2015 Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Annual Technical Report

Executive Summary

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Introduction

The 3rd Annual Illinois Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Report was produced by the research and evaluation team at the Center for Prevention Research and Development (CPRD), School of Social Work, at the University of Illinois Urbana-Champaign (UIUC). As the external evaluator for the MIECHV initiative, CPRD has completed the third full year MIECHV program evaluation, as required by the federal Health Resources and Services Administration (HRSA) under the Affordable Care Act of 2010.

Illinois' approach to the implementation of MIECHV encompasses three major strategies: (1) expanding or enhancing one or more of four evidence-based models of home visiting services; (2) ensuring that the home visiting programs are effectively connected to those community-based organizations and services required to achieve the Performance Benchmarks; and (3) further developing and strengthening a statewide system of evidence-based and innovative approaches to home visiting.

Who do the MIECHV Home Visiting and Doula grants serve?

Illinois MIECHV administers home visiting services in eight communities (Cicero, Elgin, Englewood (Chicago), Macon County, Rock Island/Moline, Rockford, Vermilion County and Waukegan) and is comprised of twenty home visiting and five doula programs. In federal fiscal year 2015, 975 families were served and 13,195 home visits were provided. In both the home visiting and doula programs, 84% of participants had family incomes below the federal poverty line. A complete profile of the demographic characteristics of participants is available in the 2015 Illinois MIECHV Annual Report on the CPRD website.

What are Illinois' MIECHV Performance Benchmark results?

MIECHV performance benchmark (PB) data collection represents annual cross-sectional data for six broad categories, which are comprised from 33 indicators. MIECHV requires grantees to demonstrate annual improvements in at least four of the six benchmark area domains over the three years of program implementation. To demonstrate improvement in at least four benchmark areas, grantees must show improvement in at least half of the benchmark constructs. Based on FY 2015 performance data reported in October 2015, Illinois has demonstrated improvement in five of the six benchmark areas, and has therefore met the grant requirement. The benchmark in which Illinois did not see improvement in at least half of the constructs was Benchmark 2: Reduction in Child Injuries, Neglect, and Emergency Department Visits. The six

benchmark categories and a summary of indicator results for FY 2013, FY 2014 and FY 2015 are presented in **Figure 1** below.

Improvements are reported for seven of eight benchmark indicators for maternal child and health results, with the largest gains for prenatal visit completion and well-child visit completion. The second benchmark area related to reduction in child injuries, neglect, and ED visits, saw great improvements in the provision of safety information over time. However, although numbers are small, progress declined in reducing child visits to the emergency room and substantiated child maltreatment reports. Improvement was seen in all school readiness and academic achievement indicators. While gains were made especially in the level of support for child's learning and development and the parent-child relationship, there remains room for growth in these constructs. The fourth benchmark area related to domestic violence saw improvement, with near universal screening completed in the doula and home visiting programs. All families with positive screens on the Futures Without Violence assessment received referrals and completed safety plans. Measures of conditions related to family economic self-sufficiency also improved from FY 2013 to FY 2015, despite the many challenges faced by participants who are pregnant or raising infants. Benchmark 6 measures to what extent families are assessed for needed services, are referred to services, and whether participants complete those referrals. While identification of service needs rose to 100%, completion of referrals declined. These results reflect the instability of small numbers, as well as the inherent challenges of addressing issues like depression, domestic violence, and developmental delay. Additional challenges have appeared in FY 2015, with many community resources limiting hours, services, or closing completely as a result of state of Illinois funding constraints.

Figure 1. Summary of MIECHV Benchmarks, FY 2013 - FY 2015

			2013	2014	2015
Improving Maternal and Newborn Health	1.1 Prenatal visit completion	Improved	35% (172)	59% (94)	73% (152)
	1.2 Prenatal use of alcohol, tobacco, or drugs	Declined	58% (24)	12% (17)	10% (29)
	1.3 Postpartum use of contraception	Improved	29% (154)	38% (84)	62% (118)
	1.4 Inter-birth interval	Improved	73% (154)	82% (84)	92% (126)
	1.5 Screening for maternal depression	Improved	69% (166)	100% (89)	99% (136)
	1.6 Breastfeeding	Improved	30% (111)	22% (77)	32% (94)
	1.7 Well-child visit completion	Improved	56% (16)	88% (76)	92% (50)
	1.8 Health Insurance coverage for mother/child	Improved	76% (249)	78% (193)	82% (154)
Child Injuries, Neglect, and ED Visits	2.1 All cause child visits to emergency department	Declined	12% (249)	21% (193)	20% (157)
	2.2 All cause mother visits to emergency department	Same	9% (245)	9% (185)	9% (148)
	2.3 Dissemination of safety information	Improved	50% (508)	94% (246)	96% (289)
	2.4 Children with injuries requiring medical treatment	Improved	3% (245)	6% (185)	1% (153)
	2.5 Suspected child maltreatment reports	Same	11% (222)	6% (185)	11% (152)
	2.6 Substantiated child maltreatment reports	Declined	4% (222)	2% (185)	6% (152)
	2.7 First time substantiated child maltreatment	Improved	4% (222)	0% (185)	3% (152)
Increase School Readiness & Academic Achievement	3.1 Level of support for child's learning and development	Improved	6% (245)	39% (185)	81% (120)
	3.2 Knowledge of child's development and developmental progress	Improved	8% (165)	21% (135)	32% (124)
	3.3 Parent-child relationship	Improved	18% (165)	40% (106)	52% (108)
	3.4 Parent level of emotional well-being	Improved	20% (130)	98% (111)	100% (120)
	3.5 Screening for developmentally appropriate communication skills	Improved	66% (164)	87% (155)	90% (126)
	3.6 Screening for general cognitive delays	Improved	66% (164)	87% (155)	90% (126)
	3.7 Screening for self-regulation	Improved	66% (164)	87% (155)	90% (126)
	3.8 Screening for social-emotional delays	Improved	45% (164)	77% (155)	87% (126)
Preventing, Identifying, and Treating Domestic Violence	4.1 Domestic violence screening	Improved	60% (240)	98% (185)	99% (148)
	4.2 Referrals for domestic violence services	Improved	83% (6)	92% (13)	100% (6)
	4.3 Safety plan development	Improved	20% (5)	69% (13)	100% (6)
Family Economic Self-Sufficiency	5.1 Household income and benefits	Improved	11% (245)	36% (185)	54% (148)
	5.2 Employment or education of adult members of household	Improved	17% (89)	30% (73)	46% (63)
	5.3 Health insurance status of all family members	Improved	69% (245)	65% (184)	75% (148)
Increase Coordination/ Referral & Completion of Community Services	6.1 Identification of need for services	Improved	91% (245)	100% (185)	100% (148)
	6.2 Family referrals to community resources	Improved	50% (12)	75% (36)	89% (18)
	6.3 Completed referrals	Declined	67% (6)	70% (27)	63% (16)

What are the characteristics of participants who complete MIECHV programs?

Research has shown that home visiting participants must complete the full complement of home visiting program activities and services to derive the maximum benefits and outcomes (dosage effect). Analysis of data from 1,050 families who exited MIECHV over the past three fiscal years show that approximately 33% (n=343) completed the program. While Illinois MIECHV program completion rates differed considerably by model, community, and agency, participant level differences in socio demographic characteristics were also observed between those who completed the program and those who dropped out prior to completion. For example, higher completion rates were observed in non-Caucasian, Hispanic, married, uninsured, less than high-school educated, and lower completion rates were observed in first time parents and WIC participants. However, these differences were not statistically significant. Multilevel logistic regression results suggest that older mothers; mothers who were not pregnant at enrollment; and those with multiple challenges--both individual and family related--such as having a history of abuse or neglect, or interactions with the child welfare system as a child or as an adult, having low achievement, and having a disabled child; were more likely to have completed MIECHV programs and services compared to other groups. These findings illustrate the need for continuous quality improvement efforts to understand and meet the needs of families exiting before program completion.

How do MIECHV participants differ in their report of and experiences with Adverse Childhood Experiences?

Based on emerging research and greater recognition of the deleterious effects of childhood trauma, the evaluation team added the Adverse Childhood Experiences (ACEs) instrument and data collection protocol in January of 2015. Preliminary data analysis was conducted on a relatively modest sample (n=163) of MIECHV participants, as the survey was only administered to caregivers who remained in the program for at least one year, and were received the one year follow-up assessments.

Results show that Illinois MIECHV families had approximately the same prevalence for the different types of ACEs, as reported in a Centers for Disease Control and Prevention (CDC) five-state study, with the exception of family member incarceration (12% in Illinois MIECHV participants compared to 7% in the five-state sample).

Other important findings include:

- higher levels of poverty, peer victimization and family incarceration in teen mothers
- lower ACE scores in married mothers compared to those in other living arrangements, and
- higher ACE scores in mothers with a high school education report compared to those who did not graduate

Future ACE analyses will continue to focus on increasing the number of ACE surveys in our MIECHV data sample and identifying the differences in ACEs by demographics, and studying the influence of ACEs on MIECHV outcomes.

What other MIECHV studies or analyses were conducted in 2015?

In addition to the evaluation results presented in this document, the evaluation team conducted a series of brief studies and data analyses that included Site Visit Review, Home Visiting Staff Turnover, Annual Home Visiting and CQI Survey, Benchmarks, Safety Policy Analysis, Community Systems Development Study and several smaller data analyses addressing special requests. A list of these studies is available on CPRD's website.

How does Illinois' Continuous Quality Improvement system improve performance benchmarks and home visiting services?

CPRD's Continuous Quality Improvement (CQI) Specialist conducts monthly technical assistance calls with each home visiting agency to determine progress, challenges, and problems, and to provide support in planning and implementing CQI activities. Additional webinars, benchmark-specific training calls, and other community-level supports are provided on an as-needed basis.

The mainstay of CQI activities is the development, implementation and evaluation of CQI Action Plans. Plans are developed based on prior performance on the MIECHV benchmarks and aim to improve benchmark performance and overall program quality.

During this fiscal year, home visiting agencies developed CQI Action Plans addressing the following benchmarks, listed in **Figure 2**.

Figure 2. Targeted Constructs for CQI Plans: Year 3 to Year 4 Changes

Construct	# of Agencies	FY 14	FY 15	Change	Improvement?
Breastfeeding	7	22%	29%	+7%	Yes
Contraception	6	38%	61%	+23%	Yes
ASQs	5	87%	91%	+4%	Yes
Education	5	30%	46%	+16%	Yes
Child ED visits	4	21%	19%	-2%	Yes
Injury prevention	3	94%	96%	+2%	Yes
Well-child visits	2	88%	91%	+2%	Yes
Income & benefits	2	36%	54%	+18%	Yes
ASQ-SE	2	77%	87%	+10%	Yes
Prenatal care	1	59%	73%	+14%	Yes
Referral completion	1	70%	62%	-8%	No
Safety planning	1	69%	100%	+31%	Yes

What have we learned to date and how can MIECHV continue to improve?

Illinois has now completed three full years of implementing MIECHV programs in priority communities. Over that time, MIECHV has continued to scale up, refine its home visiting infrastructure, and formalize policies and procedures—all ultimately leading to improved outcomes and performance benchmark results. Over the past two years, Illinois has been deeply immersed in political and financial turmoil with budget crisis after budget crisis leading to unstable and unsustainable state government services. Many health and human service providers have reduced services and several agencies have closed part or all of their operations. Multiple state funded agencies play an important role contributing to the success of home visiting services' capacity, access and referrals; but these fitful periods have paralyzed many community programs and services. In this context, the following conclusions and recommendations are made:

Performance Benchmarks

Despite important improvements in many MIECHV benchmarks, several indicators still need continued focus and attention. For example, home visiting benchmarks for prenatal visit completion (73%), breastfeeding (32%), parent knowledge of child development (32%), and completed referrals (63%) each have significant opportunities to improve their reach.

Additionally, MIECHV programs continue to improve health insurance coverage for participant families. The greatest challenges for accessing health insurance are presented by communities in which significant numbers of undocumented families reside.

The upcoming HRSA benchmark revisions will require multiple levels of training, technical assistance and technology changes. Home visitors will be required to collect parent-child interaction and home environment measures, implement new data entry procedures, and report on additional quality measures regarding staff and participant turnover.

The advent of the new HRSA benchmarks will require redesign of the Visit Tracker system used by all Illinois MIECHV programs, with both adaptations and refinements to improve data entry and reduce errors.

To improve the quality of home visiting services and data collected by MIECHV home visitors, formalized quality assurance processes and policies need to be developed in line with the updated benchmarks and data entry into Visit Tracker in order to ensure required data is complete and accurate.

The loss of subsidized childcare services by many Illinois families makes it extremely difficult for disadvantaged families to gain access to educational and employment services, since childcare allows them the opportunity to participate in these services.

Coordinated Intake and Community Systems Development

A full review of the Community Systems Development and Coordinated Intake services is needed in order to update the rapidly changing community services, and determine how to fill the gaps left by discontinuing CSD activities and supports.

MIECHV should consider integrating most or all of the ACEs survey questions into the coordinated intake process, which could then be used to assess baseline family risk and target community resources.

Home visitors and Coordinated Intake workers continue to be challenged by limited options for referrals from home visiting programs to community-based services, and by tracking referrals and outcomes. New challenges have emerged as the Illinois financial crisis has required many social services agencies to scale back.

Continuous Quality Improvement

Illinois MIECHV Continuous Quality Improvement efforts at the agency level continue to demonstrate significant improvements in performance benchmarks and related home visiting service quality. MIECHV sites have begun to commit to program improvements through agency support, willingness to engage in the CQI process, and a better understanding of benchmarks requirements.

The statewide Continuous Quality Improvement team remains active and successful in addressing statewide policies and problems. Work continues on monitoring state funding issues, safety policies and education, cost-per slot estimates, caseload census, benchmark revisions, MIECHV's eight-week intensive weekly visit policy, and Infant Mental Health services.

Home Visiting Services

The evaluation team will continue to examine data to understand the MIECHV "weekly visit" policy initiated in Fall 2014 to ensure that families receive eight home visits in the first two months after the baby is born if the guardian enrolls while pregnant, and the first two months after enrollment if the guardian enrolls while not pregnant.

Data Collection and Tracking

MIECHV needs to continue to track entry and exits into home visiting programs to better understand trends or patterns that influence participation, dropouts and completion. In FY 2016, the evaluation team will conduct a second follow-up telephone survey to MIECHV participant drop outs to gain a better understanding of factors related to departing prior to program completion.

The evaluation team will need to redesign and re-calculate the new Performance Benchmarks to ensure they are collected, calculated and reported based on the federal operational definitions.

Home Visitors

Overall, the home visiting turnover rate appears to have slowed and stabilized. However, Illinois' budget crisis has made home visiting agencies hesitant to hire new staff, because other state-funded home visiting program staff are now furloughed or have reduced schedules. Although the Illinois fiscal crisis significantly contributes to problems related to Illinois home visiting and community services, it is essential that MIECHV continues to address staff

turnover, and ensure rapid replacement of departed staff and the development of a new staff tracking system.

Illinois MIECHV intends to expand both home visiting and doula services to several other Illinois communities. This ramping up process provides a great opportunity to share lessons learned in relation to organizational management, staff hiring, caregiver engagement, training and technical assistance, using the Visit Tracker system, survey administration and other home visiting processes and procedures.

MIECHV 2016

Illinois MIECHV now has fairly well-established protocols and procedures for accessing, collecting, cleaning, validating, analyzing and submitting the MIECHV performance benchmarks to HRSA. As Illinois moves toward adopting the revised HRSA benchmarks, new challenges will likely arise, but high-quality training and monitoring will ensure proper and reliable data collection. Finally, the proposed expansion of MIECHV services to six new high-risk MIECHV communities will also create challenges and opportunities to provide high quality and effective home visiting services to meet their needs.