

Best Practices and Literature Summary

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This section contains a brief narrative summary of some compelling literature and a table that summarizes additional relevant national literature. It also contains two tables of National Best Practices that highlight program features that are comparable to Michigan's MSS/ISS program. The final best practices table provides detail on five programs that produced improved outcomes.

Literature Summary

Smoking

Nationally, there is an 18-20% smoking cessation success rate for pregnant women. Women who quit early have lower levels of stress and depressive symptoms. In women with very low levels of nicotine addictions, the association between smoking and depressive symptoms is virtually eliminated.

Alcohol and Drug Use

Approximately 20% of pregnant women use some alcohol. 3.5% of those have seven or more drinks per week or five or more drinks at one time. Screening for alcohol use during pregnancy is difficult, since women will deny or minimize their drinking.

Alcohol use during pregnancy is associated with depression and alcohol use is often combined with the use of illicit drugs. This is especially true for women who are abused. Among abused Black women, 42% use both alcohol and illicit drugs. (McFarlane, 1996). The NIDA reports 5-6% of pregnant women using illicit drugs (11% among Black women, 4.5% among Hispanics and 4% among whites).

Alcohol use is also associated with tobacco use during pregnancy. 76% of women reporting smoking in the first trimester also drank alcohol. (Day, 1992). Both alcohol and tobacco are more prevalent in women who use illicit drugs. 74% of women who used illicit drugs during pregnancy also reported smoking or drinking or both. (NIDA 1996)

Approximately 1 in 4 children under 18 are exposed to alcohol abuse or dependence in the family. (Grant, 2000) Low levels of alcohol exposure can affect the developing fetus; adverse effects have been observed at the seven drinks per week level. (Jacobson, 2002)

Mental Health

The prevalence of depressive symptoms in low-income pregnant women is in the range of 35-67%. Depressive symptoms are associated with both alcohol and illicit drug use. Symptoms increase from the first trimester to third trimester and then decrease during postpartum (Hatch, 2000; Ritter, 2000; see also Affonso, 1999; BMJ and others).

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Ethnic minority women experience rates of depression similar to white women; however, they are at greater risk for having their depression go unrecognized and untreated (Borowsky, 2000; Green-Hennessy, 1999). Ethnic minority women are more likely to express their distress through somatic symptoms. (Summit on Women and Depression, 2000)

Depression is associated with pregnancy complications, history of childhood abuse, high stress, low social support, poor weight gain, tobacco use, low self-esteem and substance abuse.

Primary Subject	Study	Sample	Major Findings	Implications
Augmented Prenatal Care	Klerman, Ramey, Goldenberg, Marbury, Hou, & Cliver (2001). “A randomized trial of augmented prenatal care for multiple-risk, Medicaid-eligible African American Women”	N=318 augmented care N=301 usual care Randomly assigned All women had scores of 10 or higher on risk assessment scale	Women in augmented care reported it as more helpful, knew more about their risk conditions, and spent more time with their nurse-providers. More women in augmented care quit smoking. No statistically significant differences in pregnancy outcomes. (although there were differences in expected direction they were not significant statistically) Intervention: Augmented care included educationally oriented peer groups, additional appointments, extended time with clinicians and other supports.	Support leads to smoking cessation
Telephone Support	Bryce, Stanley, & Garner (1991). “Randomized controlled trial of antenatal social support to prevent preterm birth”	N=983 women to program group N=987 women to control group	Intervention consisted of providing emotional social support to women via home visits and telephone contact (by midwives)	Not particularly useful study other than that it showed that only provided “expressive (emotional) social support” is not an effective intervention
Maternal Role	Mercer & Ferketich (1994) “Predictors of maternal role competence by risk status”	N=121 high risk women N=182 low risk women	High risk women were defined and recruited during an antepartal hospitalization for an obstetrical risk situation. The low risk women had no chronic disease or pregnancy problems that did not respond to routine care. No significant differences were found in maternal role competence between women at different medical risk levels.	
WIC	Buescher & Horton (2002). “The association of maternal smoking with infant mortality and low birth	Retrospective review of N. Carolina Medicaid births by WIC participation and non-participation in 1997.	WIC non-participants were more likely than participants to have low-weight babies and higher Medicaid costs even when controlling for preterm delivery and late entry to WIC. For every dollar spent on WIC a dollar was saved on Medicaid newborn costs. Cost savings were	WIC enrollment should be a primary objective of MIHP and an outcome measurement.

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	weight in North Carolina, 1999”		higher for minority women.	
Risk Assessment & Stratification	Maloni (2000) “Preventing Preterm Birth”	Monograph	Risk screening/assessment needs to be focused on behavior, medical conditions, demographic factors, and psychosocial factors. No proven method of predicting preterm birth. Risk stratification is a workable strategy, but can change during pregnancy.	Focus risk screening on key domains. Repeat screen/assessment during pregnancy and reapply stratification model.
Evidence Based Program	Foust, et al (2002) “Achieving Optimal maternal & infant health outcomes for Medicaid patients, with application for commercial populations”	Review Article	The most successful programs at reducing LBW and preterm labor focus on the following: weight gain, taking vitamins, proper nutrition, breastfeeding, substance abuse, smoking cessation, stress reduction, and depression/anxiety. The programs must be based on “credible standards and guidelines”. Women should be reassessed at least once in pregnancy. No risk assessment tool will capture 100% of the women truly at risk for a bad outcome, but the process does determine the intensity of resources a women needs.	Targeting program on evidence-based risks does improve birth outcome.
System Change	Margolis, et al (2001) “From concept to application: The impact of a community-wide intervention to improve the delivery of preventive services to children”	Observational Intervention study in 1 county (182,000) involving low income pregnant mothers and their infants, primary care practices, and departments of health and mental health	Interventions were selected that focused on major risk factors with evidence of efficacy. The interventions involved community, practice, and family-level strategies to improve care delivery. Families received home visiting by nurses and educators. Significant system and policy changes occurred at the community and practice level. For families, the intervention groups were more likely to use contraceptives, less likely to smoke, more likely to have a safe and stimulating environment for the children. The children were more likely to have the appropriate number of well visits and less likely to be injured. The mothers had fewer months of AFDC (7.7 vs. 11.3)	Systematic community and provider changes can improve outcomes.
Phone Intervention	Moore, et al (1998) “A randomized trial of nurse intervention to reduce preterm and low birth weight births”	Randomized Controlled Trial N=1554	This trial tested the effectiveness of telephone calls from RNs to low-income women at reducing low birth weight and preterm births. White women with risk factors were included, all black women were included in the study. There was no difference in LBW or preterm births	A population approach with black women is recommended. Smoking cessation early and consistently is recommended.

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			between intervention and control groups in the total sample. Black subjects 19 years old and older did have a significant difference in preterm birth rates. There were higher rates of preterm birth in white women grater than 19, but they also were more likely to smoke. The calls included perception of uterine contractions, other pregnancy changes, hydration, meals eaten, smoking, alcohol and drug use, prenatal vitamin ingestion, and any issue the mother identified.	
Smoking	Cornelius, et al (2000) “The effects of tobacco use during and after pregnancy on exposed children”	Review Article	In a study of pregnant women in Pittsburgh, 76% who reported smoking in the first trimester also drank alcohol. This was also true for 61% of smoking teens. NIDA reports that 74% of illicit drug users either smoke or drink or both. Prenatal exposure has long been associated with deficits in weight, height, and head circumference at birth. Recently, behavior problems, cognitive deficits, and memory deficits have been documented. Further, prenatal exposure has been associated with delinquency and criminality in adolescence and adulthood.	Focus on smoking cessation leads to multiple benefits.
Smoking	Klerman, et al (2003) “Smoking-related activities in prenatal care programs”	Survey of Olds projects, Healthy Start projects, CityMatCH, and state MCH units	Agencies are committing limited resources to smoking cessation. Less than half of home visiting programs provide visitors with smoking cessation training, and only 28% rated smoking cessation as a high priority. This is despite the ACOG statement that smoking cessation/reduction “would significantly lower the number of low-birth weight infants”.	You have to focus on smoking cessation to get desired outcomes.
Smoking	DiClemente, et al (2002) “The process of pregnancy smoking cessation: Implications for interventions”	Review Article	Pregnancy & postpartum period offer a window of opportunity to promote smoking cessation. Less educated, lower SES, white, unemployed, more nicotine dependent women are more likely to continue smoking during the pregnancy. For the most nicotine dependant focusing on harm reduction is a viable option. Smoking cessation needs to be embedded in care. Program recommendations are: promoting cessation among women considering childbearing, reaching pregnant	A variety of smoking cessation strategies are needed. Demographics can predict who will be successful.

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			smokers ASAP, maintain postpartum cessation, different interventions for women who continue to smoke late in pregnancy, and focus on the partner.	
Stress	Affonso, et al (1999) "Cognitive adaptation: A women's health perspective for reducing stress during childbearing"	Program Trial	Intervention strategies exist to reduce a woman's stress level and improve cognitive adaptation to childbearing.	
Depression	Hennessy, et al (1999) "Demographic differences in medication use among individuals with self-reported major depression"	National Survey	Minority status, being at either end of the age continuum, male gender, and excellent health are associated with nonuse of psychotropic medications. Lower-income, widowed, and never married individuals showed a trend toward being less likely to use medication.	Consider demographics in treatment of depression.
Depression	Buist, et al (2002) "To screen or not to screen — that is the question in perinatal depression"	Review Article	Perinatal depression has broad implications: impairs decision making regarding health & well-being for mom & baby, decreases likelihood to quit smoking, make diet changes, or quit substance abusing, impacts relationships and ability to work, and children have problems with cognition, attention, and brain function, and this may extend to school age. Recommends the valid, reliable, economical Edinburgh Postnatal Depression Scale. Screening should be universal, but interventions may need to be tailored to the local services.	Treating depression can improve outcomes. Depression interventions/best practices will need to consider local services.
Depression	Borowsky, et al (2000). "Who is at Risk of nondetection of mental health problems in primary care?"	Patient & Physician Survey	African Americans & Hispanics are less likely to be diagnosed with mental health problems.	Consider targeting African Americans & Hispanics for depression screening.
Depression	Ritter, et al (2000) "Stress, Psychosocial	Prospective Cohort Study N=191 women (139	Women became less depressed as they moved from prenatal to postpartum period. Stress increased	Women at possibly highest risk for depression

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	Resources & depressive symptomatology during pregnancy in low-income, inner-city women”	White, 52 African Americans)	depression. Social support and higher economic status decreased depression. African American women did not differ from white women in terms of depression or in terms of how they were impacted by stress or psychosocial resources.	parentally, not postpartum.
Depression	Hoffman & Hatch (2000) “Depressive symptomatology during pregnancy: Evidence for an association with decreased fetal growth in pregnancies of lower social class women”	Community-based prospective cohort study	Negative mood states experienced by low status women in late second trimester are associated with decreased gestational age-adjusted birth weight (9.1 grams). Further study is needed.	Depressed, low status women have worse birth outcome.
Home Visiting	Olds et al (2002). “Home visiting by Paraprofessionals and by Nurses: A randomized, Controlled Trial” Good article comparing effects when using paraprofessionals vs. nurses (both trained to deliver the program)	Total N= 735 N=255 controls N=245 paraprofessionals N=235 nurses	Many significant effects when program was delivered by nurses (compared to control group). Few significant effects when program was delivered by paraprofessionals (compared to control group). Except if mother had low psychological resources—they interacted more responsively with paraprofessional. Nurse visited women had greater reduction in smoking, by the child’s 2nd birthday they had fewer pregnancies and births, more time between pregnancies and worked more than the controls. Nurse visited mother/child pairs interacted more responsively, at 6 mos. Infants were less likely to exhibit emotional vulnerability & low resource moms were emotionally more stable. At 21 mos. Infants of LR moms were less likely to exhibit language delays and at 24 mos. Had superior mental development vs. controls.	Chose paraprofessionals who share many of the social characteristics of the families they serve.
Home Visiting	Olds et al (1999) “Differences in Program Implementation Between Nurses and paraprofessionals	Nurse visited N=236 Paraprofessional visited N=244	Nurses completed more visits (28 vs 23), spent more time on physical health issues during pregnancy and parenting during infancy, Paraprofessionals spent more time on environmental issues and safety issues in pregnancy. Home visitors were viewed equally by moms, the nurses	Combined nurse and CHW has benefits

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	Providing Home Visits During Pregnancy and Infancy: A Randomized Trial”		had fewer drop outs.	
Home Visiting	Olds (2002). “Prenatal and Infancy Home Visiting by Nurses: From Randomized Trials to Community Replication” Good review article of 25 yrs. of work	Elmira, Memphis, and Denver work reviewed—see other section of table.	Review of findings—see original papers. Review of community replication. Since 1996, 25 communities have implemented the program. Olds requires “strict fidelity to the model”. The Prevention Research Center works very closely with communities to ensure the model is implemented as intended, training nurses, to monitor program performance, and to ensure CQI. Rand Corporation cost analysis reports ROI within 4 years of program initiation.	Must work with Olds’ group to implement the program.
Home Visiting	Olds, et. Al (1998) “Long –term Effects of Nurse Home Visitation on Children’s Criminal and Antisocial Behavior”. 15 yr. Follow-up of the original study done in Elmira, NY.	Treatment group 1 & 2 parents n=152/184, adolescents n=144/184. Treatment gp. 3 parents n=81/100, adolescents n=77/100. Treatment group 4 (intervention group) parents n=97/116, adolescents n=94/116.	Adolescents in the intervention group whose mothers were also unmarried and of a low SES (the highest risk families) reported fewer instances of running away, fewer arrests, fewer convictions & probation violations, fewer sex partners, less smoking, less alcohol consumed. Parent & adolescents’ reports were supported by review of juvenile justice system records and interviews with teachers.	It’s the highest risk families that get the greatest benefit.
Home Visiting	Olds, et. Al. (2000) “Enduring Effects of Nurse Home Visitation on Maternal Life Course”. A 3 yr. Follow up of a RCT of primarily African American women in Memphis, Tenn.	Total N=743 Control group N=443/515 Intervention group N=203/228 Sample was higher risk than Elmira sample— had to have at least 2 risk factors (unmarried, <12 yrs education, or unemployed). Intervention group averaged 7 home visits during pregnancy and 26 before the child’s 2nd birthday. Visits delivered by Memphis/Shelby	Intervention group had fewer subsequent pregnancies, fewer closely spaced subsequent pregnancies, longer intervals between 1st & 2nd child, fewer months using AFDC & food stamps. Overall effects smaller in magnitude compared to original trial, but higher risk women. Trend toward fewer abortions, fewer NICU or SCN days, & more marriage.	More similar population to SE Michigan. Primary Olds article.

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		County HD.		
Home Visiting	Olds, et al (1997) “Long-Term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect”. 15 yr. follow-up on Elmira RCT.	Total N=324/400 Intervention group: Completed mother assessments N=97/116. Completed adolescent assessments N=94/116. (Self reports verified by CPS data in 95 cases.)	Intervention group mothers were less likely to be perpetrators of child abuse and neglect (p<.001). Mothers who also were unmarried and of low SES at initial enrollment had 1.3 vs 1.6 subsequent births, 65 vs 37 months between births, 60 vs 90 months of AFDC, less drug and Etoh use by self report, and few arrests by self report and police records.	Additional support that the greatest effects are for the highest risk women. Doug references this article, but not a must read.
Home Visiting	Marcenko & Spence (1994) “Home visitation services for at-risk pregnant and postpartum women: A randomized trial”	N=125 experimental/treatment group N=100 control group At follow-up, 225 participants were re-interviewed.	Goals of intervention: a) increase access to health and social services, b) increase maternal social support, c) decrease maternal psychological distress, d) increase maternal self-esteem, e) improve quality of home environment Women were randomly assigned to experimental or control group The intervention: Home visitors were women from same community as targeted families. Home visitors rec’d one month of intensive training on nutrition, family violence, substance abuse, child development. Role of home visitor was “to provide peer support, to assist in identification of service needs, and to engage in home-based health education and parent training. “Additionally, social workers assessed the psychological needs of the families and developed and implemented plans to address these needs. Social workers also offered case management services, connecting families with drug tax and housing options. Provided individual and family counseling and conducted groups on issues such as parenting, child development, and relationships with partners.”	Risk factors cited by AMA? (1989) see p. 470: substance abuse, homelessness, domestic violence, psychiatric illness, incarceration, HIV infection, lack of social support.

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			<p>Nurses addressed health care needs.</p> <p>Services were provided from time of mother's first prenatal visit through child's first birthday.</p> <p>During prenatal period, visited a min of every 2 weeks. From birth -6 weeks, weekly home visits. At end of 6-week period, if risk assessment indicated appropriate, visits were reduced to 2 week intervals.</p> <p>Differed from Olds in that did not take only first time only mothers</p> <p>Results: increased social support, increased access to services, decrease psychological distress.</p> <p>No changes in terms of out of home placement of infants, HOME inventory scores.</p> <p>Overall intervention lasted 10 mos.</p>	
Home Visiting	<p>Roberts & Wasik (1990)</p> <p>"Home visiting programs for families with children birth to three: results of a national survey"</p>	<p>N=643 national survey of home visiting programs. Private and public programs affiliated with health, education, and social service.</p>	<p>Survey to assess home visitation programs serving children 0-3 years. Assessed 12 areas but targeted 6 areas 6 areas reported on for programs:</p> <ul style="list-style-type: none"> a) types of agencies b) types of families served c) purposes of home visits d) services provided e) organizational structure of home visiting programs f) educational levels required of visitors and supervisors 	<p>Home visiting alone not effective unless paired with medical intervention</p>
Home Visiting	<p>Kitzman, Olds, et al (1997)</p> <p>JAMA article "Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing"</p>	<p>N=1139 primarily African-American women at less than 29 weeks gestation, with no previous live births, and with at least 2 sociodemographic risk factors (unmarried, <12 years of education, unemployed)</p>	<p>"In contrast to counterparts assigned to the comparison condition, fewer women visited by nurses during pregnancy had pregnancy induced hypertension). During 1st 2 years post delivery, women in intervention had fewer health care encounters for children in which injuries or ingestions were detect and fewer second pregnancies. No program effects on preterm birth or low birth weight, children's immunization rates, mental development, behavioral problems or mothers's education and employment.</p>	<p>Sociodemographic risk factors (unmarried, <12 years of education, unemployed)</p>

Primary Subject	Study	Sample	Major Findings	Implications
			<p>Four treatment groups (following Elmira)</p> <p>“Nurse visited women held fewer beliefs about child-rearing associated with child abuse and neglect – lack of empathy, belief in physical punishment, unrealistic expectations for infants”</p>	
Home Visiting	<p>Koniak-Griffin, Anderson, Verzemnieks, & Brecht (2000).</p> <p>“A public health nursing early intervention program for adolescent mothers: outcomes from pregnancy through 6 weeks postpartum”</p>	<p>N=121 adolescents, primarily from minority or impoverished backgrounds who were followed from pregnancy to 6 weeks postpartum.</p> <p>Criteria for Enrollment:</p> <p>Ages 14-19 with no prior live births, 26 weeks or less gestation, planning to keep infant, not chemically dependent, w/o serious medical/ob problems.</p>	<p>Intervention to half the sample:</p> <p>Intense home visitation by public health nurses and “preparation for motherhood” classes.</p> <p>Results: decreased infant mortality during first 6 weeks of life and decreased maternal school dropout.</p> <p>Long-term outcomes are being evaluated.</p> <p>Intervention targeted: helping adolescent mothers “gain skills in managing their inner world and in interacting with their external environment so as to better manage their daily lives” 17 home visits.</p> <p>Four preparation for motherhood classes</p> <p>Nurses targeted five major areas for intervention: health, sexuality and family planning, maternal role, life skills, and social support.</p> <p>Counseling was also provided related to role issues, education, mental health issues.</p>	

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Best Practices

For ease of review, we have summarized some of the key national literature and best practices in all 50 states in the following tables. References and contacts are provided for all.

The attached table highlights and summarizes six of the states' programs. Please contact Lynette Biery at IHCS for additional information.

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State	Project Name	Model Type	Target Population	Goals/Focus	Site Management	Staff	Funding	Administration	Notes
Alabama	Perinatal Program	Healthy Families		-High-risk infant follow-up -Parenting skills -Prevention of child abuse and neglect	-8 local sites -Managed by private entities			Alabama Department of Health, Bureau of Family Services	
	National Children's Advocacy Center/Healthy Families North Alabama	Healthy Families	-Medicaid eligible -First time parents & children -Reside in Huntsville/Madison counties -Score 25 or higher on Kempe Family Stress checklist			Family Support Workers	-State and federal grants -Private donation		Healthy Families 256.533.6553 http://www.nationalcac.org
	Statewide Home Visiting							Alabama Department of Health	
Alaska	Healthy Families Alaska	Healthy Families		-High-risk infants follow-up -Parenting skills -Prevention of child abuse and neglect	-7 local sites -Mainly not-for-profits entities		-State general funds -Division of Public Assistance -Division of Mental Health and Developmental Disabilities -Office of Children's Services -Alaska Mental Health Trust Authority	Alaska Department of Health, Maternal, Child and Family Health Program	-Services initiated prenatally or at time of birth -Initially offered intensely with well-defined criteria for increasing or decreasing intensity -Offered over the long-term (i.e. 3-5 years) http://health.hss.state.ak.us/ocs/HealthFamilies/default.htm Anchorage Regional OCS: 907.269.3900

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State	Project Name	Model Type	Target Population	Goals/Focus	Site Management	Staff	Funding	Administration	Notes
Arizona	Healthy Families Arizona	-Healthy Families -Utilizes best practice principles		-Maternal/infant outreach	-23 sites -Served 2,347 participants in 2002	-Family assessment workers screen for families in need of services -Family support specialists provide visits to determine how to best meet the families' needs		Arizona Department of Health Services, Office of Women's and Children's Health	-Services typically received for 12-18 months; offered up to 5 years -95% of participants received at least 4 visits http://www.de.state.az.us/dcyf/opifs/healthy.asp http://www.healthfamiliesarizona.org
	Office of Women's and Children's Health-Healthy Start		-Pregnant/postpartum women & families -Targeted communities around the state			-Lay health workers -Oversight by nurses and social workers	Title V Grant	Office of Women's and Children's Health	-Services include home visiting and case management -Provided through child's second year of life http://www.hs.state.az.us/phs/owch/healthstart.htm
Arkansas									
California	San Mateo County Prenatal to Three Initiative		-Resident of San Mateo county -Medicaid eligible -Pregnant women -Newborns up to 2 weeks of age or fragile infant up to 2 weeks after discharge from hospital nursery			Public health nurses	-50% by MediCal (State of California Medicaid) -Remaining from grants and county general fund		FY 2000-2001: -Served 2653 clients -Averaged 5.9 visits/client http://www.co.sanmateo.ca.us/smc/department/home/o.,1954_194745_194736,11.html
	Los Angeles County Prenatal Care Guidance (PNG) Program		-MediCal eligible -High-risk pregnant women and their infants				-Initially funded through MCH funds -Proposition 10 allowed for more workers to be hired		http://lapublichealth.org/mch/PCG/P CG.htm See also: Perinatal Outreach and Education (POE) Program http://www.lapublichealth.org/mch/P OE/POE.htm

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	Sonoma County Maternal Child Health Field Nursing		-Pregnant, postpartum, & parenting teens, women & families with children up to the age of 3 -Reside in Sonoma County -At-risk -Need education about parenting skills	-Treating substance abuse -Preventing domestic violence -Learning parenting skills		Public Health Nurses			-Public health nurses work with families to target specific goals under the program's foci http://www.sonoma_county.org/health/ph/chs_mch_field/index.htm
Colorado	Children's Trust Fund			-Early childhood development and prevention			-Original funding came from an additional \$10 charge added on to marriage license fees -As of July 1, 2000, funding came from dissolution of marriage docket fees -Other funding can come from federal grants, contributions, gifts and private donations	Colorado Department of Health and Environment, Family and Community Health Division	

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State	Project Name	Model Type	Target Population	Goals/Focus	Site Management	Staff	Funding	Administration	Notes
	Nurse Home Visitor Program	Olds' Nurse Partnership	-First time pregnant women & children up to age 2 -Under 200% of poverty level	-Prenatal and early childhood parenting -Child development -Goal is to expand the program annually so that by 2009, all eligible mothers have services available to them	-FY 2003-2004: 17 agencies in 49 counties received grants to establish Nurse Partnerships	-Specially trained nurse home visitors	-Tobacco settlement legislation	Colorado Department of Health and Environment, Family, and Community Health Division	
Connecticut	Healthy Start			-Prevention of infant mortality -Improvement of early childhood outcomes	-Community based with home visiting component -23 local entities (e.g. New Haven targets 6 neighborhoods with especially high infant mortality rates)			Connecticut Department of Public Health	New Haven Health Start: http://www.nhhealthystart.org
	Young Parent Program			-Pregnant and parenting teens	-Community based with home visiting component -12 local entities			Connecticut Department of Public Health	
	Healthy Choices for Women and Children		-Pregnant & postpartum women & families -At risk for substance abuse -Reside in the city of Waterbury				-Connecticut Department of Public Health -Bureau of Community Health -Family Health Division		-Clients voluntarily receive visits until their child is age 3 http://www.dph.state.ct.us/BCH/FamilyHealth/healthy_choices_for_women.htm

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State	Project Name	Model Type	Target Population	Goals/Focus	Site Management	Staff	Funding	Administration	Notes
Delaware	Home Visiting			-Early identification of cognitive or developmental delays		Professionals		Delaware Division of Public Health	-Clients receive a home visit within 48 hours of birth, with follow-up and support services as necessary
	Resource Mother Project- Perinatal Association of Delaware		-At-risk pregnant women			-Paraprofessional lay home visitors who are mothers & grandmothers from the community they serve			-Served 764 women and infants in 2002
Florida	Healthy Families	Healthy Families	-Pregnant women & families of newborns -At-risk geographically -Experiencing stressful life situations as determined by voluntary assessment -High risk families who are not active in the child protection system at the time of assessment	-Improving parenting skills -Enhancing child development -Prevention of child abuse and neglect -Establishing a stable a nurturing home environment	-38 projects in 53 counties	Paraprofessional family support workers	-Original funding was from tobacco settlement appropriations through TANF and community match funds -Now funded through TANF appropriations and community match funds	Jointly administered with the Ounce of Prevention Fund of Florida	-Intensive services provided up to 5 years http://www.healthyfamiliesfla.org

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State	Project Name	Model Type	Target Population	Goals/Focus	Site Management	Staff	Funding	Administration	Notes
	Healthy Start/MomCare	-Developed as part of larger governor's initiative to prevent infant mortality -MomCare is a program which connects pregnant women and mothers to healthcare and other resources	-Universal screening for all pregnant women & infants -Women who screen with increased risk for premature delivery & LBW -Infants who are at risk of infant mortality	-Maternity and infant outreach -High-risk infant follow-up -Parenting skills -Child development -Targets reducing premature delivery, LBW, and infant mortality	-Local Healthy Start Coalitions help with administration	-Healthcare and social work professionals -Supervised paraprofessionals	-Medicaid waiver of Federal funds -March of Dimes	Florida Department of Health	FY 2001-2002: -87,655 women received 1,207,510 services -65,163 infants received 796,372 services http://www.doh.state.fl.us/family/mc/h/hs/hs.html http://www.healthstartflorida.com
Georgia	Children First	Linked to Governor's initiative	-Families & infants with risk factors determined through analysis of birth records and hospital referral forms			Nurses			FY 2000: -Conducted 7,068 in home assessments of 17,260 infants & children who received at-risk ratings http://health.state.ga.us/programs/childrenfirst/
Hawaii	Healthy Start	Origin of Healthy Families		-Improving parenting skills -Enhancing child development -Prevention of child abuse and neglect				Hawaii Department of Health	
Illinois	Parents Too Soon			-Improving the outcomes of teen parents and their children	-Well established outcomes of Local providers throughout the state			Illinois Department of Human Services	

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State	Project Name	Model Type	Target Population	Goals/Focus	Site Management	Staff	Funding	Administration	Notes
	High-risk Infant Follow-up			-Infants with medical risks and special health care needs (e.g. those discharged from neonatal intensive care units)	-Local health departments and other local entities			Illinois Department of Human Services	
	Healthy Families Illinois	Healthy Families	-Families at risk for problems in parenting as determined by the Kempe Family Stress Checklist	-Improving parenting skills -Enhancing child development -Prevention of child abuse and neglect		-Douglas -Family support workers		Illinois Department of Human Services	FY 2002: -Provided over 50,000 visits to 3,702 families http://www/dhs.state.il.us/chp/ofh/healthlines/pdf/dhs-ofh-hfir.pdf

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State	Project Name	Model Type	Target Population	Goals/Focus	Site Management	Staff	Funding	Administration	Notes
	Family Case Management		-Families at risk for problems in parenting as determined by the Kempe Family Stress Checklist	-Case management -Coordination of family services for Medicaid beneficiaries during the prenatal and early childhood periods -Linked to goals of welfare reform and family support		Professionals		Illinois Department of Human Services	
Indiana	Care Coordination		-First time parents, from the prenatal period to approximately 3 months after delivery	-Case management -Coordination of family services for Medicaid beneficiaries during the prenatal and early childhood periods -Maternity and infant outreach -Early intervention -Improving parenting	-Local entities -Public and private	Professional and paraprofessional staff		Indiana State Department of Health, Maternal and Child Health Services	http://www.in.gov.isdh/programs/mc/h/fcc.htm

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State	Project Name	Model Type	Target Population	Goals/ Focus	Site Management	Staff	Funding	Administration	Notes
Kentucky	Home Visiting			<ul style="list-style-type: none"> -Enhancing child development -Prevention of child abuse and neglect -Improving pregnancy -Early childhood development 	<ul style="list-style-type: none"> -Local entities -Public and private 	Professional and paraprofessional staff		Kentucky Department of Public Health	http://chs.ky.gov/publichealth/hands.htm
	Health Access Nurturing Development Services (HANDS)					-Trained home visitors			http://chs.ky.gov/publichealth/hands.htm
Louisiana	Home Visiting for Families (Building Early Strengths Together, BEST)	Olds' Nurse Partnership		<ul style="list-style-type: none"> -Maternity and infant outreach -Early intervention -Improving parenting skills -Enhancing child development -Prevention of child abuse and neglect 				Louisiana Office of Public Health, Maternal and Child Health Program	
	Project Hope		-Serve a combination of first time, teen and high risk parents in the following congregations: Ouachita Parish, Calcasieu Parish, Iberia Parish, East Baton Rouge Parish			-Paraprofessionals			http://oph.dhn.state.la.us/maternalchild/parahome/

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State	Project Name	Model Type	Target Population	Goals/Focus	Site Management	Staff	Funding	Administration	Notes
Maine	Community Health Nursing			-Supporting at-risk families through community health nursing	-Local entities	Professional nursing staff		Maine Bureau of Health, Division of Community and Family Health	
	Healthy Families/PATT	Healthy Families	-First time parents	-Encourages universal access	-6 local pilot programs	Paraprofessional staff	-State appropriations	Maine Bureau of Health, Division of Community and Family Health	http://www.maine.families.com
	Public Health Nursing			-Improving the health outcomes for pregnant women and young children		Professional public health nursing staff	State Title V	Maine Bureau of Health, Division of Community and Family Health	
Maryland	Healthy Families Maryland	Healthy Families			-Blend public and private resources to support local initiatives -Each county is developing its own program				
	Healthy Start			-Improving health outcomes for pregnant women and you children	-Each county is developing its own provider network and approach		Medicaid funding		-Recipients of services must be enrolled in Medicaid
Massachusetts	FIRST Steps	Healthy Families model with some modifications		-Provide family support as part of a comprehensive approach		Paraprofessional-professional staff teams		Massachusetts Department of Health, Bureau of Family and Community Health	
	Healthy Families	Healthy Families model with some modifications						Massachusetts Department of Health -Children's Trust Fund	

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	Early Intervention		<ul style="list-style-type: none"> -Families & children up to age 3 -Child is not reaching developmental milestones -Child diagnosed with a physical, emotional, or cognitive condition which would cause a developmental delay -At risk for developmental delay due to biological/environmental factors 				<p>Massachusetts Department of Public Health</p> <ul style="list-style-type: none"> -Medicaid -HMO's pay for services -Families pay participation fee 		<p>http://www.state.ma.us/doh/fch/ei.htm</p> <p>Early Intervention Partnership Program: http://www.state.ms.us/dph/fch/eipp/index.htm</p>
	Healthy Start								<p>http://www.state.ma.us/dph/fch/hstart.htm</p>
Minnesota	Targeted Home Visiting	Unique approach which uses some of the Healthy Families model		<ul style="list-style-type: none"> -Improving parenting skills -Prevention of child abuse and neglect 	-Local health departments	Professional and paraprofessional staff teams		Minnesota Department of Health	-Part of a state effort to expand the capacity of public health nursing to provide prevention services to families
	Healthy Beginnings			<ul style="list-style-type: none"> -Primary prevention -Strengthening family function -Enhancing child development -Promoting positive parenting 				Minnesota Department of Health, Division of Family Health	-Offers home visits to all expectant & new parents

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State	Project Name	Model Type	Target Population	Goals/Focus	Site Management	Staff	Funding	Administration	Notes
Missouri	Families at Risk	Healthy Families model with the addition of a nurse role in assessment and care team		-High risk infant follow-up -Early intervention -Improving parenting skills -Enhancing child development -Prevention of child abuse and neglect				Missouri Department of Health, Bureau of Family Health, Division of Maternal, Child and Family Health	-Part of a governor's initiative focused on early childhood http://www.pcamo.org/what.htm
	Healthy Families Missouri Better Beginnings: Parenting Life Skills Center		-Families at risk for negative health outcomes, including child abuse & neglect -Focused on those with geographical disparities due to home in rural Missouri and transportation problems				\$1.2 million grant from the Missouri Foundation for Health		Outcomes include: -Increase in healthy pregnancies & births -Decrease in child abuse & neglect -Increase in parent-child interaction & healthy growth & development of infants & children http://www.ksmu.org/webaudio/Sens eofCommunity/2003/issuesjunetext 2003.html-ampremie
Montana	MIAMI (Montana's Initiative for the Abatement of Mortality in Infants)		-High risk pregnant women	-Ensuring access to maternity care -Improving infant outcomes -Targets high risk pregnant women		-Professional staff provides services and case management -Public health nurses	Includes Medicaid "targeted case management"	Montana Department of Public Health and Human Services	http://www.dphhs.state.mt.us/hpsc/p ubhealth/healsafe/famheal/homevis/ miami.htm

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	Home Visiting-Follow Me			-Enhancing child development -Improving parenting -Ensuring early intervention when needed	-Local agencies	Professional and paraprofessional staff teams	Includes Medicaid "targeted case management"	Montana Department of Public Health and Human Services	http://www.dphhs.state.mt.us/hpscd/pubneal/healsafe/famheal/homevis/foi_low.htm
Nebraska	Title V Home Visitation grants	-Variety of projects funded under Title V -Includes Healthy Families -Olds' Nurse Partnership model -Early Head Start -Public Health Nurse Case Management						Nebraska Health and Human Services Agency, maternal and Child Health Program	
	Children's Outreach Project Good Beginnings		-Mothers with infants in service area	-Local service coordination -Promotion of child health and well being	-Various service areas -Home visiting is one component of curriculum and training materials developed especially for Nebraska	-Nurses			http://www.nehelp.net/resource/svpr esourceroidex.php
Nevada	Community Connections			-Improving parenting skills -Enhancing child development	-Primary service is referral' -Delivered by local agencies	-Paraprofessional and professional staff teams -Nurses and trained specialists		Nevada Department of Human Resources	-Divides state into "Infant Support Districts" -Each district has at least one New Baby Center with scheduled & informal activities

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State	Project Name	Model Type	Target Population	Goals/Focus	Site Management	Staff	Funding	Administration	Notes
New Hampshire	Home Visiting	Combines Olds' Nurse Partnership and Healthy Families model with lessons learned from New Hampshire	-Medicaid eligible pregnant women & infants -Emphasis on teens, women under 25, first time pregnancies, women at high risk, substance abuse & child abuse & neglect	-Maternal/infant outreach -Improving parenting skills -Enhancing child development -Prevention of child abuse and neglect	-Local entities	-Professional and paraprofessional staff teams -Most have bachelors degree or equivalent		New Hampshire Department of Health and Human Services, Maternal and Child Health Bureau http://www.dhhs.state.nh.us/DHHS/HOMEVISITING/default.htm http://www.hcservices.org/PrenatalCare.html	http://www.nvcommunityconnections.com/programs.ppphp?programid = 7 -Receive visits during pregnancy & up to one year after -Target at least 2 meetings per month
New Mexico	Home Visiting Initiative			-Reducing child abuse and neglect, as well as other child health and developmental outcomes				New Mexico Department of Health, MCH-Child Health Section	-Using state Title V performance measure on home visiting http://www.state.nm.us/cyfd/
New York	Community Health Worker Program		-Communities with high rates of infant mortality, out of wedlock births, late or no prenatal care, teen pregnancy, and low income	-Maternity and infant outreach -Improving parenting skills -Enhancing child development -Altering maternal life course -Prevention of child abuse and neglect		Paraprofessionals	Title V Grant	New York Department of Health	http://www.health.state.ny.us/nysdo/h/perinata/en/chwp.htm

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State	Project Name	Model Type	Target Population	Goals/Focus	Site Management	Staff	Funding	Administration	Notes
	Maternity Care Coordination or "Baby Love"		-Medicaid eligible pregnant women -Reside in Mecklenburg county -Up to 60 days past delivery			-RN's -Medical social workers			FY 2001: -7,728 Visits -1,077 new patients http://www.charmeck.org/Department/Health+Department/Programs+and+Services/maternity+Care+Coordination/Home.htm
North Dakota	Coordination for Local Programs	-State level coordination and technical support for local programs -Utilizes a Newborn Home Visit Committee						North Dakota Department of Health	
Ohio	Early Start	-Healthy Families -Olds' Nurse Partnership -Parents as Teachers		-High risk infant follow-up -Early intervention -Improving parenting skills -Enhancing child development -Altering maternal life course -Prevention of child abuse and neglect	-Local entities -County Family and Children First Councils	Paraprofessional and professional staff	TANF dollars as partial funding	Ohio Department of Health and Department of Human Services	

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State	Project Name	Model Type	Target Population	Goals/Focus	Site Management	Staff	Funding	Administration	Notes
	Welcome Home	Provides visits to parents of firstborn babies and teen parents			-Local entities	Nurse professional staff	State, Title V, and Medicaid funds	Ohio Department of Health	
	Help Me Grow							Ohio Department of Health	http://www.ohiohelpmegrow.org
Oklahoma	Healthy Families Oklahoma	Healthy Families		<ul style="list-style-type: none"> -Maternal/infant outreach -High risk infant follow-up -Improving parenting skills -Enhancing child development -Altering maternal life course -Prevention of child abuse and neglect 				Oklahoma Department of Health	

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	Children First	Olds' Nurse Partnership		-Maternal/infant outreach -High risk infant follow-up -Early intervention -Improving parenting skills -Enhancing child development -Altering maternal life course -Prevention of child abuse and neglect				Oklahoma Department of Health, Maternal and Child Health Services	
	Sooner Start-Early Intervention	Family centered approach		-Early intervention -Improving parenting skills -Enhancing child development		Professional staff teams relevant to early intervention		-Oklahoma Department of Education -Department of Human Services -Health Care Authority, -Commission on Children	
Oregon	Health Start/Family Support	Healthy Families		-Maternal/infant outreach -Risk assessment -Early intervention -Family support	-Operating in multiple counties	-Primarily paraprofessional staff -Professional training/supervision for paraprofessionals providing intensive services		-Oregon Commission on Children and Families -Oregon Health Division	-Provides basic and intensive services

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State	Project Name	Model Type	Target Population	Goals/Focus	Site Management	Staff	Funding	Administration	Notes
	Babies First	Standard public health nursing model		<ul style="list-style-type: none"> -Maternal/infant outreach -High risk infant follow-up -Improving parenting skills -Enhancing child development -Altering maternal life course -Prevention of child abuse and neglect 				Oregon State Health Division, Child and Family Health	
	Governor's Initiative			<ul style="list-style-type: none"> -Conducted needs assessment -Determined unmet needs and overlap -Searched for opportunities to create a continuous system of services to families with young children 					-Recommendations from the process have been used to create an Oregon Children's Plan
Pennsylvania	Home Visiting at Community Health Centers (Health Federation)								<p>http://healthfederation.org/home_visiting.asp</p>

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Rhode Island	of Philadelphia) Family Outreach Program			-Maternal/infant outreach -Improving parenting skills -Enhancing child development -Altering maternal life course -Preventing child abuse and neglect	-Services delivered through local entities	-Nurses -Social workers -Paraprofessionals	Department of Public Health	Rhode Island Department of Health	www.health.ri.gov/familyoutreach/home.htm
South Carolina	DHEC Home Visits			-Maternal/infant outreach to families covered by Medicaid		Primarily professional public health nurse staff		South Carolina Department of Health and Environmental Control	- Uses state Title V performance measure http://www.scdhec.net/HS/mch/wcs/nbnv.htm Family Support Services: http://www.scdhec.gov/hs/mch/wec/fss.htm See also: http://www.scdhec.gov/hs/hhealth/hhservices.htm

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State	Project Name	Model Type	Target Population	Goals/Focus	Site Management	Staff	Funding	Administration	Notes
Tennessee	Tennessee Healthy Families	Healthy Families		<ul style="list-style-type: none"> -Maternal/infant outreach -High risk infant follow-up -Early intervention -Improving parenting skills -Enhancing child development -Prevention of child abuse and neglect 	<ul style="list-style-type: none"> -Services delivered through 9 local entities 	Professional and paraprofessional staff teams		Tennessee Department of Health	
	Maternal Infant Health Outreach Worker (MIHOW)		<ul style="list-style-type: none"> -Pregnant women & families with children up to age 3 -Economically disadvantaged -Socially and/or geographically isolated 			-Caseworker	<ul style="list-style-type: none"> -Ford Foundation -RWJ Foundation -Bernard van Leer Foundation 	Vanderbilt University Medical Center	<ul style="list-style-type: none"> -Provides services in 6 states: Arkansas, Kentucky, Louisiana, Mississippi, Tennessee & West Virginia http://www.mihow.org
Utah	Prenatal to Five Nurse Home Visiting			<ul style="list-style-type: none"> -Support and strengthen the capacity of families to meet the health and developmental needs of their children -Also provides access to needed health care services 	<ul style="list-style-type: none"> -Home visits delivered by local health departments 	<ul style="list-style-type: none"> -Specially trained local health department nurses -Staff provide consultation, technical assistance, standards development, training related to home visiting 	<ul style="list-style-type: none"> Local, state, and Title V federal funds 	Utah Department of Health, Division of Community and Family Health Service, Child, Adolescent, and School Health Program	

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Vermont	Healthy Babies, Kids & Families Intensive Home Visiting Program		-Pregnant women & families with children up to 6 years old -Experiencing problems with young age, physical & emotional problems, family disorganization, safety issues, compromised resources & addictive behaviors			-Caseworker			http://www.healthvermonters.info/cph/hbklf/homevisit.shtm
Virginia	Healthy Babies	Provides a welcome visit to every newborn in the state						Virginia Department of Health	http://www.vahealth.org/resources/mothers/index.htm
Washington	Maternal Support Services	-Part of an expanded maternity care program -Based on the Michigan Medicaid Maternal Support Services Program		-Maternal/infant outreach -Case management -Access to care -Improving parenting skills -Enhancing child development -Preventing child abuse and neglect				-Washington Department of Social and Human Services, Medical Assistance Administration -Department of Health, Maternal, and Child Health	
West Virginia	Right from the Start			-Maternal/infant outreach -High risk infant follow-up -Improving parenting skills -Enhancing				West Virginia Department of Health and Human Resources, Bureau of Public Health, Office of Maternal and Child Health	

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State	Project Name	Model Type	Target Population	Goals/ Focus	Site Management	Staff	Funding	Administration	Notes
Wisconsin	Prevention of Child Abuse and Neglect (POCAN)	Healthy Families model with modifications		<ul style="list-style-type: none"> child development -Prevention of child abuse and neglect -Early intervention -Improving parenting skills -Altering maternal life course -Enhancing child development -Preventing child abuse and neglect 			Uses grants to county health or social services agencies	Wisconsin Department of Health and Family Services	

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State	Project Name	Model Type	Target Population	Goals/Focus	Site Management	Staff	Funding	Administration	Notes
	Milwaukee Family Project	Healthy Families model with modifications		<ul style="list-style-type: none"> -Welfare reform -Improving parenting skills -Enhancing child development -Altering maternal life course -Preventing child abuse and neglect -Emphasis on parents' education, job training, employment, physical and mental health 			Medicaid targeted case management funding	Department of Health and Family Services	
Wyoming	Home Visiting for Families	Olds' Nurse Partnership		<ul style="list-style-type: none"> -Maternity and infant outreach -High risk infant follow-up -Early intervention -Improving parenting skills -Enhancing child development 		Includes professionals, primarily nurses	<ul style="list-style-type: none"> -State dollars, federal Title V funds -Medicaid administrative case management financing 	Wyoming Department of Health, Division of Public Health	

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				-Altering maternal life course -Prevention of child abuse and neglect					