

**Home Visiting Task Force Meeting
January 27th, 2020
1:00-2:30pm**

**Ounce of Prevention Fund
33 W. Monroe, 12th Floor, Chicago, IL 60603
1203 Piaget South and 1204 Piaget North**

Conference Line: 1-650-429-3300 Access Code: 790 500 301

WebEx Link:

<https://ounceofprevention.webex.com/ounceofprevention/j.php?MTID=me6b596cdb2b16bc403721fab4975c663>

MINUTES

I. Welcome and Introductions **1:00 PM**
Co-Chairs, HVTF

In attendance; Matt Sulzen, Mark Valentine, Katelyn Kanwischer, Bryce Marable, Allison Perkins Caldwell, Tia Staggers, Christine Wulbecker, Deb Hwang, Lesley Schwartz, Joanna Su, Aimee Hilado, Alli Lowe-Fotos, Dan Harris, Cindy Bardeleben, Ellen Walsh, Asia Canady, Michelle Esquivel, Jen Vidis, Jessica Wilkerson, Diana Rauner (co-chair), Gaylord Gieseke (co-chair), Kayla Goldfarb, Glendean Burton, Paula Corrigan-Halpern, Margaret Chen, Ana Maria Accove, Tracy Patton, Andrea Chua, Julia Marynus, Lenny Rivota, Laurie Roxworthy, Maricela Garcia, Noel Norris, Jordan Wildermuth, Mendy Smith, Kristin Kaufman, Jaime Russell, Stacey Reed, Bala Mutyala, Julianna Sellett, Catherine Enright, Claire Dunham, Ausannette Garcia-Goyette, Tiffany Burkhardt, Tracey Smith, Penny Smith, Zach Allen, Lynette De Dios, Denise McCaffrey, Heather Moyer, Constance Williams, Hope Cherry.

II. Serving Immigrants and Refugees with the BabyTALK model **1:10PM**
Aimee Hilado, RefugeeOne and Northeastern Illinois University

- Aimee Hilado, Ph.D., LCSW is the Founder and Clinical Director of the Wellness Program at RefugeeOne. Dr. Hilado is also an Associate Professor of Social Work at Northeastern Illinois University where she is an academic researcher and instructor in mental health practice with trauma-exposed populations.
- Her expertise includes culturally-sensitive clinical practice with immigrants and refugees, and today she will be sharing a presentation on how the BabyTALK model is being used to provide responsive home visiting services to that priority population.

Associated Documents; BabyTALK RCT Overview and Key Qualitative Results two-pagers, Ready for Success handouts from the Infant Welfare Society of Evanston and School District 69, slides from Dr. Hilado's presentation.

- Dr. Hilado's work has focused on supporting immigrant and refugee populations, serving populations from all over the world for years. She recognized the need for both clinical and non-clinical supports, with comprehensive mental health, due to the high incidence of trauma among the population.
 - o While the work she is doing uses the BabyTALK model, there are common threads/lessons learned for all programs working to support trauma-impacted families.
- Trauma is transformative, for better or for worse. With climate change, global conflict, natural disasters, etc., the UN estimates that 35,000 people are fleeing their homes every day; there are 75 million displaced people who want to rebuild their lives with safety and dignity. Every immigrant story is different; from unaccompanied minors to families fleeing Africa or the Middle East, there are some common denominators of immigration trauma.
 - o Fear & uncertainty, Desire to have safety, Missing homeland/culture, sense of homesickness
 - Social media connects people to the countries they left, but also keeps them aware of the dangers their family back home may be facing
 - o All have a cumulative impact on mental health.

- RefugeeOne started serving adults, trying to stabilize parents in order to stabilize families. In adults, the symptoms of trauma that they were seeing included prolonged sadness, low stress threshold, sleep and appetite difficulties, a lack of ability to concentrate. Physical symptoms often masked psychological and mental health issues, there were instances of suicidal behavior and mental health crisis.
- Discussing mental health with the refugee population is not easy; people don't want to be seen as 'crazy' or will understand mental health as a moral failing that should stay within the family unit. In many cases communities don't see trauma as a mental health issue because the trauma is so pervasive and exists as a community issue.
- RefugeeOne began to observe the intergenerational impact of trauma; as parents were seeking therapy they spoke about their kids, ECE programs were encountering kids entering their care with deep social-emotional and mental health needs.
- Infant and early childhood mental health in the 0-2 and 3-6 period manifest very differently than in the adult periods. Symptoms of unaddressed mental health needs can become deficits in the later years as they impact the ability of children to arrive at school ready to learn.
 - o Both experiences in the home country and the migration process and resettlement can be traumatic. Resettlement isn't always welcoming, and this all impacts the adjustment of refugees. If we don't attend to mental health needs, we see impacting entire communities.
 - o Basic needs like finding a job, housing, child care, etc. are so pressing upon arrival that many new immigrants may be less likely to seek services. Models of treatment/service are also not always appropriate, and as the socio-political climate makes immigrants feel unsafe they are more reluctant to attach to services.
- Home visiting is a particularly effective mechanism for service delivery to families because they don't have to deal with transportation, they don't need to leave the house (dealing with the learning curve of winter), they don't need to fear ICE at an agency encounter, and it's a way to help destigmatize the mental health conversation in a comfortable setting.
- The RefugeeOne team includes therapists, psychologists, 5 home visitors who are former refugees. They approached BabyTALK seeking to house services within the resettlement agency's mental health program. They needed a highly relational model that was also flexible enough to adapt to the needs of families. Services began in 2016 with support from ISBE, plus additional funding for evaluation. The home visitors include providers serving the Rohingya Burmese population,
 - o The core of BabyTALK is its relational approach. The elements of the model include a relationship-based, trauma informed approach, screening families broadly, being strategically placing programs in the community and integrating them into existing systems of care, using an extensive curriculum that allows for flexibility in implementation, and starting prenatally.
 - o The goal is to support attuned parent-child interactions to leverage that relationship as the vehicle for producing positive change in the family. The model was intuitive from a clinical perspective because it focused on parallel processes for moving the family forward, looking at parental and child mental health. The RefugeeOne program added more mental health terminology into the curriculum, integrated the trauma informed tenants, and worked to train providers to understand mental health symptoms and make appropriate referrals.
 - Families indicate they would not have accessed child/adult mental health services without the home visitor opening up that conversation.
- Home visiting is not clinical, is not intended to be therapy, but the qualitative study showed it was experienced by many as a therapeutic benefit. Parents reported that having a home visitor in their corner made them feel healthier, happier, and more able to adjust to life in the U.S.
- Video of home visitor with family from Syria; the "magic" was that the home visitor listened to the family and then listened to their goals to establish the relationship. The family indicated their cultural tradition/understanding of child development, which was that babies don't learn, they will learn when they're older and go to school. The home visitor was able to educate about early learning, as well as help the parents experience joy in interacting with their infant by observing and calling out positive behaviors.
- The RCT spanned 12 months; 200 families were recruited, the majority with refugee status, who had resettled within the last 7 years. There were 12 nationalities and 9 languages represented, and 14 families with undocumented status.

- Outcomes that speak to HomVEE evidence categories include ASQ, parent-stress index, service access and coordination, attachment to jobs, attuned communication, serve and return, positive parenting, etc. They conducted a screener for PTSD which is important as no prior studies in the field have specifically looked at trauma in this population as related to HV services.
- More than half the population was displaced 10+ years before coming to the U.S. More recently displaced populations from Iraq and Syria were coming from active conflict zones. There were many that lacked English proficiency, had high-school or lower levels of educational attainment, and used public benefits/were low-income.
- There were statistically significant findings in the domains of child social emotional development. Though not statistically significant, positive results were observed in parental stress, ability to moderate stress, coping with trauma systems, resource connections, positive parenting, and positive communication over 12 months.
- The qualitative sub-study involved 21 moms, representing 5 nationalities and 5 languages. The population was split into quadrants based on parent/child needs (high/low), using the ASQ to establish a baseline for child development. They wanted to see if home visiting was driving social-emotional development, across various levels of parent-child need.
- Key findings:
 - o Child development was only understood in terms of physical health/development. Families felt reliant on professional signaling of need; ie. when taking their children to the doctor.
 - o Meeting basic survival needs was so pressing that moms were not able to see 0-3 period as critical. Some reported that the risk of having a baby not survive while in home country or migration was so high that it kept them from forming attachments in the prenatal/early infancy period.
 - o Having a strong relationship between parent-home visitor was the key driver to improved communication and attunement between parent-child.
- The study was published in the Zero to Three journal in 2018, and has received additional discussion/attention from the Migration Policy Institute.
- The Ready for Success Network is a collaboration between the Infant Welfare Society of Evanston and District 69, using the BabyTALK model to serve a similar population.
- The importance of mental health is growing alongside recognition of trauma among immigrant populations. We need to equip the field with additional mental health terminology and training
- Gaylord raised a question about what the lessons learned tell us about how to support home visitors/train them using this lens/when serving this population.
 - o Support from the BabyTALK Learning Institute is critical. On-going supervision is necessary to complement the core model training. Because HVs are former refugees, there needs to be training for supervisors on how to support them on content that is triggering/touches on their own experiences. Monthly group supervision plus bi-weekly individual supervision has been successful. In addition, they have implemented the FAN model to support HVs to think about mindfulness and self-reflection.
- Gaylord asked in follow up; if programs working with the immigrant & refugee population don't have the same type of representative home visitor population, what would you suggest in terms of capacity building/cultivating an effective program?
 - o It's necessary to have accurate interpretation, to equip home visitors with training and language around general trauma. Need to ensure that if HV services are not occurring in the family's preferred language, that interpretation captures all of the validating statements, nuance, and relationship building elements.
 - o It is wonderful when you can recruit from families who have successfully participated in the program because they can speak to the value of home visiting.
 - o Families pull back from services when it feels like an impersonal checklist, so it's important to dedicate time to building trust between the provider and family.
- Diana raised the question of what did the control group in the RCT get?
 - o They received no home visiting services, and they received a baseline assessment of need. There was relatively low attrition among the study participants, the visit/check-in that the control

group even received was likely beneficial. The understanding was that after the 12 month RCT, control group families could enroll in HV.

- The “selling points” for families included messages around ensuring their infants and toddlers were ready to start school to learn. For families with older children, they knew what their kids would be expected to know when entering school so they were excited to have support to build those necessary skills.
- Deb Hwang raised a question about how home visiting is reducing family’s fear of encountering ICE.
 - While the majority of the refugee population has status and a pathway to citizenship, when they hear about ICE raids, as well as the discourse about immigrants in this country, it leaves a chilling effect irrespective of status or immigration group. Home visitors are able to do some basic education about what to do if an ICE agent does come to their home/community, as well as provide know-your-rights information for undocumented families. More information is always a comfort to families.
 - Home visitors are also able to tap into the programs/services that are serving immigrants and the undocumented population to explain the benefit that home visiting services can provide to the entire family. Most at risk families stay below radar because of a lack of knowledge of resources and fear.

III. Legislative session updates

1:50 PM

Asia Canady, Ounce of Prevention Fund

- Governor Pritzker announced an additional 500 slots in his effort to provide universal home visiting to eligible families. This is the first step towards the Governor’s 5 year goal of increasing home visiting slots for 12,500 families. The Governor’s office laid out a goal of HV by \$4.25million towards this effort for this FY in addition to the \$18.6 million additional federal child care funding per year, totaling \$40 million in federal funding over the next three years to improve early childhood programs across the state
 - This announcement does not deter us from our legislative asks of an additional \$4 million to DHS towards voluntary home visiting services. This ask would support an increase in wages for the workforce as well as expand services.
- These are bills HB3984 in the House & SB 2317 in the Senate that cover the Healthy Families Illinois/Parents Too Soon line items.
 - We are also committed to our ECBG ask of \$150 million. ISBE requested \$100 million. We hope that a substantial amount of money will go towards home visiting, focusing on raising salaries in the HV workforce.
- The RFPs for all programs supported by the early childhood block grant (ECBG) are now open. They are due on March 23rd.
- The Ounce and Everthrive are also working with Representative Latoya Greenwood on HB4 which would allow Medicaid to reimburse for doula and home visiting services.
- Early Childhood Advocacy is April 29 in Springfield. Advocates from around the state convene at the state capitol to show their support for early childhood.
 - Similar to last year, Advocacy Day will be hosted by the Ounce in partnership with Illinois Action for Children and the Latino Policy Forum.
 - Registration will be opening in the coming weeks and all details on the day can be found at www.theounce.org/advocacyday
 - There is free, limited bus transportation from the Chicago area on a first come first serve basis. Materials and training is available to advocates
- Lesley added that Theresa Hawley held a call with advocates to discuss the announcement of the Governor’s goal to expand HV by 12,000 slots. The Governor’s office recognizes that there was some confusion in how “universal” access to home visiting was being framed. It does not mean that every family will receive HV, but rather that we will see an expansion of services to reach the ~12,000 additional families that would be eligible for and interested in participating in home visiting. That estimate emerged from the cost modeling work that was done by the Ounce with support from GOECD and others. The model used a 35% uptake rate among eligible families, which is reflected by the research and recent enrollment figures. We still recognize this number could increase as more families are made aware of HV, with a public awareness campaign, expanded Coordinated Intake, and other initiatives. This is not an end-

goal, but a solid goal for the next 5 years. The \$4.25 million figure is what it would cost to add 500 slots; into either IDHS or block grant, but that has not been determined yet. That number emerged from the cost model where they assessed the per-family cost of delivering high-quality services, including mental health consultation, with a substantial increase to salaries to ensure recruitment and retention of the HV workforce needed to supply this level of service.

- GOECD and the HVTF will work to try to draft a blueprint/plan for expansion of services between now and September.

IV. PDG B-5 Update

2:05 PM

Lesley Schwartz, GOECD

Associated Documents: [PDG B-5 plan](#) and HVTF work plan crosswalk

- At the last meeting of the Executive Committee we reviewed the PDG B-5 renewal plan and compared it to the HVTF work plan. While we did not identify any major new additions to the work plan, as GOECD will highlight, there are opportunities for the Task Force to monitor activities in the plan that connect to the home visiting workforce.
- While the Prenatal to Three Initiative (PN3) agenda has not been finalized, we will keep the Task Force informed of any updates from the core team and will revisit our work plan as needed when the final policy agenda is released.
- I'm happy to report that Illinois has received the PDG B-5 renewal grant in the amount of 13.4 million dollars annually for three years (2020-2022). The grant includes five main items pertaining to home visiting.
 - o We are excited to see how HV is woven throughout the plan, which is unique compared to other states.
- We will continue to offer trauma informed training to the B-5 workforce. This includes FAN training for home visitors, which will be offered through IMH Consultants.
- We will implement a Coordinated Intake pilot through five regional sites involving a combination of CCR&Rs and Early Head Start or Head Start sites. The pilot was part of the recommendations from the Coordinated Intake Strategic Plan that was completed in 2019 and we appreciate all of you who attended those stakeholder meetings and offered input on the draft plan. The pilot includes engagement of families in the planning process and monitoring of referral data. Deborah Hwang from GOECD will be overseeing the pilot alongside our state agency partners. We expect the pilot to start in July 2020.
- We want to collect better data on the home visiting work force. To do this, we are proposing improvements to the Gateways Registry, to clearly define the position of home visitor and to ensure proper classification of professionals. INCCRRA will lead this project and they will be seeking input from the field during the design process.
- To help address the issue of home visitor turnover and to increase stability in the field, we also want to design an approach to home visitor credentialing, that is based on the HV core competencies previously created by the Ounce. Specifically, we want to review the home visitor Child Development Associate (commonly used by HS/EHS HV) and the Illinois Family Specialist Credential. This work will build on the earlier discussions that the Task Force and others had, when the Family Specialist Credential was first created. INCCRRA will facilitate this work with stakeholders.
- We are also planning a number of data integration and improvement projects, including standardizing home visiting data across state agencies. This work will be carried out through NIU and the Illinois Longitudinal Data System project—Charlie Rosemond shared some updates about this work at the January HVTF Executive Committee meeting.
- All of these activities are closely aligned with the HVTF workplan and the PN3 action agenda. We look forward to working with the members of the Executive Committee and the Full Task Force to carry out these steps. There is a lot of synergy between these various planning initiatives.
 - o PN3 has produced solid planning for the expansion of HV by 13,000 slots. That can be used to inform the Governor's goal/blueprint.

- Dr. Mann will provide an update to the HVTF at a future meeting about the work under FFPSA to expand HV to intact families. DCFS is finalizing the plan to turn into the feds. on how to implement FFPSA, but we know the IPPYC project was critical to informing that plan. HV specialists are engaging with intact families already.
 - o Important to note; intact families will NOT be mandated to participate in home visiting under FFPSA. We would lose MEICV funding if HV is not voluntary, GOECD will have to work with DCFS around language to ensure families know it is voluntary.
 - o Through the IPPYC project, we have learned about how to talk with families about home visiting and how to negotiate the boundaries with the DCFS case workers.
- Tia Stagers is the HV specialist with DCFS. She shared she is already getting referrals and enrolling families. Families seem very open to home visiting, the barriers they are experiencing are around placement changes and a breakdown of communication with case workers. There have been 13 referrals since December, with 6 more waiting to be referred soon. A lot of the referrals have worked through word of mouth since Tia was prior connected to HV programs. Providers have been generally very receptive; the Southern and Central providers are more willing to collaborate right now, despite not having resources.
- One of the barriers is knowing where the HV programs are. Neither SPIDER or iGrow are as up-to-date as we'd hope.
- Programs interested in participating can contact Tia directly at tstagers@erikson.edu

V. Updates from the HVTF Executive Committee

2:25 PM

HVTF Co-Chairs

- The online survey has been re-opened to allow us to gather meaningful data about our membership.
 - o Please encourage everyone in attendance to take the survey; when it was open from October through December we only received 22 responses.
 - o Additionally, please share any suggestions for new Task Force members through the survey. We welcome program advisors, home visitors, doulas, parents, community members, pediatricians, advocates, etc. and are seeking to represent a diversity of perspectives.
- The 2020 National Home Visiting Summit, hosted by the Ounce of Prevention, will be held in D.C later this week. We are excited that all four plenary sessions will be live streamed free of charge to the field. Information was sent in the pre-meeting materials about how to register for the livestream events. The exciting sessions include;
 - o Maternal Care to 5—Systems Changes Supporting the MotherBaby
 - o Home Visiting Workforce Development During Rapid Scale-Up: Lessons from Other Countries
 - o Fulfilling the Promise and Meeting the Challenge of Home Visiting: What Do Families and Home Visitors Need?
 - o The Role of Home Visiting in Building Comprehensive Early Childhood Prevention Systems to Promote Population-Based Outcomes
- The Sustainability Subcommittee has been reactivated, and will be chaired by Ireta Gasner, Vice President of Illinois Policy at the Ounce of Prevention Fund, and Mike Shaver, President and Chief Executive Officer at Children’s Home & Aid.
 - o The Subcommittee may focus on funding issues, both related to existing state dollars and exploring alternate federal funding streams for home visiting. Other important items might include workforce supports and strategic messaging on home visiting.
- The Universal Newborn Support ad hoc work group has also been reactivated, and will be chaired by Deb Daro, Senior Research Fellow at Chapin Hall, and Gina Lowell, MD, Assistant Professor in the Department of Pediatrics at Rush Medical College.
 - o As needed, this group will offer support for the scale up of the Family Connects Illinois program, and may also consider adaptations to existing universal newborn support models that would facilitate prenatal engagement.
- Anyone interested in participating in either can reply to the poll that will be sent out with the meeting minutes, or contact Kayla Goldfarb.
- New business from members:
 - o Julia Marynus shared that a reporter from the Chicago area associated with Keiser Health News will be doing on a story on Family Connects. They have also reached out to CDPH.
 - o This is great news because it will help to elevate Family Connects in Illinois to a national stage.
- **Upcoming meetings:**
 - o April 7th from 2-3:30pm, HVTF Executive Committee meeting
 - o April 28th from 1:30-3pm, HVTF meeting