



Home Visiting in Idaho: A Resource for Families

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ID PQC Summit

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Idaho Home Visiting Program**



IDAHO DEPARTMENT OF
HEALTH & WELFARE



Home visiting is a free and **voluntary** service that helps parents and caregivers raise children who are physically, socially, and emotionally healthy and ready to learn.



What does home visiting look like?

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Families are paired with a designated home visitor - typically a nurse, social worker, or other early childhood professional. Home visitors get to know each family over time and tailor services to meet their needs. They provide education and skill-building to support the well-being of young children, ensuring a great start to life.



Who is HV for?

Pregnant women and parents/caregivers of children up to 5 years old.



Where does HV happen?

In families' homes or another location of their choice.



How often does HV happen?

Enrollment = 2+ years
Visits per month = ~1-2
Visit Length = ~1 hour

What can home visiting do for parents?

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Increase their knowledge of early childhood development and positive parenting practices.



Improve their children's health and development.



Provide early screening of developmental delays and offer resources.



Increase their children's school readiness and academic success.



Help them access useful services and community resources.



Help strengthen relationships with their children, their families, and their friends.

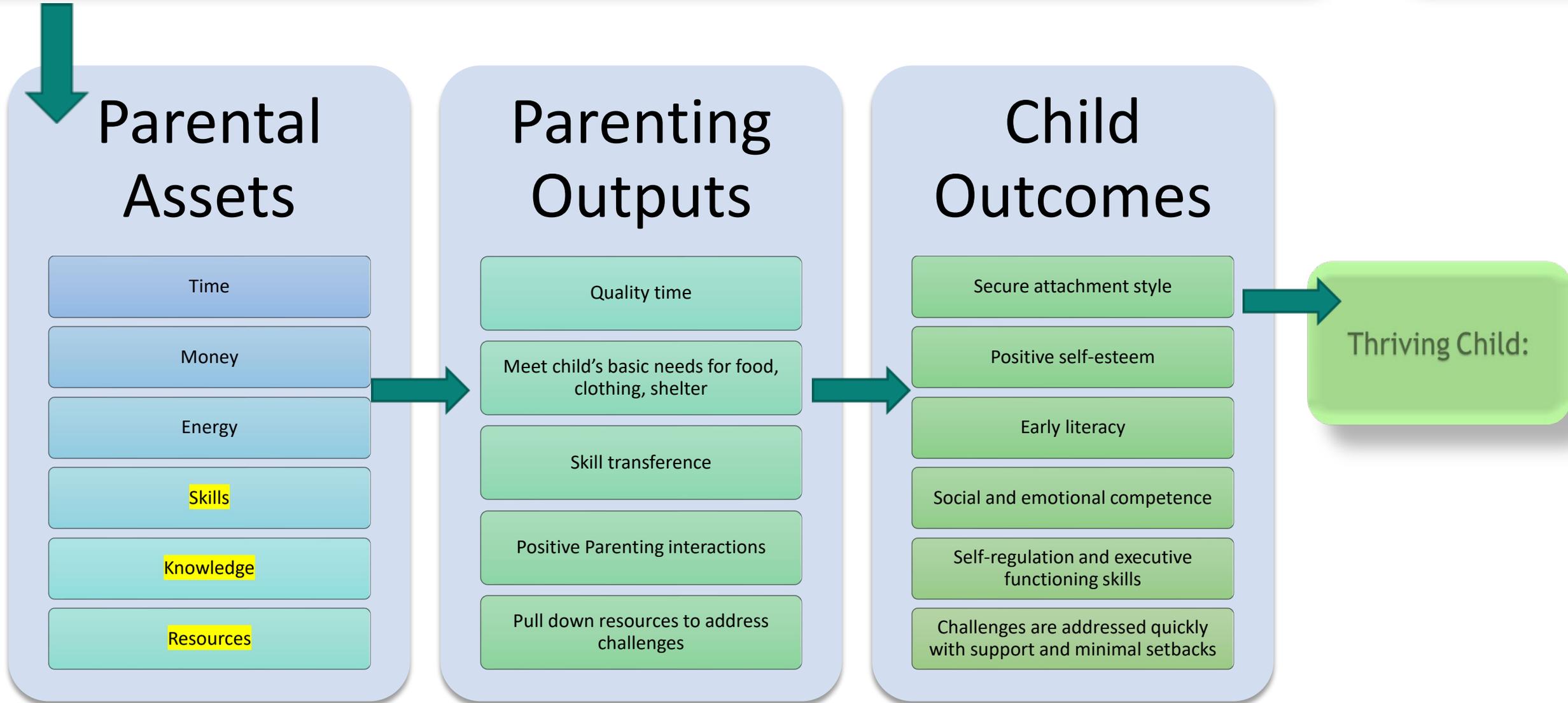
Why is this so important?

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Home Visiting helps children thrive!

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Idaho Department of Health and Welfare

Division of Public Health

Bureau of Family and Child Health

WIC

Maternal Child Health

Home Visiting

Adult and Adolescent Health

Perinatal, Infant, and Child Health

CYSHCN and Newborn Screening



- Health Program Manager
- Subgrant management and monitoring, budgeting, supervision, strategic planning, program oversight

Taryn Yates,
MSW



- Health Program Specialist
- CQI, marketing and communications, subgrant monitoring and support

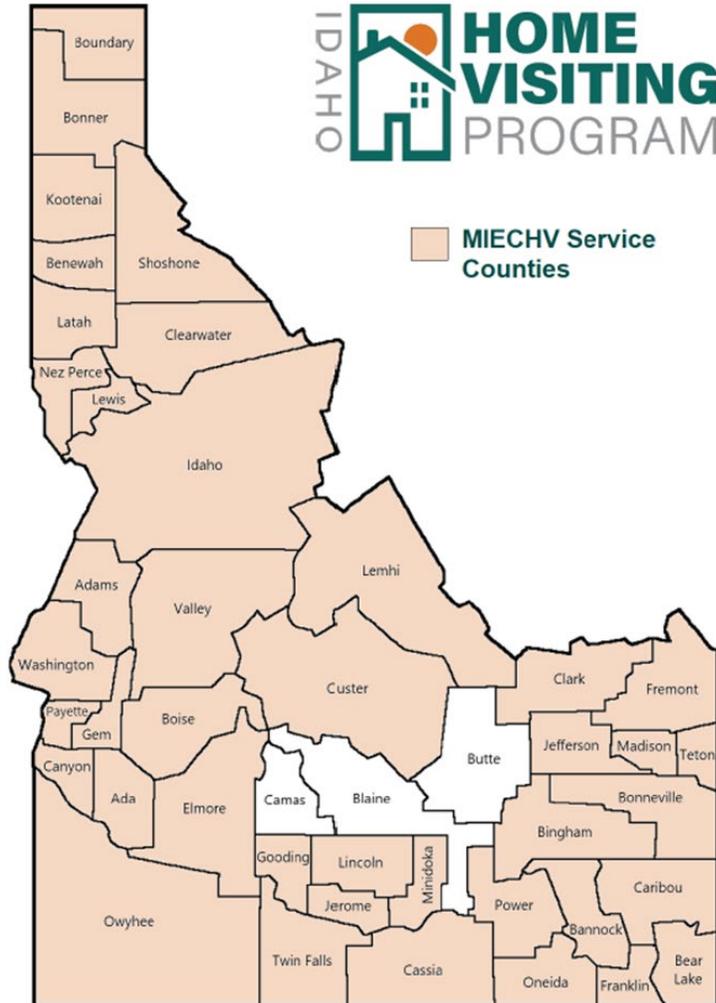
Mariana Loya-
Ponce, MPH



- Health Program Specialist
- Data liaison, professional development and technical assistance, subgrant management

Anika Levinson
LMSW





■ MIECHV Service Counties

The Idaho Home Visiting Program's mission is to serve the most families possible, with the highest quality, evidence-based home visiting models possible.

This requires a focus on expansion, when possible, and ongoing, continuous quality improvement.

Resilient, skilled, and competent home visiting staff are a key aspect to the mission.



- Began with the Maternal, Infant, and Early Childhood Home Visiting program (MIECHV) created in 2010 under Affordable Care Act.
- Programming began in 2011 with four local programs. Idaho MIECHV funded four LIAs: Mountain States Group (Jannus), Community Council of Idaho (CCI), St. Vincent de Paul ICARE, and Panhandle Health District. Services provided in four counties: Jerome, Kootenai, Shoshone and Twin Falls County.
- IHVP now serves 8 local programs in 41 counties.
- In 2018, Idaho dedicated \$1M in state general funds for home visiting.
- Home visiting is Medicaid eligible for PAT and NFP.
- Currently serves 358 families.
- Currently funds 17 home visitor FTE for an average caseload of 21 families per FTE.



The Maternal, Infant, and Early Childhood Home Visiting Grant Program (MIECHV) gathers data on 19 performance measures clustered into 6 overarching benchmarks:

Benchmark Area 1: Maternal and Newborn Health

- Preterm birth, breastfeeding, depression screening, well-child visits, postpartum care, and tobacco cessation referrals

Benchmark Area 2: Child Injuries, Abuse, Neglect, and Maltreatment and Emergency Department (ED) Visits

- Safe sleep, child injury, child maltreatment

Benchmark Area 3: School Responsibilities and Achievement

- Parent-child interaction, early language and literacy activities, developmental screening, behavioral concern inquiries

Benchmark Area 4: Crime or Domestic Violence

- IPV Screening

Benchmark Area 5: Family Economic Self-Sufficiency

- Primary caregiver education, continuity of insurance coverage

Benchmark Area 6: Coordination and Referrals for Other Community Resources and Supports

- Completed depression referrals, completed developmental referrals, IPV referrals



- Low-income (below FPL) ~ 55%
- Pregnant and under 21 years old ~ 13%
- Involvement with child welfare system ~ 9%
- Substance misuse in home ~ 9%
- Tobacco product use in home ~ 19%
- Struggled in school ~ 25%
- Children developmental delays ~ 15%
- Military service ~ 3%

Source: Form 1 Demographics, FFY2023-2024



IHVP

Local Implementing Agency (LIA)

Funding via Subgrants

Continuous Quality Improvement

Connection to resources and other programs

Technical Assistance

Data reconciliation, reporting, and visualization

Home Visitors

Professional Development

Group Reflective Consultation

Infant and Early Childhood Mental Health Endorsement

Individual Reflective Consultation

Continuous Quality Improvement

Facilitation of Peer Connection and Support

Quality Home Visiting programs with resilient, competent staff



Nurse-Family Partnership

- Home visitor is a Nurse.
- Serves women who enroll at or prior to 28 weeks gestation until their child is 2 years old. Only serves first time moms.

Primary model goals:

- Family economic self-sufficiency.
- Increased pregnancy outcomes.
- Healthy child development.

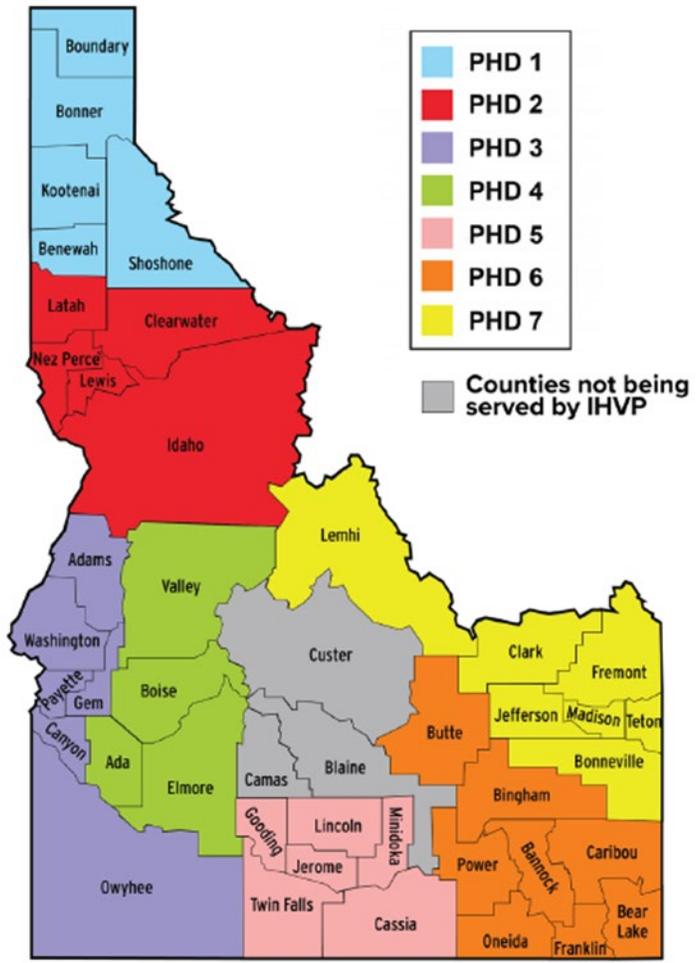
Parents As Teachers

- Home visitor usually has a degree in Early Childhood or a related field, or equivalent experience.
- Serves pregnant women and parents with children birth through five years old.
- Includes a monthly “Group Connection” meeting to allow parents to socialize with each other to form relationships and build social connections.

Primary model goals:

- Increase parent knowledge of early childhood development and parenting practices.
- Provide early detection of developmental delays and health issues.
- Prevent child abuse and neglect.
- Increase children's school readiness and school success.

How to make a referral: Health Districts



**To enroll,
contact the
local Health
District:**

- | | | |
|--|--|--|
| 1. Panhandle Health District
208-415-5298
Nurse-Family Partnership
Parents as Teachers
HVPprograms@phd1.idaho.gov | 3. Southwest District Health
208-455-5428
Nurse-Family Partnership
Parents as Teachers
Adriana.villamil@swdh.id.gov
parentsasteachers@swdh.id.gov | 5. South Central Public Health
208-737-5969
Parents as Teachers
kalexander@phd5.id.gov |
| 2. Idaho North Central District
208-799-3100
Parents as Teachers
Homevisit@phd2.idaho.gov | 4. Central District Health
208-327-8629
Parents as Teachers
pat@cdh.idaho.gov
Nurse-Family Partnership
spencer@cdh.idaho.gov | 6. Southeastern Idaho Public Health
208-239-5248
Parents as Teachers
pat@siph.id.gov |
| | | 7. Eastern Idaho Public Health
208-533-3194
Parents as Teachers
patprogram@eiph.idaho.gov |



- Krystina.Bownman@byfhome.com
- Serving families in southeastern Idaho counties beginning Fall 2025.



Capacity Today

- Waitlists in most districts due to expanding need.
- HDs are using revenue from Medicaid billing to expand programs, but program building takes time.
- New HVs are being hired and trained.

Potential Tomorrow

- Federal funding has built in increasing match funds over the next few years, but spending authority will be required.

Stories from the Field

**Michelle Worth, Parents As
Teachers Home Visitor
Southwest District Health**





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