



NO PLACE LIKE HOME: STATE HOME VISITING POLICIES AND PROGRAMS

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FOREWORD: STATE LEGISLATORS' PERSPECTIVES

Is there really a program that results in a 60 percent reduction in violent, antisocial behavior among 15-year-olds? Yes, there is. In a randomized, controlled trial—the gold standard for medical research—a home visiting program for at-risk families with young children achieved just this result. Moreover, a comparable result was obtained at a second site, and new infant brain research explains why it should be possible to have a similar impact elsewhere.

Home visiting programs work by sending child health professionals to the homes of new parents to help them create a safe, healthy, and nurturing environment for their infant or toddler. In our states, Vermont and Wyoming, the legislatures recently passed bills creating home visiting programs. Other states besieged with demands for more spending on prisons, juvenile justice, and troubled youth have enacted similar programs. Although it takes a while to achieve measurable reductions in violent crime (about 15 years), home visiting programs can help states in the nearer term (two to five years) lower welfare payments, cut health care costs, and help prepare children for school.

Our approach to introducing and passing home visiting bills in our respective states was remarkably similar. Both of us understood the great potential to help families and children. By identifying with our colleagues' concern for preventing violence and crime, we were able to capture the attention of our colleagues in the legislature. The strength of the research on home visiting's potential effectiveness spoke for itself. Although finding funds to pay for the programs was, as always, the greatest challenge, it was more easily overcome due to the persuasiveness of the evidence.

While we come to this issue with different party affiliations, levels of experience with program operations, and state approaches to family policy, both of us agree on the importance of investing in our children and of the value of home visiting programs to improve child health and well-being. The payoff, after all, lasts a lifetime.

The survey results and case study findings in this report are consistent with our experience as state legislators. We urge other policymakers to consider enacting home visiting programs as one of their investments in our country's future.

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EXECUTIVE SUMMARY

Recent years have witnessed a significant expansion of efforts to improve results for young children by strengthening their families' capacity to care for them in their first months and years of life. Many states and communities have increased investments in home visiting programs. Through such programs, trained visitors come to the homes of expectant or new parents (or guardians), to help them provide safe, healthy home environments and warm, responsive care for young children.

Investments in home visiting have been stimulated by a quarter-century of home visiting demonstration projects, which provides a large body of research on home visiting. At the same time, the convergence of several policy and research trends created a policy setting conducive to the expansion of home visiting efforts. These include growing public awareness of infant and brain development research, emphasis on early education and school readiness, recognition of the importance of family support, enactment of welfare reform policies, expansion of child health coverage, and the devolution of authority and funding in many policy areas to states.

Policymakers who fund home visiting programs are often motivated by a desire to reduce public assistance costs, maximize opportunities in early childhood development, and use approaches that have been proven effective. Home visiting efforts can be stand-alone programs, but more often figure as a key element in a broader childhood initiative. The National Governors' Association includes home visiting programs among "promising practices to improve results for young children," and the National Conference of State Legislatures reports that: "Policymakers are increasingly incorporating early care and education services into a system that provides families with comprehensive, flexible and concrete assistance.... These family support services include parent education, counseling, home visits, job training...health and social services, housing...."

Purpose of This Report

This report summarizes the results of a survey of states regarding home visiting activities. It also includes, in an appendix, in-depth analyses of selected state programs and approaches (see Table ES-1 on p. xii for a summary of case study findings). The study did not intend to evaluate program effectiveness, but rather to assess the direction of state policies and programs through a nationwide examination of state-based home visiting programs targeting low-income families with young children.

A key finding is that many states have made a substantial commitment to home visiting programs, either through policy development or direct support. Of the 42 states

that responded to the survey, 37 reported state-based home visiting programs. An additional three states have state-level quality improvement or technical assistance projects that support a range of locally based home visiting programs. Each state has adopted a unique combination of home visiting services based on what it believes effective, what it has the resources to provide, and/or what local communities will accept.

For this study, state-based home visiting programs are defined as those that are guided by state policies and administered by state agencies—a department of health, human services, or education. As a complement to local, community-based programs, these state-based programs provide public resources to support and sustain home visiting efforts. Among those that provide financial support, most use a combination of state and federal dollars.

The state-based home visiting programs described in this report vary widely in terms of program design, funding, target population, and staffing. Virtually all of the state programs identified have broad objectives for improving child and family function. They tend to serve a resource-and-referral function, with services provided by a team of lay and professional staff. Many states have adopted a preexisting program model, adapting it to their particular political and fiscal environment. About half of the programs are part of a larger initiative or intervention strategy or initiative. The size of the population served is not highly correlated with the size of the state's population. Several states operate multiple programs, with different (and sometimes overlapping) target populations and varying degrees of coordination. Most states are planning or carrying out evaluations of their home visiting programs.

Three Key Challenges

The report identified key challenges encountered by states as they institute or expand home visiting programs:

- *Managing multiple programs.* Three typical approaches used by state agencies include collaboration, shared authority, and integration. In many cases, coordination is the most difficult challenge facing home visiting programs. Political and turf battles are common. The preferred mechanism for collaboration and coordination is creation of a working group that meets regularly to share planning, budget, and program information. Determining how to integrate services is not the only issue; it is often difficult to decide where program integration should stop—at what age, with what type of service (e.g., health versus education), for what types of families.

- *Dealing with the complex requirements associated with various funding streams.* Available funding often drives policy and program decisions. States that use Medicaid financing as part of their core, base funding must deal with limits on the scope of the benefit (i.e., what Medicaid considers a reimbursable service) and eligibility requirements. In some states, home visiting programs must negotiate with the state for a “carve-out” of their payments or negotiate with managed care organizations for a provider contract. Similarly, some states use the funding from early intervention for services to children from birth to age 3 at-risk of or with developmental disability (Part C of the Individuals with Disabilities Education Act) as the basis for their home visiting effort. However, this approach may not be appropriate or workable for programs that are focused primarily on social rather than medical risk factors. In general, limits on categorical grant funds pose a challenge to states. The challenges of requiring that local home visiting agencies working with counties to do billing for case management to multiple payers was mentioned. Grants to counties, which blend funds from a number of categorical and entitlement funding streams, have permitted more flexibility in approach and management.
- *Promising—but not overpromising—results.* Advocates and agency staff who want to develop state-based home visiting programs use all available evidence to sell the concept to state legislators and executive officials. However, in this process, they frequently promise too much in the way of results. This is a difficult balance and is a constant tension in the policy-program development process. Where state home visiting legislation mandates evaluation, or state laws set out specific outcome indicators, the challenges can be particularly great. State and local program administrators must respond and are pressured to devise data collection and analysis strategies that meet such legislative mandates, while protecting families’ confidentiality and not compromising professional data standards.

Recommendations

Researchers and experts have stated that there is a need to improve the quality and implementation of existing home visiting services and a more modest view of the potential of the broad array of home visiting programs. This study of state policies supports that view and makes recommendations for specific changes in policy and programs.

- Refine and narrow program objectives and outcome measures. Currently, many programs appear to have promised more than their home visiting activities can be expected to deliver (based on previous evaluation studies). Failure to meet

unrealistic or overly ambitious program goals can undermine state program efforts. Aligning outcome objectives more closely with the actual intervention strategy is an important step. Agencies might begin by clarifying their purpose, using a “logic model” to align their objectives with the intervention (e.g., content of visit and target population).

- Promote quality among local home visiting efforts. Quality assurance is among the strongest recommendations drawn from evaluation studies on home visiting. Key challenges include matching the intervention to program objectives and ensuring consistency when implementing preexisting models. State agencies have a key role to play in assuring the quality of home visiting services. Quality improvement and assurance includes staff training, use of practice standards/ protocols, and results monitoring.
- Take explicit action to understand the flow of funds, blend funding where appropriate, and maximize public resources. Each state should conduct analyses to determine how much is being spent on state-based or state-funded home visiting efforts and to review the flow of dollars. Steps could be taken to maximize third-party payments from Medicaid and private insurance benefits. Home visiting programs also might take advantage of opportunities to pool funds; use a single administrative authority; or leverage additional federal, local, or private dollars. Eliminating unnecessary duplication of effort is yet another way public dollars could be managed better.
- Minimize unnecessary duplication of effort. When multiple home visitors serve one family, the results are likely to include overwhelmed families who reject services, frustrated staff, inconsistent and ineffective interventions, and wasted tax dollars. Continuity and consistency have been shown to be important factors in the effectiveness of home visiting interventions. States should seek to reduce unnecessary duplication and maximize fiscal and personnel resources.
- Establish mechanisms for interagency coordination. In many states, home visiting activities are carried out through many agencies and programs. Interagency coordination is needed to reduce duplication of services, maximize resources, and ensure the quality of publicly supported home visiting programs. State-level mechanisms might include a coordinating council, joint staff meetings, a unified management structure, or a consolidated program review process. Using their

grants and contracts process, states also can encourage local entities to use similar structures.

- Provide leadership to support local programs. The degree of authority or control available to state agency staff varies greatly. In some states, county officials have considerable autonomy. In some programs, state and federal dollars are passed along directly to local private agencies. The state and local political environment may accept or discourage state regulatory action. Some state legislatures and executive agencies want statutory and regulatory provisions that give them control and oversight of programs. Where adopting new regulation is not possible or desirable, state agency staff can exercise leadership and help to improve the quality of home visiting programs by facilitating development of voluntary guidelines and standards, supporting expert consultation, and providing staff or financial support for continuing technical assistance.
- Request federal policy leadership for information sharing, standard setting, performance monitoring, and evaluation within and among states. This work might be done collaboratively among federal agencies. Creating a new federal home visiting program or national guidelines was not viewed as desirable by state agency staff.
- Establish 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 clearly points to the 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, infant assessment and stimulation, adequate health services, quality child care/early education, and interventions to ensure a safe environment. Home visiting programs can provide one or more of these services and can link families to others. Moreover, different models of home visiting services may be beneficial to families at varying levels of risk. Matching family risks to interventions and needs to services is essential if programs are to enhance family strengths and promote child development and well-being.

Table ES-1. Summary of State Case Studies

State	Programs Discussed in Case Study		Highlights of State Case Study		
	Program Names	Key Program Characteristics	General Approach	Promising Practices	Future Directions
Illinois	Parents Too Soon	Provides support to pregnant and parenting teens with weekly visits.	<p>Maximizing models to provide a continuum of services.</p> <ul style="list-style-type: none"> Multiple programs using various funding sources to address different family needs and policy goals. Substantial state dollar investment. Legislative structure for key programs. Targeted funding strategies. Coordination mechanisms rely on local action. 	<ul style="list-style-type: none"> Strong emphasis on quality assurance. One evaluation team for multiple programs. Some programs maximize Medicaid financing, while others operate outside the limits of Medicaid. Collaboration with child advocates in program development. 	<ul style="list-style-type: none"> Aim to strengthen services along the continuum of family need. Hope to increase the capacity to address maternal depression. Continue to identify appropriate funding streams.
	Medicaid Family Case Management Program	Intensive service coordination for pregnant women and infants to reduce infant mortality. Uses Medicaid's administrative case management approach.			
	High-Risk Infant Follow-Up Program	Provides follow-up, early intervention, parenting skills, family support, and other preventive interventions for high-risk infants and their families.			
	Healthy Families Illinois	Considered the primary state-based home visiting program. Grantees a mix of local health departments and not-for-profit social service/child welfare agencies.			
Massachusetts	FIRSTLink	Uses the birth certificate system to identify mothers and infants at greatest risk for developmental and other health problems. Goals: screen all newborns, link families with needed services, coordinate home visiting efforts, and integrate child health information.	<p>Using a common administrative structure for a continuum of services.</p> <ul style="list-style-type: none"> Multiple programs with the shared goal of identifying high-risk families and preventing crises. Department of Public Health administers five programs. Blended funding for most programs. 	<ul style="list-style-type: none"> Common administrative structure. Continuum of services (explicit). Building on newborn screening and high-risk infant follow-up traditions. Collaboration with private sector leaders. 	<ul style="list-style-type: none"> Aim to strengthen services along the continuum of family need. Hope eventually to guarantee all newborns a home visit. Hope to provide better data system.
	Healthy Families Initiative	Comprehensive, prevention-oriented, voluntary home visiting services, and assistance for first-time teen parents.			
	First Steps	Provides comprehensive, prevention-oriented, voluntary home visiting services, with a range of complementary services such as parent groups and social supports.			
	FOR (Follow-up, Outreach, and Referral) Families	Telephone hotline and home visiting program for parents coming off welfare assistance.			
	Early Intervention Program	Provides support and education for parents on the care and management of their children.			

State	Programs Discussed in Case Study		Highlights of State Case Study		
	Program Names	Key Program Characteristics	General Approach	Promising Practices	Future Directions
Michigan	Early On	Seeks to address a wide range of child and family needs using a family-centered and primarily home-based approach. Targets children at risk for developmental disabilities.	<p>“Putting It Together” (PIT) for Families</p> <ul style="list-style-type: none"> Multiple programs with the shared goal of identifying high-risk families, emphasis on child protection and developmental needs. Programs operate like building blocks, with new pieces fitted into structure. Emphasis on local planning. Blended funding, particularly at the local level. State executive leadership (governor, lieutenant governor, and cabinet members). 	<ul style="list-style-type: none"> Local collaborative planning body. Team approach at the state level (PIT crew). Policies set at state level, with local communities setting priorities and taking responsibility for coordination, systems planning, and results-based accountability. 	<ul style="list-style-type: none"> Evaluation results shared with legislature, state agencies, and community leaders. Further refine home visiting structures under Medicaid managed care. Expand some efforts to additional counties.
	Michigan Interagency Family Preservation Initiative	Demonstration project aimed at improving the delivery of human services, as well as promoting collaborative community-based services that support children at risk for out-of-home placement.			
	Strong Families, Safe Children	Providing family preservation services, and planning and implementing services for children and families based on state-identified outcome measures.			
	Zero to Three Program	Provides home visiting services, Healthy Start-based models, parent resource centers, and parent mentors, among other services.			
	Working Together as Community Partners	Provides money to counties to enhance the services available to families whose Protective Services cases have been unsubstantiated.			
	Maternal and Infant Health Advocacy Services (MIHAS)	Through Medicaid, provides case management for high-risk pregnant women and infants.			

State	Programs Discussed in Case Study		Highlights of State Case Study		
	Program Names	Key Program Characteristics	General Approach	Promising Practices	Future Directions
North Dakota	Guidelines and technical assistance	No state program. Providing state-level leadership to advance quality guidelines, promote information-sharing among programs, improve resource and referral information for families, and provide technical assistance on program development and evaluation.	Using state leadership to help local programs improve quality. <ul style="list-style-type: none"> • “New Mothers’ Survey” data to determine prevalence of home visits. • Built collaborative group for consensus development of guidelines. • Compiled information from more than 70 local providers into a directory for infant and early childhood home visiting programs. 	<ul style="list-style-type: none"> • State support and leadership for local programs, although no single state-based program exists or was desired. • Bringing local programs together in a long-range quality improvement project and building consensus. 	<ul style="list-style-type: none"> • Continuing collaboration among local providers. • Conducting pilot studies using quality guidelines. • Supporting local application of quality guidelines through technical assistance.
Ohio	<i>Welcome Home</i> Newborn Home Visit Program	Home visiting nurses offer information, respond to questions, and provide referrals for new parents just before or just after the birth of a baby. Targets all adult parents of first-born babies and all teen parents, regardless of income.	Putting high-risk families and children first. <ul style="list-style-type: none"> • Provides an infrastructure for coordinating an array of early childhood programs. • Local councils guide work at the community level. • Visiting every newborn, plus additional home visits for at-risk families with young children. • Blending Medicaid, TANF, and other funds. • State executive leadership (governor and cabinet members). 	<ul style="list-style-type: none"> • Local delivery system under common, state administrative structure. • Local grants to support and sustain Family and Children First councils. • Maximizing available federal funding. • Integrating principles and structures of early intervention with home visiting and parent support. 	<ul style="list-style-type: none"> • In mid-year 2001, programs will be consolidated under one administrative structure and blended to maximize efficiency and effectiveness.
	Ohio Early Start Initiative	Provides funding for home visiting services and community supports for at-risk families. Focuses more on risks during the first year of life, places greater emphasis on family self-sufficiency, and continues activities to prevent child abuse and neglect.			

State	Programs Discussed in Case Study		Highlights of State Case Study		
	Program Names	Key Program Characteristics	General Approach	Promising Practices	Future Directions
Oklahoma	Children First	Based on “Olds” nurse home visiting model. Teams of nurses employed by local health departments.	Developing programs in an era of accountability. <ul style="list-style-type: none"> • Multiple programs using home visiting as a prevention and intervention strategy. • Initially adopted paraprofessional home visiting program, later added a more extensive nurse home visiting model. • Legislature involved in program structure and oversight. • Substantial state investment. 	<ul style="list-style-type: none"> • Common administrative structure in maternal and child health program. • Child abuse prevention funds allocated by district, according to a formula based on child abuse rates and child population. • Handled rapid development of nurse home visiting program. 	<ul style="list-style-type: none"> • Training is ongoing challenge. • Demonstrating effectiveness through outcomes evaluation. • Adapting program as necessary to meet changing family needs.
	SoonerStart	Program uses multidisciplinary team approach, with teams primarily comprising physical therapy, nursing, social work, nutrition, and mental health professionals.			
	Healthy Families	Child abuse prevention focus, using the 12 critical elements of home visiting identified by Healthy Families America.			
Oregon	Early Intervention Home Visiting Initiative	Addresses fragmentation in home visiting services and sets out a vision for a continuum of home visiting services (the state had 8 overlapping home visiting programs), aligns and consolidates existing programs and resources into a statewide system of early childhood supports. Provides a Home Visiting Training Development team to examine training methods and resources.	Programs set in context of comprehensive initiative launched by Governor Kitzhaber and leading from a Lieutenant Governor’s Task Force Report. Initiative includes consolidation of several early childhood programs, restructuring family preservation services, coordinated community-level grantmaking, and new funding.		

State	Programs Discussed in Case Study		Highlights of State Case Study		
	Program Names	Key Program Characteristics	General Approach	Promising Practices	Future Directions
Rhode Island	CHILD FIND and KIDSNET	Integrated statewide program to ensure early identification of children at risk, provide support for families in crisis, and link families to other needed resources (such as child care). Aims to avoid duplication of services and maximize resources. Data system supports parent and provider needs.	<p>Building an integrated child health system.</p> <ul style="list-style-type: none"> Nearly 100 years of home visiting. Integrated statewide program, supported by data system. State executive leadership (governor and “Children’s Cabinet” members). 	<ul style="list-style-type: none"> Using a child health profile and database. Coordination a top priority. Ability to address a wide range of family issues through a common data and support services system. Addressed confidentiality and privacy concerns. 	<ul style="list-style-type: none"> Strengthening early intervention services delivery system. Further expanding capacity and capability of integrated child health data system.
Wisconsin	Child Abuse and Prevention Grant Program (Act 293, also known as POCAN)	Supporting local initiatives through grants, POCAN is aimed at the prevention of child abuse. Offers parents assessed to be “at-risk” the opportunity to participate in the home visiting program. Follows the 12 critical elements outlined by Healthy Families America.	<p>Using Medicaid financing to support home-based case management.</p> <ul style="list-style-type: none"> One statewide (POCAN) and one city-focused program to meet different needs. Case management and care coordination are focus. First-time parents are target population. Medicaid managed care presented challenges. 	<ul style="list-style-type: none"> Grants to counties and American Indian tribes. Active role for public health in developing infrastructure. Fit into welfare reform and Medicaid policies, as they have changed. University-based training and technical assistance, using Extension Program— includes “train-the-trainer” approach. 	<ul style="list-style-type: none"> Hope to address creatively some of the challenges created by Medicaid managed care and limits on Medicaid financing. Need to secure long-range, stable funding. Managing devolution of responsibility to local county agencies.
	Milwaukee Family Project	Medicaid case management/home visiting benefit. Coordinated by the state Division of Public Health. Provides home visiting as a component of child protection and family preservation. Uses the 12 critical elements of home visiting programs outlined by Healthy Families America.			

NO PLACE LIKE HOME: STATE HOME VISITING POLICIES AND PROGRAMS

INTRODUCTION

Home visiting programs have a rich history, stretching from Elizabethan times in England to the social reform movement in the United States at the turn of the last century.^{1,2} Early in the 20th century, the U.S. commitment to home visiting as an intervention strategy was evidenced by the nearly 300,000 home visits made by nurses in 1925, using then-new federal funding to states for maternal and child health services under the Sheppard-Towner Act.³ Now, as then, home visiting initiatives are generally aimed at improving outcomes for at-risk families through systematic interventions beginning early in life.

In the past decade, pediatricians,⁴ public health nurses, social workers, and community-based organizations seeking to provide a range of early intervention and prevention services to at-risk families have developed new home visiting models. Home visiting is one of several family supports and intervention strategies being tested today (others include center-based interventions, comprehensive community initiatives, and welfare reform).⁵ To quote Heather Weiss of the Harvard Family Research Project, “Home visits are a necessary, but not sufficient, component of a larger national strategy to strengthen families and improve the health, well-being, and life chance of poor children.”⁶ Understanding the characteristics of home visiting programs, their results, and how they fit into the larger community and societal context is essential to developing effective future policies and programs, particularly those subsidized with public dollars.⁷

Contemporary U.S. home visiting programs serve a variety of purposes.⁸ Many developed in the 1980s were aimed at improving maternal and newborn outcomes (e.g., reducing low birthweight and infant mortality rates)⁹ using prenatal interventions.¹⁰ Others are aimed at improving parenting skills to prevent child abuse and neglect,^{11,12} injuries,¹³ or developmental delays.¹⁴ Programs also have been designed to provide respite or therapeutic care for parents of children with special health care needs (e.g., disabilities or chronic illness). With the enactment of maternity discharge¹⁵ legislation in 26 states and by Congress during 1996,¹⁶ home visits for mothers and infants who leave the hospital early were mandated in more than one-third of the states (often the legislation defines the content or number of visits that must be covered by health plans).¹⁷

Still other communities are seeking to reduce environmental risks to children through home visits that assess lead exposure or respiratory irritants that may trigger

asthma and to teach parents how to reduce such exposure. Any of these may target low-income families, which are known to be at greater risk for infant mortality, child abuse, developmental delays, disabilities, lack of home support following birth, lead exposure, asthma, and other conditions.¹⁸

This report summarizes the results of a nationwide survey of state-based home visiting activities, complemented by more in-depth analyses of selected programs and approaches. The purpose of this study was not to evaluate program effectiveness, but rather to assess the direction of state policies and programs. This report documents how state policymakers have designed and financed home visiting programs for families with young children to address a wide range of family needs and public policy goals. These findings make it clear that states are attempting to take home visiting models “to scale” through policy development and public investment. I conclude with recommendations for further refining state policies and programs, based on recent research and the approaches described here.

Background on Home Visiting Models and Research Findings

Several important demonstration projects and research clinical trials have advanced current state-of-the-art in home visiting programs. While they have few common characteristics, there is no question that these projects have led to increased awareness, knowledge, and acceptance of home visiting. David Olds and colleagues conducted randomized controlled research trials of nurse-staffed home visiting programs serving low-income families in Elmira, New York, and Memphis, Tennessee (with additional work continuing in other sites), that yielded significant improvements in outcomes that others now seek to replicate in communities across the country.¹⁹

Project Child Survival/Fair Start, launched by the Ford Foundation to targeted low-income families with health, nutrition, child development, and social services in seven sites, was able to show modest positive effects.²⁰ The Infant Health and Development Program was started as an eight-site, randomized clinical trial designed to evaluate the effect of early intervention. It found significant effects on cognitive development²¹ and is being replicated through grants from the Centers for Disease Control and Prevention (CDC). The Mother-Child Home Program, aimed at improving parent-child verbal interaction, has been replicated in about 30 sites and serves an estimated 4,000 families. The Portage (Wisconsin) Project was designed to serve children from birth to age 6 with or at risk for developmental delays and has been both replicated and used as a training model for developmental intervention using home visits.²² The first “Resource Mothers” program was established in South Carolina in 1980, and several

hundred more have been developed across the country using indigenous paraprofessional women to visit and mentor pregnant women and mothers.²³

Established in 1985 as a federal demonstration project, the Hawaii Healthy Start program has shown some positive results using paraprofessional visitors and continues to be evaluated as it grows in scope and availability. This program is said to be the first state-based home visiting program of our time. Hawaii has been a leader in developing and scaling up a paraprofessional home visiting model, and some version of this model has been replicated in two-thirds of the states as Healthy Families America.²⁴

An increasing number of federal and state programs include home visiting as a central component. The Home Start component of the federal Head Start program has been offering home-based educational services since 1972 and serves approximately 50,000 children a year.²⁵ The Department of Education has funded centers in 28 states²⁶ using models from Parents as Teachers (PAT), originally launched by the State of Missouri, and Home Instruction Program for Preschool Youngsters (HIPPY). The federal Maternal and Child Health Bureau, Department of Justice, Administration for Children, Youth, and Families, and other federal agencies also have advanced home visiting program models and funding.

Privately launched initiatives initially may combine public and private dollars or become publicly funded initiatives when they expand after a demonstration period. Healthy Families America and the HIPPY program may be the most well-known examples of this phenomenon.

Home visiting programs of the past decade vary more than they share common attributes. Staff may be professionals or paraprofessionals working on a paid or volunteer basis. The appropriate role and effectiveness of paraprofessionals, compared to nurses and other professionals, has been a subject of debate among those who develop and study home visiting programs.

Home visiting programs and the services they provide also vary widely. The service package/protocol may be related to health, education, or social needs and may be targeted at an individual child or the family as a whole. Some programs begin during pregnancy or soon after the birth of a child, while others do not begin interventions until some identified risk or sentinel event triggers action (e.g., suspected child abuse, developmental delay, special health needs, or parent substance abuse). In turn, the purpose of the intervention may be to provide assessment, support, and referral for families with a

new baby or to carry out an intensive strategy for a family in crisis. Thus, the duration and frequency of services also varies considerably.

Another variable has to do with family acceptance and program retention—in other words, who participates, who drops out, and why. Studies of maternal home visiting programs have reported attrition rates ranging from 5 percent to 60 percent. A recent research trial found that nurses had fewer families drop out than did paraprofessionals,²⁷ and a recent study of a North Carolina program found that those in greater need of social support and those with healthier behaviors were more receptive to long-term home visiting.²⁸

Considerable effort has been devoted to evaluating home visiting programs to determine what type of interventions are most effective under what circumstances. This research indicates that the most effective and cost-effective programs:

1. focus on families with greater needs,
2. intervene beginning with pregnancy,
3. can be adjusted to family need,
4. actively promote positive health and caregiving behaviors,
5. focus on more than one problem, and
6. use professional or well-trained paraprofessional staff.²⁹

A 1999 monograph of the David and Lucile Packard Foundation, entitled “Home Visiting: Recent Program Evaluations,” concluded:

- Given wide variability in results, policymakers and practitioners should moderate their expectations. Home visiting is a valuable intervention, but it cannot cure all family ills.
- The success and effectiveness of home visiting programs depends on: the skill of the staff and appropriateness of the intervention, the availability of other health and social services in the community, and the quality of center-based services for children.

- Home visiting programs can fulfill a valuable function by providing the type of social support all families need.
- Interventions should focus on educating and changing parents' behavior. In addition, children's development is better promoted through more child-focused interventions, such as center-based group care where children spend a larger portion of their time with professionals.
- Child-focused interventions that combine center-based services for children with parent involvement through home visits or other mechanisms produce positive long-term outcomes.
- Home visiting programs rely heavily on referrals and case management, and they depend on other community services. If small communities or rural areas have no services available, home visiting to make referrals is not effective.³⁰
- Home visiting is a valuable, but limited intervention. The success and effectiveness of such programs depends on: the skill of the staff and appropriateness of the intervention, the availability of other health and social services in the community, and the quality of center-based services for children.³¹

The wealth of home visiting demonstration projects and research conducted during the past 25 years paved the way for increased public investment in home visiting. However, demonstration and research evidence alone is not sufficient to stimulate public policy development.^{32,33} The synergy of several policy and research trends led to creation of new state programs that can improve outcomes for young children. These trends include awareness of infant and brain development research, emphasis on early education and school readiness, recognition of the importance of family support, enactment of welfare reform policies, expansion of child health coverage, and, last but not least, the new federalism.

The National Governors' Association includes home visiting programs among "promising practices to improve results for young children,"³⁴ and the National Conference of State Legislatures reports that: "Policymakers are increasingly incorporating early care and education services into a system that provides families with comprehensive, flexible and concrete assistance.... These family support services include parent education, counseling, home visits, job training...health and social services, housing...."³⁵ This study found that policymakers were motivated by a desire to reduce public assistance costs,

maximize opportunities in early childhood development, and use approaches that have been proven effective. Given this, home visiting program administrators have promises to keep.

Study Purpose and Methods

Study Purpose

The purpose of this study was not to evaluate program effectiveness, but rather to assess the direction of policies and programs through a nationwide examination of state-based home visiting programs targeting low-income families with young children. For this study, state-based home visiting programs are defined as those that are guided by state policies and administered by state agencies. State-based home visiting programs for families with young children were included in this study when one or more of the following characteristics were found: state-level laws, regulations, or guidelines related to home visiting; state agency staff responsible for administration of home visiting programs; state funding for state-administered programs; or multiple local efforts financed with state dollars and accountable to state agencies.

Study Methods

Home visiting programs for families with young children were identified through a review of published sources and key informant interviews. The literature review included professional journals, books, news articles, Internet sources, and organization reports. Key informants (such as national project directors, researchers, and key federal and state agency staff) were contacted by telephone and e-mail and asked to identify notable state home visiting programs. This background work led to identification of national and state programs, as well as programmatic models that were used to construct the survey instrument and as a partial measure of the survey results' validity.

SURVEY

A survey of state-based programs was conducted to determine the scope and characteristics of the state home visiting programs and policies. To identify survey participants, every state maternal and child health program director was asked to name programs and staff in state government responsible for home visiting activities. With repeated telephone and e-mail follow-up efforts, program names and contacts were identified in 46 states.

Next, a survey instrument was distributed via fax and e-mail. Four attempts, including fax, e-mail, and telephone contact, were made to obtain complete information from each identified program. A total of 42 states responded to the survey; however, some reported that there were no state-based programs.

Follow-up telephone interviews were conducted with program or agency staff in 18 states (Colorado, Florida, Illinois, Indiana, Massachusetts, Maine, Maryland, Michigan, New York, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, Utah, Vermont, West Virginia, and Wisconsin). The purpose of these interviews was to clarify survey responses and inquire about details of one or more state programs.

The following questions were included in the survey to identify key program characteristics of state-based home visiting programs:

- *Authority:* How is the program structured and governed? What is its relationship to government?
- *Approach:* What is the intervention's stated purpose? Is the project based on or associated with well-known models?
- *Funding:* What is the amount and source of current funding?
- *Population characteristics/demographics:* What are the characteristics of the target population and/or the population served (e.g., age, race/ethnicity, income, medical or social risk characteristics)? How many families are served annually? Is a particular geographic area targeted?
- *Provider/staffing:* What general types of staff are used (e.g., paraprofessionals, nurses, social workers, child development, and/or other professionals)? Is a team approach used?
- *Characteristics of the intervention:* What is the content of the intervention/visit (e.g., health care advice, social support services, mental health counseling, parent training on child development, home/family assessment)? How is the intervention delivered (e.g., frequency and intensity)?
- *Outcomes:* What are the home visiting project outcomes in: 1) child characteristics, 2) maternal/parent characteristics, and 3) decreased need for government or social intervention?
- *Evaluation:* Is a formal evaluation of this project completed, planned, or under way?

CASE STUDIES

The purpose of preparing “case studies” was to gather more detailed information about state policies and programs for home visiting, and, specifically, to explore how the policies and programs were developed and what challenges they faced. Structured interviews explored a variety of topics, ranging from political support to operational challenges.

Case study sites were selected based on preliminary survey results. Survey data were analyzed to identify common characteristics and different approaches among state-based home visiting programs. Sites were selected for case studies using the following combination of characteristics.

All sites had these characteristics:

- included low-income children and their families in the service population;
- included health advice, outreach, or services as a component (i.e., not solely education); and
- had some public funding or public administration.

States in the case study group were selected to represent a mixture of these characteristics:

- had staff who are nurse visitors, lay visitors, or a combination of professional and paraprofessional;
- identified outcomes related to child development, parent characteristics, or government support/self-sufficiency;
- represented geographic variation, governance structure, and mix of funding; or
- represented different home visiting strategies or models.

The general queries for case study interviews were:

1. Why are state policymakers willing to invest in home visiting?

2. What larger initiatives call for home visiting activities?
3. Why do states choose to use a top-down or a bottom-up approach to home visiting?
4. For states with a more grassroots approach, what role do state agencies play?
5. How are home visitors trained and supervised?
6. How do states coordinate multiple home visiting programs?
7. How do states maximize their human and fiscal resources?
8. What is the nature and direction of quality improvement and evaluation activities?
9. What specific program objectives were selected, and how is progress toward these objectives measured?
10. What challenges do states face related to home visiting programs, and how do state agencies address these challenges?

The case study states represented various regions of the country, programmatic approaches, and governance and finance structures. Case studies were completed for Illinois, Massachusetts, Michigan, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, and Wisconsin.

RESULTS

Survey Findings

Many states have made a substantial commitment to home visiting programs. These programs may be administered by a State Department of Health, Department of Human Services, or Department of Education. State Maternal and Child Health (MCH) programs frequently are involved. In support of or as a complement to local, community-based programs, these state-based programs provide public resources for home visiting efforts. Most use a combination of state and federal dollars, and a few use private funds. Some states provide staff time for training, coordinating, or evaluating local efforts, but no public dollars in direct support.

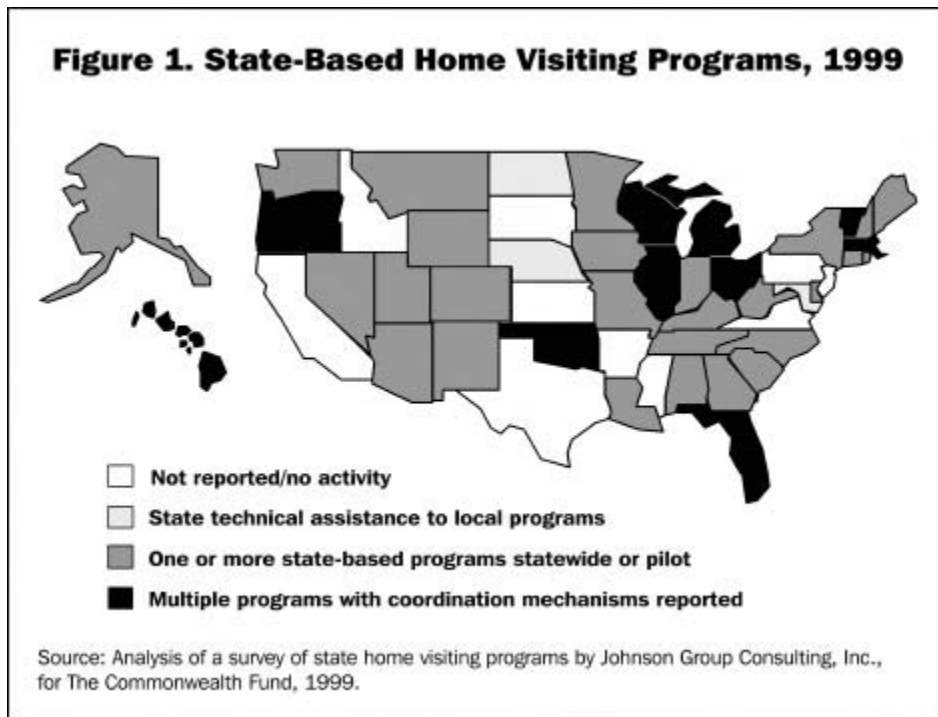
Most state-based home visiting programs are based on some preexisting program designs, and about half are part of a larger intervention strategy or initiative. The size of the population served is not necessarily related to the size of the state's population. All have broad objectives for improving child and family function, with most using a model adapted to their state's political and fiscal environment. Services tend to be resource and referral in nature and are provided by a team of lay and professional staff. Several states have many programs with varying degrees of coordination. Evaluations are planned or under way for a majority of state-based home visiting programs.

Program Structure and Authority

Of the 42 states responding, 37 reported state-based home visiting programs (Figure 1).^{*} An additional three states (Maryland, Nebraska, and North Dakota) have state-level quality improvement or technical assistance projects that support a range of locally based home visiting programs. This report does not account for the state-administered Early Head Start, Early Intervention Programs (Part C of IDEA), or Parents as Teachers programs that may have a home visiting component and are operating in the vast majority of states.

The programs identified typically are administered by a State Department of Health (28), Department of Human Services (5), or a combination of these two agencies (5). Maternal and Child Health (MCH) programs are the administrative unit responsible for implementing the majority of these state-based home visiting programs. These findings are somewhat different from the results of a 1988 survey of more than 4,000 home visiting programs (many of which were freestanding and not state-based), of which nearly four of 10 were educational.³⁶

^{*} For purposes of this report, state-based home visiting programs are defined as those that are guided by state policies and administered by state agencies. They may be funded by a variety of public and private funds.



Many of these state-based home visiting programs are part of a larger state government initiative (37 states reporting on 59 programs). Nearly half (26) of the programs were part of a larger maternal and child health initiative, 40 percent were linked to a comprehensive or integrated service initiative for young children, and 38 percent were a component of a family resource/family support initiative. This pattern is consistent with trends in early childhood initiatives reported elsewhere.³⁷ Governor-led initiatives were the impetus for home visiting programs and activities in a number of states, including Delaware, Michigan, Nebraska, Nevada, Ohio, Oklahoma, and Vermont.³⁸

Nearly half of these state-based home visiting programs are linked to a legislative mandate or legislated content (e.g., early discharge legislation, welfare reform, maternity care access, or children’s initiative). In some states (e.g., Oklahoma and Wyoming), the home visiting program was structured under home visiting legislation that mandates active oversight of program outcomes.

More than half of states and the federal government adopted legislation related to “early hospital discharge” in 1996, and the vast majority of these new laws required that private insurers cover one or more home visits following short maternal and newborn hospital stays. Some laws also define the minimum content and timing of such home visits. Interviews with selected state program managers indicate that little is known about how health plans are complying with benefit mandates, and that few state home visiting

programs bill private insurers under such mandates. This is an area for further research and policy development.

Most states currently have more than one home visiting program. If Early Head Start, Early Intervention Programs (Part C of IDEA), Parents as Teachers, and locally initiated programs are taken into account, many home visiting efforts are under way in virtually every state. These multiple programs may operate in parallel, overlapping, or coordinated fashion.

Program Financing

Most state-based home visiting programs reported using a combination of state and federal dollars. Virtually every state-level home visiting program uses dollars from multiple sources—such as general state revenues, Medicaid, welfare reform funds, and federal block grant dollars—to finance services. Survey results indicate the following.

SIZE OF BUDGETS

- State investments are substantial, with 44 percent of the reported home visiting program budget dollars coming from state revenues.
- The largest reported state spending for home visiting programs was in Florida, Illinois, Michigan, New York, Ohio, Oklahoma, and Washington. Each of these states has budgeted between \$10 million and \$50 million a year for one or more programs. Federal dollars—typically through Medicaid or Temporary Assistance to Needy Families (TANF)—are one component of these large budgets.
- The size of budgets for state-based home visiting programs is not highly correlated with the states' population overall. On a per capita basis, for example, Delaware, Hawaii, and Rhode Island spend far more than larger states. Other small to medium-size states, such as Maine, Massachusetts, New Hampshire, Nevada, Utah, Vermont, West Virginia, and Wyoming, also have made substantial public investments in home visiting strategies.

SOURCE OF FUNDING

- State appropriated funds are used to support a majority of state-based home visiting programs.
- Federal Title V Maternal and Child Health Block Grant funds are used in two ways: Some states have used a portion of their block grant allocation to support

home visiting programs. Other states have used opportunities under Title V federal grant programs (e.g., Special Projects of Regional and National Significance, commonly known as SPRANS grants) to launch and fund home visiting initiatives. These funds typically are used to support state agency staff working at the state or county level, provide local grants for home visiting programs, or contract with outside experts for technical assistance or evaluation services. The total amount of Title V funds used cannot be estimated from this survey.

- Medicaid dollars are used to finance a substantial share of home visits in several states. In several states, Medicaid's targeted case management benefit has been used to design targeted home visiting programs (see inset box). Maternity care or prenatal case management models have been used in Michigan, Montana, Washington State, and Wisconsin. Illinois uses Medicaid administrative dollars to finance care coordination, including home visits, for pregnant women, but not for its Healthy Families and family support programs. Vermont and West Virginia blend Medicaid funds into larger early childhood initiatives.
- Increased use of Medicaid managed care has posed financing challenges for some state-based home visiting programs. As with other public health department direct service components, home visits that once were covered under fee-for-service arrangements now may be included in a package of benefits covered by a capitated fee. Such loss of revenues may threaten the fiscal viability of home visiting programs and/or limit the number or content of visits. Mechanisms such as provider contracts between purchasers or health plans and home visiting agencies are being tested to remedy such problems.
- Funds from TANF, which replaced Aid to Families with Dependent Children (AFDC), are being used in such states as Ohio. State policymakers believe that the purposes of family assistance are well served by a home visiting program.
- Private insurance dollars also are available in states that adopted laws that require health plans (non-ERISA) to provide coverage (i.e., pay for) for home visits following early hospital discharge. Few state agencies monitor compliance, however, and most had not considered this as a potential source of funding, and none reported that these dollars are accounted for in the home visiting budget.

Case Management and Home Visiting Services Under Medicaid

Targeted Case Management Option: States may, at their discretion, pay for targeted case management services under Medicaid. The federal statute defines targeted case management services as “services which assist an individual eligible under the plan [Medicaid] in gaining access to needed medical, social, educational and other services.” Under this option, states can reach beyond the bounds of Medicaid to coordinate a broad range of activities and services necessary to the optimal functioning of a Medicaid client.

The services are called “targeted” because states may choose to offer them to a discrete portion of the Medicaid population. States may target a group of beneficiaries (e.g., pregnant women, young children, children with disabilities, or frail elderly). States also may target by geography (e.g., two-three counties) or by service (e.g., home visiting, care coordination).

Targeted case management services are an optional category of *medical services* and, thus, qualify for the state’s regular Medicaid matching rate and Federal Financial Participation (FFP). States must submit a separate Medicaid state plan amendment for each targeted case management option used (e.g., each population or area). This is an administrative step that involves the State Medicaid agency, the Federal Health Care Financing Administration (HCFA), and, less frequently, the state legislature.

Most states have experimented with targeted case management, and a number of them have used or are currently using targeted case management to finance home visiting services (e.g., Oklahoma). In Michigan, North Carolina, West Virginia, and other states, this optional Medicaid service has been used extensively for case management of at-risk prenatal patients and newborns. Prenatal case managers may perform their duties through home visits; however, the service package for this approach tends to be narrower than most home visiting programs designed to provide family support and education for families with young children.

States’ past experiences have set administrative and legal precedents. Use of targeted case management requires careful time and activity accounting. The service must be related to provision of Medicaid and use of health and related services. Thus, some state and local agencies find that this option does not pay for all of the services they hope to include in their home visiting programs. At the same time, it can be used to finance specific subsets of home visiting or a portion of a visit for a Medicaid beneficiary.

Administrative Case Management: This is in contrast to administrative case management, which is consistently a 50/50 federal/state split and other variations with increased FFP (e.g., skilled professional medical personnel in administrative roles). Administrative-type case management activities include outreach, eligibility determinations, utilization review, and prior authorization, which are necessary for the “proper and efficient administration” of the state Medicaid plan/program. Illinois uses administrative case management to provide “Family Case Management” through home visitors. State officials determined that this would fit better into their state Medicaid plan than would an optional targeted case management service. However, the state uses no Medicaid dollars to fund its Healthy Families Illinois program. Each program has a different purpose, and Healthy Families Illinois is targeted to all families at risk, regardless of their income.

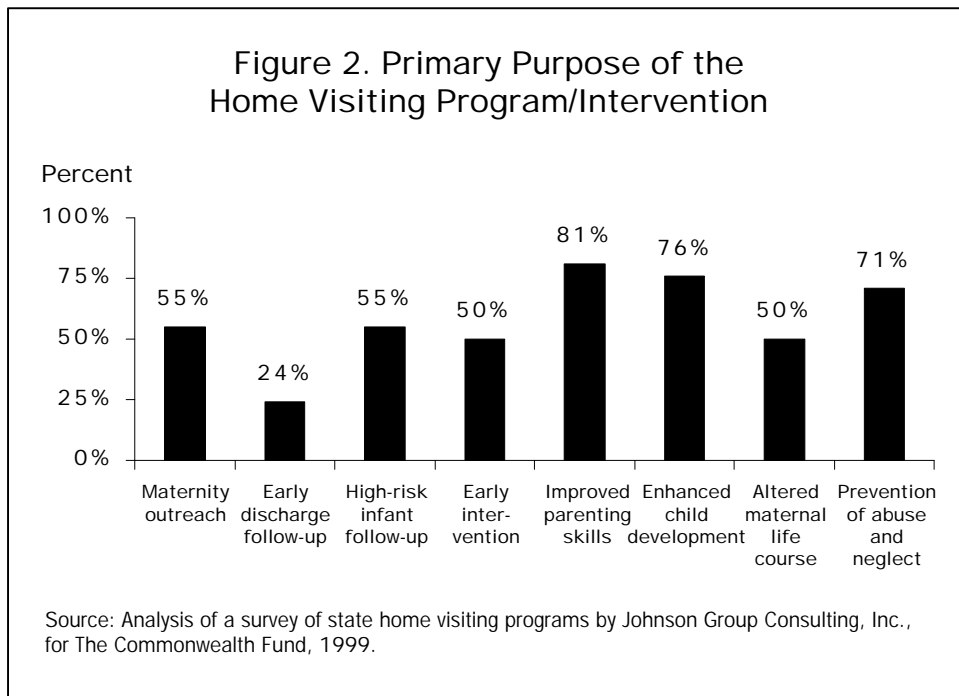
Home visiting benefits: As an alternative to using case management—either as a benefit or an administrative service—state Medicaid agencies can create categories of home visiting services and assign procedure codes to allow home visit providers/agencies to bill for the services they deliver. For example, a state might have two or three levels of visits (i.e., brief, intermediate, and extensive, or screening, case management, and treatment). Kentucky is pursuing this approach to Medicaid reimbursement for home visiting. Billing categories and codes are useful in a fee-for-service or managed care system. This overall approach also defines a benefit that might be covered by private insurers (see Rhode Island). Home visiting agencies should be involved in developing realistic categories of service, billing codes, and fees.

Program Approach and Characteristics

PROGRAM PURPOSES

Home visiting programs have been designed to address a wide array of family needs, ranging from a resource and referral intervention for first-time parents to frequent visits to deliver intensive parent education and support to high-risk families. States were asked to choose all that applied from a list of eight commonly reported types of intervention carried out through home visiting.

Figure 2 shows the primary purpose reported for 42 state-based home visiting programs, representing 31 states. The most frequently reported purposes were to improve parenting skills (81 percent), enhance child development (76 percent), or prevent child maltreatment (abuse) and neglect (71 percent). Approximately half of the programs identified maternity/infant outreach, high-risk infant follow-up, early intervention, or altering maternal life course as a main reason for the home visits. A smaller proportion (24 percent) reported that follow-up to early hospital discharge was the primary purpose of the intervention.



These findings are consistent with results of other home visiting studies. However, as stated above, some but not all of these intervention approaches have been shown to be effective. In terms of parenting, evaluation data suggest that home visiting programs may lead parents to change some of their attitudes, but not necessarily their behaviors.

Programs may help to decrease child abuse and neglect initially, particularly in those families at highest risk and with the fewest coping abilities. For enhancing child development, however, center-based programs that serve children for many hours each week produce more gains, although a combination of home visits focused on parents and center-based services focused on children may produce better long-term outcomes. Case management and outreach can help isolated families by providing a combination of social support and links to other services, assuming that quality child care, jobs, and health care are available in their communities. Only the Nurse Home Visiting Program (also known as the “Olds”) model has been shown to be effective in altering maternal life course. Thus, achieving program purposes is a substantial challenge to these home visiting efforts.

USE OF PROGRAM MODELS

States were asked if their home visiting programs were based on or associated with a well-known model for home visiting and, if so, they were asked to provide the name of the model. While at least six home visiting program models have been evaluated and described in professional journals,³⁹ only two were mentioned by states in this survey. This may be because the information request was sent to public health departments, and some models are better known among education or child welfare professionals. Of the 38 home visiting programs (representing 32 states) responding, five were said to be based on or associated with the Nurse Home Visiting Program model developed by Dr. David Olds;⁴⁰ 12 reported using the Healthy Families America model; and four said they had used both the Olds and the Healthy Families America models. Many states reported using the 12 critical elements of home visiting identified by Healthy Families America (Table 1). The remaining states said that they are using a unique approach not associated with an established model.

Most of the states that reported using an existing home visiting program model have modified that model. State officials often reported that evidence from previously successful program models was used to help design their state-based home visiting program; however, they had not used these models as strict guidelines or protocols. In making such adaptations, states may be strengthening or weakening program models. Evaluating such modified program designs to determine whether they achieve the same or different outcomes as the research model is important to future program and policy development.

Table 1. Healthy Families America: “Critical Elements” of Home Visiting

1. Initiate services before or at the time of birth.
 2. Use a standardized assessment process or guidelines to identify families in need.
 3. Offer services voluntarily and in a positive manner to build family trust.
 4. Offer services intensively (at least one per week) with well-defined criteria for varying the level of intensity for a period of three to five years.
 5. Offer culturally competent services.
 6. Focus services on supporting parents and supporting parent-child interaction and child development.
 7. Link families to a health care provider at least, to ensure timely immunization and well-child care, and link to additional services as necessary.
 8. Limit staff caseloads (typically no more than 15 families per visitor).
 9. Select staff who have appropriate personal characteristics, willingness to work in culturally diverse communities, and skills to do the job.
 10. Select staff whose education and experience enable them to manage the range of issues they may encounter working with at-risk families.
 11. Provide staff with intensive training specific to their roles.
 12. Ensure ongoing supervision so that staff are able to develop realistic plans, work effectively with families, and solve problems.
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FREQUENCY OF VISITS

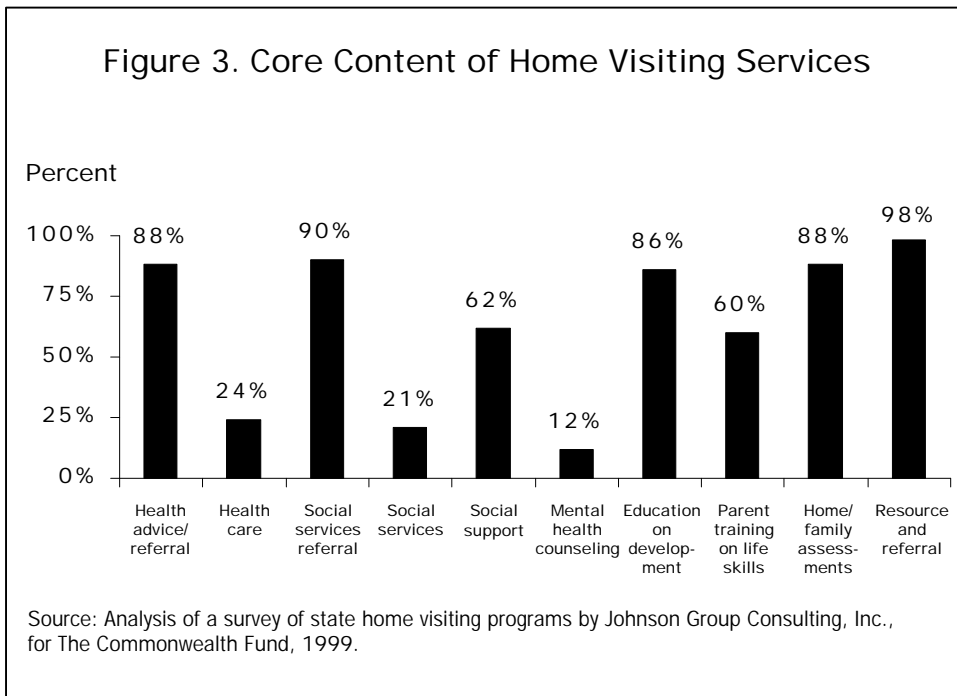
Most states reporting said that multiple home visits take place, generally on a routine schedule (e.g., monthly or weekly), but also on an “as needed” basis. A much smaller group of state-based home visiting programs limit home visits to one per family. These latter, more limited, visit schedules are used more often in programs seeking to provide a “welcome home” visit for first-time parents or to provide home-based screening services that serve as the gateway to other services by referral.

CONTENT OF VISITS

Visit content is a major defining characteristic of home visiting programs. To a certain extent, variation in the content of visits reflects the diversity in the purpose, model, and staff configuration in these state-based home visiting programs. In general, the survey indicates that most programs concentrated on offering advice and referrals, frequently in several domains/areas of life. This is consistent with the theory of change used to undergird most home visiting programs—that is, home visits can change family and child outcomes by providing parents with social support, practical assistance, and education about parenting and/or child development (Figure 3).⁴¹

Data for 42 programs (representing 31 states) indicate:

- Resource and referral is a primary function in most state-based home visiting programs (98 percent), including advice and referrals related to health or social services (88 and 90 percent, respectively).
- Home/family assessments also were reported as a component of a great majority of programs (88 percent).
- Parent education in child development was reported as a service of many programs (86 percent), as were educational services and supports to improve parents' life skills (60 percent).
- Health or mental health services (as opposed to referrals) were least likely to be delivered by home visitors (24 and 12 percent, respectively).



Population Characteristics

In selecting the target population for these programs, state-based home visiting programs tend to use age, social and health risks, or special needs as their main criteria. Among 38 programs (representing 29 states), 89 percent target by age of child (includes prenatal care), 76 percent target by social risk factors, and 63 percent target by health risks (i.e., special health care needs and disability). Most of these programs focus on the family during

pregnancy or the first year of life, often targeting first-time parents as the group most in need of a home visit. Other programs seek to serve families with one or more known factors associated with adverse child outcomes (e.g., parents younger than 18; parents' substance abuse or addiction; families with a child abuse or neglect report; or families with a history of domestic violence) or with factors associated with higher levels of family stress (e.g., families who have children with special health care needs, low income, or limited social support).

Other criteria are used less often. Among state programs reporting, 32 percent use income criteria, and 47 percent use geographic areas as targeting strategies. Moreover, most states using an income criterion in fact use Medicaid eligibility or participation as the marker. Of the total 38 programs in 29 states, 61 percent rely on referrals from other programs (e.g., Medicaid, Women and Infant Children [WIC], early intervention, child welfare) to identify families that should receive a home visit. Only two states reported using race or ethnicity as a risk factor for home visiting.

Staffing Patterns

The major distinction in staffing patterns across home visiting programs is the use of professionals or laypersons. It appears that most state-based home visiting programs use both professionals and paraprofessionals in staff roles. As reported elsewhere,⁴² the general trend has been for home visiting programs to use laypersons (also known as paraprofessionals) as home visitors. Frequently from the same community or ethnocultural background as the targeted families, lay home visitors may provide knowledge of community networks, build trust with families more easily, and serve as role models for program participants. Among 40 programs (representing 32 states), 65 percent report using paraprofessionals.

Professionally trained staff have been used exclusively in some program models and have held supporting roles (supervising paraprofessionals) in others. The vast majority (85 percent) of these state-based home visiting programs reported using nurses in staff roles. In addition, programs use professionals trained in social work (35 percent) and child development/education (23 percent).

Nearly two-thirds of the programs reported using a team approach that may include a variety of arrangements. For example, nurses are more likely to make visits that require medical expertise (e.g., prenatal) and paraprofessionals are more likely to make more routine visits; professionals supervise the work of several paraprofessionals; or a team of social workers, developmental specialists, and nurses divides cases according to family needs.

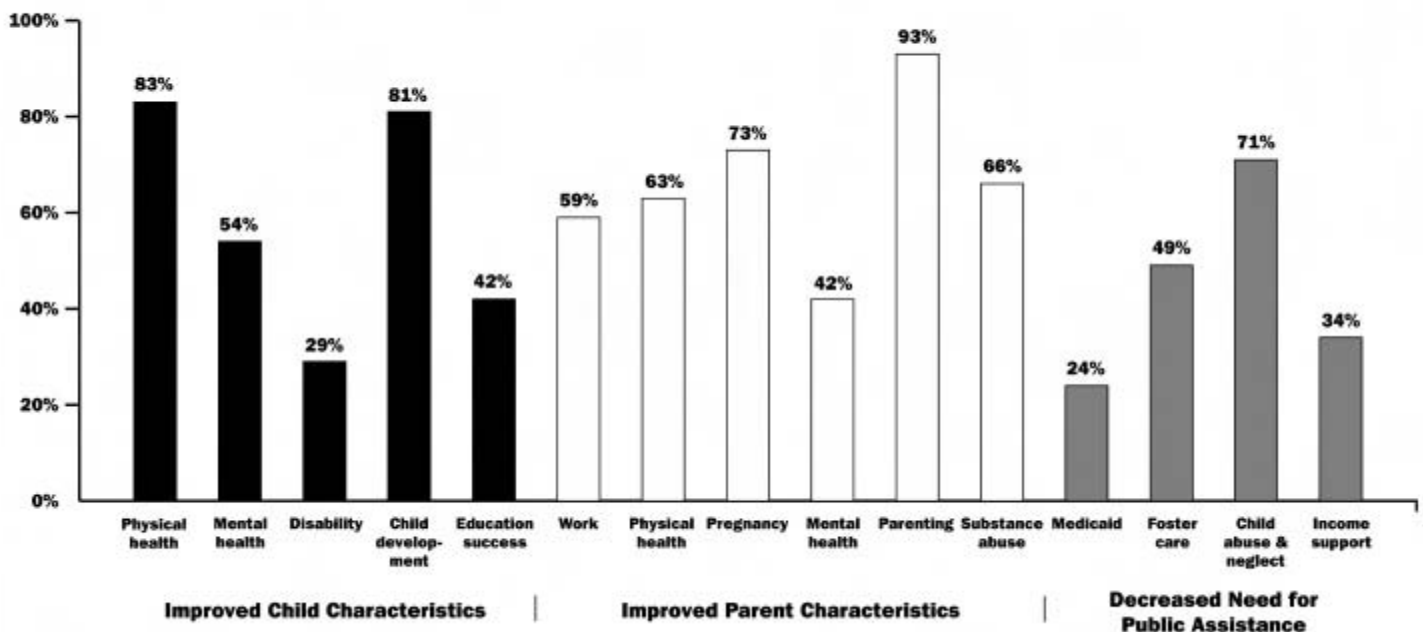
Outcome Objectives, Performance Monitoring, and Program Evaluation

OBJECTIVES

State agency staff were asked to select outcome objectives from three categories: those that tried to improve child characteristics, improve parent characteristics, or decrease the need for government services. Figure 4 shows the percentage of programs by objective type. States reported using multiple broad objectives for their home visiting programs. Specifically:

- A large majority of reporting states hope to improve child characteristics—for example, children’s physical health and development. State-based home visiting programs are less likely to try to improve mental health or reduce childhood disability.
- Virtually all state-based home visiting programs in this study tried to improve parenting skills. Many also tried to improve pregnancy timing/spacing or parental health. Substance abuse, including alcohol, drugs, and tobacco, also was mentioned frequently. In addition, more than half have objectives in other areas. These figures indicate a strong emphasis on improving parent skills and reducing known risks for poor parenting.
- In terms of decreasing the need for government services or interventions, state-based home visiting programs are more likely to try to reduce child abuse and neglect than focus on other areas. This is not surprising given the reported emphasis on parenting skills. Fewer of the state programs seek to reduce health (24%) or cash (34%) benefits.

Figure 4. Percentage of Programs by Type of Outcome Objectives, 1999



Source: Analysis of a survey of state home visiting programs by Johnson Group Consulting, Inc., for The Commonwealth Fund, 1999.

PERFORMANCE MONITORING

Consistent with a general trend toward greater use of performance monitoring and results-based accountability for government programs,⁴³ some states have set performance measures for home visiting. Each state's Title V MCH Block Grant program is required to report on seven to 10 "Negotiated Performance Measures" (i.e., determined through negotiations between federal and state Title V agencies), and six states (Kentucky, Maryland, New Mexico, Rhode Island, South Carolina, and Vermont) and Puerto Rico are using a measure related to home visiting. Table 2 shows these measures for six states.

Table 2. Title V State "Negotiated" Performance Measures

State	Measure
Kentucky	Percent of families that receive support services/parenting assistance through home visiting support programs
Maryland	Percent of at-risk infants who receive one or more prevention-focused home visits during the first eight weeks of life
New Mexico	Percent of first newborns/moms who receive support services/parenting support through community home visiting/support programs
Rhode Island	Percent of at-risk newborns who receive home visits from the Family Outreach Program during the early newborn period
South Carolina	Percent of Medicaid newborns in the state who receive a Department of Health and Environmental Control home visit
Vermont	Percent of Medicaid infants from birth through 12 months who receive two or more home visits through the Healthy Babies system of care

EVALUATION

Thirty-five of 49 programs said that a formal evaluation was planned, under way, or completed. The range of activities includes formal academic evaluations conducted by outside expert, legislatively mandated performance/evaluation guidelines, professional guidelines for quality assurance used by state programs, monitoring performance according to selected indicators, and collecting and reporting basic program data (e.g., participation, retention). Securing the funding to evaluate these programs is a constant challenge for state agencies. Even when policymakers want outcome data and to mandate that programs demonstrate results, few states have committed the resources to tackle outcome evaluation studies. There are many opportunities for private foundations and researchers outside government to aid in such efforts.

CONCLUSIONS AND RECOMMENDATIONS

Key Remaining Challenges

- State agencies face challenges and barriers as they try to manage multiple programs. Three typical (public) approaches include collaboration, shared authority, and integration. To quote one state official: “Coordination is our biggest challenge in home visiting. Political and turf battles, in addition to categorical battles, are a great obstacle.” The most favored mechanisms for collaboration and coordination are working groups that meet regularly to share planning, budget, and program information. Some states (e.g., Oregon) started when executive leadership called for an assessment, while other states started with program efforts to improve integration of data systems (e.g., Rhode Island KidsNet). Program integration is seen by some as the solution; however, given turf and political boundaries, this is not an option in many states. Moreover, it often is difficult to decide where program integration should stop—at what age, with what type of service (e.g., health versus education), for what types of families?
- Available funding often drives policy and program decisions. For states that use Medicaid financing as part of their core base funding, limits on these revenues make a difference. For example, where home visiting program budgets were developed assuming fee-for-service Medicaid payments and Medicaid managed care capitated payments became the dominant approach used in the state, home visiting programs must negotiate with the state for a “carve-out” of their payments or negotiate with managed care organizations for a provider contract. Medicaid financing also is limited by the scope of the benefit (i.e., what Medicaid considers a reimbursable service) and eligibility limits (i.e., how many families are Medicaid eligible and enrolled). Similarly, some states use the funding from early intervention for service to children from birth to age 3 at risk of or with developmental disability (Part C of the Individuals with Disabilities Education Act [IDEA]) as a core of their home visiting effort. This approach may not be appropriate or workable for programs that are focused primarily on social rather than medical risk factors. In general, limits on categorical grant funds pose a challenge to states. For example, if federal grant dollars are aimed at preventing infant mortality, improving access to medical care, supporting adolescent parents, reducing use of welfare/cash assistance, reducing substance abuse, or preventing child abuse, state-administered home visiting programs must devise mechanisms to blend funds, keep detailed accounts, and often require strict budget accountability from local contractors and providers. The challenges of requiring that local home

visiting agencies working with counties to do billing for case management to multiple payers was mentioned. Unified grants to counties have permitted more flexibility in approach and management.

- Promising—but not overpromising—results. Advocates and agency staff who want to develop state-based home visiting programs use all available evidence to sell the concept to state legislators and executive officials. However, in this process, they frequently promise too much in the way of results. This is a difficult balance and is a constant tension in the policy–program development process. Where state home visiting legislation mandates evaluation, or state laws set out specific outcome indicators, the challenges can be particularly great. State and local program administrators must respond and are pressured to devise data collection and analysis strategies that meet such legislative mandates, while protecting families’ confidentiality and not compromising professional data standards.

Recommendations

Researchers and experts have stated that there is a need “to improve the quality and implementation of existing home visiting services and a more modest view of the potential of the broad array of home visiting programs.” This study of state policies supports that view and recommends specific changes in policy and programs. Many states have made a substantial commitment to home visiting programs, and each one has adopted a unique combination of home visiting services based on what it believes is effective, what it has the resources to provide, and/or what local communities will accept.

The following recommendations are based on the results of this study (both the survey and the case studies), including specific suggestions from state agency leaders. State agency staff administering home visiting programs should consider ways to implement the following objectives.

- Refine and narrow program objectives and outcome measures. Currently, many programs appear to have promised more than their home visiting activities can be expected to deliver (based on previous evaluation studies). Failure to meet unrealistic or overly ambitious program goals can undermine state program efforts. Aligning outcome objectives more closely with the actual intervention strategy is an important step. Agencies might begin by clarifying their purpose, using a “logic model” to align their objectives with the intervention (e.g., content of visit and target population).

- Promote quality of local home visiting efforts. This is one of the strongest recommendations drawn from evaluation studies on home visiting. Matching the intervention to program objectives is the first step. For example, a program to improve pregnancy outcomes should have an intervention protocol different from a program intended to prevent mistreatment of a child or one that aims to alter a maternal life course. It is also important to ensure consistency when implementing preexisting models. Aspects of quality improvement and assurance include staff training, use of practice standards/protocols, and results monitoring.
- Take explicit action to understand the flow of funds, blend funding where appropriate, and maximize public resources. Each state should conduct analyses to determine how much is being spent on state-based or state-funded home visiting efforts and to review the flow of dollars. Steps could be taken to maximize third-party payments from Medicaid and private insurance benefits. Home visiting programs also might take advantage of opportunities to pool funds; use a single administrative authority; or leverage additional federal, local, or private dollars.
- Minimize unnecessary duplication of effort. Programs in which multiple home visitors serve one family are likely to lead to overwhelmed parents who reject services, frustrated staff, inconsistent and ineffective interventions, and wasted tax dollars. Continuity and consistency have been shown to be important factors in the effectiveness of home visiting interventions. States should seek to reduce duplication and maximize fiscal and personnel resources.
- Establish mechanisms for interagency coordination. In many states, home visiting activities are carried out through many agencies and programs (e.g., public health/maternal and child health, Medicaid, child welfare, welfare reform, early intervention/education, and/or a special cabinet-level early childhood initiative). Interagency coordination is needed to reduce duplication of services, maximize resources, and ensure the quality of publicly supported home visiting programs. State-level mechanisms might include a coordinating council, joint staff meetings, a unified management structure, or a consolidated program review process. Using their grants and contracts process, states also can encourage local entities to use similar structures.
- Provide leadership to support local programs. The degree of authority or control available to state agency staff varies greatly. In some states, county officials

have considerable autonomy. In some programs, state and federal dollars are passed along directly to local private agencies. The state and local political environment may accept or discourage state regulatory action. Some state legislatures and executive agencies want statutory and regulatory provisions that give them control and oversight of programs. Where adopting new regulation is not possible or desirable, state agency staff can exercise leadership and help to improve the quality of home visiting programs by facilitating development of voluntary guidelines and standards, supporting expert consultation, and providing staff or financial support for continuing technical assistance.

- Request federal policy leadership for information sharing, standard setting, performance monitoring, and evaluation within and among states. This work might be done collaboratively among federal agencies, including the Maternal and Child Health Bureau of the Health Resources and Services Administration; the Head Start Bureau in the Administration for Children, Youth, and Families; the State Children's Health Insurance Program (SCHIP) and Medicaid/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) programs of the Health Care Financing 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. Creating a new federal home visiting program or national guidelines was not viewed as desirable by state agency staff.

- Establish a continuum of early childhood services that can address a wide range of family needs and achieve results in a cost-effective manner. Too often legislators are encouraged to adopt one strategy to solve a range of problems. Too often agency staff try to advance their programs by making big promises. We know that no single program or service strategy can cure all that ails our nation's families. However, research[†] clearly points to the 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, infant assessment and stimulation, adequate health services (including nutrition supplements, if necessary), quality child care/early education, and

[†] Since the report of the Select Panel on the Promotion of Child Health outlined a range of strategies in 1981, many reports and projects have emphasized the importance of a continuum of services. More recently, reports by The Commonwealth Fund, the Carnegie Corporation of New York, the Harvard Family Research Project, the National Center for Children in Poverty, the David and Lucile Packard Foundation, and others have pointed to new knowledge about the critical nature of infant development, the potential impact of early intervention, and the range of interventions found to be effective.

interventions to ensure a safe environment (i.e., efforts to prevent violence, injuries, and toxic exposures). Home visiting programs can provide one or more of these services and can link families to others. Moreover, different models of home visiting services may be beneficial to families at varying levels of risk. For example, states might offer one visit to every family with a new baby, and additional visits over a period of months or years to families with high social or medical risks. Matching family risks to interventions and needs to services is essential if programs are to enhance family strengths and promote child development and well-being.

APPENDIX A. Summary of State Home Visiting Programs for Children

State/Project Name	Approach and Authority
Alabama/Perinatal Program	Based on Healthy Families model. Focused on high-risk infant follow-up, parenting skills, and prevention of child abuse and neglect. Eight local sites are managed by private entities. Administered by the Alabama Department of Health, Bureau of Family Services.
Alaska/Home Families Alaska	Based on Healthy Families model. Focused on high-risk infant follow-up, parenting skills, and prevention of child abuse and neglect. Seven local sites, mainly local not-for-profit entities. Administered under the Alaska Department of Health, Maternal, Child and Family Health Program.
Arizona/Healthy Families Arizona	Based on Healthy Families model. Maternal and infant outreach focus. Administered under the Arizona Department of Health Services, Office of Women's and Children's Health.
Colorado/Children's Trust Fund	Focused on early childhood development and prevention. Developed through the Colorado Children's Trust Fund. Now located under the Colorado Department of Health and Environment, Family and Community Health Division.
Colorado/Nurse Home Visitor Program	Based on the "Olds" Nurse Partnership model and part of the Nurse Family Partnership in Colorado. Focused on prenatal and early childhood parenting and child development. Administered by the Colorado Department of Health and Environment, Family and Community Health Division.
Connecticut/Healthy Start	Focused on prevention of infant mortality and improvement of early childhood outcomes. Community-based programs which have a home visiting component. 23 local entities funded by the Connecticut Department of Public Health.
Connecticut/Young Parent Program	Focused on pregnant and parenting teens. Community-based programs which have a home visiting component. 12 local entities funded by the Connecticut Department of Public Health.
Delaware/Home Visiting	Developed as part of a larger governor's initiative for child development. Aim is early identification of cognitive or developmental delays. Professional home visits within 48 hours after maternity discharge, with follow-up and support services as necessary. Administered under the Delaware Division of Public Health.
Florida/Healthy Families	Based on Healthy Families model. Focused on improving parenting skills, enhancing child development, and prevention of child abuse and neglect. Jointly administered with the Ounce of Prevention Fund of Florida.
Florida/Healthy Start	Developed as part of a larger governor's initiative for infant mortality prevention. Focused on maternity and infant outreach, high-risk infant follow-up, parenting skills, and child development. Administered under the Florida Department of Health, in conjunction with local Healthy Start Coalitions.
Georgia/Children First	Home visiting program linked to Governor's initiative.

State/Project Name	Approach and Authority
Hawaii/Healthy Start	Origin of Healthy Families model. Focused on improving parenting skills, enhancing child development, and prevention of child abuse and neglect. Administered under the Hawaii Department of Health.
Illinois/Parents Too Soon	Focused on improving the outcomes of teen parents and their children. Well established program with local providers throughout the states. Administered under the Illinois Department of Human Services.
Illinois/High-risk infant follow-up	Focused on infants with medical risks and special health care needs (e.g., those discharged from neonatal intensive care units). Administered through local health departments and other local entities. Administered under the Illinois Department of Human Services.
Illinois/Healthy Families Illinois	Based on Healthy Families model. Focused on improving parenting skills, enhancing child development, and prevention of child abuse and neglect. Administered under the Illinois Department of Human Services.
Illinois/Family case management	Focused on case management and coordination of family services for Medicaid beneficiaries during the prenatal and early childhood periods. Professionals provide case management services. Administered under the Illinois Department of Human Services. Linked to goals of welfare reform and family support.
Indiana/Care Coordination	Focused on case management and coordination of family services during the prenatal and early childhood periods. Purposes include maternity and infant outreach, early intervention, improving parenting skills, enhancing child development, and prevention of child abuse and neglect. Providers are local entities (public and private), using professional and paraprofessional staff. Administered under the Indiana State Department of Health, Maternal and Child Health Services.
Kentucky/Home Visiting	Focused on improving pregnancy and early childhood development outcomes. Providers are local entities (public and private), using professional and paraprofessional staff. Administered under the Kentucky Department of Public Health, Maternal and Child Health.
Louisiana/Home Visiting for Families (Building Early Strengths Together, known as BEST)	Based on the "Olds" Nurse Partnership model. Purposes include maternity and infant outreach, early intervention, improving parenting skills, enhancing child development, and prevention of child abuse and neglect. Administered under the Louisiana Office of Public Health, Maternal and Child Health Program.
Maine/Community Health Nursing	Focused on supporting families at-risk through community health nursing. Professional nursing staff, working under local entities. Administered under the Maine Bureau of Health, Division of Community and Family Health.
Maine/Healthy Families/PATT	Based on the Healthy Families model. Six local pilot programs using paraprofessional staff. Administered under the Maine Bureau of Health, Division of Community and Family Health.
Maine/Public Health Nursing	Focused on improving health outcomes for pregnant women and young children. Professional public health nursing staff. Administered under the Maine Bureau of Health, Division of Community and Family Health.

State/Project Name	Approach and Authority
Maryland/Healthy Families Maryland	Based on Healthy Families Model. Blending public and private resources to support local initiatives. Each county is developing its own program. State Title V dollars used to support this initiatives.
Maryland/Healthy Start	Focused on improving health outcomes for pregnant women and young children covered by Medicaid. Each county is developing its own provider network and approach. Medicaid funding used to support this initiative in Maryland.
Massachusetts/FIRST Steps	Based on Healthy Families model, with some modifications. Aims to provide family support as part of a comprehensive approach. Paraprofessional-professional staff teams are used throughout program. Administered under the Massachusetts Department of Health, Bureau of Family and Community Health.
Massachusetts/Healthy Families	Based on Healthy Families model, with some modifications. Jointly governed by Massachusetts Department of Health and the Children's Trust Fund.
Michigan/Maternal & Infant Support	Focused on improving health outcomes for pregnant women and infants. Professional staff model. Primarily serves Medicaid beneficiaries at social or medical risk. Jointly administered, with Medicaid as lead, for Michigan.
Michigan/Strong Families, Safe Children	Focused on "family preservation" through enhanced parenting skills, life options, and child development. Part of a larger governor's initiative for families with young children. Providers and approach vary by community, based on planning by a multipurpose collaborative body. Jointly administered, with Bureau of Community Health as lead, for Michigan.
Michigan/Zero to Three	Focused on high-risk infant follow-up and improved parenting skills. One project developed as a result of a larger lieutenant governor's initiative for families and children at risk. Jointly administered, with Bureau of Community Health and Department of Education as leads, for Michigan.
Minnesota/Targeted Home Visiting	Unique approach using some aspects of Healthy Families model. Focused on improving parenting skills and prevention of child abuse and neglect. Professional and paraprofessional staff teams. Part of a state effort to expand the capacity of public health nursing to provide prevention services to families. Administered by the Minnesota Department of Health, in conjunction with local county health departments.
Minnesota/Healthy Beginnings	Offers home visits to all expectant and new parents. Focused on primary prevention, including strengthening family function, enhancing child development, and promoting positive parenting. Administered by the Minnesota Department of Health, Division of Family Health.
Missouri/Families at Risk	Based on Healthy Families, with addition of a nurse role in assessment and care team. Focused on high-risk infant follow-up, early intervention, improving parenting skills, enhancing child development, and prevention of child abuse and neglect. Part of a larger governor's initiative focused on early childhood. Administered by the Missouri Department of Health, Bureau of Family Health, Division of Maternal, Child, and Family Health.

State/Project Name	Approach and Authority
Montana/MIAMI	Montana’s Initiative for the Abatement of Mortality in Infants is aimed at ensuring access to maternity care and improving infant outcomes. Target group is high-risk pregnant women. Professional staff provide services and case management. Administered by the Montana Department of Public Health and Human Services. Funding includes Medicaid “targeted case management.”
Montana/Home Visiting—Follow Me	Aimed at enhancing child development, improving parenting, and ensuring early intervention when needed. Local agencies deliver services using professional and paraprofessional staff teams. Administered by the Montana Department of Public Health and Human Services. Funding includes Medicaid “targeted case management.”
Nebraska/Title V Home Visitation grants	Variety of projects funded through Title V, including Healthy Families/Hawaii Healthy model, “Olds” Nurse Partnership model, Early Head Start, and public health nurse case management. Administered by the Nebraska Health and Human Services Agency, Maternal and Child Health Program.
Nebraska/Good Beginnings	Aims at local service coordination and promotion of child health and well-being. Home visiting is one component of a statewide governor’s early childhood initiative. Common curriculum and training materials developed for Nebraska.
Nevada/Community Connections	Aimed at improving parenting skills and enhancing child development. Primary service is resource and referral. Part of a larger family support and early childhood development initiative. Local agencies deliver services using paraprofessional and professional staff teams. Administered by the Nevada Department of Human Resources.
New Hampshire/Home Visiting	Combines elements of “Olds” Nurse Partnership model and Healthy Families/Hawaii Healthy Start model with lessons learned from New Hampshire. Focused on maternal/infant outreach, improving parenting skills, enhancing child development, and prevention of child abuse and neglect. Local entities provide services using paraprofessional and professional staff teams. Administered by the New Hampshire Department of Health and Human Services, Maternal and Child Health Bureau.
New Mexico/Home visiting initiative	Aimed at reducing child abuse and neglect, as well an array of child health and developmental outcomes. Part of a larger effort to develop a state-wide system of family support which promotes optimal infant and child development and well-being. Using state Title V performance measure on home visiting. Administered by the New Mexico Department of Health, MCH-Child Health Section.
New York/Community Health Worker Program	Purposes include maternity and infant outreach, improving parenting skills, enhancing child development, altering maternal life course, and prevention of child abuse and neglect. Administered by the New York Department of Health.
North Dakota/Coordination for local programs	State-level coordination and technical support for local programs, through a Newborn Home Visit Committee. Development of “Guidelines for Infant and Early Childhood Home Visiting Programs,” as well as a directory of local programs. Planning for development of quality assurance indicators. Administered by the North Dakota Department of Health.

State/Project Name	Approach and Authority
Ohio/Early Start	Based on elements of Healthy Families model, "Olds" Nurse Partnership model, and Parents as Teachers. Focused on high-risk infant follow-up, early intervention, improving parenting skills, enhancing child development, altering maternal life course, and prevention of child abuse and neglect. Operated by local entities (county Family and Children First Councils) using paraprofessional and professional staff. Uses TANF dollars as partial funding. Part of a larger governor's initiative providing family support to improve child health and development and to reduce welfare dependency. Administered jointly by the Ohio Department of Health and Department of Human Services.
Ohio/Welcome Home	Provides visits to parents of firstborn babies and teen parents. Operated by local county entities, primarily using nurse professional staff. State, Title V, and Medicaid funds are combined to fund program. Administered by the Ohio Department of Health.
Oklahoma/Healthy Families Oklahoma	Based on Healthy Families model. Focused on maternal/infant outreach, high-risk infant follow-up, improving parenting skills, enhancing child development, altering maternal life course, and prevention of child abuse and neglect. Part of a larger child abuse prevention initiative. Administered by the Oklahoma Department of Health.
Oklahoma/Children First	Based on the "Olds" Nurse Partnership model. Focused on maternal/infant outreach, high-risk infant follow-up, early intervention, improving parenting skills, enhancing child development, altering maternal life course, and prevention of child abuse and neglect. Component of a larger governor's initiative focused on early childhood development and family resources and supports. Administered by the Oklahoma Department of Health, Maternal and Child Health Services.
Oklahoma/Sooner Start—Early Intervention	Focused on early intervention, improving parenting skills, and enhancing child development. Family-centered service approach, using professional staff teams relevant to early intervention. Administered jointly by the Oklahoma Department of Education, Department of Human Services, Health Care Authority, and Commission on Children and Youth.
Oregon/Healthy Start/Family Support	Based on Healthy Families model. Focused on maternal/infant outreach, risk assessment, early intervention, and family support. Includes a "basic" and an "intensive" service approach. Primarily paraprofessional staff, with training and professional supervision for paraprofessionals providing intensive services. Operating in multiple counties. Administered by the Oregon Commission on Children and Families, in collaboration with the Oregon Health Division.
Oregon/Babies First	Based on a standard public health nursing model. Focus is on maternal/infant outreach, high-risk infant follow-up, improving parenting skills, enhancing child development, altering maternal life course, and prevention of child abuse and neglect. Administered by the Oregon State Health Division, Child and Family Health.
Oregon/Governor's Initiative	Led by the Office of the Governor, this effort conducted needs assessment, determined unmet needs and overlap, and searched for opportunities to create a continuous system of services to families with young children. Recommendations from the process have been used to create an Oregon Children's Plan.

State/Project Name	Approach and Authority
Rhode Island/Family Outreach Program	Focused on maternal/infant outreach, improving parenting skills, enhancing child development, altering maternal life course, and prevention of child abuse and neglect. Part of a larger initiative focused on family resources and supports, particularly in early childhood. Services delivered through local entities, using paraprofessional and professional staff teams. Administered by the Rhode Island Department of Health.
South Carolina/DHEC home visits	Focused on maternal/infant outreach to families covered by Medicaid. Using a state Title V performance measure. Primarily professional public health nurse staff. Administered by the South Carolina Department of Health and Environmental Control.
Tennessee/Tennessee Healthy Families	Based on Healthy Families model. Focused on maternal/infant outreach, high-risk infant follow-up, early intervention, improving parenting skills, enhancing child development, and prevention of child abuse and neglect. Services delivered through nine local entities, using paraprofessional and professional staff teams. Administered by the Tennessee Department of Health
Utah/Prenatal to Five Nurse Home Visiting	Designed to support and strengthen the capacity of families to meet the health and developmental needs of their children and to gain access to needed health care services. Home visits are delivered by local health departments using local, state, and Title V federal funds. Staff are specially trained local health department nurses. State staff provide consultation, technical assistance, standards development, and training related to home visiting. Administered by the Utah Department of Health, Division of Community and Family Health Services, Child, Adolescent, and School Health Program.
Vermont/Healthy Babies	Designed to provide a welcome visit to every newborn in the state. Part of a larger governor's initiative focused on family support and child development and well-being. Administered by the Vermont Department of Health.
Washington/Maternal Support Services	Part of an expanded maternity care program (Maternity Access Act of 1989), and based on the Michigan Medicaid Maternal Support Services program. Focused on maternal/infant outreach, case management, and access to care, as well as improving parenting skills, enhancing child development, and preventing child abuse and neglect. Administered jointly by the Washington Department of Social and Human Services, Medical Assistance Administration and the Department of Health, Maternal and Child Health
West Virginia/Right from the Start	Focused on maternal/infant outreach, high-risk infant follow-up, improving parenting skills, enhancing child development, and preventing child abuse and neglect. Part of a statewide focus on early childhood and a governor's initiative on children and families, which also includes family support service centers. Administered by the West Virginia Department of Health and Human Resources, Bureau of Public Health, Office of Maternal and Child Health.
Wisconsin/Prevention of Child Abuse and Neglect (POCAN)	Based on Healthy Families model, with modifications. Focused on early intervention, improving parenting skills, enhancing child development, altering maternal life course, and preventing child abuse and neglect. Operates using grants to county health or social services agencies. Administered by the Wisconsin Department of Health and Family Services.

State/Project Name	Approach and Authority
Wisconsin/Milwaukee Family Project	Based on Healthy Families model, with modifications. Focused on welfare reform and child welfare system priorities such as improving parenting skills, enhancing child development, altering maternal life course, and preventing child abuse and neglect. Particular emphasis on parents' education, job training, employment, physical and mental health. Uses Medicaid targeted case management funding. Administered by the Department of Health and Family Services.
Wyoming/Home Visiting for Families	Based on the "Olds" Nurse Partnership model. Purposes include maternity and infant outreach, high-risk infant follow-up, early intervention, improving parenting skills, enhancing child development, altering maternal life course, and prevention of child abuse and neglect. Staff includes professionals, primarily nurses. Funding includes state dollars and federal Title V funds, as well as Medicaid administrative case management financing. Administered by the Wyoming Department of Health, Division of Public Health.

APPENDIX B. CASE STUDIES

The case studies in the Appendix illustrate, in detail, some of the directions and issues identified by the survey of state-based home visiting programs. While not a comprehensive inventory of state structures and policies, these case studies do show how home visiting can address multiple family needs and can be adapted to different policy goals. Key themes illuminated by the case studies are:

- Why do state policymakers authorize and fund home visiting programs?
- Why do states choose a top-down rather than a bottom-up approach to program and policy development, and what are the practical implications of this decision?
- What mechanisms do states use to coordinate multiple programs or to reduce unnecessary duplication of services?
- How does financing strategy affect program and policy decisions?
- What challenges do state-based home visiting programs face?

In more detailed interviews, state program administrators emphasized the important role that state legislators and governors played in creating state-based home visiting programs. Generally, administrators believe that state policymakers have been willing to invest in home visiting because of its potential for preventing health and social problems and their attendant costs. As stated above, where governors have launched early childhood initiatives, home visiting is frequently a component. Some legislators also have responded to information about the value of early childhood interventions in enhancing child development, while others see this public investment as part of welfare reform that is aimed at increasing family self-sufficiency. In most states, evidence of the effectiveness and cost-effectiveness of home visiting has been used to argue for these investments. In a small number of states (e.g., Oklahoma), legislatures have monitored outcomes closely and made mid-course policy corrections.

Some states have chosen to use a top-down approach to home visiting by setting strong policy with detailed regulations; others seek to provide only minimal support to local programs. No clear pattern for these decisions emerged from this study. However, those using stricter state policies articulated concerns about quality assurance and performance monitoring to achieve program objectives. For those programs, state agency

staff discussed the emphasis on visit content or protocols, the need for fiscal accountability, and/or the importance of consistency to achieve expected results. At the same time, the fit between state regulations and program evaluations was not clear.

Decisions about whether to use a top-down or bottom-up approach often hinge on a home visiting program's role in a larger initiative. As noted above, between one-third and one-half of the state-based home visiting programs are part of such an initiative. The nature of the program, its source of funding, and its implementation structure all depend heavily on the nature of the initiative to which it is linked. For example, programs linked to a family resource or family support programs⁴⁴ tend to have different characteristics from those designed to reduce maternal and infant health care costs through case management of low-income pregnant women (e.g., Illinois). At the same time, the case studies describe how a number of programs are being integrated into a systems reform initiative in states such as Michigan.

The primary challenges for state-based home visiting programs appear to be coordination and financing. Perhaps the most important findings from the case studies have to do with how states coordinate multiple home visiting programs. State policymakers and program administrators concerned about duplication of effort and other problems associated with multiple home visiting programs have tackled the coordination issue.

Consolidating multiple home visiting programs under a single authority is one strategy being used to improve coordination (e.g., Oklahoma). However, this is particularly challenging at a time when home visiting may address multiple goals in education, health, and welfare. It is more likely that multi-agency coordinating councils are used (e.g., Children's Cabinets in Rhode Island, Maine, and Minnesota; Coordinating Council for Early Childhood Services in Florida; and the Putting It Together team in Michigan) to address such diverse objectives. Oregon is seeking to coordinate early childhood services through a policy development process led by the Office of the Governor. Such multi-agency coordinating councils are typical systems development/reform initiatives.

A small number of states with multiple home visiting programs are attempting to develop a continuum of services. Such a continuum may offer one home visit to all (or most) of the families with new babies at one end and an intensive, professionally staffed home visiting intervention to those at greater risk or with higher need at the other end of the continuum. For example, Vermont is seeking to expand its continuum of home

visiting, and the state legislature expanded funding in 2000 for this purpose. Other states with multiple programs are trying to improve policy and program structures to minimize overlap in home visiting, which leads to costly duplication of effort and dissatisfaction among families. Massachusetts and Illinois count on differences in function and local relationships to minimize unnecessary duplication. In states such as Hawaii, Illinois, Indiana, Maine, Michigan, Minnesota, Ohio, Oregon, and Rhode Island, state policies are specifically designed to give local county/community-level agencies the authority and responsibility for coordinating home visiting and other family support activities. One key to success in promoting local authority is to reduce categorical funding and eligibility barriers.

In terms of financing, the successful blending of federal and state, public and private dollars is illustrated in these case studies. While state appropriations make up a substantial portion of the dollars being spent on home visiting, these state funds are being matched successfully and creatively with other resources. Unlike so many other programs that operate in isolation from one another based on categorical program limitations, state-based home visiting programs generally are financed and operated across traditional agency boundaries. This may be an invention of necessity—with no dedicated federal program funding, no way to finance the whole package with Medicaid, and no major foundation initiative under way, state-based home visiting programs have put together hundreds of millions of dollars to address the needs of families with young children.

The case study process led to one other important, unanticipated finding. The state agency staff who provided information about state-based home visiting programs were extremely knowledgeable about the research and evidence that has been published about home visiting. These staff were uniformly concerned about implementing interventions that could make a difference for families and make health and human services more effective and cost-effective. This may be an artifact of program development in an era of welfare reform and results-based accountability, or, perhaps, the result of greater and more productive interaction among researchers, policymakers, and program implementation staff.



Illinois: Maximizing models to provide a continuum of services

Illinois has multiple home visiting programs that use a variety of federal and state funding sources to address different family needs and public policy goals.

For over 15 years, the Parents Too Soon program has included a home visiting component designed to provide support to parenting teens. With an FY 1999 budget, of approximately \$4.5 million, the program served 1,800 families with weekly visits.

The Illinois Medicaid Family Case Management program provides intensive service coordination for pregnant women and infants, with the goal of reducing infant mortality. The Family Case Management program uses Medicaid's administrative case management approach. (Administrative expenditures carry a 50 percent federal match and are different from targeted case management as an optional medical assistance service used in states such as Wisconsin.) The budget for FY 1999 was just over \$40 million.

Medicaid beneficiaries who are pregnant women and those with a child under age 1 are the target group for the Family Case Management Program. Pregnant women are identified when they apply for Medicaid or WIC, as well as through prenatal care providers. Names of mothers are shared with the local case management agencies, which in turn contact families to arrange for case management and home visits. Local agencies under contract with Medicaid/Family Case Management program include health departments and community-based organizations.

Family Case Management Program guidelines are set out in state regulations. The program rules require that case managers are qualified professionals (i.e., generally nurses, as well as some social workers or nutritionists under the supervision of an experienced case manager). The state regulations also define how time and activities are to be counted (such time study data are essential to states undertaking the Medicaid administrative claims approach). Through the state regulation and agency contracts the state specifies the structure/protocols for the program, defines certain time frames for contacts and visits, and requires care plan and referrals. Program evaluation and performance monitoring is focused on compliance with these regulations. State public health (maternal and child health) nurses conduct annual reviews and provide technical support visits as needed. Agencies fiscal performance is also monitored. Local agencies are certified every two years, based on review of programmatic and fiscal performance.

The High-Risk Infant Follow-up Program, provides follow-up, early intervention, parenting skills, family support, and other preventive interventions for more than 6,000 families each year. With a more traditional health focus, nurses and not paraprofessionals staff these visits. Using federal/state dollars (3:1), the program budget was approximately \$1.8 million in FY 1999.

Healthy Families Illinois is considered the primary state-based home visiting program in the state. Children's advocates, led by Voices for Illinois Children, stimulated development of the Healthy Families program in Illinois. Six years ago, Voice for Illinois Children was successful in adding two paragraphs to the administrative code that called for development of a plan to implement Healthy Families America in the state and specified who should be involved in the development process.

Their process was a success. A work group was convened in December 1994, and an initial plan was drafted by March 1995. The group, including stakeholders (and co-chairs) from inside and outside government, continued to shape and refine this plan through the legislative process. In early 1996, they secured \$2 million in the governor's budget and legislative action. As reported by one state official, "This was great. We had no pressure to spend money while planning, but, when the money came along, we knew what we wanted to do."

Healthy Families Illinois expanded dramatically in the first few years, with appropriations growing from \$2 million to \$3.5 million to \$8 million to \$10 million. State officials report that it was difficult to expand the program at that rate; however, they felt that they had to seize the opportunity to create this program with adequate resources.

By 2000, the program had about 50 sites serving more than 2,500 families. Healthy Families Illinois is serving all population centers and some rural areas, but gaps remain in Chicago and rural communities. As a result of program priorities, the sites are concentrated in areas of need and among areas able to sustain quality programs. (For example, caseloads are limited to 15–25 per visitor and staff must be trained and certified.) The grantees tend to be a mix of local health departments and not-for-profit social service/child welfare agencies (e.g., Catholic Charities, mental health centers, community health centers, Baptist Family Services, child abuse councils).

Healthy Families Illinois has a strong emphasis on quality assurance. The program aims to follow the 12 critical elements outlined by Healthy Families America and has added an additional five elements. The elements are used to structure the Request for Proposal, training, staff credentialing, and other quality assurance activities. For its program evaluation, the state has contracted with an experienced researcher at Northern Illinois University for data collection. Both intermediate- and longer-term outcome data are being collected. Training—for both Healthy Families and Parents Too Soon—is provided by the Ounce of Prevention Fund.

Similar to other states, home visiting is a part of multiple programs and initiatives under way in Illinois. For example, the State Board of Education is distributing \$30 million from the Early Childhood Block Grant to local schools for birth-to-three programs which includes Parents as Teachers and other models with a home visiting component. Early Head Start also has a home visiting component.

Unlike a number of other states, Illinois uses state appropriations to finance its two main home visiting efforts. The state does not use Medicaid financing for Healthy Families. State officials decided that, in that state, Medicaid and Healthy Families did not fit together because: 1) parent-child education and interaction is different from service coordination; 2) Healthy Families Illinois has no income restrictions; and 3) the trained paraprofessional staff did not fit the Medicaid administrative case management structure.

Likewise, Illinois elected not to use TANF dollars to finance Healthy Families or Parents Too Soon. State policymakers did not want the program to be linked to the concept of welfare and they were concerned that TANF dollars may not continue to be available to home visiting programs. (In the future, TANF dollars might be used for cash assistance in a time of recession, or they may be eliminated in a good economy.)

Illinois aims to improve coordination of programs and reduce duplication of services through several mechanisms, which primarily rely on local action. In essence, local agencies are responsible for deciding on a coordination strategy, with state oversight and facilitation. The application process for Healthy Families requires that the local entity describe how they would work with the local health department and other local programs to avoid duplication. Local grantees also are given a list of other related projects in their area. In addition, the state information system and joint training, as well as functional distinctions in the program, help to separate roles and responsibilities. However, state program officials note that it may be fine for a family to receive Medicaid Family Case Management during pregnancy and Healthy Families home visits to reduce their risk of child abuse and neglect.

Political support is generally strong for Illinois home visiting programs. While some in the state legislature had initial reservations about the Healthy Families Illinois program (ranging from concerns about privacy to the detailed nature of the bill), it now enjoys solid support. Local programs, as well as child advocates, keep the legislators informed about operations and successes through regular contact and "Capitol Days." With such feedback from local constituents, legislators have developed a positive view of the Healthy Families program. In terms of Medicaid's Family Case Management, state

policymakers see the advantages of having 50 percent federal matching for services that have been shown to be effective in improving use of prenatal care and reducing infant mortality.

Despite their success, Illinois State officials see challenges in the future. They expressed concern about the capacity of home visitors to address the incidence of maternal depression and substance abuse, given the inadequate supply of community services. While paraprofessional home visitors can screen for risks, community mental health and substance abuse treatment services are essential to the overall success of the intervention. They also emphasized the need for a continuum of family support services in order to achieve optimal outcomes for all families.



Massachusetts: Using a common administrative structure for a continuum of services

Massachusetts has many programs that deliver early childhood and family services through home visits. These programs serve different populations with varying service models. Their shared goal is to identify high-risk families before children are born and to prevent risks from becoming crises in families. Public health and Children's Trust Fund dollars have been committed and blended with other funds. By 1999, one-third or more of the at-risk population was being served through key public programs. The Department of Public Health administers five programs that include a home visiting component; among them are FIRSTLink, Healthy Families, FIRSTSteps, FOR Families, and Early Intervention. A common administrative structure helps to ensure that these programs cooperate at the community level. Together these programs blend public and private resources to form a continuum of services

Massachusetts FIRSTLink is a new statewide newborn screening and community referral system. The program uses the birth certificate system to identify mothers and infants at greatest risk for developmental and other health problems. The goals of FIRSTLink are to screen all newborns, link newborns and their families with needed services and resources, coordinate home visiting efforts, and integrate child health information. Every new mother is asked to consent to giving her baby's name to a local resource team and to having a home visit. The long-range goal is to ensure a home visit for every family with a newborn. However, current funding is sufficient only to ensure that every new mother in the state gets a "Growing Up Healthy" child health diary and/or a home visit. In Boston, all families with newborns are offered a visit.

In 1999 five other cities and towns across the state offered home visits to families at risk. The criteria for families at higher risk include a baby who has moderately low birthweight (less than 1,800 grams), a birth defect, or other medical risks; or a mother who had no insurance or Medicaid coverage for the birth, had inadequate or no prenatal care, shows evidence of excessive alcohol use, has many children, is a young adolescent, or carries hepatitis B. Birth certificates are used to identify those at highest risk. This ensures that all newborns with risks are identified, and that only the health department has access to these data (to help guarantee confidentiality).

Financing for FIRSTLink comes from several sources. For the pilot program, federal Title V demonstration project funds (from a Community Integrated Service Systems grant) were used. Statewide implementation was financed with money from a variety of existing sources, including Title V MCH Block Grant dollars, Healthy Start/Medicaid insurance, Healthy Families, IDEA funds, the Department of Education, foundation grants, and municipal budgets.

The Healthy Families initiative, serving first-time adolescent mothers and their children, includes comprehensive, prevention-oriented, voluntary home visiting services for all first-time mothers under age 20. The intervention begins during pregnancy and continues until the child reaches age 3. Program goals are to assist teen parents to develop effective parenting skills, prevent repeat pregnancies, attain maximum educational achievement, develop the capability to support themselves and their children, and have healthy birth outcomes. Center-based services are provided in addition to those delivered through home visits. The program is a joint venture of the Massachusetts Children's Trust Fund and the State Department of Public Health.

FIRSTSteps provides comprehensive, prevention-oriented, voluntary home visiting services for at-risk families with children, from pregnancy through age 3. A range of complementary services such as parent groups and social supports are also part of the program. This is a strength-based program, with a focus on families with multiple risk factors. The FIRSTSteps program goals are to promote healthy birth outcomes, achieve optimal health and development in early childhood, and prevent child abuse and neglect. The program uses a multidisciplinary staff team, including, at a minimum, a nurse, mental health professional, early childhood developmental specialist, family home visitor, and a member of the community who shares language, culture, and, in many cases, life experiences with program participants. For families with multiple risks and needs, paraprofessional home visitors alone may not have the skills and experience to assist families in coping with depression, serious mental illness, substance abuse, and the like.

Another initiative of note in Massachusetts is the FOR (follow up, outreach, and referral) Families program, which provides services to the majority of the 2,000 mothers who are leaving welfare and cash assistance. The program provides a telephone information and referral hotline and home visiting program. This program started with follow-up for those families who continued to be eligible, but did not return, for food stamps. The FOR Families effort has expanded to include anyone who is leaving cash assistance (after reaching the 24-month time limit) about whom case workers have reported concerns. Many families have not been able to enter the workforce or simply are not aware of the services and supports for which they and their children remain eligible despite losing cash assistance. The program is operated jointly by the departments of Public Health and Transitional Assistance, using administrative funds from the Temporary Assistance to Needy Families (TANF) program. This monitoring system helps the state learn about risks and gaps faced by families leaving welfare. In the view of one state official, "This is a basic system function. It was done fifty years ago and should be done in more states today."

The Early Intervention program serves children from birth to age 3 who are at established biological or environmental risk for developmental delay. Operating under Part C of IDEA, this program provides support and education for parents on the care and management of their children. The program, which includes a home visitor component, is administered by the Bureau of Family and Community Health and is operated through community-based agencies.

Each of these home visiting programs has mechanisms in place at the local and state level to foster collaboration and improve coordination. Locally, staff from the Healthy Families, FIRSTSteps, and Early Intervention programs in each community meet regularly to ensure that services are coordinated and not duplicated. (State agencies are trying to coordinate services.) One goal of this coordination and collaboration is to develop a common, core set of standards for home visits. In Massachusetts, the Department of Public Health, Bureau of Family and Community Health, has more resources and authority than the Department of Education for the population of children ages 0 to 3, so it is leading this effort. The Department of Education has the resources and lead responsibility for providing services to older children.

Massachusetts reports having "wonderful" public-private partnerships to support early childhood intervention programs, one of the key elements in home visiting. The Children's Trust Fund has led the way and made home visiting a priority. Private dollars and grants in Boston made it possible to serve a broader population through Boston

FIRSTLink. Tufts University is conducting in-depth evaluation studies of the home visiting initiatives.

One of the major challenges identified by Massachusetts state officials is overcoming narrow views on what works and what should be tried. Some organizations believe that only one model should be implemented, or one goal given priority (e.g., child abuse prevention or prenatal care). The Children's Trust Fund, which sees the larger picture, has helped state agencies address this challenge.



Michigan: Putting it together at the state and local level for families

Michigan has a large, cross-cutting, governor-led initiative for children and families, Putting It Together with Michigan Families. As part of this effort, family support and child welfare programs are coordinated by a state-level interagency team and local collaborative bodies. Home visiting programs are included in most of these programs.

Using an executive order in 1995, Governor John Engler created a Children's Commission under the leadership of then-Lieutenant Governor Connie Binsfeld. The mission of the Binsfeld Children's Commission was to make recommendations for integrated reform and collaborative direction of services to protect children from abuse and neglect. This effort was shaped by concern about how well the state's adoption, foster care, and related child welfare programs were functioning, as well as coordination of programs for early intervention, infant support, and home visiting to high-risk families with young children. The Binsfeld Children's Commission made nearly 200 detailed recommendations regarding family preservation and family support services. (Those primarily related to family preservation and child welfare can be found in the Commission report.)⁴⁵ For home visiting services, the Commission recommended expanding Maternal Support Services and Infant Support Services, and continuing Visiting Nurses Services to high-risk families.

For Michigan state officials, family support services are "focused on primary and secondary prevention, early intervention and health promotion.... They are voluntary services selected by the family, families are often involved in the development of the services, and the service providers are also selected by the family.... Family support services may be targeted to all families.... Family support should be universally available...."⁴⁶ Services provided include parent education, guidance on child development, basic health screening, etc. The Early On program is one example of a family support program in Michigan.

In contrast, family preservation services are “focused on families in acute crisis, where the intent is to prevent out-of-home placement, assist with crisis management, or in general family management when the family has been chronically disrupted. Preservation services are essential where the potential for family disruption/disintegration is high. The intent is to stabilize the family.”⁴⁷ Family preservation services are intensive and are designed to reach a small number of families with more severe risks and needs. Services may be mandated under a legal decision or they may be quasi-voluntary (i.e., accepted as an alternative to having children removed from the home).

Multiple programs that are part of the Putting It Together Initiative use these definitions and follow these concepts.

A Multi-Purpose Collaborative Body is an inclusive planning and implementation body of stakeholders at the county or multi-county level, that is responsible for articulating a vision to improve outcomes for children and families; sharing risks, responsibilities and resources; and making program, policy, and finance decisions about approaches and interventions for children and families. It is in essence the umbrella structure for collaborative initiatives to improve outcomes for children and families in Michigan. The Collaborative Body has planning and oversight responsibility for services funded through individual agencies, including coordination of budget planning. For example, a local Multi-Purpose Collaborative Body might oversee funding from the following programs (see program descriptions below): Early On (IDEA-early intervention), Strong Families/Safe Children (family support and family preservation), Michigan Interagency Family Preservation Initiative (MIFPI), Child Protective Services, Early Head Start, other home visitor programs, and the newly created All Students Achieve Program-Parent Involvement and Education (ASAP-PIE) grants.

Early On is the Michigan early intervention program (also known as “Part H” or Part 3 of the Individuals with Disabilities Education Act [IDEA]) for children birth to 3 who have or are at risk for having developmental disabilities that may affect their ability to learn. Through Early On, Michigan has created an early intervention program that seeks to address a wide range of child and family needs using a family-centered approach in the home and the center. The standard early intervention process (as indicated by the federal statute) includes inquiry (identification), screening/referral, evaluation/assessment, development of an Individualized Family Service Plan (IFSP), services based on the IFSP, and a transition plan for moving into special education or other services at age 3. In Michigan, these services are part of the responsibility of the Multi-Purpose Collaborative Body, which must include a work group that defines service needs for young children and

their families. The Multi-Purpose Collaborative Body also might oversee early intervention financing at the local level, document unmet needs, and ensure that the early intervention services fit into a comprehensive services system for infants and toddlers and their parents.

The Michigan Interagency Family Preservation Initiative (MIFPI) is a demonstration project aimed at improving the delivery of human services to children and their families. MIFPI promotes collaborative community-based planning and services that support and serve children at risk for out-of-home placement. This collaboration is taking place among state and local agencies, community members, services providers, and families. The Initiative's primary goals are to establish local demonstration sites, provide training and technical assistance to sites to facilitate changes in case flow and funding structures, and improve the financing of services. The approach of the service delivery model is individualized family-centered care focused on strengths and asset building. The families receiving services have children with severe emotional disorders or who have been adjudicated for delinquent behavior, and some programs focus on families with children younger than age 5 who have been exposed to drugs or live in families with chemical-dependency issues. An evaluation of the second year of the program concluded that the families found the process better-suited to their needs, collaboration is occurring in most communities, and outcomes are improving (e.g., decreased out-of-home placements and behavioral problems). However, categorical rules and restrictions continue to hinder collaboration and system reforms. Medicaid dollars, under a federal waiver program, are used to support a portion of this program.

Strong Families/Safe Children has been providing family support and preservation services since 1995, with communities planning and implementing services for children and families based on state-identified outcome measures. The program was recently funded at \$16 million to \$22 million for providing community grants. Local county efforts vary and may include home-based prevention, parent education, school-based prevention, counseling, and other family support services. The greatest strengths of the program are reported to be more effective community-wide system planning and improved family acceptance of and satisfaction with family preservation services.

The Zero to Three Program—not to be confused with the Early On Program, which provides early intervention services for children from birth to age 3 in Michigan—is designed to support families at-risk for child abuse and neglect. This program is based on the Hawaii Healthy Start/Healthy Families model, and uses a variety of standardized programs such as Parents as Teachers. Through the Family Independence Agency, \$2

million was made available through requests for proposals (RFPs) for secondary prevention of child abuse and neglect. An additional \$2.5 million was transferred from the Department of Education and added to the total funding for “Zero to Three” to extend the contracts for the one-year grantees, and to support funding for additional agencies unable to be funded during the first round of RFP review, but still worthwhile. Secondary prevention describes services provided when a risk has been identified, but there has been no suspicion or occurrence of negative behavior by the parent/caregiver. Twenty-five grants were awarded for supportive services to families to prevent the incidence of child abuse and/or neglect. A variety of services have been funded, including home visiting, Healthy Start-based models, parent resource centers, and parent mentors, among others. Of the total, 16 projects are developing or expanding a home visiting program to provide intensive case management, parent education, home-based therapy, parent support, comprehensive assessments, and referrals. For FY 2000, the funding rose to \$5.3 million, with additional resources from the Department of Community Health. By the end of 2000, 64 grantees were providing services throughout the state.

Beginning in FY 1998, \$7 million was allocated from the Family Independence Agency for an initiative titled, *Child Protection: Working Together as Community Partners (CP/CP)*. For most counties, \$30,000 was identified as a base, with the balance being distributed to counties based on four variables: relative percentage of children in the general population; percentage of children receiving food stamps; “screened out” protective services calls; and unsubstantiated protective services cases. The intent of these dollars is to increase/enhance the services available to families that have been reported to protective services, and whose cases have been unsubstantiated or ruled low-risk for recidivism resulting in another report, but most likely would benefit from intervention to address problems related to parent-child interaction. Counties must prepare a plan, which is reviewed and ratified by the Multi-Purpose Collaborative Body. Approximately 30 counties have completed this activity and are proceeding to implement services. The majority of agencies that have completed plans have determined that a variety of in-home services, including homemaker services, parenting skills, and wraparound services, for a small number of families at “higher-than average” risk will be of most benefit to these families. Ninety percent of the funding must be used for direct service to families.

Medicaid has a case management program for high-risk pregnant women; however, it is among those least likely to be integrated into this large new system coordination effort. The Medicaid Maternal and Infant Health Advocacy Services (MIHAS) program is designed to provide outreach to pregnant women not receiving prenatal care, assist high-risk women in continuing prenatal care, and provide expanded

health education. A team, consisting of four paraprofessional advocates and a nurse supervisor, specifically trained to address the psychosocial problems of high-risk, low-income pregnant women, delivers MIHAS. Paraprofessionals are “resource mothers” who must be indigenous to the community and have been on Medicaid in the past. To qualify for MIHAS services, a pregnant woman must be Medicaid eligible (up to 185 percent of federal poverty level) and have one or more risk factors (i.e., single marital status, social isolation, under age 20, history of abuse or neglect, maternal depression, low intellectual functioning or educational level, and HIV/AIDS risk). Services provided include assistance with making and keeping prenatal care appointments, referrals to other needed services, transportation, needs assessment, and health education related to pregnancy and parenting.

As in other states, this Michigan home visiting program has faced challenges in financing the entire package of services. Supported with \$3 million in state/federal Medicaid dollars, funds are allocated to 19 agencies that finance services delivered by 22 advocacy teams (approximately \$150,000 per team). The program was operating in 16 counties in 1998, with 13 counties targeted because of high infant mortality rates. The majority of providers are local health departments. The MIHAS program has encountered difficulties in trying to make the transition into a Medicaid managed care environment.

When the Infant Support Services component was established, the program was providing nine visits per infant, with provider discretion to offer additional visits as necessary (up to 36). In the transition to Medicaid managed care, some plans began to require prior authorization for assessments and prior separate authorizations for social work, public health nursing, and nurse home visitors. In addition, reimbursement of home visits was reduced. These issues were worked out through the intermediary efforts of child advocates. Providers are continuing to work with the plans, state agencies, and advocates to strengthen the program’s funding and operations.

Those concerned about family support and home visiting should follow Michigan’s efforts. Coordination of these early childhood programs, virtually all of which have a home visit or home-based service component, has largely been structured through the local Multi-Purpose Collaborative Bodies and the state’s Putting It Together for Michigan Families team (also known as the PIT crew) leading the initiative. Policies are set at the state level, and the local communities set priorities and take responsibility for coordination and systems planning, including results-based accountability. This is a large and important state effort, developed at the initiative of a “pro-family and children” governor, under the recommendations of a lieutenant governor’s commission, and with the administrative leadership of key cabinet members—particularly the Department of Community Health,

Department of Education, and Family Independence Agency. The legislative leadership also has been strong, with several women legislators playing important roles in advancing new funding and policy. The evaluation efforts will be used to report to the legislature and the agencies about whether the state is “doing better” in its efforts to serve children and their families, and to identify coordination strategies and program activities that work.



North Dakota: Using state leadership to help local programs improve quality
In the course of the state’s Title V needs assessment process, North Dakota conducted a “New Mothers’ Survey” in 1996, which revealed that less than one-third of mothers and infants received home visits. Moreover, the scope and duration of home visits did not seem to fit the pattern of need. State officials also identified dozens of local providers making home visits to families with young children. These providers did not want a new state mandate, and the state did not see a need for a new state program. However, it was clear that state-level guidelines and state agency technical assistance could improve and support local practice.

Through expert consultation and consensus development, the **Guidelines for Infant and Early Childhood Home Visiting Programs** were formulated. The guideline document includes the principle of successful home visiting efforts, key components of home visiting (assessment, planning, intervention, evaluation), and tips on program evaluation. The principles state that home visiting programs should:

- have clearly defined goals, objectives, and target populations;
- be offered on a voluntary basis to all families of newborns;
- offer continuing and persistent outreach;
- initiate services before or just after birth;
- use standardized assessment tools;
- focus on supporting the parent, the child, and the parent-child relationship;
- be flexible;
- be sensitive to the needs and circumstances of their clients;

- use carefully selected workers;
- provide ongoing training and supervision of staff.

In addition, the state compiled information from more than 70 local providers to create the *North Dakota Directory for Infant and Early Childhood Home Visiting Programs*. Technical assistance continues, and efforts to develop and implement quality indicators are under way.



Ohio: Putting high-risk families and children first and visiting first children
Family and Children First is a multifaceted, gubernatorial initiative focused on families with young children. The Ohio Family and Children First initiative provides an infrastructure for coordinating an array of early childhood programs. Home visiting is a component of more than one program under this initiative.

The *Welcome Home* Newborn Home Visit Program was designed to provide a home visit to parents of all firstborn babies and all teen parents, regardless of family income. The home visiting nurse offers information, answers questions, and provides referrals for new parents (just before or just after the birth of a baby). This program is administered by the Ohio Department of Health, in cooperation with Ohio Family and Children First. County-level grants, funded at several million dollars a year, are made available through the Ohio Department of Health to local county Family and Children Councils and others. To qualify for funding, local agency providers must meet the following criteria: 1) newborn home visiting is consistent with the agency's mission; 2) they are able to bill Medicaid and other third-party payers for home visitation services; 3) they have a working relationship or agreements with maternity hospitals and birthing centers in their service area; and 4) they can provide close, ongoing clinical supervision for home visiting nurses. In addition, home visiting nurses from all local agencies receiving funding must complete two days of training based on the state home visiting policy guidelines.

The Ohio Early Start Initiative provides funding for home visiting services and community supports for at-risk families with children birth to 3 to prevent abuse, neglect and developmental delay. There is an income eligibility requirement for Temporary Assistance to Needy Families (TANF) funds. Eligible families have one biological (including a teen parent) and three other risk factors. Risk factors include premature birth, low family income (less than 185 percent of the federal poverty level), parent alcohol or drug dependence, acute family crisis, severe prenatal complications, and so forth. For these

families, the program aims to 1) create a family environment conducive to the growth and development of children; 2) ensure that children receive proper medical care, including up-to-date immunizations; and 3) bring well-coordinated services to children and families who need assistance and enhance the families' abilities to meet their own needs.

The program has been under development for several years. It started small, with some early innovator counties in January 1996, when 30 of Ohio's 88 counties received funds to provide family support and interventions. In 1997, the program was expanded through a partnership with an intensive case management program for teen parents. The success of these county efforts—reaching almost twice their enrollment goal—increased confidence among state policymakers. With new federal funding and flexibility offered to states under the Personal Responsibility and Work Opportunity Reform Act (PRWORA P.L. 104-193, commonly known as welfare reform), Ohio policymakers saw an opportunity to create a much larger, statewide intervention program.

This major expansion began in 1998 when state policymakers decided to use TANF funds to make home visiting for at-risk families available in all 88 counties. The TANF expansion provided \$28 million dollars, which, when combined with state funds, brought the FY 2000 Early Start program budget to \$36 million. This newly invigorated version of Early Start focuses more on child development, particularly risks during the first year of life, greater emphasis on family self-sufficiency, and continued activities to prevent child abuse and neglect. With these expanded resources and full second-year implementation of the program, more than 20,000 high-risk infants and toddlers and their families benefit from Early Start services.

The Ohio Early Start Program is based on key components of several demonstration and research projects, such as Parents as Teachers, Healthy Families America, Early Intervention, Early Head Start, Resource Mothers, and the work of Dr. David Olds. The core services offered to all families enrolled in Early Start are:

- screening for child health and development;
- referral to services, including primary health care, family literacy, and job training programs;
- service coordination;
- home visiting;

- family support services such as parent education and support groups; and
- an individualized family service plan (IFSP), developed jointly by the family and home visitor, that identifies the family's concerns, priorities, and resources.

The program, with the goals and core services described above, is administered by the Ohio Department of Health, in cooperation with the Ohio Department of Jobs and Family Services and the Ohio Family and Children First Initiative. However, the service delivery system varies by county, based on local needs and resources. State officials report that program expansions called for greater collaboration among county departments of jobs and family services, county Family and Children First Councils, and local health departments, as well as other community organizations concerned about the health and well-being of young children.



Oklahoma: Developing programs in an era of accountability

A number of programs in Oklahoma use home visiting as a prevention strategy. State investment in this strategy has been relatively high, and state officials are currently improving program coordination and quality.

The Child Abuse Prevention Act created the Office of Child Abuse Prevention in 1984 to promote the health and safety of children and families by reducing family violence and child mistreatment. The Office of Child Abuse Prevention also conducts statewide public awareness, multidisciplinary, and discipline-specific training of professional with responsibilities for children and families, and contracts with and monitors community-based family resource and support programs. The state is divided into districts, with child abuse prevention task forces at the state and district levels.

Under the administrative guidance of the Office of Child Abuse Prevention, Child Abuse Prevention Fund money is awarded to community-based family resource and support programs, which include home visitation. The funds are allocated by district, according to a formula based on child abuse rates and proportion of children in the population. Programs are implemented primarily at the local level by private, nonprofit agencies, school districts, and county health departments that contract with the state health department. Historically, these programs have been very different. With evaluators and policymakers raising concerns about whether the programs were having their intended effect, the structure of local programs has metamorphosed from public education to group education to a combination of home visitation, center-based services, and public awareness. The 1999 specifications for programs required more quality assurance measures

and program structure. Babies can be enrolled in the programs before they are born up to three months of age. Also eligible for enrollment are first-time parents and parents with other children. The target population was modified to avoid overlap with the Children First Program (described below) and excludes first-time parents before the mother's twenty-eighth week of pregnancy.

The Office of Child Abuse Prevention has applied the 12 critical elements of home visitation identified by Prevent Child Abuse America's Healthy Families America Initiative. Changes in state purchasing laws have led to increased monitoring of contractors. The Office of Child Abuse Prevention staff conducts annual on-site visits of contractors to assess how well services are being provided and to review financial records. An evaluator was hired to develop and implement a comprehensive statewide evaluation that includes measures of quality assurance, program goal attainment, prevention model fidelity, and participant outcome. A logic model approach was used to refine the prevention design, develop the evaluation, and devise standardized data collection tools. To demonstrate program effectiveness and accountability, the Office of Child Abuse Prevention has implemented the evaluation design and standardized data collection tools. In addition, a centralized data system is under development.

In 1996, the nurse home visitation model developed and researched by David L. Olds, Ph.D., came to the attention of the Oklahoma legislature. Olds's work and his message to officials in Oklahoma (as an outside expert and advocate) were well received by state senators Ben Brown and Ben Robinson. Their leadership led to the appropriation of funds to start a pilot version of his work titled, "Children First," in May 1996. The Oklahoma State Department of Health was instructed to begin implementation immediately. With a defined target population, visit-by-visit guidelines, common forms, and a management information system, legislators wanted the Children First Program to demonstrate its effectiveness by using outcome measures. Within three years, the program grew from the 19 pilot nurses to more than 260 dedicated nurses providing service statewide.

All Children First nurses are registered nurses and are employed as public health nurses at county health departments. Teams of Children First nurses are supervised by Children First Lead Nurses. Each Lead Nurse supervises no more than eight nurses. A District Nursing Manager who is administratively responsible to a county health department administrator supervises the Lead Nurse. The Chief of Nursing at the state office directs general nursing practice. Model-specific training, technical assistance, quality assurance monitoring, and data analysis are provided by the Children First director, nurse consultants, and epidemiologist.

Each mother must fulfill three criteria to qualify for the Children First Program: 1) she must be expecting to deliver and/or parent her first child; 2) she must enroll before her twenty-eighth week of pregnancy; and 3) she must have few financial or social resources. Nurses provide a core set of services, including brief health assessments for mother and child; education in health, parenting, nutrition and safety; and referrals to myriad service agencies.

The Children First evaluation strategy includes both process and outcome measures. Weekly caseload reports are sent electronically to State House of Representative and Senate staff and to health department administrators. Extensive biannual reports are produced by Dr. Olds's staff and distributed to those mentioned above. The Children First epidemiologist provides analysis on a variety of outcome indicators, including rates of women receiving early prenatal care, smoking and alcohol consumption, low birthweight babies, childhood immunizations, and mothers who breastfeed. In addition, the Pregnancy Risk Assessment Monitoring System (PRAMS) state survey is used to provide comparison data.

SoonerStart is a collaborative interagency effort of the Oklahoma departments of Health, Education, Human Services, and Mental Health and Substance Abuse Services, and the Oklahoma Health Care Authority, the Tolbert Center for Developmental Disabilities, and the Oklahoma Commission on Children and Youth. With the Department of Education as the lead, these agencies are responsible for implementing the Individuals with Disabilities Education Act (IDEA) Part C and the Oklahoma Early Intervention Act. Services are provided through 11 regions at 26 sites across the state. The Department of Education employs regional coordinators to monitor the program and resource coordinators to provide case management services for the families. County health departments provide the direct service component of the program through multidisciplinary teams made up of speech/language pathologists, child development specialists, physical therapists, occupational therapists, nurses, audiologists, special educators, and psychologists. In 2000, the teams have added specialists in nutrition, vision impairments, and social work. The program growth trend is 4.9 percent each year. Approximately 85 percent of the services are provided in the home.

The Oklahoma Commission on Children and Youth, through the Interagency Coordinating Council (ICC), has subcommittees that work across agencies to bring multiple staff and diverse expertise to the planning and development of the SoonerStart program. The subcommittee process also helps raise interest among the various agencies and increase the funding and support agencies bring to the table.

In 2000, the ICC program evaluation committee piloted two projects to evaluate the SoonerStart program's effectiveness. The Child Longitudinal Progress Study (CLPS) was an effort to quantify early intervention outcomes for infants and toddlers receiving the services as a measurement of program success, and to provide a basis for program improvements. Through a contract with the Oklahoma State University Bureau of Social Research, a Family Satisfaction Survey was developed and implemented to assess family views of the effectiveness of the program and to measure indicators of family change. Plans are to replicate both pilots on a larger scale in the upcoming year.

Each of these three programs is placed organizationally within the Maternal and Child Health (MCH) Service at the Oklahoma State Department of Health. Consolidated oversight of these three programs is under the direct supervision of the chief of MCH. The three program directors work closely together to solve problems and coordinate services. While each program has a different focus and approach, together they form a more comprehensive set of programs and services for families. Their goal is to ensure that each family served receives home visits from the most appropriate program, and that no family has more than one case manager.



Oregon: A governor's vision for making the pieces fit together

In 1996, Governor John Kitzhaber developed the Human Investment Framework in Oregon "to empower Oregonians to be as independent, productive and self-sufficient as possible." Out of this framework, the Governor created the Social Support Investment Work Group (SSIWG) to define critical supports necessary to ensure the success of education and workforce goals. In 1998, the SSIWG included the Access to Family Support and In-Home Assistance Committee and its Early Childhood Home Visitor Work Group.

The process of this work group led to a focus on early intervention home visiting (for families with children birth to age 8). The group discovered that early childhood home visiting programs were being carried out by at least eight different state agencies, and professional leadership had been struggling with how to "do it right." Issues identified included how to identify children and families that needed services, how often they needed them, what services should be provided and for how long, and whether the services really help. The work group reported in December 1998: "This fragmentation is fueled by the many differing studies and reports issued at the national level... numerous groups have attempted to tackle this issue in the past five years. None have been successful... The Governor's direct interest, state and local officials' determination to make it work, and the carrot of new resources have helped to forward the process..."

The objectives outlined by the Governor's Office were to help the state understand the most appropriate target groups and set priorities among those target groups; identify the best interventions for these target groups; and identify the key qualifications for providers.

The eight programs identified were Healthy Start (Commission for Children and Families), Babies First (Oregon Health Division), CaCOON (Oregon Health Sciences University), Early Intervention (Department of Education), Oregon Head Start (education and nonprofit organizations), Oregon Early Head Start (education and nonprofit organizations), Together for Children (education), and Perinatal Visits (local health departments and private health providers). These eight programs were providing overlapping services, however. Case management was a component in each program, and, in some cases, more than one program case manager was assisting an individual family. Each of the programs carried administrative costs, including duplicate grant applications, data reporting, and documentation. At the same time, there were unmet needs. The programs were operating at capacity, but not all programs were available in every county, making the delivery system uneven. The number of treatment and intervention programs available to accept referrals from home visiting programs fell short of need. In addition, some programs targeting migrant families, teen parents, and children with special health care needs were related but not well linked.

The work group set out a vision for a continuum of home visiting services. The group gave priority to high-risk populations, including high-risk groups of families with multiple social issues, pregnant women with medical and social issues, and children with medical and social issues. Objectives, measurable outcomes, and intervention designs were outlined for each group. The work group also was charged with recommending "how best to align and consolidate existing programs and resources into a statewide early childhood system of supports." The criteria were: a) the system must ensure a statewide minimum level of supports to the early childhood population, with these supports linked to the Oregon Benchmarks and statewide goals; and b) the system would be supported by state dollars, giving local communities the flexibility to augment or leverage additional resources.

The group also recommended a pool into which funds from a range of early childhood programs could be diverted and then allocated to counties. The envisioned statewide system would use universal screening, with common prenatal and newborn screening tools, as well as coordinated referral and triage teams at the local level. The pooled funds would be used to support in-home visits for children with medical risks (ages 0 to 8) and with significant social risks (ages 0 to 3). The referral and triage teams also

would help ensure appropriate in-home visits for developmentally disabled children, services for whom would be financed with nonpooled funds.

Oregon has adopted the “no wrong door” concept for early intervention services and home visits as a family’s point of entry into the system of supports. The Universal Screening Committee recommended use of the Oregon Medical Association uniform record for prenatal and perinatal families. Using a universal screening form can assist pediatricians, public health nurses, early intervention specialists, educators, and others to identify the medical risks and needs of childbearing families.

Another product of this process is “quality assurance standards” for the Oregon Early Childhood System of Services and Support of Prenatal-Age 8. These quality assurance standards are designed to guide comprehensive planning, quality review, and system improvements across all aspects of the system and are linked to standards from a range of other professional organizations and agencies. The six main elements of the quality assurance standards (each with its own description, associated indicators, practices/guidance, and performance measures) are: 1) family-centered practices, 2) comprehensive and responsive services, 3) respect for diversity, 4) qualified staff, 5) effective partnerships, and 6) results-based accountability.

Linked to these efforts, the Oregon Commission on Children and Families convened a Home Visiting Training Development Team to examine current training methods and resources in the state. A survey of home visitors, supervisors, and program managers was conducted in 1999 to assess the relative importance of various training topics. The survey asked about philosophy and values, including family-centered practice, strength-based approach, culturally competent practices, and professional ethics. Another subject area was effective home visiting, including elements such as engaging families, conducting the visit, making referrals, managing cases, ensuring confidentiality, setting limits, and keeping records. The survey also asked about the inter- and intrapersonal skills, knowledge, and information required of home visitors. The special topics of concern to home visitors participating in the survey included strategies for working with children with disabilities, therapeutic relationships in long-term home visiting, parent-driven curriculum plans, conflict management, and alcohol/drug addiction and mental health issues. The results of the survey will be used to develop training resources (available from the Family Policy Program at Oregon State University).

In terms of the overall system of care, Oregon has advanced new policies for families with children. Through a combination of legislation, the state has set out a

comprehensive investment policy for Oregon youth and families. Senate Bill 55 provides for:

- a defined role for the state and local commission on children and families in coordinating and facilitating development of a comprehensive plan for children ages 0 to 18 years and their families;
- an initiative to reduce juvenile crime through coordinated state-local strategies targeted at high-risk youth as one part of the coordinated comprehensive plan;
- development of an early childhood system of supports as another part of the coordinated comprehensive plan;
- improvements in the efficacy and appropriateness of alcohol and other drug prevention and treatment services for youth and families; and
- a consistent evaluation framework based on the Oregon benchmarks.

The policy proposals were accompanied by resource recommendations. Of the resource investment through House Bill 5548, \$7 million was allocated for early childhood systems through the Oregon Commission on Children and Families. An additional \$5.2 million for specific early childhood programs was included in the Commission budget. House Bill 5063 allocated another \$1 million in family-based prevention services through the Office of Alcohol and Drug Abuse Programs. The impact of these proposals on home visiting services and integration of early childhood services in Oregon cannot be assessed yet.



Rhode Island: Building an integrated child health system

In Rhode Island, the state health agency has had a home visiting program since the early 1900s. State officials see today's programs as a continuation of that tradition. In its current form, the state home visiting program is part of a larger initiative, launched through CHILD FIND responsibilities under Part C of IDEA (the early intervention program). Thus, home visiting has become one facet of an early detection intervention effort in Rhode Island.

While the primary function was to identify children in need of early intervention services (at risk for or with disability), other preventive child health services have been linked (e.g., immunization, hearing screening, lead screening, newborn genetic screening).

For families who aren't participating in prevention programs, home visitors can identify barriers and help make linkages. The home visiting program also has the flexibility to be tailored to the needs of individual families. The program often serves as a safety net. For example, when there is a waiting list for families in crisis or when a family does not fit into existing eligibility categories for other programs, this program can reach out to them and provide or make linkage to necessary services.

An integrated, statewide program seemed logical to state officials. In a state with a small geographic area, statewide programs generally make sense. In addition, using a statewide approach to seeking out and finding makes the CHILD FIND effort more effective. Although state agencies contract with professionals and organizations at the local level for service delivery, officials place value on having a degree of oversight at the state level. In their view, they don't want to miss any children who could be identified and served through CHILD FIND. Avoiding duplication is another goal of the statewide approach. While multiple government programs may fit into and provide funding for the state's CHILD FIND model, state officials want to avoid having multiple visitors serve an individual family.

But, even in a small state, coordination among agencies and programs is challenging. The Rhode Island process is facilitated by having a statewide policymakers group—including the members of the Governor's Children's Cabinet and others—which has a subcommittee charged with looking at coordination strategies. However, challenges remain in coordinating the activities of multiple agencies with different objectives, organizational cultures, and so forth. Interagency coordination remains a priority, because, as described by one official, "Coordination is key to maximizing resources... It is obvious at the state level that a more integrated approach is needed to improve purchasing."

The MCH program is using an integrated prevention program approach. The home visiting effort is coordinated through the same process. Coordination primarily occurs at the local level with state facilitation. For example, the Department of Human Services (DHS) has an adolescent self-sufficiency program for teen moms, which includes a welfare reform linkage and job training/education. DHS has the lead role if a family chooses to use the adolescent self-sufficiency program, and MCH provides family support only as necessary. Another example is the emergency and home visiting conducted by the Division of Family Services to follow up on suspected child abuse and neglect. The family services social work staff has a legal responsibility and the professional skills to intervene and make an assessment in this situation. However, emergency programs tend to be time limited, and the social workers often need back up to help keep the family intact.

Fiscally, the program blends federal dollars with state dollars and seeks to maximize federal contributions. Title V MCH Block Grant dollars provide the largest share of support. A small portion of funding comes from lead poisoning prevention and immunization grants through the Centers for Disease Control and Prevention (CDC). Federal early intervention program funding provides another part. The state seeks to use Medicaid federal match whenever possible. (The Rhode Island Medicaid/SCHIP program covers children with family incomes up to 300 percent of the federal poverty level.) Many home visiting services qualify under Medicaid's targeted case management benefit. However, if a beneficiary is receiving duplicate case management it is not reimbursable. For this reason, poor interagency coordination has a negative fiscal impact.

State funds are distributed through contracts with leading local agencies. This follows the pattern used by the early intervention program. Contracts are awarded in each of six regions, which correspond with the regions designated for early intervention services and follow the geographic boundaries along town lines.

Staff development is done at the local level, as an obligation under the contracts with local agencies. Direct supervision of staff is done through the local lead agency. Training is done both through leading local agencies under contract and directly through the state office. State-based training tends to be informational or topical (e.g., lead poisoning screening or immunization guidelines). The state also conducts "train-the-trainer" sessions on certain topics, in order to expand the training capacity of local agencies.

Another obligation of the contract requires participation in a regional home visiting partnership that meets monthly. Representatives from home visiting or other early childhood programs in each of the six regions attend. The contract agencies, particularly local visiting nurse associations, had previously subsidized this activity to some degree. Because their Medicare and Medicaid revenues have dropped, local agencies are now less willing to support the cost of these meetings.

At present, no formal evaluation is under way in Rhode Island. State officials believe a formal evaluation of the larger coordinated system will be more useful. The home visiting program does monitor the process through monthly meeting with managers to exchange information and discuss issues. In addition, annual reports from each region include information on services, outcomes, and the monthly regional partnership meetings. Program performance is routinely assessed, based on program objectives. Some outcomes will be measured through KidsNet (an integrated child health profile system that supports the integrated program approach). With recent integration of home visiting

data into the KidsNet database, the state will be able to compare selected outcomes such as immunization coverage, lead screening rates, completion of newborn screening, participation in WIC, breastfeeding rates, and so forth. The home visiting program objectives are broad. State officials hope to make a significant impact by linking families to resources and services.



Wisconsin: Using Medicaid financing to support home-based case management
State legislature and state agency leaders have worked together to advance and improve home visiting in Wisconsin. The state of Wisconsin provides money for two major home visiting programs, both of which are aimed at preventing child abuse and neglect. However, one is limited to Milwaukee County Medicaid eligible recipients.

Recent legislation (enacted in 1998) created a new Child Abuse and Neglect Prevention Grant Program (Act 293), also known as POCAN. This legislation was the result of a Legislative Council Study Committee recommendation to establish a primary prevention program in light of growing caseloads in the child protective services system. The Child Abuse and Neglect Prevention Grant Program provides grants to pilot POCAN home visiting and other services in 10 counties and one American Indian tribe.

Each grantee must have a home visiting program that selects first-time parents who are eligible for Medicaid and offers them the opportunity to undergo risk assessment for child abuse and neglect. Parents assessed to be "at risk" are offered opportunities to participate in the home visiting program on a voluntary basis. The home visiting services follow the 12 critical elements listed below (based on the outcomes of previous research). Case management components of the POCAN program home visit must be billed to Medicaid for reimbursement under the target group: *families of children at risk of physical, mental, or emotional dysfunction*. POCAN families are a subset of Medicaid beneficiary's families that are having a first child.

The POCAN grants are flexible to permit local programs to meet the needs of the families being served. For example, a flexible fund of up to \$1,000 can be made available to purchase items and services not covered by other funding. Another flexible fund of up to \$500 for families identified as being at risk of child abuse and neglect can be made available for services when the family voluntarily works with a case manager. The project must match 50 percent of the money spent from the flexible funds.

The legislation sets out a detailed framework for the home visiting program. The legislation assigned responsibility for development of a risk assessment tool to the

Department of Health and Family Services. The legislation also required that agencies receive written informed consent for home visiting (i.e., it may not be compulsory or provided without the knowledge of the family). Strict criteria are set for filing reports of suspected child abuse or neglect (e.g., parents must be notified in advance of the report) and for protecting confidentiality. The criteria for evaluation of this grant program also are set out in the legislation. These include:

- the number and result of substantiated reports of child abuse and neglect;
- the number, nature, and frequency of emergency room visits for injuries to children;
- the number, type, and length of out-of-home placements of children;
- the immunization rates of children;
- the number of comprehensive HealthCheck (EPSDT) services received according to the recommended guidelines;
- the number of families that remain in the program for the time recommended in their case plan (retention); and
- additional criteria determined by the Department of Health and Family Services to evaluate strengthened family function, enhance family development, and promote positive parenting practices.

POCAN grants were targeted to existing home visiting programs. Most of the successful grantees have diversified funding, using county allocations, foundation funds, etc. POCAN is a way to provide additional support through state grants and Medicaid.

The Milwaukee Family Project is a community-based initiative whose vision is to strengthen the community to respond to children and their families by developing and supporting a network of community partnerships, engaging community expertise, and creating opportunities for families to work as equal partners with providers. The project served more than 800 families in 1998.

A cornerstone of the Milwaukee Family Project is the Medicaid benefit that provides reimbursement for case management services using a home visiting model and

includes prenatal care coordination (PNCC) services and Milwaukee child care coordination (MCCC) Services. Women served through the PNCC Medicaid benefit are automatically eligible for the child care coordination benefit, as are Medicaid-eligible women who meet the program assessment criteria within 60 days of delivery. The Medicaid Agency has guidelines for operation and performance measurement standards to define and monitor both benefits.

The state child welfare agency is committed to home visiting efforts as a component of child protection and family preservation. When the state of Wisconsin took over management of the Milwaukee County child welfare program (1995), state funds were set aside to create this new Medicaid case management/home visiting benefit. In Milwaukee, when a family is reported for suspected child abuse or neglect, a state-appointed team completes an assessment to determine whether the child has to leave the home or the family is safe but in need of "Safety Services." The maximum duration for this type of intervention is four months. The intent is that either the family is able to modify behaviors of concern during these four months, or the child will have to be removed. At the end of four months, families are discharged from the project.

State health officials are working with the Milwaukee Family Project to improve the continuity and scope of services in this large, urban county. Gaps in eligibility are one key issue. If a family is receiving "Safety Services," no other Medicaid case managers may bill for case management services. This means that Milwaukee Family Project families that are assigned to "Safety Services" are no longer followed by the MFP case manager. "Safety Services" families not eligible for the Milwaukee Family Project may need transitional services, but these services are not always available under the current structure.

The Division of Public Health plays a key role in developing infrastructure for and coordinating these efforts. The 12 critical elements of home visiting programs promoted by Healthy Families America are being used in Milwaukee and the POCAN grant-funded projects across the state. Both state-funded programs implement the 12 critical elements identified in the Healthy Families model, set a standard definition for home visiting, address training issues, promote consistent evaluation, and encourage blended funding.

The fiscal environment in Wisconsin for home visiting programs is evolving. During the last couple of years, funds targeted to family prevention strategies have become available in counties that did not have such resources before. Each county and tribal government has funds to plan for prevention and family preservation, and home visiting may be included in their plans. Each jurisdiction (71 counties and 11 tribal governments,

excluding Milwaukee County) receives additional money as Title IV-E incentive funds to establish programs in their communities for families at risk.

New funding has generated an interest in home visiting in local communities. County social services agencies often approach local service providers to request development of a home visiting program, and, as a result, local programs have been sprouting up across the state. This makes standards and benchmarks more important. However, it is uncertain when any state-supported expansion will occur because staff is in the midst of evaluating current funded projects.

Medicaid funding comes with its own set of constraints. The state Medicaid agency has defined case management strictly in the Milwaukee Family Project; specifically, Medicaid will not pay for more than one case manager. At times, however, compensation is available for a joint consultation for initial or exit planning. The case management benefit definition limits the type of in-home activities that are reimbursable. State health officials estimate that Medicaid pays for only about one-third of the time visitors spend in the home. A chart review suggested that the expected (and desired) intensity and duration of visits was not being achieved. Case managers report that sometimes they are not able to deliver all the services they are trained to provide because of limits on the scope of the benefit. These are complex administrative issues that must be resolved if the state, health plans, and home visitors are to use Medicaid as a source of financing for home visits under the Milwaukee Family Project.

Medicaid managed care is another factor that affects the financing and delivery of these services in Wisconsin. State health agency officials report that they have not made much headway in efforts to ensure EPSDT outreach. HMOs under Medicaid contracts are required to designate a contact for case managers; however, the state's contract requirements do not require that HMOs formally link with case management agencies. The contract language in effect in mid-1999 encouraged, but did not require, HMOs to develop memoranda of understanding (MOU) with home visiting agencies. However, none of these agencies had been certified as HMO providers. Such arrangements could streamline some aspects of care delivery for the HMOs and the home visiting agencies, but state agency facilitation may be necessary to ensure the type of collaboration and cooperation that would better serve families.

The Medicaid case management payment is a fee-for-service benefit. Medicaid certifies case management providers, who are paid directly by the state. Providers must be a county agency that can supply the state share of Medicaid matching funds; local agencies

only receive federal matching dollars. Reimbursement depends on what they are doing and where the service is delivered. The usual county case management service is reimbursed, at the rate of about 60 percent of \$40.28 per hour, or \$23.88, effective October 1, 2000. However, for the Medicaid Child Care Coordination Benefit in Milwaukee, reimbursement is at an enhanced rate of \$50 an hour for assessment and care plan development and \$40 an hour for ongoing monitoring.

The POCAN legislation included \$160,000 for training and technical assistance. The University of Wisconsin Extension Program has been the pivotal agency for advancing training, with a full-time training coordinator at the Extension office in Milwaukee for the Milwaukee Family Project and additional staff for POCAN training. A “train-the-trainer” approach is being used to build a core of basic skills across the state. Some of the training programs developed through POCAN are offered at cost to other home visiting programs in the state.

Challenges remaining in Wisconsin are related to implementing home visiting programs in a changing policy and fiscal environment. With welfare reform and health care policy changes, state officials see a growing demand for technical assistance to sustain local efforts. In Milwaukee, the biggest challenge has been securing adequate and continuous funding. Qualified providers are visiting in homes, but they often are unable to provide or refer for needed education, well-child exams, and developmental assessments. Another challenge is to build the capacity of home visiting agencies to bill for case management. While the grants to counties have permitted implementation of a comprehensive approach, the Wisconsin legislation requires accountability for home visiting and case management. These responsibilities devolve to the counties and the local agencies with which they contract, and the state agencies must help them succeed.



APPENDIX C. CONTACT INFORMATION FOR STATE HOME VISITING PROGRAMS

State	Project Name	Contact Name	Telephone	E-mail Address
Alabama	Perinatal Program	Phyllis Gilchrist	(334) 206-2978	Pgilchrist@adph.state.al.us
Alaska	Home Families Alaska	Debra Caldera	(907) 269-3403	dcalder@health.state.ak.us
Arizona	Healthy Families Arizona	Marianna Bridge	(602) 220-6550	mbridge@hs.state.az.us
Colorado	Children's Trust Fund	Scott Bates	(303) 692-2942	
Colorado	Nurse Home Visitor Program	Jan Reimer	(303) 692-2351	jan.reimer@state.co.us
Connecticut	Healthy Start	Lisa Davis	(860) 509-8074	
Connecticut	Young Parent Program			
Delaware	Home Visiting	Nina McGee	(302) 995-8617	
Florida	Healthy Families	Carol McNally	(850) 921-9070	
Florida	Healthy Start	Cindy Lewis	(850) 488-2834	CindyLewis@doh.state.fl.us
Georgia	Children First			
Hawaii	Healthy Start	Loretta Fuddy	(808) 733-9024	lfuddy@hawaii.edu
Illinois	Parents Too Soon	Hilda Beckman	(217) 785-4547	hbeckman@idph.state.il.us
Illinois	High-risk infant follow-up	Marty Milligan	(217) 785-4526	mmilliga@idph.state.il.us
Illinois	Healthy Families Illinois	Ralph Schubert	(217) 782-2736	rschuber@idph.state.il.us
Illinois	Family case management	Dorene Wright	(217) 782-6495	dwright@idph.state.il.us
Indiana	Care Coordination	Beth Johnson	(317) 233-1249	bmjohnso@isdh.state.in.us

State	Project Name	Contact Name	Telephone	E-mail Address
Kentucky	Home Visiting	Curt Rowe	(502) 564-2154	curt.rowe@state.ky.us
Louisiana	Home Visiting for Families (Building Early Strengths Together, known as BEST)	Joan Wightkin Geoffrey Nagle	(504) 568-5073	jwightkin@dhhmail.dhh.state.la.us gnagle@dhhmail.dhh.state.la.us
Maine	Community Health Nursing	Valerie Ricker	(207) 287-5396	valerie.j.ricker@state.me.us
Maine	Healthy Families/PATT	Jacquelyne Roberson	(207) 287-5692	
Maine	Public Health Nursing	Beth Patterson	(207) 287-9025	
Maryland	Healthy Families Maryland	Donna Becker	(410) 767-6708	beckerd@dnhmh.state.md.us
Maryland	Healthy Start	Rosemary Murphy		
Massachusetts	FIRST Steps	Donna Johnson	(617) 524-6028	donna.johnson@state.ma.us
Massachusetts	Healthy Families	Lisa Levine	(617) 624-6028	lisa.levine@state.ma.us
Michigan	Maternal & Infant Support	Mary Scoblic	(517)335-8915	scoblicm@state.mi.us
Michigan	Strong Families, Safe Children	Cheryl Sibilsky	(517) 373-0076	
Michigan	Zero to Three	Nanette Reynolds		
Minnesota	Targeted Home Visiting	Barb Palmer	(651) 281-9864	
Minnesota	Healthy Beginnings	Betty Kaplan	(671) 281-9889	
Missouri	Families at Risk	Karen Schenk	(573) 751-6215	
Montana	MIAMI			
Montana	Home Visiting—Follow Me	Debra Henderson	(406) 444-2794	

State	Project Name	Contact Name	Telephone	E-mail Address
Nebraska	Title V Home Visitation grants	Judi Schlife		jschlif@hhs.state.ne.us
Nebraska	Good Beginnings	Jeanine Huntoon	(402) 434-3493	
Nevada	Community Connections	Betty Weiser	(775) 688-2284	bweiser@ovmail.state.nv.us
New Hampshire	Home Visiting	Tricia Tilly	(603) 271-4268	Ttilly@dhhs.state.nh.us
New Mexico	Home visiting initiative	Doreen Sampson	(505) 476-8586	
New York	Community Health Worker Program	Linda Thornton	(518) 474-3368	
North Dakota	Coordination for local programs	Constance Keller	(701) 328-4464	
Ohio	Early Start	Debbie Cheatham	(614) 644-8389	dcheatha@gw.odh.state.oh.us
Ohio	Welcome Home	Caroleen Ferriman	(614) 644-8389	
Oklahoma	Healthy Families Oklahoma	Suzanna Dooley	(405) 271-4470	suzannad@health.state.ok.us
Oklahoma	Children First	Annette Jacobin	(405) 271-4477	Annettej@health.state.ok.us
Oklahoma	Sooner Start - Early Intervention	Sandy Ingraham Grace Kelley	(405) 964-2072	gkelley@oklaosf.state.ok.us
Oregon	Healthy Start/Family Support	Donna Middleton	(503) 373-1283	
Oregon	Babies First		(503) 731-4612	
Oregon	Governor's Initiative	Pam Curtis	(503) 378-6895	
Rhode Island	Family Outreach Program	Blythe Berger	(401) 222-4601	bberger@doh.state.ri.us
South Carolina	DHEC home visits			
Tennessee	Tennessee Healthy Families	Susan Barber	(615) 741-0329	sbarber@mail.state.tn.us

State	Project Name	Contact Name	Telephone	E-mail Address
Utah	Prenatal to Five Nurse Home Visiting	Jan Robinson	(801) 538-9459	jrobinso@doh.state.ut.us
Vermont	Healthy Babies			
Washington	Maternal Support Services	Sherilynn Casey	(360) 236-3519	sherilynn.casey@doh.wa.gov
West Virginia	Right from the Start	Robin Simmons	(304) 558-5388	rsimmons@wvdhw.org
Wisconsin	Prevention of Child Abuse and Neglect (POCAN)	Ann Steuck	(608) 266-3504	steucac@dhfs.state.wi.us
Wisconsin	Milwaukee Family Project	Colleen Cantlon	(608) 267-9300	cantlcm@dhfs.state.wi.us
Wyoming	Home Visiting for Families	Mary Anne Purtzer	(307) 777-6474	mpurtz@missc.state.wy.us

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