



Helping Hands: A Review of Home Visiting Programs in California

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Next Generation

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Preface

As a new parent, I was grateful when a public health nurse visited my home after my daughter was born. She provided support and guidance, and put my mind at ease. Bringing a baby home – to any home – can be daunting, and the stress of becoming a parent for the first time can lead many parents to feel overwhelmed, exhausted, and isolated.

For parents without a support network, these challenges are even more extreme. Home visitors, who see parents struggling with a wide range of issues every day, are well positioned to help parents see their own strengths, help relieve some of the tension, provide guidance where appropriate, and generally set families off on a positive trajectory. Families who feel supported are more likely to be able to provide the best environments for the development of their children.

California has been at the forefront of providing home visiting programs to new parents through the significant investments made by First 5 California and the local First 5 Commissions throughout the state. In recent years, California has also benefitted from a federally-funded program that supports home visiting in 21 counties throughout California.

This brief describes the types of home visiting programs across the state of California and clarifies a system that may be confusing to an outsider. Next Generation is highlighting voluntary home visiting programs because of their proven effectiveness and the promise they hold for the futures of very young children, particularly those in poverty. Study after study show wide and various benefits to children, families, and communities by providing a helping hand to parents at a vulnerable time in their lives.

This brief also highlights the need for increased state investments in these programs, given a backdrop of painful budget cuts to the programs that support at-risk children, and the threat to the existing funds that currently support California's home visiting programs. The federal funds that have allowed California to increase access to home visiting are set to expire in March 2015, and the largest source of funding for home visiting – the state tax on tobacco products that funds the First 5 Commissions – is declining. To fill this gap, the state will need to determine whether state investments should support home visiting.

In many communities across California, poverty is stark and desperate. Home visitors provide a helping hand, a connection to outside services, and many times act as a last safety net for families that may not have anything else to turn to.

Ann O'Leary
Vice President & Director
Children & Families Program

Executive Summary

Voluntary home visiting programs are a powerful tool to improve outcomes for at-risk children and families. Families enrolled in home visiting programs are visited by trained professionals on a regular basis who provide practical tips and information – as well as emotional support – on a range of issues, including maternal health, early learning, and improving parent-child interactions. Extensive evidence shows that home visiting programs can improve outcomes for families in many critical ways, including:

- Improved prenatal health;
- Strengthened family functioning;
- Reduced rates of child abuse, neglect, and maltreatment;
- Decreased dependence on social services; and
- Increased child literacy and school readiness.

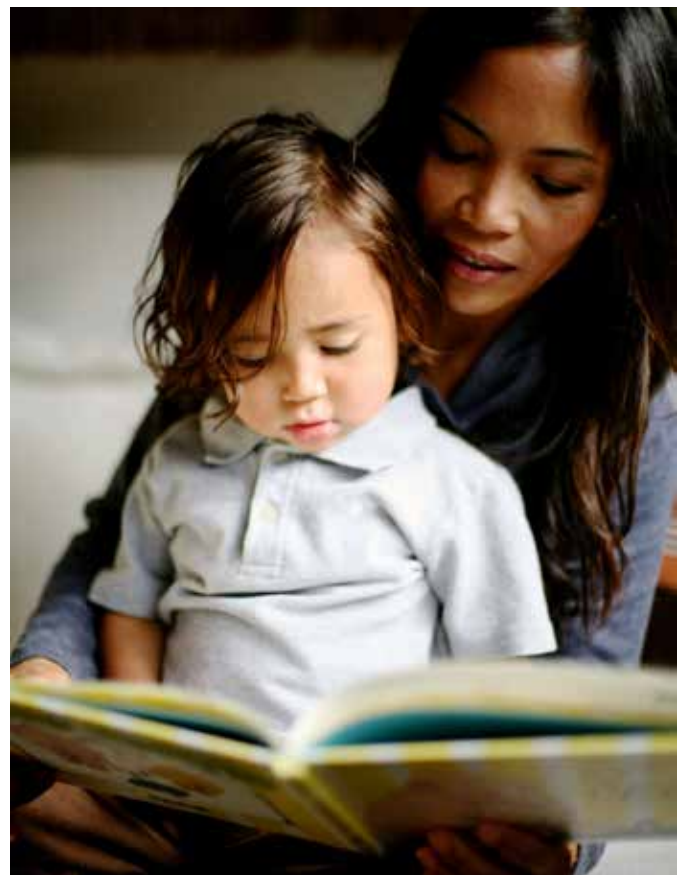
Despite the promising evidence, only 11 percent of California’s families receive a home visit between pregnancy and their child’s third birthday.

Home visiting programs in California are administered at both the state and local levels, and include a range of national models backed by rigorous research and evaluations, and local models tailored to the needs of specific communities.

The California Home Visiting Program (CHVP), created by the Maternal, Infant, and Early Childhood Home Visiting program (MIECHV) funds, administers home visiting in 21 counties using one of two evidence-based models: Nurse-Family Partnership (NFP) and Healthy Families America (HFA). MIECHV offered California an opportunity to supplement current funding for home visiting programs, as well as benefit from the federally-funded evaluation. Congress recently approved a six-month extension to the MIECHV program, ensuring its continuation through March 2015 unless it acts again to extend the funding.

First 5 County Commissions provide the largest source of funding of home visiting programs. These commissions fund four national program models, including NFP and HFA. In addition, nineteen counties have created their own models of home visiting programs that cater to the specific needs of their population.

California currently does not contribute general fund dollars to the federally-funded California Home Visiting Program, which is limited in its ability to reach a significant percentage of families with newborns at risk. Its infrastructure has been built and can be scaled up, and the state should be looking ahead to the future of that program, whether Congress reauthorizes it or not. Given that the state is now out of its fiscal crisis, this is a critical moment to pass legislation that supports proven programs among vulnerable children.



I. Introduction

The building blocks of a child's lifelong health and well-being are established in the earliest years. Negative experiences in early childhood – such as poverty, violence, and emotional or physical abuse – can become biologically embedded, derailing healthy development. Children exposed to these stimuli also go on to experience greater risks for physical and mental health conditions.¹

Voluntary home visiting programs are uniquely positioned to improve outcomes for at-risk children and make a long-lasting impact on communities by building strong families early on and linking them to the broader network of health and social services.

Federal funding for home visiting programs is set to expire in March 2015.

Although home visiting programs have been in place for generations, they have gained momentum among policymakers. President Obama has called for increased funding for home visitation as part of his early learning agenda.² Congress recently debated and extended the funding for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, underscoring its currency among federal lawmakers.

The interest in home visiting programs in part reflects a wider understanding of the importance of early brain development and family stability, as well as growing evidence of their effectiveness. Studies have shown that high-quality home visiting programs can improve family functioning, child cognitive and language development, and a child's social behavior.³

Families enrolled in home visiting programs are visited by trained professionals on a voluntary basis. The intensity of services depends on each family's needs and circumstances, but services often include health, education, and social support services. Some home visiting programs target families with newborns while others are focused on early learning and kindergarten preparedness. The primary goals and focus vary across program models, but they often overlap to include: promoting positive child

and maternal health outcomes; supporting child development and school readiness; preventing child abuse and maltreatment; improving family functioning and self-sufficiency; and encouraging positive parent-child interactions.

California's rich diversity and its large population present a challenge to designing and implementing home visiting services, though the need for these programs is demonstrably high. Its approach – a blend of program types, some administered at the state level, some at the local level – provides an opportunity to look at these different approaches and the pros and cons of each.

Because California's system of funding and administering home visiting is complex, this brief will describe the breadth of these programs and their sources of funding, with focus on those funded by First 5 Commissions and MIECHV. In addition, it highlights the importance of early interventions and the diverse needs of different communities. Federal funding for home visiting programs is set to expire in March 2015, so it is critical that states review the evidence for home visiting and assess current and future plans for investment now.

This brief is intended to provide California legislators and policymakers a clear picture of the range of benefits home visiting programs offer and the types of programs in place by funding source. Finally, it offers recommendations about the future of these programs as legislators consider ways to effectively strengthen early childhood investments and as First 5 Commissioners consider their ongoing commitments.

We focus on home visiting programs – rather than home visiting services – which offer home visiting as the primary strategy to deliver a comprehensive set of services. The programs mentioned in this brief address infant health and development, as well as early learning home visiting programs, which typically target older children before kindergarten entry. This brief is based on a literature review and interviews with state and local agency officials, program managers in local jurisdictions, and First 5 Commission officials.

II. Federal Investments in Home Visiting

The United States recently made two major investments toward the expansion of home visiting programs through the American Recovery and Reinvestment Act (ARRA) and the Patient Protection and Affordable Care Act (ACA). As part of the stimulus package in 2009, ARRA allocated \$2.1 billion for the expansion of Head Start (HS) and Early Head Start (EHS) services. Over half of the funds (\$1.1 billion) went to EHS, which provides comprehensive child developmental and family support services to low-income children and families from birth to three; EHS programs can be center-based, home-based, or some combination of the two. In the home-based model, families receive weekly home visits from educators who carry out the EHS curriculum. The new EHS funds increased enrollments by over 40,000 slots nationally. In the first year of expansion from ARRA funds, 45 percent of EHS slots were in home-based programs.⁴

The ACA marked an unprecedented federal investment in home visiting programs. The legislation authorized \$1.5 billion in new federal funding over five years (from FY 2010 to FY 2014) for states to provide voluntary, evidence-based home visiting programs to support at-risk young children and their families.⁵ As a result, the federal Maternal, Infant, and Early Childhood (MIECHV) program was created to provide funding, technical assistance, and evaluation efforts to states. Congress recently approved a six-month extension to this program, ensuring its continuation through March 2015 unless it acts again to extend the funding.⁶



III. The Evidence Base for Home Visiting

The evidence base for many home visiting models is extensive. Studies have touted their ability to improve prenatal health and family functioning, reduce rates of child abuse and neglect, decrease dependence on social services, increase child literacy, and boost school readiness.⁷ Home visiting programs typically address the development and health of a young child, the type called for by Nobel Laureate James Heckman in his recent study on the health outcomes of early childhood education:

“Our evidence shows the potential of early life interventions for preventing disease and promoting health.” James Heckman, “Early Childhood Investments Substantially Boost Adult Health.” *Science*.

Although there has been a great amount of research and evaluation on home visiting models, the heterogeneity of their design presents challenges in gathering a consistent evidence base. Launched by the Department of Health and Human Services (DHHS), the federal Home Visiting Evidence of Effectiveness (HomVEE) study was designed to piece apart the impacts of each of the different widely-used models (see Appendix A). Most of these models have shown favorable impacts on child development and school readiness (nine models), as well as positive parenting practices (eleven models). In contrast, only two models demonstrated favorable impacts on reductions in juvenile delinquency, family violence, and crime. Healthy Families America and Nurse-Family Partnership demonstrated favorable impacts in nearly all of the domains (eight and seven, respectively).⁸ The HomVEE study identified fourteen home visiting models that met the DHHS criteria for evidence-based home visiting and are therefore eligible for MIECHV funding.⁹

The MIECHV program is also mandated to have a formal evaluation of its effectiveness, which will be completed through the Mother and Infant Home Visiting Program Evaluation (MIHOPE). The study will examine the effectiveness of different home visiting programs in MIECHV and their impact on

at-risk children and families served. Four home visiting models were selected for this evaluation: Early Head Start - Home Visiting, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers. Approximately 85 home visiting program sites in 12 states are enrolled in MIHOPE, including select sites in California, and a total of 5,100 families are expected to participate in the study.¹⁰ MIHOPE’s evaluation will better inform policymakers and practitioners on MIECHV’s effectiveness and the pathways through which evidence-based home visiting can improve outcomes for children and families. Results from the study will be available in 2015, with a follow-up in 2018.¹¹

Benefits of Nurse-Family Partnership in California

One of the most well studied home visiting models is Nurse-Family Partnership (NFP), a national model targeted at first-time, low-income mothers. In a California-specific analysis, researchers found that NFP yielded positive short- and long-term outcomes that included:

- 56 percent reduction in risk of infant deaths;
- 43 percent reduction in crimes and arrests; and
- 29 percent reduction in child maltreatment through age 15.¹²

These outcomes generated significant savings, estimated at \$38,483 per family served (see Figure 1). Total savings from the program’s reductions in infant deaths, child maltreatment, youth crimes and arrests far exceeded its operating costs.

Benefits of Nurse-Family Partnership per Family Served in California

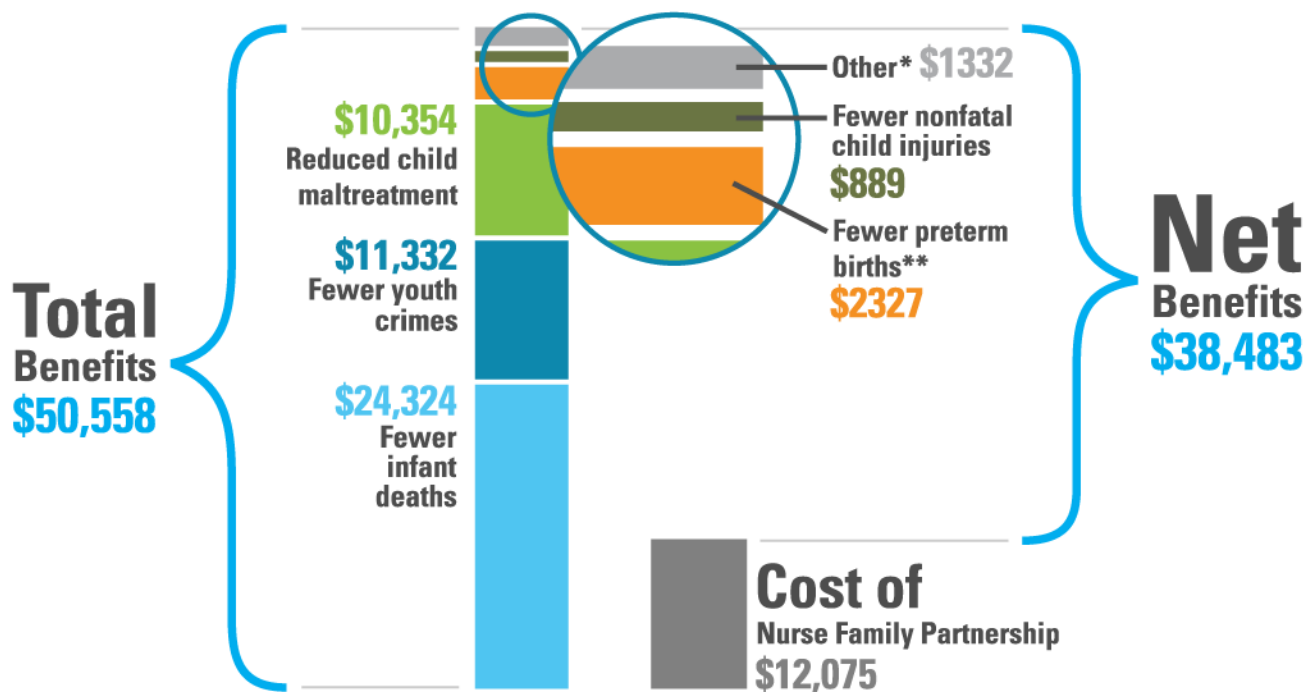


Figure 1

* "Other" includes the categories: reduced preeclampsia, fewer subsequent births, more immunizations, fewer remedial school services, reduced youth substance abuse, and reduced smoking while pregnant.

** "Fewer preterm births" includes both first and subsequent preterm births

Source: Unpublished data provided by Nurse-Family Partnership National Service Office. Date of contact: May 2014. California-adjusted estimates based on initial report from Ted R. Miller, "Nurse-Family Partnership Home Visitation: Costs, Outcomes, and Return on Investment" (Beltsville: Pacific Institute on Research and Evaluation, 2013).

IV. At-Risk Communities in California

Thousands of California's children are vulnerable, and may be in need of early interventions. 1.4 million children in California are under three years old, making up 12 percent of the nation's population for that age group. Among those children, almost half (47 percent) are low-income, and nearly two-thirds (65 percent) experience one or more risk factors such as parental unemployment or residential instability.¹³ Despite the high need, only 11 percent of California's families receive a home visit between pregnancy and their child's third birthday.¹⁴

Only 11 percent of California's families receive a home visit between pregnancy and their child's third birthday.

To qualify for MIECHV funding, states were required to submit a statewide home visiting needs assessment that identified at-risk communities with concentrations of one or more of these indicators:

- Premature birth
- Low birth weight infants
- Infant mortality
- Poverty
- Crime
- Domestic violence
- School dropout rates
- Substance abuse
- Unemployment
- Child maltreatment

In addition to these required indicators, California also included seven supplemental indicators in its assessment: prenatal care; prenatal substance abuse; maternal depression; birth interval; breastfeeding; children with special needs; and foster care. Through this needs assessment, California identified that all 58 of its counties are "at-risk."

Six indicators were particularly prevalent – in these areas, half or more of the counties demonstrated need above that of the statewide median. Substance abuse, or use of illicit drugs other than marijuana, was identified as a significant problem in 40 counties; infant mortality, child maltreatment, poverty, crime and unemployment were prevalent in 29 counties.¹⁵



V: The Home Visiting Landscape in California

California has a rich diversity of home visiting programs across the state. Before the advent of the MIECHV program, California did not have a state-wide home visiting program. In the absence of state funding dedicated to home visiting, local First 5 Commissions in many counties have made home visiting programs available to at-risk families. MIECHV funding, along with First 5 Commissions and other federal programs, combine to make a range of home visiting programs available for California families. Many counties also operate federally-funded Early Head Start home visiting programs, and across the state approximately 1,800 children ages 0 to 3 are served by those programs.^{16 17}

First 5 County Commission-Funded Home Visiting Programs

First 5 is California's innovative system of providing and coordinating services for young children, funded by a dedicated tax on tobacco products. First 5 local Commissions in each of California's 58 counties fund direct services for children ages 0 to 5, as well as integrate the systems of care for those children. Programs and services are tailored to the needs of the local population.

First 5 County Commissions are far and away the biggest funders of home visiting programs in the state. In a 2014 survey, First 5 reported investing \$55.9 million in home visiting programs in 22 counties, reaching over 27,000 families.¹⁸ In eleven counties, all or almost all families with young children receive home visiting services, most of these through a locally designed program.¹⁹

First 5 programs offer a mixture of nationally recognized evidence-based models and locally developed models.

National, evidence-based models

National home visiting models follow a set of program standards and have demonstrated their effectiveness through independent evaluations. Their national offices provide support to sites adopting their models and ensure fidelity to program standards across sites. Training requirements vary for the different models. See Table 1 for a description of the types of background and training required by several models.

County First 5 Commissions (often in partnership with other local agencies, including departments of public health) fund four national program models that serve families with young children (ages 0 to 5):

- **Nurse-Family Partnership** targets low-income, first-time pregnant women. Public health nurses begin visits with families during pregnancy, and continue the relationship through the toddler years. The program focuses on the health and well-being of the baby and emphasizes the importance of building a support network for mothers. Twenty counties administer the NFP model, funded by First 5s and/or MIECHV.²⁰
- **Healthy Families America** serves low-income, at-risk families from birth to five. Family support workers address the needs of families who may have histories of violence, mental health or substance abuse, and/or other significant risk factors. The program is available in eleven counties, funded by First 5s or MIECHV, or a combination of the two.²¹
- **Parents as Teachers (PAT)** aims to support positive parenting practices, improve a child's school readiness, increase parents' knowledge of early childhood development, detect early developmental delays and health issues, and prevent child abuse and neglect. Families are paired with trained paraprofessionals who provide weekly to monthly home visits starting in pregnancy to a child's kindergarten enrollment. Twelve counties use PAT as the model for their home visiting programs, funded by First 5s.²²

Home Visiting Staff and Training Requirements, by Program

Model	Home Visiting Staff	Background	Pre-Service Training Requirements
Nurse-Family Partnership	Registered Nurse	Home visitors must be registered nurses and possess at least a Bachelor's degree in nursing.	Home visitors must complete three core training sessions over a nine-month time frame.
Healthy Families America	Family Support Worker	HFA does not have formal requirements for home visiting staff, but recommends that home visitors have prior experience working with at-risk families with diverse needs.	Home visitors must complete the mandatory HFA core training, a five-day workshop.
Parents as Teachers	Parent Educators	Home visitors must possess a high school diploma or general equivalency degree (GED), and have two years of prior work experience with young children and/or parents.	Home visitors must complete a three-day foundational training and a two-day model implementation training. Programs that serve children ages 3 to 5 also have additional training.
Parent Child Home Program	Para-professionals	PCHP does not have formal requirements for home visitors, but recommends that they demonstrate an interest in working with children and families and good judgment.	Home visitors must complete at least 16 hours of training.
Pregnant and Parenting Teen Program (Alameda model)*	Advocates and Family Case Managers	Family advocates and case managers typically hold a Bachelor's degree.	Home visitors are trained on reflective practice techniques and receive additional training based on the Growing Great Kids curriculum.

Table 1

* A local home visiting model in Alameda County targeted at pregnant/parenting teens from pregnancy until the child turns five. For more information, see Applied Survey Research, "Home Visiting Programs in Alameda County" (2011) available at <http://www.acphd.org/media/53995/homevisit.pdf>.

Source: U.S. Department of Health & Human Services, Administration for Children & Families. For more information on each national program model's staff and training requirements see "Model Implementation Reports" available at <http://homvee.acf.hhs.gov/implementations.aspx>.

- Parent Child Home Program (PCHP)** focuses on closing the school readiness gap. Home visitors work with parents to support their child's early literacy and language development. Families are also connected to social services and parenting education opportunities. Home visitors visit families twice a week over the span of two years, or before the child enters preschool. PCHP currently operates in Riverside and Fresno counties, funded by First 5s. First 5 Siskiyou is considering adding PCHP to its home visiting programs.²³

Local models

Nineteen counties have created their own models of home visiting programs, in some cases based on the curriculum of national models.²⁴ Of particular importance to these communities was designing programs that would cater to the specific needs of their target population.

By and large, locally-developed programs do not have the benefit of years of rigorous evaluation to prove their effectiveness. However, some counties have been able to evaluate their local models and demonstrate effectiveness. For example, Orange County developed the MOMS program to address a need for prenatal health care. The program provides prenatal care, health education, and health screenings to participants and refers them to resources in the community. Program administrators partnered with researchers at the University of California, Irvine, to evaluate the program. They found that pregnant women enrolled in the MOMS program had better birth outcomes than the average for the county.²⁵ The boxes below describe locally-developed programs in Alameda and Los Angeles Counties.

Local vs. National Models

First 5 Commissions weigh a number of factors when deciding how to invest their funds. All funding decisions are the result of local strategic plans, required by the Children and Families Act approved by California voters in 1998. Of particular importance are the needs of the most at-risk families. First 5s use their needs assessment data to determine which models are most appropriate for the families they serve.

National models have the advantage of long-standing bodies of research that demonstrate their effectiveness.

Home Visiting in Alameda County

Alameda County operates a range of home visiting programs that cater to different target populations and stages of early childhood development. Ten home visiting programs targeted to pregnant and parenting women, newborns, and children up to the age of 3 are in operation in the county, funded by a combination of First 5, MIECHV dollars, county general funds, Title V, and leveraged federal funds. Target populations for the programs include those living in certain high-needs neighborhoods, teen mothers, medically fragile infants, and women at risk for poor pregnancy outcomes. One program works specifically with fathers and their children. Interested families are referred through a universal referral process administered by First 5 Alameda County, a critical funder and thought partner in the development of the home visiting system of care.

The majority of the programs within the system were locally-developed to best meet the needs of the diverse populations in the county and allow for the hiring of home visitors who could provide culturally and linguistically responsive care. The system currently includes one national, evidence-based model – Nurse-Family Partnership – and will soon include Healthy Families America. Recognizing the strengths of evidence-based models, Alameda plans to expand its Nurse-Family Partnership program and transition more families from home-grown programs into Healthy Families America. In addition to an increasing focus on evidence-based models, the benefits of building a home visiting system include incorporating common standards of care across all programs (such as screening protocols), developing common outcomes and training and workforce development.²⁶

First 5 Los Angeles's Welcome Baby Program

First 5 Los Angeles's Welcome Baby program offers voluntary, universal hospital and home-based services for pregnant women and new mothers. The goals of the program are to enhance parent-child relationships; improve the health, safety and security of the baby; and improve access to family support services. It offers different levels of service to all new parents who give birth in partner hospitals, based on their risk level and community of residence. The program has demonstrated positive results. Evaluators found that participants from the pilot community showed improvements in the quality of the home learning environment (e.g. more storytelling and books take place, more responsive parenting, and less television time). In addition, evaluators found that:

- 99 percent of participants attended well-baby visits;
- 95 percent of babies received their immunizations;
- Mothers were more likely to breastfeed exclusively in the first 4 months.²⁷

The program was expanded in 2013 from its original community to include 13 others. With this expansion, Welcome Baby will touch approximately 40 percent of all births in Los Angeles County. Preliminary outcome data from the expansion of the program are expected soon. The program is funded by First 5 LA, and is not supported by MIECHV funding, though Los Angeles County is one of the programs participating in CHVP. First 5 LA is working with stakeholders at the county, state and federal levels to raise policymaker awareness on the benefits of home visiting programs and advocate for expanded funding to support them.²⁸

National models have the advantage of long-standing bodies of research that demonstrate their effectiveness. Home visitors receive standardized training to ensure that the program adheres to its goals and maintains its integrity. These trainings may provide home visitors with a wide range of tools to draw from when confronted with challenging situations. The MIECHV program was built upon the national evidence base that demonstrates the effectiveness of these programs, and increasingly federal and state funding is tied to the ability to demonstrate outcomes.

Home-grown programs may be designed for specific populations or issues facing families, or they may be adaptations of national models.

Home-grown programs, however, may be able to fulfill the needs of the local community in ways that the national models may not. They may be designed for specific populations or issues facing families,

or they may be adaptations of national models. For example, rural **San Benito County** with a high rate of poverty designed and operates an early learning-focused home visiting program for families of young children living in mobile homes. **El Dorado** operates a universal program for families using nurses and early childhood specialists to provide the new family with the right level of engagement, and offers the county flexibility in its mode of service delivery.

In addition, national models are expensive to administer. National models, like Healthy Families America, require programs to participate in centralized trainings in order to maintain their program integrity. These trainings, however, can be costly. Moreover, the staffing called for by Nurse-Family Partnership – namely public health nurses – increases the costs of operating those programs over programs that employ trained paraprofessionals. For these reasons, the estimated cost per family of NFP and HFA far exceed that of California's local programs (see Table 3). Counties providing universal access to home visiting do not use national models, likely because of the costs associated with them, and because the level of intervention offered by national models may not be appropriate to every birth in a county.

The California Home Visiting Program (CHVP)

The MIECHV program offered California an opportunity to supplement current funding for home visiting programs, as well as benefit from the federally-funded evaluation. A division of the California Department of Public Health, the Maternal, Child and Adolescent Health (MCAH) program administers the MIECHV funds through the California Home Visiting Program (CHVP), a state-wide home visiting program. MCAH was responsible for applying for the initial and subsequent federal funding, identifying the home visiting models that could be used by the local communities, setting the benchmarks for measuring success, collecting baseline and outcomes evaluation data, and offering the local jurisdictions technical support.

CHVP funds programs in 21 counties, which were identified through the state's needs assessment as having the greatest need and potential for impact based on factors such as poverty rate, rates of child abuse and neglect, and ability to find and enroll at-risk parents. Local jurisdictions used the framework set by the state to build their programs, but ensured their relevance to the community by defining the target population most in need, selecting the model that was most appropriate, and convening the local network of organizations to build a strong program. Depending on funding availability, MCAH plans to expand funding to ten additional sites. No state funds are dedicated to CHVP.

Annual Cost per Family by Program Model

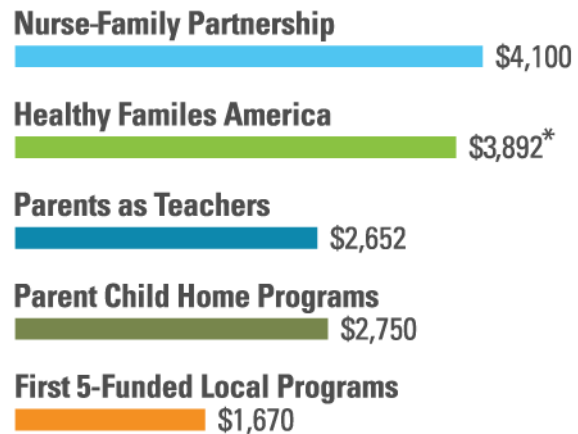


Figure 2

* The average annual cost of Healthy Families America ranges from \$3,214 to \$3,892 per family.

Source: U.S. Department of Health & Human Services, Administration for Children & Families. For an implementation profile of all program models, including estimated costs, see "Model Implementation Reports" available at <http://homvee.acf.hhs.gov/implementations.aspx>. First 5-funded local program estimates based on personal communication with official from First 5 Association. These costs do not include evaluation efforts or overhead. Date of contact: March 2014.

Home Instruction for Parents of Preschool Youngsters (HIPPY)

Home Instruction for Parents of Preschool Youngsters (HIPPY) is a nationally-acclaimed, evidence-based home visiting model that has been in use in the United States for 25 years, and meets the criteria for MIECHV-funded programs. The model targets families with preschool-aged children (ages 3 to 5), and helps parents prepare their young children for school entry. Trained home visitors visit families biweekly to provide the parent with educational tools that emphasize child development concepts and skill building activities. Families are also encouraged to engage in the biweekly group sessions with other participants where they can share practices and learn from one another. Until recently, HIPPY was used in a few California counties, funded in part through State School Readiness match funds provided by First 5 California and the local First 5 County Commissions. Recently, funding priorities for home visiting have largely shifted to models that serve newborns and their families. No local First 5 is currently funding HIPPY.

MCAH identified the Nurse-Family Partnership (NFP) and Healthy Families America (HFA) as the models to be funded with MIECHV funding in California. Both are nationally-recognized, evidence-based, and seek to improve outcomes among high-needs families. See Appendix B for a description of the two models. HFA and NFP's strong evidence base that demonstrates a breadth of favorable impacts was an important factor in California's decision to select these two models for its first state-level home visiting program.

Communities completed needs assessments, which served as the basis for selecting either the NFP or HFA model. Communities that were already operating one of these models were encouraged to expand it under the new funding. Pre-existing programs were able to offer advice to sites starting a program from scratch. For example, **Imperial County** collaborated with Butte to learn from its Butte Baby Steps HFA program. **Butte** offered program input on policies and procedures that Imperial could modify and adopt.²⁹

CHVP has not identified targets in terms of program reach or number of families to be served, however, and has not yet released any data on the number of families served by county. Since its inception, MCAH reports the program has conducted over 22,000 home visits. Approximately 2,000 families are actively enrolled.³⁰ CHVP measures impact in six benchmark areas. Home visitors collect the majority of this information through forms and screening tools administered to the participants, and the data is later reported to the state for evaluation. The first outcome reports are due to be released in 2015.

MCAH strives to be a close partner with the local sites, offering technical assistance and communication across sites to share lessons learned. It has developed a detailed web site with a wealth of resources, including assessment tools, reporting forms, and training guides. In an effort to share knowledge more broadly, MCAH has made technical assistance information available to all evidence-based home visiting programs in the state, not just those funded by MIECHV. It has also developed a single data entry system to support counties' data management of their NFP and HFA programs, as well as additional MIECHV reporting requirements.



VI. Conclusion

Fifteen years ago, First 5 Commissions were born out of a need to better serve children, particularly low-income, at-risk children, given a system that was not sufficiently addressing them. In recent years, the state endured painful budget cuts, poverty rates rose and the need for First 5 programs became particularly acute. Many First 5-funded home visiting programs continued to enroll new families and develop during those years. As the safety net got thinner, the demands of home visitors became more critical.

First 5 Commissions approach the work of serving families in a pragmatic and focused way. To meet the needs of the most children, they turn to locally-developed programs because they are cheaper and more flexible to administer.

The need for state investments in home visiting will only increase as tobacco sales, and therefore First 5 funding, decline.

California currently does not contribute to the federally-funded California Home Visiting Program, which is limited in its ability to reach a significant percentage of families with newborns at risk. Its infrastructure has been built and can be scaled up, and the state should be looking ahead to the future of that program, whether Congress reauthorizes it or not. The MIECHV program will be able to provide initial evaluation findings in 2015, but the state already has ample evidence of the importance and impact of well-executed home visiting programs. The need for state investments in home visiting will only increase as tobacco sales, and therefore First 5 funding, are on the decline. Currently only 11 percent of families receive home visiting services in a state that has determined every one of its counties a high-risk community. Given that the state is now out of its fiscal crisis, this is a critical moment to consider legislative proposals that support proven programs for vulnerable children.

State legislators should investigate how the California Home Visiting Program can be strengthened and coordinated with local programs. Regardless of the reauthorization debate at the federal level, MIECHV funding is insufficient to fill the need for home visiting in the state, and should be supplemented by state-only dollars.

At a basic level, there is a critical need to collect data across the state. CHVP has made initial steps to build a data system that would allow all home visiting programs – those funded by MIECHV and those not – to enter utilization data in order to track the number of families served statewide. Counties describe being desperate for additional support with data. This data system will not be built without significant outside support from the Brown Administration, but it is a clear need if California hopes to collect the data necessary to know how many families are receiving this assistance, and whether it is helping them. And this is a clear-cut way in which county First 5s can make their programs more transparent. In addition, First 5 California could play a critical role in boosting the infrastructure of home visiting programs and should consider what role it could play in this space, including potentially funding evaluation efforts for local models.



Appendix A: Favorable Impacts Across Eight Domains, by Program Model³¹

Program Model	Child Health	Maternal Health	Child Development and School Readiness	Reductions in Child Maltreatment	Reductions in Juvenile Delinquency, Family Violence, & Crime	Positive Parenting Practices	Family Economic Self-Sufficiency	Linkages & Referrals
Child FIRST		●	●	●				●
Early Head Start-Home Visiting			●	●		●	●	●
Early Intervention Program for Adolescent Mothers	●						●	
Early Start (New Zealand)	●		●	●		●		
Family Check-Up		●	●			●		
Healthy Families America	●	●	●	●	●	●	●	●
Healthy Steps	●					●		
Home Instruction for Parents of Preschool Youngsters (HIPPY)			●			●		
Maternal Early Childhood Sustained Home Visiting Program	●	●				●		
Nurse-Family Partnership	●	●	●	●	●	●	●	
Oklahoma's Community-Based Family Resource and Support (CBFRS) Program		●				●		
Parents as Teachers (PAT)			●	●		●	●	
Play and Learning Strategies (PALS) Infant			●			●		
SafeCare Augmented				●				●

Appendix B: Description of Nurse-Family Partnership and Healthy Families America ^{32, 33}

	Nurse Family-Partnership	Healthy Families America
Home visiting staff	Registered Nurse	Family Social Workers (FSWs)
Target population	Low-income, first-time pregnant women	Low-income, at-risk families
Estimated cost per family	\$4,100	Between \$3,214 and \$3,892
Length and frequency of visits	Between 1 – 1 ½ hours. Frequency of visits may vary depending on each family’s circumstances.	
Visits during pregnancy	<p>Visits start out weekly for the first four weeks and transition to every other week. Conversations between nurses and participants emphasize how to prepare for childbirth and what to expect when the baby is brought home. Nurses also teach participants about important concepts such as stages of pregnancy and development of the fetus. Nurses counsel on diet and nutrition and, depending on the client, the negative impact of smoking, alcohol-use, and substance abuse on the fetus.</p>	<p>Visits occur once a week. FSWs are positioned as the participant’s formal support system. Visits focus on helping the participant plan for the new baby and FSWs address the physical and emotional changes that come with pregnancy. FSWs and participants also set goals together, and discuss how participants can reach those goals. Some common goals are to complete school or gain employment. The goals are revisited and revised throughout all phases.</p>
Visits during infancy	<p>Visits occur on a weekly basis for six weeks after birth and transition to every other week or monthly. Home visits emphasize parenting practices and infant care. Nurses address an array of topics, including breastfeeding and positive attachment. Participants learn how to bond and develop positive relationships with their child. Nurses encourage participants to read and talk to their babies, and there are ongoing conversations child development and milestones.</p> <p>Goal-setting is an important component throughout all phases. Participants and nurses set and discuss goals, and nurses provide additional support by connecting participants to relevant community resources.</p>	<p>Visits typically continue on a weekly basis for six months after birth. There is a strong emphasis on the parent-child relationship, or nurturing positive attachment.</p> <p>FSWs teach participants about the importance of bonding with their babies, and encourage bonding through ways like talking the baby and holding and touching the baby. FSWs also provide participants with important information about child development and milestones, and how parents can support that.</p>
Visits during toddler years	<p>Frequency of visits range from every other week to monthly. Visits during this phase are a continuation of what happens in previous phases. There is an even stronger emphasis on building a broader support network of family and friends as some families prepare to enter the workforce.</p>	<p>Depending on the family’s needs, frequency may decrease to twice a month. Visits during this phase are a continuation of what happens in previous phases, focusing on healthy child development and supporting families to reach their goals.</p>

Notes

- 1** Center on the Developing Child at Harvard University, “The Foundations of Lifelong Health Are Built in Early Childhood” (2010).
- 2** The White House, Factsheet President Obama’s Plan for Early Education for all Americans (Office of the Press Secretary, 2013), available at: <http://www.whitehouse.gov/the-press-office/2013/02/13/fact-sheet-president-obama-s-plan-early-education-all-americans>.
- 3** Harriet J. Kitzman and others, “Enduring Effects of Prenatal and Infancy Home Visiting by Nurses on Children: Follow-up of a Randomized Trial Among Children at Age 12 years” *Arch Pediatr Adolesc Med* 164 (5) (2000): 412-418. For a good summary of the literature on home visiting, see Pew Charitable Trusts, “Expanding Home Visiting Research: New measures of Success” (2013).
- 4** Stephanie Schmit, “Early Head Start Participants, Programs, Families and Staff in 2010” (Washington: Center for Law and Social Policy, Inc. 2011), available at <http://www.clasp.org/resources-and-publications/publication-1/EHS-PIR-2010-Fact-Sheet.pdf>.
- 5** “Home Visiting Grants & Grantees” available at <http://mchb.hrsa.gov/programs/homevisiting/grants.html> (last accessed April 2014).
- 6** Jennifer Stapleton, “U.S. Congress Extends Funding for Vital Family Program” The Pew Charitable Trusts, March 31, 2014.
- 7** Ted R. Miller, “Nurse-Family Partnership Home Visitation: Costs, Outcomes, and Return on Investment.” (Beltsville: Pacific Institute on Research and Evaluation, 2013). Also see Heather Weiss and Lisa G. Klein, “Changing the Conversation About Home Visiting: Scaling up with Quality” (Cambridge: Harvard Graduate School of Education, 2006).
- 8** Sarah Avellar and others, “Home Visiting Evidence of Effectiveness Review” (Washington: Mathematica Policy Research, 2013).
- 9** For a list of the 14 home visiting models that met the criteria for evidence-based home visiting, see “Home Visiting Models” available at <http://mchb.hrsa.gov/programs/homevisiting/models.html>.
- 10** For a list of California sites participating in MIHOPE see Letter from MCAH Title V Director to MCAH/CHVP Directors and Coordinators, NFP Nurse Supervisors, and HFA Program Managers, November 5, 2013, available at <http://www.cdph.ca.gov/programs/mcah/Documents/MO-CHVP-MIHOPEExtensionLetterPolicyAlertLetter2013-14-01.pdf>.
- 11** For more information on the MIHOPE study see MDRC, “Mother and Infant Home Visiting Program Evaluation: Project Description” (2012).
- 12** Unpublished data provided by Nurse-Family Partnership National Service Office. Date of contact: May 2014. California-adjusted estimates based on initial report from Ted R. Miller, “Nurse-Family Partnership Home Visitation: Costs, Outcomes, and Return on Investment.”
- 13** National Center for Children in Poverty, “Young Child Risk Calculator” (2011). Risk factors include: households without English speakers, large family, low parental education, residential mobility, single parent, teen mother, and unemployed parent(s). State data retrieved from 2010-2012 American Community Survey.
- 14** National Survey of Children’s Health “Indicator 4.4: home visiting program, age 0-3 years” (Portland: Data Resource Center for Child & Adolescent Health, 2011), available at <http://www.childhealthdata.org/browse/survey/results?q=2503&r=6>.
- 15** Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health, “Supplemental Information Request for the Submission of the Statewide Needs Assessment.”
- 16** California Head Start Association, “2012-2013 California Head Start Data Report” (2013). According to the California Head Start Association, 16,369 children ages 0 to 3 are served by Early Head Start (EHS), and 11 percent of all Head Start/EHS children are served in the home-based programs. We multiplied the total number of children served by EHS by the percent of all children served in the home-based program to estimate the number of children enrolled in EHS’s home-based option (1,820).
- 17** In addition to the programs described here, some counties administer home visiting programs funded by county-only dollars or leveraged Title XIX funding. This brief focuses on programs funded primarily by either county First 5 Commissions or CHVP because those are the lion share of programs in the state. Early Head Start programs are federally-funded and thus state policymakers have little ability to make changes to those home visiting programs. They are not a central focus of this brief.
- 18** First 5 Association of California, “First 5 Investments in Home Visiting,” (2014) available at <http://first5association.org/wp-content/uploads/2014/04/Home-visiting-investments-2014.pdf>.
- 19** Unpublished data provided by First 5 Association of California. Date of contact: March 2014.
- 20** Unpublished data provided by First 5 Association of California. Date of contact: March 2014; “California Home Visiting Program (CHVP) Funded Counties by Home Visiting Model” available at <http://www.cdph.ca.gov/programs/mcah/Documents/MO-CHVP-FundedCountiesMap.pdf>. All data are as of 2014.
- 21** Ibid.
- 22** Unpublished data provided by First 5 Association of California. Date of contact: March 2014. Data are as of 2012.
- 23** Personal communication with officials from First 5 Association of California. Date of contact: April 2014.
- 24** Unpublished data provided by First 5 Association of California. Date of contact: March 2014. Data are as of 2012.
- 25** MOMS Orange County, “Report Highlights Home Visitation Program 2009-2010” (2011), available at http://momsorangecounty.org/MOMS_Executive_Summary_Test3.pdf.
- 26** Summary of local home visiting models based on personal communication with officials from Alameda County Public Health Department, Family Health Services Division. Date of contact: April 2014.
- 27** Armando Jimenez, “Home Visiting Briefing” (Los Angeles: First 5 Los Angeles, 2014) available at <http://first5association.org/wp-content/uploads/2014/03/HV-Presentation-022514.pdf>.
- 28** Summary of Los Angeles’s Welcome Baby program based on personal communication with local officials from First 5 Los Angeles. Date of contact: April, 2014.

29 Personal communication with local officials from Imperial County Public Health Department. Date of contact: February 2014.

30 Figures based on personal communication with state officials from the California Home Visiting Program. Date of contact: January 2014.

31 Sarah Avellar and others, "Home Visiting Evidence of Effectiveness Review." This table combines primary and secondary measures. According to HomVEE, primary measures are data collected through direct observation, direct assessment, or administrative record, or self-reported data collected using a standardized instrument. Secondary measures include other self-reported measures.

32 Descriptions of program models are based on contact with nurse supervisors from local sites implementing home visiting programs. Date of contact: December 2013 - January 2014. For more information on NFP and HFA home visits, see Nurse-Family Partnership, "Nurse-Family Partnership: Home Visit Guidelines" (2010) and Prevent Child Abuse America, "Healthy Families America: Site Development Guide" (2000), p. 137.

33 Estimates of cost retrieved from the U.S. Department of Health & Human Services, Administration for Children & Families. For an implementation profile of all program models, including estimated costs, see "Model Implementation Reports" available at <http://homvee.acf.hhs.gov/implementations.aspx>.