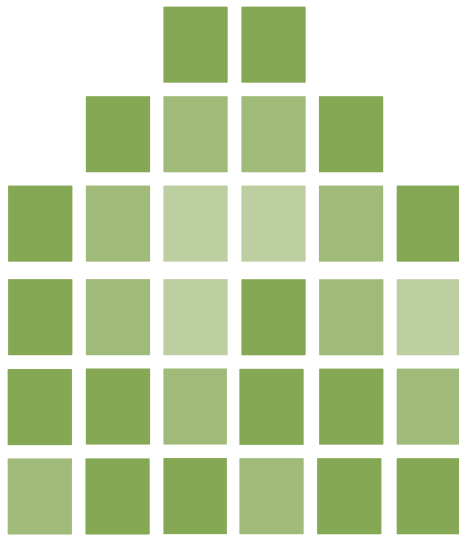


THE
PEW
CENTER ON THE STATES



POLICY FRAMEWORK TO STRENGTHEN HOME VISITING PROGRAMS

Introduction

A child's first experiences and relationships set the stage for the learning and literacy that lead to achievement in the school years and beyond, as documented by an ever-expanding body of research from a range of disciplines—neuroscience, behavioral research, program evaluation and economic analysis.

For children born to young single mothers in low-income families, early interventions such as voluntary home visiting can help mitigate risks and build parenting skills, significantly improving a child's chances of growing up healthy and prepared to succeed. Economists have found that, over time, when well designed and well implemented, home visiting programs can return up to \$5.70 per taxpayer dollar invested by reducing societal costs associated with poor health and academic failure.

What follows is the Pew Home Visiting campaign's policy framework: six policy elements critical to strengthening the effectiveness and accountability of home visiting programs, and, when implemented, support strong families and ensure that tax dollars are well spent. The approaches are the result of the campaign's review of state legislation, statutes and regulations across the country. The policy components seek to align state home visiting investments with many of the requirements set out in the federal government's new Maternal, Infant, and Early Childhood Home Visiting Program, which makes an unprecedented \$1.5 billion available to states. They also serve as a tool for state policy makers looking to reexamine or enact home visiting policy for the first time. For more information on the federal home visiting program, please see the campaign's Web site, www.pewcenteronthestates.org/homevisiting.

The Pew Home Visiting campaign is a project of the Pew Center on the States, which is a division of The Pew Charitable Trusts that identifies and advances effective solutions to critical issues facing states. The campaign works with policy makers to evaluate state home visiting systems and, where warranted, use this framework to advance policies that will strengthen a state's programs. To learn more about the framework or to discuss how it might be applied in your state, please contact **Ingrid Stegemoeller** at istegemoeller@pewtrusts.org.

Challenge

Most states lack a home visiting system that directs funding to evidence-based or promising programs. Few integrate home visiting services into the broader early childhood system and continually monitor and enhance programs to reach the greatest number of eligible families and maximize outcomes. This challenge prevents states from most effectively utilizing new federal funding, such as the Race to the Top–Early Learning Challenge, that can fill system gaps and improve outcomes. In a survey of agency leaders in all 50 states and the District of Columbia, Pew researchers found that, while nearly all states and the District are making critical investments in quality,

voluntary home visiting programs, evidence of effectiveness too rarely determines how those dollars are spent, oversight is insufficient and funding is inadequate. In this time of persistent state budget deficits and heightened economic stress, we cannot afford to waste public resources on ineffective programs. States must raise the bar for home visitation so they can deliver on the promise of healthier, more successful children and families and secure a return of millions of dollars in taxpayer savings.

Solution

Overarching policy designed to leverage home visiting investments and to maximize savings to taxpayers is key to delivering results, but most states do not have such a policy. Although some states are moving toward program coordination and system building, home visiting programs have typically been isolated from one another and the broader early childhood system. States can enhance the quality and effectiveness of their home visiting programs by articulating the purposes of the programs, coordinating home visiting resources with other early childhood programs and establishing data collection and evaluation infrastructure to ensure ongoing program improvement. When

For more information on the federal home visiting program please see the Campaign's website, www.pewcenteronthestates.org/homevisiting.

adequately and carefully planned, these activities will put states in a stronger position to achieve improved outcomes in the six benchmarks outlined in the federal program: maternal and newborn health; child injuries, abuse and neglect; school readiness and achievement; crime or domestic violence; family economic self-sufficiency; and coordination of other community supports.

A Note on Promising Practices

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 those 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.

Core Policy Components

To promote meaningful monitoring, accountability and quality of voluntary home visiting programs, as well as sustainable funding to ensure the best outcomes for families and the highest returns on taxpayer investment, model policy should:

- 1 Clearly define the purpose and expected outcomes of the home visiting program.
- 2 Invest in home visiting models that have a proven record of success.

3 Track public dollars.

4 Monitor and evaluate publicly funded programs to ensure effectiveness.

5 Target at-risk communities and/or high-risk populations.

6 Invest enough money to reach all eligible families.

Each component provides a key piece of a comprehensive home visiting system. While many states might have statutes that set in place one or two pieces of the system, all components are needed to have an effective system that reaches a substantial number of eligible families. For example, a state home visiting program might have a clear definition of purpose and the outcomes it seeks, but if there is inadequate monitoring or a failure to evaluate, the state will not know if the program's purpose is realized. Recognizing that each state is at a different stage of developing its home visiting services, the framework provides a variety of policy options and examples for states. The campaign recommends that states examine their home visiting statutes, add pieces where they are missing, strengthen existing law and/or enact the overall framework. The Campaign recommends that states examine their home visiting statutes to add pieces where they are missing, strengthen existing law and/or enact the overall framework.

Clearly define the purpose and expected outcomes of the home visiting program.

The first step toward meeting the needs of families and ensuring that taxpayer dollars are well spent is to understanding and define the problem(s) and need(s) states hope to address with home visiting services. This facilitates development of relevant outcomes. For example, a program definition might identify high rates of child abuse and neglect or infant mortality, or poor school readiness in the state. Related outcomes include improved maternal and prenatal health, infant health and child health and development; reduced child maltreatment; improved parenting practices related to child development outcomes; improved school readiness; improved family socioeconomic status; and reduced incidence of injuries, crime and domestic violence.

The precision of the definition will drive the selection of the home visiting model. Although home visiting programs can achieve several outcomes, states should clearly identify the outcome(s) they seek and ensure that the program(s) align with model selection.

For more information about specific models and their outcomes, visit the U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness Website, <http://homvee.acf.hhs.gov/>.

SAMPLE LANGUAGE

FROM STATUTES IN THE STATES OF WASHINGTON AND TENNESSEE FOLLOWS.

■ LEGISLATION/POLICY: **RCW 43.215.145**¹

■ STATE: **WASHINGTON (2007)**

RCW 43.215.145 (HOME VISITATION PROGRAMS—FINDINGS—INTENT)

The legislature finds that:

(1) The years from birth to three are critical in building the social, emotional, and cognitive developmental foundations of a young child. Research into the brain development of young children reveals that children are born learning.

(2) The farther behind children are in their social, emotional, physical, and cognitive development, the more difficult it will be for them to catch up[M1].

(3) A significant number of children age birth to five years are born with two or more of the following risk factors and have a greater chance of failure in school and beyond: Poverty; single or no parent; no parent employed full time or full year; all parents with disability; and mother without a high school degree.

(4) Parents and children involved in home visitation programs exhibit better birth outcomes, enhanced parent and child interactions, more efficient use of health care services, enhanced child development including improved school readiness, and early detection of developmental delays, as well as reduced welfare dependence, higher rates of school completion and job retention, reduction in

frequency and severity of maltreatment, and higher rates of school graduation.

The legislature intends to promote the use of voluntary home visitation services to families as an early intervention strategy to alleviate the effect on child development of factors such as poverty, single parenthood, parental unemployment or underemployment, parental disability, or parental lack of a high school diploma, which research shows are risk factors for child abuse and neglect and poor educational outcomes.

■ LEGISLATION/POLICY: **T. C. A. § 68-1-1402 LEGISLATIVE INTENT**²

■ STATE: **TENNESSEE (1992, 1996)**

T. C. A. § 68-1-1402— LEGISLATIVE INTENT

(a) It is the intention of the general assembly that the program:

(1) Be designed with the main emphasis of the program aimed at reducing the infant mortality and low birth weight rates in the state;

(2) Facilitate good health practices and the utilization of health care services through prenatal and well-child visits and compliance with medical recommendations;

(3) Be targeted to reach teenagers pregnant with their first child, but may also serve high risk pregnant women on a limited basis;

(4) Be structured to provide services at least through the infant's first birthday; and[M2]

(5) Be structured to ensure that participation by those persons targeted to be reached by the program be totally voluntary.

(b) It is further the intention of the general assembly that the following results be attained:

(1) A decrease in the percentage of low weight births;

(2) An increase in the proportion of postpartum teens returning to school;

(3) A reduction in smoking and other risk behaviors among teenagers served; and

(4) Improvement in parenting skills.

Invest in home visiting models that have a proven record of success.

Nearly every state and the District of Columbia make investments in home visiting programs. Yet, all programs are not equal. Selected programs have been subjected to intensive scrutiny, building a research base through scientifically validated tests that document their impact and return on investment, but others have no independent evidence establishing their effectiveness.

To ensure that programs yield expected savings in health care and other public expenditures, state home visiting policy should use a rigorous definition for “evidence based” and should prioritize funding for programs and models that satisfy that criterion. Mandates for use of evidence must be accompanied by sufficient resources so that models are implemented with fidelity.

For promising programs and models that do not meet this high bar, states should support strong, independent evaluation to confirm efficacy, including allocating appropriate funds for rigorous study, building the necessary research base and identifying and implementing needed modifications.

STATUTORY LANGUAGE

FROM WASHINGTON STATE AND THE NEW FEDERAL PROGRAM FOLLOWS.

■ **LEGISLATION/POLICY:**

RCW 43.215.146-147³

■ **STATE: WASHINGTON (2007)**

RCW 43.215.146 (HOME VISITATION PROGRAMS—DEFINITIONS)

The definitions in this section apply throughout RCW *43.121.170 through 43.121.185 unless the context clearly requires otherwise.

(1) “Evidence-based” means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.

(2) “Home visitation” means providing services in the permanent or temporary residence, or in other familiar surroundings, of the family receiving such services.

(3) “Research-based” means a program or practice that has some research demonstrating effectiveness, but that does not yet meet the standard of evidence-based practices.

RCW 43.215.146-7 (Home visitation programs — Funding — Home visitation services coordination or consolidation plan — Report.)

(1) Within available funds, the council for children and families shall fund evidence-based and research-based home visitation programs for improving parenting skills and outcomes for children. Home visitation programs must be

voluntary and must address the needs of families to alleviate the effect on child development of factors such as poverty, single parenthood, parental unemployment or underemployment, parental disability, or parental lack of high school diploma, which research shows are risk factors for child abuse and neglect and poor educational outcomes.

(2) The council for children and families shall develop a plan with the department of social and health services, the department of health, the department of early learning, and the family policy council to coordinate or consolidate home visitation services for children and families and report to the appropriate committees of the legislature by December 1, 2007, with their recommendations for implementation of the plan.

■ **LEGISLATION/POLICY: SEC. 2951 PUBLIC LAW 111-148 — PATIENT PROTECTION AND AFFORDABLE CARE ACT⁴**

■ **JURISDICTION: FEDERAL (2010)**

MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM

(A) SERVICE DELIVERY MODEL OR MODELS.—

(i) **IN GENERAL.**—Subject to clause (ii), the program is conducted using 1 or more of the service delivery models described in item (aa) or (bb) of subclause (I) or in subclause (II) selected by the eligible entity:

(I) The model conforms to a clear consistent home visitation model that has been in existence for at least 3 years and is research-based, grounded

in relevant empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement, and has demonstrated significant, (and in the case of the service delivery model described in item (aa), sustained) positive outcomes, as described in the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), when evaluated using well-designed and rigorous—

(aa) randomized controlled research designs, and the evaluation results have been published in a peer-reviewed journal; or

(bb) quasi-experimental research designs.

(II) The model conforms to a promising and new approach to achieving the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), has been developed or identified by a national organization or institution of higher education, and will be evaluated through well-designed and rigorous process.

(ii) MAJORITY OF GRANT FUNDS USED FOR EVIDENCE-BASED MODELS.—An eligible entity shall use not more than 25 percent of the amount of the grant paid to the entity for a fiscal year for purposes of conducting a program using the service delivery model described in clause (i)(II).

(iii) CRITERIA FOR EVIDENCE OF EFFECTIVENESS OF MODELS.— The Secretary

shall establish criteria for evidence of effectiveness of the service delivery models and shall ensure that the process for establishing the criteria is transparent and provides the opportunity for public comment.

(B) ADDITIONAL REQUIREMENTS

(i) The program adheres to a clear, consistent model that satisfies the requirements of being grounded in empirically-based knowledge related to home visiting and linked to the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B) related to the purposes of the program.

(ii) The program employs well-trained and competent staff, as demonstrated by education or training, such as nurses, social workers, educators, child development specialists, or other well-trained and competent staff, and provides ongoing and specific training on the model being delivered.

(iii) The program maintains high-quality supervision to establish home visitor competencies.

(iv) The program demonstrates strong organizational capacity to implement the activities involved.

(v) The program establishes appropriate linkages and referral networks to other community resources and supports for eligible families.

(vi) The program monitors the fidelity of program implementation to ensure that services are delivered pursuant to the specified model.

Track public dollars.

Funding for quality, voluntary home visiting, like all public investments, must be tracked to determine which programs are supported and at what cost. Most state spending, however, is not sufficiently documented to ensure that taxpayer dollars are directed as intended. The likelihood that home visiting spending is tracked is closely tied to the funding strategy employed. Programs using categorical funding—state appropriations that exclusively support home visiting programs—can more readily document how public dollars are being spent. Programs that utilize broad-based funding—state appropriations that local communities can use for a variety of child and family services, including home visiting—frequently do not adequately track those dollars. States should seek to leverage multiple funding streams, but should carefully analyze all sources of home visiting money.

Local agencies may track their spending, but they are not always required to report expenditures to the state, meaning that taxpayers cannot be certain how their dollars are spent. Ensuring that local communities are accountable for spending need not stifle innovation and local control. Tracking dollars actually can help states and communities better manage resources, collaborate efficiently to deliver better services and bring promising models to scale. States that have systems in place to track dollars will be better positioned to deploy new resources, and those without such systems should address that need while developing a plan to effectively administer federal home visiting funds.

STATUTORY LANGUAGE

FROM OKLAHOMA DESCRIBES AN EFFECTIVE TRACKING SYSTEM.

■ **LEGISLATION/POLICY: 2006 OKLAHOMA CODE—TITLE 63.—PUBLIC HEALTH AND SAFETY⁶**

■ **STATE: OKLAHOMA**

§63-1-110.1. CHILDREN FIRST FUND

B. The State Department of Health shall submit to the Speaker of the House of Representatives, the President Pro Tempore of the Senate, and the Governor by January 15 of each year, an annual report, including a full accounting of administrative expenditures from the fund for the prior fiscal year, and a summary detailing the demographic characteristics of families served including, but not limited to, the following:

1. Age and marital status of parent(s);
2. Household composition of families served;
3. Number of families accepted into the program, by location, and average length of time enrolled;

4. Referrals made on behalf of families not accepted into the program; and

5. Average actual expenditures per child during the most recent state fiscal year.

C. Projects shall comply with the uniform components of the State Plan for the Prevention of Child Abuse.

D. The Department shall forward to the Oklahoma Health Care Authority a report of the total number of hours of nursing services provided to families under Children First family resource programs. The Oklahoma Health Care Authority shall submit such information to the Centers for Medicaid and Medicare Services for purposes of applying for federal matching funds and shall submit any necessary applications for waivers to accomplish the provisions of this subsection.

E. The State Department of Health shall contract with a university-related program for a performance-based evaluation of programs. Program sites shall fully cooperate and comply with the evaluation process, and sites shall provide weekly caseload and referral information to the State Department of Health.

Monitor and evaluate publicly funded programs to ensure effectiveness.

To ensure that state investments yield desired returns for families and taxpayers, home visiting programs—even those employing research-proven models—require routine evaluation and monitoring. Many states' accountability and oversight efforts, however, are generally inadequate to assess the reach and effectiveness of programs, even with respect to the most basic measures of performance and outcomes.

Operating multiple home visiting programs can enable states to target services to meet diverse needs. However, running multiple programs also has great potential to cause duplication of effort and, without substantial coordination among administering agencies, can complicate efforts to ensure effectiveness.

Whether running one or more programs, states can assure accountability in two ways:

- 1. Monitoring 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
- 2. Evaluating 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 promised results.

STATUTORY LANGUAGE

FROM MINNESOTA, OHIO AND LOUISIANA PROVIDES MULTIPLE SUGGESTIONS FOR HOW TO ENSURE PROGRAM EFFECTIVENESS.

■ LEGISLATION/POLICY: **M.S.A. § 145A.17**⁷

■ STATE: **MINNESOTA**

145A.17 FAMILY HOME VISITING PROGRAMS.

Subd. 6. Outcome and performance measures. The commissioner shall establish measures to determine the impact of family home visiting programs funded under this section on the following areas:

- (1) appropriate utilization of preventive health care;
- (2) rates of substantiated child abuse and neglect;
- (3) rates of unintentional child injuries;
- (4) rates of children who are screened and who pass early childhood screening;
- (5) rates of children accessing early care and educational services;
- (6) program retention rates;
- (7) number of home visits provided compared to the number of home visits planned;
- (8) participant satisfaction;
- (9) rates of at-risk populations reached; and
- (10) any additional qualitative goals and quantitative measures established by the commissioner.

■ LEGISLATION/POLICY: **3701-8-07 MONITORING AND COMPLIANCE.**⁸

■ STATE: **OHIO**

3701-8-07 HELP ME GROW (HMG) MONITORING AND COMPLIANCE.

(A) The department shall monitor each county HMG system for compliance with this chapter, part C regulations and the terms of any contract or grant authorizing the award of HMG funds to the county.

(B) The director shall ensure a help me grow system review is conducted for every county HMG program receiving HMG funding. The department review may include an onsite visit, a desk review, or both.

(1) An onsite visit or desk review may be conducted by one or more of the following team members as designated by the department:

(a) The director of health or the director's designee, who shall serve as team coordinator;

(b) The director of the Ohio department of developmental disabilities or the director's designee;

(c) A representative of the Ohio office of family and children first; and

(d) Additional members as appointed to the team by the director of health which include a parent of a child that is or has received services offered under the HMG program.

(2) An onsite visit may include but is not limited to observation of the administration of HMG and provision of direct services, examination of records relevant to HMG, and focus group or individual interviews.

(3) A desk review may include review of electronic data, county records and consumer satisfaction surveys and other documentation as requested.

(C) Following the HMG system review, the team shall submit a written report to the director. The report shall include the team's findings of fact and conclusions related to the county's compliance with this chapter, part C regulations and terms of any contract or grant authorizing the award of HMG funds.

(D) If the director determines that the county is not in compliance with this chapter, part C regulations or the terms of a contract or grant authorizing the award of HMG funds, the director shall, within fifteen days of receiving the team's report, notify the county of non-compliance.

The director's notice shall also require the county FCFC [Family and Children First Council] to submit a continuous improvement plan addressing the areas of non-compliance in the report and timelines for achieving compliance.

(E) The county FCFC shall cooperate with the director and review team during any review process and shall provide access to any and all documents and information requested by the director or review team.

(F) The director may withhold funds to a county if:

(1) The county FCFC receives the director's finding of noncompliance and fails to submit a plan of continuous improvement or fails to come into compliance in accordance with the plan of continuous improvement; or

(2) The county FCFC does not cooperate with the director or review team during a review.

The director's finding of non-compliance and decision to withhold funds is final and is not subject to appeal.

■ LEGISLATION/POLICY: **46:1941.8⁹**

■ STATE: **LOUISIANA**

CHILDREN AND YOUTH SERVICES ADVISORY BOARDS; MEMBERS; DUTIES

A. Each planning board shall consist of a minimum of eleven, but not more than twenty-five members. Special care should be given in the appointments to ensure that the board is representative of the community in terms of gender, age, ethnicity, and geography, as well as knowledge and expertise. Those appointed shall include the following, if available and willing to serve, but need not be limited to:

(1) Members of the education community that are representative of and knowledgeable about early childhood, elementary, secondary, and special education.

(2) Members of the criminal justice community that are representative of and knowledgeable about law enforcement, prosecution, public defense, and the judiciary. Wherever possible, a member of the judiciary elected to the juvenile court bench should be included.

(3) Members of the health care community that are:

(a) Representative of and knowledgeable about physical health, mental health, and early childhood substance abuse prevention and treatment services.

(b) Representative of the Louisiana Youth Enhanced Services Consortium, if established in a judicial district in any parish included within the consortium, to provide information, input and assistance regarding development of a comprehensive "system of care" for children

with serious mental health problems and their families, including but not limited to system of care principles and practices and to coordinate planning and implementation efforts by the children and youth planning boards in such parishes and the consortium.

(4) Members of the social services community that are representative of and knowledgeable about child in need of care services, foster parenting, and child and family support programs.

(5) Members of the faith-base communities.

(6) Members of the business and labor communities.

(7) Members of parenting and youth organizations.

B. The parish governing authority shall make the appointments for a period of two years.

In the case of a judicial district which encompasses more than one parish, cooperating parish governing authorities may formulate a plan of representation and may add representatives to the board from each participating parish.

C.(1) The children and youth planning boards shall actively participate in the formulation of a comprehensive plan for the development, implementation, and operation of services for children and youth and make formal recommendations to the parish governing authority or joint parish governing authorities at least annually concerning the comprehensive plan and its implementation during the ensuing year.

(2) In its formulation of the comprehensive plan, the children and youth planning boards shall do

all of the following, but shall not be limited to the following:

(a) Identify all resources available to meet the needs of children and youth by comprehensively examining resources and services that target children and youth. These services may include but are not limited to prevention, early intervention, education, and treatment.

(b) Assess the needs of children and youth in the local community, incorporating reliable data sources.

(c) Develop and select the appropriate evidence-based strategies or programs to meet those needs identified by soliciting community input and developing a strategic plan to best address the needs of children and youth in the respective community. This strategic plan should have measurable goals and objectives and should be evaluated annually to ensure its effectiveness.

(d) Collaborate with schools, law enforcement, judicial system, health care providers, and others to ensure goals and treatment needs are being met.

(e) Ensure effective delivery of prevention programs in the community through training, technical assistance, monitoring, and evaluation to ensure effective outcomes are achieved.

(f) Report annually by October first to the office of youth services and the Children's Cabinet the results of such assessments. Performance indicators and benchmarks from the reports will be used for planning at both the state and community levels.

Target at-risk communities and/or high-risk populations.

As states identify opportunities to expand access to home visiting services, it is vital to focus limited dollars 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.¹⁰

The majority of Most states, however, are not prioritizing resources to the most-at-risk communities. The Pew survey found that more than half—nearly \$727 million—of total available home visiting FY2010 funding was allocated to programs without any state-designated eligibility requirement. States can do more to provide clear, evidence-based guidelines about who is eligible for services and to develop systems to ensure that state dollars are directed as intended.

In defining home visiting eligibility, 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
- **Establish** mechanisms to guarantee continuity of services as family circumstances change.

LEGISLATIVE LANGUAGE

FROM MINNESOTA DESCRIBES ELIGIBLE FAMILIES FOR THE STATE'S PROGRAM.

■ LEGISLATION/POLICY:

M.S.A. § 145A.17¹²

■ STATE: MINNESOTA**FAMILY HOME VISITING PROGRAMS**

Subdivision 1. Establishment; goals. The commissioner shall establish a program to fund family home visiting programs designed to foster healthy beginnings, improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency for children and families. The commissioner shall promote partnerships, collaboration, and multidisciplinary visiting done by teams of professionals and paraprofessionals from the fields of public health nursing, social work, and early childhood education. A program funded under this section must serve families at or below 200 percent of the federal poverty

guidelines, and other families determined to be at risk, including but not limited to being at risk for child abuse, child neglect, or juvenile delinquency. Programs must begin prenatally whenever possible and must be targeted to families with:

- (1) adolescent parents;
- (2) a history of alcohol or other drug abuse;
- (3) a history of child abuse, domestic abuse, or other types of violence;
- (4) a history of domestic abuse, rape, or other forms of victimization;
- (5) reduced cognitive functioning;
- (6) a lack of knowledge of child growth and development stages;
- (7) low resiliency to adversities and environmental stresses;
- (8) insufficient financial resources to meet family needs;
- (9) a history of homelessness;
- (10) a risk of long-term welfare dependence or family instability due to employment barriers; or
- (11) other risk factors as determined by the commissioner.

Invest enough money to reach all eligible families.

States must ensure that all at-risk families can access quality programs—and that significant portions take advantage of available services.

Expanding programs to serve all eligible families requires not only phasing in funding increases, but also allowing time to build capacity at administering agencies and the local level, and to coordinate outreach to families. Increasing access over time enables leaders to conduct 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 #4 above), they should have more and better data about who participates and how best to engage hard-to-reach families and increase take-up rates.¹³

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 all available funding streams, including Medicaid, TANF,¹⁴ public health and early childhood resources; ensure that allocations are sufficient to serve the entire target population; and allow agencies the time to build capacity and conduct outreach to targeted families.

Using the best available data about families to determine appropriate home visiting allocations and to establish a realistic plan for expansion will help states guarantee access for all eligible families.

A JOINT CONCURRENT RESOLUTION

FROM LOUISIANA LAYS OUT ONE WAY TO STUDY THE PATH OF TAKING A HOME VISITING PROGRAM TO SCALE STATEWIDE.

■ LEGISLATION/POLICY: **LOUISIANA SENATE CONCURRENT RESOLUTION NO. 70¹⁵**

■ STATE: **LOUISIANA**

**NURSE-FAMILY PARTNERSHIP
A CONCURRENT RESOLUTION**

To create the Nurse-Family Partnership Advisory Council and to urge and request the Department of Health and Hospitals in conjunction with the Nurse-Family Partnership Advisory Council to study the expansion of the evidence-based Nurse-Family Partnership program and to report to the House and Senate committees on health and welfare prior to November 1, 2008.

WHEREAS, the United Health Foundation ranks Louisiana forty-ninth in infant mortality with a rate of 9.9 deaths per one thousand live births; and

WHEREAS, the United Health Foundation ranks Louisiana forty-ninth in immunization coverage with only 72.3 percent of children ages nineteen to thirty-five months immunized; and

WHEREAS, the United Health Foundation ranks Louisiana forty-ninth in overall health; and

WHEREAS, the Annie E. Casey Foundation, 2007 Kids Count Databook ranks Louisiana forty-ninth in overall child well-being, continuing a series of twelve consecutive years for the state being forty-ninth or fiftieth in the nation; and

WHEREAS, studies have demonstrated that prenatal and early childhood care and support are essential to the development of young children; and

WHEREAS, the Nurse-Family Partnership is an evidence-based home visiting program that improves the health, well-being, and self-sufficiency of low-income, first time parents and their children with intensive bi-weekly home visits, prenatally through the child's second birthday; and

WHEREAS, research has shown that the Nurse-Family Partnership improves pregnancy outcomes by helping women engage in preventative health practices, including obtaining thorough prenatal care, improving their diet, and reducing their use of cigarettes, alcohol and illegal substances; and

WHEREAS, research has shown that the Nurse-Family Partnership improves child health and development by helping parents provide competent care for their babies; and

WHEREAS, research has shown that the Nurse-Family Partnership improves families' economic self-sufficiency by helping parents develop a vision for their future, plan future pregnancies, continue their education and find work; and

WHEREAS, the Nurse-Family Partnership has consistent evidence, based on more than twenty-five years of randomized controlled trials replicated with varied populations; and

WHEREAS, among other outcomes, these studies have observed a forty-eight percent reduction in child abuse and neglect, fifty percent reduction in language delays at age twenty-one months, sixty-seven percent reduction in behavioral and intellectual problems at age six, twenty-six percent

improvement in math and reading achievement test scores for first through third grades, fifty-nine percent reduction in arrests at age fifteen, sixty-nine percent fewer maternal arrests, and a fifty-seven percent reduction in emergency room visits for accidents and poisonings; and

WHEREAS, a study by Tulane University concluded that the Nurse-Family Partnership in Louisiana demonstrated a fifty-two percent reduction in premature births, fifty-one percent reduction in alcohol use or intoxication by the mother, fifty percent reduction in emergency room visits for any reason by the time the child was fifteen months old, forty-three percent reduction in prenatal depression and thirty-three percent reduction in subsequent pregnancies by fourteen months postpartum; and

WHEREAS, an independent study conducted by the Rand Corporation has demonstrated that the cost of the program is recovered by the time the child has reached the age of four and a savings of four dollars is realized for every dollar spent by the time the child reaches the age of fifteen; and

WHEREAS, an independent study by the Washington State Institute for Public Policy examined the evidence from research dating back to 1970 and concluded that the Nurse-Family Partnership provided the largest cost benefit of all the early intervention, child welfare, and home visiting programs studied and additionally concluded that the Nurse-Family Partnership saved seventeen thousand dollars per family in welfare, criminal justice and medical costs; and

WHEREAS, the office of public health of the Department of Health and Hospitals first implemented a pilot program of the Nurse-Family Partnership in 1999; and

WHEREAS, the Louisiana Nurse-Family Partnership program currently operates in forty-one of the sixty-four parishes but has the capacity to serve only a small fraction of eligible first-time mothers; and

WHEREAS, more and more states, including Tennessee and Texas, have passed legislation to greatly increase the capacity of their Nurse-Family Partnership programs.

THEREFORE, BE IT RESOLVED that the Legislature of Louisiana does hereby create the Nurse-Family Partnership Advisory Council comprised of the following members:

- (1) One member representing and appointed by the Louisiana Chapter of the American Academy of Pediatrics.
- (2) One member representing and appointed by the Baptist Community Ministries.
- (3) One member representing and appointed by BrightStart.
- (4) One member representing and appointed by the Council for a Better Louisiana.
- (5) One member representing and appointed by the Institute of Mental Hygiene.
- (6) One member representing and appointed by the Juvenile and Family Court Judges Association.
- (7) One member representing and appointed by the Louisiana Association of Non-Profit Organizations.
- (8) One member representing and appointed by the Louisiana Maternal and Child Health Coalition

(9) One member representing and appointed by the Louisiana Partnership for Children and Families.

(10) One member representing and appointed by the Louisiana Public Health Institute.

(11) One member representing and appointed by the Louisiana State University System.

(12) One member representing and appointed by the Tulane University Institute of Infant and Early Childhood Mental Health.

(13) One member representing and appointed by Prevent Child Abuse Louisiana.

(14) The assistant secretary of the office of public health, Department of Health and Hospitals, or his designee.

(15) The director of the bureau of health services financing, Department of Health and Hospitals, or his designee.

(16) The assistant secretary of the office of family support, Department of Social Services, or his designee.

(17) The commissioner of administration or his designee.

(18) Any other members deemed necessary and appointed by the secretary of the Department of Health and Hospitals.

BE IT FURTHER RESOLVED that the secretary of the Department of Health and Hospitals shall convene the first meeting of the Nurse-Family Partnership Advisory Council.

BE IT FURTHER RESOLVED that the legislature does hereby urge and request the Department of Health and Hospitals in conjunction with the Nurse-Family Partnership Advisory Council to explore the expansion of the Nurse-Family Partnership program and to report to the Senate and House committees on health and welfare prior to November 1, 2008.

BE IT FURTHER RESOLVED that the report should include but not be limited to the following:

- (1) An examination of how other states are implementing the Nurse-Family Partnership program.
- (2) The financial resources needed for expansion.
- (3) The potential funding sources available for expansion.
- (4) The workforce development strategies to address the number of nurses needed to deliver the program.
- (5) The recommendations for community outreach that may lead to innovative partnerships and leveraged resources.

Endnotes

1 *Washington State—Home Visitation Program—Findings—Intent*, <http://apps.leg.wa.gov/rcw/default.aspx?cite=43.215.145>.

2 *Legislative Intent (Tennessee Resource Mothers Program)*, http://www.lawsolver.com/law/state/tennessee/tn-code/tennessee_code_68-1-1402.

3 *Washington State—Home Visitation Programs*, <http://apps.leg.wa.gov/rcw/default.aspx?cite=43.215.146>; <http://apps.leg.wa.gov/rcw/default.aspx?cite=43.215.147>.

4 *Patient Protection and Affordable Care Act—Maternal, Infant, and Early Childhood Home Visiting Program*, (March 23, 2010), http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf.

5 “States and the New Federal Home Visiting Initiative: An Assessment from the Starting Line,” (Pew Center on the States, 2011).

6 *Oklahoma Public Health Code*, <http://law.justia.com/codes/oklahoma/2006/os63.html>.

7 *(Minnesota) Family Home Visiting Programs*, <http://www.health.state.mn.us/divs/fh/mch/fhv/admin/ms145a17legislation.pdf>.

8 *Help Me Grow*, <http://codes.ohio.gov/oac/3701-8-07>.

9 *Children and Youth Services Advisory Boards; Members; Duties (Louisiana)*, <http://www.legis.state.la.us/lss/lss.asp?doc=100499>.

10 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); J. Isaacs, “Cost-Effective Investments in Children,” *Budgeting for National Priorities* (2007).

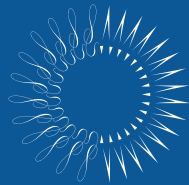
11 These figures are calculated from data provided by 117 of the 119 state programs. The other two programs were unable to provide relevant spending information.

12 *(Minnesota) Family Home Visiting Programs*.

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

14 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.

15 *A Concurrent Resolution (Regarding the Nurse-Family Partnership Program)*, <http://www.legis.state.la.us/billdata/streamdocument.asp?did=499486>.



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