THE PEW CENTER ON THE STATES

# States and the New Federal Home Visiting Initiative:

# An Assessment from the Starting Line

AUGUST 2011

The Pew Home Visiting Campaign partners with policy makers and advocates to promote smart state investments in quality, voluntary home-based programs for new and expectant families.

The Pew Center on the States is a division of The Pew Charitable Trusts that identifies and advances effective solutions to critical issues facing states. Pew is a nonprofit organization that applies a rigorous, analytical approach to improve public policy, inform the public and stimulate civic life.


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For additional information on Pew and the Home Visiting Campaign, please visit www.pewcenteronthestates.org/homevisiting.

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# Contents

# Introduction

The first months and years of a child's life are a time of critical cognitive, social and emotional development that builds the foundation for future success. Infants and toddlers who receive the love, care and stimulation they require during this period thrive. But when parents lack the knowledge or resources to meet the needs of their babies, the resulting damage can be grave and lasting. In fact, many of a state's costliest social problems—such as poor infant and maternal health, child abuse and neglect, school failure, poverty and crime—are rooted in this same crucial early period. Fostering healthy, safe and stimulating environments for infants and toddlers not only gives them a strong start but also helps to prevent serious—and expensive—problems later in life.[1]

Voluntary home visiting programs pair families with trained professionals, who provide ongoing information and support services in the families' homes during pregnancy and through their child's first three years. When programs adhere to approaches with scientifically documented effectiveness, set clear standards for child and family outcomes and are monitored to ensure that they meet these goals, they

are proven to help states and communities recoup substantial savings in health care and other public expenditures. This is particularly true when public investments are directed toward those families most at risk for low birthweight, child abuse and neglect, poor nutrition and other problems. Indeed, economists have found that, when well designed and implemented, home visiting programs return up to $5.70 per taxpayer dollar invested.[2]

In 2010, as part of the Patient Protection and Affordable Care Act, Congress established the new Maternal, Infant, and Early Childhood Home Visiting Program, a major national commitment—$1.5 billion over five years—to expand and improve state-administered home visitation.[3] This initiative mandates that federal funds be spent only on approved models that meet designated, rigorous evidentiary standards and are effectively coordinated and monitored.

The federal effort is driven by the recognition that quality home visiting can dramatically improve children's health and wellbeing, increase family self-sufficiency and save taxpayers money in both the short and long term. If this potential is to be realized, however, states must ensure that the almost $1.4 billion they make available annually for home visiting also is supporting proven, evidence-based models, and that public expenditures are yielding expected returns.

A first-of-its-kind survey, conducted by the Pew Center on the States, investigated the extent to which states are meeting these investment objectives. Pew researchers surveyed agency leaders in all 50 states and the District of Columbia about their state-administered home visiting funding and policies for fiscal year 2010 and looked at each state's programs—documenting their quality, funding, administration and oversight—to provide a comprehensive picture of the national landscape of state-administered home visiting.[4] The survey found that although nearly all of the states and the District are making critical investments in home visiting programs, evidence of effectiveness too rarely determines how these dollars are spent, oversight is insufficient and funding is inadequate. This report—together with the companion inventory of states' programs available at the Pew Home Visiting Campaign Website, www.pewcenteronthestates.org/homevisitinginventory—outlines Pew's findings and provides concrete recommendations for policy makers.

In this time of persistent state budget deficits and heightened economic stress among families, especially those already at risk, we cannot afford to waste precious public resources on ineffective programs. If states raise the bar for home visitation, they can deliver on the promise of healthier, more successful children and families and billions of dollars in taxpayer savings.

## KEY FINDINGS OF PEW'S SURVEY OF STATE HOME VISITING PROGRAMS

**1. Most home visiting funding was not adequately tracked at the state level.**

In FY2010, states made almost $1.4 billion available for home visiting programs. Of these dollars, states could not document the use of $575 million, or more than 40 percent of available funds. States that dedicated funds exclusively for home visiting (categorical funding) effectively tracked spending of $462 million. States that provided broad-based funding to local communities to support a variety of child and family services could document only the allocation of $337 million—$52 million to home visiting and $285 million to other services. Collection of spending data was likely more robust at the local level, but states too infrequently required reporting and tracking of statewide expenditures. To ensure the most effective investments, states must more efficiently track taxpayer money supporting specific programs.

**2. States frequently provided funding with few, if any, requirements that programs invest in models with a proven record of success.**

Leading home visiting models have been subjected to rigorous testing with scientifically validated control groups. Evidence-based models do not come with guarantees, but when well implemented they have a proven record of effectiveness and return on public investments. Yet, 58 percent of FY2010 state funding (48 programs in 32 states) was provided with minimal guidance regarding selection of models, quality standards or expected outcomes. In these instances, service-delivery decisions such as curricula, training and caseloads were left to local discretion, and states could not ensure program quality or cost effectiveness.

**3. States did not adequately monitor publicly funded programs to ensure effectiveness.**

States generally did not provide enough oversight of programs to guarantee that services are of high quality, reach targeted populations and deliver desired results. Most states did not provide even basic data on program performance, such as the cost of the program, the number of visits per family and, most important, if parents and families who received services did better. Programs should be required to track both program performance and child and family outcomes, and states need to use those data to inform funding and policy decisions.

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## KEY FINDINGS OF PEW'S SURVEY OF STATE HOME VISITING PROGRAMS

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**4. States did not consistently target at-risk families, where the return on investment is highest.**

While states can choose to serve more families, prioritizing high-risk populations yields the best return on public investments. Yet, more than half of available home visiting funding—nearly $727 million—was allocated to programs without state-designated eligibility requirements. States can do more to provide clear guidelines about who is eligible for services and to ensure that state dollars are directed as intended.

**5. In every state, far too few at-risk families got home visiting services.**

No state had either sufficient funding or the infrastructure to reach all of its highest-risk families. To reap meaningful savings from home visiting investments, state funding must be sufficient to significantly lower the rates of costly problems.

# Home Visiting: The Evidence Base

High-quality, voluntary home visiting can improve both immediate and lifelong family and child outcomes.

- Mothers who received home visits were half as likely to deliver low-birthweight babies as were mothers who were not enrolled in a home visiting program.[5]
- Children who participated in a nurse home visiting program were 35 percent less likely to end up in the emergency room, and 40 percent less likely to need treatment for injuries and accidents between the ages of two and four.[6]
- Mothers who participated in home visits were more sensitive and supportive in interactions with their children, according to several studies, and they reported less stress than those mothers who did not receive home visits.[7]

Creating a stable, supportive environment for at-risk children through home visiting programs also benefits society through direct cost savings, more self-sufficient families and a well-developed workforce.

- Mothers participating in a nurse home visiting program had a 30-month reduction in welfare use,[8] an 82 percent increase in the number of months they were employed[9] and a 46 percent increase in the father's presence in the household.[10]
- By age six, children who participated in a nurse home visiting program had higher cognitive and vocabulary scores than those in the control group. These gains persisted through third grade, with participants posting higher grade-point averages and achievement test scores in math and reading.[11]

With their potential to reduce the demands on cash-strapped health care and child welfare systems, home visiting programs are a smart investment for both the short- and long-term strength of families and states' economies.

Yet, to achieve these outcomes, states need to adopt models with scientifically documented effectiveness, set clear standards for child and family outcomes and monitor state-funded programs to ensure that they meet these goals. The Pew survey found that too often that is not the case.

# Findings in Depth

## **Finding 1:** Most home visiting funding was not adequately tracked at the state level.

Funding for quality, voluntary home visiting, like all public investments, needs to be tracked to determine what programs are supported and at what cost. As of FY2010 however, state spending on home visitation was not sufficiently documented to ensure that taxpayer dollars were well spent.

The Pew survey found that in FY2010, 46 states and the District of Columbia made nearly $1.4 billion available for home visiting and other early childhood programs through one or both of two funding strategies:

- Categorical funding: appropriations that exclusively support home visiting programs

  Forty-three states and the District provided $462 million in categorical funding—34 percent of all resources available nationwide[12]—for a total of 88 programs.[13]

## STATE SNAPSHOT: CALIFORNIA & KANSAS— TWO APPROACHES TO TRACKING BROAD-BASED FUNDS

In 1998, **California** voters, frustrated with slow progress in meeting the needs of young children, approved Proposition 10, creating First 5 California, a statewide commission funded by tobacco tax revenues. First 5 California was charged to build and implement a comprehensive system of high-quality early childhood programs and services, including voluntary home visiting, with the goal that all "children in California enter school ready to achieve their greatest potential."[i] In the 13 years since its approval, First 5 California has brought critical services to millions of parents, caregivers and children from birth to age five.

Prop 10 empowers the First 5 California state commission to oversee only 20 percent of funds, with the remaining 80 percent directed to the state's 58 First 5 county commissions. These 58 independent entities individually decide which programs to implement with their initiative dollars and are responsible for tracking outcomes related to their expenditures. They are not required to report to the state how they are spending their funds. Without the ability to track the majority of the funds, which totaled $410 million in FY2010,[ii] the state commission cannot collect key information about the type or cost of local programs.

While locally driven decision making is important to addressing the state's diverse geographic and demographic realities and to fostering needed innovation, providing information to policy makers and the public on a statewide basis is constrained by this lack of consistent, reliable data collection. If First 5 California were statutorily empowered to track expenditures, the state commission could document returns on taxpayers' investments, ensure that services address the full range of birth-to-five development, identify the most cost-effective programs and bring strong models to scale statewide, all while preserving and even enhancing local control and creativity.

Some states have established mechanisms that allow local communities to retain the needed flexibility and innovation that come from broad-based funding initiatives while ensuring that dollars are tracked and cost data are collected.

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## STATE SNAPSHOT

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The **Kansas** legislature created the Children's Cabinet in 1999 to leverage the tobacco settlement funds to improve children's health and well-being in the state. The Children's Cabinet was directed to develop and implement a comprehensive early childhood system in the state and to guarantee accountability for public expenditures.

To that end, the Children's Cabinet created two broad early childhood initiatives, Smart Start Kansas and the Early Childhood Block Grant, which provide flexible dollars—currently slightly more than $19 million statewide—to communities to address specific local needs not covered by other programs.[iii] Communities receiving these funds must submit annual progress reports that document how the money was spent. Due to this tracking system, Kansas identified all early childhood programs funded through broad-based initiatives, including $2.58 million on home visiting, and monitored program performance. The federal initiative will require all states to track outcome data. Kansas is well positioned to meet that mandate.

**That's what's happening in Kansas and California. Learn about what's happening in your state at www.pewcenteronthestates.org/homevisiting.**

- Broad-based funding: appropriations that local communities can use for a variety of child and family services, including home visiting

  A total of $912 million was available for early childhood programs, including home visiting, through 29 broad-based initiatives in 22 states.[14]

The findings also showed that the likelihood a state can and does track home visiting spending is closely tied to the strategy it employs. Specifically, while programs utilizing categorical funding spent all of those dollars on home visiting, of the 29 programs that use broad-based funding to support some or all of their home visiting efforts:

- Nineteen programs documented their home visiting spending, for a total of $52 million.

- Ten programs could not specify how much, if any, of their $575 million in available early childhood resources went to support home visiting at the local level. Notably, almost all of these funds—$559 million—were from two states: California and Illinois.

Taken together, our study found just $514 million in documented state home visiting spending out of the available $1.4 billion. (See exhibit 1.)

Broad-based initiatives provide vital funding for health care, pre-kindergarten, home visiting and other programs and are typically undertaken to allow flexibility and foster innovation at the local level. Several, such as those in Arizona and California, are the result of voter-approved ballot measures. At the state level, administrators have often been reluctant to require local agencies to report on their expenditures, so taxpayers cannot be certain how their dollars are being spent. Many local communities likely already track their use of broad-based funds, but the survey found that such data were too infrequently shared with and verified by state agencies. Ensuring that local agencies are accountable to the state for their spending need not stifle creativity. It can actually help states and communities better manage resources, collaborate efficiently to improve services and bring promising models to scale.

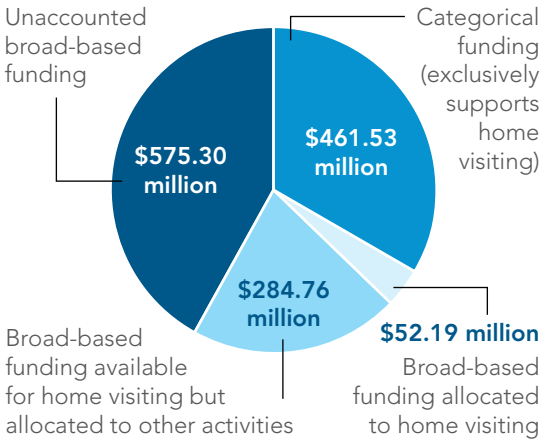
In fact, the new federal Maternal, Infant, and Early Childhood Home Visiting Program requires states to devise a plan for addressing the needs of their target communities. States with systems in place to track public dollars will be better positioned to deploy new resources, and those without such systems should address that need as part of developing a plan to effectively administer federal home visiting dollars.

Exhibit 1

## More tracking of public funding is needed

Only $462 million of the nearly $1.4 billion available for home visiting in FY2010 was provided through categorical funding: i.e., appropriations that exclusively support home visiting programs. The remaining $912 million was allocated through broad-based initiatives, and states could document only that 52 million of these dollars were spent on home visiting.

**TRACKING AND SPENDING OF ALLOCATED FUNDS FOR HOME VISITING PROGRAMS, 2010**




SOURCE: Pew Center on the States

## FEDERALLY APPROVED EVIDENCE-BASED HOME VISITING MODELS AT A GLANCE[iv]

**These models typically have national organizations and require accreditation. While all of the approved models have the minimum required research base, the extent and rigor of the cumulative evidence vary among them.[v] Further, the U.S. Department of Health and Human Services will periodically provide states and communities with the opportunity to submit models for review and approval.**

**Early Head Start-Home Visiting (EHS)[vi]** is a federally funded program for low-income pregnant women and families with children from birth to age three. EHS provides home visits and group-based services designed to promote healthy prenatal outcomes, improve the development of very young children and support healthy family interactions.[vii]

**Family Check-Up (FCU)[viii]** addresses a range of needs from prevention to treatment for families with children ages two to seventeen years at risk for behavioral problems, with a focus on the influences of a child's immediate environment. Professional home visitors, known as "school-home liaisons," tailor services to each family's individual needs and conduct yearly visits to track family and child behavior over time and proactively prevent problems.[ix]

**Healthy Families America (HFA)** is designed to serve families at risk for child abuse and neglect. The home visitor provides parent education and support, links to community resources and child development screenings.[x]

**Healthy Steps[xi]** emphasizes collaboration between health care professionals and parents in supporting the health and wellbeing of children from birth to age three. Specialists work with families in their homes to address behavioral and developmental issues and share information.

**Home Instruction for Parents of Preschool Youngsters (HIPPY)[xii]** helps parents support the development of their children ages three to five. HIPPY provides parents with curricula, books and other materials designed to strengthen their children's cognitive and early literacy skills and social, emotional and physical development[xiii] in order to increase their success in school and future development.

The **Nurse-Family Partnership (NFP)** provides home visitation services to low-income, first-time mothers by registered nurses beginning early in pregnancy and continuing through the child's second year of life. The program targets several outcomes, with a focus on maternal and child health and on family self-sufficiency.[xiv]

**Parents as Teachers (PAT)** focuses on supporting a parent's role in promoting school readiness and healthy development. PAT visitors provide information on children's development, teach parents to encourage their child's learning, provide referrals to community resources and conduct screenings of children's development and health issues.[xv]

## **Finding 2:** States frequently provided funding with few, if any, requirements that programs invest in models with a proven record of success.

To ensure an optimal return on public investments, states should concentrate their funds on home visiting models backed by a strong foundation of evidence. Reflecting the extensive research base in this field, the new federal home visiting initiative has adopted this approach and requires that states direct at least 75 percent of federal funding to a group of models with a scientifically proven record of effectiveness.[15] This standard provides a benchmark states can use to ensure cost-effective investments, not only with federal grant funds but all public home visiting dollars.

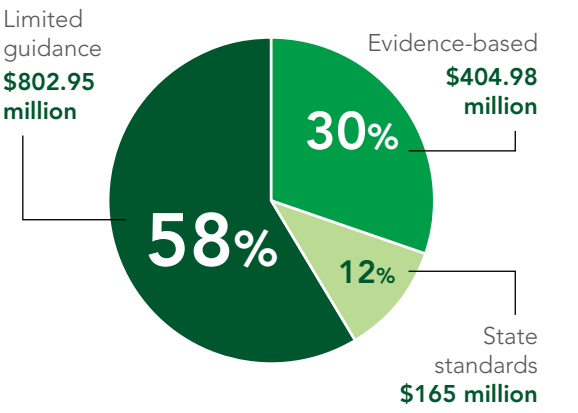
After conducting an extensive research review, in February 2011 the U.S. Department of Health and Human Services (HHS) published the minimum research criteria—evaluations using a high-quality, rigorous design—to qualify a model as evidence based and eligible for new federal dollars. HHS identified seven[16] models that meet those criteria: Early Head Start-Home Visiting, Family Check-Up, Healthy Families America, Healthy Steps, Home Instruction for Parents of Preschool Youngsters, Nurse-Family Partnership and Parents as Teachers.[17] (See sidebar on page 11.)

Exhibit 2

### Most funding is not tied to state requirements for use of evidence of effectiveness

Despite the lack of underlying data, programs run with limited guidance receive more than half of all funding.

**WHERE DOES THE MONEY GO?**




SOURCE: Pew Center on the States

Pew's survey found that states took three approaches in FY2010 to using evidence to guide model selection and program design: requiring an evidence-based model, prescribing state standards and providing limited guidance to local communities. (See exhibits 2 and 3.)

a) **Require an evidence-based model:** Thirty-nine programs in 32 states[18] reported allocations totaling $266 million—19 percent of available funding[19]—to implement the three most widely used of the federally approved, evidence-based models:[20]

- Thirteen states invested a total of $126 million in Healthy Families America.

- Fourteen states allocated nearly $80 million to the Nurse-Family Partnership.
- Eight states spent nearly $60 million on Parents as Teachers.[21]

Additional state or local programs likely utilize these models, but they either did not specifically report doing so or did not provide funding figures. Further, the other four federally approved models are probably in use in some states and local communities, but they were not included in the survey for various reasons; see Pew's program definition on page 30 for more information.

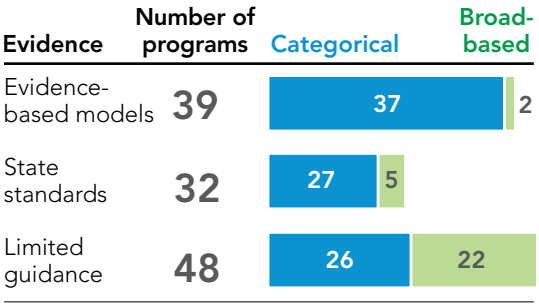
Selecting an evidence-based model offers several important advantages for state home visiting programs, including a track record of effectiveness, accredited service quality, adherence to data-driven standards and, typically, technical assistance available from a national office. Although these features improve the likelihood that state-administered programs will deliver quality services, selecting an evidence-based model is not a guarantee of effectiveness. Implementation is key to the quality of the services delivered and the strength of returns on public investments.

**Which approach is your state taking to the use of evidence in home visiting? Find out at www.pewcenteronthestates.org/homevisiting.**

Exhibit 3

## Most use of evidence-based models is funded with categorical dollars

Slightly more than half of state programs tie their categorical funding for home visiting to the use of evidence-based models or data-driven standards for performance and outcomes. By contrast, nearly all broad-based dollars are allocated with little guidance regarding the use of evidence.




SOURCE: Pew Center on the States

b) **Prescribe specific, data-driven standards to local communities:** Thirty-two programs in 25 states tied approximately $165 million—12 percent of total available funding—to state-defined standards for performance and outcomes.

Programs were counted in this category if the state required them to use models with at least three of the following six features:

- Require a prescribed curriculum
- Require training of home visitors
- Provide guidance on home visitor caseload

- Provide guidance on supervisor caseload
- Provide guidance on frequency of visits
- Use a common screening instrument to determine eligibility (e.g., inventory of risk factors, maternal depression, developmental delays)

Some states allowed local communities to select any model that meets the required standards; others have branded their own state-developed models, such as Kentucky's Health Access Nurturing Development Services (HANDS) and Tennessee's Child Health and Development (CHAD) programs. State-developed models have the potential to be as effective as their federally approved counterparts, but in most cases they lack an established research base to confirm their effectiveness. Of the states using their own models, at the time of the survey, none had yet undertaken research meeting the highest scientific standard: a randomized controlled trial.[22]

c) **Provide limited guidance on services, standards or models:** Forty-eight programs in 32 states made $803 million—58 percent of total funding—available to local communities with minimal guidance regarding selection of models, quality standards or expected outcomes. Decisions about curricula, training, caseloads and scope of services are left to local discretion. More than half of this pool of funding—$513 million—was provided in California.

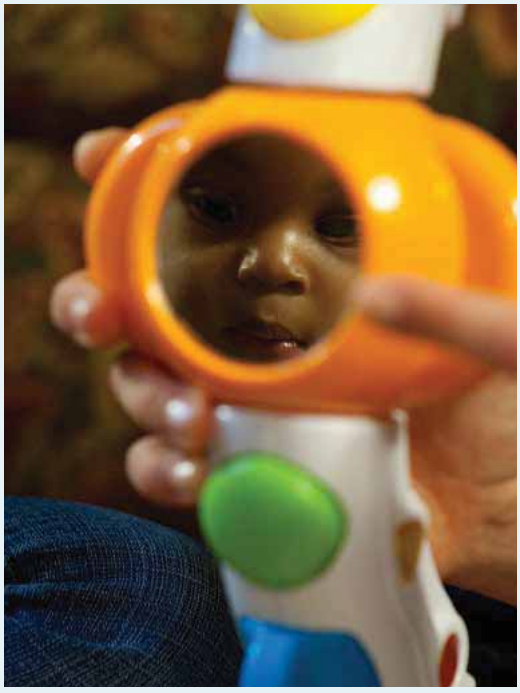
This approach was favored by broad-based early childhood initiatives, most of which could not account for how much money was spent on home visiting at the local level. Many local communities likely track their home visiting expenditures, but the state agencies responsible for funding allocations frequently did not collect and could not provide statewide data on home visiting expenditures or use of evidence. More than 80 percent of available broad-based dollars—nearly $733 million—was allocated to communities with little or no guidance and gave either communities or individual home visitors complete flexibility in organizing services.

This policy of local control can create enormous challenges for states in monitoring program performance and improving quality. Most notable among these is the complexity of evaluating and supervising the wide range of models and services used. Most of these states also provided little or no oversight to track the use of state funds or the effectiveness of their investments.

## FAMILY STORY: HEALTHY FAMILIES AMERICA[xvi]

When Evelyn G. first learned about the Healthy Families America (HFA) program, she wasn't sure it was right for her and her daughter, Lesly. Evelyn was living with Lesly's father, who had been unsupportive of her pregnancy. She felt unprepared and alone, and decided she could use the extra help.

With its focus on reducing abuse and neglect, HFA has been shown in rigorous evaluations to help new parents provide safe, nurturing environments for their children and become more self-sufficient. For Evelyn, it provided an opportunity to break the cycle of violence and build a better life. "It was a blessing for me," Evelyn said through a translator, adding that the program provided both economic and emotional support.



Once Evelyn began meeting with Zelma, an HFA family support worker, her feelings of isolation, depression and insecurity began to dissipate. Zelma helped Evelyn realize she was suffering from postpartum depression and referred her to a support group. In addition, Evelyn's own childhood involved violent experiences, leaving her with little understanding of how to help Lesly develop in a healthy way.

"Without the program, I would not have learned how to raise my daughter better than I was raised," Evelyn said.

Through her collaboration with Zelma, Evelyn also came to realize that her boyfriend was abusive. She decided to leave him. While Evelyn initially experienced economic difficulties because she didn't have a job, Zelma provided her with referrals for furniture, clothes and diapers until she secured work at a hotel.

Zelma also helped Evelyn learn how to set goals for herself. Starting small, with the aim of getting a library card, Evelyn now has a driver's license and has received a promotion at work to supervisor. She said she "couldn't have done it without the program."

"At the beginning, she didn't see a future for herself," said Zelma. "She never had support or a trusting relationship. That was the base of everything. But she accepted help and support. Now she feels independent."

## STATE SNAPSHOT: OHIO & SOUTH CAROLINA—USING STANDARDS TO ENSURE QUALITY AND COST EFFICIENCY

The **Ohio** Help Me Grow program, started in 2001, is one of the nation's largest home visiting initiatives. Administered by the state health department, the program serves families with children from birth to age three and operates in all 88 counties through local Family and Children First Councils.[xvii]

In 2009, state leaders sought to raise performance standards across Help Me Grow. "The goal for us in Ohio was to draw from the pockets of excellence … and raise the threshold for all local services," said Alicia Leatherman, the state's former director of the Early Childhood Cabinet.[xviii] At the same time, state leaders wanted to preserve local flexibility and innovation.

"We didn't want to mandate models, but rather give communities a set of evidence-based practice standards by which they can run any program they choose," said Karen Hughes, chief of the Division of Family and Community Health Services at the Ohio Department of Health.[xix]

The new standards, approved in July 2010, change the program in several ways. New eligibility criteria target Ohio's highest-risk families with children up to age three. The home visit schedule, previously left to the discretion of the visitor and family, now includes a requisite number of visits. Home visitors must adhere to a caseload—25 to 45 cases—and visits must be structured according to an evidence-based curriculum. Program screening tools were expanded to include maternal depression and home safety assessments.[xx]

As the Ohio example suggests, local flexibility does not mean states cannot demand accountability. Even when using a broad-based funding strategy, Georgia, Nebraska and South Carolina require communities to meet state-specified program standards for home visiting, and they monitor programs to ensure that sites are meeting benchmarks.

**South Carolina**'s First Steps to School Readiness initiative, funded with $17.2 million in general revenues, allows local boards to decide which services to offer, but requires that those services meet certain standards. Communities choosing to offer home visiting must target high-risk families, provide a minimum number of monthly visits and participate in ongoing quality assessments.[xxi] In FY2010, local boards spent $6.2 million on home visiting, and South Carolina's oversight and guidance made certain those dollars were well spent.

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## STATE SNAPSHOT

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The difficult economic climate has driven the state to seek greater efficiency and effectiveness from its First Steps investments without prescribing particular models, programs or services. Accordingly, the home visiting standards are becoming more rigorous, both to deliver better services for families and to help hold local communities accountable. During FY2011, programs must retain at least 75 percent of home visiting clients to ensure that a significant majority of families receives enough services to yield meaningful results. First Steps requires programs to administer appropriate developmental screenings, and visitors must participate in annual professional development activities. Additionally, the state set eligibility criteria to ensure that programs target families who meet identified risk factors.[xxii]

Susan DeVenny, executive director of First Steps, explained the importance of setting eligibility criteria: "We had to [focus] on the kids who really need our help the most."[xxiii] State Rep. Rita Allison, a First Steps board member since 2009, agreed that directing money where it is most needed is crucial, noting, "If you spread it too thin, then it doesn't really end up helping anybody."[xxiv]

## **Finding 3:** States did not adequately monitor publicly funded programs to ensure effectiveness.

To ensure that state investments yield the desired returns for families and taxpayers, home visiting programs—even those employing research-proven models—must be subject to routine evaluation and monitoring. Most states' accountability and oversight efforts, however, were generally inadequate, even with respect to the most basic measures of performance and outcomes. This problem can be compounded when states are operating multiple programs.

The Pew survey found that across the 46 states and the District of Columbia that invest in home visiting, public dollars support 119 programs[23] (see exhibit 4), administered within and across agencies with responsibility for children and families, including departments of health, human services and education.

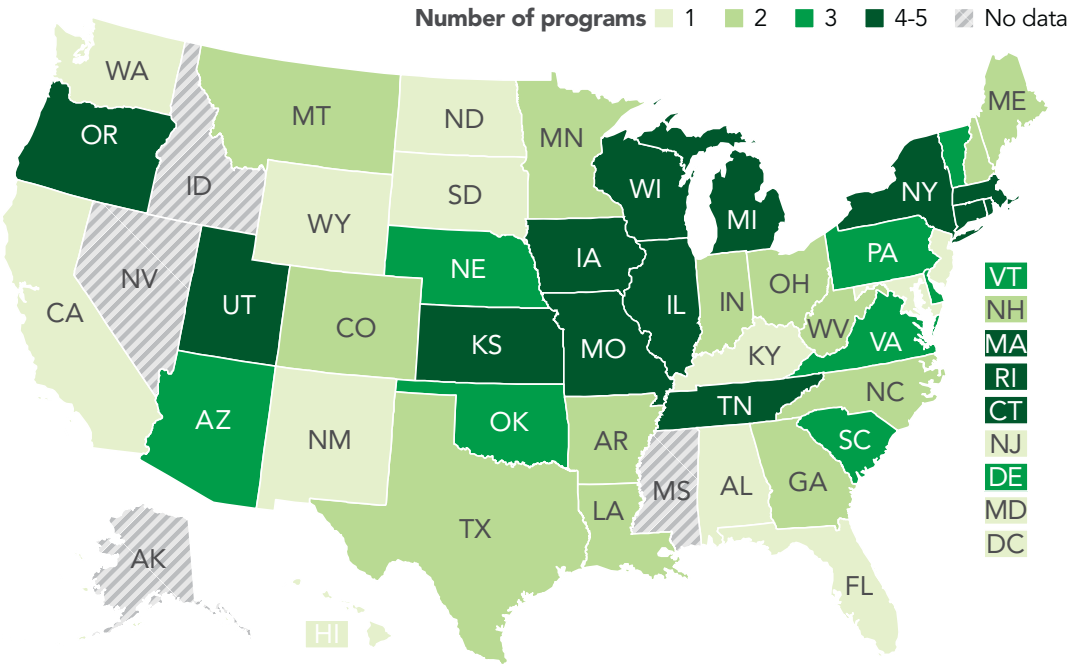
- Twelve states and the District have just one program.
- Another 13 states run two programs.
- Twenty-one states have three or more programs.

**Does your state monitor its home visiting programs to ensure effectiveness? Find out at www.pewcenteronthestates.org/homevisiting.**

Exhibit 4

## More than half of states operate multiple home visiting programs

The 46 states and the District of Columbia that invest in home visiting administer 119 programs with responsibility for children and families—with most states running multiple programs.




SOURCE: Pew Center on the States

Among these 119 programs, relatively few tracked even the most basic performance criteria (see exhibit 5):

- Slightly more than one-third of programs could document the cost per family.
- Only 42 percent of programs tracked the number of visits families receive.
- Nearly one-third of programs could not document the number of families or children served.

Operating multiple home visiting programs can enable states to target services to meet diverse needs. However, this approach can cause duplication of effort and waste public resources, and without substantial coordination among administering agencies it further complicate efforts to ensure effectiveness.

Whether running one program or many, states can assure accountability in two ways:

*Monitor program performance*—such as how many families are receiving services, number of visits and attrition rates—to assess whether communities are executing selected models as designed and to identify and correct poor performers; and

Exhibit 5

## Insufficient monitoring

Relatively few programs track even the most basic performance measures.

| Performance measures | Percentage of programs that track |
|---|---|
| Cost per family | 35% |
| Number of visits | 42% |
| Number served | 68% |

SOURCE: Pew Center on the States

*Evaluate program outcomes*—such as reductions in smoking, low birth weight and child abuse, and improved parenting skills and school readiness—to determine if home visiting is delivering on promised results.

Documenting effectiveness is a central component of the new federal initiative; the legislation outlines monitoring procedures for quality and implementation and requires programs to deliver on at least four of the following six outcomes within three years:

1. Improved maternal and child health
2. Childhood injury prevention and/or fewer emergency room visits
3. Increased school readiness and academic achievement
4. Reduced crime or domestic violence

## STATE SNAPSHOT: MINNESOTA—LIMITED STATE GUIDANCE FOSTERS LOCAL-LEVEL DISPARITY

In **Minnesota**, the state allows local agencies to implement the model of their choice and has not provided guidance or set standards to ensure the quality and efficacy of services delivered with state dollars. According to a 2010 report to the state legislature, in addition to adopting a selection of evidence-based models, local boards also used various other home visiting approaches and curricula.[xxv] These programs included many in which the home visitor has discretion regarding the content and scope of services, as well as some that are primarily designed to screen and refer families to other services. The state has recently implemented requirements for evaluating local programs, but the continued lack of statewide guidelines means that disparities in the quality and efficiency of local services likely will remain.

5. Improved family economic self-sufficiency
6. Greater coordination with community resources and support[24]

The federal initiative also takes a strong position on interagency coordination. States have been directed to designate a lead entity to provide oversight, and all entities that administer home visiting programs will be required—under that leadership—to collaborate on a statewide needs assessment that includes ongoing coordination as part of their plan for the use of federal dollars. States that receive grants must report on their success in achieving the goals outlined in their plans.

The survey also found that existing state evaluations of program outcomes are not collecting the range of data to meet the federal requirements or to ensure effective use of public funds. (See exhibits 6 and 7.) Only about half of state programs tracked outcomes covered by the federal benchmarks. Of the 119 state-administered programs, only 17 follow more than four outcomes, including just nine programs that receive funding with limited guidance from the state.

Exhibit 6

## Inadequate tracking of child and family outcomes

Fewer than one-quarter of programs are collecting the necessary range of data to meet federal requirements or to ensure effective use of public funds.

| Federal benchmark | Percentage of programs that track |
|---|---|
| Maternal and child health | 50% |
| Coordination with other resources | 50% |
| Injury prevention and/or ER visits | 27% |
| Family economic self-sufficiency | 23% |
| Crime or domestic violence | 20% |
| School readiness/ academic achievement | 19% |

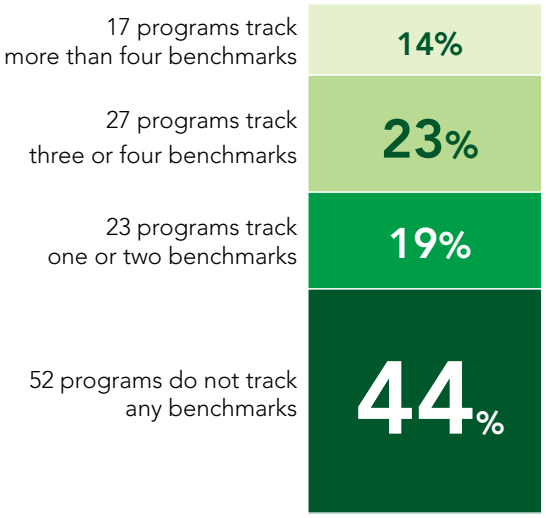
SOURCE: Pew Center on the States

Exhibit 7

## Program effectiveness is not sufficiently monitored

Of the 119 state-administered programs, only 17—14 percent—track more than four outcomes.

**NUMBER OF BENCHMARKS TRACKED BY STATE-ADMINISTERED PROGRAMS**




SOURCE: Pew Center on the States

## **Finding 4:** States did not consistently target at-risk families, where the return on investment is highest.

Although states should seek to expand access to home visiting services as funding becomes available, limited dollars should be used where they can do the most good for families and produce the strongest returns for taxpayers. According to one cost-benefit analysis, evidence-based home visiting programs serving high-risk populations generate nearly twice the returns of programs serving all families.[25] As of FY2010, however, most states were not directing resources to the appropriate communities. States can do more to ensure that programs prioritize the highest-risk families so that taxpayer investments generate the greatest possible returns.[26]

The Pew survey found that more than half of the available home visiting funding—nearly $727 million—was allocated to programs without state-designated eligibility requirements.[27] (See exhibit 8.)

The federal program requires states to prioritize high-risk families as defined by 10 criteria:[28]

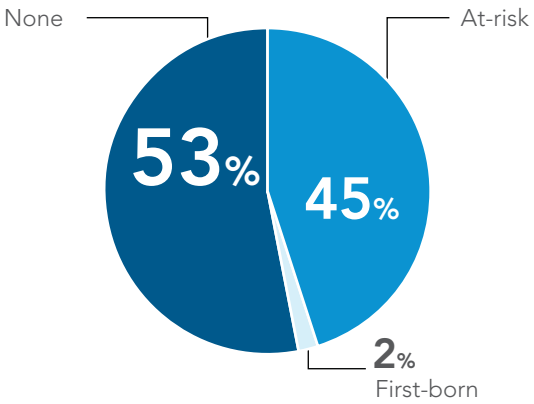
1. Eligible families who reside in communities identified in the needs assessment
2. Low-income families
3. Pregnant women under 21 years of age
4. Eligible families with a history of child abuse or neglect
5. Eligible families who have had contact with the child welfare system
6. Eligible families with a history of substance abuse or in need of substance abuse treatment
7. Eligible families with tobacco users in the home
8. Children with low student achievement
9. Children with developmental delays or disabilities
10. Eligible families with individuals currently or formerly serving in the Armed Forces, including those with multiple deployments outside the United States

Exhibit 8

### Ensuring programs allocate resources effectively

More than half of available home visiting funding—53 percent—was allocated without priority for serving high-risk families.[i]

**CURRENT ELIGIBILITY REQUIREMENT BY PERCENTAGE OF DOLLARS INVESTED**




i: These figures are calculated from data provided by 117 of the 119 state programs. The other two programs did not provide relevant spending information.

SOURCE: Pew Center on the States

## STATE SNAPSHOT:

### OKLAHOMA—COORDINATION ACROSS AGENCIES HELPS MEET DIVERSE NEEDS

**Oklahoma** has three home visiting programs. The state's Department of Health runs Children First, which uses the Nurse-Family Partnership model (see page 11 for more information) to promote maternal and infant health among first-time mothers. The state developed Start Right to deliver similar services for women who already have a child, while providing a greater emphasis on prevention of child abuse and neglect. Additionally, the state's Department of Education runs Parents as Teachers, a home visitation model focused more on school readiness. All three programs deliver services in the home to support and educate parents, but their different goals, strategies and curricula enable Oklahoma to tackle a range of costly early childhood problems and serve a diverse population of families.

To ensure that programs work together effectively—without duplicating effort—to reach the largest possible population of at-risk families, the Oklahoma State Department of Health Family Support and Prevention Service, in collaboration with the Oklahoma State University Cooperative Extension Office, created the Home Visitation Leadership Advisory Coalition (HVLAC) in 2003.[xxvi] HVLAC members include both agency and program personnel who work to strengthen state and local collaboration around home visiting.[xxvii]

### PENNSYLVANIA—EVALUATION AND MONITORING SUPPORT SMART INVESTMENTS

Policy makers in **Pennsylvania** wisely chose to invest in both the expansion of an evidence-based program and ongoing evaluation to make sure it works. In 2001, the state dedicated $20 million to implement the Nurse-Family Partnership (NFP) to reduce rates of certain health and social problems among new and expectant families.[xxiii] The Pennsylvania Department of Public Welfare funded PolicyLab, a nonprofit research organization, to conduct a rigorous program evaluation. The study aimed to test two areas: 1) whether programs achieved successful results immediately, or after an initial start-up period, and 2) if geography affected outcomes.

The results were promising: Participants consistently displayed improved outcomes three years after enrollment. Furthermore, mothers from rural areas matched or exceeded the outcome rates of their urban counterparts. PolicyLab's work underscored the importance of understanding and managing expectations about the time required to produce results when implementing a program.[xxix] The study also determined that with careful monitoring and fidelity to the model, NFP can be implemented effectively across the state, assuring Pennsylvanians that they are paying for positive results.[xxx]

## **Finding 5:** In every state, far too few at-risk families got home visiting services.

For states to reap meaningful savings from home visiting investments, they need to be sufficient enough to significantly lower the rates of costly problems. A key way to achieve this is to ensure that all at-risk families can access quality programs—and that a significant portion takes advantage of available services.

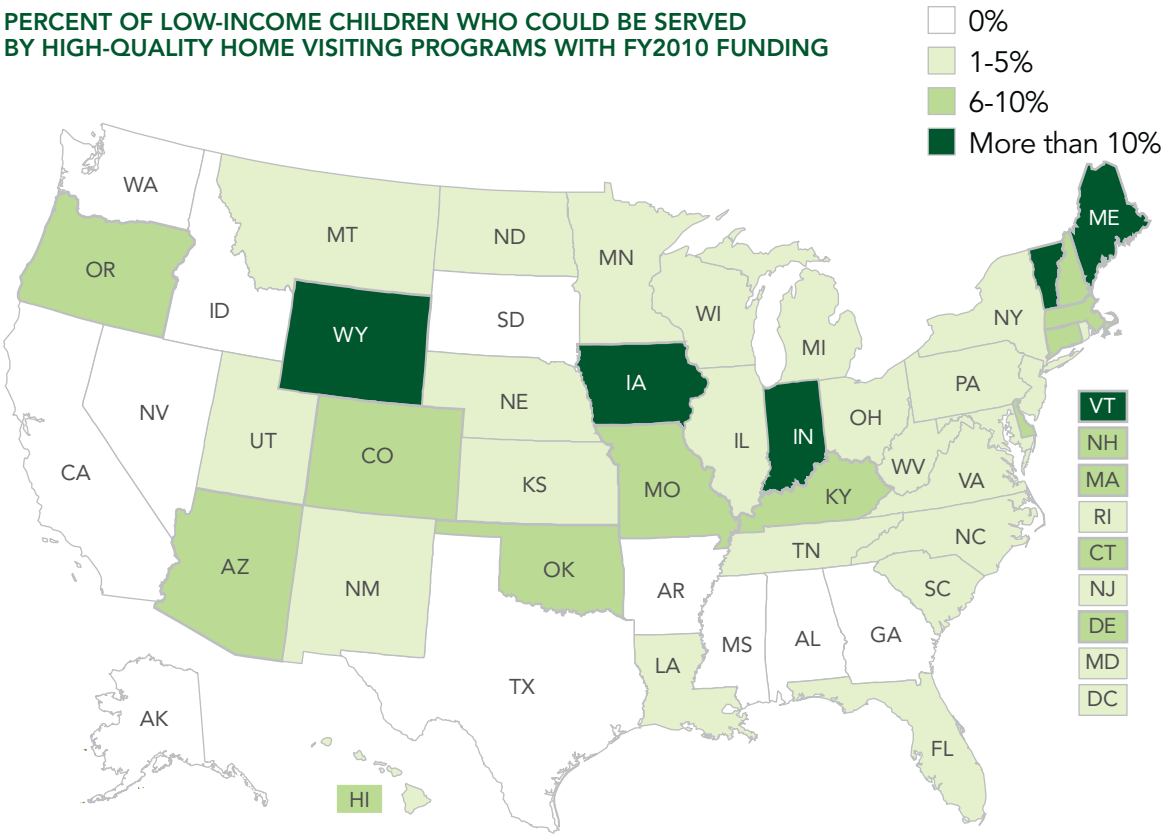
The Pew survey found that, given the total funds—$514 million—that states can confirm were spent on home visiting in FY2010 nationwide, high-quality services could be available to about 3 percent of

Exhibit 9

### Not enough funding to serve at-risk families

At the FY2010 level of funding—the $514 million that states can confirm was spent on home visiting nationwide—high-quality services could be made available to only about 3 percent of the nation's 4.5 million low-income infants and toddlers.[i] Funding levels vary widely by state, but even the best, Vermont, could satisfy only about a quarter of the demand.

**PERCENT OF LOW-INCOME CHILDREN WHO COULD BE SERVED BY HIGH-QUALITY HOME VISITING PROGRAMS WITH FY2010 FUNDING**




i: To assess the size and scale (geographic breadth) of state investments, Pew examined state funding in proportion to the number of low-income children. See endnote 20 for more information.

SOURCE: Pew Center on the States

the nation's 4.5 million low-income infants and toddlers.[29] On a state-by-state basis, funding levels could provide between 1 percent and 26 percent of low-income infants and toddlers with a high-quality program. (See exhibit 9.) (For the purposes of this calculation, low-income status was used in lieu of multiple risk factors for which comprehensive national demographic data were not available.)

Expanding programs to serve all eligible families requires not only funding increases but also time to build capacity at administering agencies and the local level, and to coordinate outreach to families. Phasing in access allows leaders to conduct needed evaluations, select models, determine funding, hire personnel, develop materials and curricula, provide training and identify target populations.

Further, as states improve program monitoring, evaluation and coordination (see Finding #3 on page 17), they should have more and better data about who participates and how best to engage hard-to-reach families and to increase take-up rates.[30] Gradual expansions also reduce the fiscal shock that any sudden, large-scale new investment can cause, and they promote building political and public will.

**Is your state ready to make the most of new home visiting investments? Find out at www.pewcenteronthestates.org/homevisiting.**

Although the economic downturn will hamper states' ability to provide funding increases in the near term, the federal initiative presents a critical opportunity to evaluate program quality, pilot strategies for improvement and expansion, and plan for the future. The new federal home visiting dollars, which equal roughly one year's worth of total available state funding, cannot support high-quality services for all at-risk families in any state. When budgets improve, however, they can help build the infrastructure and research base upon which increased state investments can grow.

## FAMILY STORY: NURSE-FAMILY PARTNERSHIP[xxxi]

When Amanda, 19, learned she was pregnant just five months into a new relationship, she did not feel at all prepared for motherhood. As a child, she had dealt with her parents' divorce and stints of homelessness. And now, her baby's father often lashed out at her aggressively.

Two years later, however, baby Nolan is healthy and strong, and Amanda has earned her associate's degree and has a steady income. She also gained the confidence to end an abusive relationship and developed the skills to raise her son patiently and competently.

Amanda credits the Nurse-Family Partnership (NFP) home visitor, Valerie Carberry, with helping her become a successful mother. Carberry, a longtime public health nurse, came to her home regularly during her pregnancy and until Nolan's second birthday. "She really believed in me," Amanda said.

Carberry taught Amanda about the importance of prenatal health care and eating well, helped her through postpartum depression and provided her with information about her baby's development. She also offered words of encouragement that Amanda said gradually gave her the self-confidence she needed.

Amanda enrolled in college and eventually moved into her own apartment.

"Before, I remember always thinking I was going to be stuck," Amanda said. "But it wasn't just me now. I knew I could do it—I just didn't know how.

"I wasn't in the situation to be the best mom. I didn't have the tools," Amanda said. NFP gave her the resources she needed. "There were no excuses not to know something or not to do something, because the tools were all there. [It] was the perfect opportunity to be the best mom I could be."

## STATE SNAPSHOT: LOUISIANA—EXPANSION EFFORT SEEKS TO ENSURE MEANINGFUL IMPACTS

**Louisiana** recently embarked on a plan to phase in expanded access to the Nurse-Family Partnership (NFP) program from 15 to 50 percent of eligible families by the end of 2014. The state expects this expansion to yield savings through reduced incidence of child abuse and neglect as well as premature births. Louisiana currently spends more than $600 million annually on law enforcement, health, child welfare and other costs associated with abuse and neglect, and approximately $208 million in Medicaid costs over the first year of life for premature infants.[xxxii]

To realize the goal of serving half of eligible families, the Department of Health and Hospitals (DHH) and the NFP Advisory Council jointly laid out a five-year timeline for expansion. They determined that the state would need to invest an additional $2.5 million in the first year of expansion and $5 million more in each of the next four years. In FY2010, Louisiana spent more than $12 million on NFP, including state general funds, federal maternal and child health dollars, Medicaid and Temporary Assistance for Needy Families.[xxxiii] To meet the additional costs, the report outlined such funding options as using federal and state dollars as well as garnering support from local and private partners.

The expansion plan includes adding 200 home visiting nurses to deliver the program. To help recruit enough top-quality professionals, DHH and NFP recommended competitive salaries, student-loan forgiveness and partnerships with Louisiana nursing schools.

NFP enjoys broad support statewide, but it needs continued community outreach to increase innovative partnerships and leverage resources. Policy makers in the state have embraced the DHH's recommendation to expand NFP. At the end of the phase-in, the program is projected to cost an additional $22.7 million and have the capacity to reach half of the eligible families in the state. This significant investment could help Louisiana lift families out of poverty; reduce crime, poor health, family violence, low educational attainment and unemployment; and deliver strong returns on taxpayer dollars.

# Policy Recommendations

Pew's first-of-its-kind survey of state home visiting investments found that states make approximately $1.4 billion available to support services for families. But the quality, accountability, reach, oversight and coordination of the programs funded with these dollars vary widely across and even within states. New federal dollars will be tied to rigorous standards, which states can use for improving existing programs and for strategically expanding their investments in these services.

In light of these findings, Pew offers five recommendations to help states prepare to deploy new federal resources and get the highest returns on their investments in home visiting.

### Require the tracking of all home visiting funds.

Policy makers should require home visiting programs to track and document the use of funds, whether broad-based or categorical, to guide allocation decisions and help both local- and state-level

agencies manage resources efficiently, avoid duplication, ensure quality and deliver services effectively.

**Insist on—and invest in—programs with a foundation in research.**

Policy makers should look to the federal guidance on the appropriate use of evidence to ensure that models and standards are data-driven and rigorously evaluated, and should require that at least 75 percent of public home visiting funding supports evidence-based delivery models. Mandates for use of evidence must be accompanied by sufficient resources to ensure that models are implemented with fidelity.

**Support and require programs to monitor performance and evaluate key outcomes.**

Policy makers should both mandate and provide necessary resources and training to enable local and state programs to coordinate services, monitor performance measures and track participant outcomes using criteria aligned with federal benchmarks.

**Learn more about your state's home visiting investments and how to prepare for and maximize new federal resources at www.pewcenteronthestates.org/homevisiting.**

**Set clear, evidence-based eligibility guidelines and develop systems to ensure compliance.**

Policy makers should identify target populations using risk factors outlined in the federal initiative; require and fund administering agencies to ensure that programs adhere to established eligibility standards, especially in states with limited guidance, for use of state early childhood funds; and ensure the continuity of services as family circumstances change.

**Use the best available data about families to determine appropriate home visiting allocations and to establish a realistic plan for expansion.**

As they prepare for the new federal dollars, state policy makers should look to cost-benefit, demographic and other data to determine the number of eligible families, existing program capacity and potential long-term savings; identify available funding streams, including Medicaid, Temporary Assistance for Needy Families,[31] public health and early childhood resources; ensure that allocations are sufficient to serve the entire target population; and allow time for agencies to build capacity and conduct outreach to targeted families.

# Conclusion

In the current constrained fiscal climate, young, vulnerable families are confronting more challenges that can have negative, long-term effects on infants and toddlers during the crucial early years of life—resulting in costly social problems later. High-quality home visiting is proven to help parents provide safer, more supportive and stimulating environments for their children while mitigating risk factors that can limit future success. Over time, improvements in birth outcomes and maternal and child health and reductions in child abuse and neglect, poverty and crime can return as much as $5.70 per taxpayer dollar invested.

New federal funds, combined with difficult revenue circumstances, present states with both challenges and opportunities. Strained state budgets have become a nationwide reality and are not likely to improve in the near future. Nevertheless, states must prioritize home visiting funding based upon evidence of effectiveness and must demand that programs are run and families are served more efficiently.

While preparing to apply for $1.5 billion in new federal money, states have an incentive and responsibility to ensure that they are investing the bulk of other public funds in research-backed programs that are well implemented and evaluated. Tracking participation, monitoring program performance and evaluating outcomes, even when using an evidence-based model, are vital for states seeking federal support.

Only through a data-driven policy approach that maximizes current funding, takes full advantage of new federal resources, invests in programs using evidence-based models or standards and demands accountability can states realize the ultimate promise of home visiting: healthy and safe children, strong, productive families and significant returns on public investments.

# Methodology

## The Pew Definition of Home Visiting

For the purposes of this survey, a state-administered home visiting program:

- Is managed by a state agency—such as health and human services—that directs funding to local communities to support service delivery, articulate standards and regulations, set performance measures and provide oversight and infrastructure;
- Delivers services mainly in families' homes, though visits may be complemented with other supports such as group classes; and
- Receives support through state allocations, using state or federal dollars.

The survey *excluded* programs that employ home visiting as a strategy but do not fully satisfy the definition above, such as:

- Involuntary visits resulting from a child protective services investigation or a court order;
- Programs targeting children four or older, unless they are enrolled before the age of two;[32]
- Programs that use home visiting as a component of a broader family support strategy but do not identify the home as the primary location for service delivery (such as family resource centers or other primarily center-based initiatives);
- Home-based services delivered as required by the federal Individuals with Disabilities Education Act;
- Federal funding allocated directly to localities and not state-administered (such as Healthy Start and Early Head Start); and
- Funding from private organizations and local communities.

## Data Sources

As a first point of contact in each state, Pew interviewed the State Maternal and Child Health Early Childhood Comprehensive Systems (ECCS) coordinator, who is the federal designee to coordinate states' early childhood systems. In some cases, the ECCS coordinator provided information about a program and referred the data collector to other agencies in which there might be home visiting programs.

Because home visiting programs are often administered across different agencies in the state, data collectors reached out to multiple state agencies to gather information on programs that might not be housed in the Maternal and Child

Health office, including departments of early learning, children's trusts, the lead child-abuse-prevention agencies and children's cabinets or children's bureaus.

Data collectors conducted phone interviews with staff members at these agencies and used information from those interviews to complete the survey. A draft of the completed survey was returned to the agency staff to verify data and fill in any gaps. After data collection was completed, the information was summarized and returned to the program staff to verify.

## Data Collection Period

Data were collected between December 2009 and May 2010, and focused on funding for FY2010. Some programs might have experienced agency cuts over the course of the year, which are reflected in the final data when possible. Unless noted, the service population data is from FY2009, which was often the most recent information available during the data collection period.

## Per-Capita Spending

To assess the size and scale (geographic breadth) of state investments, Pew examined state funding in proportion to the number of low-income children. The per-capita expenditure was calculated by dividing a state's home visiting investment by the estimated number of low-income infants and toddlers who live at or below 125 percent of the federal poverty level, based on the U.S. Census' Current Population Survey.[33]

## Accuracy and Comprehensiveness

To ensure the accuracy of the data presented in this report, Pew staff members implemented numerous quality control measures. First, Pew identified multiple informants to verify data. When possible, data were compared with publicly available documents such as legislative reports, agency budget documents and evaluation reports. Second, agency staff members were given the opportunity to review the final survey and a fact sheet summarizing the data. In August 2010, the U.S. Department of Health and Human Services released a list of the governors' newly appointed designees to lead state efforts on home visiting. As a final data check, Pew staff members sent a summary of each state's programs to its home visiting lead for verification. The state lead or program-level staff confirmed data from all states except Alaska, Maryland, Minnesota, Mississippi, Oklahoma, South Dakota, Vermont and Wyoming. Pew researchers did not receive a response to repeated outreach to these states.

# State-by-state findings

| | Number of programs | Total funding | Percent to evidence-based models | Percent to state standards | Percent with limited guidance |
|---|---|---|---|---|---|
| ALABAMA | 1 | $5,594,000 | - | - | 100% |
| ALASKA | 0 | 0 | - | - | - |
| ARIZONA | 3 | $129,800,000 | 5% | 2% | 93% |
| ARKANSAS | 2 | $111,581,000 | 99% | - | 1% |
| CALIFORNIA | 1 | $513,247,000 | - | - | 100% |
| COLORADO | 2 | $18,037,000 | 78% | - | 22% |
| CONNECTICUT | 4 | $9,821,000 | 92% | 3% | 5% |
| DELAWARE | 3 | $3,809,000 | 43% | - | 57% |
| DISTRICT OF COLUMBIA | 1 | $750,000 | - | - | 100% |
| FLORIDA | 1 | $18,114,000 | 100% | - | - |
| GEORGIA | 2 | $16,859,000 | - | 100% | - |
| HAWAII | 1 | $1,320,000 | 100% | - | - |
| IDAHO | 0 | 0 | - | - | - |
| ILLINOIS | 4 | $67,670,000 | 25% | 7% | 68% |
| INDIANA | 2 | $50,999,000 | 69% | - | 31% |
| IOWA | 5 | $22,593,000 | 3% | 89% | 8% |
| KANSAS | 5 | $28,449,000 | 27% | - | 73% |
| KENTUCKY | 1 | $31,685,000 | - | 100% | - |
| LOUISIANA | 2 | $13,803,000 | 89% | - | 11% |
| MAINE | 2 | $9,740,000 | - | 53% | 47% |
| MARYLAND | 1 | $4,590,000 | 100% | - | - |
| MASSACHUSETTS | 4 | $13,584,000 | 78% | 13% | 9% |
| MICHIGAN | 5 | $28,358,000 | - | 14% | 86% |
| MINNESOTA | 2 | $10,008,000 | - | - | 100% |
| MISSISSIPPI | 0 | 0 | - | - | - |

SOURCE: Pew Center on the States, 2011

# State-by-state findings

*continued from page 32*

| | Number of programs | Total funding | Percent to evidence-based models | Percent to state standards | Percent with limited guidance |
|---|---|---|---|---|---|
| MISSOURI | 4 | $28,095,000 | 89% | - | 11% |
| MONTANA | 2 | $851,000 | - | 31% | 69% |
| NEBRASKA | 3 | $2,743,000 | - | 77% | 23% |
| NEVADA | 0 | $0 | - | - | - |
| NEW HAMPSHIRE | 2 | $1,782,000 | - | 89% | 11% |
| NEW JERSEY | 1 | $11,100,000 | 100% | - | - |
| NEW MEXICO | 1 | $2,572,000 | - | 100% | - |
| NEW YORK | 4 | $40,142,000 | 83% | 12% | 5% |
| NORTH CAROLINA | 2 | $19,329,000 | 100% | - | - |
| NORTH DAKOTA | 1 | $250,000 | 100% | - | - |
| OHIO | 2 | $26,569,000 | - | 93% | 7% |
| OKLAHOMA | 3 | $19,046,000 | 79% | 21% | - |
| OREGON | 4 | $13,356,000 | 68% | 27% | 5% |
| PENNSYLVANIA | 3 | $21,321,000 | 84% | 16% | - |
| RHODE ISLAND | 4 | $1,623,000 | 40% | 6% | 54% |
| SOUTH CAROLINA | 3 | $17,873,000 | 4% | 96% | - |
| SOUTH DAKOTA | 1 | Not Available | - | - | - |
| TENNESSEE | 5 | $13,513,000 | 34% | 52% | 14% |
| TEXAS | 2 | $15,537,000 | 57% | - | 43% |
| UTAH | 4 | $1,546,000 | 40% | 38% | 22% |
| VERMONT | 3 | $5,567,000 | - | - | 100% |
| VIRGINIA | 3 | $10,451,000 | 52% | 48% | - |
| WASHINGTON | 1 | $1,180,000 | - | 100% | - |
| WEST VIRGINIA | 2 | $2,755,000 | - | 27% | 73% |
| WISCONSIN | 4 | $2,910,000 | 9% | - | 91% |
| WYOMING | 1 | $3,252,000 | 100% | - | - |

SOURCE: Pew Center on the States, 2011

# Endnotes

1 J. J. Heckman and D. V. Masterov, "The Productivity Argument for Investing in Young Children" (paper presented at the T.W. Schultz Award Lecture at the Allied Social Sciences Association annual meeting, Chicago, January 5-7, 2007).

2 L. A. Karoly, M. R. Kilburn, and J. S. Cannon, *Early Childhood Interventions: Proven Results, Future Promise* (Santa Monica, CA: RAND Corporation, 2005).

3 "Patient Protection and Affordable Care Act," Public Law 111-148, 111th Congress, accessed November 30, 2010, http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ148.pdf.

4 See the Methodology on page 30 for additional information on how Pew defined home visiting for the purposes of the survey and for details on excluded program types.

5 E. Lee, et al. "Reducing Low Birth Weight through Home Visitation: A Randomized Controlled Trial." *American Journal of Preventive Medicine*, 36 (2), 154-160.

6 D. L. Olds, C. R. Henderson, and H. Kitzman. "Does Prenatal and Infancy Nurse Home Visitation Have Enduring Effects on Qualities of Parental Caregiving and Child Health at 25-50 Months of Life?" *Pediatrics*, 93 (1), 89-98.

7 K. S. Howard and J. Brooks-Gunn. "The Role of Home-Visiting Programs in Preventing Child Abuse and Neglect." The Future of Children, 19 (2), 119-146.

8 D. L. Olds, et al., "Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect: A 15-Year Follow-up of a Randomized Trial," *Journal of the American Medical Association* 278, no. 8 (1997): 637-643.

9 D. L. Olds, et al., "Improving the Lifecourse Development of Socially Disadvantaged Mothers: A Randomized Trial of Nurse Home Visitation." *American Journal of Public Health* 1988: 78 (11):1436-1445. 13.

10 Nurse-Family Partnership, "Evidentiary Foundations of Nurse-Family Partnership" (accessed April 7, 2010). www.nursefamilypartnership.org/assets/PDF/Policy/NFP-Evidentiary-Standards_4-28-09.

11 D. L. Olds, et al. "Effects of Nurse Home Visiting on Maternal and Child Functioning: Age-9 Follow-Up of a Randomized Trial." *Pediatrics*, 120 (4), e832-e845.

12 South Dakota has a categorical home visiting program called Bright Start, but the agency's staff was unable to provide the funding levels for the program.

13 One additional program was also funded with categorical dollars, but the state did not provide a precise amount so it was not included in the total categorical funding.

14 South Carolina has funding available for home visiting through a broad-based program called Family Literacy, but agency staff was unable to provide the program's funding levels.

15 The remaining federal funding—as much as 25 percent—can be used to support "promising service delivery models" as defined in the guidelines. See: U.S. Department of Health and Human Services, Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program (OMB 0915-0336), accessed February 27, 2011, http://www.hrsa.gov/grants/manage/homevisiting/sir02082011.pdf.

16 At press time, an eighth model had received federal approval. Pew expects additional models to receive approval in the coming months.

17 For information on U.S. Department of Health and Human Services's review, see Appendix B in http://www.hrsa.gov/grants/manage/homevisiting/sir02082011.pdf.

18 These include 37 categorical funding programs and two supported through broad-based initiatives.

19 Almost all of the programs that require an evidence-based model are categorical funding, requiring that

funds be spent on home visiting. However, two programs requiring the use of national models are funded through broad-based initiatives—Alabama's Better Chance for Success and North Carolina's Smart Start. These initiatives fund other early childhood programs in the states. Although a larger funding pool may be used for home visiting in any given fiscal year, only the dollars that the states actually spent on home visiting are included in the total for FY2010.

20 The Department of Health and Human Services included Home Instruction for Parents of Preschool Youngsters (HIPPY) as an approved model, but the program serves three- to five-year-old children, which was not included in Pew's definition of home visiting.

21 The total number of states noted in these bullets exceeds the 32 noted in the introductory paragraph due to the use of multiple models by individual states.

22 Since Pew collected this data, results from a randomized controlled trial of Child FIRST in Connecticut were published. For more information, see: D. I. Lowell, et al., "A Randomized Controlled Trial of Child FIRST: A Comprehensive Home-Based Intervention Translating Research Into Early Childhood Practice." *Child Development*, 82 (1), 193-208.

23 See endnotes 18 and 19 for qualifications to the program count.

24 "Patient Protection and Affordable Care Act," Public Law 111-148, 111th Congress, accessed December 3, 2010, http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ148.pdf.

25 L. A. Karoly, et al., *Investing in Our Children: What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions*, (RAND Corporation) 1998, www.rand.org/pubs/monograph_reports/MR898/; J. Isaacs, "Cost-Effective Investments in Children," *Budgeting for National Priorities*, (January 2007), www.brookings.edu/views/papers/200701isaacs.pdf.

26 L. A. Karoly, et al., "Many Happy Returns: Early Childhood Programs Entail Costs, but the Paybacks Could Be Substantial," (RAND Corporation), (2005). http://www.rand.org/publications/randreview/issues/fall2005/returns.html.

27 These figures are calculated from data provided by 117 of the 119 state programs. The other two programs did not provide relevant spending information.

28 For the purposes of these criteria, the federal legislation defines an eligible family as "'(A) a woman who is pregnant, and the father of the child if the father is available; or (B) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the child's primary caregiver from birth to kindergarten entry, and including a noncustodial parent who has an ongoing relationship with, and at times provides physical care for, the child."

29 To assess the size and scale (geographic breadth) of state investments, Pew examined state funding in proportion to the number of low-income children. The per capita expenditure was calculated by dividing a state's home visiting investment by the estimated number of low-income infants and toddlers who live at or below 125 percent of the poverty level, based on the U.S. Census Current Population Survey. This figure was calculated using the average annual costs of Nurse-Family Partnership ($4,500) and Healthy Families America ($3,500).

30 For instance, several programs provide an initial visit to all new families to determine if more extensive intervention is needed.

31 Temporary Assistance for Needy Families (TANF) is a federal block grant program that provides provisional cash assistance to low-income families while they achieve economic self-sufficiency.

32 For example, while Home Instruction for Parents of Preschool Youngsters (HIPPY) has been identified as an evidence-based program by the U.S. Department of Health and Human Services, it was not included in the Pew survey because the target population is children ages three to five years.

33 "Current Population Survey (CPS) Table Creator," U.S. Census Bureau, (accessed November 30, 2010). http://www.census.gov/hhes/www/cpstc/cps_table_creator.html.

# Sidebar Notes

i "About Us." http://www.ccfc.ca.gov/commission/about_us.asp.

ii In FY2010, First 5 California collected a total of $513 million; 80 percent of this ($410 million) was distributed directly to the First 5 county commissions according to the formula set forth in Proposition 10.

iii "History." http://www.kschildrenscabinet.org/history.htm. The Kansas Children's Cabinet & Trust Fund, 2006. Web. January 21, 2011.

iv See main content endnote 16 on page 34, regarding the approval of additional models.

v For an in-depth review of each model's evidence base, see: http://homvee.acf.hhs.gov/Default.aspx.

vi No state-administered program currently uses EHS as its primary model for home visiting service delivery. Therefore, EHS programs were not included in the Pew survey. See Pew's program definition on page 30 for more information.

vii http://www.ehsnrc.org/.

viii The Pew survey did not find any state-administered programs implementing this model.

ix http://pages.uoregon.edu/cfc/intervention.htm.

x "About Us: Overview." http://www.healthyfamiliesamerica.org/about_us/index.shtml. Healthy Families America, n.d. Web. January 21, 2011.

xi http://www.healthysteps.org/.

xii HIPPY was not included in the Pew survey because the target population is children ages three to five years. See Pew's program definition on page 30 for more information.

xiii http://www.hippyusa.org/about_us.php.

xiv U.S. House Ways and Means Subcommittee on Income Security and Family Support; statement of Sharon Sprinkle, Nurse Consultant for the Southeast Region, Nurse-Family Partnership, (June 9, 2009), (accessed January 21, 2011) http://www.nursefamilypartnership.org/assets/PDF/Policy/Sprinkle_Written_testimony.

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xviii Leatherman, Alicia. 2010. Personal interview, 26 August.

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xx Ohio Administrative Code, "Chapter 3701-8, Help Me Grow Program," (2010), (accessed January 25, 2011). http://www.odh.ohio.gov/rules/final/fr3701-8.aspx.

xxi SC First Steps Board of Trustees, "FY10 First Steps Program Standards Research-Based Home Visitation Strategies," SC First Steps to School Readiness FY10 Program Standards (March 26, 2009).

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xxv Community & Family Health Division/Maternal and Child Health Section, Minnesota Department of Health, "Family Home Visiting Program," (January 2010). (accessed January 21, 2011). http://www.health.state.mn.us/divs/fh/mch/fhv/documents/2010FHVlegreportprint.pdf.

xxvi "Home Visitation Leadership Advisory Coalition (HVLAC)." http://www.ok.gov/health/Child_and_Family_Health/Family_Support_and_Prevention_Service/Meeting_Groups/Home_Visitation_Leadership_Advisory_Council_(HVLAC)/index.html. Oklahoma State Department of Health, n.d. Web. January 21, 2011.

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xxix K. Johnson, "New Evidence on Program Impact Can Guide Implementation of Federal Home Visiting Program," *Archives of Pediatrics & Adolescent Medicine* 164 (2010): E1. Accessed November 1, 2010. doi: 10.1001/archpediatrics.2010.220.

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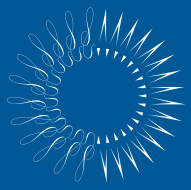

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