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<thead>
<tr>
<th>Department of Health and Human Services</th>
<th>Maine Families Home Visiting Program</th>
<th>Hornby Zeller Associates, Inc.</th>
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<tr>
<td>Sheryl Peavey, Director</td>
<td>Pam LaHaye, Coordinator</td>
<td>Darshana Mutz Spach</td>
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<tr>
<td>Early Childhood Systems Initiative</td>
<td>96 Weymouth Road</td>
<td>Project Evaluator</td>
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<tr>
<td>State House Station #11</td>
<td>Morrill, Maine 04952</td>
<td>373 Broadway</td>
</tr>
<tr>
<td>Augusta, ME 04333</td>
<td>(207) 322-2319</td>
<td>South Portland, ME 04106</td>
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<td>(207) 624-7992</td>
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<tr>
<th>Androscoggin County</th>
<th>Aroostook County</th>
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<tr>
<td>Betsy Norcross-Plourde</td>
<td>Dora Davis</td>
<td>Melissa Wedge</td>
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<td>Program Manager</td>
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<tr>
<td>Advocates for Children</td>
<td>Aroostook Council for Healthy Families</td>
<td>Youth Alternatives Ingraham</td>
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<tr>
<td>P.O. Box 3316</td>
<td>37 Bangor Street Suite 7</td>
<td>50 Lydia Lane</td>
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<tr>
<td>Auburn, ME 04212</td>
<td>Houlton, ME 04730</td>
<td>South Portland, ME 04106</td>
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<tr>
<td>(207) 783-3990</td>
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<th>Hancock County</th>
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<tr>
<td>Renee Blanchet</td>
<td>Catherine Jacobs</td>
<td>Lanelle Freeman</td>
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<td>Program Manager</td>
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<td>Franklin County Children’s Task Force</td>
<td>Downeast Health Services, Inc.</td>
<td>Kennebec Valley Community Action</td>
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<td>113 Church Street</td>
<td>52 Christian Ridge Road</td>
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<tr>
<td>Farmington, ME 04938</td>
<td>Ellsworth, ME 04605</td>
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<tr>
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<td>PO Box 278</td>
<td>PO Box 1162</td>
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<td>(207) 594-1980</td>
<td>South Paris, ME 04281</td>
<td>Bangor, ME 04402</td>
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<td>Wesley Neff</td>
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<td>Elizabeth Johnson</td>
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<tr>
<td>University of Maine Cooperative</td>
<td>Down East Community Hospital</td>
<td>Goodall Hospital</td>
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<tr>
<td>Extension</td>
<td>11 Hospital Drive</td>
<td>25 June Street</td>
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<tr>
<td>992 Waterville Road</td>
<td>Machias, ME 04654</td>
<td>Sanford, ME 04073</td>
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<tr>
<td>Waldo, ME 04915</td>
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Executive Summary

The home visiting model developed and delivered by Maine Families is designed to promote child and family well-being. Maine Families uses current information regarding child development, health, safety, and nutrition that is based in sound research and practical knowledge of human development and public health. The program supports new families of infants and young children statewide. Maine Families’ goals for enrolled children and families include:

- Nurturing families and their relationships
- Promoting positive and effective parenting
- Encouraging healthy living, considering all aspects of development
- Providing guidance in creating positive and creative learning environments
- Protecting children from violence, abuse and neglect
- Protecting children from preventable illness and injury
- Providing connections to needed resources and the community
- Encouraging family self-sufficiency

With this focused agenda, Maine Families is addressing the national public health priorities at the state and local levels while considering the unique needs of families in Maine. Maine Families’ public health approach emphasizes prevention and early intervention while operating in a comprehensive, collaborative, community-based milieu.

According to Shonkoff, et al. (2007) early childhood education programs delivering significant return on investment have four common elements consistent with the Maine Families Home Visiting Program: targeted service populations, integrated programming, quality standards, and outcome-based program evaluation. While such elements are commendable because of the priority placed on family and child health and well-being, they are also desirable because they can contribute to financial savings. As the Center on the Developing Child at Harvard University has stated, “investments in young children and their families would be strengthened considerably by greater attention to long-term societal benefits relative to program costs.” In other words, investing in children now saves money later.

The cost burden associated with poor health policy and practices is significant. For example, the 50,000 premature births that occur annually in the United States cost the nation $26 billion a year. Logically, any steps taken to alter behaviors and mitigate problems can substantially impact associated health costs on both state and national levels.

As the well-established core of a continuum of home visiting services available statewide, Maine Families has the capacity and infrastructure in place to provide services to a large proportion of new and expecting families. In FY2010 the program experienced significant cuts in MaineCare, resulting in a loss of staff and impacting its ability to reach the target population as it had in years past. Nonetheless, 63 (full-time equivalent) home visitors served 2,580 families;
of these, 38 percent were new families joining the program for the first time. Maine Families Home Visiting Program has also reached its goal of enrolling at least half of all Fiscal Year 2010 (FY2010) participants prenatally.

Maine Families tracks and measures several key health indicators as summarized below. This year’s results are discussed in greater detail later in this report.

**Caregiver and Child Relationships.** Ninety-two percent of families surveyed expressed a great to moderate increase in their confidence in parenting. Additionally, 63 percent said their child greatly benefits from participation in the program. Maine Families screens new mothers for postpartum depression and supports parent-child attachment. Supporting this critical primary relationship, some programs have developed successful working partnerships with mental health providers, such as Project LAUNCH and THRIVE.

**Prenatal Care.** Almost 94 percent of expecting mothers received at least adequate prenatal services; the same percentage of all caregivers in the program had access to a primary care provider. Of women who enrolled prenatally, about seven percent had their babies under 35 weeks gestational age, and six percent had babies with low birth weight. Programs continue to work with local hospitals on enrolling expecting parents as early as possible. Many sites also rely on Women, Infant, and Children (WIC) program staff to help them reach out to families, as they serve a similar target population.

**Developmental Screening and Intervention.** Of all eligible children in the program, 83 percent were routinely screened for developmental delays. Seven percent of those screened were referred for further evaluation, and as a result 72 percent of those children initially referred through home visiting now have a formal plan and services to address developmental issues.

**Breastfeeding Support.** Some home visitors are trained lactation counselors and all staff actively encourage mothers to breastfeed. With encouragement from staff, the number of breastfeeding women is about the same as last year: 71 percent in early postpartum and 38 percent at six months, down from 41 percent last year.

**Preventing Unintended Pregnancy.** Home visitors work with families to ensure their decision to have additional children is in their family’s best interest. Results from FY2010 show a 29 percent increase in families using methods to prevent unplanned pregnancy from the time of their enrollment compared to most recent data. Only six percent of all families enrolled are reportedly “not making any effort” to prevent pregnancy.

**Health Care for Children.** Each goal identified by Maine Families relates to the health of young children. The vast majority of all infants and children in this program have insurance and access to a primary care provider (95% with insurance, 99.5% primary care provider). Likewise, 98 percent of all children are up-to-date on well-child exams; 93 percent are up-to-date on childhood immunizations.
**Home Safety.** Home visitors provide information and resources for families to assist them in understanding and addressing potential hazards in the home and automobiles. All seven categories routinely assessed with families showed a positive change in home and car safety, with the greatest improvements in outdoor environment safety, fire prevention, car safety, and choking hazards.

**Tobacco Use and Secondhand Smoke.** Maine Families provides information and support to families for whom tobacco use is an issue. Of the 698 families served by home visiting for which secondhand smoke was a concern, 44 percent have eliminated their child’s exposure and another 28 percent have reduced their child’s exposure. Of the 880 families where caregiver smoking was a concern, 27 percent have reported stopping use, and an additional 29 percent have reported reducing use.

**Protecting Children from Violence, Abuse and Neglect.** Home visitors are mandated reporters of child abuse and neglect who are required to take action for the protection of children. In FY2010, there were 31 substantiated reports about participating families made to the Department of Health and Human Services, Child Protective Services Division, 10 of which were made by home visitors. The reports being tracked varied in nature from witnessing abuse or neglect of a child to believing a child is at risk of being abused or neglected. The most common reason indicated for reports made (regardless of the outcome) was in the at-risk category (57%). This category was followed by suspected abuse or neglect (27%) and by witnessed abuse or neglect (15%).

**Increasing Family Self-Sufficiency.** To help families access needed resources, program staff partner with and make a significant number of referrals to a variety of federally funded, state and community resources such as WIC, Temporary Assistance for Needy Families (TANF), childcare services, housing, legal services, transportation and counseling. Maine Families staff made more than 23,000 referrals on behalf of families this past year. Families reported that having a home visitor to help them make these connections is a significant benefit of their participation in the program. Nearly all enrolled families had adequate food and heat in their homes, facilitated in part by referrals of assistance to those in need.

Maine Families Home Visiting provides a much needed service and system of support to families with young children in an effort to increase child and family health and well-being while alleviating some of the concern or uncertainty that new parents may experience. The program recognizes the importance of respecting each family’s culture and unique circumstances while providing the most current child health and development information. This is work that cannot be accomplished in isolation and cannot be short-term. This report provides data intended to inform home visiting practice and guide programs to plan future activities, as well as refine their goals and objectives to provide the greatest benefit to families in Maine.
Maine Families Home Visiting Program

History
Since the 1960s, when the United States government began a serious focus on addressing high rates of poverty, home visiting has been a public health strategy for promoting the health and well-being of children and families. Concurrently, emerging child development research highlighted the connection of early experiences and outcomes for adults, forming a rationale for programs to incorporate home visitation in an effort to prevent child abuse and neglect, promote healthy pregnancies, and support new parents with parenting and child development information.

These issues require even more attention when working with families in stressful environments, complicated by poverty. Public health nurses and social workers in the United States first began providing in-home education and healthcare to urban families who did not have access to such services on their own. With demonstrated success in reducing infant mortality, these programs expanded to promote child development information and effective parenting practices. While the field has evolved, health professionals, educators and policymakers have committed to the home visiting model, recognizing the value of programs such as Early Head Start, Nurse Family Partnerships, and Parents as Teachers. By the late 1990s, the American Academy of Pediatrics called for the inclusion of home visiting in the healthcare system for children.

Extensive national evaluations of home visiting programs have produced mixed results, as it can be difficult to assess program effectiveness with differing data collection methods and program priorities. Some studies have concluded that while very high-risk groups are most likely to benefit from home visiting, programs focused solely on these groups can become stigmatizing to families, which significantly hampers program effectiveness in the long term. Today, there is agreement that successful home visiting programs that succeed in helping children and families are “intensive and comprehensive, flexible, and staffed by professionals with the time and skills to establish solid relationships with their clients.” Furthermore, new research is being conducted on outcomes related to the different home visiting models, pushing the field to concentrate on the characteristics of high-quality programs, and consider the most efficient use of the minimal funds available for such programs.

In Maine, home visiting began at the grassroots level, with various regions establishing programs either on their own or in affiliation with other service providers in the community. Given the diverse demographics of the 16 counties, home visiting throughout the state could, and did, look very different depending on the needs of the population served and resources available in a particular area. Home visitors may have been known as Parent Partners, Parent Educators, Visiting Nurses, or Family Advocates, to name a few, though they all seemed to assume the role of primary support for parents of newborns and young children.
The home visiting programs have worked closely with or were a part of community health organizations and early childhood education systems. Some of those connections enabled the program to grow into what it is today, one that makes sure Maine families are aware of and have access to programs and services offered by local hospitals, clinics, and mental health and substance abuse service providers, as well as WIC and other federally funded programs. Following a pilot program initiated in 1995, Maine continued to develop an integrated statewide system and launched the Maine Home Visiting Program in 2000. Initially, agencies could choose from one of three curriculum models, and participating agencies developed ways to collaborate and make the best use of available knowledge and resources within the home visiting community; these efforts continue today.

**Home Visiting Today**
Home visiting as a service delivery model for expecting parents and families with young children is now gaining greater recognition at the federal level as an effective and direct way of addressing many health and development priorities for vulnerable populations. In Maine, the Department of Health and Human Services’ Office of Child and Family Services, along with the Maine Center for Disease Control’s Division of Maternal and Child Health and the Maine Children’s Trust Fund have worked collaboratively to raise the standards for home visiting, developing Standards of Practice based on evidence in research.

Since 2000, Maine has provided universal home visiting to eligible families in every county of the state. This universal approach is based on the assertion that all parents of infants and young children should have access to needed support in raising healthy children.

While universally offering home visiting services is the desired policy, limited resources led Maine to focus its efforts on families who are expecting their first baby or are first-time parents of a newborn, as well as all adolescent parents.

**Maine Families Home Visitors**
Maine Families seeks to positively impact the lives of young children and their families, starting with the employment of qualified professionals. To prepare for the numerous and complex issues faced by new parents, all
home visitors must have empathy and compassion, as well as the ability to establish trusting and respectful relationships. They must meet the minimum educational requirements of a bachelor’s degree in Child Development, Social Work, or Public Health (or a related field), and participate in extensive annual training. Home visitors are trained extensively in the Parents as Teachers (PAT) curriculum, Infant Mental Health, Great Beginnings, and the well-regarded Brazelton Touchpoints Approach™. Additional core knowledge training is required in cultural competence, professional ethics, child development, nutrition, parent/child attachment and bonding, newborn care, and family violence and substance abuse issues. This foundation provides the home visitors with the knowledge base and skills needed to support families in difficult situations, working toward improved outcomes for both caregiver and child.

The guiding philosophy underlying all work with families is derived from the Touchpoints Approach. Important elements of this relationship-based model include:

- Recognition of what each person brings to the interaction
- Awareness of opportunities to support mastery
- Awareness of the child’s behavior and cues
- Ability to focus on the caregiver-child relationship

While the program can be molded to the needs of the population in each county within the Standards of Practice (2010), Maine Families’ core components are informed by national indicators such as those provided by the Healthy People 2010 Initiative, recommendations provided by the American Academy of Pediatrics, as well as current research related to child health and development. Serving families at the prenatal stage is a major goal of the program, since a healthy pregnancy is more likely to result in the birth of a healthy baby.

Maine Families provides home-based parent education and support services on a range of topics, from child health and nutrition to caregiver guidance. Home visitors provide positive supports to families, with the focus on effective parenting, child development and parent-child attachment.
Though there are a handful of reputable curriculum models for home visiting, over the past two years Maine Families has fully adopted the national Parents as Teachers (PAT) model, certifying all home visitors in its evidence-based curriculum. First developed in the 1970s, PAT articulates specific standards of practice for working with families; this recently updated model now provides guidance for comprehensive assessment of programs. This report includes an overview of services provided by the Maine Families Home Visiting Program, taking into consideration the PAT guidelines as they relate to the Standards of Practice (2010) that all state-funded home visiting sites in Maine must follow.

Currently, services are delivered by the full-time equivalent of 63 home visiting staff associated with 12 individual programs serving all 16 counties in Maine. Each county averages five home visitors, ranging from two or three home visitors in Franklin County, to the team of ten who cover both Kennebec and Somerset Counties. Seventy-nine full time equivalent staff members (including administrative and support staff) work for Maine Families statewide, down from 90 in 2009. Operating on a total annual budget of just over $5 million in Fiscal Year 2009-10, it is managed by the Early Childhood Division of the Maine Department of Health and Human Services’ Office of Child and Family Services.

The Maine Families Home Visiting network is a model of collaboration and effective service delivery. According to a study conducted by Kay Johnson (2009), program design and service delivery directly affect outcomes for participants, both of which have been carefully considered in the evolution of the program. Maine was cited in Johnson’s study as an example of how states can work collaboratively to strengthen existing programs; focusing on improving effectiveness and quality of home visiting.

Program Eligibility and Service Delivery

As mentioned earlier, this program is open to all Maine families expecting their first child and to all adolescent parents under the age of 22. Enrollment is completely voluntary, and services are delivered primarily in the families’ home, at a frequency and intensity that is matched to the needs of each household. Program participants may receive visits ranging in rate of recurrence from weekly to monthly, and can change this rate as needed. Recognizing that direct home visiting support might not be necessary for all families, participants may also stay connected to the program through other means, including receiving information by mail, getting referrals to local resources, and connecting with other parents through group activities and events sponsored by the agencies.

During FY2010, Maine Families staff served more than 2,580 families and 2,616 children. The program completed 21,050 successful visits to families; an annual average of thirteen visits.
per family. There were an additional 121 families who participated in educational groups for parents, attended child playgroups, or received resources and referrals and child development information from the program. Despite budget reductions in both county-level resources and statewide MaineCare funding, fewer home visitors completed more visits to families in 2010, compared to the previous year, reflecting conscientious stewardship of public resources.

The Home Visit

The areas of focus for each visit to a family’s home are based on the PAT and Touchpoints™ curricula and are then adapted to the unique needs and interests of the family. All home visitors are trained and prepared to discuss prenatal care and health-related concerns for both the mother and developing baby, as well as infant and child growth and development (and typical and atypical patterns of each), positive parenting skills, and ways to strengthen the parent-child relationship. Home visitors also perform regular developmental screenings using the Ages and Stages Questionnaire® to assist the parent in understanding his or her child’s development, and to assess for possible developmental delays or the need for intervention. Home visitors help families recognize their strengths and set goals using the resources available to them. Each program uses a Family Service/Family Goals Plan to shape the content of interactions between a family and its home visitor; programs also track a family’s outstanding needs as well as its accomplishments.

Maine Families staff work to encourage interaction with children through parent-child activities (both in the home and the community), answer family member questions, make referrals to other providers when needed, and offer emotional support by listening to the parent concerns and sharing in the family experiences. They provide written, detailed information on a range of topics including: child growth and development, infant and child nutrition, breastfeeding, home safety and childproofing, car seat safety, understanding behaviors and appropriate discipline, and the impact of smoking and secondhand smoke.

Efforts to engage families and meet their needs go far beyond the provision of information and resources. In formal focus groups and through their responses to the annual family survey, the vast majority of participating families who provided feedback expressed sincere gratitude for the true compassion and support that their home visitor has provided them. Many respondents stated that they would not be the confident, informed parent that they are if it were not for the Maine Families Home Visiting Program.

A new parent says:

“This is a wonderful program. I recommend it to all new moms. The education materials are the best I have seen; I share them with my friends.”
Home visiting staff generally allocate an average of three to four hours for every visit, including preparation and travel time. With Maine being a large and generally rural state, home visitors are sometimes required to travel more than an hour each way to the participant’s home. The duration of each home visit varies, again based on the family’s need and topics discussed, but typically last between one and two hours.

Eighty percent of scheduled home visits are achieved (meaning completed versus canceled), which is a testament to the administrative preparation and planning that goes into each home visit. Home visitors travel an average of 18 miles per visit, ranging from one mile or less in Androscoggin County to 40 miles or more in Aroostook County. When combined with visit preparation, travel time and post-visit administrative work, including data entry and referrals, each visit represents an average of three to four hours of staff time.

Ninety-eight percent of the time the visit is conducted with the primary caregiver, and 33 percent of the time the secondary caregiver also participates. (The secondary caregiver in this program could be a biological parent, step-parent, grandparent, or any other family member who shares in care-giving responsibility.) Regardless of primary or secondary status as tracked in the database, both individuals can be considered equally responsible for the child; home visits may also include any other family members or individuals involved in the child’s life.

As reported recurrently in the annual Home Visiting Family Survey, families overwhelmingly feel respected by their home visitors. Building such respect comes from the focus home visitors have based on guiding principles of Touchpoints, and the non-judgmental acceptance of families regardless of differences in a family’s approach to parenting, circumstances, or other cultural norms. Home visitors understand that ambivalence, disorganization and vulnerability are opportunities to reach out to the caregiver, knowing that these can be characteristics of any first-time parents.

Home visitors are trained to identify where and how the parent-child relationship is developing and how best to encourage that connection. Home visitors must be responsive to what the family will present to them and adapt to their needs, whether it is a better understanding their child’s stages of development, recognizing parental depression, identifying patterns of substance abuse, or securing basic needs such as food or clothing.
The Families
Efforts are made to enroll women prior to giving birth to ensure optimal prenatal care and to have the greatest impact on developmental outcomes for the baby-to-be. Last year, an average of 35 percent of mothers enrolled prenatally; this year the statewide percentage of prenatal enrollments has increased to nearly 40 percent, with 49 percent of FY2010 participants having joined the program prior to the birth of the baby.

As with all pertinent information regarding the services provided and content covered during the family visits, demographic information is collected and organized by each county using a statewide database. The information entered this year reveals the following characteristics of program participants:

- 95 percent of all families noted race to be white
- 98 percent of primary caregivers are listed as biological mothers
- 71 percent of mothers were between 18 and 29 years of age at the time of their child’s birth
- 68 percent of all primary caregivers were between 18 and 29 years of age
- 68 percent of parents were either married or partnering
- 30 percent of parents were single

The table at right describes the demographic information of all program participants in more detail, including marital status, race, education and income data. On average, families are enrolled in the program for 19 months, with more than a quarter of enrolled families staying for two years or longer. The 934 newly enrolled families in FY2010 make up 41 percent of all families enrolled in the program; this is a similar proportion to last year. Many programs maintained a waiting list and were unable to enroll as many new families as in years past.

Each year, participating families have the opportunity to respond to an anonymous survey about their experiences in the program. For FY2010, 97 percent of the responding families reported they are very satisfied with their home visitor; 97 percent said their home visitor was very well trained; 99 percent reported their home visitor

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understood their needs and treated them very well; and nearly 100 percent indicated that their home visitor was respectful of their culture or background. These findings are indeed positive, speaking to the quality of service according to the respondents. Parents see the program as a vital resource for child development information, an outlet to escape the isolation associated with parenting young children, as well as an opportunity to learn from other parents.

One mother says:

“We love this program and look forward to our visits. As a first-time mom living far away from family, I really value the time with my home visitor to ask questions, express concerns, get advice, and generally feel more confident. The support has been wonderful!”
Performance Measures

All sites are accountable for their adherence to the Standards of Practice and are required to participate in the statewide evaluation. Each program collects and reviews data using the Home Visiting Tracking System developed and maintained by the program evaluator, Hornby Zeller Associates, Inc. Home visitors report findings and issues to the evaluation team and program management on a quarterly basis (or more frequently, if needed) using this system. As part of the affiliation and certification process with PAT, programs also maintain accurate records of services and families served in order to fulfill the requirements of the PAT evaluation.

This section of the report covers the performance measures currently used by Maine Families. While describing the specific details of the data collected is beyond the scope of this report, the measures related to maternal and child health outcomes that will be discussed include:

- Nurturing Relationships Between Caregiver and Child
- Improving Prenatal Care
- Child Development and Early Intervention Services
- Increasing Breastfeeding Rates
- Reducing Unintended Pregnancy
- Accessing Health Care for Children
- Protecting Children from Preventative Illness and Injury
- Home Environment and Safety
- Protecting Children from Violence, Abuse, and Neglect
- Increasing Family Self-Sufficiency

Nurturing Relationships

Research has demonstrated that a nurturing family relationship in a child’s early years is associated with that child’s better long-term outcomes. These outcomes include increased academic performance, improved health behaviors, positive peer interactions, and increased ability to handle stress.\(^1\) Children who grow up in environments that are not supportive and stable, or without a positive, nurturing relationship, often have disrupted development, which can result in lasting consequences.\(^2\) For example, lack of physical contact or interaction with a primary caregiver can change an infant’s body chemistry, resulting in lower growth hormones necessary for brain and heart development.\(^3\) More broadly, studies conclude that, “because the United States under invests in both quantity and quality of early care and education, the nation forgoes many of the potential benefits at an annual cost estimated in the billions of dollars.”\(^4\)

Home visitors in the Maine Families program describe the importance of establishing trusting relationships with families, describing the personal, unique connection to each family defining the work that they are able to perform. Families’ perceptions about the effects of home visitation on their parenting skills and child’s outcomes are presented in Figure 1. As shown, the vast majority of families believe the program has been responsible for a moderate to great
increase in their confidence as a parent and their knowledge of caring for babies, while the benefit to their children resulting from their participation is equally strong.

Improving Prenatal Care
Receiving prenatal care is an important health factor for both mother and child. The American Medical Association recommends 14 prenatal care visits during a 40-week pregnancy for a typical, low-risk pregnancy. The benefits of prenatal care include improved birth outcomes through the diagnosis of treatable conditions and encouragement of better maternal health habits, as well as decreased rates of pregnancy complications in comparison to women who initiate late or no prenatal care. Mothers who receive care are both less likely to deliver prematurely and have serious complications during pregnancy, and are also more likely to give birth to healthy babies.

In Maine, the CDC reported an average of just over 12 percent of births were to women who did not receive care in the first trimester of pregnancy. The average annual number of premature births is 1,195, or close to nine percent. By providing regular and frequent care for pregnant women, doctors can identify potential problems before they become significant health complications for both mother and child. Together with medical professionals, home visitors who work with women during the prenatal months contribute to early identification of possible complications for parent and child, and help women get regular prenatal visits.
To consider the impact of Maine Families on this outcome, the program looks at state and county level data on birth weight and gestational age as well as data collected by the program. As an example, families who enrolled in home visiting prenatally were less likely to have a low birth weight or premature baby. Likewise, just 19 percent of babies who were involved in the program prior to birth were ever hospitalized in infancy. The program staff share their knowledge of prenatal and newborn care during regular home visits in attempt to address a state public health issue.

Using a nationally recognized tool, the Kotelchuck Index, home visitors measure the adequacy of prenatal care received by expecting mothers with whom they are working. As in years past, prenatal care of enrolled mothers exceeded state average, as well as the goals set by Healthy People 2010; 94 percent of expecting mothers received at least adequate prenatal care, as shown in Figure 2. Slightly more than two percent were reported in the Home Visiting Tracking System to have received “inadequate” care.

The work of the home visitor in supporting families continues after the birth of the baby. All home visitors working with women with newborns offer the Edinburgh Postnatal Depression Scale (EPDS) screening. The EPDS is a short, five-minute questionnaire designed to screen for postpartum depression. Women at risk or showing signs of postpartum depression can then be referred for appropriate support, and home visiting services can be adjusted as necessary to provide assistance tailored to the family’s needs. Maine Families began tracking the use of EPDS in the last six months. Based on the data available thus far, 531 women have been screened either by the home visitor or by a health professional. Of those screened by home visiting, 77 were flagged for follow-up, resulting in referrals for postpartum depression for 37 new mothers in the program.

**Child Development and Early Intervention**

As described earlier, the United States began formal programs to respond to high poverty rates and associated issues during the 1960s. At the same time, early intervention as we know it today gained wider public support. Decades of child development research influenced political leaders and legislation, and along with home visiting and other social programs, attention (and funding) was designated to develop programs for children with mental retardation. By 1974 there was dedicated funding and guidelines for providing early intervention services specifically to infants and preschool children with disabilities. Today, these services are delivered according to the law entitled the Individuals with Disabilities Education Act (IDEA). Under IDEA, early intervention is defined as “developmental services designed to meet a child’s needs in any one
or more of the following areas: physical development, cognitive development, language and speech development, social emotional development, or adaptive (self-help) development. Maine Families home visitors understand child development and are trained to use the Ages and Stages Questionnaire (ASQ) with caregivers to screen all children for possible delays. They may also use a supplemental tool called the ASQ-SE when the family or home visitor has concerns specifically about the child’s social emotional development. The results of the screening, the home visitor’s professional assessment, and perhaps most importantly, the parent’s level of concern determine the next steps in further evaluation or intervention.

According to the National Survey of Children’s Health, 19 percent of children four months to five years old are at moderate or high risk of having developmental, behavioral, or social delays, a risk that increases with added stressors such as poverty, homelessness, parental substance abuse and maternal depression. Screening is the crucial first step toward early detection of delays and improved growth and development for children. Early screening and identification of disabilities allows caregivers and teachers to work together to find the most appropriate intervention for the child. Individualized services (including treatment and therapy) can significantly improve a child’s functioning while reducing the need for lifelong interventions. Meisels and Shonkoff (2000) describe the importance of early investment and attention to our society’s most vulnerable children which decreases the need for special education, custodial care, social services support, and reduces the likelihood of the child later entering the justice system which are all much more costly than early intervention services to children birth through kindergarten.25

The National Survey of Children’s Health last reported the number of children who received a developmental screening during a health care visit in 2007. At that time, about 22 percent of children who had a visit to a health care provider within the past year received a developmental and behavioral screening completed by their parent.

Maine Families completes the ASQ with the caregiver at regular intervals based on the infant or child’s age. Approximately 83 percent of all children in the program were routinely screened during Fiscal Year 2010, either by the home visitor or another provider (i.e., pediatrician, Child Development Services (CDS), mental health professional). A small percentage of children were not screened because of a preexisting condition, parent preference, or because the child was not yet old enough to undergo screening. Of the children screened, seven percent were referred for further assessment or evaluation by a specialist. Of those children referred, 116 (or just over 7% of the total screened), now have a formal Individual Family Service Plan (IFSP) or an Individualized Education Plan (IEP) through CDS and are receiving early intervention services. Looking at this from another perspective, 72 percent of the children referred through home visiting have a current education or family plan to support their development.
Increasing Breastfeeding Rates

Promoting breastfeeding as a means to improve the health of mothers and their children is stated as a primary goal by the Centers for Disease Control and Prevention (CDC). Health professionals, home visitors included, recognize that breastfeeding promotion efforts can reduce health care costs as breast milk is the most important nutritional substance available to the newborn child. Breastfeeding decreases rates of multiple health problems among infants, (including diarrhea, respiratory infections, and ear infections), and helps build healthy immune systems. For mothers, breastfeeding promotes a quicker return to health after the birthing process. Mothers who breastfeed have a reduced level of postpartum bleeding, are more likely to return to their pre-pregnancy weight, and can prevent further pregnancies (while exclusively breastfeeding prior to the first six months postpartum).

Breastfeeding is also an ideal way to form a secure bond between mother and child, with inherently built-in time for mother and child to communicate and establish a rhythm. Maine Families home visitors trained in postpartum care support mothers who breastfeed, meeting the Standard of Practice goals of nurturing families and their relationships, promoting positive and effective parenting, protecting children from preventable illness and injury, and providing connections to the community and needed resources.

While nationwide more women are starting to breastfeed, the rates of “exclusively breastfed at three months” and “breastfeeding at six and twelve months” remains lower than the targeted percentages set by Healthy People 2010. The Healthy People 2010 national targets toward increasing proportions of breastfeeding mothers are:

- 75 percent in early postpartum
- 50 percent at six months
- 25 percent at 12 months
- 40 percent exclusively (no other liquids or solids) breastfed through three months
- 17 percent exclusively breastfed through six months

With these national targets in mind, along with the program’s stated intentions to foster optimal physical and emotional health for parents and their children, and strengthen bonding and attachment between parents and their children, home visitors work diligently to assure supports are in place for women who want to breastfeed. Having connections in the mother’s home on a regular basis during the first few weeks postpartum is the ideal setting for addressing breastfeeding and newborn nutrition. Many home visitors have extensive knowledge in this area; some are registered nurses or are certified lactation counselors and consultants. This level of expertise and comfort with the sensitive needs of breastfeeding mothers assures priority is given to this national effort.

Maine Families actively encourages new mothers to breastfeed, and connects them to resources such as hospital breastfeeding classes and lactation consultants when on-staff services are not available. As shown in Figure 3, this year fewer mothers in the program either
currently or have ever breastfed than the Healthy People 2010 goals, a percentage that is also lower than found statewide and nationally. The percentage of women who continued to breastfeed at the six-month interval fell slightly from last year, and also decreased slightly at the 12-month mark, from 30 to 28 percent, matching statewide trends.

Reducing Unintended Pregnancy

Women who have unintended pregnancies are less likely to seek prenatal care, especially within the first trimester.29 As a result, their babies may have lower birth weights and increased risk of unhealthy and atypical development within the first year of life. Mothers who give birth to children through unintended pregnancies are also at an increased risk for post-partum depression.30 Additionally, children born from unintended pregnancy tend to have poorer physical and mental health as compared to children born from intended pregnancies. They may also have lower vocabulary scores and increased social challenges. Children born from unintended pregnancies are also less social and less emotionally-connected with their mothers than those from an intended pregnancy and are at an increased risk for adolescent delinquency.31

It is estimated that every public dollar spent on family planning services saves three dollars in Medicaid costs for prenatal and newborn care.32 According to the Guttmacher Report on Public Policy (2003),33 only 23 percent of low-income women of childbearing age have private health insurance, and are also very likely to find the co-pay costs for contraception to be unaffordable, therefore increasing the likelihood of being without contraception.
Preventing unplanned pregnancy has financial benefits that stem from reducing the health risks and long-term consequences associated with these pregnancies. Those benefits include reduced Medicaid expenditures, a lower abortion rate, a drop in infant mortality, fewer cases of child abuse and neglect, and less welfare dependence. As part of the Maine Families Home Visiting Program’s goal of fostering optimal health, home visitors support parents in making a conscious decision to have subsequent children, so that it is in the family’s best interests.

Maine Families looks at unintended pregnancy rates because of the negative outcomes associated with unplanned and unwanted pregnancy, both for the mother and unborn child. Families face many challenges in raising healthy babies even when the pregnancy is planned; these challenges are further complicated by poor health outcomes and stress on the parent-child relationship when a baby is born to an unprepared or disassociating mother. The lack of use of contraceptives or the lack of knowledge about the proper use of contraceptives are the primary reasons for unintended pregnancies, as found by Finer and Henshaw (2006).  

![Effort to Prevent Unintended Pregnancy](image)

Figure 4

While national statistics show that most women do use some form of contraception, seven percent of the women at risk of an unintended pregnancy use no method of contraception at all, and account for nearly half of all unintended pregnancies. Of these pregnancies, almost half result in abortions. Those at increased risk for such pregnancies are categorized by specific subpopulations including: adolescents, unmarried women, and women with an annual household income below 200 percent of the federal poverty level. This past year, Maine Families served 192 mothers younger than 18 years old, 820 single women, and 862 women with income below the federal poverty level. The program strives to provide objective and accurate information to families; by knowing the reality of risk factors associated with these categories, home visitors can be mindful of how important it is to connect with their families. Regardless of the socio-economic situation for mothers, home visitors attempt to relate to families on a personal level, facilitating discussion and increasing understanding of the benefits
and planning their pregnancies. As shown in Figure 4, in line with national averages, eight percent of Maine families do not use contraception. However, an increased percentage of the families participating in the Maine Families Home Visiting Program take measures to prevent unplanned pregnancy after enrollment.

Accessing Health Care for Children
Health insurance coverage is an important predictor of a child’s health and well-being. Uninsured children suffer worse health and are more likely to lack a consistent source of health care; they are also more likely to go without needed care than insured children. In general, children and adolescents tend to be healthier than adults; however infants have a higher mortality rate than any age group under 55. Additionally, having a regular primary care provider increases patient rapport and ensures better communication between patient and provider. Although studies have shown children are more likely than adults to have a regular source of care, insurance still plays a major role in determining the likelihood of a child having a regular primary care provider. Children with private insurance are 94 percent more likely to have a regular source of care, while children with public insurance are 88 percent more likely, and only 68 percent of children without any form of health insurance are likely to have access to a regular primary health care provider.

Parents of uninsured children are also more likely to delay seeking care when problems do arise, resulting in higher levels of care needed during visits to health care providers. Not only does this place a greater financial burden on the family, it also burdens taxpayers. It is estimated that the poorer health of those who are not insured costs between 65 and 130 billion dollars annually.

Studies have also shown that children with health insurance are more likely to do well in school and have improved social and emotional development. Children without health insurance are twice as likely not to be up-to-date on well-child exams. Still, one out of every eight children nationally lacks health insurance. For children enrolled in Maine Families, however, the results are strikingly better. Nearly every child enrolled in the program this year had access to a primary care provider, and almost as many had either private insurance or MaineCare coverage, as shown in Figure 5.

The introduction of the Affordable Care Act, signed into law by President Obama in March 2010, has prompted greater health care
coverage of children. Health insurers are now prohibited from excluding coverage for children due to pre-existing conditions. This new act also promotes improvement in the quality of care children receive, as well as encourages innovations in health care with the aim of preventing illness and disease before incurring costly treatment.

New this year is the tracking of oral health information for enrolled children. In collaboration with the Kids Oral Health Partnership, home visitors provide oral health information as recommended by the American Academy of Pediatrics Oral Health Initiative. The goals of this program are to reduce the incidence of oral diseases, and improve access to appropriate and timely dental care for children in Maine. Home visitors have age-appropriate questionnaires for families to discuss oral health routines and make referrals to dental care providers for preventive care.

**Protecting Children from Preventable Illness and Injury**

Immunization has proven to be an effective and reliable tool for controlling and even eradicating diseases. It represents the most significant way children can be protected from over a dozen deadly infectious diseases such as measles, tuberculosis, and tetanus, eliminating many diseases that once were cause of death or permanent disability. Immunization is also extremely cost effective. A 2005 study showed the United States vaccination program “saved more than five dollars for every one dollar spent in direct costs, and approximately eleven dollars for every one dollar spent in additional costs to society.” According to the World Health Organization, which leads global efforts to reduce child mortality through immunization programs, children need 80 percent of their vaccinations in the first two years of their lives.

While the percentage of fully-immunized two year-olds in Maine has increased from 69 percent in 2003, reaching a high of 76 percent in 2005; it has since decreased slightly to 73 percent in 2007.

Through the provision of objective information, encouragement, and referrals to health professionals, the program works with families to ensure that their children are immunized as recommended by the Centers for Disease Control. Last year, Maine Families achieved an up-to-date immunization rate of 96 percent; this year, that rate has dropped to 91 percent for all children of enrolled families, but is still significantly higher than state and national averages, as shown in Figure 6.

![Figure 6](image)
Home Environment and Safety

Accidents are the leading cause of death for children between the ages of one and four, and the fifth leading cause of death among children from birth to age one. A lack of child restraint is a significant contributor in motor vehicle injury and deaths, with motor vehicle accidents being the number one cause of death for children from birth to age five, accounting for more than one third of deaths by preventable injury. Research has shown up to 90 percent of child restraint systems are misused such that a child’s risk of injury is increased. On the other hand, proper use of child safety seats can reduce the risk of death in a passenger car by 71 percent for infants and 54 percent for toddlers (children ages 1 to 4 years old).

Home visitors review topics related to injuries that might occur in the family’s home. For instance, many children die each year from preventable and unintended suffocation accidents. Suffocation can be caused in numerous ways, from improper sleeping arrangements to access to dangerous materials such as plastic bags and food. Sixty percent of infants who suffocate do so while sleeping as the result of pillows or cushions blocking their airway. Unintentional suffocation can also occur as a result of strangulation from many common household items such as pacifier strings, clothing draw-strings, and window cords. Cribs, strollers, playground equipment, and anything else that has openings large enough to allow a child’s body through but are too small for a child’s head pose a threat of entrapment and strangulation.

Although such injuries clearly account for a large portion of infant and child mortality, they are entirely preventable. Educating parents about these risks and helping them implement safe practices are important means of reducing potential dangers.

To help prevent childhood injuries, home visitors identify safety hazards in the home, problem-solve with families about needed changes, and help families implement these changes. All home visitors complete an age-appropriate Home Safety Checklist together with the family as a way to regularly check the environment.

The categories addressed are extensive, and the completion of these checklists can take up much of the time allotted for a home visit. They are therefore scheduled with the family and followed up on until all concerns have been appropriately addressed to the extent possible.
Figure 7

Figure 7 shows the major home safety categories on which families’ environments and practices are assessed, regardless of the child’s age. The Home Visiting Tracking System allows home visitors to keep track of the assessments that are due, as well as their progress in meeting safety recommendations within each category. The program (along with the family members), can then compare results from the initial home assessment to the most recent information available to determine effectiveness. In several areas there are statistically significant increases in the number of families making improvements for their household safety, particularly for fire prevention, car safety, and outdoor safety.

Exposure to tobacco smoke is a serious environmental hazard for young children. An average of 23 percent of adults ages 18-44 smoke, as reported in 2010 by the Maine Behavioral Risk Factor Surveillance System. Home visitors consider these statistics when working in families’ homes where exposure to secondhand smoke is likely. Children's exposure to environmental tobacco smoke results in substantial public health and economic impacts, and in Maine 28 percent of children birth to age 17 live in households where someone smokes. Children are more likely than adults to suffer health effects from secondhand smoke, in fact, babies born to mothers who smoke have significantly lower birth weight, a key health indicator closely related to infant mortality. There are also negative implications for the mother; smoking during pregnancy is associated with adverse conditions such as premature rupture of the placenta, as well as poor pregnancy outcomes, such as preterm delivery and stillbirth.

Clearly, children’s exposure to tobacco carries significant and numerous health risks. Reducing exposure to tobacco can be considerably beneficial to children and to the larger health care system, in terms of health cost savings alone. For example, a study conducted on neonatal health care costs related to smoking during pregnancy found that maternal smoking increased the risk of newborn admissions to the NICU by nearly 20 percent. This same study also found
that babies born to mothers who smoke had a longer stay in the NICU than those who did not. These are examples of costs that are seen by the CDC and US Surgeon General as being avoidable.\textsuperscript{59} Maine Families provides information and support to families for whom tobacco use is an issue. Of the 698 families served by home visiting programs in Maine for whom secondhand smoke was a concern, 44 percent have eliminated their child’s exposure and another 28 percent have reduced their child’s exposure. Of the 880 families where caregiver smoking was a concern, 27 percent have reported stopping use and an additional 29 percent have reported reducing use. The number of caregivers enrolled this year that smoke is lower than years past, however smoking and exposure to secondhand smoke remains a concern for about 11 percent of caregivers in the Maine Families Home Visiting Program.

**Protecting Children from Violence, Abuse and Neglect**

As reported by the National Center on Child Abuse Prevention Research, an estimated 905,000 children were substantiated as victims of child maltreatment in 2006, a national rate of 12.1 per 1,000 children. Maine had a similar rate in 2009 of 13.3 per 1,000 children (up slightly from a reported 12.6 per 1,000 children in 2006).\textsuperscript{60} In infancy and early childhood, abuse can significantly affect brain development, leading to lasting physical, cognitive, and social-emotional problems. Research indicates that early child maltreatment increases the risk in adolescence for poor academic performance and problematic behavior. Emotional and psychological consequences can emerge, including: low self-esteem, depression and anxiety, attachment difficulties, and poor peer relations.

The repercussions are not limited to an individual’s childhood; adults who were maltreated as children are at increased risk for numerous challenging health and behavioral issues including: substance abuse, mental health problems, and criminal and violent behavior. In 2007, the total estimated cost on a national level of child maltreatment was approximately $104 billion per year, demonstrating the strain placed on the nation’s health, school, and criminal justice systems.\textsuperscript{61,62}

According to FRIENDS National Resource Center for Community-Based Child Abuse Prevention (CBCAP), there are five protective factors that home visiting and early intervention programs can focus on in the community.\textsuperscript{63} These protective factors may reduce the incidence of child maltreatment:

- **Parental Resilience** (coping ability)
- **Social Connections** (people who provide emotional support and assistance)
- **Knowledge of Parenting and Child Development** (accurate information including defining appropriate expectations for children)
- **Concrete Support in Times of Need** (health and social services and day to day expenses)
- **Children’s Social and Emotional Development** (healthy attachment, positive interaction, and effective communication of emotions)
Maine Families works to enhance the protective factors through its various activities and social supports. They work in partnership with the Maine Children’s Trust, a statewide child abuse prevention organization, which works with communities to prevent children from experiencing violence, abuse, and neglect by promoting the protective factors and safety information.

One example of this partnership with Maine Children’s Trust is the sharing and reviewing of materials developed by the National Center on Shaken Baby Syndrome. Parents of newborns are given a short video called *The Period of PURPLE Crying* after their baby is born. Recognizing that parents may leave the hospital overwhelmed with the amount of information for their new baby, the home visitor has the opportunity to revisit these topics as they become more relevant to the family’s daily living situation. The reason for going over this information again is to give the family an opportunity to have an in-depth conversation about crying and sleeping patterns, the dangers of shaking a baby, and the importance of managing the stress that can be overwhelming with a crying baby. Parents can rely on the home visitor as a resource for information and hopefully prevent unnecessary harm to their child.

It can be difficult to measure impact in the areas of abuse and neglect prevention and child protection due to several factors, including the confidentiality of Child Protective Service (CPS) activities, the reluctance of families to share this information, and the fact that home visitors themselves are mandated reporters for child abuse and neglect.65

As part of the state Home Visiting Needs Assessment66 completed this year, the program looked at available statistics on child maltreatment to get a better sense of where to focus efforts for children in high-risk areas. In 2009, there were a reported 3,703 substantiated cases of maltreatment (of any form), for children from birth to seventeen years old. This is an important statistic to be aware of, as any form of maltreatment has serious negative effects on a child’s development.
For FY2010, there were 238 documented contacts made to CPS on behalf of the 2,162 children enrolled in Maine Families, 42 (or 18%) of which were made by a home visitor. These contacts were not necessarily intended to make allegations; rather they were often attempts to seek guidance from CPS to determine the best support to families who may be working on appropriate care for their child. Out of the total documented contacts, 31 resulted in substantiated reports, a rate of 14 per thousand children enrolled in Maine Families. While home visitors may not be aware of all protective services activities, this is far below the national rate of substantiated reports for children under age one, the highest-risk group, which is just under 21 per thousand \(^{67}\) or the rate in Maine which in 2009 was twice as high as the national rate for this age group. \(^{68}\)

In addition to abuse and neglect rates, a proxy measure of health and safety is the number of families that remain enrolled even after CPS involvement. During this fiscal year, 92 percent of these families remained active with the program for at least three months, while many stayed involved far beyond that timeframe. Home visiting professionals are aware of the sensitive nature of being mandated reporters and participate in annual training updates as well as reflective supervision to do what is best – and what is required – for children.

### Increasing Family Self-Sufficiency

Home visiting is not intended to be a permanent service for families. Since one major tenet of the program is that families have strength and the ability to adequately provide for their children if given the proper resources at the right time, the service is available until the child enters kindergarten. Home visiting is just one part – the first link – in a comprehensive system of care for those needing longer-term support. It is difficult to measure a variable that can change dramatically through the course of a year and from family to family.

Maine Families, however, has attempted to capture some information to determine program participants’ self-sufficiency through tracking topics raised and referrals made at each visit, as well as through self-reported information provided by participants through the annual Family Survey.

For this group of variables, families were considered self-sufficient if they had secured (even with support) basic amenities related to: housing, food, child care and education, transportation, and health care including mental health support. Interestingly, a large percentage of families reported that information was available but “not needed” by survey respondents (see Figure 8).
As this was a new question on this year’s survey, it is not possible to determine a change from previous years in this area. While it is important to help families gain the skills and experience necessary to attain eventual self-sufficiency, it is also vital that the program supports them in other ways, providing validation and encouragement while they learn to balance the demands of parenting.

To help families access needed resources, program staff make a significant number of referrals to a variety of federal-, state- and community-funded resources such as WIC, TANF, childcare services, housing, legal services, transportation and counseling. Maine Families staff made just over 23,000 referrals on behalf of families this past year. Families reported that having a home visitor to help them make these connections is a significant benefit of their participation in the program.

With regard to meeting their family’s basic needs, the program attained a statistically significant difference in the number of families who had adequate food and heat in their homes. At enrollment, 82 percent of families reported having adequate food. This increased to 94 percent after program involvement. Eighty-six percent reported at enrollment that their homes were adequately heated, a figure which increased to 96 percent after program involvement. For those remaining families with food and home heating needs, the programs...
reported working to improve their status. Figure 8 lists the major community resources to which families are linked and shows the percent of families that found the information to be helpful to them.

One parent says:

“This program has greatly expanded my knowledge and confidence as a parent. I appreciate all of the wonderful help and hard work put into every visit.”
Conclusion

Maine Families home visiting program has clearly stated core beliefs which have formed the Standards of Practice and program performance measures discussed in this report. These three core beliefs are:

- The first years of a child’s life are critical for development and are the foundation for success in all future experiences.
- Parents are the most important teachers children will ever have.
- The program is grounded in prevention, and is designed to promote optimal development, positive parenting, enhanced parent-child relationships, and to ensure child health while preventing abuse and neglect.

With these values in mind, we consider the impact of home visiting on promoting positive outcomes for children and families. This program has a well-established group of providers who believe in the importance of developing trusting, empathic relationships with families. They strive to meet parents where they are in their level of skill and knowledge of child growth and development, and trust parents to determine what amount of support is necessary to meet their goals.

The outcomes associated with involvement in Maine Families home visiting are extremely positive. Comparing these outcome measures to national health indicators, women who participate in the program have adequate – and often optimal – prenatal care; children in the program are more likely to have a primary care provider and are up-to-date with well-child exams and immunizations; and almost all children and their caregivers have health insurance coverage. In addition, those families who enroll prenatally begin thinking about the connection between their actions and outcomes for their babies. Knowing the importance of early detection of developmental issues and subsequent intervention, all children are routinely screened for developmental delays, which also help parents form age-appropriate expectations. Parents are regularly provided with ideas and activities suited to their child’s interest and ability, and have reported feeling validated by their home visitor, leading to an increased self-confidence in parenting ability.

Caregivers report that their participation in home visiting has contributed to positive changes in many areas as a result of information provided by the program. The adjacent table shows the percent of families reporting positive change in specific topic areas that home visitors address. Note that child development, nutrition, and discipline top the list, but all categories are exceptionally high.

<table>
<thead>
<tr>
<th>Report of Positive Change as a Result of Participation</th>
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<tbody>
<tr>
<td>Child Development                                     98%</td>
</tr>
<tr>
<td>Child Nutrition                                       98%</td>
</tr>
<tr>
<td>Child Discipline                                      98%</td>
</tr>
<tr>
<td>Home Safety                                            97%</td>
</tr>
<tr>
<td>Car Seat Safety                                       95%</td>
</tr>
<tr>
<td>Secondhand Smoke                                      92%</td>
</tr>
<tr>
<td>Breastfeeding                                          90%</td>
</tr>
</tbody>
</table>
The positive effects reported by program participants are the result of both the home visitation component as well as the other services provided by staff. These include activities such as playgroups and workshops that afford parents an opportunity to connect with others in the community, which in turn reduces isolation; parents also use these opportunities to gauge their own child-rearing efforts and experiences.

In providing home and community-based services, Maine Families contributes a valuable service to the state through support, education, and resources for first-time families and adolescent parents. The current research on early childhood home visiting programs promotes the importance of quality over quantity in home visiting service delivery. Likewise, if programs are to be effective, they must be implemented according to the intended model and must include an evaluation component that provides the feedback necessary to assure fidelity and consistency throughout.

Agency administrators have also displayed resilience in light of difficult economic times. Despite losses in funding, the program has developed strategies that maximize available resources. They do this by reducing administrative costs, partnering with other providers in the community, and looking for supplemental funds and grants to support services to families.

Through this year’s statewide Home Visiting Needs Assessment, Maine Families has also played a significant role in helping the state to determine the gaps in services to at-risk populations, as well as helping identify the home visiting services available in each county. While Maine Families is universally available to families regardless of their socioeconomic status, the statewide data show that families enrolled this year are likely to be challenged by various risk factors that home visitors must be prepared to address. These include: loss of income or eligibility for financial assistance, poor housing conditions or risk of homelessness, mental illness, and alcohol or substance abuse. Maine Families administrators and home visitors are aware of these trends and work to ensure staff have appropriate support and adequate training. The following suggestions may help programs consistently implement and deliver high-quality services.

**Family Service Plan.** Develop a standardized Family Service Plan that can be used to track family goals and achieved results that are connected to other indicators such as child growth and development and health indicators. The ideal plan would also track outcomes related to specific referrals or services that were offered by the program, providing information on the value of service.

**Collaborative Efforts.** Continue developing relationships and connections with community health providers such as hospital labor and delivery staff, public health departments and clinics, and community health nurses, in order to promote home visiting to as many expecting mothers as possible. It is clear that programs that currently maintain these partnerships are able to recruit women earlier in pregnancy and have access to community providers with relevant expertise.
Mental Health Support. Explore opportunities for increased collaboration with mental health professionals that may be able to support direct service staff when faced with complex family situations related to poverty, substance abuse, and mental illness. Clinical support not only provides a different perspective on working with families, but may reduce the compassion fatigue and burnout common to professionals working in social services or caregiving roles.

Early Childhood Education. Continue developing relationships with area preschools, Head Start centers, and Pre-Kindergarten sites to connect families with quality early learning experiences for three to five year olds. Connections between home visiting staff and educators will provide yet another resource for parents, and the combination of home visiting and preschool experiences will contribute to children being prepared for kindergarten.73

Next steps for the Maine Families program may include taking a closer look at the system of care now in place for families, including the community providers mentioned above. Maine Families providers should continue to be part of the statewide needs assessment being conducted for the Patient Protection and Affordable Care Act and to use the information on service gaps to help inform their own plans and initiatives for program enhancement.
Endnotes


9 Average is calculated based on number of families actively enrolled for a complete year.

10 Five of Maine’s 16 counties include a non-rural area with a population greater than or equal to 50,000 as defined by the US Census. Retrieved from [http://quickfacts.census.gov/qfd/states/23000.html](http://quickfacts.census.gov/qfd/states/23000.html)


An explanation of how the Kotelchuck Index is used can be found at http://www.mainefamilies.org/Files/Kotelchuck%20Table.pdf


Ibid.


Ibid.


Ibid.


A regular source of care includes: an urgent care or walk-in clinic, doctor’s office, clinic, health center facility, hospital outpatient clinic or emergency department (ED), health maintenance organization or preferred provider organization, military health care, or other place.


The Home Visiting Needs Assessment can be found at: http://www.maine-eccs.org/miechv.html


Ibid.


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