Home Visiting Services Account Annual Report, 2019

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Key Findings

- HVSA served 2,806 families with 2,791 children across 25 counties in Washington State
- From the beginning of State Fiscal Year 2018 (SFY 2018) to the end of SFY 2019, performance on specific measures was noted:
  - Percent of filled funded slots increased from 72% to 83%
  - Daily literacy activities significantly increased from 68% to 79%
  - Intimate Partner Violence screening rate improved from 66% to 70%
- Performance varied across geography and home visiting models
- Visit dosage and family retention remained below model goals
- 60% of local implementing agencies were rewarded for reaching the 85% enrollment performance milestone, while 38% reached the dosage performance milestones
- During SFY 2018 and 2019, 36 local implementing agencies participated in Continuous Quality Improvement projects focused on improving family engagement

Future Directions for the HVSA

- Support competency and confidence in screening and referral tools for depression, intimate partner violence and child development
- Deepen understanding of family engagement including what supports better engagement, what role does workforce have on engagement and how does engagement affect family outcomes
- Identify opportunities for workforce development

Introduction

Home visiting is a voluntary, family-centered service offered to expectant parents and families with new babies and young children to support the physical, social and emotional health and development of the child. These services are an effective strategy for improving child health and development, especially in populations with limited resources. The Home Visiting Services Account (HVSA) was established by the legislature in 2010 (RCW 43.216.130) and is administered and led by the Department of Children, Youth & Families (DCYF) in partnership with Thrive Washington and the Washington State Department of Health (DOH).

Local implementing agencies (LIAs) have been contracting directly with DCYF (formerly Department of Early Learning, DEL) for just over two years to provide home visiting services. LIAs are obligated to high levels of data collection and reporting, expending significant resources to comply with these requirements, all while providing high quality services to families. These data collection and reporting requirements allow the HVSA to assess the services received, by whom and with what outcomes. Prior to July 2017, the statewide HVSA partners (DCYF, Thrive Washington and DOH) engaged programs in a process to select home visiting performance measures that reflect model efforts as well as HVSA priorities. Starting with the federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) measures, the HVSA selected a subset of six process and two outcome measures that reflect the breadth and depth of the home visiting work in Washington. These eight Aligned Measures, incorporated in the state fiscal year 2018 (SFY 2018) contracts, started in July 2017 (see definitions, Appendix 1A). In the

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1 Ounce Washington is listed as Thrive Washington throughout this report. The official transfer of Thrive Washington to Ounce Washington occurred on Feb. 1, 2020, following this reporting period."
following fiscal year, SFY 2019, the HVSA initiated a new performance-based contracting effort to improve family enrollment and home visit frequency. Financial incentives were offered to LIAs who met specific Performance Milestones during the contract period (see definitions, Appendix 1B). This report highlights a few successes and opportunities to focus improvement efforts going forward based on performance in SFY 2019.

In SFY 2019 (July 1, 2018 - June 30, 2019), the HVSA administered a mix of federal and state funding streams to support 40 LIAs, offering eight home visiting models in 25 counties. This report focuses on the characteristics and experiences of families served. However, during the same period of the report, LIAs engaged in training, coaching, technical assistance and evaluation and research studies. Details on other aspects of home visiting system development and support can be found on the DCYF website.

Families Served in SFY 2019

In SFY 2019, the HVSA served 2,806 families with 2,791 children across Washington State. Among all families served, 41% newly enrolled in home visiting during SFY 2019. Over half (57%) of newly enrolled families enrolled prenatally.

Families resided in 25 counties (Adams, Benton, Clallam, Clark, Cowlitz, Douglas, Franklin, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Okanogan, Pierce, Skagit, Snohomish, Spokane, Thurston, Wahkiakum, Walla Walla, Whatcom and Yakima) (Figure 1). The number of families served by county of residence ranged from ≤10 families to 539 families.

The HVSA prioritizes serving pregnant women and families with infants and toddlers up to 36 months of age. One-third (33%) of caregivers served were pregnant during some portion of the year and 81% of children enrolled were between 0 and 36 months old, with the largest majority between one and two
years of age. In total, nine out of every 10 families included a pregnant caregiver and/or a child between the ages of 0 to 36 months.

Pregnant and parenting teens are another priority population for the HVSA. Pregnant and parenting teens age 19 and younger may face unique challenges to caregiving. In SFY 2019, 14% of HVSA families included a teen parent (n=378). Of those teen parents, a majority were 18 to 19 years old and only 6% were 15 years old or younger (Figure 2). Statewide the teen birth rate has steadily decreased from a high of 10% in 2000 to 3% in 2018 (Community Health Assessment Tool, March 2019).

Compared with population estimates of adults in Washington, several racial groups were represented in higher proportions among HVSA caregivers, including American Indians and Alaska Natives (AI/AN), Black/African Americans and those reporting multiple races (Figure 3).

Figure 3. Race of HVSA caregivers compared to adults (18+) in Washington State

Source for Washington: Community Health Assessment Tool (CHAT), March 2019

The ethnic make-up of HVSA caregivers also differed as compared to a population estimate of Washington adults. While an estimated 10% of adults in Washington State are Hispanic/Latinx, 40% of HVSA caregivers reported being Hispanic/Latinx.

HVSA Priority Populations

HVSA LIAs are required to enroll families with two or more high priority characteristics (Box 1). Due to differences in data reporting systems by model, data was not available for all participants across all of the priority population characteristics. However, each model funded by the HVSA aims to serve families reflecting these priority populations.

Low-income families are one of the most commonly enrolled groups in the HVSA. The Maternal, Infant and Early Childhood Home Visiting program (MIECHV), which comprises over 60% of the funded HVSA slots, defines low income as living at or below 100% of the federal poverty level. This means that a family of two would have a household income of $16,910 or less per year. In SFY 2019, nearly 60% of all HVSA families reported living at or below 100% of the federal poverty level. An additional 20% of
families were living between 100% and 200% of the federal poverty level. Note that 1 out of 5 families were missing data on annual household income or number of household members supported by their annual income. While we continue to work with programs to improve data collection, it remains a challenging data point to track.

Data also suggest that at least half of HVSA families have experienced one of the six adverse experiences listed as an HVSA priority (Box 1). An estimated 22% of caregivers reported a history of or potential current experience with IPV; 30% reported a familial history or current experience with substance use, including tobacco; and 39% reported depressive symptoms per routine screenings by the home visitors. When asked at enrollment or during an annual update, 4% of families reported being homeless. Because data on homelessness are collected infrequently, this may be a conservative depiction of families’ experiences with homelessness and housing instability.

### Box 1: HVSA Priority Populations

<table>
<thead>
<tr>
<th>Demographic Characteristics</th>
<th>Adverse Experiences</th>
<th>Other Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>- American Indian/Alaskan Native Non-Hispanic</td>
<td>- Prior Child Welfare System Involvement</td>
<td>- Parents with Low Educational Attainment</td>
</tr>
<tr>
<td>- Poverty/Low Income</td>
<td>- Intimate Partner Violence</td>
<td>- Parents with Disabilities</td>
</tr>
<tr>
<td>- Teen Parents</td>
<td>- Familial History or Current Experience with Substance Use, Including Tobacco</td>
<td>- Families Currently or Formerly in The Military</td>
</tr>
<tr>
<td>- Non-English Speaking or Recent Immigrant</td>
<td>- Parent Mental Illness</td>
<td>- Children with Disabilities, Especially Those Not Linked with Early Intervention Services</td>
</tr>
<tr>
<td>- Enrolled in Workfirst/TANF</td>
<td>- Current and Previously Incarcerated Parents</td>
<td>- Parents with Disabilities</td>
</tr>
</tbody>
</table>

The Jones family enrolled in Parents As Teachers (PAT) in August 2015 when their baby was 3 months old. Prior to participating in PAT, the parents were homeless and residing at the Salvation Army. They were placed into emergency housing following the birth of their daughter. They were referred for TANF and the PAT program. The PAT parent educator (PE) worked with both parents supporting positive parenting, teaching about developmental stages and domains, helping with goal setting, offering resources and referrals and generally giving support to help cope with the many stressors and challenges of having a newborn. The PE also assisted the family with healthy communication skills as it became more and more obvious there were difficulties in their relationship. In 2017, the mother gave birth to a second child. Around the same time, the mother disclosed to her PE that there were multiple domestic violence incidents, as the father’s mental health problems escalated. He kidnapped their 2-year-old daughter and took her out of state. The CPS worker was on the verge of issuing an Amber Alert when the father made contact from the East Coast and acknowledged he had their daughter and she was safe. Some months later, he returned to Washington and a protection order was filed immediately and CPS removed both children from the mother. She was extremely distraught and the PE continued doing supervised PAT visits at the DSHS office. The mother complied with all court-ordered mandates including mental health counseling and DV classes. The PE supported her visits with her children and helped prepare her to get them back, reinforcing the importance of structure and routines both for the mother and the children’s successful reunification. The mother repeatedly stated she and her children could not have been successful without the help and support of their PE and the ongoing stability and predictability of the visits. The children are on track developmentally and the mother is continuing with mental health counseling and has integrated meditation and mindfulness exercises to deal with her stress.

Please note: names and other identifiable information have been changed for the safety of families throughout this report.
Home Visiting Program Engagement

Program Referrals

Coordinated outreach and referral systems are the first steps in successful family engagement. These community-based home visiting programs depend on a wide referral network to identify, locate and contact families who might benefit from home visiting services.

Among families served by the HVSA in SFY 2019, the largest source of referrals were healthcare providers and clinics (27%); families, friends and self-referral accounted for an additional 11% (Figure 4).

Figure 4: Reported referral sources for home visiting services for families served, SFY 2019

<table>
<thead>
<tr>
<th>Number of Referrals to Home Visiting</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>Healthcare Provider/Clinic</td>
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Program Enrollment & Visit Dosage

In SFY 2018, DCYF introduced Performance Milestones focused on family enrollment in home visiting and the frequency of home visits received. The HVSA contracts prioritized quality assurance and improvement activities for LIAs to maintain enrollment for 85% of their funded slots. Recognizing that a singular focus on enrollment may adversely affect the number of home visits, the HVSA identified a complementary milestone to maintain or improve the frequency, or dosage, of home visits for families. This second milestone required LIAs to deliver at least 80% of the model-recommended home visits each quarter to 60% of the families enrolled (see definitions, Appendix 1B). To support LIAs’ improvement on both of these milestones, DOH shared quarterly performance data dashboards, Thrive provided CQI support and DCYF offered incentive payments in SFY 2019 for those LIAs meeting the performance thresholds.

From the beginning of SFY 2018 to the end of SFY 2019, the percent of HVSA-funded slots filled increased steadily from 72% to 83% (Figure 5). During this same period, the dosage of home visits to these families remained steady, 52-54% of families received at least 80% of the model recommended quarterly visits. There were some model differences in the enrollment and dosage measures for the two predominant models, PAT and NFP. One model made more gains in enrollment, while the other made more gains in dosage. This performance aligns with model priorities and is similar to patterns seen in
other states. At this time, DOH has not done further analysis to examine reasons for these differences. Similarly, the additional models supported by the HVSA typically performed stronger in one measure or the other.

Figure 5: HVSA performance on family enrollment and visit dosage by quarter, SFY 2018-2019

A review of the Performance Milestones achievements in SFY 2019, found that 27 LIAs earned at least one performance payment during the year, while four LIAs met each Milestone every quarter (see definitions, Appendix 1B). Overall, 22 (60%) LIAs successfully reached 85% enrollment in one or more quarters and 14 (38%) LIAs reached 80% dosage for 60% of their families in one or more quarters.

To promote program improvement and achievement of the Performance Milestones, the HVSA simultaneously launched Continuous Quality Improvement (CQI) projects with LIAs to test rapid improvements. LIAs engaged in two annual CQI projects, completed in six-month cycles. LIAs had the opportunity to select from a menu of topics, yet over the two contract years, SFY 2018 and SFY 2019, all 36 participating HVSA LIAs focused at least one CQI project on some aspect of family engagement— including enrollment, dosage, retention and reducing missed visits.

Applying CQI methods of small-scale, iterative tests of change, home visiting programs tested new strategies to improve family engagement related to communication, recruitment, incentives, scheduling visits and Group Connections (PAT). Of those programs that focused on increasing or maintaining enrollment, CQI appears to have had a positive impact on these efforts. As discussed above, overall rates for dosage remained relatively stagnant, despite the CQI focus. However, some individual programs who focused CQI on dosage and visit frequency did experience positive change.

Program Retention

In SFY 2019, the HVSA added a new Performance Milestone—Family Retention, or how long a family remains in a home visiting program. For most of the models supported by the HVSA, typical programming provides two years of education and support, with extensions dependent on additional...
births or ongoing family needs. Together with dosage and content of services, family retention is a necessary component of program implementation (Anne et al., 2018). Dosage and retention measure the “quantity” of home visiting. Whether this “quantity” is associated with family outcomes is a question for further research. During SFY 2019, 1,139 families exited from home visiting services. A third of the exited families remained enrolled for 24 months or more, half reached 12 months of enrollment and 15% exited prior to reaching three months (Figure 6). At the time of exit, families were asked why they were leaving the program. Nearly one-third of exiting families graduated from the program, aged-out of services, reported returning to school or starting a job or reported receiving services elsewhere. However, 1 in 5 families was lost to follow-up, highlighting the barriers and competing demands for populations eligible for home visiting.

Figure 6: Family retention among SFY 2019 exits

Family retention is a priority for CQI, as well as performance awards. In SFY 2020 all LIAs will engage in a year-long CQI Learning Collaborative project, focused on either Caregiver Depression or Family Retention. Family Retention was identified as a key component of family engagement and an area with room for improvement and learning. As reflected in the data related to exit reasons, a family’s decision to remain or disengage in home visiting services is nuanced and not always positive or negative. Sustained engagement in home visiting services is dependent on a number of factors, including family circumstances and commitments, the relationship between the family and home visitor, home visiting staff transitions and more generally how home visiting is able to meet family needs. In SFY 2020, 24 HVSA programs have chosen to participate in the Family Retention CQI Learning Collaborative.

Home Visiting Services Provided

HVSA Aligned Measures

HVSA Aligned Measures include eight performance indicators that all HVSA programs collect and report on for participating caregivers and children (Box 2). These eight measures cover four domains that encompass the children’s and caregivers’ health, well-being and development. Most of the HVSA Aligned measures are process measures, with just two outcome measures, Breastfeeding and Child Maltreatment. A process measure articulates whether or how much an activity happened, whereas an outcome measure is how well did something happen. Some measures are assessed once per child or
caregiver (e.g., IPV screening) while others are tracked annually (e.g., parent-child interaction). See Appendix 1 for measure definitions.

The Aligned Measures have been generally stable over the past two years although some differences were observed (Figure 7). Differences were noted across home visiting models, possibly reflecting the differences in how data are collected or the model-specific priorities (Appendix 2) and across geographies (Appendix 3). For example, a greater proportion of NFP clients completed developmental screenings and well-child visits compared to other models, while more PAT clients reported daily literacy activities. Given that SFY 2019 was only the second year using this performance measurement framework, there is work being done to support programs to meet these requirements including individual technical assistance and data dashboards to monitor progress.

Figure 7: Statewide performance on eight HVSA Aligned Measures, SFY 2018 and 2019

Box 2: HVSA Aligned Measures

Domain 1. Improved Maternal and Newborn Health
- Continued Breastfeeding at 6 months of age
- Routine Well Child Visits completed on time
- Depression Screening completed for caregivers

Domain 2. Reduced Child Injuries, Abuse and Neglect
- Investigated case of Child Maltreatment initiated

Domain 3. Improved School Readiness and Achievement
- Observation of Parent-Child Interaction completed
- Child receives Daily Literacy Activities from family member
- Child Developmental Screenings completed on time

Domain 4. Reduced Crime or Domestic Violence
- Intimate Partner Violence (IPV) Screening completed for caregivers
Improved Maternal and Child Health

In SFY 2019, 53% of infants whose mothers enrolled during pregnancy, continued to receive some breastmilk at six months of age. This is lower than the statewide breastfeeding rates (71%, Breastfeeding Report Card) and the Healthy People 2020 Goal of 61% (Healthy People 2020). Variation across DCYF Regions is significant (p<0.05), ranging from 76% in Region 4 to 42% in Region 1 (Figure 8). Note that the decline in breastfeeding rates between SFY 2018 and SFY 2019 may reflect a change in data collection methodology for NFP in SFY 2019 and a high percentage of missing values (30%).

Figure 8: Percent of infants’ breastfed any amount at 6 months of age in SFY 2019, by DCYF Region

The other indicator for infant and child health, well child visits, assesses whether a child received the most recent visit recommended by the American Academy of Pediatrics. Overall more families were up-to-date on well child visits statewide compared to breastfeeding rates; however, the regional highs and lows were quite different (Figure 9, range 58% to 80%). For example, the highest breastfeeding rates were in Region 4 with lowest rates found in Region 1; in contrast, well child visits were higher in Region 1 and lowest in Region 4.

Figure 9: Percent of children who received recommended well-child visits in SFY 2019, by DCYF Region
Identifying potential caregiver mental health issues and providing services and referrals is a key role for home visitors. In SFY 2019, depression screenings and referrals were added as Performance Milestones in an effort to elevate the importance of timely screening. The goal of the depression screening performance award was to incentivize screening for all newly enrolled caregivers within three months of enrollment or three months following the birth of their child if the caregiver enrolled prenatally. Home visitors screen caregivers with the Patient Health Questionnaire-9 (PHQ-9). For SFY 2019, LIAs received incentive awards for the 720 caregivers screened for depression during the screening window in the fiscal year. Depression screening rates across the HVSA remained constant at 74%, with regional variation from 54% to 83% (Appendix 3).

The depression referral performance award is designed to incentivize appropriate follow-up and connection to services for caregivers who screen positive or disclose depressive symptoms. This may include making a new referral for mental health services, completing a referral or confirming the caregiver is receiving the recommended services and documenting the work. In SFY 2019, incentive awards were made for 145 caregivers who received a referral following a positive depression screening; however, this only accounted for one-third of the positive screenings reported. Additional support to home visitors may include education on mental health and depression, coaching on supporting discussions with clients about mental health, improving data collection and understanding the value of data reporting. Systems-level issues such as the availability of mental health providers in rural communities and the availability of culturally appropriate services may need to be addressed. In SFY 2020, 13 home visiting programs selected to participate in the caregiver depression screening and referrals CQI Learning Collaborative.

**SF 2019 Depression Performance Milestones**

- **Screenings:** 720 Caregivers
- **Referrals:** 145 Caregivers

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**A Clark County Public Health client** wrote under "What I like about NFP"

“A kind and caring nurse that comes to your home on a regular basis. My nurse was eager to help with my many questions about my changing body from birth to 2 years old. She brought lots of good reading material and movies. Healthcare is so confusing these days but she helped me navigate and find me and my daughter good doctors and dentists. She listened and genuinely cared. This program is amazing. Being a first time mom is so scary, but because of NFP I embraced being the best mom I can be. Thank you so much!”

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**Reduced Child Injuries, Abuse and Neglect**

While reducing child abuse and neglect is often cited as one of the primary goals for home visiting, it is difficult to measure. This is the only Aligned Measure that relies on administrative data collected by Child Protective Services (CPS), rather than using parent self-report. In Washington, what that means is that the HVSA is dependent on parents providing consent to the HVSA to use confidential individual identifiers to match with CPS data. In SFY 2019, 67% of the children enrolled in home visiting had a parent or guardian who consented to share confidential data with the HVSA. Among these children, 3% had a case investigation initiated in SFY 2019.

**Improved School Readiness and Achievement**

The three indicators for school readiness and achievement cover interactions in the home between adult and children and routine child developmental screenings by the home visitor. Nurturing the
parent-child relationship is one of the primary goals for all of the home visiting models funded by the HVSA; yet measuring the strength of that relationship is challenging. Instead, the HVSA uses a process measure to monitor that the parent-child interaction (PCI) is assessed at minimum annually.

Despite the focus on the relationship by home visitors, the formal assessment and reporting of PCI is low. In SFY 2019, only 47% of parents were assessed using an HVSA-approved tool. For both SFY 2018 and 2019, the Home Observation for Measurement of the Environment (HOME) tool was the primary assessment tool included in this measure. Additional MIECHV-approved tools used by LIAs will be reviewed in SFY 2020 by the HVSA and may expand the list of approved tools for PCI assessment.

Many home visiting models use the Ages & Stages Questionnaires, Third Edition (ASQ-3) to routinely screen for potential developmental delays. The screening tool assesses development in skill areas including communication, gross and fine motor, problem-solving and social development. The expectation is that at a minimum, children are screened at 9-10 months, 18 months and 24 or 30 months of age. Screening rates for the HVSA were 61%, comparable to performance in SFY 2018. Regional variation follows a similar pattern to the other school readiness measures with higher rates in Eastern Washington and lower rates in urban centers (Appendix 3).

Figure 10: Percent of children screened for developmental delays by Region, SFY 2019

Centralia College had a mother of a 2-year-old share her story:

“I feel the PAT program helped me grow personally with my son by giving me new ideas with approaching a situation with him and many new activity ideas for keeping my busy energetic toddler happy. I also feel it helped me to see what stages my son will go through next and what to expect from it when I had absolutely no idea. I think all of the information and fun books have really helped progress my kiddo big time. Overall, this program is so helpful and really useful for first time moms and of course for all of the moms out there. Thanks PAT! And our home visitor. Our family is really grateful!”

After being enrolled in PAT for several months, this mom had the confidence to enroll for classes at Centralia College. Being in the PAT program was her gateway to becoming a college student.
Reduced Crime or Domestic Violence

The one measure in this domain, Intimate Partner Violence (IPV) screening improved from 66% in SFY 2018 to 70% in SFY 2019. IPV screening rates were significantly higher in Eastern Washington regions (Regions 1 and 2) compared to Western Washington regions (Regions 3, 4, 5 and 6) (Figure 11, range 52% to 82%). During SFY 2019, three eastern Washington LIAs participated in a national CQI Learning Collaborative that worked to improve IPV screenings and referrals. IPV screening rates for these three LIAs remained high in SFY 2019 (82-97%).

Figure 11: Percent of caregivers screened for IPV in SFY 2019, by Region

Lessons Learned and Future Direction

SFY 2019 was a year of learning and growth for the HVSA. The end of June 2019 marked the two-year anniversary for accountability to the Aligned Measures and the one-year anniversary for the Performance Milestones. Congratulations are due across the HVSA for the significant accomplishment of adopting a uniform set of measures and milestones to monitor progress statewide. This effort required dedicated home visitors and LIAs to implement, modify and improve home visiting services and reporting, as well as state-level HVSA leadership commitment to provide trainings and support for model fidelity, data collection and reporting.

Looking at the Aligned Measures, in SFY 2019 there was improved performance in daily literacy activities and IPV screening, yet the majority of measures remained unchanged from the prior year. Several performance indicators displayed geographic variation. The reasons for these geographic differences may be due to differences in distribution of models, model goals, how models collect the data and population served by programs (e.g., the population in Seattle metropolitan area vs. other areas; urban vs. rural populations). Further geographic analyses are warranted.

Health screenings and referrals for depression, IPV and child development continue to require training support for the home visitor to promote competency and confidence in the tools. CQI methods will continue to promote practice improvements for depression and IPV screenings and referrals, with improved outcomes anticipated in SFY 2020. Additionally, a deeper understanding of the parent-child relationship, including how to support and assess the relationship, continues to be a priority for the LIAs and the HVSA. As the HVSA expands the performance-based contracting work to include program
outcomes, the parent-child relationship continues to be recognized as one of the foundational outcomes of interest across all of the home visiting models.

Two areas of particular ongoing interest to the HVSA are workforce development and family engagement. In 2019, the HVSA along with regional MIECHV partners, published findings from the MIECHV Innovation Grant focused on the home visiting workforce in Region X (Green et al, 2019). This body of work provides insights into the current makeup of the home visiting workforce, challenges to hiring, retention and staff advancement in the field, as well as opportunities for further analyses of the associations between workforce and family outcomes. Family engagement, which encompasses enrollment, dosage, retention and overall participation in home visiting, is another area ripe for additional exploration. While HVSA-funded LIAs were successful in reaching more families in SFY 2019, visit dosage and retention remained below model expectations. In 2019, the HVSA began to explore the relationship between home visitor workload with family engagement and outcomes. This is a rich area for further study moving forward.

Lastly, the HVSA continues to engage in national communities of practice dedicated to advancing home visiting and continue to seek insights from national and local studies, including but not limited to the national Maternal and Infant Home Visiting Program Evaluation (MIHOPE) study results recently published (see Duggan et al, 2018 and Michalopoulos et al, 2019 studies in references).

Data Limitations
It is important to note that the data and information included in this annual report are subject to a number of limitations. The report should to be interpreted with these limitations in mind.

First, families enrolled in home visiting programs are often experiencing many challenges and may be reluctant to share fully with their home visitor until a trusting relationship is built.

Second, the data collection and reporting requirements for the HVSA allow for routine monitoring and evaluation across all models, LIAs and families funded by the HVSA. The burden to meet these requirements, however, is high for the home visitor and is variable across models, dependent on model priorities, data collection forms and supporting data systems. Changes to the HVSA measures, the HVSA data system and the model data collection and reporting systems create opportunities for improved measurement, while also presenting challenges to producing comprehensive, routine monitoring data.

Third, this report used available data, feedback from the field and best practices for combining data from different sources. Select models or programs were not included in some analyses if data elements were not available. For example, some models do not report the number of family members in a household, making the calculation of the federal poverty level unobtainable. In SFY 2019, the HVSA adopted a new quality assurance plan and committed to working with programs and models to ease the reporting burden while meeting the monitoring needs of funders and stakeholders.
Selected References


## Appendix 1: Measure Definitions

### A. HVSA Aligned Performance Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Breastfeeding</td>
<td>Percent of infants (among mothers who enrolled in home visiting prenatally) who were breastfed any amount at 6 months of age</td>
</tr>
<tr>
<td>Depression screening</td>
<td>Percent of primary caregivers enrolled in home visiting who are screened for depression using a validated tool within 3 months of enrollment or delivery</td>
</tr>
<tr>
<td>Well child visits</td>
<td>Percent of children enrolled in home visiting who received the last recommended well child visit based on the American Academy of Pediatrics (AAP) schedule.</td>
</tr>
<tr>
<td>CPS involvement</td>
<td>Percent of children enrolled in home visiting with at least one investigated case of maltreatment following enrollment within the reporting period</td>
</tr>
<tr>
<td>Parent-child interaction</td>
<td>Percent of primary caregivers enrolled in HV who receive an observation of caregiver-child interaction using a validated tool</td>
</tr>
<tr>
<td>Literacy activities</td>
<td>Percent of children enrolled in home visiting with a family member who reported that during a typical week s/he read, told stories and/or sang songs with their child daily, every day</td>
</tr>
<tr>
<td>Child development screenings</td>
<td>Percent of children enrolled in home visiting with at least one screening for developmental delays with a validated tool according to the AAP-defined age groups</td>
</tr>
<tr>
<td>IPV screening</td>
<td>Percent of primary caregivers enrolled in home visiting who are screened for interpersonal violence (IPV) within 6 months of enrollment using a validated tool</td>
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### B. HVSA Aligned Performance Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Enrollment</td>
<td>Program meets or exceeds enrollment of 85% of their Maximum Service Capacity (caseload) during the report period, using cross-sectional count of families currently served at the end of each month. Evaluated Quarterly.</td>
</tr>
<tr>
<td>Dosage</td>
<td>Program with at least 60% of their total enrolled families receiving minimum of 80% of expected number of home visits (per model requirements) during the report period. Evaluated Quarterly.</td>
</tr>
<tr>
<td>Depression screening</td>
<td>Primary caregivers enrolled in home visiting screened for depression using a validated tool within 3 months of enrollment or delivery during the report period. Evaluated Annually.</td>
</tr>
<tr>
<td>Depression Referrals</td>
<td>Primary caregivers referred to or connected with services during the report period following a positive screening. Evaluated Annually.</td>
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</tbody>
</table>
### Appendix 2: HVSA Aligned Measures by Model

<table>
<thead>
<tr>
<th>HVSA Aligned Performance Measures for Caregivers</th>
<th>Maternal Depression Screening Completed</th>
<th>IPV Screening Completed*</th>
<th>Parent Child Interaction Observed*</th>
<th>Daily Literacy Activities*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>D</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>NFP</td>
<td>335</td>
<td>435</td>
<td>(77.0%)</td>
<td>307</td>
</tr>
<tr>
<td>PAT</td>
<td>290</td>
<td>404</td>
<td>(71.8%)</td>
<td>273</td>
</tr>
<tr>
<td>Portfolio</td>
<td>30</td>
<td>46</td>
<td>(65.2%)</td>
<td>38</td>
</tr>
<tr>
<td>Total HVSA</td>
<td>655</td>
<td>885</td>
<td>(74.0%)</td>
<td>618</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HVSA Aligned Performance Measures for Children</th>
<th>Breastfeeding at 6 Months*</th>
<th>Last Well Child Visit Received*</th>
<th>Development Screening Completed*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>D</td>
<td>%</td>
</tr>
<tr>
<td>NFP</td>
<td>127</td>
<td>291</td>
<td>(43.6%)</td>
</tr>
<tr>
<td>PAT</td>
<td>58</td>
<td>76</td>
<td>(76.3%)</td>
</tr>
<tr>
<td>Portfolio</td>
<td>17</td>
<td>17</td>
<td>(100.0%)</td>
</tr>
<tr>
<td>Total HVSA</td>
<td>324</td>
<td>479</td>
<td>(52.6%)</td>
</tr>
</tbody>
</table>

*p-value <0.05 based on Chi-square test across models

Note: Investigated child maltreatment measure is not included due to the small number of investigated cases reported.
### Appendix 3: HVSA Aligned Measures by DCYF Region

#### HVSA Aligned Performance Measures for Caregivers

<table>
<thead>
<tr>
<th>Region</th>
<th>Maternal Depression Screening Completed</th>
<th>IPV Screening Completed*</th>
<th>Parent Child Interaction Observed*</th>
<th>Daily Literacy Activities*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>D</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Region 1</td>
<td>105</td>
<td>127</td>
<td>(82.7%)</td>
<td>106</td>
</tr>
<tr>
<td>Region 2</td>
<td>172</td>
<td>221</td>
<td>(77.8%)</td>
<td>184</td>
</tr>
<tr>
<td>Region 3</td>
<td>82</td>
<td>118</td>
<td>(69.5%)</td>
<td>77</td>
</tr>
<tr>
<td>Region 4</td>
<td>53</td>
<td>99</td>
<td>(53.5%)</td>
<td>72</td>
</tr>
<tr>
<td>Region 5</td>
<td>61</td>
<td>84</td>
<td>(72.6%)</td>
<td>41</td>
</tr>
<tr>
<td>Region 6</td>
<td>182</td>
<td>236</td>
<td>(77.1%)</td>
<td>138</td>
</tr>
<tr>
<td>Total HVSA</td>
<td>655</td>
<td>885</td>
<td>(74.0%)</td>
<td>618</td>
</tr>
</tbody>
</table>

#### HVSA Aligned Performance Measures for Children

<table>
<thead>
<tr>
<th>Region</th>
<th>Breastfeeding at 6 Months*</th>
<th>Last Well Child Visit Received*</th>
<th>Development Screening Completed*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>D</td>
<td>%</td>
</tr>
<tr>
<td>Region 1</td>
<td>17</td>
<td>41</td>
<td>(41.5%)</td>
</tr>
<tr>
<td>Region 2</td>
<td>47</td>
<td>96</td>
<td>(49.0%)</td>
</tr>
<tr>
<td>Region 3</td>
<td>15</td>
<td>30</td>
<td>(50.0%)</td>
</tr>
<tr>
<td>Region 4</td>
<td>41</td>
<td>54</td>
<td>(75.9%)</td>
</tr>
<tr>
<td>Region 5</td>
<td>28</td>
<td>62</td>
<td>(45.2%)</td>
</tr>
<tr>
<td>Region 6</td>
<td>54</td>
<td>101</td>
<td>(53.5%)</td>
</tr>
<tr>
<td>Total HVSA</td>
<td>202</td>
<td>384</td>
<td>(52.6%)</td>
</tr>
</tbody>
</table>

*P-value <0.05 based on Chi-square test across models

Note: Investigated child maltreatment measure is not included due to the small number of investigated cases reported.