# Vermont MECSH Triennial Report

# 2019-2021

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# Vermont MECSH Program Triennial Report

## Program Years 2019 – 2021

## Introduction

In the State of Vermont, the Maternal Early Childhood Sustained Home Visiting (MECSH) program was introduced in 2015 and selected as the evidence-based nurse home visiting program for state-wide implementation in the end of 2018. MECSH is delivered under the Strong Families Vermont Home Visiting continuum as part of Children's Integrated Services. Children Integrated Services, (CIS) is a system of care in each Vermont region where a cohesive organization of core early childhood services, focusing on pregnant and postpartum people, and families with young children through age six have shared intake and referral systems and collaborate across four services: Home Visiting, Early Intervention, Early Childhood Family Mental Health, and Specialized Childcare.

The Vermont Department of Health is an awardee of federal funding (Maternal, Infant, Early Childhood Home Visiting, MIECHV) which supports subrecipient grant agreements with seven Home Health Agencies who employ nurses and supervisors in all 14 counties in Vermont. The Home Health Agency's nurses deliver MECSH services statewide with ongoing programmatic support directly from the Vermont Department of Health's Nurse Home Visiting Program Administrator and Data Administrator in partnership with CIS.

This report encompasses implementation and outcomes from the first three years of Vermont statewide implementation of the MECSH program from 2019 through 2021. All quantitative data, aside from MIECHV outcomes, follow the calendar year (1/1-12/31). MIECHV performance measurement outcome data follows the MIECHV program year schedule (10/1 – 9/30). This report was also prepared by holding facilitated discussions to collect qualitative verbal and written input by MECSH nurses on their program implementation experiences.

## Client Enrollment in the MECSH Program

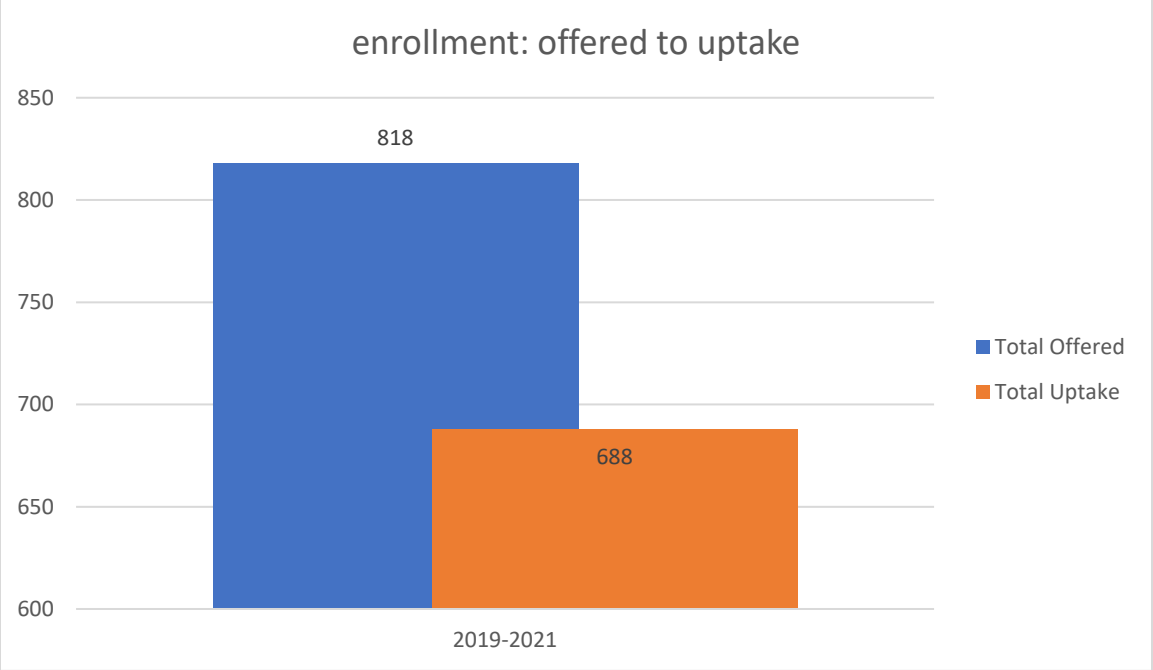
1. **Are all eligible families being identified and offered the program by their Nurse and Social Care Practitioner (where relevant)?**

Since the launch of MECSH statewide, the Vermont Department of Health and CIS partners developed referral flow guidance for CIS providers to support the CIS intake & referral process (see Appendix A) which encourages MECSH be offered to any eligible person (prenatal and up to 6 weeks postpartum). This CIS referral guidance is an adopted practice in most regions, however there are some complexities and limitations in how well this is practiced in some regions. Most MECSH providers have a range of other services such a CIS responsive (prevention) nurse home visiting and skilled nursing care services (medically necessary) which can lead into a soft entry into MECSH. For example, a family may engage with a nurse for a medical or a prevention reason which lends an opportunity for a client to meet a nurse, begin to develop a trusting connection, whereby the nurse offers and explains MECSH and supports engagement into the program. This is a common approach within local agencies.

2. **Are most eligible families taking up the offer to participate in the program?**

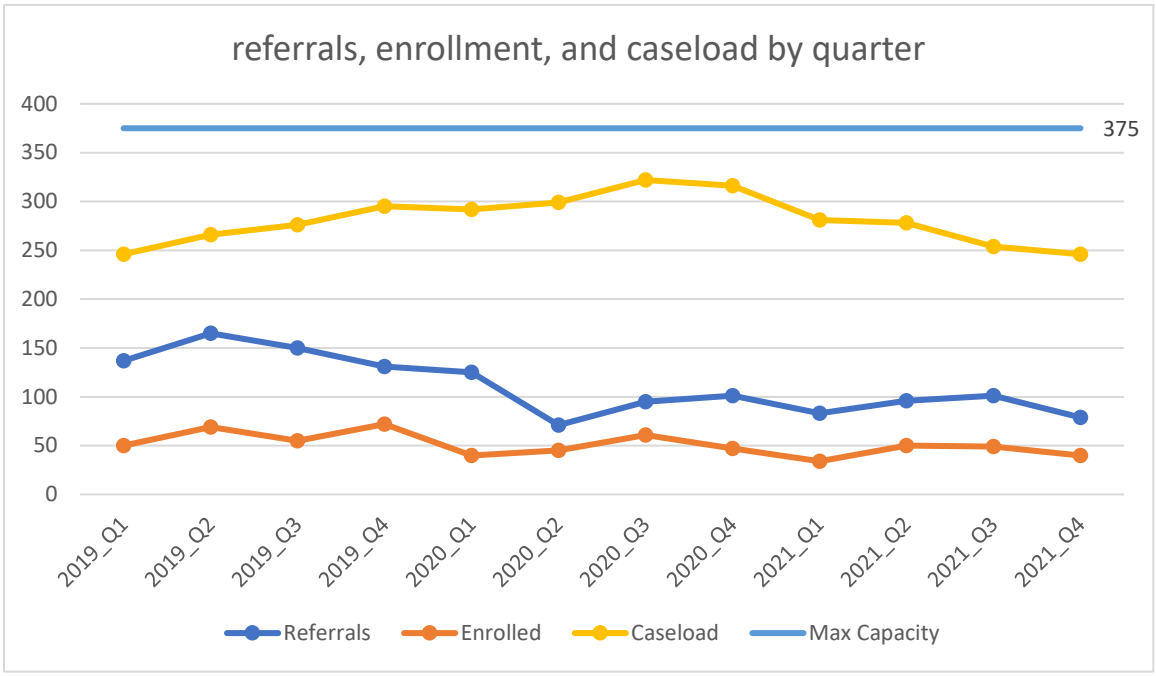
During this three-year period, 818 clients were offered the program and 688 were enrolled. This is an 81% uptake from referral to enrollment. And over the 3-year license period, 860 families were served during this time and 688 families were enrolled.

Table 1



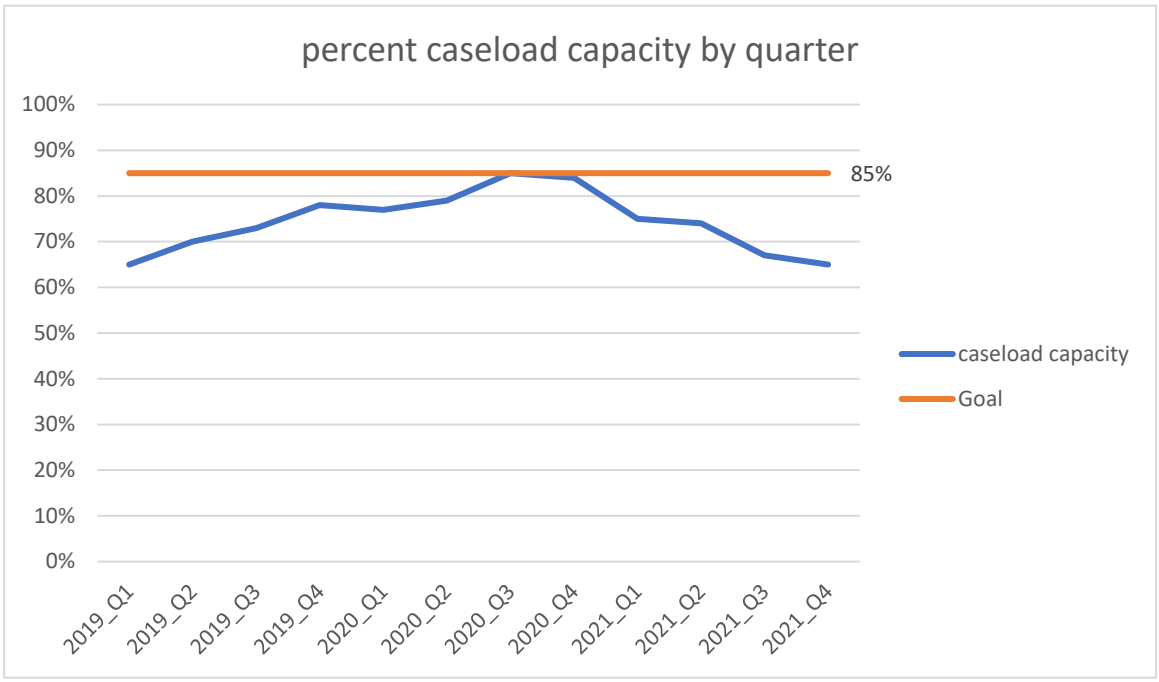

The reach of the MECSH program is statewide and there is funding to have a total capacity of 375 families served or enrolled at any point during the year. Vermont keeps track of referrals to the program, number of newly enrolled clients, and overall active caseload trends each quarter. This data is pictured here in Table 2.

Table 2




Vermont also has a goal of keeping 85% of caseload capacity which is tracked quarterly as well and shown in Table 3.

Table 3



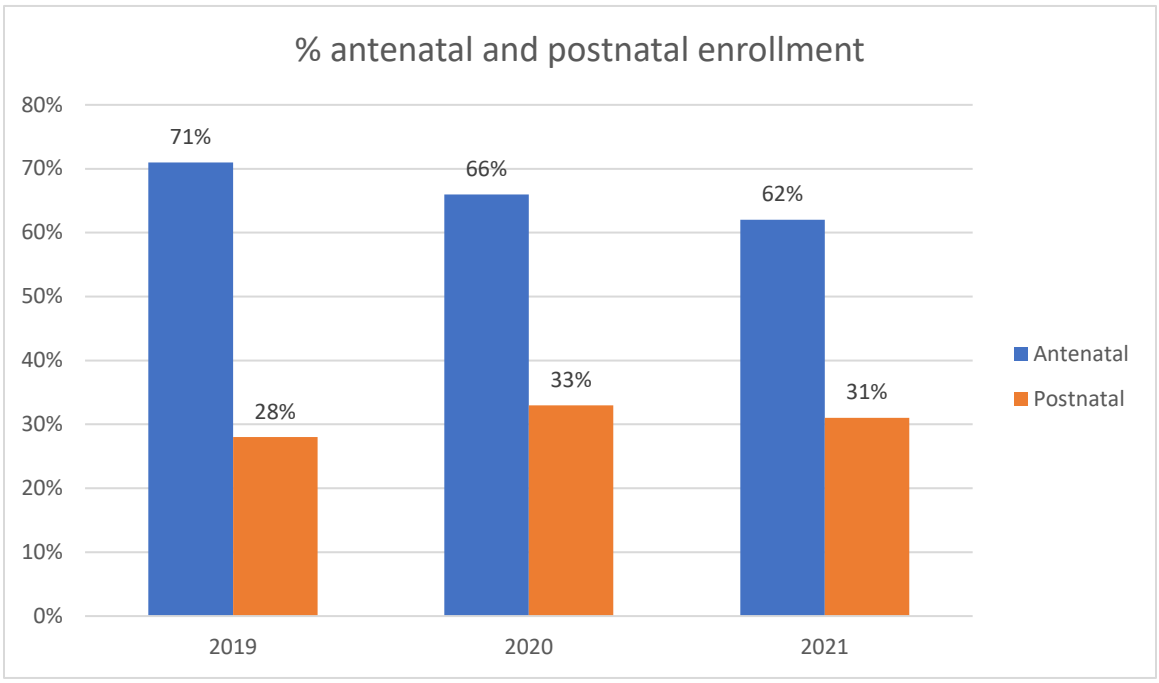
3. **Are there any groups/types of families that are difficult to enroll in the program?**

Families who may be more challenging to engage and remain consistent with the program may be experiencing severe and persistent mental health issues, substance misuse, or other risks such as homelessness or intimate partner violence. Families with complex family needs such as adults with cognitive delays or families who may be involved with child protective services, may find it difficult to engage in the program. Other reasons why families may decline enrollment when offered the program are they don't think they "need it", they may feel overwhelmed by a sustained or more long-term program, a family may have several other services in place and may perceive it as duplicative of other services.

4. **Are most eligible families taking up the offer antenatally?**

Many families are taking up the program during the prenatal (antenatal) period. If a referral is received early in the prenatal period and the family is not ready to accept services, nurses continue to check in with clients and later points with the goal for prenatal engagement at a later trimester. Despite explaining the benefit of commencing the program before the baby is born, sometimes it is difficult to engage clients before birth as they may be working until delivery of their baby. Prenatal enrollment can also be challenging because families may not think they need it and therefore be more receptive once the baby is born and their need for support is more concrete. The graph below outlines how Vermont's program is performing regarding the fidelity measure for 80% of clients enrolled prenatally.

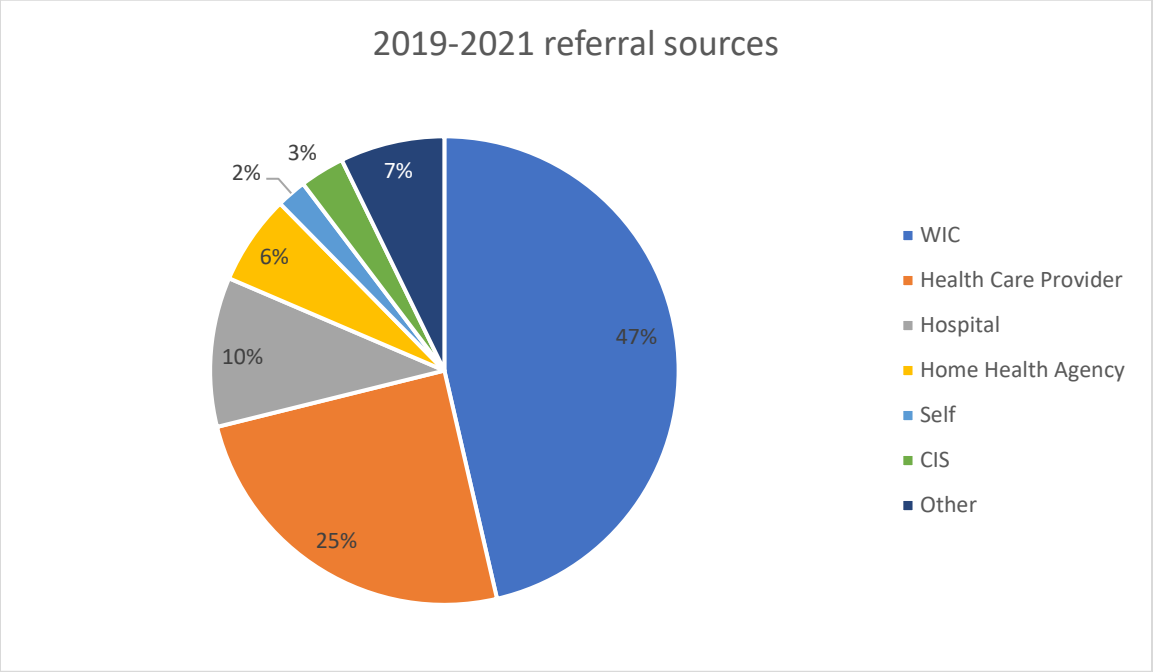
Table 5



5. **Where there are areas of success, please discuss any process and/or factors that have contributed to this success:**

Home Health Agencies having well established connections with Obstetrical (OB) provider practices and Women, Infant's, and Children's Nutrition & Education Programs (WIC) is very beneficial. Over the years, WIC has generated our biggest referral source statewide for the program. Other processes that support prenatal referrals include CIS teams referring to MECSH providers in accordance with the algorithm, school nurse partnerships, and program brochures in public. Table 6 below represents the primary referral sources over this reporting period.

Table 6




Other strategies to support client engagement include connecting as close to the referral time as possible and asking what their biggest stressor in that moment is and how a nurse can help work well. Key effective messages include statements such as "having a baby is a time when things are changing a lot, we can address hot topics or questions." Other approaches included explaining that the program is flexible and voluntary and if one decides the program isn't for them, that is alright. Other typical talking points when talking about the program by phone include the nurse offering help with breastfeeding support, weighing the baby, and/or parenting and child development. Other successful ways of promoting engagement are stating they are not alone, can receive support to be the kind of parent they want to be, or the program can make things easier.

Nurses being creative in finding a connection that isn't necessarily related to a person needing a nurse such as being practically useful by helping make phone calls or completing paperwork or addressing a current need and offering concrete solutions or incentives work well. Sometimes joint visits with another provider can support a warm introduction or other strategies such as texting or calling at the right time, or a statement about there being no pressure and services can be shaped to meet their needs can help with receptivity and engagement into the program.

6. **Where there are areas of concern, please discuss any action taken to identify the basis of the concern and outline the implemented and/or proposed strategies for addressing these:**

When Vermont began implementing MECSH, printed program materials were created for parents and providers for agencies to use locally in addition to statewide outreach and education with providers and statewide partners. At the time there was no need for a promotional media campaign as caseloads were at target and referral volumes were functioning well. Referral pathways were disrupted during the COVID-19 pandemic. The Women, Infant's, and Children's (WIC) Health & Education Program has been our number primary referral resource for many years. With the pivot from in person to virtual delivery for WIC and OB medical appointments, the MECSH program's referrals decreased. Other challenges such as some nursing staff turnover, challenges engaging or retaining newer client's over virtual technology, along with many families graduating in the same time frame, have all resulted in lower percent caseload capacity of families being reached at this time.

Another challenge is the United States does not have a universal health care system, therefore, services that people qualify for are somewhat dependent on health insurance coverage type and providers do not universally refer for nurse home visiting services, as it is not a universal benefit. In Vermont, to be eligible for MESCH, clients need to be low income or on Medicaid insurance. There is work currently underway by state leaders regarding the development of a social media campaign to normalize and promote home visiting in the perinatal and early childhood space with the aim of increased awareness about home visiting and the intent to make the referral process simpler. A new strategy to overcome referral concerns in a one community is having a universal, "there is something for everyone" approach, encouraging OBs to refer everyone, and letting the service providers sort out the challenges of eligibility, simplifying the referral process for providers.

## Client Engagement in the MECSH Program

1. **Are participating families fully engaging in the program for the duration of the program?**

Completion of the program includes those who "graduate early", who feel as though they've received what they needed, and their nurse agrees they have a good ability to adapt and self-manage. Common discharge before completion of the program reasons are lost to follow up (client disengages and is unresponsive), moved out of service area, and returned to work or school.

Table 7

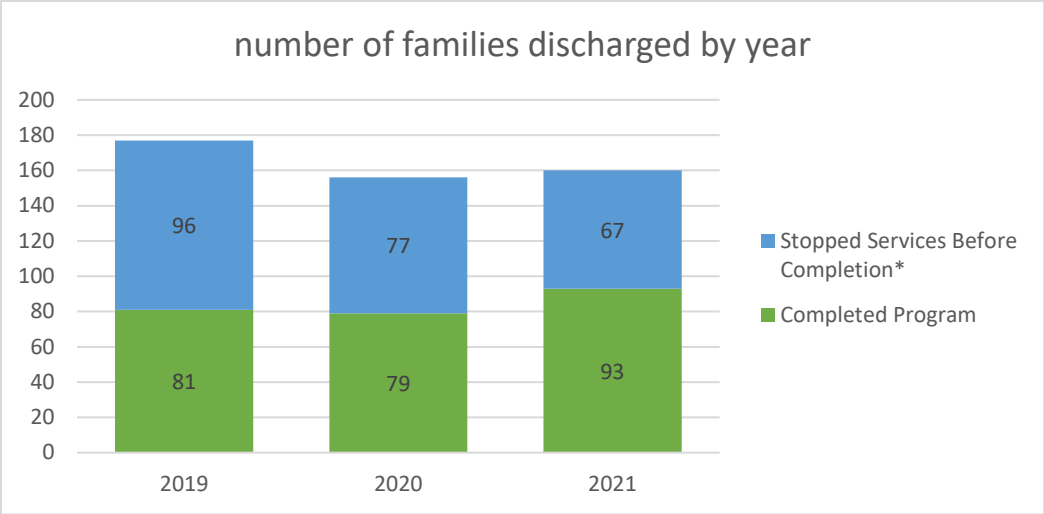
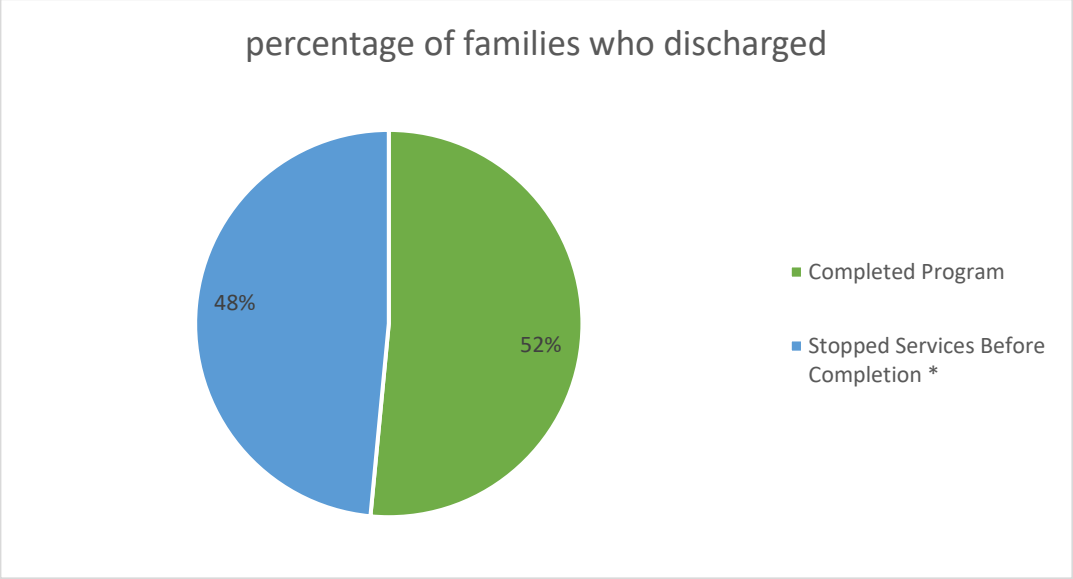



Table 8




*This count does not include the discharge reasons fetal or infant death, miscarriages, nurse safety or moving out of service area

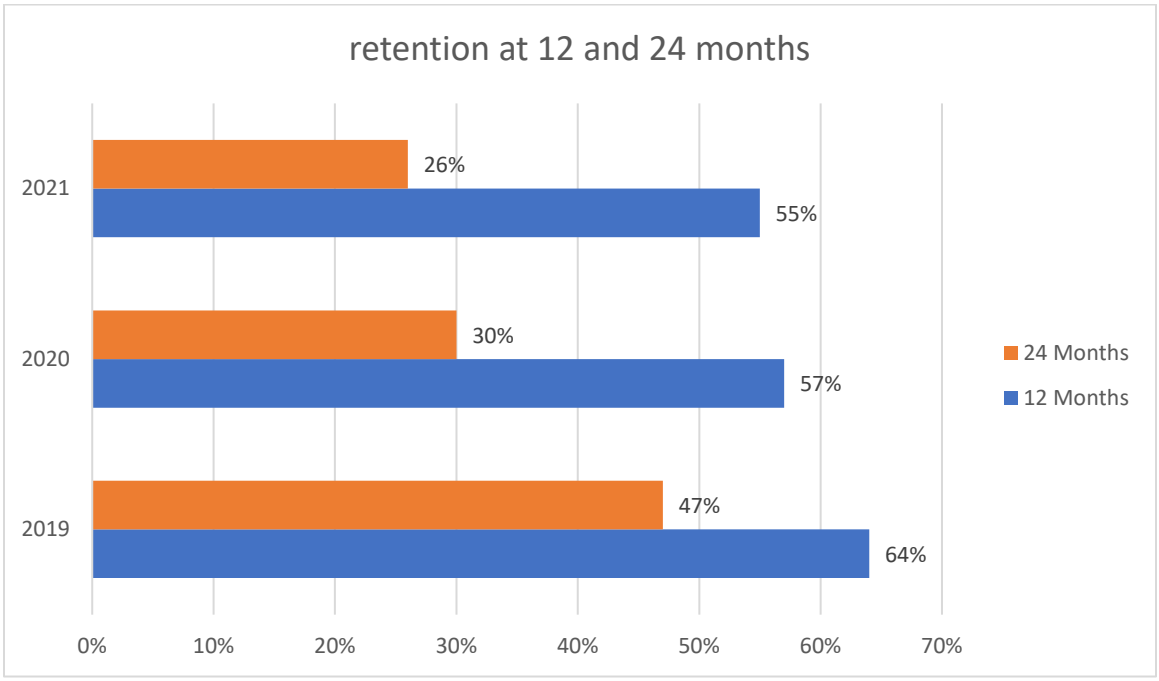
The above graph in Table 8 shows that over the reporting period, more than half of clients enrolled successfully completed the program.

2. **What is the retention rate of enrolled families at child-age 12 months and child-age 24 months? What is the average and over time/look at the category of "received what they needed" and see how long they were engaged.**

An average of 59% of clients over the three reported program years stayed engaged in the program through the child's age of 12 months (MECSH fidelity target is > 65% at 12 months). An average of 34%

stayed enrolled through 24 months of the program (MECSH fidelity target is >50% at 24 months). Many of those who disengage in the last year of the program "graduate early" receiving what they need from the program, feel they have a strong ability to adapt and self-manage and are looking to focus on other things such as work or school. Table 9 below shows the engagement at 12 and 24 months for each of the reporting years.

Table 9



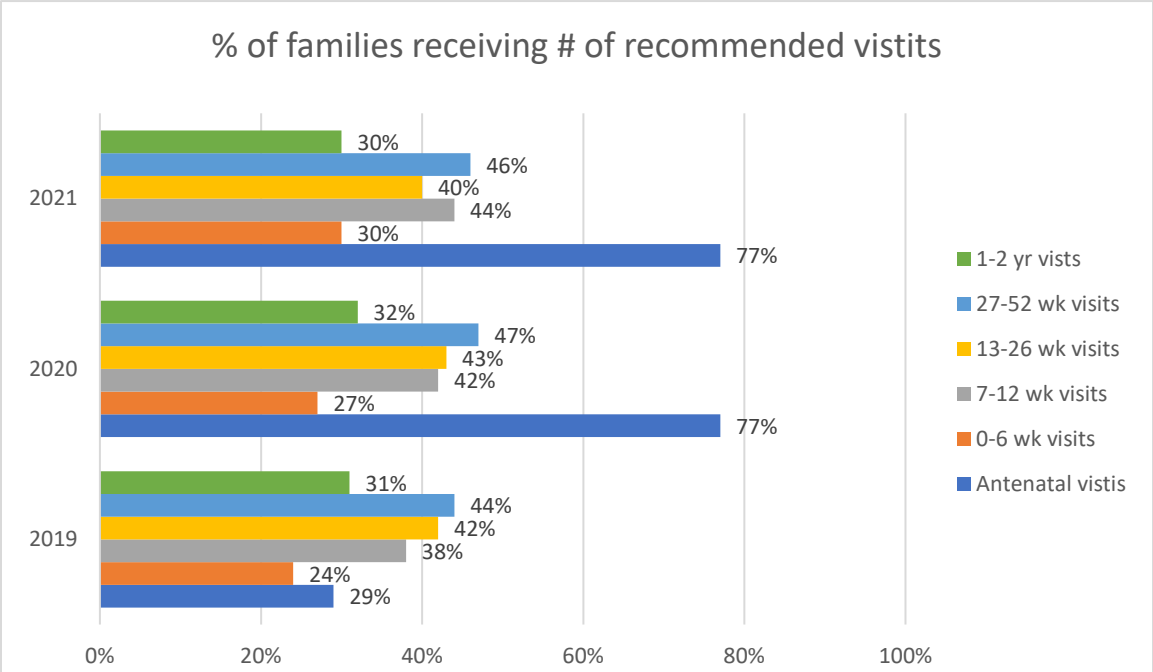

**3. Are there any groups/types of families that engage particularly well, or particularly poorly in the program?**

Those who may engage particularly well are first time mothers, goal orientated families, and families that can identify life challenges they don't want to repeat with their children. Also, families without a social network engage well in the program. Sometimes families faced with more adversity such as homelessness or other psychosocial challenges do engage well. The pairing of the nurse and the client's connection and desire for that consistency and support can be key factors to staying engaged.

**4. Are participating families receiving the correct number of scheduled visits?**

There is a higher percentage of scheduled visit completion during the prenatal period while the 0-6 weeks and 1–2-year periods are much more difficult to reach the minimum frequency of visits. Nurses have said that during the 0-6 weeks period it is difficult for families to fit in visits around other doctor's appointments and settling in with a new baby. During the 1–2-year period, many clients are juggling the MECSH program with returning to work or school. Below Table 10 shows the percentage of families and at what percentage they receive the visits at the expected frequency.

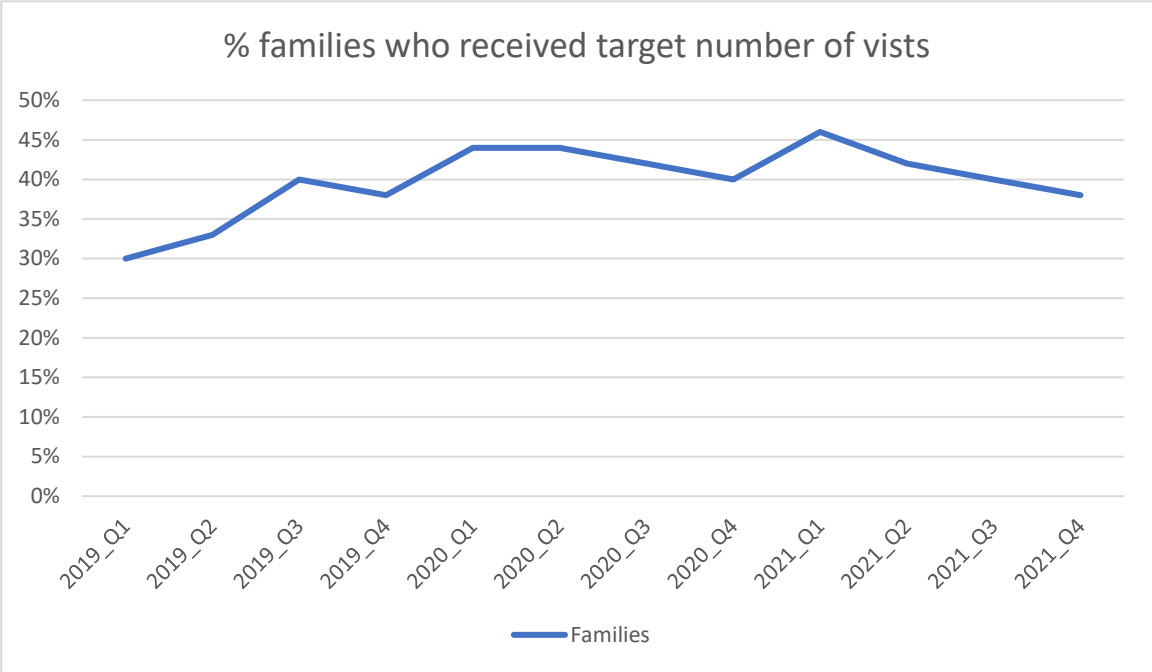
Table 10




* Of note in the graph above, in 2019, many enrolled clients were former Nurse Family Partnership clients who joined the MECSH program postnatally which impacts our data trend with antenatal visits.

Table 11 shows the total percentage of families who received the target visits each quarter over the reporting year. The average number of visits has risen over time but leaves room for improvement with regard to achieving the minimum visit frequency for enrolled families.

Table 11




**5. What is the mean number (and range) of visits received by families?**

Our data system is limited in that it's difficult to pull apart visits by clients to get a mean or range number of visits by family. Instead, Table 12 shows the number of visits made each year and the number of households served. This would include families who engage and enroll for any duration.

Table 12

| Year* | Total Number of Visits Made | Number of Households Served |
|---|---|---|
| 2019 | 3733 | 448 |
| 2020 | 4036 | 469 |
| 2021 | 3231 | 464 |

*MIECHV data and program year

**6. What portion of families receive more than 75% of scheduled visits?**

Our data system is limited in this regard and would require an extensive manual count of visits for every client enrolled during the time to answer this question. Our best representation of this metric was shown above in Table 10 which outlines by age band, the percentage of families receiving the recommended number of visits.

Some strategies the nurses shared to keep families engaged and on track with the visit schedule include going over the visit schedule with families prenatally and explaining why the visit schedule is important. Other approaches include calling the day before to confirm visits, and when confirming visits, offering something practically useful and sharing a plan for the next visit. Nurses may offer incentives such as a developmentally appropriate toy or useful item they will bring. Home visitors may also explain that at

the next visit they will complete milestone pages for a baby book they will have at completion of the program. Another approach is to be as flexible as possible, such as offering a telehealth visit if the in-person home visit is presenting logistical challenges instead of cancelling the visit entirely. Nurses find that keeping the appointments consistent as far as the same day of the week and same time can be helpful as well. Another strategy is to schedule the visit in advance of when they are due for clients who frequently cancel, and texting clients in between visits to let them know they are thinking of them or remind them of visits.

Through qualitative input, the MECSH nurses identified these common challenges with visit frequency at specific stages of the program:

Table 13

Common Minimum Visit Frequency Challenges:

| | |
|---|---|
| Prenatal: | "Maybe when the baby is born?"<br>Repeat of OB provider visits<br>Premature delivery<br>With work, it's difficult to have visits |
| 0-6 weeks: | So many appointments, clients feel overloaded<br>1 missed visit=missed data<br>Too much data collected.<br>Collection + Overwhelming to a new parent |
| 7-12 weeks: | So many appointments (1-3 months)<br>Going back to work<br>Busier<br>More comfortable with being a mom |
| 13-26 (3 to 6 month): | Relapses of substance use<br>Too far space for some people |
| 27-52 (6 mo. to 1 year) | Less acute need<br>They are settled in at daycare |
| 53-104 (1 -2 years): | Work<br>Daycare<br>Toddler frequency can be difficult because it's a longer time between visits and because their nap schedule changes |

**7. Are families receiving the appropriate visit content as outlined in the MECSH Program Manual?**

Since its creation, our database tracks minimum frequency of visits per age band and the utilization of compulsory curriculum, Learning to Communicate. Vermont's MECSH database tracks the utilization of each focus module over stages enrolled in the program. Minimum visit frequency correlates with the family receiving the curriculum content. Vermont has 2 focus modules: Maternal Well Being, Healthy Beginnings, beyond the compulsory modules of Learning to Communicate and Promoting First Relationships. This next section will provide additional information regarding the use of the compulsory and focus modules and provide further information on how families receive the curriculum content.

Vermont began collecting data on the additional content and focus modules (Promoting First Relationships, Maternal Wellbeing, & Healthy Beginnings) when database enhancements were completed in July 2020. The release of the database enhancements occurred a few months after a staff training was held and was delayed due to the pandemic. Furthermore, the pandemic's pivot from in person to virtual service delivery and the challenges and stressors families and nurses faced had an impact on content delivery. It is also necessary to note that our 2 full time Vermont Department of Health MECSH staff were both partially deployed to the pandemic response for a year and a half during this reporting period, supporting both the work of the MECSH program and the assigned duties as part of the Public Health COVID-19 emergency, which had an influence overall on program management.

8. **Where there are areas of success, please discuss any process and/or factors that have contributed to success or using the curriculums.**

Nurses shared several techniques to support the use of the curriculum with families such as bringing their passion to the content and being as natural and engaging as possible while sharing the content being discussed. Other approaches include asking clients to come up with examples of what the nurses are teaching and using lots of demonstration and bringing topics back to the other children in the household. Additionally, nurses find success with using the curriculum as an opportunity to reinforce the sensitive and positive parental practices families are doing.

9. **Where there are areas of concern, please discuss any action taken to identify the basis of the concern and outline the implemented and/or proposed strategies for addressing these:**

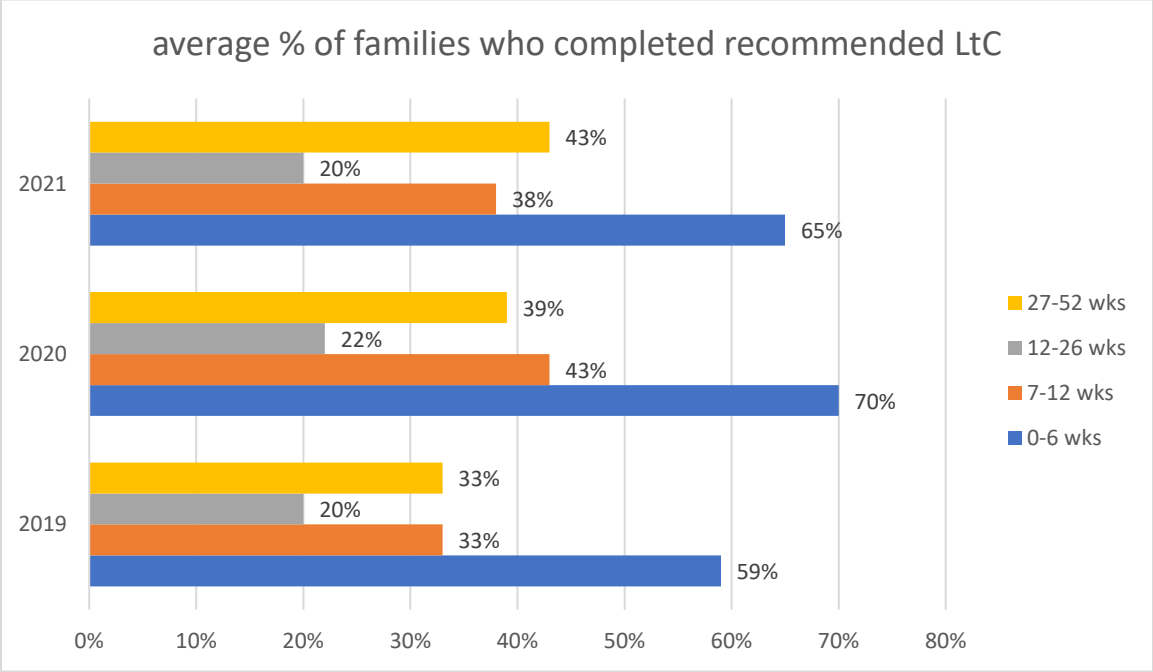
It has been noted that overall, the Promoting First Relationships (PFR) curriculum appears to be the most underutilized. Steps taken to further support staff with utilization have included the State Nurse Home Visiting Program Administrator providing additional training in 2021 at a quarterly meeting on the curriculum, purchasing social emotional cue cards and provider licenses to use the handouts in Spanish to support further use. In addition, the Program Administrator purchased 14 additional training hours of the curriculum (Level One PFR Training was conducted by the University of Washington's Parent – Child Relationship Program) in May of 2022 for all MECSH home visitors.

Other measures to address the utilization of core curriculum and other fidelity measures occurred in 2021 when the State Data Administrator and Nurse Home Visiting Program Administrator, post height of the pandemic, met with each site over the course of several months to conduct virtual site visits of each program, to review overall program performance and operations. Questions regarding documentation were addressed individually at these sites visits. Furthermore, MECSH Steering Committee meetings are an opportunity to collectively monitor statewide level performance and discuss challenges and identify opportunities for improvement.

10. **Are families receiving the Learning to Communicate curriculum?**

Vermont's most optimal utilization of Learning to Communicate occurs in the 0–6-week postpartum stage. Table 14 shows the utilization of Learning to Communicate at each age band over the reporting period. Overall, Vermont is working on increased use of this curriculum across all age bands.

Table 14

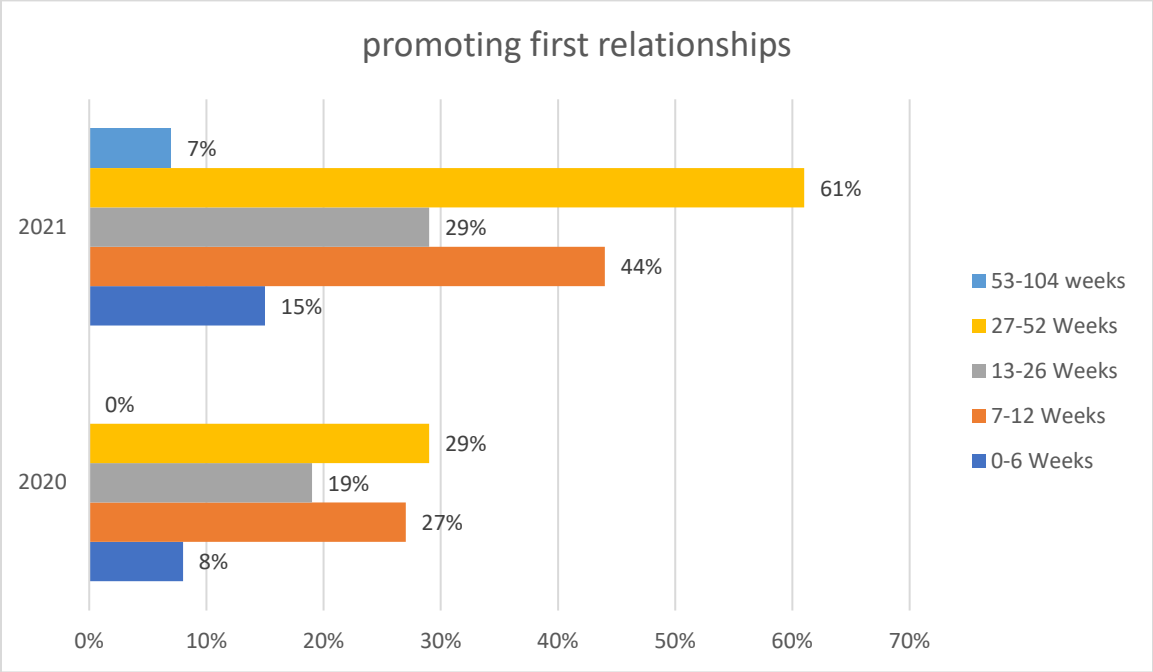



**11. What proportion of families (with children aged over 12 months) have received the scheduled twelve Learning to Communicate sessions?**

This is data we cannot currently query and provide. Vermont's database is only able to track data on the percentage received during each age band, not cumulative for each family.

The next three tables will provide quantitative data on the utilization of Promoting First Relationships, and Vermont's focus modules, Maternal Wellbeing, and Healthy Beginnings over the reporting period. To review, these three curriculum content areas are newer enhancements to our database therefore we only have two years of data on this area of the program.

Table 15




Per Table 15, it appears the trend is improving regarding utilization of the Promoting First Relationships, which is designed to promote attachment and support social and emotional development of children, with the highest percentage of use in the 27-52 weeks of the MECSH program.

Table 16 shows the utilization of Healthy Beginnings, Vermont's focus module to support nutrition and physical activity and prevent childhood obesity. In 2021, the use of the curriculum increased significantly compared to the year before.

Table 16

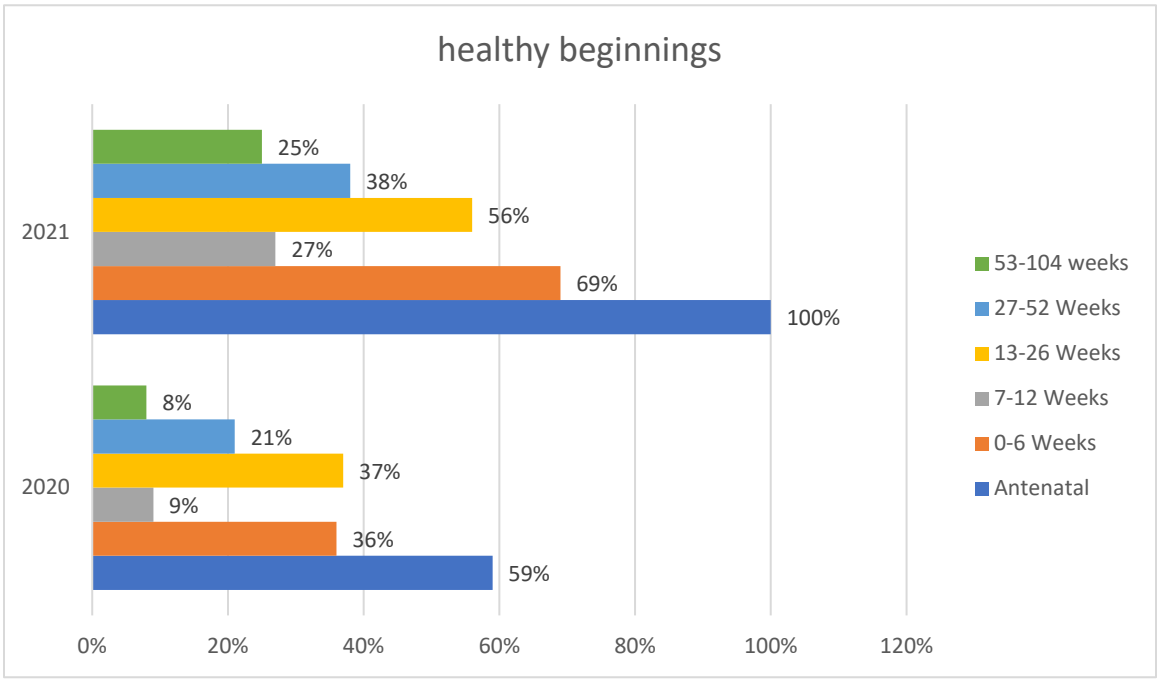
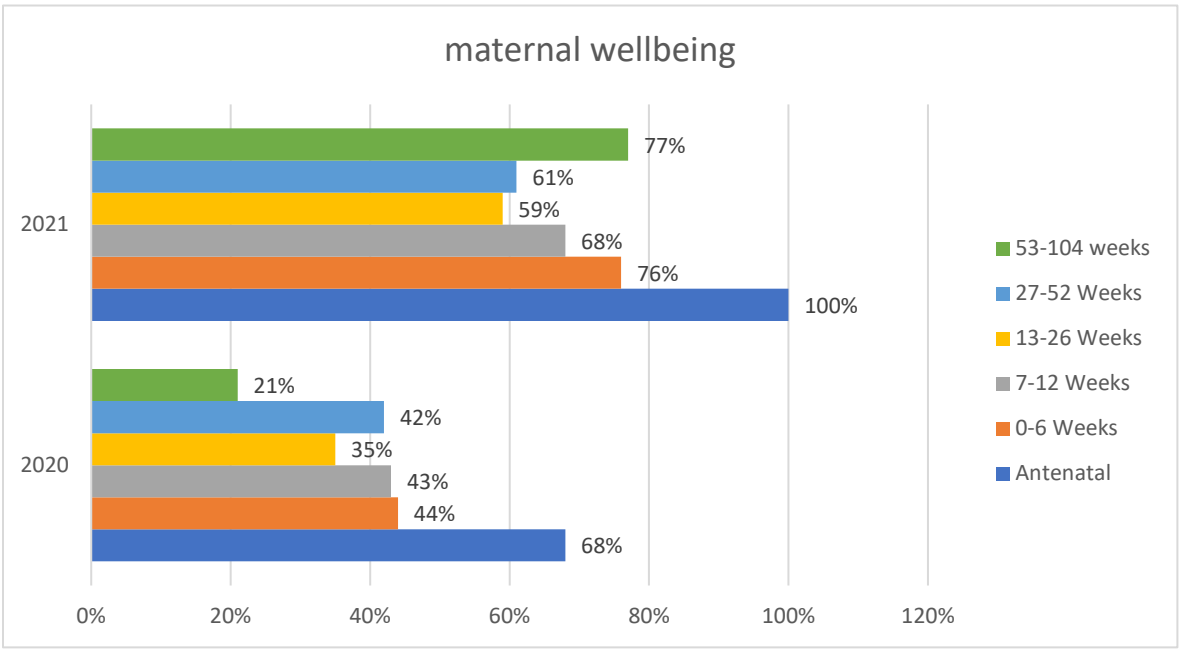



Table 17




Lastly, Table 17 shows the Maternal Wellbeing focus module which is designed to provide anticipatory guidance and identify supports for the postpartum period where clients may face blues or other more serious postpartum mental health concerns. This particular focus module utilization increased in 2021 when compared to 2020 as well and addressed in more than 50 % in all age bands.

## Nurse and Social Care Practitioner Capacity to Deliver the MECSH Program

1. **Are the Nurses and Social Care Practitioners provided with the training to deliver the program?**

Yes, Vermont holds an annual 5-day MECSH Foundation Training. We also provide "distance learning" training to new nurse home visiting staff hired to provide them with abridged model training and allow them to begin practicing MECSH until they attend the full Foundations 5-day training. Our training is tracked in our MECSH database, and the state team has worked with program sites to document accordingly. Nurses aren't counted as fully trained until they complete the 5-day MECSH Foundational Training. Table 18 shows the percentage of nurses trained in the model.

Table 18

| | |
|---|---|
| **2019** | 84% |
| **2020** | 90% |
| **2021** | 97% |

For some nurses, having the distance learning training while working with a mentor to observe several MECSH visits and even begin to have a few cases prior to attending the 5-day training, has been a beneficial approach to orientation and training process. Bringing those implementation experiences and questions to the 5-day training has been beneficial for new nurses and group learning.

2. **Are the Nurses and Social Practitioners provided with the supervision to deliver the program?**

Vermont MECSH sites document Reflective Supervision in the database. There are MECSH supervisors at each of the 7 sites. Reflective Supervision occurs within each respective agency among the MECSH supervisor and nurse. Table 19 shows that Vermont MECSH nurses are consistently receiving reflective supervision to support their MECSH practice.

Table 19

| | |
|---|---|
| **2019** | 84% |
| **2020** | 90% |
| **2021** | 86% |

3. **Are the Nurses and Social Practitioners provided with the resources to deliver the program?**

This question was answered by the nurses with a resounding, yes. The nurses appreciate the curriculum and the opportunity for ongoing professional development. It was noted that there is good access to basic needs items to support families with securing diapers, hygiene items and other essentials.

4. **Are the Nurses and Social Practitioners provided with multidisciplinary support to deliver the program?**

Through qualitative input, the MECSH nurses described there to be strong multidisciplinary support to deliver the program. The Children's Integrated Services (CIS) intake and referral and consultation teams provide good structure to foster multidisciplinary teaming consultation. Feedback was received that

having social workers to help manage clients with many providers would be helpful. Also, sometimes it's challenging to have each CIS territory set up uniquely.

5. **Where there are areas of success, please discuss any process and/or factors that have contributed to this success:**

Vermont has built up its capacity of Trained MECSH Trainers at each of the Home Health Agency program sites. Often, these Trainers are MECSH Supervisors. This effort has strengthened localized programmatic expertise and to be embedded at each local program site. Trainers are asked to help facilitate parts of the 5-day MECSH Foundations training and periodic MECSH distance learning trainings when needed. This structure allows for MECSH Supervisors to have, at least annually, an opportunity to train which results in a refreshening of MECSH practice and supports program implementation and dynamic training from those in practice.

Another aspect that supports nurses in their capacity to deliver the program occurs through quarterly statewide meetings facilitated by the State's Nurse Home Visiting Program Administrator. Quarterly meetings are an opportunity to address areas of MECSH program implementation, performance improvement, and offer a robust opportunity to learn and support one another in MECSH practice.

6. **Where there are areas of concern, please discuss any action taken to identify the basis of the concern and outline the implemented and/or proposed strategies for addressing these:**

One area of concern is staff turnover and the ongoing need and resources it takes to prepare for and conduct MECSH Training. Having additional states practice MECSH in the USA did result in a virtual MECSH Foundations Training amongst Vermont and Minnesota in the Fall of 2020 which was a great opportunity to hold a larger more dynamic training and streamline training. One strategy is updating Vermont's Distance Learning checklist to make it more streamlined and to develop shared hub electronically for all programmatic policies and support tools, in addition to having the materials on MESCH's Scodle website.

## Service System Capacity to Respond to the Needs of MECSH Families

1. **How aware is the health system of the MECSH program and how is MECSH promoted throughout the service system?**

The program is promoted at the local level through community-based outreach and on a statewide level with presentations to state-wide partners such a WIC, Reach Up, (TANF Transitionary Aid to Needy Families) the Statewide Early Childhood Council, and OB Grand Rounds.

There is an opportunity for increased awareness and understanding of the MECSH program statewide. There is some ambiguity and misinformation as to the target population and that it is only for high-risk families, or it only helps with lactation. The hospital systems have various points of contact and are generally not as aware as the Obstetric or Pediatric practices regarding the program. Sometimes providers are aware and not referring or are unclear about the community service providers or systems. Staff turnover at provider offices is a detriment to referral processes. State positions like the WIC Program, or Maternal Child Health Coordinators from local Health Departments are often a good sources of referrals and support community-based awareness of MECSH and CIS.

2. **Are there pathways for referrals to support and specialist services for MECSH families (parents and children) with identified health, development and/or social issues?**

Yes, there are pathways for referrals needs for a variety of health, developmental and social needs. The Vermont MECSH program tracks connections to services in a few different areas. Table 20 below displays those who screened positive for tobacco use, or intimate partner violence, who received referrals to services by home visiting nurses. The last two rows look at depression and developmental referrals a little differently and show those who were positive what percentage were connected with services.

Of note, in 2021, Vermont conducted a successful continuous quality improvement (CQI) project on completed depression referrals. The previous year's CQI project was on increasing our depression screening percentages and at that time a gap was identified regarding completed referrals. Efforts ensued to hold a training for MECSH nurses in the evidence-based Mothers (Partners) and Babies curriculum to leverage further support to address the increased stress and mental health needs of the population during the COVID-19 pandemic. The project led to the development of a policy that clearly defined what was considered a completed depression referral. This project opened discussion around stigma and inequity impacting people seeking help for mental health and resulted in a significant improvement in completed depression referrals from 29% to 97%.

Table 20

| | 2019 | 2020 | 2021 |
|---|---|---|---|
| **Tobacco Referrals** | 95% | 83% | 85% |
| **Intimate Partner Violence Referrals** | 100% | 73% | 100% |
| **Completed Depression Referrals** | 36% | 54% | 97% |
| **Completed Developmental Referrals** | 12% | 29% | 97% |

3. **How effectively are these pathways working for MECSH families?**

When there is a complete workforce amongst the CIS team the pathways for multidisciplinary teaming and specialized services work very well. Barriers include staffing and communication with service providers.

4. **How, and how effectively are the Nurses and Social Care Practitioners delivering universal and specialist health, development, and social services?**

The nurses consistently screen for social determinants of health, health needs and other developmental or specialized services. Screenings, referrals and missing data and outstanding referrals, are tracked by our database, monitored at each program site and statewide, and reported to our federal funders, MIECHV. Care coordination across these domains occurs effectively. The quantitative measure is summarized in Table 20 which captures completed referrals to services for positive screenings. Each

MECSH nurse and team works closely with their health care, CIS team, and other specialty services providers and effectively coordinates the needs of families identified through this program.

## Outcomes of the MECSH Program

1. **What outcomes have been observed for families receiving the MECSH program?**

Nurses shared many outcomes they have observed for children and families enrolled in MECSH. One important outcome as an output of Promoting First Relationships, is observing increased parent attachment and skill development with how parents respond and build connection with their infant. MECSH families have demonstrated other outcomes such as breastfeeding success. For example, supporting parents who have not breastfed before to breastfeed for the first time or who breast feed longer than they anticipated. Other outcomes include increases in utilization of mental health services, young parents staying in school and graduating, increased child-care placements, parents attending groups in the community, parents leaving unhealthy relationships and having increased self-confidence. A wonderful example of increased self-confidence and program outcomes is when young parents early on in MECSH programming feel like they're just staying afloat and then gain confidence through goal setting and achievement, and further adapt their parenting through the information given from the program. Other successes of the program occur when parents develop a vision of their future and become goal directed. For some parents, they have never been asked about their goals.

The table below represents some of the outcome measures taken from the annual report done for the MIECHV grant. This table also outlines further outcome impact of the MECSH program.

Table 21

| | 2019 | 2020 | 2021 |
|---|---|---|---|
| **Breastfeeding (any amount) at 6 Months** | 64% | 50% | 33% |
| **Depression Screening** *(in first 4 months of enrollment)* | 74% | 89% | 95% |
| **Age-Appropriate Developmental Screening Made** *(9 months or 18 months)* | 71% | 66% | 86% |
| **Age-Appropriate IT-HOME Assessment Done** *(1 month, 16 months, 18 months)* | 73% | 81% | 93% |
| **Early Language and Literacy** *(adult in household reads, sings, and/or tells stories to child daily)* | 94% | 77% | 84% |
| **Up to Date with Well Child Visits** | 54% | 90% | 97% |
| **Postpartum Care** | 100% | 84% | 81% |

**2. What outcomes have been observed for the broader child and family population?**

There is a resounding impact on services utilized and connection with the community as an outcome of the MESCH program. One nurse stated, "there is increased connection to referrals as the nurse/client connection increases." What a testament to trust and community partnership! Nurses help families see referrals in a more positive light rather than something to be worried about or afraid of. The nurse client relationship influences the presentation of the referral and through partnership, supports utilization of services. This program helps to reframe one's outlook by challenging constructs and bridging social capital. Families are getting connected to early intervention, physical therapy, occupational therapy, Early Head Start, Head Start, primary, dental, and mental health services, and, have transition plans to other services.

The next data points will show 2 outcome surveys results of data available during this reporting period. The Parent Enablement Instrument is completed 3 times or more during the enrollment, capturing how confident the client is feeling about caring for themselves and their baby as an outcome of the MECSH program.

Table 22

| **Percentage Responding Better/Much Better on PEI Assessment** | | | | | | |
|---|---|---|---|---|---|---|
| | *Cope With Life* | *Understand Baby* | *Cope with Baby* | *Keep Yourself Healthy* | *Confident About Health* | *Able to Help Self* |
| **Q1 2020** | 81% | 95% | 86% | 76% | 70% | 78% |
| **Q2 2020** | 87% | 87% | 80% | 80% | 80% | 80% |
| **Q3 2020** | 91% | 96% | 100% | 91% | 74% | 87% |
| **Q4 2020** | 87% | 91% | 87% | 78% | 65% | 78% |
| **Q1 2021** | 83% | 91% | 91% | 83% | 71% | 77% |
| **Q2 2021** | 89% | 96% | 84% | 91% | 82% | 91% |
| **Q3 2021** | 83% | 94% | 94% | 72% | 72% | 92% |
| **Q4 2021** | 83% | 91% | 89% | 83% | 71% | 77% |

The Parent Satisfaction Questionaries listed in Table 23 are the final quantitative outcome measurement and data points to be reviewed. This survey is also completed anonymously regarding the clients' general satisfaction with their experience with the MECSH program. The Adapt and Self-management data is not available for the reporting period but will be in subsequent reports.

Table 23

| Percentage reporting Agree/Strongly Agree on PSQ Assessment | | | | | |
|---|---|---|---|---|---|
| | *Communication* | *General Satisfaction* | *Interpersonal Manners* | *Time Spent* | *Accessibility and Convenience* |
| **Q1 2020** | 100% | 100% | 95% | 97% | 95% |
| **Q2 2020** | 100% | 94% | 81% | 88% | 88% |
| **Q3 2020** | 100% | 96% | 74% | 96% | 87% |
| **Q4 2020** | 100% | 100% | 100% | 100% | 100% |
| **Q1 2021** | 91% | 91% | 88% | 91% | 91% |
| **Q2 2021** | 100% | 100% | 93% | 98% | 100% |
| **Q3 2021** | 100% | 94% | 97% | 91% | 89% |
| **Q4 2021** | 100% | 95% | 89% | 100% | 97% |

3. **What outcomes have been observed for Nurses and Social Care Practitioners during the MECSH program?**

There were several reports and statements that reflect high job satisfaction. They are all so important and listed here:

- Watching people grow develop.
- Giving families the ability to sit and listen to them.
- Unique opportunity to watch families and teams grow.
- Building relationships with families helps build job satisfaction.
- Predictability that comes with working with the same family.
- Knowing schedule and working with families on schedule. This reduces stress.
- Good reminder to take care and reflect to reduce burn out when working with families.
- Parallel process. Using what we teach with families in our own lives.
- Relating what you're teaching to what you're living.
- Strong team component. Working together and feeling like you are part of something.
- This is the best job I've had, and it delivers nursing care at the preventive level rather than the crisis level.

There were also comments shared about the challenges of the position:

- Burnout related to chasing clients, stress of clients lives, lack of staff.

## Conclusion and Recommendations

This concludes the Triennial report for the first 3 years of program implementation. There have been areas of growth during this three-year period, and certainly many areas of strengths in the MECSH program during this time.

In summary the areas of strength include:

- The majority of clients successfully complete the program.
- Increased ability to have data collection for all focus modules and PEI, PSQ outcomes surveys.
- Creation of a MECSH Steering Committee.
- Quarterly state-wide meetings with all staff for MECSH implementation and Community of Practice.
- Increased numbers of MECSH Trained Trainers.
- Promoting First Relationships additional 14 hours of training for all staff.
- Strong utilization of Maternal Well Being
- Strong linkage to services
- Strong Patient Satisfaction Survey Outcomes

In summary, the areas of opportunity for improvement include:

- BMI data collected at exit as an outcome measure for Healthy Beginnings.
- Increased awareness and universal referrals for MECSH through social media.
- Cohesive platform for all training, programmatic policies, and program documents to be accessed by all Vermont MECSH staff.
- Obstetrical providers and Birth Hospitals referring universally.
- Streamlined Distance Learning checklist for MECSH training.
- Leverage opportunities amongst USA MECSH sites for joint MESCH Training and Communities of Practice.
- Increased prenatal enrollment.
- Increased visit minimum frequency.
- Increased use of Learning to Communicate at all age bands.

**Appendix**

**A.** Children's Integrated Services intake & referral process for Nurse Home Visiting Program (MESCH).