State Home Visiting Approaches Improve Early Childhood Outcomes and Systems

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> *“Starting at birth and continuing throughout life, our ability to thrive is affected by our ongoing relationships and experiences and the degree to which they are healthy, supportive, and responsive or not.”*
> –Center on the Developing Child at Harvard University

INTRODUCTION

The early years of a child’s life are crucial for building the foundation of health and wellness needed to succeed in school and later in life.[1] Early exposure to adverse experiences and stressors, such as poverty, unstable home environments, violence, and a lack of access to quality early education, can negatively affect a child’s development and long-term health and well-being. Early adversity is associated with many public health challenges, including school failure, substance misuse and abuse, mental illness, and adult heart disease.

Early experiences and their long-term impacts on a person’s life are not set in stone, however. Stable and responsive caregiving relationships and other protective factors, such as high-quality early care and education, can buffer the effects of these early adverse experiences and promote healthy development for vulnerable, at-risk children.[2] A coordinated early childhood approach that aligns health and early learning systems can help promote safe, stable, and responsive relationships and homes, experts say. CDC finds that integrating relationship-based prevention and intervention services early in a child’s life, when his or her brain is developing most rapidly, can “optimize developmental trajectories.”[3] States are adopting a wide array of strategies to bridge the gaps between systems and programs that have historically operated separately from one another. Although states’ approaches vary, their efforts apply early child development science to develop state capacity and infrastructure that support healthy children and strong families. Evidence-based home visiting is among the most effective strategies for bridging these systems to improve outcomes for children and help them achieve their full potential.

This primer examines how evidence-based home visiting (“home visiting”) fits into a state’s overall early childhood approach, and how states are strengthening their home visiting services to promote maternal and child health and well-being. In addition to improving maternal and child health outcomes, home visiting programs that coordinate and align with other services and family supports can help state and local agencies develop strong early childhood systems of care. ASTHO interviewed state leaders in four states to learn how states are strengthening home visiting programs to both improve maternal and child health outcomes and reinforce the broader system of care within which they operate.

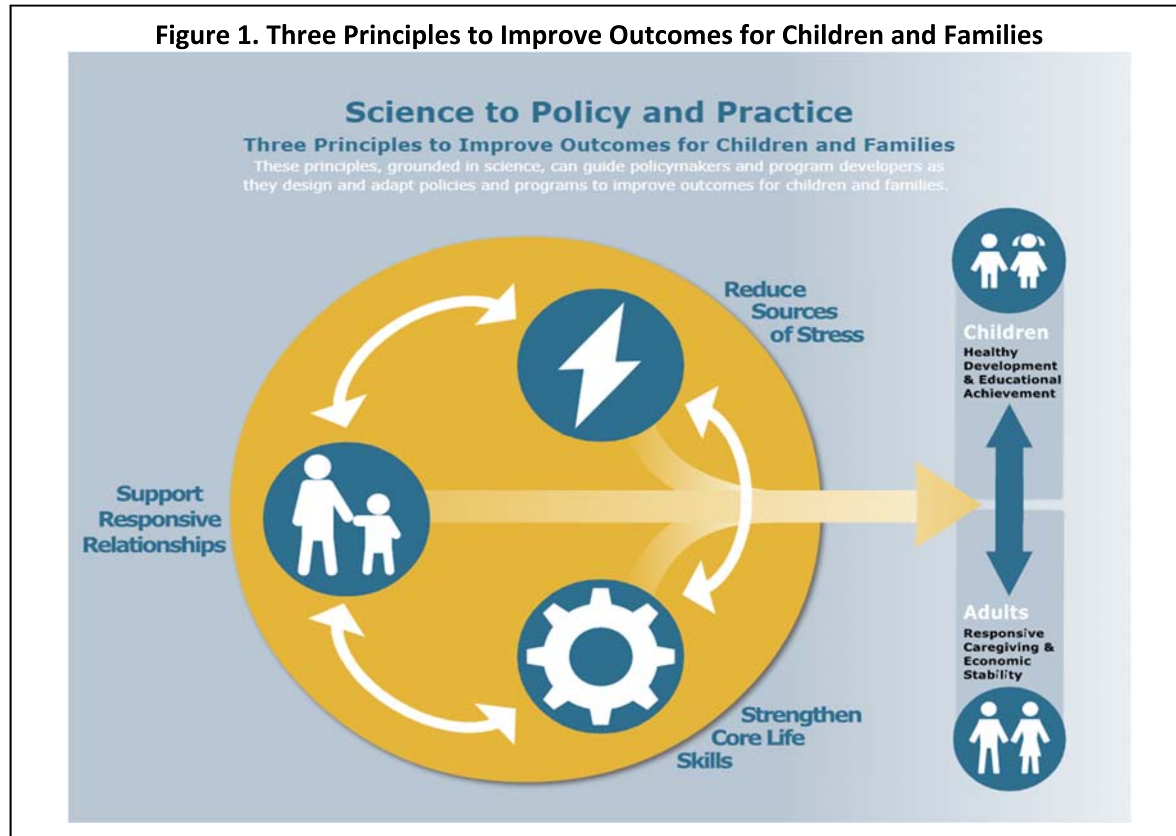
The primer provides an overview of home visiting and highlights the following seven promising approaches that emerged from interviews with state leaders in Georgia, Kansas, Texas, and Washington state:

1. Align and coordinate health and early learning systems.
2. Build local home visiting capacity and infrastructure.
3. Strengthen home visiting workforce capacity.
4. Implement maternal depression screening to promote healthy development.
5. Help home visiting families prepare for natural disasters and emergencies.
6. Fund and sustain home visiting initiatives.
7. Develop, measure and reward meaningful outcomes

HOME VISITING OVERVIEW

Researchers at the Center on the Developing Child at Harvard University have identified a set of “design principles” that policymakers can use to develop policies and services that improve outcomes for children and families. As shown below in Figure 1, to be most effective, policies and services should support responsive relationships between children and adults, strengthen core life skills, and reduce sources of stress in the lives of children and families.[4]

Figure 1. Three Principles to Improve Outcomes for Children and Families



Many home visiting programs do all three. Early childhood home visiting is a service delivery strategy that links expectant and new parents with a nurse, social worker, early childhood specialist, or paraprofessional who is trained to work with families in their homes. Home visitors evaluate families’ needs and provide tailored services that support positive parent-child interactions, promote early learning and language development, conduct developmental screenings, and connect families to appropriate services and resources.[5]

State Administration and Funding

Many state agencies—including those representing health, human services, early childhood, or family and protective services—administer home visiting programs, usually by working with local agencies to deliver services to families. States may administer a wide array of home visiting programs, including programs that meet evidence of effectiveness criteria described below, as well as state- or locally-developed home visiting models.

Every state, the District of Columbia, and five U.S. territories receive federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funds. In addition, states may blend federal, state, and local funding sources to support home visiting programs and serve more families in need. State funding for home visiting varies considerably, and states may leverage a variety of funding sources, including Title V of the Maternal and Child Health Block Grant Program, Temporary Assistance for Needy Families (TANF), Medicaid funds, state general funds, state dedicated funds (e.g., from state tobacco settlements), and funds from private philanthropic organizations. (Appendix A describes how state agencies administer home visiting in the four profiled states.)

Maternal, Infant, and Early Childhood Home Visiting

Established in 2010, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program gives pregnant women and families, particularly those considered at-risk for poor health outcomes, needed resources and skills to raise children who are physically, socially, and emotionally healthy and prepared to learn.[6] HRSA works with the Administration for Children and Families (ACF) to administer MIECHV and fund states, territories, and tribal entities to develop and implement voluntary, evidence-based programs that are tailored to meet community needs. The Tribal Home Visiting Program, funded from a 3 percent set-aside from the MIECHV program, currently awards 25 tribal entities to develop, implement, and evaluate home visiting programs.[7] (See HRSA's MIECHV funding web page for a list of 2017 funding awards to states and territories, and view the Tribal Home Visiting Grantees web page for information about funding to tribal entities.) HRSA's MIECHV infographic summarizes the program's reach, funding, and benchmarks.

MIECHV-funded programs aim to improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness.[8] Grantees must give priority to families living in at-risk communities, as identified by a statewide needs assessment. MIECHV law requires state and territory grantees to invest at least 75 percent of federal grant funds in evidence-based models, with the opportunity to invest up to 25 percent of funds in promising or new approaches that do not yet qualify as an evidence-based model, but that will undergo evaluation.[9] The U.S. Department of Health and Human Services (HHS) created the Home Visiting Evidence of Effectiveness review to assess home visiting program models and ensure their effectiveness. Currently, 18 models meet HHS' criteria for evidence of effectiveness.

Home visiting supports parent and child development by delivering a range of evidence-based services, including developmental screenings, information on child development, social supports, referrals to community services, and a link to enrollment in other public programs—all delivered in the home setting. Home visiting programs are accountable for achieving improvements in at least four of the following six benchmarks:

- Improvement in maternal and newborn health.
- Reduction in child injuries, abuse, and neglect.
- Improved school readiness and achievement.
- Reduction in crime or domestic violence.
- Improved family economic self-sufficiency
- Improved coordination and referral for other community resources and supports.

Home visiting programs have made a significant impact in the lives of vulnerable children and families, with 98 percent of grantees reporting demonstrated improvement in at least four of the above benchmarks.[10] According to the National Home Visiting Resource Center, home visiting's evidence base and cost effectiveness are strong, and the programs have contributed to:[11]

- **Better infant and child health**. Expectant moms involved in home visiting are more likely to access prenatal care and carry their babies to term.
- **Safe homes and nurturing relationships**. Home visitors reduce the risk of unintended injuries and they teach parents how to interact with their children in positive, nurturing ways.
- **Optimal early learning and long-term academic achievement.** By helping parents understand the importance of reading and talking with babies, home visiting has achieved positive developmental outcomes, including improvements in early language and cognitive development and academic achievement in first through third grade.
- **Self-sufficient parents**. Home visitors work with parents to set goals to promote self-sufficiency. As a result, parents in home visiting programs have higher monthly incomes and are more likely to be enrolled in school or employed.

Moreover, new research finds that home visiting programs have long-term positive effects on maternal and child health and well-being. A 2017 brief on the long-term effects of home visiting found that these programs improve outcomes for parents and children across a wide array of child ages, outcome areas, and national home visiting models. The brief summarized various studies on the effects of early childhood home visiting on children from 5 to 21 years old, focusing on four evidence-based models. The studies compared long-term effects for children enrolled in evidence-based home visiting compared with those who had been randomly assigned to non-home visiting services in the community. For example, a Nurse-Family Partnership study in Elmira, New York found reduced adolescent involvement with the criminal justice system for participating children between 15 to 19 years old. Other studies found long-term improvements in maternal mental health, reductions in the prevalence of child maltreatment for children between ages 5 to 15 years, and reductions in substance misuse and abuse among young adolescents.[12]

Importantly, home visiting is cost-effective; evidence-based programs can return up to $5.70 in savings for every dollar invested.[13] Home visiting can specifically provide a positive return on investment through savings in emergency room visits, child protective services visits, and special education services, as well as through higher tax revenues associated with parents' earnings.[14]

Collaborative Improvement and Innovation Networks Strengthen Early Childhood and Home Visiting Systems

Collaborative Improvement and Innovation Networks (CoIINs) engage multidisciplinary teams of federal, state, and local leaders to address a common problem that aligns with state Title V Maternal and Child Health program priorities and related issues that other community-based organizations are addressing. Two such efforts that support home visiting as part of a coordinated early childhood system are described below.

Early Childhood Comprehensive Systems

HRSA's Maternal and Child Health Bureau created the Early Childhood Comprehensive Systems (ECCS) Impact Grants and Early Childhood Comprehensive Systems Collaborative Improvement and Innovation Network (ECCS CoIIN) to advance state and local childhood system coordination efforts. Established in 2016, the ECCS CoIIN built off the original ECCS Impact Grants, which encouraged states to build comprehensive early childhood systems. The CoIIN engages 12 states to improve outcomes in population-based children's developmental health and well-being, including a 25 percent increase in age-appropriate developmental skills among their communities' 3-year-old children. Recipients identify up to five communities within their state or territory to participate in the CoIIN, including at least one community that has received state or tribal MIECHV services.

Community backbone or hub organizations at the state and community level serve as a developmental promotion hub to strengthen systems to improve the developmental well-being of children in the earliest years. In addition to improving children's developmental skills, the project seeks to promote broad, cross-system collaboration, implementation of evidence-based approaches, integrated data systems, continuous quality improvement, and an upstream approach for ensuring that babies are on track to achieve their developmental milestones.

Home Visiting

Created in 2013, the Home Visiting CoIIN focuses on quality improvement and innovation and helping states achieve breakthrough impacts across the legislatively-mandated home visiting benchmark areas. Several significant improvements in developmental promotion, screening and linkage, breastfeeding rates, and maternal mental health resulted from the original Home Visiting CoIIN. Home Visiting CoIIN 2.0, created in 2016, focuses on spreading and scaling innovations to more states and expanding to address additional focus areas, including intimate partner violence. Because of these efforts, the program has identified partnerships with the Individuals with Disabilities Education Act Part C and centralized access points as key to improving developmental promotion, screening, and linkage.

SEVEN APPROACHES FOR PROMOTING HEALTHY DEVELOPMENT THROUGH HOME VISITING SYSTEMS

In early 2018, ASTHO interviewed state health and early learning officials in Georgia, Kansas, Texas, and Washington state. These interviews identified several challenges facing states and communities, and a number of concrete approaches that states are adopting to address those challenges. While not a comprehensive review of state home visiting approaches, the primer examines select state approaches for strengthening home visiting services and aligning them with the broader early childhood system.

Key Challenges

Despite their geographic and demographic differences, home visiting programs experience similar barriers and challenges. States expressed that home visitors must be equipped to deal with clients' increasingly serious and complex problems, including high rates of anxiety, depression, trauma, and opioid and other substance misuse and abuse. According to Laura Alfani, assistant administrator of Strengthening Families Washington in the Washington State Department of Early Learning (DEL), "the level of acuity and trauma families enrolled in home visiting are experiencing are intense and have increased over time." Communities have varying resources to respond to these challenges.

Twanna Nelson, home visiting program director for the Georgia Department of Public Health (GDPH), says that meeting the diverse needs of the state's rural and urban communities, including those with large numbers of migrant workers and military families, is also a challenge. Deborah Richardson, Kansas Department of Health and Environment home visiting manager, cited several challenges that persist across the state, including language barriers, lack of a bilingual workforce, transportation for home visiting families, and long travel distances for home visitors. To address cultural challenges, including some families' reluctance to participate, home visitors must build trust within the community. Moreover, coordination can be challenging, especially within communities where multiple models, including MIECHV and others, are operating.

Addressing Challenges

To meet these challenges, states cite the need for improved access to quality health and social services, workforce development, strengthened partnerships with health and social services, centralized access points, and strong systems of coordination and alignment. The four states we interviewed have developed a wide array of approaches for strengthening their early childhood and home visiting systems to respond to these challenges—and they continue to build those systems to respond to community needs. As described below, their approaches fall into seven primary categories.

1. ALIGN AND COORDINATE HEALTH AND EARLY LEARNING SYSTEMS AT THE STATE LEVEL

Across the country, many states are taking steps to integrate home visiting programs into a comprehensive and coordinated early learning system. The Zero to Three report "The MIECHV Program: Smart Investments Build Strong Systems for Young Children" found that state administrators are coordinating leadership and program financing, ensuring accountability across health, mental health, home visiting, early care and learning, early intervention, and child welfare systems. According to the report, "Systems-level work is a complex endeavor, but one that leads to more timely and targeted services that will ultimately save taxpayers money and contribute to a school-ready, career-ready workforce."[15] The interviewees from Georgia and Washington state highlighted distinct approaches for aligning and coordinating home visiting as part of the broader early childhood system of care.

Georgia

In June 2017, Georgia's home visiting program moved from the Department of Health Services to GDPH—a move Nelson says helped to facilitate linkages with other child-serving GDPH divisions, including injury prevention, environmental health, emergency preparedness and response, health promotion, and disease prevention. The organizational change made it easier to partner with other divisions at both the state and community levels, as well as with other programs in GDPH's Maternal and Child Health Section. The Maternal and Child Health Section also oversees Babies Can't Wait, the state's Individuals with Disabilities Education Act Part C Program; Early Hearing Detection Intervention; and Children's First, a population-based system that facilitates early identification of at-risk children and links them with early intervention services, as well as other public health services and community-based resources.

Washington State

Washington state was recognized by the Center on Budget and Policy Priorities as a leader in coordinating early learning in public and private sectors.[16] In 2010, the state created a state Home Visiting Services Account (HVSA), administered jointly by DEL and Thrive Washington, the state's private-public partnership for early learning. Home visiting plays a key role in achieving Washington state's 2020 goal of having 90 percent of children ready for kindergarten, with race and family income no longer predictors of readiness. According to Alfani, assistant administrator of Strengthening Families Washington, "We have a history of caring about what implementation looks like in communities." Home visiting advocates have long-understood the importance of building a structure and formalizing support for high quality home visiting through legislation, she says. When the HVSA was created in 2010, Washington Governor Christine Gregoire required agency leads to work together. Although the governance structure has shifted over time, there is still cross-agency leadership at the highest levels supporting home visiting, says Judy King, Strengthening Families Washington administrator.

DEL partners with the Washington State Department of Health, which provides data evaluation and support, performance measurement, data systems, and quality assurance. In addition, DEL funds program staff in the Department of Health Maternal and Child Health Services Title V Block Grant Program to coordinate efforts and identify opportunities to leverage funding and program initiatives. The cross-sector process "takes a lot of time and care and feeding, but it's helped us," King says.

2. BUILD LOCAL HOME VISITING CAPACITY AND INFRASTRUCTURE

Coordinating home visiting services can be a challenge, especially within communities where multiple models, including MIECHV-funded services and others, are operating. According to Deborah Richardson, Kansas' home visiting manager, "Collaboration and coordination and building in-depth relationships is an ongoing process, not just a one-time thing." The examples highlighted below illustrate several approaches for strengthening capacity and aligning resources, including through centralized intake and referral, family engagement, and community-level collective impact and strategic planning efforts.

Centralized Intake and Referral

Many states use MIECHV as an opportunity to establish centralized or coordinated intake systems, defined as a one-stop entry point in which screening helps to identify a family's needs and generate referrals to programs that are the best fit for the family.[17] Centralized intake helps to build a broader early childhood

system of care that can efficiently meet the comprehensive needs of children and families.[18] The systems also reduce duplication of effort and help administrators track whether families received needed services.[19]

States opt to centralize their intake and referral processes for many reasons, including to better coordinate enrollment, recruitment, and retention efforts; to connect families with needed services; and to support systems integration across multiple delivery systems, including health, mental health, early learning, and child welfare.[20] Features of a centralized system include outreach and recruitment, a common screening and assessment tool, a decision tree or other process for determining best fit, and referrals to appropriate services. For example:

- Georgia used MIECHV funds to create a central home visiting data system, the Georgia Home Visiting Information System (GEOHVIS) to serve expectant parents, children from birth through age 5, and their families. Coordinators in Georgia's First Steps program, a parenting support service for all expectant parents and families with a child less than five years old, complete an intake form to determine if families qualify for a home visiting program and if they need additional resources. GEOHVIS helps to "take the burden off home visitors and get families into the home visiting system," says Jeannine Galloway, GDPH maternal and child health director. Georgia's home visiting program receives referrals from First Steps, the community, or from the state child health central intake system. Last year, GDPH used MIECHV funding to connect GEOHVIS to the GDPH child health central intake system for the state, allowing referrals to be shared across programs.
- Centralized intake and referral systems were listed as one of five goals in Kansas' 2014-17 home visiting strategic plan. Kansas used MIECHV funds to expand its centralized intake system in MIECHV-targeted communities, where coordinated, centralized outreach and referral systems help at-risk families identify and connect to needed services.[21]

Family Engagement

According to a 2016 HRSA Home Visiting Program State Fact Sheet, targeted improvements in family engagement and retention helped Georgia expand its home visiting services by 68 percent between 2015 and 2016. HRSA is providing technical assistance to develop a site-specific plan for recruiting and retaining families, Nelson says. Building rapport and trust with families "so they know it's a safe place" is key, Nelson says. Coordination among GDPH programs is essential to ensure that families are not burdened by receiving multiple visits from different services.

Community-Level Collective Impact and Strategic Planning

MIECHV funding helps partners work together to deliver a coordinated system of high-quality home visiting services. Prior to MIECHV, local agencies in Kansas were working individually to address community needs, but did not see themselves as a coordinated system, Richardson says.[22] To support a more synchronized approach, the Kansas MIECHV team engaged community partners to set common goals and objectives. "We created deepening trust and respect, addressing misunderstandings and improving protocol to create a collective perspective as a team, and as a system," Richardson told attendees at a 2017 conference.

Richardson said that contracting with a neutral facilitator to work through programmatic, outreach, referral, enrollment, and quality improvement issues at the local level has been a successful approach. These community-level strategies have improved relationships in communities served by multiple programs and

services. While community collaboration has required "a lot of effort, growth, and attention," Richardson sees improvement specifically in community-level collaboration, including between the local health department and home visitors and other programs. For example, as a result of enhanced collaboration, local partners created a new coordinated intake system, My Family, which seeks to engage and retain families as well as address mental health, substance use disorders, and domestic violence.[23]

According to a 2017 legislative update, Washington DEL and its partners at Thrive Washington continue to take steps to support community readiness, rural expansion and tribal participation. "For us, home visiting is such a strong, powerful intervention, but it's also nested in communities with an array of services and supports that are also successful," says King. "We don't know what works for any family at any one point in time, but we do want all the right options to be there."

3. BUILD HOME VISITING WORKFORCE CAPACITY

States expressed concerns about the ability of the current workforce to meet existing and future demand for services. In Kansas, Richardson says that several locations are struggling to fill open positions and some sites are not able to meet their targeted enrollment numbers because they are unable to find qualified candidates to fill those positions. Georgia and Washington state highlighted their approaches for developing the home visiting workforce capacity to meet the needs of the communities and families served by home visiting, as well as integrate home visiting workforce development into broader early childhood system efforts.

Georgia

During fiscal year 2017, Georgia received a HRSA Home Visiting Innovation Award to support the state's work in developing and retaining a trained, highly-skilled home visiting workforce.[24] The funds will help formalize the home visiting workforce through certified child development associate certificates. In addition, GDPH is working with the Georgia Department of Early Care and Learning to develop a home visiting training repository, which will be integrated into the existing Georgia Professional Development System for Early Childhood Educators. Once complete, this home visiting repository will keep an updated record of credits and training that an individual has received, and list mandatory trainings and professional development opportunities. "This collaboration elevates the field of home visiting, highlighting its critical importance and synergy with early childhood workers," Galloway says.

Georgia also supports current home visitors and home visiting agencies through technical assistance and other resources. The Georgia Center for Family Research provides technical assistance and evaluation for the state home visiting program. According to Nelson, GDPH partners with the center to ensure that home visitors receive required training. In addition, home visiting programs receive assistance from the center, which has a designated point-person for each of the home visiting models operating in Georgia.

Georgia's Talk with Me Baby initiative uses a collective impact model to support early language development by increasing the quality and quantity of language exposure among low-income infants and children accessing the Special Supplemental Nutrition Program for Women, Infants, and Children. The effort focuses on training key workforces to coach parents and caregivers to talk, read, and sing with their young children, with an emphasis on reinforcing home languages for families who speak languages other than English. Key partners include GDPH, the Georgia Department of Education, the Atlanta Speech School, Emory University's School of Nursing and Department of Pediatrics, the Marcus Autism Center at Children's Healthcare of Atlanta, and the Get Georgia Reading Campaign for Grade Level Reading.[25]

Washington State

In 2016, HRSA awarded a HRSA Home Visiting Innovation Award to Washington DEL as the lead agency in a collaboration with three other states—Alaska, Idaho, and Oregon—to support workforce development. Through this award, the states focus on three levels of innovation: systems, policy, and practice. At the practice level, the collaboration aims to directly support home visitors by providing them with tools and learning opportunities to more effectively support themselves and families experiencing mental health, substance misuse and abuse, and domestic violence. Through this funding, states hope to address their workforce attrition rates, which range between 25 percent and 33 percent, and provide training, coaching, and other innovations that support home visitors' well-being and professional development.

4. INCREASE MATERNAL DEPRESSION SCREENINGS

Unaddressed maternal depression has been associated with poor birth outcomes, poor mother-child bonding, and negative parenting behaviors, which can in turn harm young children's development, health, and safety.[26] Maternal depression is prevalent among women who receive home visiting services: the 2015 Mother and Infant Home Visiting Program Evaluation found that 40 percent of these women exhibited symptoms of depression or anxiety when entering the study.[27] Early identification is a critical tool for disrupting the negative and far-ranging effects associated with maternal depression and for promoting healthy relationships and development.

Washington State

Screening for depression is a required MIECHV performance measure under the maternal and newborn health benchmark. In 2016, the overall maternal depression screening rate among states reporting comparable data was 82 percent, with 15 states reporting screening rates of 95 percent or more.[28] Among these 15 states, the overall screening rates increased by an average of nearly 11 percent between 2014 and 2016.[29]

Washington state has high screening rates for both maternal depression and substance use disorder, with 85 percent of moms receiving screening for depression within their first six months of enrollment, and 86 percent receiving screening for alcohol, tobacco, and illicit drug use in the first six months after enrollment. According to Alfani, "we're working hard to connect families to services when home visitors identify issues through screening."

Kansas

Maternal screenings are also a key strategy within the ECCS CoIIN. As one of 12 participating states, Kansas works with two rural communities that "have experienced the challenges of rural service delivery, access to healthcare, growing diversity, and ongoing impacts of poverty."[30] To reach the project's goals of increasing developmental skills for 3-year-olds, activities in Geary County use standardized tools to conduct maternal depression screenings and developmental screenings for children birth to age 5. The Delivering Change approach used in Geary County aims to eliminate disparities in perinatal health by focusing on individual and family health, evidence-based practices, standardized approaches, and quality improvement.[31]

5. HELP HOME VISITING FAMILIES PREPARE FOR NATURAL DISASTERS AND EMERGENCIES

While all children are vulnerable to the adverse effects of emergencies and disasters, a 2015 article published in the *Journal of Emergency Management* found that children with developmental disabilities and special healthcare requirements may encounter even greater risks than their peers due to the complexity of their healthcare needs.[32] Disasters—which may include natural disasters, man-made hazards, or pandemic infectious diseases—pose a serious challenge for vulnerable populations, including pregnant women, wrote Wanda Barfield MD, FAAP, in a 2016 newsletter published by the Association of Maternal and Child Health Programs.

According to Barfield, "Research has shown that pregnant women may have increased post-disaster medical risks such as hypertension, anemia, preterm birth, and low birth weight infants." Georgia and Texas have both taken steps to strengthen home visiting services during emergencies and to coordinate and link home visiting with the broader system of care.

Emergency Preparedness Resources for Public Health Professionals

In partnership with local, state and federal agencies, CDC developed several pregnancy-related emergency response online tools and resources for state and local health department use.

- The reproductive health assessment after disaster toolkit, which assesses the reproductive health needs of women aged 15-44 affected by natural and man-made disasters.
- A reproductive health emergency preparedness and response online course for public health professionals.
- A Zika communications toolkit developed by the Texas Department of State Health Services, which includes an English and Spanish newsletter and social media content.

Georgia

The Georgia Home Visiting Program and GDPH's emergency preparedness program have an emerging, important partnership in which home visiting programs help families prepare for natural disasters, such as hurricanes or flooding, and connect them with needed community resources afterward.

GDPH regional emergency preparedness teams meet with key stakeholders on a quarterly basis to plan for emergencies and to discuss action plans and challenges. To better prepare families for future disasters, Georgia's home visiting program staff recently attended a quarterly meeting to discuss strategies for disseminating information to families involved in the home visiting system during an emergency. Galloway says that GDPH intends to build on this partnership moving forward. "We should be involved with the process, so home visiting knows ahead of time the evacuation route, who is the transportation group, and how to work with that group to help clients during an emergency," she says. This collaboration with the regional teams will help ensure that home visiting programs connect families with community resources in the critical time leading up to and following a natural disaster.

Texas

In response to an increased number of Zika cases in Texas, the state Office of Border Services trained community health workers, or *promotoras*, in U.S.-Mexico border counties on strategies to reduce the risk of becoming infected with mosquito-borne diseases. The community health workers conducted surveys during home visits and provided 250 households with education and prevention kits.[33] The Region 8 Office of Border Services in the Texas Department of State Health Services also partnered with the Southwest

Texas Area Health Education Center to assess Zika awareness in border communities and provide education to reduce the risk of mosquito-borne diseases.

6. FUND AND SUSTAIN HOME VISITING INITIATIVES

States adopt a variety of policy, investment, and infrastructure strategies to fund and sustain home visiting efforts, leveraging private and public funding sources in order to serve more families. For example, several states already finance part of their home visiting programs using Medicaid.[34] Below, we discuss home visiting program financing approaches from Texas and Washington state.

Texas

Strong bi-partisan legislative support has helped to build and sustain home visiting and early intervention capacity in Texas. In 2013, the state passed legislation establishing the Texas Home Visiting Program and requiring the Health and Human Services Commission to develop a strategic plan to serve at-risk pregnant women or families with children under 6. The legislation also directed the commission to submit a report on state-funded home visiting programs to the legislature. In 2015, legislators funded evidence-based programs for parenting education, home visiting, and family support services designed to prevent or address child abuse and neglect.

In 2016, the Texas Home Visiting Program and the Nurse Family Partnership were transferred from the Texas Department of State Health Services to the Prevention and Early Intervention Division in the Department of Family and Protective Services (DFPS).[35] The move merged home visiting into one division that administers all home visiting funding streams, including MIECHV funds, state general funds, TANF funds, and state funds for the Healthy Outcomes through Prevention and Early Support program. According to Sofia Santillana, early childhood team lead for Texas' Prevention and Early Intervention Division, state investments and support for home visiting have helped DFPS manage funds effectively to support systems change through both research and use of accountability measures, which are described later in this document.

DFPS also works closely with communities to help sustain services and systems change work. DFPS developed a funding strategy that it is testing in four Texas communities; to receive funds, communities were required to partner with stakeholders, including local hospitals, clinics, or foundations, to match state funds. Local matched funds result in an increase in state investment, thus incentivizing diversified funding profiles. As a result of this early work, communities are engaging stakeholders and adopting strategies such as Family Connects, a new-to-Texas evidence-based approach for supporting newborns and their families. According to Santillana, the local matches, which come in the form of office space or other contributions, support sustainability at the local level.

Washington

Jointly administered by the DEL and Thrive Washington, Washington state's HVSA brings together state, federal and private dollars to support a portfolio of evidence-based and promising programs. Since the account was created in 2010, it has grown from funding four grantees serving 120 children to funding almost 40 local implementation agencies with the capacity to serve 2,000 children statewide.

Funding sources include federal MIECHV funds, private funds, and two state funds—including general funds and a marijuana tax fund. Washington is one of several states that use TANF funds to partially finance home

visiting services for eligible families by linking it to one of four core TANF purposes. States have considerable flexibility in how they spend federal and state TANF funds for activities that meet any of the program's four purposes, one of which aims to help needy families care for their children in their own homes. HVSA only funds a portion of all the early childhood home visiting in Washington state, and some funding sources from other agencies do not run through the account. (For more information, visit DEL's website.) In addition, Washington state is researching and developing recommendations about how to leverage additional Medicaid resources for home visiting.

7. DEVELOP, MEASURE, AND REWARD MEANINGFUL OUTCOMES

States are adopting varied approaches to define and measure outcomes for children and families served by home visiting. As described below, these approaches seek to help state and local officials measure and track home visiting services and broader early childhood system progress toward desired maternal and child health outcomes.

Defining and Measuring Systems-level Change in Texas

Texas DFPS administers all of the state's home visiting programs and has adopted different approaches for incorporating systems change into its contracts with the local agencies that provide home visiting services. DFPS awards contracts that achieve measurable improvement in maternal and child health or school readiness by:

- Developing and enhancing community early childhood coalitions that effectively coordinate services and address broad, community-level issues that impact young children and families.
- Expanding home visiting services for at-risk pregnant women and parents and caregivers of children birth to age 5.[36]

Common features of early childhood systems change methods include a coordinated outreach and intake, matching families with the most important combination of services, and changing organizational operations to align with collectively-identified goals.[37] At the community level, systems change engages key stakeholders to make long-term adjustments that impact all children and families living in the community, including those not served through home visiting services. Because every family may not need or want home visiting services (or may not stay in the program for the optimal duration of time), a systems approach provides an opportunity to make a broad impact on the overall community. "If we can—in tandem—provide home visiting for [participating]families and make those systems changes that improve the community, we feel like we're making the most optimal changes for families, whether they're part of home visiting or not," Santillana says.

The DFPS contracting process emphasizes meeting communities where they are, recognizing their unique needs, strengths, and resources. Contracting with local agencies to provide home visiting or coalition services involves prioritizing community issues, developing a community agenda, identifying partners with influence and key champions, engaging cross-sector partners, identifying a coalition structure, and proposing measurement strategies that will help the community track its progress against its own baseline. DFPS encourages communities to use tools like those described below in order to define and measure systems change.

- A process like the Community Readiness Model, developed by the Tri-Ethnic Center for Prevention Research at Colorado State University, can help communities identify (1) their baselines with respect

to systems change, (2) what strategies they can use to move forward, and (3) how they will measure progress.

- The Early Development Instrument, a population measure of school readiness for kindergarten-aged children, measures five developmental domains that affect child well-being and school performance: physical health and well-being, social competence, emotional maturity, language and cognitive skills, and communication skills and general knowledge. Results are reported as percentages of children living in the community who are vulnerable, at-risk, or on-track in these five categories. The data often helps communities identify areas that need the most systems changes, and it can help decisionmakers track progress to assess how investments and policies are impacting child health and well-being.[38]
- Community coalitions also have the option of utilizing the Results-Based Accountability (RBA) framework to identify indicators that the community deems most important to address. The Ready Kid San Antonio Coalition identified three RBA indicators for happy, healthy, and school-ready children. (For example, happy children are defined as those who grow up in safe, stable, and nurturing environments.) An RBA scorecard provides population-level indicators—such as the percentage of preschool-aged children enrolled in school or the percentage of children in families experiencing employment instability—that quantify the community's progress toward these indicators.

Texas Department of Family and Protective Services' Role in Community Coalitions

DFPS supports communities in a variety of ways, such as matching each community with a designated program specialist who serves as its designated point of contact. The specialists visit communities, understand their strengths and barriers, and help them navigate the home visiting services procurement process. They also work with communities to connect with stakeholders to move their work forward—for example, by attending established meetings with the mayor's office or local school board—and help deliver needed training and technical assistance. In addition, DFPS works closely with communities to provide peer-to-peer networking, webinars, resources, and training, particularly regarding health and mental health. DFPS also works closely with the home visiting models across the state to address community needs, such as training home visitors to address the growing opioid crisis.

Washington State

Washington state home visiting officials are also attuned to the importance of developing meaningful outcomes. "We attend to global program and family outcomes to support programs to examine their performance and overall progress," Alfani says. "We also want to explore outcomes that measure incremental, but meaningful gains, like finding a childcare provider or enrolling [a] child in a pre-kindergarten class." She adds, ""We have lots of measures that we use and a lot of tools, but what really matters is the change families want and can make in their lives and do in partnership with a home visitor." King agreed that outcomes and successes often depend on what assets and adversity families come in with. Assessing sensitive, incremental changes is an ongoing challenge and pursuit for the home visiting services program.

LOOKING AHEAD: CONSIDERATIONS FOR STATES

States and communities across the country face persistent and evolving challenges, ranging from increasing substance misuse and abuse among parents to growing unmet needs for behavioral health services and

supports. States and communities recognize that coordinated policies and investments can make a difference by strengthening relationships, identifying and addressing problems early, and protecting children from the long-ranging effects of stress and adverse experiences. The examples profiled above offer multiple options that can inform other states' approaches to building a strong early childhood and home visiting system. The interviewed state leaders' experiences suggest several common themes and considerations that other states may be able to replicate, including:

- **Support and build community capacity to deliver coordinated early childhood services that are right for that community.** Straightforward contracting procedures, collective impact or strategic planning, or well-developed coordinated outreach, intake, or referral systems can facilitate community capacity and systems change.
- **Leverage federal (e.g., MIECHV, Medicaid, or HRSA Home Visiting Innovation Awards) and other public and private funds to support coordinated home visiting approach.** States can examine opportunities to use MIECHV funds to expand the centralized intake system or to fund program staff who liaise with communities, home visiting models, and state stakeholders.
- **Assess the current governance and organizational structure to assure that it can support coordinating health and early learning investments and strategies.** Some states have transferred home visiting programs to different agencies or programs to facilitate coordination and cross-sector partnerships.
- **Cultivate and maintain home visiting support among policymakers, local champions, local providers, communities, and families.** State health officials and home visiting administrators play an important role in educating state leaders, legislators, and other key stakeholders about home visiting and its demonstrated impact on vulnerable families.
- **Engage stakeholders to set a common and unifying goal.** A common goal, such as ensuring that children are healthy and ready for school, can help align stakeholders working to achieve the same end.
- **Learn from other states.** States are adopting multi-faceted approaches to strengthen home visiting and improve outcomes for children and families. Through initiatives such as ECCS and Home Visiting CoIINs and the HRSA Innovation Awards, states can learn from, and consider how other states' approaches might fit within their own contexts.

As the states profiled here attest, the work is not easy and involves multiple stakeholders—including state and local health officials, legislators, home visitors, community advocates, and managed care officials—working together to develop multi-faceted approaches to achieve better child and family outcomes.

APPENDIX A: HOME VISITING LANDSCAPE IN FOUR PROFILED STATES

Kansas

Launched in 2011, Kansas' Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program targets two high-risk communities located in eastern Kansas: urban Wyandotte County, which encompasses Kansas City, and a cluster of rural southeast Kansas counties. A 2017 technical report published by Kansas Home Visiting found that "These counties face the state's highest rates of poverty, child abuse, domestic violence, teen and single parenthood, and unemployment."

Home visiting programs include Early Head Start, Healthy Families America, and Parents as Teachers. Wyandotte County has implemented a promising approach, known as the Team for Infants Endangered by Substance Abuse (TIES), which assists pregnant and postpartum women (and their families) affected by alcohol or other drugs until their children are two years old. TIES specialists offer support for substance use disorder treatment, supportive counseling, child health and development support, parenting education, and connection to other community services. In addition, the Kansas Department of Health and Environment administers a universal home visiting program that supports families and children from pregnancy until a child enters kindergarten. Local programs also exist in communities throughout the state.

Georgia

Georgia Department of Public Health administers the Georgia Home Visiting Program, which aims to improve child and family outcomes in the state by implementing home visiting as a major service strategy. According to the agency, MIECHV funding "affords Georgia the opportunity to create a statewide home visiting infrastructure to expand and improve existing home visiting services, to more effectively replicate home visiting models, and to link home visiting to other community efforts focused on promoting optimal early childhood health and development." This program is designed to:

(1) Strengthen and improve the programs and activities carried out under Title V funding.
(2) Expand and improve the coordination of services within at-risk communities.
(3) Provide home visiting services to those families who are most in need of support in providing safe, nurturing environments for children.

In addition to its evidence-based programs, Georgia operates First Steps, which provides universal support services for all expectant parents and for children under 5 and their families. Through First Steps, families receive a localized community resource guide, referrals to relevant resources, and age-appropriate information about maternal and child health, safety, school readiness, and economic self-sufficiency.

Texas

Texas Home Visiting's goal is "to help good people be great parents." It pursues this by assisting expectant parents and individuals with children under seven via three models: Home Instruction for Parents of Preschool Youngsters, Nurse Family Partnership, and Parents as Teachers. Statewide, 114 local agencies run at least one of these models.[39]

In 2016, the Texas Home Visiting Program and the Nurse Family Partnership were transferred from the Texas Health and Human Services Commission to the Prevention and Early Intervention (PEI) Division in the Department of Family and Protective Services.[40] The PEI division "was created to consolidate child abuse prevention and juvenile delinquency prevention and early intervention programs within the jurisdiction of a single state agency. Through home visiting programs and other initiatives, PEI aims to help communities build strong families by:[41]

- Designing programming and targeting high-risk communities based on an understanding of both risk factors and protective factors for child abuse, neglect, and juvenile delinquent behavior.
- Contracting with community organizations to provide a variety of evidence-based child and family support services.
- Funding public awareness campaigns to promote community parenting norms and child safety.

PEI services include home visiting to educate at-risk parents of newborns to school-aged children, parenting classes and support groups, and crisis intervention and counseling for families and teens.

Washington State

Washington state is a recognized leader in developing a comprehensive and coordinated early learning system, and voluntary, family-focused home visits are a key service within this system.[42] Home visiting has a decades-long history in Washington state, beginning in 1989 with the creation of the state's First Steps program. In 2010, the Washington State Legislature established the Home Visiting Services Account to leverage public and private dollars to support home visiting services and infrastructure. Jointly administered by the state Department of Early Learning (DEL) and Thrive Washington, the Home Visiting Services Account brings together state, federal, and private dollars to support a portfolio of evidence-based and promising programs.

According to the Washington State Department of Early Learning's 2017 Home Visiting Scan, the goals and objectives for the state's home visiting program include:

- *Service Delivery and Access*: Ensure that high-quality, culturally competent home visiting services that meet the needs of local communities are available and accessible to at-risk families across the state.
- *Governance and Planning*: Integrate the home visiting system as part of the broader early learning planning and governance structure, encourage collaboration at the state and local levels, and engage and reflect the communities served.
- *Finance and Sustainability*: Build finance strategies and generate resources to sustain and grow the home visiting system in Washington state.
- *Quality and Accountability*: Ensure high-quality services and effective implementation of home visiting models and programs.
- *Public Engagement*: Build community and public will for a home visiting system that provides high-quality services to families in local communities.

The Washington State Department of Early Learning administers the home visiting program, which includes Nurse-Family Partnership, Parents as Teachers, Parent-Child Home Program, Early Head Start, and Family

Spirit. For more information on Washington state's early learning accomplishments and milestones please visit the Thrive Washington web page.

APPENDIX B. SELECT TOOLS AND RESOURCES

State-Specific Resources and Fact Sheets

- HRSA's Maternal and Child Health Bureau maintains an interactive state map of Maternal, Infant, and Early Childhood Home Visiting (MIECHV)programs and an overview of state home visiting funding.
- The National Home Visiting Resource Center maintains comprehensive information about early childhood home visiting, and the 2017 yearbook provides state profiles, including evidence-based models operating in the state and caregiver education and other demographic data.

Financing Resources and Tools

- The HRSA and Center for Medicaid and Children's Health Insurance Program Services 2016 Joint Informational Bulletin addresses ways that states can design a benefit package to provide home visiting services for pregnant women and families with young children.
- A 2017 state checklist from the Center for American Progress outlines for the state process for expanding Medicaid to cover home visiting.
- The National Academy for State Health Policy's checklist for state decisionmakers discusses payment approaches, Medicaid managed care, and other financing options.

Program Implementation Tools

- The 2016 webinar and policy brief "Planting Seeds in Fertile Ground: Steps Every Policymaker Should Take to Advance Infant and Early Childhood Mental Health," developed by Manatt Health for Zero to Three, highlights what states can and should do to promote infant and early childhood mental health.
- HRSA's 2017 brief "Creating a Trauma-Informed Home Visiting Program" outlines the importance of trauma-informed care and equipping home visitors to support families experiencing trauma.

Measurement and Evaluation Tools and Resources

- Communities can use the Community Readiness Model, developed by the Tri-Ethnic Center for Prevention Research at Colorado State University, to identify their readiness to adopt a specific action and identify strategies and measures.
- The Early Development Instrument, a population measure of school readiness for kindergarten-aged children, measures five developmental domains that affect child well-being and school performance.
- Communities can use the Results Based Accountability (RBA) framework to identify indicators that the community deems most important to address. For example, the Ready Kid San Antonio Coalition identified three RBA indicators around happy, healthy, and school-ready children.

Policy Development Resources and Tools

- The National Conference of State Legislatures' 2016 "Policy Strategies for Strengthening Infant and Early Childhood Mental Health" webinar highlighted actionable strategies for policymakers to consider to address the healthy development of young children.

- The National Conference of State Legislature's 2016 Enacted Legislation on Early Care and Education web page lists state legislative actions related to child care, pre-kindergarten, home visiting, parent engagement, governance, and early care financing.

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