



Federal Home Visiting Legislation and its Implementation in Region X

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The delivery of health services to low-income pregnant women and new mothers in their homes is not new. Home visiting in the United States can be traced to several major, largely philanthropic efforts in the late 19th century to improve the health and social conditions of women and children in impoverished inner-city and immigrant communities. (For a history of home visiting in the United States, go to [MCH Timeline: History, Legacy and Resources for Education and Practice](#).) What is new is the decades of research, begun in the 1970s, that established an evidence base for the benefits of specific models of home visiting services, delivered to specific groups of high-risk families, at specific points in their lives. Also new is increased attention and funding for home visiting programs by local private foundations and state governments.

The most recent milestone in home visiting in the United States is the creation and massive federal investment in the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, authorized by the Patient Protection and Affordable Care Act, and signed into law by President Obama in 2010. Its goal is to deliver home visiting services, on a national scale, to families in high-risk communities and evaluate the impact on maternal and newborn health, childhood morbidities, school readiness, inter-personal violence, and family self-sufficiency.

This issue of the *Northwest Bulletin* describes opportunities provided by the MIECHV legislation for Region X. Dr. Willis' editorial broadly describes the legislation, including the use of evidence-based home visiting models and the collection of data to measure improvements in six benchmark areas. He also emphasizes the importance of collaborations and integration of services to broaden early childhood systems of support. Lorrie Grevstad's article describes the implementation of MIECHV in Region X. According to Ms. Grevstad, the legislation is challenging because it requires that grantees reach "...the highest risk, hardest-to-serve communities with evidence-based home visiting models that require the most rigor and fidelity to the model."

Region X has the largest population of American Indian and Alaska Natives in the United States, and the highest number of tribal MIECHV grantees. This issue has two reports from tribal grantees, one from the United Indians of All Tribes and the other from the Kodiak Area Native Association.

In the State Reports, the states of Alaska, Idaho, Oregon, and Washington describe their progress in implementing MIECHV.

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Updates

Welcome Sue Grinnell, Crystal Tetrick, and Jacquie Watson to the editorial board. Sue Grinnell is the director of the Office of Healthy Communities, Washington State Department of Health. She is the new Washington State representative to the editorial board. Crystal Tetrick is the manager of Parent and Child Health, Public Health – Seattle & King County. Jacquie Watson is the manager of the Maternal and Child Health Program, Idaho Department of Health and Welfare. She is the new Idaho State representative to the editorial board.

We would especially like to thank Dr. Maxine Hayes, State Health Officer, Washington State Department of Health, for her guidance in developing this issue; and Dr. David Willis, Director, Division of Home Visiting and Early Childhood Systems, Maternal and Child Health Bureau, for his editorial. Prior to joining the Maternal and Child Health Bureau, Dr. Willis was a long-standing early childhood leader and advocate in Oregon State.

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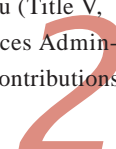
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Editorial . . .

The Maternal, Infant, and Early Childhood Home Visiting Program:

Building a System of Early Childhood Services

David W. Willis, MD, FAAP

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act and an amendment of Title V of the Social Security Act authorized the creation of the [Maternal, Infant, and Early Childhood Home Visiting \(MIECHV\) Program](#). This program aims to improve health and developmental outcomes for at-risk children and mothers through implementation of evidence-based home visiting models. The program is administered by the Health Resources and Services Administration in close collaboration with the Administration for Children and Families, which has lead responsibility for evaluating the program.

The \$1.5 billion investment over five years to states, territories, and tribal organizations has an explicit goal of advancing the field of maternal and child health and development, translating science into policy, and demonstrating data collection frameworks to drive quality improvement practices. The legislation requires that grantees complete a statewide needs assessment to identify communities with concentrations of poor birth outcomes, poverty, crime, domestic violence, high rates of high school drop-outs, substance abuse, unemployment, and child maltreatment. Grantees then generated plans to effectively implement evidence-based home visiting programs in these high-risk communities. This work included building collaborations across early childhood systems, programs, and communities, often expanding upon the Maternal and Child Health

Bureau's Early Childhood Comprehensive Systems grant activities of the last decade and the more recent activities of Early Childhood Advisory Councils.

The legislation also requires that grantees develop a plan to collect data to measure progress in each of six benchmark areas and demonstrate quantifiable, measurable improvement in at least four of the benchmark areas at year three and all benchmark areas by year five. Each grantee has created a comprehensive data collection plan for these six benchmarks, selecting from a set of 35 performance indicators. (See "MIECHV Benchmarks and Performance Indicators" on page 4.) Baseline data has just been uploaded into the federal Discretionary Grant Information System and the Health Resources and Services Administration has begun its analysis and reporting. The alignment of MIECHV indices and



benchmarks, state aggregate data, and metrics from the Children’s Health Insurance Program Reauthorization Act and the Maternal and Child Health Bureau improves the quality of reporting of early childhood programs across the country and represents a new level of accountability.

Currently, grantees are using one or more of thirteen home visiting models determined as evidence-based by [Home Visiting Evidence of Effectiveness](#). (1) (See table on page 5.) The models vary from one another by the populations served and the targeted risks. Seventeen states and territories are implementing only one model, while 37 are implementing multiple models, occasionally with efforts to coordinate universal intake and then referral to available programs based upon family need.

In the past three years, MIECHV has released over \$618 million in formula grants to 53 state and territory

grantees, and 26 tribal grantees. As of September 30, 2012, MIECHV grantees have made over 160,000 home visits to nearly 20,000 high-risk families in 544 communities nationally. (See article on page 7 for a description of MIECHV in Region X and state reports on pages 15-19.)

Early Childhood Science to Practice

The MIECHV program brings an unprecedented investment in early childhood. It has now been well established that the foundations for health and development are built by proximal hour-by-hour, day-by-day, early interactive experiences between an infant and an attuned, positive, and ever-present caregiver (2), and that toxic stress negatively affects developing brains (3, 4).

The MIECHV home visitor embraces the science of relational experiences and early brain development. That

Continued on Page 5

MIECHV Benchmarks and Performance Indicators

Improved maternal and newborn health

Prenatal care; alcohol, tobacco, and illicit drugs; preconception care; inter-birth intervals; depression screening; breastfeeding; well-child visits; insurance status

Prevention of child injuries; child abuse, neglect, or maltreatment; reduction of emergency department visits

Child and maternal emergency department visits, injury prevention, child injuries requiring treatment, reported suspected child maltreatment, reported substantiated maltreatment, first-time victims of maltreatment

Improvement in school readiness and achievement

Parent: support for learning and development, knowledge of child development, parent-child relationship, emotional well-being
Child: communication level, cognitive skills, pos-

itive approach to learning, social and emotional well-being, physical health and development

Reduction in crime or domestic violence

Screening for domestic violence, referrals, completed safety plan

Improvements in family economic self-sufficiency

Household income and benefits, employment or education of adults, health insurance

Improvements in the coordination and referrals for other community resources and supports

Families identified as requiring services, families receiving referrals, Memorandums of Understandings with community social services agencies, agencies sharing information with home visiting provider, completed referrals

person utilizes evidence-based models and innovations that mitigate the risks of toxic stress. Intentional activities support maternal health and safety, positive mental health and well-being, community engagement and social supports, and critical parent-child interactions that are present, attuned, positive, and attentive. Our MIECHV investment brings this “science to the crib-side” approach to create the foundations for a healthy life, school readiness, and social sturdiness while simultaneously helping families build skills and become self-sufficient.

Expanding Early Childhood Systems

The success of MIECHV rests solely on the degree to which home visiting programs can partner and broaden

early childhood systems of support. Given the high incidence of depression, domestic violence, and parental histories of adverse childhood experiences in at-risk communities, grantees have found it challenging to train staff, bring needed technical assistance, recruit mental health partners, create trauma and domestic violence coalitions, develop infant mental health interventions, and hire supervisors with experience in reflective practice and continuous quality improvement.

At regional MIECHV meetings there are many examples of grantee innovations to meet these challenges, including mental health consultation and integration with

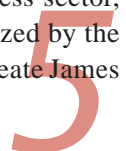
Table. MIECHV Evidence-Based Home Visiting Models Approved by Home Visiting Evidence of Effectiveness .	
Model	Number of states using the model
Nurse-Family Partnership (NFP)	43
Healthy Families America (HFA)	39
Parents as Teachers (PAT)	31
Early Head Start Home Visiting (EHS)	20
Home Instruction Program for Preschool Youngsters (HIPPY)	8
Healthy Steps	3
Child First	1
Family Check Up	1
Models approved by Home Visiting Evidence of Effectiveness but not implemented: Early Intervention Program for Adolescent Mothers, Early Start (New Zealand), Oklahoma Community-Based Family Resource and Support Program, Play and Learning Strategies (PALS) for Infant, and SafeCare Augmented.	

The success of MIECHV rests solely on the degree to which programs can partner and broaden early childhood systems of support

evidence-based, parent-child relationship interventions (e.g., Louisiana), and maternal depression screening and referral for in-home cognitive behavioral therapy (e.g., [Moving Beyond Depression](#) in Kentucky, Massachusetts, and Kansas). Other innovations build upon a decade of work begun with the Early Childhood Comprehensive Systems and expanded with [Early Childhood Advisory Councils](#), [Project LAUNCH](#), [Promise Neighborhoods](#), [Race to the Top - Early Learning Challenge](#), and local early childhood collaboratives. For example, the states of Georgia, Oregon, Alabama, and North Carolina, among others, are implementing universal intakes; the [Help Me Grow](#) states of Utah, Connecticut, and Ohio, among others, are creating resource utilities; and the states of Nebraska and Rhode Island are developing longitudinal integrated and linked early childhood data. The next few years will surely be exciting as innovations, such as these, bring breakthroughs in accountability, integration, and collaborations leading to sturdier child health and development, and kindergarten readiness.

The Future

It is a good time for early childhood. President Obama has articulated his [second-term, early childhood education agenda](#) that includes expansion of early learning, reforming and expanding Head Start (specifically Early Head Start), boosting the quality of child care, and empowering parents through home visiting and parenting education. Simultaneously, the business sector, led by [Ready Nation](#) and others, and galvanized by the return-on-investment research of Nobel Laureate James



Heckman, is building leadership in every state for early childhood programs.

Home visiting has now become an essential program, along with wrap-around and intensive birth-to-three early education and child care programs, including Early Head Start. This continuum of services provides a foundation for young families with known generational and trauma risk, creating “ladders of opportunity” to help raise poor children out of poverty.

To improve the educational readiness of all of our nation’s young children requires collective vision, shared measurement systems, mutually reinforcing activities, and continuous communication. (5) A dedicated backbone organization will be essential to support evidence-based practice, sturdy and healthy brain development, and a

This continuum of services provides a foundation for young families with known generational and trauma risk, creating “ladders of opportunity” to help raise poor children out of poverty

strong early education environment. It will be only by a seamless, integrated cradle-to-career system of building healthy and robust human capital that our country assures its future economic and educational success. The investments of our MIECHV program are that beginning. ☺

David W. Willis, MD, FAAP, is director of the Division of Home Visiting and Early Childhood Systems, Department of Health and Human Services, Health Resources and Service Administration, Maternal and Child Health Bureau. He joined the Maternal and Child Health Bureau in July 2012. Dr. Willis is board certified in behavioral and developmental pediatrics. He was a clinician for 30 years and long-standing early childhood leader and advocate in Oregon State.

Dr. Willis was a previous Harris Mid-Career Fellow with ZERO TO THREE, past-president of the Oregon Pediatric Society, executive committee member of the American Academy of Pediatrics’ Section on Early Education and Child Care, and first chair of the American Academy of Pediatrics’ Board’s Early Brain and Child Development Strategic Initiative.

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Maternal, Infant, and Early Childhood Home Visiting Program: Implementation in Region X

*Based upon an interview
with Lorrie Grevstad*

It has been an amazing journey over the past two years to provide oversight and support to Region X states (Alaska, Idaho, Oregon, and Washington) as they worked to implement the federal [Maternal Infant Early Childhood Home Visiting \(MIECHV\) Program](#) in their respective states. Despite difficult deadlines and complex requirements, states recognized the importance and significance of this federal legislation and its potential to improve the lives of children and families in high-risk communities.

The MIECHV program is charged with reaching the highest risk, hardest-to-serve communities with evidence-based home visiting models that require the most rigor and fidelity to the model. These home visiting models are challenging to implement in areas where infrastructure and capacity may be limited—areas that represent a large part of Region X.

Alaska, Idaho, Oregon, and Washington have met these challenges with a great deal of commitment and innovation. States have had to design, build, and fly...all at the same time. Timing was also a challenge as the federal legislation passed as states were struggling with budget cuts as a result of the economic crisis. States were building infrastructure, hiring staff, and creating contracts at the same time they were dealing with hiring freezes, program cuts, and contract and grant management office reductions.

Needs Assessment

As part of the MEICHV legislation, \$91 million was awarded by formula to state Title V agencies to conduct an extensive needs assessment to identify at-risk communities and determine which were eligible to receive home visiting funding. This involved:

- ◆ identifying risk factors behind the six benchmarks areas (see “MIECHV Benchmarks and Performance Indicators” on page 4)
- ◆ using these risk factors to identify the highest risk communities
- ◆ determining which communities to serve first
- ◆ determining if those high-risk communities had the interest and capacity to implement home visiting



- ◆ determining which evidence-based model best addressed the risks identified in the community

Once the needs assessment was done, states were required to write an updated state plan that identified the:

- ◆ communities where they would implement home visiting
- ◆ home visiting models that best matched risks in those communities
- ◆ process to address model fidelity
- ◆ process to collect and monitor data as part of a continuous quality improvement plan
- ◆ plan for orienting and training home visitors

It was the responsibility of each state governor to decide what state agency would update and implement the state plan. In this region, responsibility for updating state plans stayed with state Title V agencies, except for Washington State. In that state, the Department of Health was responsible for conducting the statewide needs assessment and the Department of Early Learning was responsible for updating the state plan and integrating it with the Washington State Early Learning Plan and other early learning efforts coordinated through the Department of Early Learning.

Model implementation

The four models being implemented in Region X are [Early Head Start Home Visiting](#), [Healthy Families America](#), [Nurse Family Partnership](#), and [Parents as Teachers](#). Alaska is implementing Nurse Family Partnerships in the municipality of Anchorage as nearly 50% of births and 50% of the population reside in the municipality. (See Alaska State Report on page 15.)

Idaho is implementing Early Head Start Home Visiting, Parents as Teachers, and Nurse Family Partnership in four counties. The Nurse Family Partnership was the model most suited to the risk factors in north Idaho; however, the populations in those counties were too small to meet the model fidelity. To solve this problem, Idaho created the first ever cross-state Nurse Family Partnership between the Panhandle Health District in Idaho and the Spokane County Health District in Washington. (See Idaho State Report on page 16.)

Oregon is implementing Early Head Start Home Visiting and Healthy Families America. The state had previous experience with Healthy Families America, so expanding and enhancing existing sites expedited

implementation in those communities. (See Oregon State Report on page 17.) Washington is implementing Nurse Family Partnership and Parents as Teachers. (See Washington State Report on page 19.)

Both Oregon and Washington applied for and received competitive grants in addition to the base formula grant. Oregon used its competitive grant to add Nurse Family Partnerships as their third model. Washington used its competitive grant to further develop an implementation hub to support use of implementation science in its home visiting programs. Washington is also exploring how best to serve tribal populations residing in the identified high-risk communities, as well as expand Nurse Family

Idaho created the first ever cross-state Nurse Family Partnership between the Panhandle Health District in Idaho and the Spokane County Health District in Washington

Partnerships and Parents as Teachers. The competitive grants also require states to enhance their already existing efforts to incorporate their state home visiting system inside a larger early childhood system.

Fiscal Support

In Alaska and Idaho, only federal monies support MIECHV. There is no state support at this time. If the federal dollars go away, both states have shared it will be difficult to continue the program. Oregon has some state and county monies to support Early Head Start Home Visiting, Healthy Families America, and Nurse Family Partnerships. Washington has leveraged federal, state, and private dollars through its public-private partnerships and a legislatively created Home Visiting Services Account.

Tribal Grantees

In addition to states, MIECHV grants have also been awarded to American Indian and Alaska Native tribes and tribal organizations, both urban and rural. Region X has one of the largest populations of American Indians and Alaska Natives of any region in the United States. It also has the highest number of tribal grantees of any region in the country: three in Alaska, three in Washington, and two in Oregon. State needs assessments consistently identify American Indians and Alaska Natives as a priority population using the risk factors behind the six benchmark areas.



Tribes were required to go through a competitive application process to determine awards. Because of the limited research available regarding the provision of evidence-based home visiting services in tribal com-

A required formal evaluation component in tribal home visiting programs will help build the evidence base to better serve tribal children and families

munities, tribal grantees are required to have a formal evaluation component in their home visiting program. This information will help build the evidence base to better serve tribal children and families. (See articles on pages 10-14 for a description of tribal home visiting programs.)

Opportunities

The requirements of the MEICVH legislation provide many opportunities for states and tribes (see box below). Being able to take advantage of these opportunities will not only improve services for children and families but also support sustainability of home visiting programs in communities. For example, the requirement to build and expand partnerships, both public and private, provides the opportunity to leverage federal, state, regional, and

Opportunities for Home Visiting Programs

- Strengthen capacity to provide high-quality, evidence-based home visiting services
- Contribute to a comprehensive, coordinated early childhood system
- Evaluate evidenced-based programs and promising practices
- Transform the field by implementing interventions that have been shown scientifically to improve outcomes
- Build and reinforce partnerships and encourage collaboration

local dollars, and helps support sustainability. Region X has held one summit bringing all state and tribal grantees together for training and networking. More opportunities are being explored to continue these collaborations in the future.

Conclusion

Evidence-based home visiting is a common and useful strategy for improving outcomes in multiple domains in early childhood. But MIECHV is not just about home visiting. It is also about early childhood systems and collaborations between systems, and ultimately about improving outcomes across multiple sectors and domains. It is about helping high-risk families move across the various home visiting programs as these programs best meet their needs, and then helping families move to other community services and resources as they best meet their needs. This integration is important not just for improved outcomes but also for sustainability. ☺

Lorrie Grevstad, RN, MN, is regional project officer for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, Region X, Health Resources and Services Administration, Maternal and Child Health Bureau, Division of Home Visiting and Early Childhood Systems. A nurse for 40 years, Lorrie’s career has been devoted to public health.

She led the development of Healthy Child Care Washington and then became lead for Washington’s Early Childhood Comprehensive Systems grant. She was a past recipient of the Healthy Mothers, Healthy Babies Cynthia F. Shurtleff Award for outstanding leadership and collaborative efforts promoting the health and well-being of young children and families. She encourages collaboration across systems and working to connect research with policy and practice to help assure children are healthy and ready to succeed in school.

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What Urban American Indians Want in a Home Visiting Program

Katie Hess and Lynnette Jordan¹

In July 2011, United Indians of All Tribes Foundation received funding through the Tribal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program to develop and implement home visiting services for American Indian and Alaska Native families living in urban King County, Washington. This funding allows the Ina Maka Family Program to expand services we currently provide through Head Start and Early Head Start.

Population

The United Indians of All Tribes Foundation is located at the Daybreak Star Indian Cultural Center within Discovery Park in Seattle. King County is home to over 39,000 American Indians and Alaska Natives. These people are more likely to live in poverty and have poor health than other populations in King County. For example, compared to all other races, American Indian and Alaska Native children under the age of five years are 3.5 times more likely to live in poverty and adults are more than twice as likely to be unemployed. Infant mortality and teen birth rates are approximately three times higher than for all other races.

Needs Assessment Methodology

For the needs assessment we used: 1) existing data from state, county, and local agencies; 2) qualitative data from focus groups or Talking Circles composed of caregivers, elders, youth, and home visitors; 3) key informant interviews with service providers; and 4) data from a survey of expecting and current parents of young children to determine knowledge of existing services and perceived gaps in available services.

Quantitative Results

We surveyed 188 families to determine knowledge of existing services and perceived gaps in available services. The majority of respondents were women and most were American Indian and Alaska Native. Over 40% reported an income of less than \$10,000 per year, with 43% unemployed in the past year. The majority of respondents were the biological mother of a child



Ko-Kwal-alwoot, the Maiden of Deception Pass

under five years of age (53%), though 21% were fathers and 13% were aunts, grandmothers, or foster parents. (See table.)

Table. Percent participants answering “yes” to questions about what they wanted in a future home visiting program. N=188	
Question	Percent
Should the home visitor be American Indian or Alaska Native?	70
Should the home visitor be professionally trained?	86
Should the home visiting program include cultural resources?	97
Should the home visitors use traditional stories to teach children?	77
Should the home visiting program make available healthy American Indian and Alaska Native foods?	76
Should the home visiting program make available cultural activities?	74

Qualitative Results

Ninety community members—caregivers, elders, youth, and home visitors—participated in Talking Circles to discuss challenges they saw in serving their community and what sort of home visiting program they envisioned for their community. They identified as challenges: lack of awareness of services, lack of transportation, bureaucracy, mistrust and often fear of service providers, and culturally incompetent services. Community members felt many service providers could misunderstand and potentially punish American Indian or Alaska Native cultural expression.

Home Visiting Services

Caregivers identified home visitors with American Indian or Alaska Native heritage as best able to understand them and overcome their fears and mistrust. All community

members and service providers felt that home visitors should connect families to resources—and in some cases, elders and caregivers said, may help families navigate home visiting systems or advocate for them.

Culture in Home Visiting Services

There was broad consensus that it is both important and beneficial to incorporate American Indian and Alaska

“I could not relate to her at all, and that was just really uncomfortable for me to have some strangers like that in my home. They start asking about my powwow music, and I’m supposed to teach them about who I am or something and it kind of got on my nerves”

Native cultures into home visiting services. As one participant observed, “I really would love a program that teaches about the culture and the heritage, not just about the ABC’s and everything.” Community members felt that home visitors who are grounded in their culture would not misjudge their homes and lifestyles. One participant reflected “I could not relate to her at all, and that was just really uncomfortable for me to have some strangers like that in my home. They start asking about my powwow music, and I’m supposed to teach them about who I am or something and it kind of got on my nerves.”

In addition, they wanted someone who would support their desire for more connection to their culture, for both themselves and their children. Youth were enthusiastic about opportunities to learn more about their heritage and observed that not all families have the “luxury” of knowing about their culture and heritage. Service providers reported challenges using a curriculum that was not culturally relevant and identified the potential health value of learning about American Indian and Alaska Native foods.

Community members agreed that elders have valuable cultural, historical, and practical parenting knowledge to share with younger families. Elders and caregivers said



that elders' wisdom could help guide younger families, and that respecting elders was seen as an important cultural value to instill in children. Participants stressed that many urban American Indian and Alaska Native families do not have their own elders and could benefit from this important source of support, mentorship, and role modeling. Caregivers and youth expressed a rich appreciation for what they learned from elders, including life lessons and history. As one caregiver observed, "Elders are good. They know everything. They've been here longer than us."

Community members shared stories of experiencing both blatant and subtle racism from schools, service providers, and the general public. As one elder said, "You feel and know there is still prejudice against all Natives, all tribes. And it's really horrible. It's terrifying, it's disgusting, and it makes you angry. And there again, you have this stress, and you can't take it out." Caregivers expressed fear of how prejudice would impact their children. Parents were also concerned about how their children were treated in school and identified navigating the school bureaucracy and dealing with inappropriate discipline as a significant source of stress.

Conclusion

While tribes representing the American Indian and Alaska Native Communities in King County are diverse, respondents articulated a common respect for native cultures, elders, and the role of mothers and fathers. We invite you to read the full needs assessment report on our website www.unitedindians.org. ☺

Katie M. Hess, MPH, is the program manager for the Ina Maka Family Program, United Indians of All Tribes Foundation. She is a Native Hawaiian. She discovered her passion for social justice and early childhood development as an AmeriCorps volunteer. Katie's MPH degree is from the University of Washington, Seattle.

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Lynnette Jordan, is the director of Children and Family Services, United Indians of All Tribes Foundation, began her career providing advocacy services to Native American youth in the juvenile justice system. She eventually transitioned into working in the foster care system, certifying homes and facilitating placement of Native American youth in those licensed homes. She has a BA degree from Bemidji State University, Minnesota.

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Kodiak Area Native Association's Cama'i Home Visiting Program

Cassie Hickey

Funded by the Affordable Care Act Tribal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, the Cama'i Home Visiting Program provides services for Alaskan Native families with children, aged four years and under, as well as families expecting a child, who live in the City of Kodiak and four other villages: Old Harbor, Akhiok, Ouzinkie, and Port Lions. These villages are located within the [Kodiak Area Native Association](#) service area, which serves the Koniag Region of Alaska (see map). Each village has an estimated population of about 200, with about 20 children, aged four years and under. Almost all of the villages depend to some extent on subsistence activities for food, including salmon, crab, halibut, shrimp, clams, ducks, deer, and rabbit.

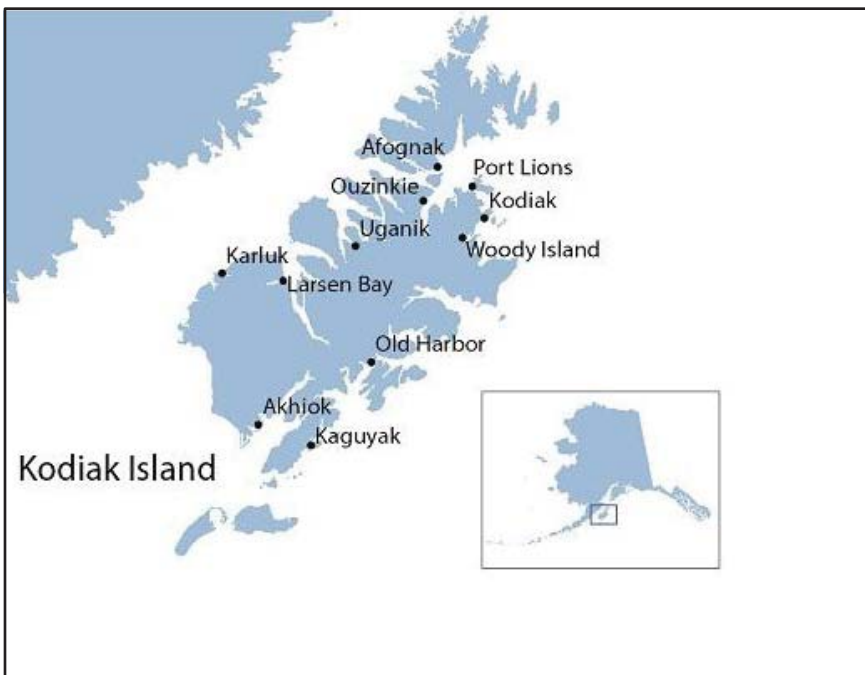
Home Visitors

The four villages the Cama'i Home Visiting Program serves are not accessible by motor vehicle. The program's two home visitors who live in the city of Kodiak must travel either by boat or by plane out to the villages. Weather is a huge factor in providing services to the villages. If visibility is limited, a home visitor is not able to fly out to a village or return to the city. The Cama'i Home Visiting Program has tried to hire village residents, but because of seasonal work and a subsistence lifestyle, most of the residents are unavailable to work a year-round position. These challenges to providing services are encountered throughout the state of Alaska (see side bar on page 14).

The best home visitors are able to build relationships and establish a sense of trust with each tribe and the families

The best home visitors are able to build relationships and establish a sense of trust with each tribe and the families. We ask that our home visitors be familiar with or willing to learn about the Alutiiq (Koniag Alaska Native) people of Kodiak Island. Our two home visitors who travel weekly to the villages have established weekly, informal coffee groups in which the whole village is invited to learn more about the program and converse with each other.

Alutiiq Elders have joined these coffee groups to give advice and they have also been incorporated as expert parents for the program. Their participation has positively influenced the communities' perceptions and knowledge of the program. Most Alutiiq elders have encouraged families to join the



program or at least participate in the coffee groups.

Development of the Program

The development of the Cama'i Home Visiting Program has been a direct response to Kodiak Island Alaska Natives' requests for improved services in parent education and child wellness. The top three answers to the program's needs assessment were: improve the quality of parent involvement with their children; prevent child abuse, neglect and maltreatment, and injuries; and improve school readiness and achievement.

The Cama'i Home Visiting Program uses the [Parents as Teachers tribal home visiting curriculum](#) and has enhanced the curriculum to fit the cultural needs of the Alutiiq people. This curriculum offers promising approaches to help children realize their full potential, prevent children from being abused and neglected, prevent children from being involved in child welfare, and help keep children who have been abused or neglected in permanent families. ☺

Cassie Hickey, is coordinator for the Cama'i Home Visiting Program and the Indian Child Welfare Act, Kodiak Area Native Association. She moved to Kodiak, Alaska, in December of 2011, right after graduating from Western Oregon University, Monmouth. Her experience with coordinating both programs "...has been an amazing adventure, and I have learned so much that will help better my career and life experiences."

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Delivering Health and Social Services in Alaska

The state of Alaska is larger than the states of California, Texas, and Montana combined, yet ranks 47th in total road miles due to harsh terrain, weather conditions, and vast distances between communities. Fifty-nine percent of Alaska's total population resides in the cities of Anchorage, Juneau, and Fairbanks. The remaining population lives in smaller communities and villages, many in remote areas. Approximately 75% of Alaskan communities, including the capital of Juneau, are not connected to the road system and rely on air and boat travel. An estimated 25% of Alaskans live in communities of less than 1,000 people. Alaska's low population density results in high service delivery costs, if services are even available. As a consequence, significant disparities exist between those who have access to health and social services and those who do not. (1)

Nonprofit corporations such as the Kodiak Area Native Association were formed throughout the state of Alaska after the Alaska Native Claims Settlement Act was enacted in 1971. This legislation, an agreement between the United States Government and the Alaska Native Tribes, distributed land to regional and village entities to establish for-profit corporations. Each of these regional corporations formed a separate non-profit corporation to assist their members with health and social services.

1. Early Childhood Comprehensive Systems Plan. (2006) Early Childhood Comprehensive Systems Program, Office of Children Services, Alaska Department of Health and Social Services. Available at <http://dhss.alaska.gov/dpa/Documents/ocs/child-plan/ECCSFullChildPlan.pdf> Accessed March 2013.

State Reports . . .

Home Visiting Fills a Critical Gap in Services

Alaska Department of Health and Social Services

Yvonne Wu Goldsmith

The state of Alaska is implementing the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program within the municipality of Anchorage. The [Section of Women's, Children's and Family Health](#) (also the state Title V agency) in the Division of Public Health, Alaska Department of Health and Social Services, has partnered with Providence In-Home Services to provide the Nurse Family Partnership program to 100 low-income, first-time moms. The

Central Foundation participate on one another's Nurse Family Partnership Community Advisory Boards. Many members of the state steering committee who oversee the home visiting program are also members of the state child policy team and the Interagency Early Childhood Steering Committee.

One issue discussed during the needs assessment was the capacity of rural communities to support a home visiting program. Small population centers are often unable to support specialty services and facilities because of high labor costs and difficulty recruiting skilled staff. For those having to travel to places where health care is available, transportation costs are high, often because there is no road access. Rural Alaskans have the added hurdle of bad weather. While the needs of mothers and infants living in rural Alaska are great, the home visiting model may not be the most cost-efficient way to deliver prenatal and postpartum services. ☺

Yvonne Goldsmith, MS, tracks health indicators and engages in research on maternal, child, and family health for the Alaska Department of Health and Social Services, Division of Public Health. She also serves on the editorial board of the Northwest Bulletin: Family and Child Health.

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While the needs of mothers and infants living in rural Alaska are great, the home visiting model may not be the most cost-efficient way to deliver prenatal and postpartum services

MIECHV program is filling a critical gap in services: prenatal care to at-risk families who are not eligible to participate in the Alaska Tribal Health System.

From 1996 to 2005, Alaska operated Healthy Families, a home visiting program. After that program was discontinued, the only other home visiting service for pregnant women was through the South Central Foundation, a tribal health organization serving Alaska Native women. Currently, South Central Foundation is implementing Nurse Family Partnership, with approved modifications, under the Tribal MIECHV program. There are also two other Alaska Tribal MIECHV grantees, one in Fairbanks and the other in Kodiak. (See article on page 13.)

Providence In-Home Services; the Section of Women's, Children's and Family Health; and South Central Foundation have looked for ways to coordinate services across both the private health care system and the tribal health system. While we have seen each other's benchmark plans and talked about sharing training sessions to cut costs, the three entities target different populations. Still, there are benefits from knowing what each other has learned. Both Providence In-Home Services and South

Home Visiting: Shaping the Landscape for Pregnant Women and Children

Idaho Department
of Health and Welfare

Laura Alfani

The [Idaho Maternal, Infant, and Early Childhood Home Visiting](#) (MIECHV) program is funded at \$1,000,000.00 annually and supports implementation of three home visiting models—Early Head Start Home Visiting (EHS), Nurse Family Partnership (NFP), and Parents as Teachers (PAT)—at four sites serving Kootenai, Shoshone, Twin Falls, and Jerome counties.

Prior to the establishment of the program in 2010, the only state-administered early childhood home visiting services were delivered through the Individuals with Disabilities Education Act (IDEA) Part C, and there were no systematic efforts to integrate high-quality home visiting into prenatal and early childhood systems of care. The Idaho MIECHV program built on existing local home visiting capacity to implement PAT and EHS and initiated a cross-state collaboration with Washington State’s Spokane Regional Health District to implement NFP. The Spokane Regional Health District’s NFP program supervises, mentors, and coordinates training for nurse home visitors employed by Idaho State’s Panhandle Health District who serve clients in Kootenai and Shoshone counties.

Between July and December 2012, nine home visitors enrolled 78 pregnant women, infants, young children, and their families in the Idaho MIECHV program and delivered more than 500 home visits. Families participated in parenting groups and classes, learned about healthy child development, and established goals for themselves and their children. Home visitors and their supervisors continue to develop partnerships in communities to connect families with the resources they need.

Continuous Quality Improvement

Similar to all state MIECHV programs, the Idaho program is in the midst of developing and implementing a robust continuous quality improvement plan to monitor and improve program performance and outcomes. The

continuous quality improvement plan has two overarching objectives: 1) improve individual capacity to use data to improve service delivery, and 2) improve organizational capacity to integrate continuous quality improvement into business processes and performance improvement activities. Other public health programs who are partners in the Idaho MIECHV program have been able to learn from these activities and apply continuous quality improvement to their work.

Home Visiting and Parent Education Committee

In 2012, the state’s Early Childhood Coordinating Council established an eight-member Home Visiting and Parent Education Committee to support the development of statewide systems and resources for home visiting and parent education services. The committee will develop a strategic plan for home visiting systems and make recommendations regarding best practices. Using the [Zero to Three Home Visiting Self-Assessment Tool for States](#), the committee will analyze components of the Idaho MIECHV program, including evaluation and quality assurance, standards, professional development, financing and sustainability, collaborations and partnerships, public engagement, and governance and administration.

These efforts have the potential to shape the landscape of home visiting and services for pregnant women, infants, and young children in Idaho for years to come. ☺

Laura Alfani, MPH, Health Program Manager for Idaho Department of Health and Welfare, leads the Idaho MIECHV program. Prior to coming to the state, she obtained an MPH degree at Tulane University, New Orleans, Louisiana, and worked with Early Childhood Comprehensive Systems programs in Louisiana and Iowa.

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Accessing Appropriate and Cost-Effective Home Visiting Services and Supports

Oregon Department of Human Services

Cate Wilcox

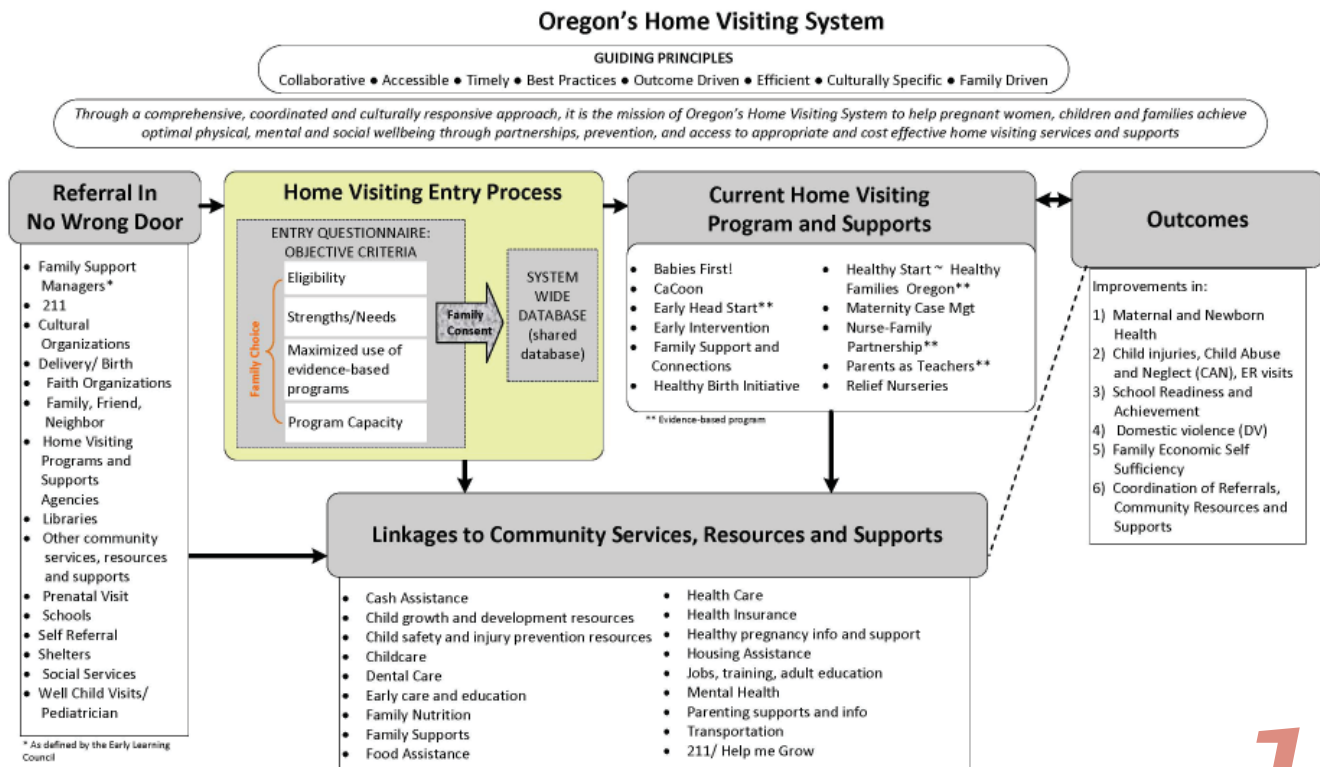
In late 2009, under the leadership of Governor Kulongoski, agencies representing the various home visiting programs in Oregon met to develop a state-wide home visiting system. These agencies included Head Start/Early Head Start; the Oregon Commission on Children and Families; the Public Health Division; and the Department of Human Service’s Children, Adults, and Families Division. This group then became the State Home Visiting Steering Committee and added partners, including the Governor’s Office, Addictions and Mental Health Services, the Oregon Health and Science University, and the Oregon Center for Children and Youth with Special Health Needs. The goals of the committee are to capitalize on the strengths of each home visiting

program, decrease duplication and administrative barriers, and ensure that clients are getting appropriate, cost-effective services as their needs change.

To meet these goals, the committee established the Stakeholders System Design Workgroup, composed of representatives of all state and local home visiting programs, foundations, and tribes; and a family representative. The workgroup developed mission and vision statements, guiding principles, and a system map of the state’s home visiting system (see figure below).

This set the framework for implementing the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program in 2010. The grant funded expansion of two existing evidence-based home visiting

continued on page 18



models—Healthy Families America and Early Head Start Home Visiting—and a competitive grant funded the establishment of Nurse Family Partnership in five additional counties.

At the same time, the newly elected Governor Kitzhaber launched an Early Learning Initiative to improve kindergarten readiness for all children. Home visiting is a key part of this initiative.

Lessons Learned

High-level support is critical to success. The leadership of Governor Kulongoski played a key role in bringing home visiting agencies together to develop a statewide system. The Early Learning Initiative supported by Governor Kitzhaber is key to providing a framework for home visiting.

People make all the difference. We purposefully built into the competitive grant four staff positions to implement the home visiting system locally. With this additional staffing, we are able to change how home

visiting services are coordinated at the local level. One of these staff members is a specialist in community development and facilitates the development of new collaborations.

Seed funding is a game changer. While programs continue to use their individual funding streams, the MIECHV grants provides resources to initiate and implement a better integrated statewide home visiting system. Having all the programs work together in a more efficient and effective way is the game changer. ☺

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Home visiting models chosen by each Region X state as part of their Maternal, Infant and Early Childhood Home Visiting (MIECHV) program. A total of 13 models meet the Department of Health and Human Services’ criteria for evidence-based models as determined by the Home Visiting Evidence of Effectiveness .	
State	Home Visiting Model
Alaska	Nurse Family Partnership
Idaho	Early Head Start Home Visiting Parents as Teachers Nurse Family Partnership (with Spokane County Health District in Washington State)
Oregon	Early Head Start Home Visiting Healthy Families America Nurse Family Partnership
Washington	Nurse Family Partnership Parents as Teachers

Home Visiting a Key Component for Supporting Healthy Families

Washington State
Department of Health

Judy King and Kathy Chapman

Strong partnerships and innovative funding across the public and private sector help Washington's children succeed in school and life. Home visiting, a vital part of a comprehensive and interconnected early learning system, is a key strategy in the [Washington State Early Learning Plan](#) (Strategy #5) and in the [Birth to Three Plan](#) (Strategy #2).

Led by the Department of Early Learning, partner agencies and stakeholders most knowledgeable about the needs of at-risk populations and communities in Washington identified five goals and objectives crucial to developing an effective statewide home visiting system:

- ◆ Integrate the home visiting system as part of early learning system development work
- ◆ Generate resources that sustain and grow home visiting system and services
- ◆ Increase access to voluntary home visiting services that meet the needs of local communities and at-risk families
- ◆ Ensure high-quality and effective home visiting services
- ◆ Build community and public support for high quality services for families (1, 2)

Through an innovative public-private partnership established by the Washington State Legislature in 2010, the Home Visiting Services Account increases the state's capacity to serve more families with the highest quality home visiting services. Administered by [Thrive by Five Washington](#) and overseen by the Department of Early Learning, the Home Visiting Services Account centralizes technical assistance and training for home visiting programs and leverages matching non-state public and private funds. The influx of federal home visiting funds through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, part of the federal Affordable Care Act, has allowed Washington to further expand direct home visiting services, deepen the development

of the centralized supports for local programs, and improve data collection and evaluation.

Washington's strong emphasis on continuous quality improvement for home visiting programs is supported by on-going research and evaluation by the departments of early learning, health, social and health services; Thrive by Five Washington; and the Washington State University Area Health Education Center. Working closely with local programs, Washington is researching what infrastructure best increases the capacity, quality of coordination, and available resources to home visiting programs, and how these efforts support the highest quality home visiting services for children and families. ☉

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2. Washington State Department of Early Learning, Washington State Home Visiting Goals and Objectives. Available at www.del.wa.gov/publications/development/docs/HV_Goals.pdf Assessed March 2013.

Resources . . .

Children's Defense Fund. New Investments to Help Children and Families: The Patient Protection and Affordable Care Act and the Maternal, Infant, and Early Childhood Home Visiting Program
www.childrensdefense.org/child-research-data-publications/data/new-investments-to-help-children-early-childhood-home-visiting-program.pdf

Del Grosso P, Kleinman R, Esposito AM, Martin ES, Paulsell D. Assessing the Evidence of Effectiveness of Home Visiting Program Models Implemented in Tribal Communities. August 2011. Office of Planning, Research, and Evaluation, Administration for Children and Families.
<http://homvee.acf.hhs.gov/TribalReport.pdf>

Detailed Summary of Home Visitation Program in the Patient Protection and Affordable Care, Center for Law and Social Policy
www.clasp.org/admin/site/publications/files/home-visiting-detailed-summary.pdf

Home Visiting, Child Welfare Information Gateway, Administration for Children and Families, Department of Health and Human Services
www.childwelfare.gov/preventing/programs/types/homevisit.cfm

Home Visiting Evidence of Effectiveness, Department of Health and Human Services
<http://homvee.acf.hhs.gov/>

Home Visiting Resource Brief, MCH Library
<http://mchlibrary.info/guides/homevisiting.html>

Key Components of a Successful Early Childhood Home Visitation System, ZERO TO THREE,
www.zerotothree.org/public-policy/webinars-conference-calls/home-visitation-tool-june-16-2010.pdf

Maternal, Infant, and Early Childhood Home Visiting Program, Health Resources and Services Administration
<http://mchb.hrsa.gov/programs/homevisiting/>

The Pew Center on the States. The Case for Home Visiting: Strong Families Start with a Solid Foundation. Issue Brief May 2010.
www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/State_policy/067_10_HOME%20Moms%20Brief%20Final_web.pdf?n=9905

Planning and Implementing Home Visiting Programs, Child Welfare Information Gateway, Administration for Children and Families, Department of Health and Human Services

www.childwelfare.gov/preventing/programs/types/planning_implementing.cfm

Supporting Evidence-Based Home Visiting
<http://supportingebhv.org/home>

Thrive by Five Home Visiting
<http://thrivebyfivewa.org/home-visiting/>

ZERO TO THREE Home Visiting
www.zerotothree.org/public-policy/infant-toddler-policy-issues/home-visit.html



MCH Navigator is a portal to training opportunities for maternal and child health professionals and students. On the website, you will find archived webcasts and webinars, instructional modules and self-guided short courses, video and audio recordings of lectures and presentations from university courses and conferences.

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