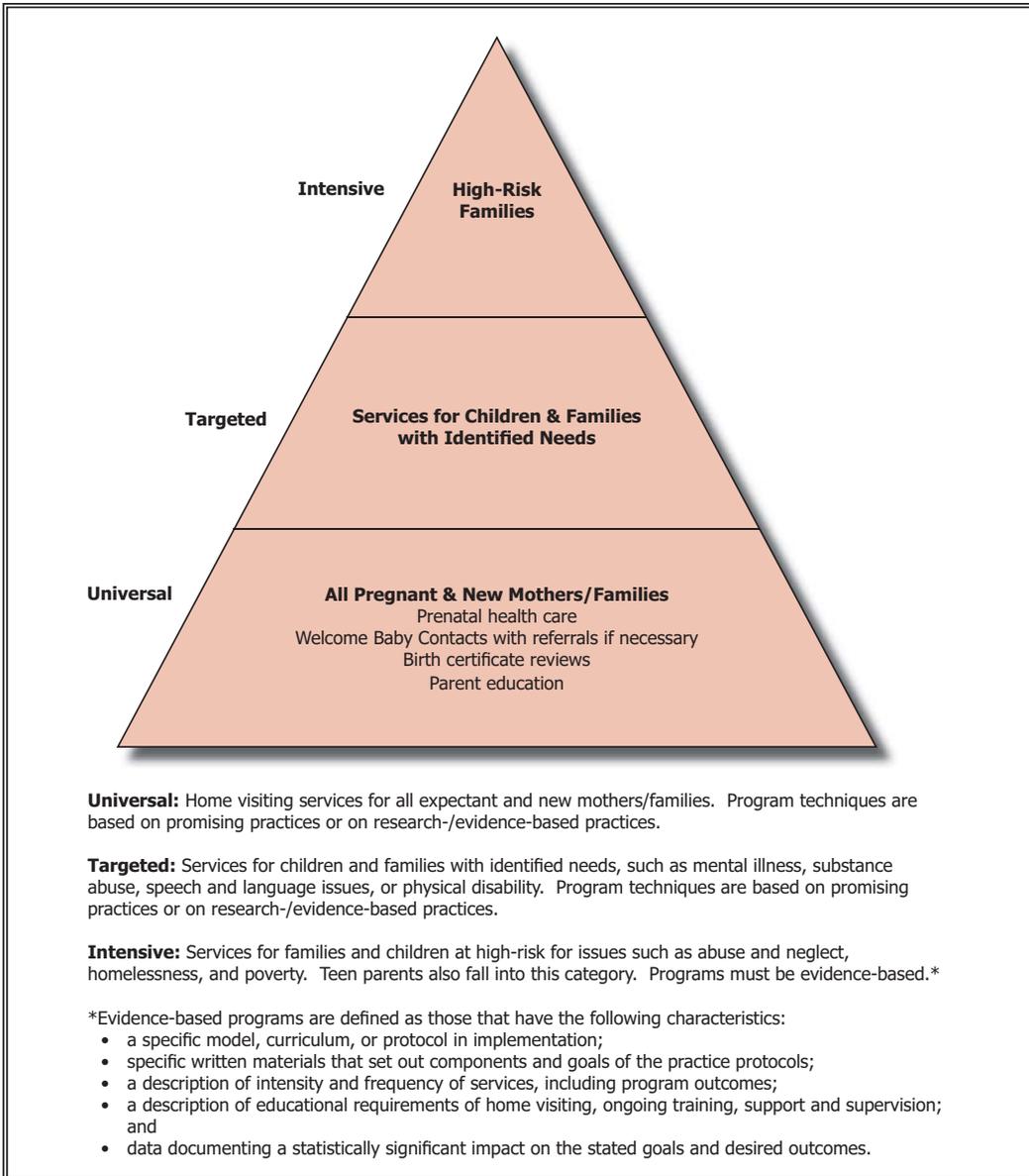
In general, home visiting programs that are not a component of another system, but that are specifically focused on families with new babies, work with those families in their homes by providing direct services or assessing need, connecting families with appropriate services, and monitoring ongoing well-being. Some comprehensive models follow a family and child until the child is ready for school. Home visiting is an extension of the once societal norm of families passing on knowledge about parenting from generation to generation. While at-risk families are more likely to experience poor health and economic outcomes than other families, all families could benefit from home visits.

Investments in home visiting programs have been shown to reduce costs associated with foster care placements, unintended pregnancies, hospitalizations and emergency room visits, and other costly interventions.² Home visiting can also assist with the identification of domestic violence, substance abuse, and other negative issues within the family. Staff is often the front-line reporting and referral system in those cases. Home visits are particularly effective because they occur *in the home*, allowing staff to observe families in their own environment, where they are comfortable. These in-home visits also

make it easier for families to participate, since the home visitor comes to them. Staff can also visit with the entire family to get a better view of what factors are influencing a child, and are able to build on the family's strengths. Staff may also become involved with the care of other children in the family (in addition to the one targeted for the visit), and can be helpful in addressing issues affecting siblings.

Ideally, universal home visiting programs focus on primary prevention by addressing and working to improve parenting skills, social-emotional and cognitive development, and physical and mental health. Thus, they also help to prevent child abuse and neglect, and improve birth outcomes (including increasing the spacing between pregnancies). Longer-term outcomes for children include stronger school performance, fewer behavioral problems, and higher high school graduation rates. For parents, programs that include life skills training can result in longer-term outcomes including reduced welfare dependency, higher educational completion and increased job retention, and a reduction in the frequency and severity of abuse and neglect.³ The decrease in maltreatment is a direct result of increased parental skills—parents learn in home visiting programs how to manage their anger, how to discipline their children effectively and without violence, and how to ask for help and support when they need it.

Postpartum services for infants and toddlers vary based on community need and priority. Ideally, these programs focus on education. They promote early literacy and school readiness by teaching parents the importance of interacting with their infant or toddler by singing, storytelling, reading, and drawing. Screening for risk of health concerns like autism, hearing loss, lead poisoning or developmental delays can be augmented by teaching techniques that address those difficulties and offer early treatment. Parents can benefit by learning that resources are available to address their own literacy or educational issues, and by taking advantage of those resources to build a better future for themselves and for their children.



National data estimates the cost of home visiting programs at \$5,000 - \$9,000 per child. On average, programs return \$2.24 for each dollar invested.⁴ However, investments and returns fluctuate depending on the range of services offered and the geographic location of the program.

New York State Data

There were 245,402 live births in New York State in 2005 (the most current year for data). Of those, 174,854 received prenatal care beginning in the first through third month, 45,563 received initial prenatal care in the fourth through sixth month, and 10,567 did not receive

prenatal care until the seventh to ninth month. While 795 women received no care, data was unavailable for an additional 13,623.⁵ Whereas 50% of white, non-Hispanic women received prenatal care, only 24% of Hispanic and 16% of black non-Hispanic women received care.⁶

A 2006 survey conducted by the New York State Bureau of Child and Adolescent Health asked 57 local health departments (LHDs) how they were handling births in the state, in terms of providing home visiting services. Of the 56 that responded in January 2007, 53 counties provide home visiting for pregnant and/or postpartum women and their babies. Of those, 39

provide services only through LHD-supported maternal and child health services. Thirteen provide services through structured grant-supported programs and through LHD-supported services, and one county provides services only through a structured grant-supported program. Of the 52 counties providing home visiting with some sort of LHD support, 38 target their services to specific families—those with multiple social risks, mothers of premature infants, pregnant teens or teen mothers, first-time or single mothers, and/or those with histories of child abuse and neglect.

The survey found that clients are referred to home visiting programs by health and human services providers, hospitals, primary care providers, and county government agencies, as well as by state or federal government programs (about half). Other client identification mechanisms include family request, birth certificate review, direct outreach at hospital during maternity stay, and review of hospital maternity logs. According to the survey, initial contacts are generally made via telephone, while contacts are also made via in-person visits in the client's home, in the hospital, and by mail.

LHD-sponsored home visiting programs served 4,615 pregnant women and 12,293 postpartum families in 2004. Postpartum families are the major focus of LHD activities, receiving an average of 2.2 visits during the reporting period. However, prenatal visits played a more important role in several counties. Ten reported reaching 20% of pregnant women, while one county served 70%. Yet the average prenatal client received 2.6 home visits, only enough to make referrals and “put out fires.”

Current Funding

Currently, New York State has a patchwork of funding for home visiting projects and programs. In 2007-08, TANF provided \$21.6 million in federal funding for Healthy Families New York (HFNY), which also received \$3.6 million from the state general fund. Early Head Start received approximately \$4.5 from federal Head Start funds. Counties used a combination of child welfare preventive money and Article VI (State Aid to Cities and Counties) money to fund community health workers and the Nurse Family Partnership (NFP).

Guiding Principles for an Ideal System

The ideal home visiting system is:

- Universal, but targeted for high-needs.
- Model-neutral (not based on one particular model).
- Voluntary in nature.
- Dependant on community-choice.
- Sufficient in terms of the infrastructure necessary to support it and the capacity to support all those who are eligible for services.
- Flexible enough to accommodate needs that might at first glance seem outside the range of typical home visiting services.
- Focused on the family and the parent and child (in this context, “parent” refers to the child’s primary caregivers).

“Will the health visitor be seen as someone who can be truly useful and accepted like a member of the old, lamented, extended family...I believe that, to a large extent, this will depend upon whether the program is started for all people, rich or poor, black or white, brown or red, or whether it is limited once again to the disadvantaged or the minorities. To my mind, only a universal program will develop quality and be successful.”

Dr. C. Henry Kempe, 1977
Physician and child abuse expert

- Culturally and linguistically sensitive and able to provide a comfortable, safe environment for the family.
- For families in need of the most intensive services, accountable for outcomes that are demonstrated through research and evaluated over time.

The cornerstone of the ideal system is its integration with other systems—an understanding that home visiting cuts across issues such as health, mental health, substance use, child welfare, criminal justice, and social services. The “three Cs”—cross-systems communication, collaboration, and coordination—are necessary to ensure that services are not provided piece-meal. Instead of being disjointed and fragmented, services are comprehensive and provided holistically. While the system addresses the needs of the “whole child,” it also understands that the child is just one part of a larger family unit. The intent, again for high-need families, is to build a relationship between the family and the home visitor that is supportive, nurturing, and educational.

The model is dependant on community choice in that communities would choose the program, or programs, that best suit the needs of the families in their area. The state, ideally, would issue a Request for Proposals that communities would respond to—explaining their program choices—and would then fund those programs accordingly. This would allow for intentional planning, instead of the piecemeal system that exists today.

The model system includes three components: prenatal, post-partum, and expanded/extended services. Currently, different models focus on different pieces of these services. Ideally, one system would focus on continuity of care throughout the continuum of pregnancy, birth, and early childhood.

► **Universal Prenatal Care and Screening**

Quality prenatal care greatly improves the birth experience. But preconception care, which is care prior to becoming pregnant, is equally important. A healthy woman is simply more likely to have a healthy baby. By age 25, approximately half of all women in this country have

experienced at least one birth.⁷ With 49% of all pregnancies in the United States unintended, quality preconception care is imperative.⁸

Are women seeking and receiving that care? One study found that adolescents who were white or African American, had higher verbal skills, or who came from families with insurance, were more likely to report having had a physical in the past year.⁹ Another analysis found that pediatricians provided the largest number of outpatient visits for early adolescent girls—43%. After age 16, a much smaller proportion saw pediatricians and family physicians, but had more visits to physicians overall due to higher numbers of visits to Ob/Gyns.¹⁰

In another analysis, the Youth Risk Behavior Surveillance survey showed that preventive visits for females varied little across the age range—58% of 15 year olds and 68% of 18 year olds reported having a preventive exam in the past year.¹¹

In a 2004 survey of women aged 18 – 44 years, 84% had a health care visit during the previous year. In any given year, 55% receive preventive care.¹² These are opportunities for physicians to provide preconception care—education about good health and screening and treatment for illnesses or risky behaviors that would affect a fetus.

According to the Centers for Disease Control and Prevention (CDC), 11% of women smoke during pregnancy, 10% drink alcohol, 31% are obese, 4% have preexisting medical conditions, and 3% take either over-the-counter or prescription medications that are known teratogens (cause structural abnormalities following fetal exposure). An additional 69% do not take folic acid supplements.^{13,14} Most prenatal care, which occurs during the 11th or 12th week of pregnancy, comes too late to prevent some major problems that a fetus is susceptible to during the first four to ten weeks.¹⁵ Intervention opportunities help to increase awareness and curb risky behaviors during the preconception period, so that a fetus is off to a healthy start even before a woman may realize she’s pregnant.

A healthy woman is simply more likely to have a healthy baby.

Interventions may also take place after the birth of one child and before a pregnancy with another. In fact, care and education during this period can help delay another pregnancy, leaving a healthy space between babies. Pregnancy spacing is best between two and a half and three years, in order to allow the mother's body to restore valuable nutrients, and to increase optimal bonding between mother and baby. Research shows that infants born to women who conceived less than six months after giving birth were 40% more likely to be born prematurely and had a 61% chance of low birthweight, compared to infants whose mothers waited 18 months to two years between pregnancies.¹⁶

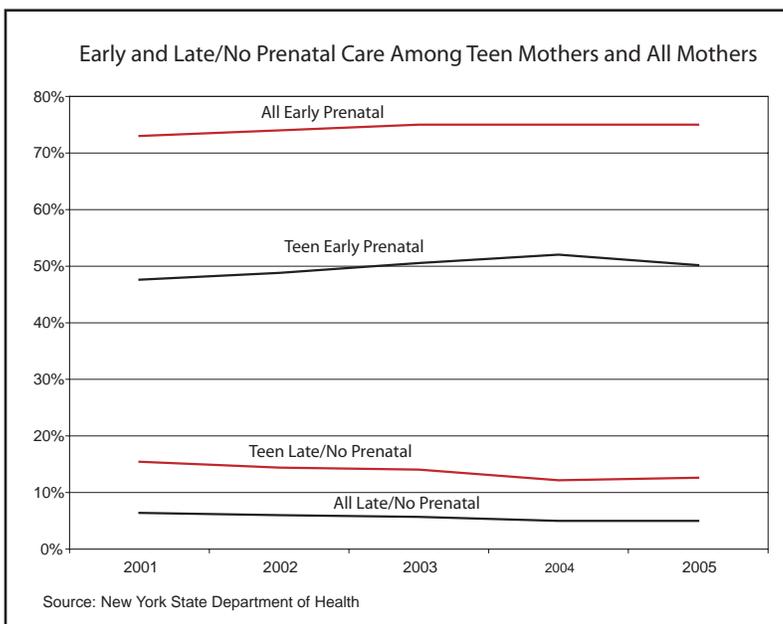
Once a woman is aware of her pregnancy, quality prenatal care is essential and is shown to improve birth outcomes. More than 60% of low birthweight babies are preterm/premature. In the U.S., premature birth is the leading cause of neonatal mortality (death in the first month of life), and accounts for 35% of all health care spending on infants.¹⁷ Research shows that home visiting programs not only improve access to prenatal care overall, but reduce preterm birth and low birthweight.¹⁸

How can New York State ensure that more pregnant women receive prenatal care? The state could provide universal, comprehensive maternity health insurance coverage. Covering

pregnant women through the birth process and postpartum, for a total of two years, would allow for not only quality prenatal care, but for quality postpartum care including education about pregnancy spacing. According to the American College of Obstetricians and Gynecologists (ACOG), there were 8,469 uninsured deliveries in New York State in 2004. Also according to ACOG, prenatal care expansion to 300% of the Federal Poverty Level (FPL) would cost the state an estimated \$12 million. Based on 2004 data, of the 249,000 live births that year, 4,235 were estimated to be Medicaid participants up to the proposed 300% FPL. Assuming that \$6,000 is the average cost of prenatal care, delivery, and postpartum services in New York State, the total federal/state cost of prenatal care expansion to 300% FPL would be \$25,410,000. The federal/state share split would amount to \$12,705,000 each.¹⁹

Until such coverage exists, the state can promote enrollment and increase access through a variety of means. One way to promote enrollment is to reduce the declination rate—the number of women who decline home visits initially. The issue becomes—how do you reach them later, when they may be more willing to accept care, having experienced the birth process and the early days of their child's infancy? County health workers appear to have more luck with outreach than state agencies, perhaps because they are a known entity that many of these women have had contact with before. With that in mind, the state should encourage county health workers to reach out to this population, and should track their progress—monitoring outreach and evaluating what efforts work to reduce the declination rate. Creative ideas that are successful may be used in prenatal outreach, as well.

New York should also aim to reduce the percentage of women receiving inadequate care by half in three years time. Currently, 10% of women receive late prenatal care, or none at all. The reduction goal can be achieved through a system where the focus is on quality of care. Ob/Gyns, primary care physicians, and midwives should identify and refer pregnant women to home visiting programs early. In addition,



health care providers should be trained to screen not only for physical health issues (such as chronic diseases like diabetes and HIV), but should be able to spot substance abuse and domestic violence and be equipped to refer women for treatment of those issues. While perhaps not able to diagnose social-emotional issues and mental illness, providers should be equipped to screen for those issues and refer—with the understanding that all health issues are interconnected and that mental health issues often co-occur with substance use and chronic diseases. Providers should coordinate resources and link between different specialties to decrease gaps, utilize overlaps, and increase referrals. In essence, health care providers must treat the whole woman if our hope for her is a healthy baby.

In addition, self-assessment can be a valuable tool in circumstances where resources are stretched and time is tight. A brief survey that a woman fills out as she waits for an appointment can then be used by her doctor to diagnose, refer, or simply start a discussion about issues of concern. However, self-assessment will only work if the woman is comfortable with her health care provider and trusts him/her to provide her with the best counsel and treatment. Fear is a great barrier to not seeking treatment. The care environment should be one that is accommodating, accessible, and responsive to the patient's needs.

► **Universal Postpartum Care and Screening**

The birth moment is critical and an important opportunity for outreach and education. New York State should take steps to expand both data collection and outreach initiatives. The state should direct all local health departments to conduct birth certificate reviews, in order to track and document the number of live births in each county. This would provide the state with much-needed data, as well as document home births so that home visiting can occur in those families. In hospitals, knowledgeable staff should conduct Welcome Baby contacts—reaching out to all new parents before they leave the hospital or via phone immediately

after, dropping off literature regarding the basics of infant health including home visiting information, and answering any questions. This first exposure to postpartum supports is critical. Women who leave the hospital feeling confident may well have doubts or concerns later and will be able to access the information and contacts provided by the Welcome Baby visit.

Health care providers/hospitals, mental health/substance use providers, managed care plans, and home visiting programs should identify existing resources and coordinate them, linking programs and services wherever possible. A “no wrong door” approach will increase access and save valuable time where intervention or treatment is necessary. These providers and programs should also agree on a universally-used, standardized screening tool, so that all assessments are consistent and take into account the same criteria.

► **Expanded and Extended Services**

All home visiting programs provide services postnatally. While offering support to new parents is critical, touching base with them before they become parents is both advisable and optimal. Services should begin prenatally—preparing parents-to-be for the changes a baby will bring, enhancing the birth experience, and preventing abuse through education and early intervention.

Finding pregnant women requires outreach, especially if they are skeptical of health care providers, suspicious of motives, uneducated about the importance of care, or dealing with issues such as mental illness or substance abuse. A number of outreach programs currently exist in New York State. Some of these are targeted to specific groups of women with similar needs. *Detailed descriptions are located in the appendix.*

One model is the **New York State Office of Mental Health's New Mothers Wellness Project**, which was developed with the input of women with mental illness. The Project tackles the issues that pregnant women and new mothers with mental illness face. Not surprisingly, those issues are often identical to those faced by women without mental illness.

The birth moment is a critical and important opportunity for outreach and education.

Another is the **Buffalo Home Visiting Program**, a Healthy Families NY (HFNY) program that has engaged in a **Fetal Alcohol Spectrum Disorder (FASD) Project** since 2006. The Program screens potential participants and enrolls those women with positive alcohol screens. It now assesses approximately 300 families per year and conducts home visits for over 400 families. Prevent Child Abuse NY provides training on motivational interviewing (MI) and is currently working with four other HFNY programs on MI. The plan is to eventually provide the training to all HFNY sites.²⁰

The **Community Health Workers Program** has 23 sites statewide. Workers are paraprofessionals who target communities with specific needs or risk factors, such as high rates of infant mortality and poor birth outcomes, large numbers of unwed or teenage mothers, and large populations of low-income families. They focus on getting pregnant women into prenatal care and then assist families in accessing services, addressing concerns and problem areas, dealing with domestic issues, and ensuring the health of the infant and family.

Other programs, such as **Community Action for Prenatal Care (CAPC)**, also work to improve birth outcomes. CAPC works, in particular, on lowering HIV transmission by recruiting high-risk pregnant women into prenatal care.

Teenage Services Act (TASA) programs counsel teenagers and provide pregnancy and parenting information, as well as life skills training.

In addition, over the past 20 years, the **Comprehensive Prenatal-Perinatal Services Network Program (CPPSN), or Perinatal Networks**, has provided information about and facilitated enrollment in Medicaid and Child Health Plus, assisted with access to prenatal care, and promoted healthy behaviors.

The New York State Department of Health also administers the **Early Intervention Program (EIP)**, modeled after the national program for infants and toddlers with disabilities and their families. Children under age three with a disability or developmental delay

are eligible for therapeutic and support services, including home visits. This is a different type of home visiting, focused specifically on the child's disability. However, it only makes sense that these services should be aligned with other home visiting services, and that communication should take place between the two systems in order to coordinate efforts.²¹

New York State should identify all existing outreach programs and ensure that they work together wherever possible. Community-based organizations should be encouraged to collaborate and share resources. At the very least, existing programs can share information on evidence-based practices and can mentor each other on what works and what doesn't.

In addition to the coordination of outreach services, an ideal model stresses and promotes service collaboration—a “no wrong door” approach—so that pregnant women can access care regardless of where they enter the system. Once home visits take place, those visits should address a host of issues and workers should be trained to both educate and inform, as well as to refer for treatment. Follow-up with families is also important and should include ongoing education for the family and ongoing training for the staff. And, assessment after a family leaves care would allow documentation of the family's progress, updates on the child's health and wellness, and insight into how effective the program is.

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Current Programs

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There are a number of home visiting programs active in New York State, some geared more toward certain populations. *Detailed descriptions are located in the appendix.*

Healthy Families New York (HFNY), based on the national Healthy Families America (HFA) model, is an evidence-based, community-based prevention program that targets expectant parents and parents with an infant less than three months of age who are con-

sidered to be at high-risk for child abuse and neglect. Specially trained paraprofessionals, who typically share the same language and cultural background as participating families, may deliver home visitation services until the child reaches five or is enrolled in Head Start or kindergarten.

HFNY currently operates in 29 high-need communities throughout New York State including 10 entire counties and 9 sites in New York City. Since HFNY began in 1995, the program has provided over half a million home visits to more than 17,000 families. **OCFS recently awarded grants to support 10 new HFNY programs across the state, bringing the total number of programs to 39. The per family per year cost averages between \$3,500 - \$4,000, with slightly higher costs in New York City. That figure is based on the state's investment plus 10% local share, divided by the number of families served.**

The **Nurse-Family Partnership (NFP)** is a national, nurse-led, evidence-based home visiting program targeted to low-income, first-time mothers in designated high-risk communities. Specially trained registered nurses, who carry a caseload of no more than 25 families, conduct frequent home visits during pregnancy and until the child's second birthday.

The NFP now operates in over 250 counties in 23 states, serving over 20,000 families per year. **Currently, there are 3 counties implementing NFP in New York State (Onondaga, Monroe and New York City). As of October 2007, the New York City Department of Health and Mental Hygiene (NYC DOHMH) will be funded to serve 1,300 families, and by fall 2008, will expand to serve over 2,400 families. The NYC DOHMH estimates that the program it runs in New York City costs approximately \$5,500 per family per year.**

Early Head Start is a federally-funded, evidence-based grant program that provides low-income pregnant women and families with

children from birth to age three with family-centered services that facilitate child development, support parental roles, and promote self-sufficiency. Across the state, Early Head Start programs look different depending on the grantee's plan; however, all Head Start programs follow strict performance standards as regulated by the federal government. All Head Starts include a home visitation component and all programs must screen enrolled children in the areas of child development, health, and mental health.

There are 40 Early Head Start programs across New York State. The average cost per child is \$10,000, although costs vary widely from program to program.

No "wrong door" means women can get care and services regardless of where they enter the system.

The **Parent-Child Home Program**, an evidence-based

home visiting model, prepares young children for school success by increasing language and literacy skills, enhancing social-emotional development, and strengthening the parent-child relationship. The Program targets families with two- and three-year-olds who face multiple obstacles to educational and economic success, including living in poverty, low parental education level, being a single or teenage parent, experiencing illiteracy, being homeless, and having language barriers. Families receive twice-weekly home visits over a two year period (typically on a school year calendar). **There are 29 sites in New York, plus the national office. On average the cost of the Program is \$2,250 - \$2,500 per family per year.**

Home Instruction for Parents of Preschool Youngsters (HIPPIY) is a parent involvement, school readiness program that helps parents prepare their three-, four-, and five-year old children for success in school and beyond. The program provides parents with a set of carefully developed curriculum, books and materials designed to strengthen their children's cognitive skills, early literacy skills, social-emotional and physical development. A model HIPPIY site serves up to 180 children with one coordinator and 12-18 part-time home visitors. **There are three HIPPIY sites in New**

York State, in the Bronx, Bedford-Stuyvesant, and Yonkers. The cost per child per year is approximately \$1,500.²²

Parents as Teachers (PAT) has the overarching program philosophy of providing parents with child development knowledge and parenting support through four program areas: Born to Learn, Professional Development, Meld and Advocacy. The four-part intervention model known as Born to Learn delivers its mission-based program through intermediaries (parent educators) to the ultimate recipients (parents), while Professional Development is delivered directly to end users (professionals). Meld is a facilitated group model that draws on peer support. *There are 53 Parents as Teachers sites in New York State. Many of the HFNY sites are also PAT sites and use the PAT curriculum. The cost per child per year is between \$1,400 and \$1,500.²³*

Each of these programs has different eligibility requirements and program lengths. *Specifics are detailed in the chart in the appendix.*

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Recommendations

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The following recommendations describe the components of an ideal system for universal prenatal care, postpartum screening, and comprehensive home visiting.

- **Provide universal contact.** Known high-risk families are not the only ones who could benefit from home visiting. Preconception and prenatal care can help prepare women for pregnancy and childbirth. Welcome Baby visits can provide families with resources and linkages to services they may use in the future.
- **Phase in a universal system.** This type of reform cannot happen overnight. The state should pull together key policymakers, program experts, and advocates to study and determine the most effective implementation and expansion process. Programs should be built up over time. Communi-

ties should be the deciding voice on which program(s) to use, and how to proceed with outreach and enrollment.

- **Build capacity at both ends.** The state must have both prenatal and postpartum services in place and available, so that when those at high-risk are referred for services, they receive them in a timely manner.
- **Strengthen the web of services geographically as well as conceptually.** There are pockets around the state where programs do not exist and, in rural areas, even existing programs may be difficult to access. The state should identify where these areas are, collaborate with communities on determining which program(s) to offer, research effective outreach strategies, and then implement the chosen program(s). Services should be integrated, take a “no wrong door” approach, and adhere to the “three Cs”—cross-systems communication, collaboration, and coordination.
- **Patch the holes in the safety net.** The state should increase the number of avenues available to catch people who fall through the cracks, both prenatally and immediately postpartum.
- **Institute a cross-county referral system.** In order to refrain from duplicating effort, the state and its programs should collaborate by sharing information on program participants and potential enrollees. This communication would help to strengthen the safety net. The state should examine federal privacy laws to determine what information can be easily shared, and then direct state and county agencies to do so. The state should fund the planning, technical assistance, and start-up tools necessary to make such data-sharing a reality. The state should also create a central intake facility, where all information is stored.
- **Enhance parent education, school readiness and early literacy.** Children should be happy, healthy, and ready to learn when they enter preschool. This means providing them with a solid foundation on which to grow and preparing them

for the educational system. School readiness begins at home and encompasses the physical, cognitive and social-emotional development of children. Early literacy is one component that must be addressed to ensure that children are ready for school and for life. Parenting education gives parents access to accurate, helpful information and strong support, as well as positive role models for parenting so that they are better equipped to teach their children.

- **Invest in the evaluation and assessment of program outcomes.** The state should identify what works and what doesn't, as well as what challenges and barriers exist in taking such an effort to scale.
- **Increase funding.** The state should fund home visiting in the pyramid context—start-up and long-term implementation funds for universal services; funding to support programs that provide services to children and families with identified needs; and the bulk of the funding to programs that provide intensive services to high-risk children and families. The state should also fund a cross-county referral system and an evaluation of program outcomes.

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Conclusion

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It is time for New York State to concentrate and coordinate its home visiting efforts for pregnant women and new families. Services need to be comprehensive, while remaining broad enough to meet the needs of different people and communities. The ideal system outlined in this white paper would accommodate the needs of a larger population and would pave the way for healthier births, healthier babies, and healthier families, with an investment that pays back for generations to come.

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Endnotes

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- ¹ In this context, evidence-based refers to those practices proven through research and evaluated as having value.
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- ³ Dar, Deborah; *Supporting Children and Families through Home Visitation Strategies*; Chapin Hall Center for Children at the University of Chicago; presentation 2007.
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- ⁵ New York State Department of Health; 2005; http://pandora/nysdoh/vital_statistics/2005/table12.htm
- ⁶ New York State Department of Health; *Distribution of Prenatal Care by Race/Ethnicity*; 2005.
- ⁷ Johnson, Kay; Posner, Samuel; Biermann, Janis; Cordero, Jose; Atrash, Hani; Parker, Christopher; Boulet, Sheree; and Curtis, Michele; *Recommendations to Improve Preconception Health and Health Care—United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care*; April 2006.
- ⁸ 2001 data from Finer, Lawrence and Henshaw, Stanley; *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*; 2006.
- ⁹ National Longitudinal Study of Adolescent Health data, as presented by Cynthia Rand, MD, MPH at the NVAC Meeting; January 9, 2005.
- ¹⁰ Analysis of the 2000-02 National Ambulatory Medical Care and National Ambulatory Medical Hospital Care surveys, as presented by Cynthia Rand, MD, MPH, at the NVAC Meeting; January 9, 2005.
- ¹¹ 1999 data as presented by Cynthia Rand, MD, MPH at the NVAC Meeting; January 9, 2005.
- ¹² Johnson, Kay; Posner, Samuel; Biermann, Janis; Cordero, Jose; Atrash, Hani; Parker, Christopher; Boulet, Sheree; and Curtis, Michele; *Recommendations to Improve Preconception Health and Health Care—United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care*; April 2006.
- ¹³ Centers for Disease Control and Prevention; *Why is Preconception Care a Public Health Concern?*; April 2006; <http://www.cdc.gov.ncbddd/preconception/whypreconception.htm>
- ¹⁴ Folic acid is a B vitamin. If a woman has enough in her system prior to becoming pregnant, it can help prevent major birth defects of the brain and spine.
- ¹⁵ Ibid.
- ¹⁶ Boyles, Salynn; *Pregnancy Spacing Affects Outcome*; WebMD Medical News; April 2006; <http://www.webmd.com/news/20060418/pregnancy-spacing-affects-outcome>
- ¹⁷ O'Neill, Cassandra; *Healthy Babies: Efforts to Improve Birth Outcomes and Reduce High Risk Births*; National Governors Association Center for Best Practices; June 2004.
- ¹⁸ Association of State and Territorial Health Officials (ASTHO); *Bringing Home Better Birth Outcomes*; ASTHO; June 2006.
- ¹⁹ *Estimated New York State Cost to Expand Prenatal Care to 300% of the Federal Poverty Level*; ACOG.
- ²⁰ Information provided by Joy Griffith, Office of Children and Family Services; September 2007.
- ²¹ http://www.health.state.ny.us/community/infants_children/early_intervention/
- ²² <http://www.hippyusa.org>; July 2007.
- ²³ <http://www.parentsasteachers.org/>; July 2007.

APPENDIX A

Current Programs

There are a number of home visiting programs active in New York State. While some are geared more toward certain populations, each serves a purpose.

- **Healthy Families New York (HFNY)**, based on the national Healthy Families America (HFA) model, is an evidence-based, community-based prevention program that targets expectant parents and parents with an infant less than three months of age who are considered to be at high-risk for child abuse and neglect. Specially trained paraprofessionals, who typically share the same language and cultural background as participating families, may deliver home visitation services until the child reaches five or is enrolled in Head Start or kindergarten.

Through community health and social service agencies and hospitals, the HFNY programs screen potential participants for risk factors that are predictive of child abuse and neglect, such as single parenthood, teen pregnancy, poverty, poor education, unstable housing, substance abuse or mental health problems. Parents who screen positive are referred to the HFNY program, which conducts an assessment interview to determine their eligibility, using the Family Stress Checklist, a tool that measures their risk of abusing or neglecting their children. Parents who score above a pre-determined cut-off on the Family Stress Checklist are offered the opportunity to receive home visitation services.

Home visitors provide families with support, education, and linkages to community services aimed at addressing the following goals: promoting positive parenting skills and parent-child interaction; preventing child abuse and neglect; ensuring optimal prenatal care and child health and development; and increasing parents' self-sufficiency. Home visits are scheduled biweekly during pregnancy and weekly during the first six months or so of the child's life. As families progress through the service levels based on their needs, the frequency of home visits declines, from biweekly, to monthly, and then quarterly.

HFNY currently operates in 29 high-need communities throughout New York State including 10 entire counties and nine sites in New York City. Since HFNY began in 1995, the program has provided over half a million home visits to more than 17,000 families. The Office of Children and Family Services (OCFS) recently awarded grants to support 10 new HFNY programs across the State, bringing the total number of programs to 39. The per family per year cost averages between \$3,500 - \$4,000, with slightly higher costs in New York City. That figure is based on the State's investment plus 10% local share, divided by the number of families served.

- The **Nurse-Family Partnership (NFP)** is a national, nurse-led, evidence-based home visiting program targeted to low-income, first-time mothers in designated high-risk communities. Specially trained registered nurses, who carry a caseload of no more than 25 families, conduct frequent home visits during pregnancy and until the child's second birthday. The consistent schedule fosters the setting of small, achievable goals. With each visit, nurses follow specific guidelines focusing on several domains: personal health, environmental health, quality of caregiving for the child, maternal life course development, family/friend networks, and health and human service utilization. The program emphasizes recognizing and enhancing the mother's ability to determine her own future.

The Washington State Institute for Public Policy estimated the implementation costs per family (in 2003) at \$9,118 and benefits at \$26,298, leaving a net return to society of \$17,180 per family served. The New York City Department of Health and Mental Hygiene (NYC DOHMH) estimates that the program it runs across New York City costs approximately \$5,500 per family per year.

The NFP now operates in over 250 counties in 23 states, serving over 20,000 families per year. Currently, there are seven NFP sites in New York State, including in Monroe and Onondaga counties. In October 2007, the NYC Department of Health and Mental Hygiene will expand the NFP to serve additional communities.

- **Early Head Start** is a federally-funded, evidence-based grant program that provides low-income pregnant women and families with children from birth to age three with family-centered services that facilitate child development, support parental roles, and promote self-sufficiency. Across the State, Early Head Start programs look different depending on the grantee's plan; however, all Head Start programs follow strict performance standards as regulated by the federal government. All Head Starts include a home visitation component and all programs must screen enrolled children in the areas of child development, health, and mental health. There are 40 Early Head Start programs across New York State. The average cost per child is \$10,000, although costs vary widely from program to program.
- The **Parent-Child Home Program**, an evidence-based model, prepares young children for school success by increasing language and literacy skills, enhancing social-emotional development, and strengthening the parent-child relationship. The Program targets families with two- and three-year-olds who face multiple obstacles to educational and economic success, including living in poverty, low parental education level, being a single or teenage parent, experiencing illiteracy, being homeless, and having language barriers. Families receive twice-weekly home visits over a two year period (typically on a school year calendar). Each week a gift of a book or educational toy, the curricular material for the week, is given to the family. During the home visit, Home Visitors model reading, play, and quality verbal interaction activities for parent and child together. The site Coordinator and the Home Visitor also connect families to other community services and to the next appropriate educational step for the child. On average the cost of the Program is \$2,250-\$2,500 per family per year.
- **Home Instruction for Parents of Preschool Youngsters (HIPPIY)** is a parent involvement, school readiness program that helps parents prepare their three-, four-, and five-year old children for success in school and beyond. The

program provides parents with a set of carefully developed curriculum, books and materials designed to strengthen their children's cognitive skills, early literacy skills, social/emotional and physical development. All HIPPIY programs around the world follow the HIPPIY model: a developmentally appropriate curriculum, with role play as the method of teaching, staffed by home visitors from the community, supervised by a professional coordinator, and with home visits interspersed with group meetings as the delivery methods. A model HIPPIY site serves up to 180 children with one coordinator and 12-18 part-time home visitors. There are three HIPPIY sites in New York State, in the Bronx, Bedford-Stuyvesant, and Yonkers.

Although HIPPIY is for any parent who wants educational enrichment for his/her child, the HIPPIY model was designed to remove barriers to participation due to lack of education, poverty, social isolation and other issues.

The cost per child, per year, is approximately \$1,500.ⁱ

- **Parents as Teachers (PAT)** is the overarching program philosophy of providing parents with child development knowledge and parenting support. The organizational vehicle for delivering that knowledge and support is Parents as Teachers National Center. The National Center drives that philosophy, or mission, through four program areas: Born to Learn, Professional Development, Meld and Advocacy. All of these program areas work through a strong network of state leaders and partners. The four-part intervention model known as Born to Learn delivers its mission-based program through intermediaries (parent educators) to the ultimate recipients (parents), while Professional Development is delivered directly to end users (professionals). Meld is a facilitated group model that draws on peer support. Advocacy works through both public and private sectors to promote positive policies for young families. Although several vehicles are used to implement the mission-based programs, the network is an organized affiliation of many organizations and people with a common mission.

There are 53 PAT sites in New York State. Many of the HFNY sites are also PAT sites and use the PAT curriculum. The cost per child, per year, is between \$1,400 and \$1,500.ⁱⁱ

- The **New York State Office of Mental Health's** New Mothers Wellness Project was developed with the input of women with mental illness. The Project tackles the issues that pregnant women and new mothers with mental illness face. Not surprisingly, those issues are often identical to those faced by women without mental illness. The *New Mothers Wellness Project* has both prenatal and post-partum resources available: both a Prenatal and Postnatal Information Guide, a Prenatal and Postnatal Knowledge Inventory, a Prenatal and Postnatal Material Resource Inventory, a Prenatal and Postnatal Educational Resource Inventory, a Prenatal and Postnatal Support Checklist and Personal Support Inventory, and a Prenatal and Postnatal Goal Planning Sheet.

The information guides provide women with information regarding wellness planning for body, mind, and spirit. The knowledge inventories allow women to evaluate how much they know about health and wellness, as well as what they need to concentrate on to keep themselves and their babies healthy. The material resource inventories are designed to get women thinking about things like Social Security, child support, and transportation. The educational resource inventory provides information on child-birth classes, parenting classes, and pregnancy resource books. The support checklists and personal support inventories offer answers to questions, emotional support, and referrals. The goal planning sheets do just that—allow women to set goals for their future and the future of their child.

- The **Buffalo Home Visiting Program**, a Healthy Families NY (HFNY) program that has engaged in a **Fetal Alcohol Spectrum Disorder (FASD) Project** since 2006. The Program screens potential participants and enrolls those women with positive alcohol screens. The primary intervention used to reduce alcohol consumption is Motivational Interviewing (MI).

Once enrolled, women with positive alcohol screens are assigned to Family Support Workers (FSWs) specifically trained in MI. Each family assessed is given educational material about FASD. All enrolled families receive an educational session in FASD, including viewing the SAMHSA video, *Recovering Hope* and participating in discussions with the FSW. All women are encouraged to practice family planning and use birth control if they are using alcohol and refrain from drinking if they are pregnant. Women are referred to Planned Parenthood for services and they also provide group informational sessions for program participants.

The initial project funded through the federal Substance Abuse and Mental Health Services Administration (SAMSHA) and the New York State Office of Alcoholism and Substance Abuse (OASAS) allowed for a caseload of 25 women. Funding was discontinued in March 2007 due to federal cutbacks, but OCFS was able to provide additional funds to continue and expand the program. Training and continued follow-up support on MI is provided by Prevent Child Abuse NY (PCANY), funded by OCFS. The Program now assesses approximately 300 families per year and conducts home visits for over 400 families. PCANY is continuing to provide training on MI and is currently working with four other HFNY programs. The plan is to eventually provide the training to all HFNY sites.ⁱⁱⁱ

- The **Community Health Workers Program** has 23 sites statewide. The Workers are paraprofessionals who target communities with specific needs or risk factors, such as high rates of infant mortality and poor birth outcomes, large numbers of unwed or teenage mothers, and large populations of low-income families. Workers are trained to educate and refer for services. They focus on getting pregnant women into prenatal care and then assist families in accessing services, addressing concerns and problem areas, dealing with domestic issues, and ensuring the health of the infant and family. Workers make home visits at least once a month throughout a pregnancy and through a baby's first year of life.

- **Community Action for Prenatal Care (CAPC)** works, in particular, on lowering HIV transmission by recruiting high-risk pregnant women into prenatal care. Understanding that high-risk women may be hesitant to seek prenatal care or undergo necessary treatment, CAPC uses a specialized approach to contact, identify, and intervene. The program has community coalitions in Brooklyn, the Bronx, Northern Manhattan, and Buffalo. Outreach workers develop trusting relationships with high-risk pregnant women who are not in prenatal care, and utilize a behavior change and harm reduction approach to get them into care. An outreach worker may need to explain the importance of care and what that care would entail. Workers also develop plans for accessing case management services and keeping appointments. The overall intent of the program, aside from reducing poor birth outcomes and HIV transmission, is to make prenatal care more user-friendly to this population.^{iv}
- **Teenage Services Act (TASA)** programs counsel pregnant and parenting teenagers by providing life skills training. TASA programs are available only to those youth who enroll before age 20 and who are receiving public assistance or Medicaid. TASA case managers perform family assessments, work with the youth to develop a service plan, and help the youth obtain and access services. TASA helps youth with health services both before and after birth. Furthermore, in addition to providing parenting skill training, the program assists with entitlements (such as food stamps), housing, education, and job skill training.^v
- The **Comprehensive Prenatal-Perinatal Services Network Program (CPPSN), or Perinatal Networks**, has, for the past 20 years, provided information about and facilitated enrollment in Medicaid and Child Health Plus, assisted with access to prenatal care, and promoted healthy behaviors. The Networks are Department of Health-sponsored community-based organizations that partner with local health and social service providers to identify and address gaps in prenatal services. They often host programs and do outreach on specific issues, such as smoking cessation, nutrition, and screening for substance abuse.
- The New York State Department of Health also administers the **Early Intervention Program (EIP)**, modeled after the national program for infants and toddlers with disabilities and their families. Children under age three with a disability or developmental delay are eligible for therapeutic and support services, including home visits. This is a different type of home visiting, focused specifically on the child's disability. However, it only makes sense that these services should be aligned with other home visiting services, and that communication should take place between the two systems in order to coordinate efforts.^{vi}

ⁱ <http://www.hippyusa.org>; July 2007.

ⁱⁱ <http://www.parentsateachers.org/>; July 2007.

ⁱⁱⁱ Information provided by Joy Griffith, Office of Children and Family Services; September 2007.

^{iv} <http://www.cicatelli.org/Expertise/sub6CAPC.htm>; August 2007.

^v http://www.nyc.gov/html/acs/html/support_families/preventive_services_tasa.shtml; August 2007.

^{vi} http://www.health.state.ny.us/community/infants_children/early_intervention/

APPENDIX B

Children's Trust Identified Home Visiting Models									
Children's Trust of Washington / www.wcpca.n.wa.gov (formerly WA Council for Prevention of Child Abuse & Neglect)									
	Program	Target Population	Age Range of Children	Service Intensity/Duration	Program-Identified Outcomes	Identifying Characteristics/Differences Between Models	Approx. Cost/Family Year	Notes	For More Program Information
 High Intensity, High Frequency, Long Duration	Nurse Family Partnership	First-time, low-income mothers	Early pregnancy through age 2 (families must enroll in early pregnancy)	Home visits occurring weekly to monthly by public health nurses for approximately 3 years.	<ul style="list-style-type: none"> Improved prenatal health Fewer childhood injuries Fewer subsequent pregnancies Increased intervals between births Increased maternal employment Improved school readiness 	<ul style="list-style-type: none"> Implemented by local public health districts, and visits must be completed by a public health nurse Focus on health outcomes Families cannot have any other children (First-time mothers only) 	\$5,000	Children's Trust Research Advisory Group identified as having the "Best Support"***	www.nursefamilypartnership.org
Moderate - High Intensity, Long Duration	Parents As Teachers	Universal	Pregnancy through age 5	Home visits weekly to monthly by trained paraprofessionals from pregnancy through age five. Families can enroll at any time during this period.	<ul style="list-style-type: none"> Increase parent knowledge of early childhood development and improve parenting practices Provide early detection of developmental delays and health issues Prevent child abuse and neglect Increase children's school readiness 	<ul style="list-style-type: none"> Implemented by school districts and non-profit entities. Flexible model depending on who is implementing and population being served. 	\$2,000	Children's Trust Research Advisory Group identified as a "Promising Practice"***	www.parentsteachers.org
Low Intensity, High Frequency, Moderate Duration	Parent-Child Home Program	At-risk parents (single, low-income, teen parents, multiple risk factor families, etc.)	16 mo. through age 4, but typically 2 and 3 year olds are the target	Home visits twice weekly for ½ an hour each visit for two years (23 weeks is minimum amount of weeks that constitute a program year).	<ul style="list-style-type: none"> Early Literacy Increased school readiness Enhanced social-emotional development Strengthen parent-child relationship 	<ul style="list-style-type: none"> Home visitor brings a book or educational toy once a week for families to keep and model interaction with the item. 	\$2,400	Children's Trust Research Advisory Group identified as having "Good Support"***	www.parent-child.org
Moderate Intensity, Moderate Frequency, Long Duration	Home Instruction for Parents of Preschool Youngsters (HIPPY)	Universal	Ages 3 through 5	Bi-weekly home visits and bi-weekly group meetings for two to three years.	<ul style="list-style-type: none"> Early Literacy School Readiness Parent Involvement 	<ul style="list-style-type: none"> Home visitors are members of the participating communities and are also parents in the program. Visitors are supervised by a professional coordinator. 	\$1,250	Children's Trust Research Advisory Group identified as having "Good Support"***	www.hippyusa.org

	Program	Target Population	Age Range of Children	Service Intensity/ Duration	Program-Identified Outcomes	Identifying Characteristics/ Differences Between Models	Approx. Cost/ Family/ Year	Notes	For More Program Information
High Intensity, High Frequency, Long Duration	Intensive Home Visiting for At-Risk Parents (multiple models can fit under this category)	At-risk parents (TANF eligible; refugee/immigrant; teen/young parent; disability; homelessness; depression/mental health issues; unemployment; single parent; substance abuse issues; domestic violence; limited english proficiency)	Pregnancy through age 5	A program in this category must: <ul style="list-style-type: none"> • Have a specific model, curriculum or protocol for implementation • Have a book, manual, or other writings that specify components and goals of the practice protocols • Describe frequency and duration of services including: how often families are visited; how many total visits; how long each visit typically lasts (research suggests at least bi-weekly visits for more than four months are necessary) • Describe intensity of services, including program outcomes • Describe educational requirements for home visitors and ongoing training, support and supervision 	<ul style="list-style-type: none"> • Improved Child Health and Development • Prevention of Child Maltreatment • Healthy Parent-Child Attachment 	<ul style="list-style-type: none"> • This is a flexible category where a number of program models may fit • Programs that apply for funding under this category will need to clearly describe components of their model • To view the document required of programs applying under this category, go to our website 	\$3,000 - \$6,000	Children's Trust Research Advisory Group identified as a "Promising Practice"***	www.ChildrensTrust.wa.gov
High - Moderate Intensity, Long Duration	Healthy Families - New York	At-risk families identified by Family Stress Checklist and Kempe Assessment	Enrollment before child reached 3 months of age continuing up to age 5.	Weekly home visits by trained paraprofessionals during at least the first six months of the child's life with intensity decreasing based on family need.	<ul style="list-style-type: none"> • Support positive parent-child bonding and relationships • Promote optimal child health and development • Enhance parental self-sufficiency • Prevent child abuse and neglect 	<ul style="list-style-type: none"> • Visits are done by trained family support workers. 	\$3,500	Children's Trust Research Advisory Group identified as a "Promising Practice"***	www.healthyfamiliesamerica.org
High Intensity, High Frequency, Short Duration	Project SafeCare	Families at risk for abuse and neglect	Birth to age 5	Bi-weekly or weekly home visits for 15 weeks by a trained paraprofessional.	<ul style="list-style-type: none"> • Prevention of child maltreatment, particularly neglect • Promote optimal child health and development • Increase parent's use of behavior mgmt skills • Improve parent-child bonding 	<ul style="list-style-type: none"> • One of very few programs shown to be effective with neglectful families 	\$2,000	Children's Trust Research Advisory Group identified as a "Promising Practice"***	www.cachildwelfareclearinghouse.org/program/6/detail

*** The Children's Trust Research Advisory Group identified three levels of evidence. "Best Support" indicates at least two between-group design experiments or a large single case experiment. "Good Support" indicates at least two experiments showing statistical significance against a wait-list, one between group experiment or a small series of single case experiments using a manual. "Promising Practice" indicates a practice that has a sound theoretical basis, a book or manual delineating protocol and substantial clinical-anecdotal literature indicating the practice's value with parenting behavior. For a full description of criteria or if you have other questions contact Kristen Rogers at kristen@wcpccan.wa.gov.

APPENDIX C

