

State-based Home Visiting

Strengthening Programs through State Leadership

Kay Johnson

February 2009



The National Center for Children in Poverty (NCCP) is the nation's leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Using research to inform policy and practice, NCCP seeks to advance family-oriented solutions and the strategic use of public resources at the state and national levels to ensure positive outcomes for the next generation. Founded in 1989 as a division of the Mailman School of Public Health at Columbia University, NCCP is a nonpartisan, public interest research organization.

State-based Home Visiting: Strengthening Programs through State Leadership

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This report examines whether states are investing in home visiting in ways that promote better outcomes for young children and whether they meet the needs of children facing the greatest social and developmental risks. The purpose was to assess the direction of state policies and programs, not to evaluate program effectiveness.

AUTHOR

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Executive Summary

A home visiting program may be distinguished by asking three questions: Does the program design assume home visits as the primary method for delivering the intervention? Are a majority of services delivered (or a majority of clients served) through home visits? Are staff trained to deliver services and supports through home visits?

Introduction

Home visiting for families with young children is a longstanding strategy offering information, guidance, risk assessment, and parenting support interventions at home. The typical “home visiting program” is designed to improve some combination of pregnancy outcomes, parenting skills and early childhood health and development, particularly for families at higher social risk.

This report is designed to help inform the field about two central questions related to home visiting:

- 1) Are states investing in home visiting in ways that promote improved outcomes for young children?
- 2) How, in this context, do they meet the needs of those facing the greatest social and developmental risks?

The report describes the results of an NCCP survey and a roundtable discussion, each designed to increase knowledge about state-based home visiting programs, that is, those administered, managed, or coordinated by state governments.

Survey Design, Methods, and Results

The study focused on two core questions:

- 1) What is the overall approach? For example, do state agencies administer, fund local jurisdictions directly, or provide technical assistance)?
- 2) Has the state undertaken interagency planning regarding home visiting and how has that planning occurred?

For each program, we examined:

- ◆ purpose, structure and approach;
- ◆ authority/management;
- ◆ linkages to other programs;
- ◆ funding – sources and budgets;
- ◆ intervention design and support; and
- ◆ evaluation and outcomes.

In total, 46 states submitted survey responses, and of these 40 reported having one or more state-based home visiting programs.

Key Findings

- ◆ State-based home visiting programs were reported by 40 states, representing 70 distinct programs. Most states described one or two state-based home visiting programs. Five states reported on three or more home visiting programs, including Pennsylvania, Virginia, Illinois, Massachusetts, and Oregon.
- ◆ Seventeen programs across 14 states are using widely recognized home visiting program models. These included the: Healthy Families America, HIPPI, Nurse-Family Partnership, and Parents as Teachers.
- ◆ Interagency planning efforts were reported for 34 states. Fifteen states reported a focus on developing a continuum of home visiting services based on family risks and needs.
- ◆ Across 10 states, 16 programs use federal funding alone.
- ◆ Thirty-one states reported using general revenues not used for matching (such as appropriations for education, health, child welfare, etc.).
- ◆ The aggregate support for the 30 states reporting specific budget levels for 55 programs reached more than \$250 million in funds allocated.
- ◆ In 31 states, 55 programs use an approach intended to provide more intensive services to families with identified risks and needs.

How States are Strengthening Home Visiting

States are using two key strategies to improve the effectiveness and cost-effectiveness of home-based services. One strategy is to improve linkages and aim for a more seamless continuum of services. A second strategy is to focus on improving the quality of home visiting services, which might take the form of improved training and supervision for staff, better data collection, enhanced evaluation, or other activities. Both require leadership and each has the potential to maximize available resources.

Recommendations

National Leadership

National leaders, both public and private can to assist home visiting programs and ultimately families through:

- ◆ the creation of multi-state learning collaboratives;
- ◆ more research on how to effectively deliver different models of service;
- ◆ federal leadership to support state and local programs;
- ◆ federal legislation that supports state home visiting efforts; and
- ◆ an increase in the understanding of the role and limits of home visiting in the early childhood agenda.

State-level Leadership

State leaders can improve the quality of home visiting services, more effectively replicate model programs, and link home visiting programs to other efforts focused on promoting optimal early childhood health and development by:

- ◆ implementing deliberate strategies, policies and program designs to achieve quality and improved child and family outcomes from their investments in home visiting;
- ◆ strengthening mechanisms for interagency and cross-program coordination;
- ◆ helping communities and programs align the home visiting intervention with family needs;
- ◆ supporting a continuum of early childhood services that can address a wide range of family needs and achieve results in a cost-effective manner;
- ◆ refining and narrow program objectives and outcome measures;
- ◆ promoting quality and assuring staff training and supervision;
- ◆ analyzing current spending on home visiting programs to blend funding where appropriate; and
- ◆ supporting research and data systems that expand knowledge of programs and gaps.

Introduction

This report is designed to help inform the field about two central questions related to home visiting:

- 1) How are states investing in home visiting in ways that promote improved outcomes for young children?
- 2) How, in this context, do they meet the needs of those facing the greatest social and developmental risks?

Our purpose was to assess the direction of state policies and programs, not to evaluate program effectiveness.

The report first discusses the nature of home visiting programs, and then highlights the results of a survey on how state-based home visiting programs are structured and financed and respond to diverse family needs. The third section describes how states are strengthening home visiting programs. It details three state strategies. The fourth section illuminates major points that surfaced as a result of an NCCP roundtable on the role of home visiting in serving more vulnerable, higher risk families. The report ends with conclusions and recommendations for national and state-level leadership.

Setting the Context

Home visiting for families with young children is a longstanding strategy offering information, guidance, risk assessment, and parenting support interventions at home. As with terms such as “outreach” and “case management,” the label “home visiting” has taken on many meanings and is often seen as a tool to cure a variety of ills among families with children at medical or social risk. Home visiting was used systematically in the U.S. at the turn of the 19th century and early in the 20th century,¹ and is now undergoing a resurgence.

Today, while many programs use home-based service delivery, the typical “home visiting program” is designed to improve some combination of pregnancy outcomes, parenting skills and early childhood health and development, particularly for families at higher social risk. Home visits are used to deliver a variety of services; however, most are aimed at improving parents’ capacity and skills and children’s health and developmental outcomes.^{2 3 4 5 6 7 8 9} When funded by government, such programs generally target low-income families who face excess risks for infant mortality, family violence, developmental delays, disabilities, social isolation, unequal access to health care, environmental exposures, and other adverse conditions.

A home visiting program may be distinguished by asking three questions:

- 1) Does the program design assume home visits as the primary method for delivering the intervention?
- 2) Are a majority of services delivered (or a majority of clients served) through home visits?
- 3) Are staff trained to deliver services and supports through home visits?

Home visiting programs have special characteristics that make them distinct from most center-based programs. Home visiting programs deliver services and supports in the home where family life takes place, making it useful in serving hard-to-reach families where knowledge about a family’s day-to-day life can be especially helpful in tailoring services. An additional benefit is the opportunity to model appropriate parenting and life skills when problems arise in the home environment. Another feature is one-to-one contact. While not unique to home visiting, the general approach of these programs offers a greater opportunity to build a supportive and continuing one-to-one relationship between provider and family.

Program models vary not only in purpose but also in structure, intensity, and effectiveness. Home visitors may be professionals (such as nurses or social workers) or trained community workers, often called paraprofessionals. The duration and frequency of services vary considerably.¹⁰ Most programs begin during pregnancy or soon after the birth of a child, while others do not begin interventions until some identified risk or seminal event triggers action (such as suspected child abuse, developmental delay, special health needs). Some efforts are intended to promote school readiness¹¹ and are more likely to serve preschool age children, as opposed to the birth-to-age-three population.

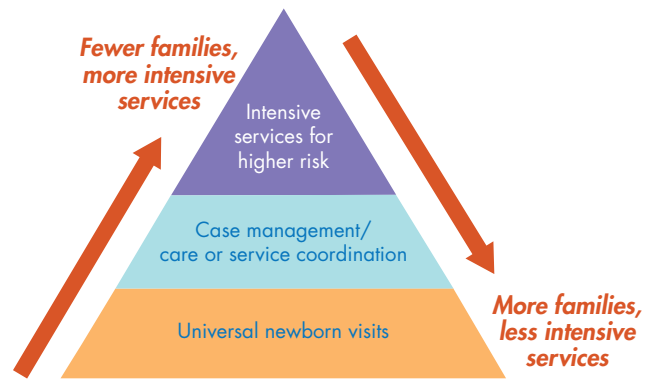
Several important research and demonstration projects have advanced the current state of the art in home visiting programs, including the Project Child Survival/Fair Start,¹² Nurse Family Partnership,¹³ Infant Health and Development Program,¹⁴ and Hawaii’s Healthy Start program.¹⁵

Currently, leading models used in home visiting programs include: Parents as Teachers (PAT), Healthy Families America (HFA), Home Instruction Program for Preschool Youngsters (HIPPY), Nurse-Family Partnership (NFP). Early Head Start and Part C Early Intervention programs also deliver a majority of services through home visits. (See box.)

Research tells us that a range of program options can help fit the needs of different families through different supports and services.¹⁶ The *purpose* of the program also may drive the choice or intensity of the intervention. For example, different approaches would be used to provide: resource and referral for families with a new baby (as in “welcome every baby”), care coordination when a mother or child has complex health needs, or an intensive intervention for a family at high social risk. Figure 1 illustrates how different approaches fit in a continuum, from more-to-less intensive.

Notably, some states have undertaken focused efforts to build a continuum of services and supports by aligning the purposes of programs, tailoring efforts to specific groups of children and families, and linking home-based early childhood interventions to center-based services. A few have aimed to align programs to assure a home visit for

Figure 1: Working Across a Continuum



Source: Johnson, 2007.

every family (so called “universal” approaches). Efforts to build linkages and a continuum of service are of particular value if the aim is to support early childhood health and development. There is no magic bullet or single approach that will assure optimal development. As described by Daro: *“the rapid expansion of home visitation... has been fueled by a broad body of research that highlights the first three years of life as an important intervention period for influencing a child’s trajectory and the nature of the parent-child relationship rather than on positive findings regarding a specific service model.”*¹⁷

As described elsewhere, many program evaluations, including randomized trials, have been conducted for these models.^{18 19 20 21 22} Ongoing efforts are aimed at quality improvement. Several systematic reviews have also been conducted to assess the overall effectiveness of these efforts.²³ In general, this research indicates that the characteristics of effective programs include: an intervention designed appropriately to fit family needs, home visitor qualifications to fit program design, ongoing staff training and supervision, cultural competency, family-centered approaches, and appropriate intensity and duration through frequent home visits.²⁴ Ongoing quality improvement has been recognized as essential by each of the major home visiting models.²⁵

Programs Extensively Using Home Visiting and Home-based Service Delivery

Early Head Start Created in 1994, Early Head Start is a federally funded community-based program for low-income families with infants and toddlers and pregnant women. Its mission is to promote healthy prenatal outcomes for pregnant women, enhance the development of very young children, and promote healthy family functioning. The more than 700 Early Head Start projects across the country offer services through center-based, home-based, and combination program options. The Head Start Program Performance Standards provide specific quality standards for the provision of Early Head Start services. For more information on Early Head Start, please go to: www.headstartinfo.org/infocenter/ehs_tkit3.htm (Also see box below on Early Head Start Evaluation.)

Healthy Families America (HFA) HFA exists in over 430 communities in 35 states. The national program goals are: to promote positive parenting, to enhance child health and development, and to prevent child abuse and neglect. Initially, this model drew largely from research and experiences of the Hawaii Healthy Start program. The model uses trained family support workers to make home visits. The program was launched in 1992 by Prevent Child Abuse America (formerly known as the National Committee to Prevent Child Abuse). HFA is built on a set of 12 research-based benchmarks and has a credentialing system. Approximately 30 evaluations have been or are currently being conducted at the state or site level across the country. For more information on HFA, please go to: www.healthyfamiliesamerica.org.

Home Instruction for Parents of Preschool Youngsters (HIPPIY) HIPPIY is a parent involvement, school readiness program operating in 146 sites across 25 states that helps parents prepare their 3-, 4-, and 5-year-old children for success in school and beyond. Based on the curriculum, each participating parent is provided books and materials designed to strengthen their children's cognitive skills, early literacy skills, and social/emotional and physical development. This international program, started in Israel in 1969 as a research and demonstration project, was launched in the United States in 1984. Guidelines, program credentialing, and self-assessments undergird program quality efforts.

Healthy Start The federal Healthy Start program operates in 37 states in 97 communities where the infant mortality rate is above 150 percent of the national average. It has been successful in reducing rates of infant mortality. Healthy Start uses a community-based approach to address infant mortality, including initiatives that engage social workers, medical providers,

and community leaders. Evaluations have found that the major advantage of being a Healthy Start client is the receipt of case management, both during the prenatal and the interconception care periods. A majority of these case management services are delivered through home visits, and some Healthy Start sites use nationally recognized models for prenatal and infant home visiting. For more information on Healthy Start, please go to: <http://mchb.hrsa.gov/about/dhsp.htm>.

Nurse Family Partnership (NFP) NFP is a nonprofit organization serving more than 20,000 mothers in over 200 sites in 20 states across the United States. Based on the model developed and studied by David Olds and his colleagues, NFP uses trained nurses to deliver services to first-time mothers, beginning prenatally. The NFP has rigorous standards, highly developed clinical protocols, and maintains data on its interventions and outcomes. For more information on NFP, please go to: www.nfp.org.

Parents as Teachers (PAT) PAT is an early childhood parent education and family support program serving families throughout pregnancy until their child enters kindergarten. Launched in the 1970s by Missouri educators, the program has spread to more than 3,000 sites across all 50 states. In 1999, "Born to Learn" (a curriculum model that uses home visits and group meetings) became the official curriculum for all PAT sites serving families with children birth to three. PAT released standards and a self-assessment guide in 2004. A major evaluation was released in 2007. For more information on PAT, please go to: www.patnc.org.

Part C Early Intervention Created under the Individuals with Disabilities Education Act (IDEA), Part C Early Intervention programs provide services to infants and toddlers (from birth to the third birthday) who have developmental disabilities and delays, have diagnosed conditions highly likely to lead to delays, and, at state option, are at risk for delays. Eligible children and families are entitled to certain services under an Individualized Family Service Plan (IFSP). In 2006, more than 85% of Part C Early Intervention services for enrolled children were delivered at home and all but three states delivered more than half of all Part C services at home. Only five percent of Part C services were delivered in community settings such as clinics or early intervention centers. An increasing proportion of services are delivered in-home. All state programs are monitored by the federal government, and most have been privately evaluated. For more information on Part C, please go to: www.nectac.org.

Survey Design, Methods, and Results

The purpose of this survey was to increase knowledge about state-based home visiting programs, that is, those administered, managed, or coordinated by state governments. These state-based programs may be funded fully or in part with public dollars. They include programs that operate statewide or only in one city in the state, based on their fiscal and administrative structures in relationship to state government. They do not include all of the many community-based home visiting programs. Although an increasing number of programs that started in one community have become part of statewide efforts, many remain free-standing local efforts.

The survey results also exclude Early Head Start/Head Start, Healthy Start Infant Mortality Reduction, Part C Early Intervention, and Title V Children with Special Health Care Needs care coordination programs that provide a proportion of their services in-home. They are not included because these programs do not assume home visits as the primary method for delivery of their interventions and services. For example, while a majority of Part C Early Intervention services (such as physical therapy) may be provided in the families' homes, the program design does not assume this as the primary delivery method. Similarly, many care coordination services in Healthy Start are offered in-home; however, the program design assumes an array of services and supports delivered in a range of settings including the home, in medical settings, and in the community. Some Early Head Start programs do provide only home-based service, but this is a local program option.

To design the survey, a literature review of published sources and key informant interviews with national project directors, researchers, and key federal and state agency staff were conducted. The survey instrument was prepared by NCCP, based on a similar survey conducted in 1998 but updated to elicit new information.²⁶ The 15-question instrument was piloted with three states and revised. State maternal and child health program directors were asked to identify programs and staff in state government who were responsible for home visiting

activities. Three attempts were made to obtain complete information from each state, using email, fax, and telephone methods.

The following topics were included in the survey to identify key program characteristics of state-based home visiting programs and, to the extent it exists, an overall state approach to rationalizing the delivery of home-based services.

State approach to home visiting – What is the overall approach (as in, do state agencies administer, fund directly to local jurisdictions, provide technical assistance)? Has the state undertaken inter-agency planning regarding home visiting and how has that planning occurred?

For each program:

- ◆ **Purpose, structure and approach** – What is the primary purpose of the intervention (improve birth outcomes, promote early learning, prevent child abuse and neglect)? How is the program structured and does it operate statewide?
- ◆ **Authority** – Is the program linked to a legislative mandate or legislated content? What unit of government administers the program?
- ◆ **Linkages** – What formal linkages exist between this program and others?
- ◆ **Funding** – What are the sources of current funding (federal, state, philanthropic, corporate)? What is the annual program budget?
- ◆ **Intervention design and support** – Is the program based on or associated with well-known models? Is the intervention designed to provide more intensive home visiting services to families with identified risks and needs (such as risks related to maternal depression, child abuse and neglect, substance abuse)? Are staff trained to address such needs?
- ◆ **Evaluation and outcomes** – Is there a formal evaluation associated with this program? What are the desired outcomes? For example, 1) child characteristics such as improvements in physical health, mental health, disability, early child development, and educational success; 2) maternal/

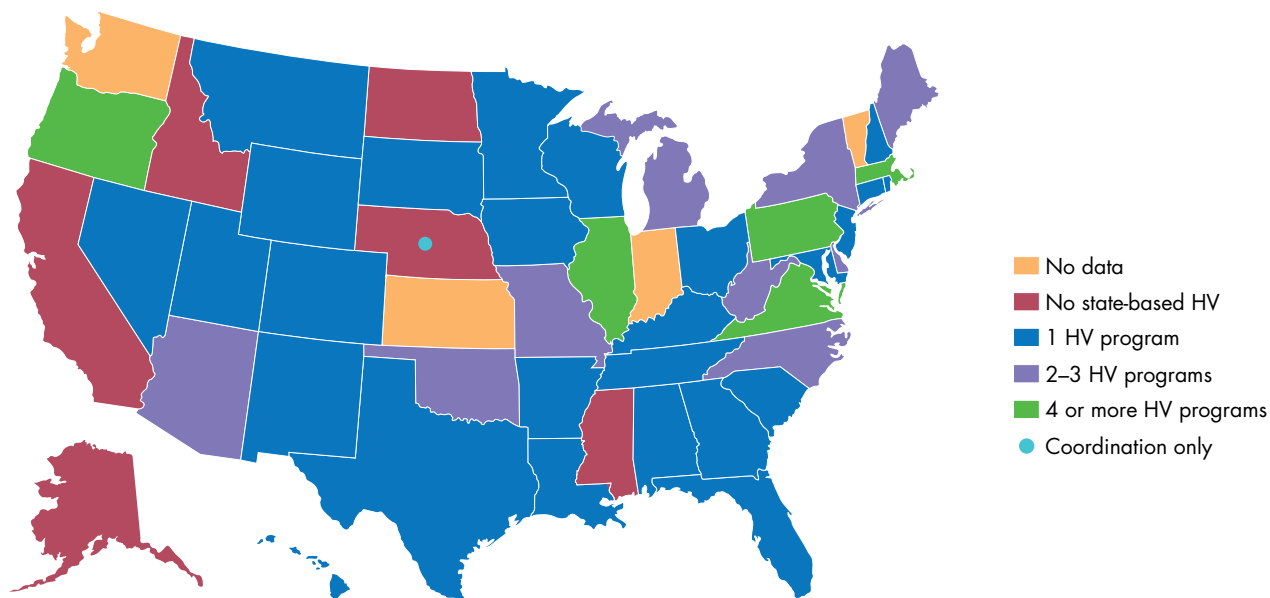
parent characteristics such as improvements in education and employment, physical health, pregnancy timing and spacing, mental health, parental care giving skills, and substance abuse including alcohol, drugs, tobacco; and 3) decreased need for government services, such as health coverage, foster care, child abuse and neglect, and income support.

Overall, 46 states responded to the survey. Data are presented for the 40 states that reported they have state-based home visiting programs or coordination efforts (See Figure 2). Notably, in Nebraska, the state’s role is more coordination than program administration and is not included in the counts below. Five states reported that they did not have a state-based home visiting program. As mentioned above, for purposes of this report,

we have excluded data on: Early Head Start, Head Start, Healthy Start Infant Mortality Reduction, Part C Early Intervention,* and Title V Children with Special Health Care Needs care coordination programs (While a few states reported on the home-based services delivered in these programs, these responses are not included in this report.).

Thus, our findings are based on data from 40 states, which submitted survey responses for 70 programs. (See Appendix A for a list of states responding.) Most states described one or two state-based home visiting programs. Five states reported on three or more home visiting programs. This group includes information on more than 10 programs in Pennsylvania and Virginia, as well as three or more in Illinois, Massachusetts, and Oregon.

Figure 2: State-based Home Visiting Programs



*An exception is Ohio, where the Part C Early Intervention Program has been integrated with a discrete home visiting approach in a program called Help Me Grow. The home visiting portion of the program is counted here. Vermont is considering a similar integrated services approach blending Part C Early Intervention, home visiting and early childhood mental health services.

Findings

Structuring State-based Home Visiting Programs

Our survey asked about several characteristics of the state's approach and the structure of individual programs within that approach. The approach and expectations matter for state-based programs and, potentially, have an influence on other local programs. State structures may or may not be guided by legislative authority or funding requirements. There is particular interest on whether or not states have undertaken interagency or cross-program planning and about whether or not there is a statewide vision for a continuum of service. The survey also gathered information in an attempt to understand the linkages among home visiting programs and between home visiting and other early childhood services and supports. Our findings are as follows.

States were asked about their overall approach to home visiting. Of the 40 states reporting, 33 have state-level management/administration of their state-based home visiting programs, with four reporting that the state gives funds directly to local entities to administer one or more programs. Eight additional states play other roles (for example coordinating a group of local programs, providing systematic technical assistance, developing guidance, etc.).

Across 24 states, 32 programs operate under legislative mandate or with legislated content.²⁷ This does not include programs delivering home based services, such as Head Start, Early Head Start, Healthy Start Infant Mortality Reduction, Part C Early Intervention, or Title V Children with Special Health Care Needs programs.

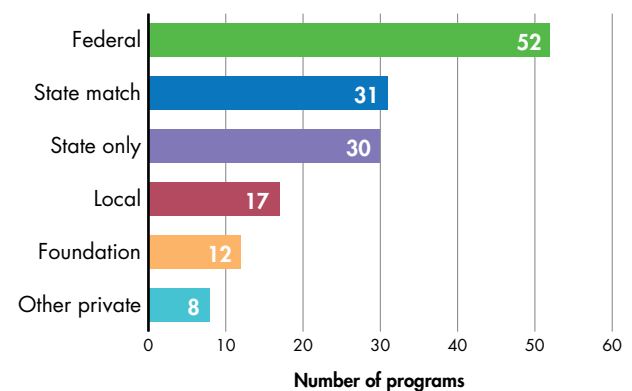
Interagency planning efforts were reported for 33 states. Fifteen states reported a focus on developing a continuum of home visiting services based on family risks and needs. For some states, these efforts were designed to develop mechanisms to link home visiting programs to one another (13) or to center-based early childhood programs (5) or other programs (18).

The survey also asked about existing linkages that support these home visiting programs. Home visiting programs were linked to other home-based programs in 25 programs in 13 states. Formal linkages to center-based early care and education were reported in 24 programs across 13 states home visiting programs. Nine states reported both other home-based and center-based program linkages (Florida, Illinois, Kentucky, Maine, North Carolina, Oklahoma, Pennsylvania, South Carolina, and Virginia).

Financing State-based Home Visiting Programs

In this survey, 40 states reported on the sources of funding used to support 69 home visiting programs. (See Figure 3.) Across 10 states, 16 programs use federal funding alone. Federal funds typically include Title V Maternal and Child Health Services Block Grant, Temporary Assistance for Needy Families (TANF), and Medicaid Federal Financial Participation. When Medicaid or Title V dollars are used, states are required to match federal funding and such funds are being used for 31 programs. Federal grant programs that provide resources to local community projects are sometimes used to support a larger home visiting initiative, such as Healthy Start and Early Head Start.

Figure 3: Sources of Funds for Home Visiting Programs



In addition, 31 states reported using general revenues not used for matching (such as appropriations for education, health, child welfare, etc.). Some of these state funds come from tobacco settlement dollars. Of the reporting states, five reported using only state general revenues to finance their home visiting programs.

Other funding sources are less widely used. A few states use local public funds (as in county taxes or school funds) to support these state-based home visiting programs. Only a small number reported using private foundation and other private funds (such as United Way).

Fewer states were able to report the annual budget for their home visiting programs. The aggregate support for the 31 states reporting specific budget levels for 55 programs reached more than \$250 million in funds allocated. These figures are consistent with a recent report of the National Conference on State Legislatures, *Early Care and Education State Budget Actions*, which compiled data provided gathered through a survey of state fiscal staff in the 50 states and territories.²⁸ Previous reports show similar distribution of funds.²⁹

As found in the 1998 survey of state-based home visiting programs, the size of home visiting budgets is not strongly correlated with the size of the states' population overall. For example, on a per capita basis, states with small child populations such as Hawaii, Maine, West Virginia, Delaware, Arkansas, and Connecticut, are spending more than larger states. Moreover, medium size states such as Oregon, Kentucky, and Massachusetts reported substantial per-child investments in home visiting.

Designing Home Visiting Programs to Meet Family Needs

Research has shown that the design and implementation of home visiting programs matter very much to their outcomes. While our study did not seek to evaluate or even to collect outcome data from the surveyed programs, it did collect information about how states are designing their programs. The results tell us about what program models are being used and how states are blending models. Since one of the purposes of this study was to understand how

states are aiming to serve families with higher risks and needs, we asked whether or not the program was intended to serve such families and if staff were trained to screen and intervene for risks. The survey also asked about evaluation activities and about the intended outcomes of the state-based home visiting program. Our findings are as follows:

- ◆ Seventeen programs across 14 states are using widely recognized home visiting program models. These included the: Healthy Families America, HIPPIY, Nurse-Family Partnership, and Parents as Teachers.
- ◆ Another 14 programs in 14 states are using multiple program models and blended designs. Past work indicates that some states have adapted an approach that is a combination of what they believe is effective, what they have the resources to provide, and/or what local communities will accept. They also may want to go beyond a model such as Nurse-Family Partnership, which is designed for first-time families and uses nurses as staff.
- ◆ In 31 states, 55 programs use an approach intended to provide more intensive services to families with identified risks and needs. Among these programs, staff support varies. Staff receives training to screen for risks in 82% (45 programs) and training in how to intervene in 71% (39 programs). Staff routinely has specialist professional back-up support in fewer programs (31 programs).
- ◆ Evaluations were underway or completed in 39 programs across 30 states.
- ◆ States reported using multiple broad objectives for their home visiting programs. State agency staff was asked to select outcome objectives from three categories; those aimed at improved child characteristics, improved parent characteristics, or decreased need for government services. The most frequently identified categories were early childhood development, physical health of the child, and parenting, each at approximately 70%. Less than half of these programs reported objectives to prevent childhood disability or improve maternal mental health.

Supporting Evidence-based Home Visitation Programs to Prevent Child Treatment

On Sept. 30, 2008, the Administration for Children and Families, Children's Bureau announced the award of 17 cooperative agreements in 15 states to support the state and local infrastructure needed for the high quality implementation of existing evidence-based home visiting programs to prevent child maltreatment. The awards are up to \$500,000 per year for five years. The program goals are: 1) to build state and local infrastructure and implement systems changes designed to spread the use of evidence-based home visiting programs; 2) to support the implementation of specific evidence-based home visiting approaches within selected target populations, and with strong fidelity to proven, effective models; 3) to conduct rigorous local evaluations examining the degree to which system change has occurred, the effects of home visiting programs in reducing child maltreatment and achieving other family and child outcomes; and 4) to conduct a cross-site evaluation drawing data and cross-cutting lessons from the grantees' local evaluations. Mathematica Policy Research, Inc. and Chapin Hall Center for Children have been selected to conduct a cross-site evaluation.

The following 17 sites were selected: University of Oklahoma- Health Sciences Center, Oklahoma City, OK; The Children's Trust Fund of South Carolina, Columbia, SC; Child and Family Tennessee, Knoxville, TN; County of Solano Department of Health and Social Services, Fairfield, CA; Rady Children's Hospital, San Diego, CA; Illinois Department of Human Services, Springfield, IL; Minnesota Department of Health State Treasurer, St. Paul, MN; Le Bonheur Community Outreach, Memphis, TN; Rochester Society for the Prevention of Cruelty to Children, Rochester, NY; DePelchin Children's Center, Houston, TX; St. Vincent Mercy Medical Center Foundation, Toledo, OH; Rhode Island KIDS COUNT, Providence, RI; Utah Department of Health, Salt Lake City, UT; Colorado Judicial Department, Denver, CO; State of Hawaii Department of Health, Honolulu, HI; Children and Families First Delaware, Inc., Wilmington, DE; State of New Jersey Department of Children and Families, Trenton, NJ.

For more information, contact Federal Project Officer Melissa Brodowski, Children's Bureau, Office of Child Abuse and Neglect at: Melissa.brodowski@acf.hhs.gov.

How States are Strengthening Home Visiting Programs

Some states have deliberately designed statewide home visiting programs ("top-down"), while others are trying to support and coordinate a number of programs that were developed by communities ("bottom-up").³⁰ A majority of states are trying to mix and match services models in order to best meet families' needs. Program funding and service capacity often drive decisions. At the same time, a number of states have deliberately undertaken efforts to strengthen and stretch their home visiting programs.

States are making use of two key strategies to improve the effectiveness of home-based services. One strategy is to improve linkages and aim for a more seamless continuum of services. For some, this work begins by developing an inter-program, interagency approach for linking home visiting programs. In other states, key stakeholders are aiming to link both traditional home visiting programs and other home-based services such as Early Head Start and Part C Early Intervention.

A second strategy is to focus on improving the quality of home visiting services, which might take the form of improved training and supervision for staff, better data collection, enhanced evaluation, or other activities. Both require leadership and each has the potential to maximize available resources.

State leadership to create a continuum of services

- ◆ Gubernatorial initiatives to create a continuum of early childhood services, with intensive review and coordination among home visiting programs (Oregon and Virginia).
- ◆ Interagency task forces or planning groups making recommendations to improve continuum and better allocate resources (Virginia, New Jersey, New Mexico, and Pennsylvania).
- ◆ System designs intended to provide universal service capacity along a continuum of needs and services (Maine).

- ◆ Integrated home visiting with Part C Early Intervention (Ohio) or linkages among home visiting, Part C early intervention, and early childhood mental health services (Vermont).

State support for quality improvement

- ◆ Coalitions of home visiting programs to advance evidence-based practice, training, and coordination (Colorado and Nebraska).
- ◆ State leadership and support for training, quality assurance, technical assistance, evaluation and funding to all counties (Kentucky).
- ◆ Intensive evaluations and reporting (Kentucky, New York, and New Hampshire).

Highlights of efforts in two states – Maine and Virginia – illustrate some of the ways states are strengthening their home visiting programs. Each of these states has been guided by a cross-system group of professional leaders and administrators. (Note, as mentioned above, other states have undertaken similar efforts.) While they are at different stages of development and implementation, each of these examples shows how a state can build on existing efforts.

Coordinating Programs toward Universal Access in Maine

Maine has made a commitment to supporting families with young children to ensure healthy development and school readiness. In 1998-99 the state convened a task force on strategies to support parents as children's first teachers. They identified three key strategies:

- 1) home visiting services for all new parents;
 - 2) support for parents as children's first teachers; and
 - 3) family support services, including quality child care.
- The task force went further to identify the characteristics of effective home visiting programs, recommend the development of a core curriculum for parents and caregivers, and identify ways to improve current community-based services. They also outlined a fiscal plan for expansion of state-funded child and family support initiatives, including use of tobacco settlement monies for prevention efforts.

Universal home visiting is a key initiative of the Maine Children's Cabinet and the Task Force on Early Childhood. The Maine Home Visiting Program is offered universally to any first-time family regardless of the parents' level of risk, education or income. Home visiting is also available to teen parents even if they already have other children. Families are served in all counties across the state, and while different models of service are available (such as Healthy Families America, Parents as Teachers, Parents Are Teachers Too), all programs operate under Standards of Practice developed from national evidence and best practices.

The overall program is administered by the Maine Office of Child and Family Services, Early Childhood, in partnership with the Maine Center for Disease Control, Division of Family Health (Title V agency).

The program provides nearly \$5 million in grants to community agencies that maintain sites within each of Maine's counties. Local efforts are also supported by a mixture of other public and private funding. Services are offered on a voluntary basis, at no cost to families.

In fiscal year 2008, this state-based approach with local service providers served 2,801 families through 21,595 home visits. More than one-third of families served enroll in the prenatal period. Services are available through age 4. Each of the home visiting programs offers periodic child development assessments, parent education and support, and linkage to other community programs and resources. Program services are designed to enhance family functioning through support for trusting relationships, problem-solving skills, and family's natural support systems. Healthy child development, founded in positive parent-child interaction, is supported through a focus on child development and attachment. The state has emphasized development of a sustainable professional training infrastructure for providers and adoption of the Brazelton Touchpoints, as an evidence-based approach for enhancing the competence of parents and strengthening parent-child relationships.

For more information, visit: www.maineamilies.org or contact: sheryl.peavey@maine.gov

Supporting a Continuum of Services in Virginia

In Virginia, Governor Kaine established the Working Group on Early Childhood Initiatives to coordinate executive branch efforts on early childhood programs and strengthen public and private programs. The working group, chaired by the secretary of education, brings together high-level staff from cabinet offices and state agencies in the areas of education, health and human resources, economic development, finance and policy. The first goal of Virginia's early childhood initiative is to engage all sectors and create and sustain state and local collaborative entities to secure public and private investments; develop and expand programs; and provide effective coordination, oversight and accountability for systemic services for young children. From the beginning, state leaders recognized the need to develop links between home visiting services, medical services and early care and education.

In this context, the Home Visiting Discussion Group started work in December 2006. The charge to the group was to: a) examine the role of home visiting in improving health and well-being, b) review the current publicly funded Virginia home visiting services for pregnant women and families with children ages 0-5 years, c) look for opportunities to increase the efficiency and effectiveness; and d) recommend changes. The group identified achievements and challenges with home visiting programs. The systemic difficulties identified included: weak linkages among programs; inconsistent definitions of "risk" and "success"; lack of standardized screening tools; gaps in service by geography; childcare and medical providers not well informed about available programs; and lack of systematic mechanisms of making referrals.

They concluded that Virginia's home visiting programs can be improved through cultivating increased collaboration in the areas of policy planning, training, data collection, staff core training and development, and quality improvement systems. They also called for an increase in efficiencies and effectiveness by building a continuum of home visiting services in localities so that the family risk factors are matched to the intervention.

These efforts continue through a Home Visiting Consortium. The consortium meets regularly, providing oversight, exploring joint grant opportunities, consulting with each other on service delivery, and sharing research, information and resources. In August 2007, the Home Visiting Consortium presented recommendations for improving the efficiency and effectiveness of home visiting practices in Virginia to the Governor's Working Group on Early Childhood Initiatives. With approval, the consortium began implementation by developing four task groups: infrastructure, training, data collection and evaluation, screening and assessment. The consortium activities in SY2008 include:

- ◆ A matrix of the current training conducted by all 10 programs, noting the topics, curricula, timing and method of the training, and identified training needs;
- ◆ Initial work on supervisory practices and mental health information modules;
- ◆ Introductory workshop to promote local system agreements and efficiencies scheduled across the state in the fall;
- ◆ Work started on internet registration program for a home visitor's core training record to be maintained at a state university;
- ◆ A data matrix of current information elements collected by each program; In-depth exploration of the core data for evaluation;
- ◆ Common referral and feedback form for health care, child care providers, and home visiting programs, which will allow tracking family progress across programs and decrease the amount of times families must provide information;
- ◆ A guidance document on financing and collaboration for local home visiting programs; and
- ◆ A memorandum of understanding for the state consortium members which can serve as a model for the local community coalitions.

For more information, visit: www.education.virginia.gov/Initiatives/EarlyChildhood/GovWorkingGroup.cfm
or contact: kathy.glazer@governor.virginia.gov.

Helping More Vulnerable Families through Home Visiting Programs

To supplement the state survey and underscore the importance of an issue that deeply impacts programs but is not much discussed in research or policy, NCCP convened a roundtable discussion on home visiting, with a special focus on vulnerable children and families, on Dec. 4, 2007. The purpose of the meeting was to advance knowledge and promote awareness about how to address significant parental adversities in the context of home visiting programs. While most home visiting programs are designed to serve families at risk, evaluation and anecdotal reports point to the particular challenges in serving more vulnerable, higher risk families (as in those affected by family violence, substance abuse, or mental health conditions).

Participants in this roundtable included researchers, state officials, and local program administrators with knowledge and experience related to home visiting and vulnerable family services. The discussion of this group underscored several current challenges and opportunities for the field. (See Appendix B for a list of participants.)

Cross-systems coordination urgently needed to facilitate better access for vulnerable families

First and foremost, early childhood leaders need to collaboratively address unmet needs and design systemic approaches to better serve more vulnerable families. Participants pointed to ineffective or inefficient referrals to the mental health, health, child welfare, or other systems. Strategies that might be effective for vulnerable families such as two-generation strategies (parent and child) are uncommon. These are challenges that center-based programs also face; however, when providing services to hard-to-reach and higher risk families, this work becomes paramount.

Programs' structures hamper their ability to appropriately meet the needs of vulnerable families

A second challenge is that home visiting programs often are not structured to serve multi-risk, more vulnerable families.³¹ Participants at the roundtable noted that home visitors may not have the skills,

tools, or level of comfort needed to serve the highest risk families. They characterized some families as having multi-risk or super-risk situations (such as a 14-year-old raped by mom's boyfriend who is not in school and recently moved out of a child protection group home; or women who are HIV positive and have a history of substance abuse and intimate partner violence).

While many program evaluations show positive effects on primary prevention by improving daily reading, parent communication skills, discipline strategies, and parent confidence, fewer have shown impact on maternal depression, family violence, and substance abuse. Some limited success was shown with highly tailored models for specific concerns such as substance abuse, as opposed to multi-risk families.³² Opportunities exist to improve the training and supervision for home visitors, as well as to create enhanced interventions that engage and embed more highly trained professionals from the social work, mental health, or substance abuse fields.

There was consensus among roundtable participants that home visiting is a means to deliver multiple services to address different needs, but that program design is often not well aligned with objectives. As discussed above, programs often set objectives that exceed their capacity or intensity. Moreover, there is a tendency in setting program objectives to promise more than might be expected of any single program serving higher risk, more vulnerable families. For example, home visiting programs alone should not be expected to eliminate serious issues such as ongoing child abuse and neglect or family violence.

Interventions through existing programs can be an effective approach to serving children and families

Third, embedding more effective interventions into existing early childhood programs, where children and parents are served at the community level, is a more promising approach than referrals. For home visiting programs, this may mean delivering more intensive interventions in-home or being more effectively linked to other service systems. It also calls for development of ongoing relationships with the family.^{33 34}

- ◆ One home visiting program in Cincinnati, for example, has embedded in-home cognitive behavioral therapy.³⁵ A randomized control trial is now in progress, and preliminary data suggest that the program's success rates are comparative to antidepressants or typical cognitive behavior therapy.³⁶
- ◆ The Louisiana Nurse Family Partnership Program augmented standard nurse home visiting with intensive training in mental health issues and with mental health professional consultation.³⁷
- ◆ In Boston, the Family Connections project is training Early Head Start (EHS) and Head Start (HS) staff and parents to help them recognize and address signs of depression and other adversities that get in the way of effective parenting. Using home visiting, group and individual counseling, community resource development, and staff training, the project teaches EHS and HS staff how to assist and support parents and children suffering from depression.³⁸ (See box on Early Head Start for more information regarding the use of home-based services.)

While we were particularly interested in how home visiting programs can serve more vulnerable children and families, in the course of the meeting a number of other basic challenges also surfaced, some reported by participating state leaders. Other concerns included the following.

- ◆ **Creating a continuum of services is key.** Communities and families need an array of services to address the needs of young children and their families. Structures to support an array of home visiting programs within a state will help to maximize available resources. Equally important is that home visiting programs be linked to other service systems, particularly to center-based early care and education, child welfare, and mental health systems. Such linkages are essential to better meet the needs of the most vulnerable.
- ◆ **Programs are inventing their own tools and curricula that are not always research informed.** Many community and state-based home visiting programs are trying to develop their own tools and curricula on an ad hoc basis, but this means it is very difficult to interpret the results, and the tools and curricula do not always reflect the research-informed knowledge. In addition, even well established models with clear curricula

may not have all the tools needed at hand. This was especially a concern around screening for maternal depression, where validated tools are available.

- ◆ **Programs are limited by lack of research on blended models, although they are being used.** For example, many programs are aiming to use blended program designs and staff team models (such as mental health professionals supporting nurses who in turn are supporting community workers). Debates continue about the effectiveness of different staff models, yet practice indicates mixed models are being deliberately used.³⁹ A few states are studying blended program designs; however, this is more the exception than the rule. More research is needed about the effects of different program designs for families with various needs (e.g., at-risk or high risk, special health care needs or social risk alone, first-time or multiparous mothers). The federal Administration on Children and Families has recently funded some such research related to child abuse prevention. (See box.)
- ◆ **Available funding often drives policy and program decisions.** When it comes to program design and operations, experts agreed that political and budgetary factors may be more important than knowledge of evidence-based practice. Problems arise with program effectiveness when existing funds are insufficient to hire professionals, provide the intensity of services needed, offer ongoing staff training, or reach the full target population. Programs need sufficient funding to provide quality services and achieve desired outcomes.
- ◆ **Cultural competency is essential.** Home visiting programs and their staff need to provide services that are culturally competent and responsive to the needs of a wide range of families (as in immigrant families, higher risk families, ethnically diverse families) in order to recruit, retain, and effectively serve them.⁴⁰ Attention to cultural competency should be reflected in both staff training and intervention design.^{41 42}

Early Head Start

While Early Head Start programs were beyond the scope of this survey, findings from a national evaluation of Early Head Start have implications for home visiting programs and policy at the federal, state, and local levels and offer insights into the importance of linking and “mixing” home visiting with center-based services. Early Head Start is a two-generation program designed to provide high-quality family and child development services to low-income pregnant women and families with infants and toddlers age birth to 3. Many of the more than 700 Early Head Start projects across the country use a home-based service delivery model, that is, they use home visits to support families.

A randomized control evaluation study of 3,000 children and families in 17 sites compared children who received Early Head Start to those who did not. This national evaluation found that Early Head Start programs had statistically significant, positive impacts on children’s cognitive, language, and social-emotional development by age 3. In particular, significant positive improvements in parent-child interactions were found, including increased parent emotional support, daily reading, language and learning support, and appropriate discipline strategies.

Early Head Start programs use different approaches to serving families, including center-based, home-based, and mixed (providing center-based services to some families, home-based services to other families, or a mixture of center- and home-based services either at the same time or different times). Full implementation of

the Early Head Start program – whether center-based, home-based, or mixed – made a significant difference. Evaluators found that levels of participation, intensity of service use, and results also varied across program approaches.

- ◆ Early Head Start home-based programs showed greater impact on cognitive and language development at age 3 than found in evaluations of home visiting programs in general.
- ◆ While the significant effects of center-based programs were concentrated on enhancing children’s cognitive and social-emotional development, home-based programs also improved child development and additionally reduced parenting stress.
- ◆ Mixed-approach programs had better retention rates, stronger impact, and more consistent effects across a broad range of parenting behavior and child development. This may reflect the benefits of families receiving both home-based and center-based services, the value of programs’ flexibility to fit services to family needs, or the fact that these programs were able to keep families enrolled longer.

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Conclusions: Opportunities for State Action

We conclude that states and the families they serve can benefit from implementing a systematic approach to home visiting. Based on the 2007 survey, the changes since a 1998 survey, and many published reports regarding home visiting, some important characteristics of state-based home visiting efforts have emerged. A snapshot of some of these characteristics was revealed in our survey and reported above. Experts at the NCCP roundtable reinforced these conclusions. States need deliberate strategies, policies, and program designs to achieve quality and improved child and family outcomes from their investments in home visiting. The bottom line is to promote healthy parent-child relationships that are a foundation for development, particularly healthy social-emotional development.

The following areas merit attention by agencies in every state seeking to effectively use home visiting as an intervention to improve early childhood development and family well-being.

Strategies that Support Better Services Across Systems and Programs

- ◆ **Strategies for aligning and coordinating multiple home visiting programs** – Many states have multiple home visiting programs currently underway. Typically, this includes some developed at the state level and some that grew from community interest. These programs, rightfully, serve different families with different needs. Aligning and coordinating multiple programs helps to maximize available resources, both human and fiscal. For example, efforts in states such as Maine, Pennsylvania, and Virginia identified six to 14 programs, which are now being better coordinated through state-level leadership.
- ◆ **Linkages to center-based early care and education, as well as health, mental health, child welfare and other service systems** – Research indicates that some of the value of home visits is related to effective referrals and service coordination. For families at higher risk, this might include support for appropriate use of prenatal or well baby care, help in finding maternal depression

treatment, or referral to the Part C Early Intervention program. Other studies point to the value of transitioning families to center-based services as children grow and develop. Both functions depend on having clear linkages and effective referral pathways. Development of mechanisms to link programs and services is a good role for state-level, cross-agency planning efforts.

- ◆ **Integrate and link to effective strategies for serving higher risk families** – Virtually all home visiting programs serve some higher risk, more vulnerable families, such as those where a parent has depression, a substance abuse problem, is at risk for abuse and neglect, and/or is experiencing family violence, either singly or in combination. Effective intervention models are emerging that can be used through home visits or delivered as a result of screening and referrals. States should give attention to the implementation of strategies that will address the needs of higher risk families.
- ◆ **Maximizing multiple funding streams** – Most state-based home visiting programs are blending funding, including a variety of federal funds, some state general revenues, and some local or private funding. Using funds in more strategic and innovative ways can help to grow and sustain successful programs.

Strategies Designed to Strengthen Services Within Home Visiting Programs

- ◆ **Deliberate program design, with fidelity to research-informed models** – Research shows that deliberate home visiting program design with clear protocols, curriculum, staff training, and a logic model contribute to success and improved outcomes. The program should be “relationship based.” It should strengthen and build on the relationships between parents and young children. Effective home visiting programs nurture parental competence and child development simultaneously. Research, evaluations and brain science indicate that strengthening parent-child relationships and parenting skills is of critical importance.

◆ **Staff training and development** – While staff training may be thought of as the purview of individual programs, state leadership can make a difference. Having common training about early childhood development is one state-level strategy. Also, having certain shared, statewide standards, competencies, or guidelines can promote quality across programs.

◆ **Continuous quality improvement** – Research has shown that commitment to quality is essential. Well-trained staff and appropriate service intensity increase the likelihood that home visiting programs will achieve results; however, these elements require ongoing attention. Quality improvement efforts and evaluations of program impact are essential.⁴³

Recommendations

National Leadership

National leaders, both public and private, have an opportunity to assist home visiting programs and ultimately families. We recommend:

- ◆ **Creation of multi-state learning collaboratives.** Currently, lessons learned on a state-by-state basis are only shared haphazardly. A multi-state learning collaborative could cross-fertilize best practices in: evidence-based practice and quality improvement, staff training and support inter-agency linkages, blended funding, and evaluation strategies. Such an effort would require creation of state teams. Federal and/or private foundation funding will be required to launch and sustain such an effort. This was a concept strongly supported by participants at the roundtable.
- ◆ **More research on how to effectively deliver different models of service.** Much more could be learned about what works for which families. For example, many states rely on the Nurse Family Partnership (NFP) because it has been evaluated with a randomized clinical trial; however, it is designed for use with first-time parents. The Early Head Start evaluation points to more questions about how to effectively link home-based and center-based services. Studies of interventions for maternal depression also may hold clues on how to build new and more effective models of home visiting services. There is woefully little research on how to embed services for higher risk families into home-visiting programs, given that referring out does not work in and of itself. Knowledge about how to assure cultural competency is lacking. Experts at the roundtable reminded us that financing evaluation studies, participatory

action research, and quality studies are important. (See box on recent home visiting federal grants.)

- ◆ **Federal leadership to support state and local programs.** Federal leadership on home visiting can support cross-program information sharing, standard setting, performance monitoring, and evaluation within and among states. This work could be done collaboratively among federal agencies, including: Maternal and Child Health Bureau of the Health Resources and Services Administration; Early Head Start in the Administration for Children, Youth, and Families; Substance Abuse and Mental Health Services Administration; the State Children's Health Insurance Program (SCHIP) and Medicaid-Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) staff of the Health Care Finance Administration; Part C of the IDEA in the Department of Education; and the National Institute for Child Health and Human Development of the National Institutes of Health. The federal interagency workgroup focused on early childhood systems might lead the way in this activity.
- ◆ **Federal legislation that supports state home visiting efforts.** Currently, no federal law or program provides ongoing support for state home visiting programs. While the Title V statute included some special short-term funding and a recent appropriation offered an opportunity for grants from the Administration on Children and Families, these are not permanent and structured programs. Both federal guidance and funding could be beneficial to states. For example, the Education Begins at Home Act would provide funding and technical assistance to a variety of ongoing state efforts, but to date it has not been enacted. (See box.) Additionally, the budget

The Education Begins at Home (EBAH) Act would provide grants to help establish or expand voluntary home visiting programs for families with young children.⁴⁶ On January 15, 2009, Senators Bond (R-MO), Murray (D-WA), and Clinton (D-NY) reintroduced EBAH in the 111th Congress as S. 244. Rep. Davis (D-IL) and Platts (R-PA) are expected to reintroduce EBAH in the U.S. House of Representatives in the near future. Last year, as Senators, both President Obama and Vice-President Biden were co-sponsors of this legislation. The bill would authorize \$500 million in federal funding over three years to expand quality programs of early childhood home visitation that increase school readiness, child abuse and neglect prevention, and early identification of developmental and health delays, including potential mental health concerns. These new funds would support quality home visitation at the state and local level. This effort also would strengthen the early childhood home visiting component of Head Start/Early Head Start. Parts of the monies also are earmarked for specific groups of children and families, such as English language learners. This approach builds on existing models of quality early childhood home visitation programs, which together can help to meet the special needs of different children and families. No one model is encouraged. This legislation will help states to create a system of early childhood home visitation that will ensure that families are receiving the most appropriate services to meet their needs. The legislation has the official support of 15 major national children's organizations, including the Center for Law and Social Policy; Child Welfare League of America; Children's Defense Fund; Fight Crime: Invest in Kids; Home Instruction for Parents of Preschool Youngsters (HIPPPY) USA; National Child Abuse Coalition; Nurse Family Partnership; Parents-As-Teachers National Center; Prevent Child Abuse America; The Parent-Child Program; and Voices for America's Children.

outline recently released by President Obama – “A New Era of Responsibility: The 2010 Budget” – proposes creation of the Nurse Home Visitation program, which will provide funds to States to provide home visits by trained nurses to first-time low-income mothers and mothers-to-be.

- ◆ **Increased understanding of the role and limits of home visiting in the early childhood agenda.** Home visiting is not the only or most important program for serving at-risk families with very young children; however it is a widely used service strategy. Raising the awareness of policy makers about the importance of a mix and continuum of early childhood services and

supports, including home visiting, is essential. Continuity of effort across the early years is important, and home visiting should be part of a larger overall effort to create a set of services and supports that comprise an early childhood comprehensive system birth to 5.

State-level Leadership

Researchers and experts have stated that there is a need to improve the quality of home visiting services, more effectively replicate model programs, and link home visiting programs to other efforts focused on promoting optimal early childhood health and development. At the state and local level, the challenge is to tackle the hard issues of program integration and coordination and matching programs to need, as well as financing. The findings from our survey of state policies support these views and point to specific recommendations for state leaders. We recommend that states:

- ◆ **Strengthen mechanisms for interagency and cross-program coordination.** In many states, home visiting activities are under way through multiple agencies and programs without coordination. Interagency coordination has been modeled in a few states where leadership and commitment led to more efficient use of existing human and fiscal resources, but these efforts need to occur within every state.
- ◆ **Help communities and programs align the home visiting intervention with family needs.** Matching the intervention design to program purposes is the first step. For example, a program to improve pregnancy outcomes should have an intervention protocol different from a program intended to prevent child maltreatment or one designed to reduce the impact of infant-toddler developmental disabilities. Home visiting programs intended to provide more intensive home visiting services to families with identified risks and needs must have appropriate training and supervision for staff.
- ◆ **Support a continuum of early childhood services that can address a wide range of family needs and achieve results in a cost-effective manner.** No single program or service strategy can cure all that ails our nation's families. However, research points clearly to a need for an array of early childhood services that can meet the diverse needs

of families. This continuum includes pregnancy planning and prenatal services, parent education and support, adequate health services, quality child care/early education, and interventions to ensure a safe environment. Home visiting services can fill one or more of these functions and can link families to others.

- ◆ **Refine and narrow program objectives and outcome measures.** In 1998 and again in 2008, states reported an array of targeted objectives and outcomes. Most programs have promised more than their activities can be expected to deliver. More closely aligning the outcome objectives with the actual intervention strategy is an important step. Failure to meet ambitious program goals can undermine confidence in state program efforts. Be realistic.
- ◆ **Promote quality and assure staff training and supervision.** This is among the strongest recommendations drawn from evaluation studies on home visiting. Quality improvement and assurance would include: staff training, use of practice standards/protocols, and results monitoring. Our survey suggests shortfalls in this area. Studies of the Every Child Succeeds program in Cincinnati point to some key opportunities in quality improvement.⁴⁴

- ◆ **Analyze current spending on home visiting programs and blend funding where appropriate.** Allocations to state-based home visiting programs total hundreds of millions of dollars. Some states have blended funds from various federal, state, and private sources to finance these efforts. Other states could take advantage of opportunities such as pooling dollars for training, use a single administrative authority, or leveraging federal, local, or private matching funds. We call this “spending smarter.”⁴⁵
- ◆ **Support research and data systems that expand knowledge of programs and gaps.** Too many programs operate without adequate data and evaluative supports. Funding for home visiting programs interested in conducting evaluation research and randomized research trials is needed. In addition, most states do not routinely conduct analyses to assess the number of families who meet qualifications for home visiting programs, but are not served due to budgetary or other program constraints. This type of gap assessment requires ongoing data systems support.

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Appendix A: Selected Survey Results, By State

	Number of programs reported	States reporting statewide program*	States reporting interagency planning*	States reporting use of established model*	States with programs linked to legislation*	States with programs designed for intensive services to high risk*
ALABAMA	1	Yes	Yes	No	No	Yes
ALASKA	0	—	—	—	—	—
ARIZONA	2	Yes	No	No	Yes	Yes
ARKANSAS	1	Yes	No	Yes	Yes	No
CALIFORNIA	0	—	—	—	—	—
COLORADO	1	Yes	**	Yes	Yes	Yes
CONNECTICUT	1	Yes	No	No	Yes	Yes
DELAWARE	2	Yes	Yes	No	Yes	Yes
DISTRICT OF COLUMBIA	No response					
FLORIDA	1	Yes	Yes	No	Yes	Yes
GEORGIA	1	No	Yes	No	No	No
HAWAII	1	Yes	Yes	Yes	Yes	Yes
IDAHO	0	—	—	—	—	—
ILLINOIS	3	Yes	No	Yes	No	Yes
INDIANA	No response					
IOWA	1	No	Yes	No	No	Yes
KANSAS	No response					
KENTUCKY	1	Yes	Yes	No	Yes	Yes
LOUISIANA	1	Yes	Yes	Yes	No	No
MAINE	2	Yes	Yes	No	Yes	Yes
MARYLAND	1	Yes	Yes	No	No	Yes
MASSACHUSETTS	4	Yes	No	Yes	Yes	Yes
MICHIGAN	2	Yes	Yes	Yes	No	Yes
MINNESOTA	1	Yes	Yes	No	Yes	No
MISSISSIPPI	0	—	—	—	—	—
MISSOURI	2	No	Yes	Yes	No	Yes
MONTANA	1	No	Yes	No	Yes	Yes
NORTH DAKOTA	0	—	—	—	—	—
NEBRASKA	0	—	**	—	—	—
NEVADA	1	No	Yes	No	No	Yes
NEW HAMPSHIRE	1	Yes	Yes	No	No	Yes
NEW JERSEY	1	No	Yes	No	No	Yes
NEW MEXICO	1	Yes	Yes	No	Yes	No
NEW YORK	2	Yes	Yes	Yes	Yes	Yes
NORTH CAROLINA	2	Yes	Yes	Yes	No	Yes
OHIO	1	Yes	Yes	No	Yes	No
OKLAHOMA	2	Yes	No	Yes	Yes	Yes
OREGON	3	Yes	Yes	Yes	No	Yes
PENNSYLVANIA	13	Yes	Yes	Yes	Yes	Yes
RHODE ISLAND	1	Yes	Yes	No	No	Yes
SOUTH CAROLINA	1	Yes	Yes	No	No	No
SOUTH DAKOTA	1	No	Yes	No	No	Yes
TENNESSEE	1	Yes	Yes	No	No	Yes
TEXAS	1	Yes	Yes	No	Yes	No
UTAH	1	Yes	Yes	No	No	No
VERMONT	No response					
VIRGINIA***	4	Yes	Yes	Yes	Yes	Yes
WASHINGTON	No response					
WEST VIRGINIA	1	Yes	Yes	No	Yes	Yes
WISCONSIN	1	No	Yes	No	Yes	Yes
WYOMING	1	Yes	Yes	Yes	Yes	Yes
TOTAL NUMBER	70	32	33	15	22	31

Notes:

* The state receives a “yes” if one or more of their state-based home visiting programs meets criterion.

** Colorado and Nevada have unique efforts to support interagency coordination.

*** Virginia has additional state programs (for a total of 10) for which surveys were not included.

Appendix B: Home Visiting Roundtable Participant List

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