



An Assessment of the St. Louis Region's Home Visiting Programs

January 2019

*The Initiative for Healthy
Babies & Families*

FLOURISH

STL

TABLE OF CONTENTS

Executive Summary and Recommendations	2
Background and Methodology.....	10
Stakeholder Interviews: A Summary of Key Themes	13
Home Visiting in the US: A Review of the Literature	18
Home Visiting Assessment Survey Results	21
Home Visiting in the US: An Environmental Scan of National, State and Local Programs, Practices, and Resources	29
Evidence-Based Home Visiting Models	31
Local Home Visiting Programs.....	34
Programs and Initiatives in Other Regions	41
Meeting the Challenges of Home Visiting Service Provision	51
Centralized Services and Coordinated Intake	55
Funding Sources.....	57
Resources for Additional Information on Home Visiting	64
Appendix.....	66

EXECUTIVE SUMMARY AND RECOMMENDATIONS

The Rome Group, in partnership with the Missouri Foundation for Health and Generate Health's FLOURISH Initiative, was tasked with assessing the state of home visitation programs in the St. Louis region. In recent years, many groups, agencies and organizations, including FLOURISH's Steering Committee, have recognized the value of home visiting as an approach to improve many factors related to maternal and child health – from infant mortality and healthy development in infants and children to perinatal and postpartum behavioral health in new mothers.

The research for the assessment focused on three key areas to better understand the existing network of home visiting programs and to identify ways to advance it. The questions included the following:

1. What home visiting services are being provided in the St. Louis region? How many families are they reaching? What outcomes are they measuring? What ZIP codes or geography are part of their service areas?
2. What are the strengths, challenges and opportunities – real and perceived – facing service providers and the families they reach in their work?
3. What steps can providers, advocates, policymakers, funders and other stakeholders in the St. Louis region take to: a) improve the quality of home visiting services offered to families in the region; b) better coordinate how services are delivered in the region; and c) work together in collaborative ways to find efficiencies and reach more families in need?

In addition to gathering information about the landscape of home visiting providers and programs in the region, an important goal of the project was to engage leaders in the process both to seek their feedback and to involve them in solutions for improving the quality of services in St. Louis.

The assessment confirmed some of what stakeholders throughout the home visiting services field knew, illuminated other strengths and challenges of the network, and elevated the voices of clients to determine what is working for families in our region and what needs attention and improvement.

The findings included the following:

- The St. Louis region has a robust network of providers providing home visiting services using a range of curricula and approaches.
- While there are many providers, these agencies do not regularly or systematically coordinate delivery of services, referrals between providers are sporadic and difficult for clients to complete, stakeholders believe that some families are receiving similar services from many programs, and clients find it difficult to connect to the providers that can assist them.
- Home visiting services are not always targeted to the geographic areas where the need is greatest. Some ZIP codes with many risk factors for infant mortality have no

or few providers serving their residents; other areas are being served, but the number of families in need of services greatly exceeds the number of families actually receiving services. The ZIP codes where the need for services is greatest are in communities where the majority of residents are Black – failure to prioritize these areas exacerbates existing issues with access to services and disproportionately poor maternal and child health outcomes for Black St. Louisans.

- Funders and policymakers have enormous influence over what services families receive – mandating specific curricula or interventions and what outcomes to prioritize, such as those specifically related to child abuse and neglect or medical diagnoses. They also have influence over the geographic areas in which these services are delivered.
- Providers find themselves in competition with each other for both funding and clients, and sometimes express that collaborating, sharing data, or working together makes them feel vulnerable or could put them at a disadvantage for future funding and sustainability of their programs.
- Clients feel that the relationship with the home visitor is key to their success and their overall desire to engage in the program, and many report positive relationships and experiences with agencies in the St. Louis region. At the same time, clients are skeptical of staff's ability to understand their life circumstances, and they often do not trust the provider organizations to be helpful or expect them to be supportive. Their experiences in the past with providers and other institutions – such as interactions with social workers investigating reports of child abuse or neglect, or home visitors who made them feel judged – make this concern understandable.

For a full report of the findings of the assessment, as well as to read an environmental scan of home visiting at the national, state, and local levels, please visit the FLOURISH Initiative's website at <https://www.flourishstlouis.org>.

While collectively home visiting services provide critical and lifesaving support to families, some of the above factors also likely have contributed to a growing gap between outcomes for White and Black infants and children in the St. Louis region.

The recommendations below will build on the region's strengths to ensure that home visiting services meet the needs of all families and address gaps in delivering care. Based on the results of the assessment, including research on evidence and best practices, as well as input from providers, policymakers, funders, and clients themselves – the following recommendations will:

- Help expand home visiting services to reach more families that are eligible and in need of the program.
- Streamline existing services so that they are effective and efficient.
- Build the necessary infrastructure to support the work that provider organizations do in communities every day.

- Encourage coordination among stakeholders at all levels to improve the network, strengthen services and better serve families.
- Ensure that provider organizations are prepared to meaningfully and respectfully engage with families in our region to provide supportive and safe environments for working together.

Recommendation 1: Build trust among providers and between all stakeholders as the foundation for a truly collaborative effort on home visiting in the region.

In order to achieve full participation in a coordinated, collaborative effort to promote home visiting, providers must be willing to share data and information about their programs and trust that stakeholders will act in their best interest, as well as the interests of clients.

- Action: Establish the credibility and trustworthiness of the backbone organization of a collective effort to improve home visiting in the St. Louis region.
 - Task: Establish a lead organization and leadership group that will manage the logistics and deployment of the home visiting implementation plan.
 - Task: Through an open process that seeks input from various stakeholders, determine the structure and function of the ongoing, collective effort to promote home visiting.
- Action: Develop mutually beneficial opportunities for stakeholders, including provider organizations, to participate in an ongoing, collaborative effort on home visiting.
 - Task: Disseminate the findings of the home visiting assessment to continue to educate stakeholders about regional activities and priorities.
 - Task: Continue to make the case to provider organizations and other stakeholders that a coordinated effort can both improve services in the overall region and provide support to their individual organizations (i.e. answer the question, “What’s in it for me?”).
 - Task: Create agreements between the backbone and provider organizations that outline the terms of the partnership and detail roles, responsibilities, and expectations of all involved.
 - Task: Recruit diverse members of the collaborative – from funders to providers – who will participate in implementation and ongoing activities.
- Action: Raise awareness about the need for improved infrastructure for home visiting programs and the need for investment in administration, operations and coordination of efforts in the region.
 - Task: Establish a working group on infrastructure and administration to identify specific requests for funders and policymakers.

- Create a strategic plan for the leadership group/lead agency in the coordinated effort and identify infrastructure and administrative needs for the group to support ongoing coordination.
- Encourage funders to invest in training, technical assistance, data collection, staff support for the collaborative, and other infrastructure needs across regional provider organizations through the collaborative/lead agency.

Recommendation 2: Improve the regional capacity to use data to drive efforts to design, improve and evaluate home visiting efforts.

Data, outputs, and outcomes for home visiting programs and services overall are difficult to capture because organizations have varying capacity to collect and analyze data. Different organizations collect data on different outcomes depending on funders' demands and their programs' focus. Providers also have little incentive to share the data with others.

- **Action:** Improve the ability of home visiting organizations to collect and report on process and outcome data related to delivery of home visiting services.
 - Task: Inventory current systems that providers/collaborative members are currently using for data collection, noting any overlap.
 - Task: Engage organizations that have implemented shared data in their regional work for lessons learned and guidance on the process (e.g. Promise 1000 in Kansas City, Every Child Succeeds in Cincinnati).
 - Task: Provide extensive technical assistance and training to organizations to increase their capacity to collect and use data in their work.
- **Action:** Create systems to allow for data to be shared in order to identify trends in process and outcome data, opportunities for professional development, and other characteristics of note among the service population and providers.
 - Task: Identify an outside evaluator or quality improvement expert to manage the process of analyzing data across providers.
 - Task: Provide regionwide training opportunities to develop the skills of home visitors and others in provider organizations.
- **Action:** Provide support for quality improvement to address issues that data collection highlights across the region.
 - Task: Develop a quality improvement and performance management process to address issues with implementation that become apparent through data analysis, or at the request of partners/providers.
- **Action:** Leverage data to perform large-scale outcome evaluations and other research with information available from program site data collection in order to understand the effectiveness of home visiting efforts in the region.
 - Task: Identify an outside evaluator to conduct research and analysis of data collected through the shared system, manage Institutional Review Board (IRB)

approval and other administrative issues, and prepare providers to participate in studies as necessary.

- Task: Establish partnerships with local researchers who have an interest in maternal and child health for potential projects.
- Explore “official” lists of evidence-based programs, their requirements, and the criteria for review to determine if the shared data system positions the collaborative to submit data for inclusion (e.g. the Home Visiting Evidence of Effectiveness (HomVEE) list through the Department of Health and Human Services (HHS) and Health Resources and Services Administration (HRSA).

Recommendation 3: Create a seamless intake and referral process that connects clients and their families to appropriate and desired home visiting programs and services.

Collaborative home visiting efforts across Missouri and the country have found ways to successfully connect clients to home visitors by dedicating resources to a single system that matches them to an available, appropriate service.

- Action: Develop and maintain a database of providers, the services they offer, their geographic locations, and their areas of expertise to better understand where to direct clients.
- Action: Explore strategic options for intake as a strategy for connecting clients to home visiting services offered across our region.
 - Task: Engage organizations and agencies that have implemented central or coordinated intake processes in the past (e.g. Promise 1000, Every Child Succeeds, St. Louis City and County Continuum of Care, Missouri Department of Health and Senior Services, Illinois Department of Public Health, etc.) to glean lessons learned and best practices related to their efforts.
 - Explore centralized intake as a potential strategy for the St. Louis region.
 - Explore coordinated intake as a potential strategy for the St. Louis region.
 - Explore other options to achieve a seamless intake and referral process for consumers in the St. Louis region.
- Action: Improve cooperation and coordination among providers with the goal of coordinating services, decreasing competition between providers, and achieving greater geographic reach with programs and services.
 - Task: Encourage major funders of home visiting services in the region (e.g. Department of Health and Senior Services, Department of Social Services, Department of Elementary and Secondary Education) to review targeted geographic areas/ZIP codes to increase coordination with the goal of reaching more clients.

Recommendation 4: Educate funders and policymakers about the breadth of home visiting services in the region to help strengthen investment in programs and services with the goal of reaching more individuals.

Because funders and policymakers have significant influence on whether, how, and where providers deliver services, it is critical that they have opportunities to learn about what is working well in communities, potential areas for improvement, and opportunities for expansion.

- **Action:** Continue analysis of high priority geographic areas to use to increase knowledge among funders and policymakers about where the need for home visiting services is greatest.
 - Task: Require submission of program data by ZIP/geographic area in the agreement for participation in the collaborative.
 - Task: Continue to collect data and information about programs and services from providers whose information was not included in the initial assessment.
 - Task: Establish working groups for funders and policymakers to provide regular updates and discuss opportunities for collaboration.
- **Action:** Encourage funders/policymakers to coordinate grantmaking efforts to reduce duplication, align reporting among grantees, and leverage the data collected from providers to identify trends, gaps, and needs in the region.
 - Task: Establish a policy and advocacy working group to identify issues that legislation and administrative changes could address to improve home visiting, as well as coordinate with other policy and advocacy efforts across the state.
- **Action:** Ensure that funders' focus on quality early childhood education includes support for home visiting services and programs, which reaches the same audiences and has similar goals.
- **Action:** Engage institutional and major funders to encourage alignment of grantmaking with strategies that encourage coordination among providers.
 - Task: Establish a funders/grantmakers working group.
 - Task: Compare reporting requirements of funders and identify areas of overlap, opportunities for consolidation, information that might be missing, etc.

Recommendation 5: Adopt a regionwide approach to family recruitment and engagement for home visiting programs that is client-centered, trauma-informed, and promotes cultural competence among providers and organizations.

Providers and organizations should engage in ongoing training and education to ensure that they are delivering services in a manner that clients find educational, edifying, and supportive, which will help ensure steady enrollment and that clients continue with programs through completion.

- **Action:** Ensure that all providers working with eligible families with children ages 0 to 5 (e.g. early childhood, pediatricians, etc.) are equipped to make referrals to home visiting providers.
 - Task: Create a dissemination plan for the list of providers the backbone/lead organization creates and any other efforts to streamline referrals and intake.
 - Task: Provide training and information on a wide scale on any resulting centralized/coordinated intake effort for interested organizations and agencies (e.g. training on an online tool that helps route families to appropriate providers).
- **Action:** Provide training and educational opportunities for home visitors and their organizational staff to ensure they are well prepared to recruit and retain families in their programs and provide meaningful, respectful engagement throughout their enrollment.
 - Task: Survey provider organizations on their professional development and training needs to determine relevant topics for the training calendar.
 - Task: Create an annual professional development and training calendar for home visiting providers.
 - Task: Create a standard satisfaction survey that can be used across all organizations to evaluate clients' experiences with home visiting in the region and can also be leveraged for performance management and quality improvement.
 - Coordinate existing training efforts to ensure they include cultural competence, trauma-informed service delivery, and other topics that will improve the quality of interactions between providers and clients.
- **Action:** Determine the need for structural changes to home visiting services that could lead to better, more responsive interactions with families.
 - Task: Consider changes to the titles of key positions that interact with families to signal a strengths-based approach to home visiting (e.g. coaches vs. visitors).
 - Task: Provide support for broader screening and assessment of maternal health issues, such as depression and anxiety.

- Task: Develop a “Clients’ Bill of Rights” document to communicate to home visiting consumers about the power they have in interactions with home visitors.
- Task: Consider a formal feedback mechanism for providers to use in order to allow consumers to communicate with their organizations about their experiences in various programs.

BACKGROUND AND METHODOLOGY

The Rome Group, in partnership with the Missouri Foundation for Health and Generate Health's FLOURISH Initiative, was tasked with assessing the state of home visitation programs in the St. Louis region. In recent years, many groups, agencies, and organizations, including FLOURISH's Steering Committee, have recognized the value of home visiting as an approach to improve many aspects of maternal and child health – from infant mortality and healthy development in infants and children to perinatal and postpartum behavioral health in new mothers.

The research for the assessment focused on three key areas to better understand the existing network of home visiting programs and to identify ways to advance it. The questions included the following:

1. What home visiting services are being provided in the St. Louis region? How many families are they reaching? What outcomes are they measuring? What ZIP codes or geography are part of their service areas?
2. What are the strengths, challenges and opportunities – real and perceived – facing service providers and the families they reach in their work?
3. What steps can providers, advocates, policymakers, funders and other stakeholders in the St. Louis region take to: a) improve the quality of home visiting services offered to families in the region; b) better coordinate how services are delivered in the region; and c) work together in collaborative ways to find efficiencies and reach more families in need?

In addition to gathering information about the landscape of home visiting providers and programs in the region, an important goal of the project was to engage leaders in the process both to seek their feedback and to involve them in solutions for improving the quality of services in St. Louis.

Background

A range of organizations in the St. Louis region provide services delivered in clients' homes – or in community settings other than clinics and agency offices – as a way to reach people interested in programs in a more comfortable, consistent setting, as well as to foster connection and build rapport. These programs focus on myriad health, educational, economic, and social outcomes – such as newborn health and reducing infant mortality, maternal and infant mental health, positive parent-child interaction, school readiness, and preventing child abuse and neglect.

These programs, however, may also use home visits to varying degrees as the primary tool for service delivery. For example, many early childhood education providers include home visits in their models (often as required by a federal Head Start grant), but the education and support services they provide are primarily delivered in center-based child care settings.

For the purposes of this assessment, we focused on programs that use home visits as the primary vehicle for delivering services to clients and families. While we were also interested in learning about programs with goals and targeted outcomes, besides maternal and child health and child development services, we were unable to capture this work in a substantial way using our methodology. This could be evidence that existing home visiting programs overwhelmingly focus on maternal and child health, or that outreach to a broader group of providers was a limitation of this assessment. We also recognize that the categories for types of providers and/or focus of services are not necessarily discrete – for example, providers focused on behavioral health could be serving new parents, to whom depression and anxiety screenings could be critical.

The environmental scan provides a thorough examination of the definition of home visiting, what is considered an evidence-based program, and the outcomes that programs in our region and across the country are measuring to determine success.

Methodology

The assessment included the following components to assess the home visiting landscape and engage stakeholders in the process:

Leadership Team Meetings

In addition to Generate Health, the FLOURISH Initiative’s backbone organization, and the Missouri Foundation for Health, a small team of leaders in maternal and child health and home visiting provided in-depth guidance and feedback to the project, including team members from Children’s Hospital’s Raising St. Louis program, Nurses for Newborns, and a parent leader from the community.

Stakeholder Convening

In order to engage providers, policymakers, community leaders, funders, and others with an interest in home visiting, the leadership team organized a stakeholder convening. The purpose was to educate attendees about some existing home visiting approaches, inform them about the focus of the assessment, and gather information about additional resources that could help advance their work in this area.

Stakeholder Interviews

The consultants interviewed key informants, including a significant number of families and consumers, about the strengths and challenges of the home visiting landscape; trends in the field, opportunities to improve quality; and what providers, funders, and policymakers can do to promote quality interventions and programs.

Literature Review and Environmental Scan

The assessment was informed by existing research about home visiting approaches, previous evaluations and assessments of state and local programs, and a scan of comparable and innovative approaches across the United States.

Mapping Service Providers

Using both web searches and surveys, the report includes information about service providers in St. Louis City and County, the geographic areas they serve, outcomes they measure, and the number of clients, as well as other data.

STAKEHOLDER INTERVIEWS: A SUMMARY OF KEY THEMES

Stakeholders recognize that an array of home visiting services are available across the St. Louis region, through various agencies, funding by federal, state, and local partners, and using a variety of different curricula and approaches. At the same time, many recognize the challenges that exist in both providing and accessing home visiting programs despite a robust network and that service delivery could be more coordinated than it currently is.

In order to ensure that the voices of consumers and potential consumers of home visiting services were included in the assessment, The Rome Group conducted two additional listening sessions with families who had received home-based services. The purpose was to gather feedback on their experiences and where they see opportunities for improving the quality of services that they might receive in the future. The sessions were attended by 20 participants.

Strengths

Robust Network of Home Visiting Providers

Stakeholders throughout the region and state see the many organizations delivering services to prenatal and postpartum women, and their children and families in St. Louis, as an asset. In particular, policymakers and funders agree that the region does not necessarily need *additional* home visiting programs; existing home visiting services should simply be more coordinated.

Providers Refer to One Another When Possible

Administrators and providers of home visiting services generally have policies in place that allow them to refer to other organizations when necessary (and when they have the systems in place to make regular referrals). Many providers were forthcoming about the limitations of their models (e.g. they can only serve first time moms, they are not equipped to attend to medically fragile babies, or they do not provide therapy or counseling in home), and do their best to refer to agencies that can meet clients' specific needs. One provider described a practice of "warm handoffs" with a provider agency that delivers in-home counseling services, coordinating a joint visit with both home visitors, in order to introduce the client to the behavioral health provider.

Connection with the Home Visitor is Key to a Successful Engagement

Families emphasized the importance of feeling that they could trust a home visitor as essential to being satisfied with the services they received. Many participants suggested that their initial distrust was cultural, and that inviting people to whom they were not related into their homes could be unusual, uncomfortable, and a potential violation of long-held boundaries and norms. Participants reported that often they were of a different race or ethnicity than their home visitor. Many participants noted that when a home visitor was of the same race/ethnicity, they assumed they would be better able to relate to them. At the same time, many noted that it was more important to them that a home visitor treat them

with respect and work hard to build rapport, so that regardless of racial differences they felt comfortable building a relationship. Families told stories of successful, long-term relationships with home visitors, including stories in which they had to meet a few home visitors before they found the best fit for their families.

Home-Based Service Delivery Matters

Overall, clients acknowledge the fact that visitors' coming to them has a positive effect on their ability to access services for their children and themselves. In particular, clients reported very positive feelings about home visitors who were able to accommodate their busy lives; for example, some clients shared anecdotes about their houses being too messy or chaotic to feel comfortable inviting in a visitor and feeling relieved when the home visitor agreed to meet elsewhere. Clients also acknowledged that not having to worry about how they would make it to an agency or office, and instead simply preparing for a visitor to come to them, made them continue with a program. Participants were also highly complimentary of home visitors who were willing to "go above and beyond," texting them in the evenings and on weekends about items they had discussed during visits, helping with home repairs and organization, and being hands-on with their children in their homes.

Challenges

Retention of Families

Providers struggle to retain families with the highest need because they tend to be transient and/or have stressors and life circumstances that can make ongoing participation in a program challenging. Many cited the fact that in addition to moving their places of residence frequently, clients' phone numbers change often as well, making it hard to track families when they move. This is especially challenging in programs that require long-term enrollment.

Intimate Partner Violence

For some clients, the inability to track them after a move is purposeful. At least one provider spoke of intimate partner violence as a challenge that makes retention difficult. A client and her child may move to escape abuse and purposely avoid sharing her new address/number, so that her partner is not able to find her.

Referrals, but No Coordination

While some providers refer to other providers in the region when necessary and appropriate, there is some recognition that coordinating referrals more would be helpful to families. For example, many families present with several needs – such as a baby who has special medical needs and a first-time mom who needs help with breastfeeding – and could benefit from an entity that coordinates follow-up with the various organizations that might be able to attend to the family's needs.

Demand for Home Visiting Exceeds Supply

Some agencies spoke of having waiting lists to receive their services. In particular, an organization that reserves spots in its programs specifically for prenatal home visits – making maintaining a wait list infeasible since potential clients will soon give birth – spoke of the demand for the services and information they provide in home as in high demand. Without additional funding, they are unable to expand these services to more families.

Distrust of Home Visitors is Driven by Past Negative Experiences

Some participants explained their hesitation to engage in programs that provide home-based services related to past experiences with social services workers or other professionals whose interaction was mostly punitive or corrective in nature. In some cases, participants' fears were confirmed by their interactions with home visitors. One attendee described a relationship with a nurse who over the course of their engagement coached her to put her infant to sleep on her back; because this mother was struggling with sleep for herself and her child, she described their interactions as the nurse "looking for a 'gotcha'" rather than offering support, to which the mother responded by avoiding the topic altogether during their visits. Many participants described their initial interactions with home visitors as overcoming the fear that this person had come to take their children away.

Maternal Mortality

National studies have found that maternal death rates for Black women far exceed those of their White counterparts, and many providers suspect that the same is true for Black women in the St. Louis region. Unfortunately, there is not much focus on tracking the number of maternal deaths and not many home visiting programs and services focus on moms in a concentrated way.

Opportunities

Shared Data

Stakeholders agree that sharing data among providers and funders is an important step to better understanding the outcomes providers are measuring and how programs are making a difference in the lives and well-being of the families they reach. Transparency in sharing data could also lead to better collaboration. If one organization is performing well on a particular outcome, such as ensuring that babies receive immunizations on time, groups that are not performing as well on that outcome could learn strategies from the successful group. States that have existing collaborative home visiting initiatives highly value shared data and often report that it was among the first areas in which they dedicated substantial resources.

Coordination with Early Childhood

Stakeholders working on and investing in early childhood see coordinating with home visiting as a natural area of overlap. Since the majority of infants and children ages 0-3 are not in a center-based early childhood education setting, home visiting is often an important

way to reach families of those children with resources and information that will support them as they help their children develop. It is also reasonable to assume that some recipients of home visiting services are in-home early childhood providers themselves, and are potentially responsible for the care of many children. Home visiting could be an avenue for supporting in-home providers with professional development and resources that might help them better serve the children in their care.

Parents Value Opportunities to Connect with Other Parents

Participants overwhelmingly recognized the opportunity to connect with other parents of small children as valuable and necessary. At the same time, they do not report that opportunities currently provided through the various programs in the region help them to meet this need for social connection. Parents describe the sessions as cursory at best and chaotic at other times. When they are able to focus on the resources provided, some suggest that they are not always applicable or interesting, and in other cases sessions are poorly run to the point of distraction from the content. Participants often agree to attend sessions with the expectation of receiving support from peers and an opportunity to discuss their parenting challenges; they often are met with classroom-style lectures rather than the support group setting they are expecting. Participants appreciate the incentives some agencies provide and are motivated to attend because of them.

Coordinated Intake or a “Front Door” for Home Visiting

Existing collaborative home visiting initiatives have established coordinated intake for home visiting. In Kansas City, consumers can answer a questionnaire, with or without the assistance of an intake worker, who will provide them with the contact information of a home visiting program for which they are eligible, that meets their particular needs, and that does not have a wait list. Many stakeholders in St. Louis spoke of such a system as potentially helpful to ensure that clients can find a program when they need it. Previous funding in the St. Louis region had supported such a coordinated intake system but it no longer exists.

Broad Lens on Outcomes

While funders and agencies often consign organizations and particular curricula to certain program areas – such as school readiness, child abuse and neglect prevention, or behavioral health – providers recognize that their services often benefit families more broadly and can help address a wide range of the needs of infants and young children. For example, a prenatal home visiting program that encourages healthy pregnancy may also be teaching a family how to “baby proof” their home or manage a crying/fussy child, helping to mitigate abuse and neglect. Put another way, the lines between providers who are working directly with families are not as bright as the ones that funders create to determine which programs to support. Administrators also spoke of the need to measure outcomes related to the range of behaviors and circumstances they help families address (e.g. low birthweight, educational attainment of parents, connection to primary care, etc.). There are also opportunities to encourage existing programs to focus on maternal health and wellness and preventing maternal mortality – a few providers are focused intensely on

supporting those who give birth and many programs include as well as pre- and perinatal behavioral health screenings, which could be expanded.

Policy Opportunities and the Shifting Funding Landscape

At the federal and state level, public agencies and the funding they dedicate to home visiting has an enormous influence on organizations' approach to home visiting, including what curricula they use and which counties are the focus for service delivery. Recent shifts in the policy and funding landscape have affected the programs being delivered in the St. Louis region, which some fear may result in a disruption in services for families.

Policymakers have an opportunity to ensure that changes to the home visiting landscape do not have a negative impact on families and that they are coordinating with organizations that are implementing the services on the ground throughout the state.

Parents Have a Need for In-Home Mental and Behavior Health Services

Participants – moms who had given birth, in particular – were open about their struggles with postpartum anxiety and depression, as well as other mental health challenges that they sought help for while they were participating in home visiting programs. While the experience of struggling with mental health and mental illness was near universal, participants reported wildly different experiences with getting the help they needed. Some participants report being asked questions about their mental health during each visit. Others reported having to advocate strongly for themselves in order to receive support, making the case that they could not raise their babies well if they themselves were not well. Participants reported receiving in-home counseling only to have those services stop abruptly, without explanation from the agency. Overall, participants expressed a need for these services to be more readily available.

Evidence-Based Practice vs. Practice-Based Evidence

Researchers in child trauma and child abuse and neglect point out that the delineations some stakeholders make between home visiting curricula and approaches are somewhat arbitrary. Regardless of whether we characterize a program as a "school readiness" curriculum or a "child abuse and neglect prevention" approach, they are in many ways accomplishing many of the same outcomes for families. An initiative in Kansas City instead focuses on the outcomes they want to achieve for each family, examines the data that the organizations collect for their programs, and uses what they have actually achieved to determine the effectiveness of the approach.

HOME VISITING IN THE US: A REVIEW OF THE LITERATURE

The importance of early intervention for young children, to help them (and their parents) address the challenges of living healthy, stable, and productive lives, has been recognized in the U.S. since the late 19th century. The first public kindergarten in the U.S. was established in St. Louis in 1872. Shortly thereafter, kindergartens grew in popularity and became a regular feature of the public school system (Shonkoff & Meisels, p. 4). The concept of home visiting began during a similar time period when visitors, often associated with religious organizations, were sent to the homes of those in poverty to help address children's health and development by working with their parents (American Academy of Pediatrics, p. 1). These efforts were informed by the popular philosophy that children entered the world as *tabula rasa*, or "blank slates," and needed assistance to soak up as many benefits as they could while their brains and bodies were still in formation (Shonkoff & Meisels, p. 4).

Both approaches (early childhood education and home-based assistance) developed incrementally, applying new knowledge and types of assistance, into the 20th century. During the 1960s, as part of the War on Poverty, the use of home visitors became a valued strategy for addressing children's health and development. Now, nearly 60 years later, the importance of early intervention is supported by increasingly sophisticated research into brain development, which shows that the first few years of a child's life are a "particularly sensitive period in the process of development, laying a foundation in childhood and beyond for cognitive functioning; behavioral, social, and self-regulatory capacities; and physical health" (RAND, 2005).

The Center on the Developing Child at Harvard University has summarized the research that makes the case for early intervention:

- Neural circuits, which create the foundation for learning, behavior and health, are most flexible or "plastic" during the first three years of life.
- Persistent "toxic" stress, such as extreme poverty, abuse and neglect, or severe maternal depression, can damage the developing brain, leading to lifelong problems in learning, behavior, and physical and mental health.
- The brain is strengthened by positive early experiences, especially stable relationships with caring and responsive adults, safe and supportive environments, and appropriate nutrition.
- Early social/emotional development and physical health provide the foundation upon which cognitive and language skills develop.
- High quality, early intervention services can change a child's developmental trajectory and improve outcomes for children, families and communities.
- Intervention is likely to be more effective and less costly when it is provided earlier in life rather than later¹.

¹ Quoted in "The Importance of Early Intervention for Infants and Toddlers," distributed by the National Early Childhood Technical Assistance Center (NECTAC). Published in 2011, it can be accessed at: <http://www.nectac.org/~pdfs/pubs/importanceofearlyintervention.pdf>

Today, home visiting is an approach used across multiple disciplines for both prevention and intervention. Trained workers, either professionals or paraprofessionals, typically provide services, information, education, and access to other services/resources while overcoming some of the barriers families face in going to agencies, clinics or other institutions for assistance.

A primary driver of the use of home visiting programs at the local, state, and national levels is the growing body of research on its effectiveness, as well as the increase in the number of evidence-based models identified by the U.S. Department of Health and Human Services (HHS). The American Academy of Pediatrics published a thorough review of outcomes achieved by home visiting in the article “Effectiveness of Home Visiting in Improving Child Health and Reducing Child Maltreatment” (Avellar & Supplee, 2013²). The table below shows their findings by outcome categories, along with specific outcomes, and the models that both measured and showed significant results in those areas.

Outcome Category	Specific Outcome Types	Associated Models ³
Child Health	Birth outcomes (low birth weight, premature birth)	Healthy Families America (HFA), Nurse Family Partnership (NFP) when paraprofessionals were used
	Breastfeeding	NFP
	Health care coverage or use, immunizations, well-child visits	Early Intervention Program for Adolescent Mothers (EIP), Early Start, HFA, NFP, Parents As Teachers (PAT), Oklahoma’s Community-Based Family Resources and Support (CBFRS)
Child Development	Cognitive development (includes language development)	Child FIRST, Early Head Start (EHS), HFA, NFP, Home Instruction for Parents of Preschool Youngsters (HIPPY)
	Social development, attachment, alleviation of problem behaviors	Child FIRST, EHS, Early Start, Family Check-Up, HFA, NFP, HIPPY, PAT, PALS for Infants
Child Maltreatment	Treatment for injuries or poison, parenting behaviors, involvement with Child Protective Services	Child FIRST, Early Start, EHS, HFA, NFP

² Available at: http://pediatrics.aappublications.org/content/132/Supplement_2/S90

³ Each model was evaluated through randomized, controlled trials and are listed with HHS as meeting the standards for evidence-based programs. Information on individual models is available at: <https://homvee.acf.hhs.gov>

In addition, five evidence-based models (not specified in the article) demonstrated positive outcomes related to family health care usage, including a reduction in emergency department visits and hospitalizations. Outcomes related to maternal health were not addressed.

As a result of their review, the report's authors note that home visiting "shows promise as a way to work with families who may be difficult to engage in supportive services. The rigorous research to date has indicated that home visiting has the potential to yield positive results for high-risk families." But they also note that most programs have more outcomes (than those shown in the preceding table) for which there is **no discernible effect** than outcomes **with** favorable effects. Thus, although home visiting can be very effective, it is not a "magic bullet" in the achievement of positive, sustainable impacts on the lives of children and families.

Another research review (Peacock et al., 2013⁴), this one with the purpose of examining the effectiveness of paraprofessional home visitors on family outcomes, came to a similar conclusion. In examining 21 studies that utilized randomized, controlled trials, the authors (like the authors of the American Academy of Pediatrics report) conclude that "home visitation by paraprofessionals is an intervention that holds promise for socially high-risk families with young children." They also note that home visiting programs have difficulties to overcome, including the challenges of gaining trust with families who can benefit the most from their services. They note that target families may view home visitors as intrusive, or they may not feel inclined to open their homes to those they do not know (at least at the outset of services). Another major hurdle, they write, is achieving consistency in program delivery. The review's summary states:

This review highlights that home visiting program effectiveness is greatest when: (a) a higher dose of the intervention over a longer period of time is used; (b) mothers are approached prenatally; (c) paraprofessionals are trained adequately to meet the needs of the families they are serving; and (d) the program's focus is on a particular issue rather than trying to remedy multiple problems. This review addresses the need to assess in detail what is the most beneficial dose of a home visiting intervention in order to produce intended outcomes.

The Environmental Scan that begins on page 28 summarizes programs and initiatives from various parts of the U.S., along with information on funding sources, other resources, and strategies for effectiveness.

⁴ Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3546846/>

HOME VISITING ASSESSMENT SURVEY RESULTS

Ten different home visiting providers responded to an online survey by providing information on their target populations, program purposes, services provided and other information. The programs that responded are:

Provider	Program Mission/Purposes
Family Forward: PathBuilders	PathBuilders provides mental health and wraparound services to address family stressors related to safety, parenting, shelter, unemployment, advocacy, connections to community resources, and building social networks.
Good Shepherd Children & Family Services	Good Shepherd provides case management, counseling, and parenting education to pregnant and postpartum women, as well as families with children ages 0 to 3.
Great Circle Healthy Families St. Louis	Great Circle's Healthy Families St. Louis serves teen mothers and young mothers up to age 30 with the primary purposes of reducing child maltreatment, improving parent-child interactions, increasing school readiness, and promoting access to primary medical and other community services.
Nurses for Newborns	Nurses for Newborns provides a safety net for families most at risk in order to prevent infant mortality and child abuse and neglect by providing in-home nursing visits, which promote health care, education, and positive parenting skills.
Lutheran Family and Children's Services	The primary goals of Lutheran Family and Children's Services' home visiting program are to provide parent education, prevent child abuse and neglect, and provide alternatives to abortion.
Parents as Teachers (PAT) ¹	Parents as Teachers promotes the optimal early development, learning and health of young children by supporting and engaging their parents and caregivers.
Raising St. Louis	The primary purpose of Raising St. Louis is to provide preventive care through home visitation, community health coordination,

	and father engagement to address social determinants of health while reducing the infant mortality rate within highly impacted areas.
St. Louis County Department of Public Health	The St. Louis County Department of Public Health regularly assesses the health and environment of the county and responds with sound policies and services that help assure the availability of high quality public health services for everyone.
St. Louis Crisis Nursery	St. Louis Crisis Nursery prevents child abuse while “saving babies’ lives, keeping kids safe, and building strong families.”
YWCA Metro St. Louis Head Start/Early Head Start ²	The goal of the YWCA of Metro St. Louis Head Start/Early Head Start program is to ensure that children, from birth through 5 years of age, are provided with a research-based, quality curriculum and teaching that will prepare them for future school success.

Areas Served

All 10 of the responding organizations provide services to families in both St. Louis City and County. While the St. Louis County Department of Public Health focuses on County residents, it also provides home visiting to City residents who use County health clinics³.

Nine of the 10 respondents provided the 4 or 5 top ZIP codes served (as determined by percentages of the families they serve that live in those areas)⁴. The table below shows their responses for St. Louis City and County, in order of prevalence.

ZIP Code (St. Louis City/County Only)	No. of Programs Reporting the ZIP Code is in Their Top 4-5 Served
63136	8
63112	3
63115	3
63121	3
63104	2
63106	2
63107	2
63111	1

63114	1
63116	1
63118	1
63120	1
63123	1
63130	1
63135	1
63137	1
63138	1

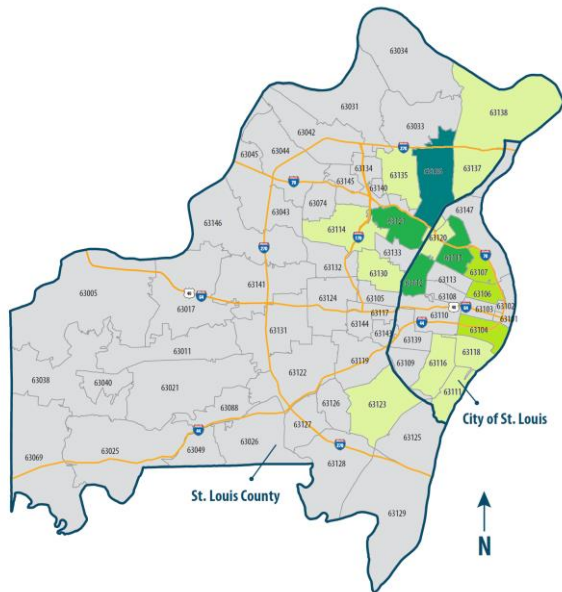


Figure 1: Number of programs reporting each ZIP code that is in their top 5 served.

Data provided by PAT included the ZIP codes they serve across St. Louis City and St. Louis County that included 63136, 63112 (families served by the Normandy School District), 63121, 63123, 63130, 63137, and 63138 (all of which are also shown in the table above).

Each program provider also provided the number of clients they serve in their top 5 ZIP codes (Figure 2).

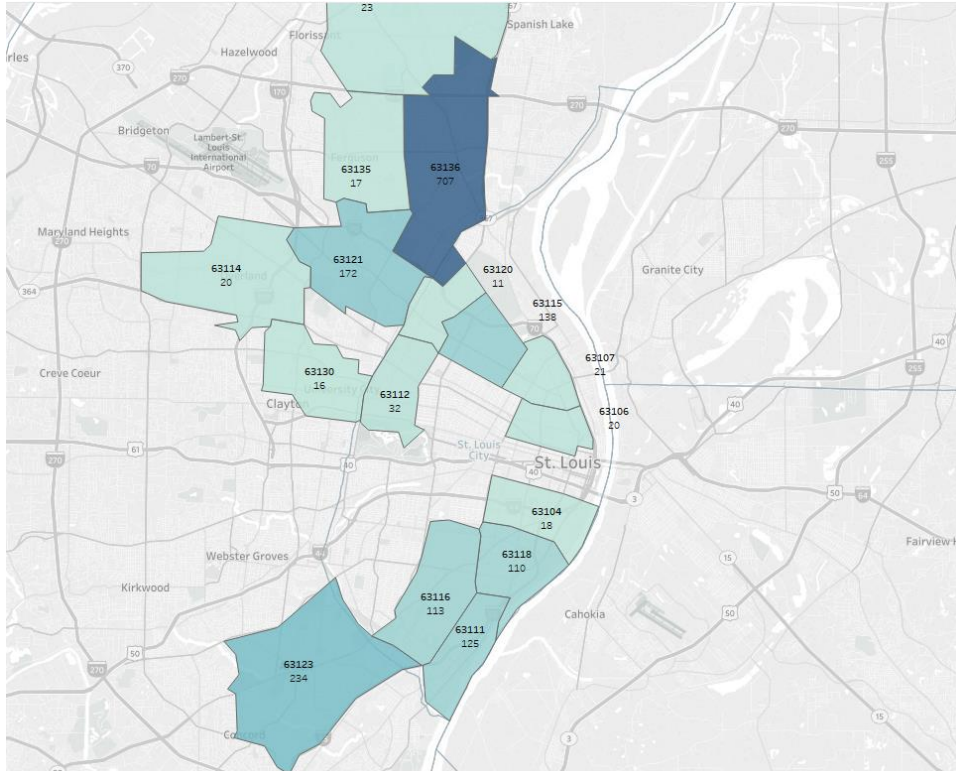


Figure 2: Number of clients in responding providers' top 5 ZIP codes.

Previous work done by Generate Health determined ZIP codes that are highly impacted by risk factors for infant mortality, such as low birthweight, lack of prenatal care and pre-term birth. Eight programs were able to report the number of clients they served in the ZIP codes most impacted by these risk factors.

High Impact ZIP Codes	Program 1	Program 2	Program 3	Program 4	Program 5	Program 6	Program 7	Program 8	Subtotal
63104	3	10	1	1	13	--	--	--	28
63107	3	21	3	2	-- ⁵	--	--	--	29
63113	8	17	4	3	--	--	--	--	32
63115	4	24	1	9	--	--	8	105	151
63118	4	6	7	4	--	118	--	--	139
63120	15	12	1	5	--	--	--	--	33
63147	2	4	2	0	--	--	--	--	8

The following map demonstrates the number of clients served in a “high impact” ZIP code as a percentage of the total number of children ages 0-5 in that ZIP code (note: a darker shaded ZIP code demonstrates more penetration in that area, or a higher percentage of children in the area served through home visiting programs that participated in the survey).

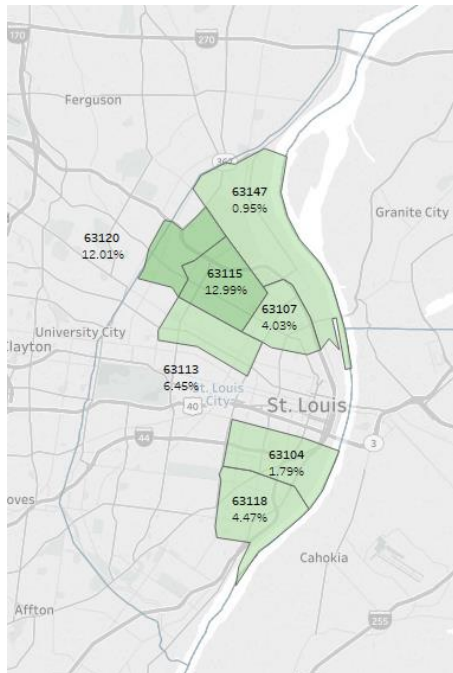


Figure 3: Number of children served in “high impact” ZIP codes as compared to the total number of children under five in the ZIP code.

Appendix 1 contains a version of Figure 1 in greater detail and a figure that details how these ZIP codes overlap with “high impact” ZIP codes, respectively. The latter suggests that there could be a misalignment of where resources are targeted and where the need for home visiting services is greatest.

Families and Individuals Served⁶

Programs reported serving from 140 to 8,315 families⁷ each. When the number of families served across the 10 programs is summed together, the total is more than 16,600 families⁸. This number is likely to include duplications.

Types of families and individuals served by the 10 programs are shown in the next table. All responding programs served pregnant and postpartum women, fathers, teen moms, and children from infancy through 2 years.

Target Group	No. of Programs Serving This Group
Pregnant Women	10
Postpartum Women	10
Fathers	10
Teen Moms	10
Infants	10
Children ages 6 months – 1 year	10
Children ages 1 – 2 years	10
Children ages 2 – 3 years	9
Children ages 3 – 5 years	6
Children older than 5 years	3

Socioeconomic Characteristics of Families Served

Most programs (8 of 10) primarily serve families that either qualify for Medicaid or for free/reduced-price school lunches, with 87%-100% of families served falling in this low-income category.

Five of the 10 programs reported that 80% or more of their families were families of color (typically African-American/Black but also including small percentages of Hispanic/Latina families). Four programs reported that 57%-72% of their families were families of color. One program reported a percentage of families of color below 50% and the final program did not have a breakdown of racial/ethnic characteristics available.

Services Provided by Home Visitors

Programs provide an array of services to the families they reach. All programs reported providing behavioral health screening/assessment; referrals for behavioral health, health, and developmental delays, and parent education.

Type of Service	No. of Programs Providing This Service
Behavioral health screening/assessment	9
Behavioral health monitoring	6
Referrals to behavioral health services	10 ⁹
Health care screening/assessment	5

Health care monitoring	4
Referrals to health services	10
Assistance in accessing prenatal care	2
Child developmental screening	8
Child development monitoring and education	7
Referrals for developmental delays	10
Parent education	10
Peer/social support	7
Case management	9
Referrals for basic needs	8
Direct assistance with basic needs	2

Credentials of Home Visitors

Six of the 10 programs indicated a minimum requirement for their home visiting staff of a Bachelor's degree. Other required credentials are shown below.

Minimum Required Credential	No. of Programs Requiring the Credential ¹⁰
Bachelor's degree	6
Master's degree	1
Associate's degree	1
No minimum credential required	1

Primary Sources of Funding, Trends in Demand and Trends in Funding

Many of the programs that provided information on funding sources (seven of 10) indicated they receive city/county funding for home visiting services while six receive state/federal funding. Two organizations used organizational funds from their operating budgets while one wholly funded their home visiting program through their institution's budget. One program indicated it receives reimbursements from Medicaid (data not shown). Most programs use funding from multiple sources.

Funding Source	No. of Programs Receiving this Type of Funding
State/federal grants and contracts	6
City/county grants and contracts ¹¹	7
Grants from private foundations	4
Funded through organizational/institutional operating budget	3

Responses related to trends in home visiting service demand/requests for services and funding are shown below.

	Increased	Decreased	Stayed About the Same
Over the past 2-3 years, have the demands/ requests for home visiting services increased, decreased or stayed about the same?	5	--	4 ¹²
Over the past 2-3 years, has your funding for home visiting services increased, decreased or stayed about the same?	3	3	3 ¹³

This data suggests that, although demand for home visiting services is increasing for half the programs represented in the assessment, funding levels are not keeping pace with this growth.

HOME VISITING IN THE US: AN ENVIRONMENTAL SCAN OF NATIONAL, STATE AND LOCAL PROGRAMS, PRACTICES, AND RESOURCES

For more than two decades, home visiting has been recognized as an effective service delivery method for families in need. In 1999, researchers estimated that more than half a million families participated in six major programs alone, with thousands of home visit providers in existence across the country.⁵ In Missouri, approximately 370 agencies statewide provide home visiting services utilizing evidence-based models, including Early Head Start, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers⁶.

According to the Nurse Home Visiting Resource Center⁷, the following positive impacts are associated with evidence-based home visiting models⁸.

Healthier Babies

- Pregnant home visiting recipients are more likely to access prenatal care and carry their babies to term.
- Home visiting promotes infant caregiving practices, like breastfeeding, which has been associated with positive long-term outcomes related to cognitive development and child health.

Healthier Moms

- Some studies have noted that nurse-provided home visiting can help prevent maternal mortality⁹ and result in fewer subsequent pregnancies, longer intervals between births, and longer relationships with current partners¹⁰.
- Therapeutic interventions linked to home visiting can help improve mothers' behavioral health, with fewer and less severe depressive symptoms, decreased anxiety, and improved coping with stress¹¹.

Safer Homes and Nurturing Relationships

- Home visitors teach parents how to “baby proof” their homes to prevent accidents leading to emergency room visits, disabilities or even death.

⁵ https://www.jstor.org/stable/3696493?seq=1#page_scan_tab_contents

⁶ <http://kidswinmissouri.org/2018/02/12/home-visiting/>

⁷ The National Home Visiting Resource Center is led by James Bell Associates in partnership with the Urban Institute with support from the Heising-Simons Foundation and the Robert Wood Johnson Foundation.

⁸ <https://www.nhvrc.org/discover-home-visiting/why-home-visiting/>

⁹ See the two-decades-long randomized, controlled study of a home visiting program in Memphis, Tennessee available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4235164/>

¹⁰ <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.615.3955&rep=rep1&type=pdf>

¹¹ See the information on the Moving Beyond Depression program later in this report. This program is offered to caregivers through the Every Child Succeeds initiative in Cincinnati, Ohio.

- Home visitors teach parents how to engage with their children in positive, nurturing ways, thus reducing child maltreatment.

More Optimal Early Learning and Long-Term Academic Achievement

- Home visitors help parents recognize the value of reading and other activities for early learning.
- Children experience improvements in early language and cognitive development, as well as academic achievements in grades 1 through 3.

More Self-Sufficient Parents

- Compared with their counterparts, parents enrolled in home visiting have higher monthly incomes, are more likely to be enrolled in school, and are more likely to be employed.

Studies have shown that investment in evidence-based home visiting models reduce public costs by anywhere from \$1.80 to \$5.70 for every dollar invested in home visiting programs¹².

¹² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3776454/>

EVIDENCE-BASED HOME VISITING MODELS

The U.S. Department of Health and Human Services (HHS) conducts thorough reviews of home visiting research through the HomVEE (Home Visiting Evidence of Effectiveness) assessment, which gathers and shares evidence of effectiveness for models that target families with young children from birth to kindergarten entry, as well as pregnant women¹³. As of June 2017, 20 home visiting models met rigorous HHS criteria for evidence of effectiveness, as determined by HomVEE. The programs listed in this assessment are eligible for replication through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant program. They include the following:

- Attachment and Biobehavioral Catch-Up (ABC)
- Child First
- Early Head Start Home-Based Option (EHS)
- Early Intervention Program for Adolescent Mothers
- Early Start (New Zealand)
- Family Check-Up (FCU)
- Family Connects
- Family Spirit
- Health Access Nurturing Development Services (HANDS)
- Healthy Beginnings
- Healthy Families America (HFA)
- HealthySteps
- Home Instruction for Parents of Preschool Youngsters (HIPPY)
- Maternal Early Childhood Sustained Home-Visiting (MECSH)
- Minding the Baby
- Nurse-Family Partnership (NFP)
- Oklahoma's Community-Based Family Resource and Support (CBFRS) Program
- Parents As Teachers (PAT)
- Play and Learning Strategies (PALS)
- SafeCare

For a short summary of information on 14 of these models, please see Appendix 1. What follows is a description of some of the most widely implemented evidence-based home

¹³ <https://homvee.acf.hhs.gov>

visiting models, which include those utilized by programs in the St. Louis area and across Missouri¹⁴ (paragraphs taken verbatim from HomVEE model descriptions).

Early Head Start (EHS)

Early Head Start (EHS) targets low-income pregnant women and families with children from birth through age 3, most of whom are at or below the federal poverty level or who are eligible for Part C services under the Individuals with Disabilities Education Act in their state. The program provides early, continuous, intensive, and comprehensive child development and family support services. EHS programs include home- or center-based services, a combination of home- and center-based programs, and family child care services (services provided in family child care homes). The focus of this report is on the home-based service option. EHS home-based services include weekly 90-minute home visits and two group socialization activities per month for parents and their children. Home visitors are required to have knowledge and experience in child development and early childhood education; principles of child health, safety, and nutrition; adult learning principles; and family dynamics. This report also includes a review of an infant mental health home-based services adaptation of EHS home-based services, IMH-HB EHS, which aims to help parents build stronger relationships with their infants and toddlers, foster healthy family functioning, and support the emotional health of both parent and child¹⁵.

Healthy Families America (HFA)

Healthy Families America (HFA) goals include reducing child maltreatment, improving parent-child interactions and children's social-emotional well-being, and promoting children's school readiness. Local HFA sites select the target population they plan to serve and offer hour-long home visits at least weekly until children are 6 months old, with the possibility for less frequent visits thereafter. Visits begin prenatally or within the first three months after a child's birth and continue until children are between 3 and 5 years old. In addition, many HFA sites offer parent support groups and father involvement programs. Sites can also develop activities to meet the needs of their specific communities and target populations¹⁶.

Parents as Teachers (PAT)

The goal of the Parents as Teachers (PAT) program is to provide parents with child development knowledge and parenting support, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness. The PAT model includes one-on-one home visits, monthly group meetings,

¹⁴ <https://health.mo.gov/living/families/homevisiting/>

¹⁵ <https://homvee.acf.hhs.gov/Model/1/Early-Head-Start-Home-Visiting--EHS-HV-/8/1>

¹⁶ <https://homvee.acf.hhs.gov/Model/1/Healthy-Families-America--HFA--sup---sup-/10/1>

developmental screenings, and linkages and connections for families to needed resources. Parent educators conduct the home visits using structured visit plans and guided planning tools. Local sites offer at least 12 hour-long home visits annually with more offered to higher-need families. PAT serves families for at least two years between pregnancy and kindergarten. PAT affiliate programs select the target population they plan to serve and the program duration¹⁷. Parents as Teacher was founded in St. Louis and its national center remains in the region.

Nurse Family Partnership

The Nurse-Family Partnership (NFP) is designed for first-time, low-income mothers and their children. It includes one-on-one home visits by a trained public health registered nurse to participating clients. The visits begin early in the woman's pregnancy (with program enrollment no later than the 28th week of gestation) and conclude when the woman's child turns 2 years old. NFP is designed to improve (1) prenatal health and outcomes, (2) child health and development, and (3) families' economic self-sufficiency and/or maternal life course development¹⁸.

The HomVEE database also includes programs that have been submitted for review, do not meet the criteria for inclusion on the list of evidence-based programs, but are otherwise considered promising or innovative approaches. This includes Nurses for Newborns, a home visiting program that was developed and is being replicated in the St. Louis region.

¹⁷ <https://homvee.acf.hhs.gov/Model/1/Parents-as-Teachers--PAT--sup---sup-/16/1>

¹⁸ <https://homvee.acf.hhs.gov/Model/1/Nurse-Family-Partnership--NFP--sup---sup-/14/1>

LOCAL HOME VISITING PROGRAMS AND INITIATIVES

A number of home visiting approaches are being used within organizations that serve St. Louis City and County. The information in this section is taken from two primary sources: information provided by program staff on Home Visiting Assessment Surveys and information available on program websites.

FamilyForward/Nurturing Families PathBuilders and Home Visiting Services with the Missouri Mentoring Partnership and St. Louis Volunteer Resource Parents

PathBuilders provides mental health and wraparound services to address family stressors related to safety, parenting, shelter, and unemployment while providing advocacy and connections to community resources and social networks. The program helps families develop internal and external skills/resources to address crises and work toward stability over an 18- to 24-month period.

- The goals of the home visiting program include improving parenting knowledge and skills to prevent/reduce instances of child abuse and neglect.
- Home visiting services are provided under a contract with Lutheran Family and Children's Services, serving St. Louis City and County and St. Charles. PathBuilders services are offered to residents of St. Louis County only (with funding from the County Children's Service Fund) and are focused, in part, on Spanish Lake, Ferguson-Florissant, Jennings, and other North County ZIP codes.
- The programs serve the following: Pregnant women, postpartum women, infants, children 6 months to 5 years, older children, teen moms, and fathers.

Youth and families served are "at risk" for child abuse/neglect, with some families having children in the custody of the Department of Social Services with active plans for reunification.

- Number of families served: approximately 140 per year.
- Services provided during home visiting: Behavioral health screening/assessments, behavioral health monitoring and education, referrals to health and behavioral health services, child development screening/assessments, child development monitoring and education, parent education, referrals to programs/services addressing developmental delays, peer support/social support, case management, referrals for services/resources related to basic needs (food/nutrition, housing, education/training, employment, public assistance, etc.). Programs also provide budgeting and money management services.

Good Shepherd Children and Family Services

According to its website, Good Shepherd Children and Family Services “connects children with families and keeps families connected”¹. The organization is a member of the Catholic Charities federation of agencies within the Archdiocese of St. Louis.

- The primary purposes of the home visiting program is to provide case management, counseling, and parenting education to pregnant and postpartum women and families with children up to age 3.
- Good Shepherd’s home visiting services are provided to families in St. Louis City and County and in St. Charles and Jefferson Counties.
- The program serves the following: Pregnant women, postpartum women, infants, children 6 months to 3 years, teen moms, and fathers.
- Number of families served: approximately 200 per year.
- Services provided during home visiting: Behavioral health screening/assessments, referrals to health and behavioral health services, parent education, referrals to programs/services addressing developmental delays, case management, and referrals for services/resources related to basic needs (food/nutrition, housing, education/training, employment, public assistance, etc.). They also provide direct support for basic needs, including diapers and baby/toddler supplies, with limited financial assistance for rent, utilities, and transportation.

Great Circle’s Healthy Families Program

Great Circle’s Healthy Families program serves teen mothers and young mothers up to age 30 in the greater St Louis metro area and includes: 1) screenings and assessments to identify families at risk for child maltreatment or other adverse childhood experiences; 2) home visiting services; 3) routine screening for child development, and 4) routine screening for maternal depression. In addition, Great Circle offers monthly parent support groups that include education and opportunities for social support.

- The primary goals of the program are to reduce child maltreatment, improve parent-child interactions, increase school readiness, promote child health and development, promote positive parenting, self-sufficiency, and access to primary medical services and community services.
- Healthy Families serves all of St. Louis City and County with a focus on the following zip codes: 63106, 63107, 63113, 63104, 63115, 63118, 63121, 63133, 63136, 63138, 63139.
- The program serves the following: Pregnant women, postpartum women, infants, children 6 months to 5 years, teen moms, and fathers (if they are involved with the mothers being served).

In accordance with the Healthy Families America model, parents are enrolled prenatally or within 3 months after the child’s birth. Other demographic characteristic may also apply to the parents, including: 1) eligibility for public assistance (WIC, Food Stamps, TANF, Medicaid,

etc.); 2) household incomes under 185% of the federally defined poverty line; 3) those who are unemployed, under-employed (working less than 40 hours per week), and/or participating in an education or job training program, and 4) living in shelters or temporary housing.

- Number of families served: approximately 100 per year.
- Services provided during home visiting: Health care screening/assessments, health care monitoring and education, behavioral health screening/assessments, behavioral health monitoring and education, referrals for prenatal care and other health services, referrals to behavioral health services, child development screening/assessments, child development monitoring and education, parent education, referrals to programs/services addressing developmental delays, peer support/social support, case management, referrals for services/resources related to basic needs (food/nutrition, housing, education/training, employment, public assistance, etc.).

Lutheran Family and Children's Services of Missouri

Lutheran Family and Children's Services (LFCS) provides a variety of services to the St. Louis area, extending across Missouri with services in Cape Girardeau, Columbia, Springfield, and Franklin County. LFCS's current programs include counseling, adoption services, crisis/unplanned pregnancy assistance, foster care, child care, youth mentoring services, and advocacy on behalf of children and families.

- The primary goals of LFCS's home visiting services are to provide parent education, prevent child abuse and neglect, and provide alternatives to abortion.
- Home visiting services are available in St. Louis City and County, as well as Jefferson and Franklin Counties.
- Their program serves the following: Pregnant women, postpartum women, infants, children 6 months to 3 years, teen moms, and fathers.

Families served have incomes below the federal poverty level and are "at risk" of child abuse/neglect.

- Number of families served: approximately 280 per year.
- Services provided through home visiting: Referrals to health and behavioral health services, child development screening/assessments, child development monitoring and education, parent education, referrals to programs/services addressing developmental delays, case management, and referrals for services/resources related to basic needs (food/nutrition, housing, education/training, employment, public assistance, etc.).

Nurses for Newborns

Nurses for Newborns (NFN) provides a safety net for families most at risk in order to prevent infant mortality and child abuse/neglect by providing in-home nursing visits that promote health care, education, and positive parenting skills. According to its website, the NFN home visitation model was named a "Promising Approach"² in Missouri in 2012 and Tennessee (their second location is based in Nashville, Tennessee) in 2013³.

- As mentioned above, the primary goals of the program are to prevent infant mortality and child abuse and neglect.
- Nurses for Newborns serves all of St. Louis City and County. Their services also extend to 12 additional Missouri counties (Jefferson, Warren, Lincoln, St. Charles, Franklin, St. Francois, Wayne, Butler, Carter, Shannon, Reynolds, and Iron).
- The program serves the following: Pregnant women, postpartum women, infants, children 6 months to 2 years, teen moms, and fathers.

In addition, while the pregnant mother or infant is at the center of home visiting services, staff also address multiple social determinants of health, including family beyond the pregnant mother or immediate caregiver. Thus, home visitors may also address issues for older children, grandparents or other family members who live in the home.

- Number of families served: approximately 2,500 per year.
- Services provided during home visiting: Health care screening/assessments, health care monitoring and education, behavioral health screening/assessments, behavioral health monitoring and education, referrals to health and behavioral health services, child development screening/assessments, child development monitoring and education, parent education, referrals to programs/services addressing developmental delays, peer support/social support, case management, referrals for services/resources related to basic needs (food/nutrition, housing, education/training, employment, public assistance, etc.).

Parents as Teachers

Founded in Missouri in 1984, Parents as Teachers (PAT) is an evidence-based, international program that serves more than 195,000 children in the U.S. and abroad. The program provides parent education through personal visits and group meetings. Its mission includes "equipping parents with knowledge and resources to prepare their children, from prenatal through kindergarten, for a stronger start in life and greater success in school"⁴. Originally focused on home visits, PAT programs now operate in a variety of settings, including, not only schools, but also hospitals, faith-based organizations and housing communities.

- As mentioned above, the primary goal of the program is school readiness for young children.
- PAT serves families in school districts across St. Louis City and County and beyond.

- Parents as Teachers serves the following: Pregnant women, postpartum women, infants, children 6 months to 5 years, and teen moms.
- Number of families served: approximately 8,315 families in St. Louis County and 226 families in St. Louis City per year.
- Services provided during home visiting: Health care screening/assessments, health care monitoring and education, behavioral health screening/assessments, behavioral health monitoring and education, referrals to health and behavioral health services, child development screening/assessments, child development monitoring and education, parent education, referrals to programs/services addressing developmental delays.

Raising St. Louis

According to its website, "Raising St. Louis connects with mothers, fathers, and other family members to help build and sustain the family unit, reduce the high infant mortality rate, promote literacy, and increase access to health care"⁵. This community outreach program of St. Louis Children's Hospital provides services through PAT-certified parent educators and Nurses for Newborns.

- The primary purposes of Raising St. Louis's home visiting services are to provide preventive care through home visitation, community health coordinators, and father engagement programs to address social determinants of health and reduce infant mortality in high impact areas.
- Raising St. Louis serves 21 targeted zip codes in St. Louis City and County.
- The program serves the following: Pregnant women, postpartum women, infants, children 6 months to 5 years, teen moms, and fathers.

As mentioned above, services are available in highly impacted zip code areas where families lack access to preventive care and face barriers related to the social determinants of health.

- Number of families served: 200 to 400 per year.
- Services provided during home visiting: Behavioral health screening/assessments, behavioral health monitoring and education, prenatal care, referrals to other health and behavioral health services, child development screening/assessments, child development monitoring and education, parent education, referrals to programs/services addressing developmental delays, peer support/social support, case management, and referrals for services/resources related to basic needs (food/nutrition, housing, education/training, employment, public assistance, etc.). Families are also able to access other services provided by St. Louis Children's Hospital.

Saint Louis County Department of Public Health

According to its website, the Saint Louis County Public Health Home Visiting Program through the Nurse Family Partnership provides: 1) professional nursing consultation and

intervention for women with high-risk pregnancies and infants; 2) holistic in-home nursing assessment and education to promote health and wellness, and 3) case management and coordination of client care through a multidisciplinary approach⁶.

- As mentioned above, the primary goal of the program is to support the health and wellness of mothers and infants.
- While the program primarily serves families in St. Louis County, home visiting services also reach families in St. Louis City and Jefferson and St. Charles counties if they are clients of the County health clinic.
- The program serves the following: Pregnant women, postpartum women, infants, children 6 months to 5 years, older children, teen moms, and fathers.
- Number of families served: approximately 160 per year.
- Services provided during home visiting: Health care screening/assessments, health care monitoring and education, behavioral health screening/assessments, referrals to health and behavioral health services, child development screening/assessments, parent education, referrals to programs/services addressing developmental delays, peer support/social support, case management, referrals for services/resources related to basic needs (food/nutrition, housing, education/training, employment, public assistance, etc.). The program also provides environmental assessments.

Saint Louis Crisis Nursery

According to its website, the Saint Louis Crisis Nursery is “committed to the prevention of child abuse and neglect and provides emergency intervention, respite care and support to families in crisis through: 1) short-term care for young children in a safe and nurturing environment; 2) helping families resolve crises; 3) offering resources for empowerment, ongoing support and parent education; 4) community outreach and awareness, and 5) advocacy for children and families.”

- The primary goals of the program are to prevent infant mortality by assuring the safety of children and building strong families.
- Saint Louis Crisis Nursery serves “the entire St. Louis Metropolitan Area.”
- The program serves the following: Pregnant women, postpartum women, infants, children 6 months to 5 years, older children, teen moms, and fathers.
- Number of families served: approximately 2,200 per year.
- Services provided during home visiting: Behavioral health screening/assessments, behavioral health monitoring and education, referrals to health services, referrals to behavioral health services, child development screening/assessments, child development monitoring and education, parent education, referrals to programs/services addressing developmental delays, peer support/social support, and case management. They also provide direct basic needs support.

YWCA Metro St. Louis Head Start

The YWCA of Metro Head Start program “provide[s] a research-based, quality curriculum and teaching” to children from birth to age 5” utilizing the federal Head Start model. Features of the program include “a rich overall learning environment, intentional instructional practices to meet individual needs of each child based on developmentally appropriate assessments, meaningful interactions . . . and family engagement [that includes] comprehensive services ensuring parents are a partner in their children’s learning and are able to advocate for their children’s learning and development”⁷.

- The primary goal of the Head Start/Early Head Start program is to prepare young children for future success in school.
- The YWCA of Metro St. Louis Head Start/Early Head Start program serves the following zip codes in St. Louis City and County: 63031, 63106, 63107, 63108, 63110, 63112, 63115, 63116, 63118, 63119, 63120, 63121, 63123, and 63136.
- The program serves the following: Pregnant women, postpartum women, infants, children 6 months to 5 years, teen moms, and fathers.
- Number of families served: approximately 2,100 per year.
- Services provided during home visiting: Health care screening/assessments, health care monitoring and education, behavioral health screening/assessments, prenatal care, referrals to health and behavioral health services, child development screening/assessments, child development monitoring and education, parent education, referrals to programs/services addressing developmental delays, peer support/social support, case management, referrals for services/resources related to basic needs (food/nutrition, housing, education/training, employment, public assistance, etc.).

PROGRAMS AND INITIATIVES IN OTHER REGIONS

Many successful home visiting programs and initiatives exist across the country – these range from single, evidence-based interventions to regionwide coordinated efforts that deliver a number of programs to eligible families. A number of these successful efforts are described below.

Every Child Succeeds (Cincinnati, Ohio)

Every Child Succeeds (ECS) is an independent organization, founded in 1999, by three organizations – Cincinnati Children’s Hospital Medical Center, Cincinnati-Hamilton County Community Action Agency and the United Way of Greater Cincinnati – with the mission of “ensuring an optimal start for children by promoting positive parenting and healthy child development prenatally and during the important first 1,000 days of life”¹⁹. In partnership with nine health and human service providers, ECS delivers in-home services to low-income families with children utilizing four national home visiting models: Early Head Start, Healthy Families America, Health Access Nurturing Development Services (HANDS) and SafeCare^{20,21}.

Serving three counties in Ohio and four in Kentucky, ECS has a staff of approximately 20 people (social workers, Early Head Start home visitors and community health workers in addition to coordinators, researchers and administrators) and partners with parenting centers, educational service centers, behavioral health services and community service agencies (for a list of these agencies, see Appendix 2). In Ohio, ECS is part of the statewide Help Me Grow initiative²².

ECS home visitors provide the following services:

- Support for parents and babies/young children in reaching developmental milestones.
- Promoting safe and supportive home environments.
- Providing up-to-date information on parental and child health.
- Screening mothers for behavioral health concerns.
- Encouraging parental engagement and promoting children’s school readiness.
- Linking families to needed community resources, with an emphasis on the important role of communities in helping parents raise healthy and thriving children²³.

¹⁹ <https://www.cincinnatichildrens.org/service/e/ecs>

²⁰ http://www.movingbeyonddepression.org/?page_id=2363

²¹ See Appendix 3 for descriptions of HANDS and SafeCare

²² See Appendix 4 for information on Ohio’s Help Me Grow

²³ <https://www.everychildsucceeds.org/programs/>

Another important service feature is the **Moving Beyond Depression™** (MBD) program, which gives mothers who screen positive for depression the treatment they need to take care of both themselves and their babies/young children. Developed by ECS and researchers at the Cincinnati Children's Hospital Medical Center, MBD provides In-Home Cognitive Behavioral Therapy to mothers and is the only evidence-based treatment program designed specifically for mothers in home visitation programs²⁴. For more information on this program and its outcomes, please see Appendix 5.

In addition to staff and partners, ECS is supported by an eight-person Executive Committee that includes the presidents and CEOs of the founding organizations (the Cincinnati Children's Hospital Medical Center, the United Way of Greater Cincinnati, and the Cincinnati-Hamilton County Community Action Agency) along with business people, community volunteers, and an Assistant Chief Nursing Officer) and a 22-member Board of Directors (including business leaders, community volunteers, additional representatives of the Cincinnati Children's Hospital Medical Center, leaders of other non-profits, a pastor, a home visitor, and a "graduate" of ECS).

Since 1999, ECS has served more than 26,000 families through more than 600,000 home visits. According to a brief available from the Association of Maternal and Child Health Programs on best practices and program innovation²⁵, outcomes of ECS include a "demonstrated reduction in infant mortality" for the children served.

In a study published in *Pediatrics* in 2007 using ECS participants and data, the authors reported a 60% reduction in the infant mortality rate for participants, compared to matched controls. A review of participant data collected from 2003-2008, showed encouraging long-term results. Findings include:

- Of children who were delayed at 3 or 9 months, over 72% are on track by 27 months, or after approximately two years of home visitation.
- Over 83% of children initially behind in language are also on track at 27 months.
- Of those parents who displayed high-risk parenting attitudes and beliefs at 2 months, 43%-63% move into the average to low-risk range by 18 months.
- Across seven measurements, the great majority of home environments are in the low-risk range at 18 months.
- Of high-risk homes at 3 months, 78%-95% move into the average to low-risk range by 18 months.

²⁴ http://www.movingbeyonddepression.org/?page_id=2363

²⁵ http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/ISDocs/Every-Child-Succeeds_2015.pdf

This same brief notes that ECS uses “a business model in a social service world [which] has resulted in programming cost-effectiveness,” allowing ECS to achieve its results at an approximate cost of \$2,600 per family per year. The brief also identified challenges of program implementation, which included the following:

...external forces from funders and political entities that sometimes both added to the overall burden of the data collection and practice objectives or steered the organization in directions that were not fully consistent with its aims. ECS leadership and staff have had to be especially vigilant to resist these efforts through education and rigorous data collection, which documents the outcomes of the home visiting intervention and demonstrates the problems associated with drift.

For additional information, please refer to the brief itself at:

http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/ISDocs/Every-Child-Succeeds_2015.pdf.

Promise 1000 (Kansas City, Missouri)

Promise 1000, an initiative of the United Way of Greater Kansas City, Children’s Mercy Hospital, and the Health Care Foundation of Greater Kansas City, connects families to 15 partnering agencies that provide in-home support. The initiative, modelled after Every Child Succeeds in Cincinnati²⁶, serves expectant parents or those with a young child (up through the age of 3 or 5, depending on the provider) across 15 counties (nine in Missouri and six in Kansas). Along with connecting families to needed community services/resources, home visitors provide coaching and education to help caregivers support the health and well-being of their children.

Partnering agencies implement a variety of models, including Healthy Families America (the Child Abuse Prevention Association, Children’s Mercy Hospital, Cornerstones of Care, Kansas Children’s Service League, and Douglas County/Wyandotte County Departments of Health), the Nurturing Parenting Program (Easter Seals Midwest), Early Head Start (The Family Conservancy and Project Eagle), Parents as Teachers (school districts unspecified), Nurse Family Partnership (agencies unspecified) and others²⁷.

Even though a variety of service models are used, all programs offered by Promise 1000 partners provide screening, case management, family support, links to community resources, and caregiver skills training to address health, behavioral health, and developmental needs while strengthening emotional bonds between parents and their children.

²⁶ http://www.unitedwaygkc.org/sites/default/files/Flyer_Promise1000.pdf

²⁷ <https://www.promise1000.org>

Initiative components include centralized intake, referral and data collection; professional development for providers; continuous quality improvement; links to medical homes, and a research-based treatment program for maternal depression. The goals of Promise 1000 include:

- Improved maternal and newborn health.
- Reduced incidence of child maltreatment and intimate partner violence.
- Increased school readiness.
- Improved economic self-reliance and safety of participating families²⁸.

As stated on the website of the United Way of Greater Kansas City, "Promise 1000 strives to strengthen an entire system of home visiting, improving outcomes for vulnerable children and families across the Kansas City region²⁹."

Hawaii Home Visiting Network

The Hawaii Home Visiting Network (HHVN) developed a cross-sector collaboration among social service agencies, mental health providers, and hospitals utilizing an Early Identification (EID) program to screen and enroll families into services based on the Healthy Families America (HFA) service model. HHVN partners (including Catholic Charities, Child and Family Service agencies, and the YWCA) used a variety of strategies to reach out to pregnant women, as well as to engage with families in birthing hospitals. Early outreach efforts included participation in community fairs and events, building relationships with community health centers, and door-to-door neighborhood contacts (among other direct efforts). Pregnant women and families were screened using a 15-point screening tool to determine eligibility according to federal funding (MIECHV) and initiative-specific guidelines. Screening personnel also linked families to other community resources for additional support, including for those who opted out of home visiting. Overall, EID services were located in five different hospitals on the various islands of the state.

While partners delivered services, HHVN as a whole developed and sustained collaborative relationships with other service providers and community entities throughout the state to support the health of mothers and babies across a variety of systems. This collaboration included the state Executive Office of Early Learning, which supports a comprehensive state childhood system consisting of public and private partnerships focusing on the health and well-being of families with children. In cooperation with the state Early Childhood Educational System, HHVN sought to assist in the implementation of a standardized approach to children's developmental assessments during children's progression from the home, through preschool, pre-kindergarten, and kindergarten.

Additionally, the HHVN collaborated with Family-Centered Medical Homes (FCMHs) by working with families to develop effective, supportive relationships with children's

²⁸ http://www.unitedwaygkc.org/sites/default/files/Flyer_Promise1000.pdf

²⁹ See Note 21

pediatricians that included collaborative practices for sharing information to help families engaged in multiple service systems. One of the aims of the HHVN was to make sure that enrolled children received all their immunizations on a timely basis and that parents/guardians followed through with their young ones' well child visits. Home visitors worked collaboratively with pediatricians' offices to monitor and support families in receiving these services.

Home visitors also administered the Ages and Stages Questionnaire (ASQ) to participating children, helping parents to identify and articulate concerns they may have about their children's development. If screenings showed potential delays, families were referred to appropriate services. In addition, the HHVN offered training and technical assistance with the Executive Office of Early Learning and the Early Childhood Educational System to continue the administration of the ASQ to establish consistency in the assessment of children's development across the state.

As home visitors monitored ASQ results and other benchmarks (e.g. the frequency of emergency room visits by caregivers and children, and their insurance status to help reduce the number of unnecessary ER visits and connect all families to health insurance), the HHVN collaborated with the state chapter of the American Academy of Pediatrics to determine the best methods for communicating and building relationships between physicians and home visitors, so the latter could address any challenges to establishing FCMHs for each family. Health care providers were encouraged to support prenatal families in choosing home visiting services during their time in hospitals following the births of their infants³⁰.

Strong Beginnings (Grand Rapids, Michigan)

According to its website, "Strong Beginnings is a federal Healthy Start program created in 2004 to improve the health and well-being of African American and Latino women, men, and their babies, from pregnancy through early childhood. Strong Beginnings seeks to promote racial equity and eliminate disparities in birth outcomes between Whites and people of color in Kent County."

The initiative, which operates with fiduciary support from Spectrum Health (an integrated health system), involves a partnership of the Grand Rapids African American Health Institute, the County Health Department, Michigan State University, community clinics, the Spectrum Health Infant Health Program, and community behavioral health and early childhood education providers³¹.

Home visiting services are provided by community health workers (CHWs) who meet with families either in their homes or in other convenient locations, providing "social support, education and encouragement" throughout pregnancy and the first two years of a child's

³⁰ <https://www.ncbi.nlm.nih.gov/pubmed/24843840>

³¹ <https://www.strongbeginningskent.org/About-Us>

life. CHWs work collaboratively with nurses and social workers to help families access needed information and resources.

Serving/supporting fathers is an important component of Strong Beginnings. Men are paired with male CHWs, with special outreach to Latino men, as well as African Americans.

Behavioral health services are provided as needed through individual counseling and weekly support groups. Caregivers may also participate in a breastfeeding support group and a variety of additional parenting education programs. The Strong Fathers initiative offers weekly discussion groups for men along with father-child engagement activities.

Across the overall initiative, Strong Beginnings promotes racial equity and seeks to improve the overall system of care by addressing the social determinants of health and fostering access to transportation, housing and other services/resources³².

According to an initiative brief prepared by the W.K. Kellogg Foundation³³ (one of Strong Beginnings' funders), the program completed a quasi-experimental design evaluation of client outcomes in 2015:

The study showed Strong Beginnings' African-American-female clients significantly face more barriers than African-American women [who are also on Medicaid but not participating in the initiative] in Kent County including poverty and depression, but receive better prenatal care than their counterparts. Among its findings, 65 percent of Strong Beginnings clients receive first trimester prenatal care compared to 58 percent of Medicaid recipients. Additionally, Strong Beginnings clients receive more postpartum exams and well-child visits than Medicaid recipients.

Strong Beginnings staff also encourages new mothers to breastfeed, which helps protect infants from chronic and infectious disease. The organization offers a weekly breastfeeding support group and numerous parenting and education programs to the community at large. Of the women who participate in the program, 72% initiate breastfeeding and 33% breastfeed for six months or more.

The Pregnancy Medical Home Program (North Carolina)

Launched in 2011, the Pregnancy Medical Home (PMH) Program is made possible through a partnership between Community Care of North Carolina (CCNC, the largest and longest-running community-based medical home system in the U.S.³⁴) and the North Carolina

³² <https://www.strongbeginningskent.org/What-We-Do/Client-Services>

³³ <https://www.wkkf.org/what-we-do/featured-work/strong-beginnings-uses-holistic-approach-to-reduce-infant-mortality-among-communities-of-color>

³⁴ <https://www.communitycarenc.org/who-we-are>

Divisions of Medical Assistance and Public Health. The goals of the program, which now includes the majority of maternity care providers across the state (more than 350 practices and 1,600 individual providers), include improving the quality of maternity care, improving maternal and infant outcomes, and reducing health care costs. This includes supporting prenatal care providers in increasing access to care and improving outcomes for Medicaid recipients with a primary focus on the prevention of preterm births.

The CCNC provides home visiting services in all 100 North Carolina counties with physical clinics located in 16 counties³⁵. Affiliates have an OB team with one or more physicians and at least one nurse coordinator that recruits and supports local OB providers serving Medicaid recipients.

According to their website, the PMH program is an outcome-driven initiative monitored for specific performance indicators, such as the rate of low birth weight and the primary cesarean delivery rate. Participating providers receive:

- Financial incentives from Medicaid for risk screening and postpartum visit completion.
- Ongoing collaboration with a pregnancy care manager.
- Local CCNC network support.
- Data and analytics from CCNC's Informatics Center.
- Clinical guidance materials and resources.

In turn, practitioners agree to work toward quality improvement goals, such as eliminating elective deliveries before 39 weeks, using 17p [progesterone treatment] to prevent recurrent preterm birth, reducing primary c-section rates, improving the postpartum visit rate, and more³⁶.

A report published in the North Carolina Medical Journal noted that PMH's physician team identified the following pathways focused on medical management of specific conditions: hypertensive disorders, use of cervical length screening and progesterone therapy for preterm birth prevention, and induction of labor among women who have not previously experienced a live birth³⁷.

According to a program description of the North Carolina Medical Home on zerotothree.com, in 2012, the most recent fiscal year with publicly released evaluation data, more than 75% of all pregnant women who received Medicaid were screened for risk. Of these, 70% were determined to have high-risk pregnancies and were referred to a pregnancy care manager. Preliminary results from the Pregnancy Medical Home Program

³⁵ <https://www.communitycarenc.org/networks>

³⁶ <https://www.communitycarenc.org/what-we-do/clinical-programs/pregnancy-medical-home>

³⁷ <http://www.ncmedicaljournal.com/content/76/4/263.long>

indicate downward trends in the rates of low birth weight and primary cesarean delivery among Medicaid recipients³⁸.

Partners Advancing Childhood Education (Atlanta, Georgia)

Partners Advancing Childhood Education (PACE) is a school readiness initiative funded by the United Way of Greater Atlanta. The initiative provides technical assistance, coordination, and resources to 13 counties in Metropolitan Atlanta to address the early learning needs of young children through parent engagement and school transition support. The mission of PACE is that all children in Metropolitan Atlanta are prepared for and successful in kindergarten as a result of engaged families and strong community partnerships. PACE utilizes a program model developed through SPARK Georgia, a previous school readiness initiative, funded through the W.K. Kellogg Foundation. Through SPARK (Supporting Partnerships to Assure Ready Kids), the United Way developed “highly focused partnerships and strategies” that “resulted in increased parent participation and leadership in early education and schools; increased parental awareness of child developmental stages and improved parenting practices; and the creation of School Readiness Councils and KinderCamps to generate dialogue between childcare providers and elementary schools and to familiarize children and families with the transition to kindergarten.”

The United Way partners with schools, family services, and social service agencies in high-needs communities that function as Community Hubs. Personnel at these Hubs work with parents, community leaders, schools, early learning centers and various partners to implement three core strategies: home visitation, parent leadership, and school transition for children from birth through 3rd grade.

Home visitation services utilize the Parents as Teachers model to provide education and training to increase parents’ knowledge of child development, enhance their parenting skills, link families with resources and social networks, and conduct health and developmental screenings of children. Parent educators and Hub staff that have been trained on the PAT curriculum are responsible for conducting home visits, facilitating group meetings, and administering child development screenings.

Community Hubs receive funding to engage local stakeholders in developing countywide Early Learning Plans that include the implementation of PAT and the development of School Transition Teams made up of childcare providers, school staff, parents, and community partners. Hubs also work with parents to advocate for policy and system improvements that benefit children and families³⁹.

³⁸ <https://www.zerotothree.org/resources/866-north-carolina-pregnancy-medical-homes>

³⁹ <https://www.settingthepace.org/about>

Illinois MIECHV and the igrow Home Visiting Collaborative

With support from the federal Maternal, Infant, Early Childhood Home Visiting (MIECHV) program (received in 2013), the Illinois Department of Human Services, the Illinois Head Start Collaboration Office, and the State Board of Education, Illinois supports a network of more than 300 service providers that reach approximately 17,000 families per year⁴⁰. In addition, the Illinois MIECHV program funded 32 sites to “provide vital support for the early childhood infrastructure,” expand evidence-based models, and strengthen services carried out under the state’s Title V Maternal and Child Health Program. The program supported the following outcomes:

- Improvements in maternal and child health.
- The prevention of child injuries and maltreatment.
- The reduction of emergency room visits.
- Improvements in school readiness and achievement.
- Reductions in crime and domestic violence.
- Improvements in family economic self-sufficiency.
- Improvements in the coordination and referral processes that link families to other community resources and supports⁴¹.

Additional features of the program include a centralized intake system and medical home care coordination with services utilizing Early Head Start (Home Based), Healthy Families America, Parents as Teachers, and Nurse Family Partnership models. The infrastructure for the Illinois program includes the Home Visiting Task Force, a standing committee of Illinois’ Early Learning Council. The Task Force includes approximately 200 members representing state agencies and private sector health, early childhood and child welfare organizations, along with researchers and advocates. The Task Force serves as a strategic advisory group and works with the Governor’s Office to strengthen the quality and coordination of home visiting services across funding streams and relevant departments.

According to an evaluation of the funded sites, the Illinois MIECHV program supported the following outcomes:

- Parents in the program demonstrate significant improvement in their abilities to support their children’s social, emotional and cognitive growth during the first six months of life.
- Children are more likely to be up to date on their immunizations, to have had a developmental screening, and to be read to on a regular basis.
- Mothers are more likely to initiate and maintain the breast feeding of their infants.

⁴⁰ <https://www2.illinois.gov/sites/OECD/Pages/MIECHVP.aspx>

⁴¹ <http://illinoisaaap.org/home-visiting/>

Another notable feature of the igrow Home Visiting Network is the availability of training for all home visitors in the state that utilize the Health Families America, Parents Too Soon, and Parents as Teachers evidence-based models. The Ounce of Prevention Fund⁴² supports and operates birth-to-five programs in the city of Chicago while providing home visitor training to personnel across the state. Other professional development opportunities available to Illinois home visitors include the following:

- Futures Without Violence, providing intimate partner violence and child abuse prevention training and education.
- Gateways to Opportunity, a statewide support system that provides guidance, encouragement, and recognition to individuals and programs serving children, youth, and families.
- Illinois Coalition Against Domestic Violence.
- Illinois Resource Center, which provides support to teachers and school administrators serving linguistically and culturally diverse students.
- Mothers and Babies, a program of Northwestern University that promotes mental well-being and supports parent-child bonding.
- Prevent Child Abuse Illinois.
- STARnet Northwest Region and Central Region III, which provides development opportunities for personnel who work with children (ages birth through 8) with an emphasis on children with special needs.
- Strengthening Families Illinois, a statewide initiative to build protective factors in vulnerable families.
- Department of Children and Family Services online training program⁴³.

⁴² The Ounce of Prevention Fund is a multi-faceted organization dedicated to “ensur[ing] that all American children, particularly those born into poverty, have quality early childhood experiences in the crucial first five years of life.” The “Ounce” uses private funding to develop innovative intervention programs that apply scientific evidence about children’s early brain development, then leverages public funding to support their implementation and replication. In addition to operating birth-to-five programs in Chicago and supporting the statewide network of home visiting programs, the organization provides training and technical assistance for doulas and the early childhood workforce, funds and conducts research into early childhood education, and advocates for child/family-friendly public policy, strong service infrastructures, and adequate funding for high quality programs (see <https://www.theounce.org/who-we-are/>).

⁴³ <http://igrowillinois.org/programs/>

MEETING THE CHALLENGES OF HOME VISITING SERVICE PROVISION

Typical challenges of home visiting programs include:

1. Securing/developing the skilled workforce needed to develop trust with families while also having the experience needed to address complex needs.
2. Recruiting families who could benefit from home visiting but opt out of services due to mistrust or a lack of information.
3. Sustaining the participation of families in high-stress situations long enough for home visiting to support meaningful positive outcomes.

These challenges are addressed below.

Home Visitor Education and Credentials

As the Home Visiting Yearbook notes, home visitors and supervisors comprise a skilled workforce with specialized knowledge of topics, such as maternal and child health and interpersonal skills for serving diverse families. Some home visiting models require registered nurses or social workers as home visitors, with at least a bachelor's degree, while others employ paraprofessionals. Minimum hiring requirements for home visitor education vary across models. Minding the Baby requires home visitors to have a master's degree, while Parents as Teachers requires a high school diploma or GED and two years of early childhood experience.

Many states have taken proactive steps to professionalize the home visiting workforce, including the following in 2015:

- Alabama, Iowa, Oregon, Pennsylvania, Rhode Island, and West Virginia are some of the states that have developed core competencies that define knowledge and skill expectations for home visitors.
 - The development of Oregon's core competencies was spearheaded by the Oregon Public Health Division with funding from the Health Resource Services Administration (HRSA). A Core Competencies Workgroup reviewed evidence-based and best practices and then defined the competencies based on research from the National Center on Child Care Professional Development Systems and Workforce Initiatives Center (PDW Center) and the Workgroup Summary Report on Core Competencies for the Prenatal through Age Three Field from Zero to Three⁴⁴.

⁴⁴ <https://oregonearlylearning.com/wp-content/uploads/2017/02/APPENDIX-B-HomeVisitingCoreCompetencies.pdf>

- Pennsylvania's Core Competencies were developed under the leadership of the state's Office of Child Development and Early Learning, the Department of Education, and the Department of Human Services⁴⁵.
- Washington, DC, partnered with the Georgetown University Center for Child and Human Development to create a learning community offering in-person training, online modules, and an active email list for sharing information⁴⁶. The Ounce of Prevention Fund in Chicago has also developed a comprehensive home visitor training program that is utilized by the State of Illinois' home visiting providers and is also available online⁴⁷.

Marketing and Recruitment

Another barrier to reaching families who could benefit from home visiting is recruitment, or the reluctance of some to enroll in services when given the opportunity. A number of sources note that the way home visiting is presented to families can make a big difference in their willingness to participate. In an Issues Brief released in October of 2015, the Pew Charitable Trusts noted the following:

The field of early childhood home visiting has two primary audiences with which it must communicate effectively in order to be successful in improving outcomes for vulnerable children and families. The first includes those who are essentially responsible for regulating and funding programs: policymakers and voters. Home visiting advocates and practitioners must be able to communicate the value of their services to this audience to ensure sustainable program funding and political support. The second audience consists of the families that are invited to enroll in programs. Because home visiting is voluntary, families that do not clearly understand how they would benefit from participation are more likely to decline.

In recognizing the importance of effective communication, Pew Charitable Trusts spearheaded an extensive project to develop language that would most successfully communicate to each audience an explanation of home visiting services and providers, achievements, and the types of families that can benefit. Pew's research included broadly based surveys of policymakers, voters, home visitors, and mothers who were eligible for or had participated in home visiting. Through these surveys, along with results from personal interviews and focus groups, Pew was able to identify the distinctive language that worked best with each audience about home visiting programs, as well as areas of overlap. As their website notes: Most significantly, the research found that both voters and prospective

⁴⁵ <http://www.pakeys.org/wp-content/uploads/2018/01/PHVC-Competencies-Book-final9-1-15.pdf>

⁴⁶ https://www.nhvrc.org/wp-content/uploads/NHVRC_Yearbook_2017_Final.pdf#page=22

⁴⁷ <https://www.theounce.org/what-we-do/professional-development/>

participants respond negatively to the widely used name for these services: “home visiting.” Concepts such as “family support and coaching” were much better received.

Researchers found that voters were most receptive to:

- An emphasis on training of service providers and on local implementation of the programs.
- A description of those receiving services as “vulnerable” and “motivated parents who want to do well by their children.”
- A focus on increased participant self-sufficiency; this outcome was the most popular with voters across the political spectrum.

Prospective participating mothers were most receptive to:

- Messages focused on their personal needs, such as career goals, stress reduction, and referrals to services (e.g., child care).
- The idea of working with a “family support provider” rather than a “home visitor” or a “nurse.”
- Programs that demonstrate flexibility and an understanding that each family is unique.

Prospective participating mothers who were unlikely to participate said they:

- Worried about being negatively judged, with some concerned that such judgment might affect custody of their children.
- Were uneasy about strangers coming to their homes.
- Already had the kind of support they needed in their lives.

After examining the study findings in detail, Pew offered the following recommendations to help advocates and service providers improve their outreach to key audiences and more effectively communicate the value of their services for children, families and taxpayers:

- For all audiences, change the name of the services from “home visiting” to “family support and coaching” and refer to the people who deliver services as “family support providers” rather than “home visitors.”
- Focus on different outcomes, depending on the audience:
 - For policymakers and voters, stress increased family self-sufficiency.
 - For prospective participating mothers, emphasize help with setting career and educational goals, reducing stress, accessing services, and obtaining referrals for services, such as affordable day care or reduced-price car seats.

Ongoing Engagement of Families

Another one of the challenges of delivering effective home visiting services is enrolling families and keeping them engaged for an appropriate period of time. As noted by a “Call to

Action” issued in 2013 by the Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN⁴⁸), the “effectiveness of home visiting interventions depends on families receiving a sufficient number of visits. There are gaps between what we know and what we do-between the number of families we know could benefit from home visits and those who actually enroll and persist in services.” This need to do a better job engaging and sustaining the participation of families in home visiting gave way to the HV CoIIN, which engaged home visiting programs across the country in a learning community that shared best practices and new, intentional ways of intensifying early engagement practices that “strengthen relationships between the home visitor and family, and empower the family as partners – supporting retention beyond three months.” Across the 3-4 years of HV CoIIN participation, agencies made progress in providing the needed number of home visits (as specified by special service models) to 76% of families served, with 33% of referred households receiving their first face-to-face visits within 14 days of referral. Eighty-five percent of families were retained for three months while 72% were still receiving surveys at six months⁴⁹.

⁴⁸ From 2013 to 2016, the Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN), was the first national initiative using the Institute for Healthcare Improvement’s Breakthrough Series Model in an effort to improve outcomes for families. HV CoIIN “brought together teams from local home visiting service agencies across 11 states, and one non-profit grantee to seek collaborative learning, rapid testing for improvement, sharing of best practices and building of Quality Improvement capacity.”

⁴⁹ See <http://hv-coiin.edc.org/sites/hv-coiin.edc.org/files/FE%20CHARTER%20Y4%20Scale%20Up%202017.pdf>

CENTRALIZED SERVICES AND COORDINATED INTAKE

In efforts to better coordinate home visiting across program/initiative services, centralized or coordinated intake systems have been found to be a “promising practice” by the federal Health Resources and Services Administration (HRSA). According to several sources⁵⁰, at least nine states (Ohio, Illinois, California, Georgia, Iowa, Kansas, New Jersey, New Mexico, Wisconsin) have adopted central intake processes to accomplish objectives like the following:

- Provide a single point of entry for families requesting/needing services.
- Enable family access to a range of support services available from participating providers.
- Encourage uniformity across programs (in terms of screening processes and service protocols).
- Reduce duplication in paperwork/information gathering from participants.
- Streamline recruitment, enrollment, service provision, and follow up.
- Promote collaboration among providers.

However, barriers still exist among home visiting providers when it comes to full participation in a coordinated, collaborative system. According to a report from the state of Iowa, the following are “cautions” of central intake:

- When funding is tied directly to the number of families served by individual providers, giving up control of program referrals is difficult; trust is essential.
- Trust and buy-in from all system stakeholders takes time to develop. Ongoing meetings and other effective forms of communication are necessary.
- Central intake requires a strong organization with positive stakeholder relationships to lead and coordinate the process.
- Developing a common consent/release of information that all programs can use is challenging and time-consuming.

The need to develop trusting and open relationships is a primary challenge to developing effective central intake systems. Participating providers must be focused on identifying family needs and matching families to the programs that best address their particular situations, even when it means “giving up turf” to others. The Iowa report further recommends that all participating service providers:

- Meet regularly.
- Remain honest, openly discussing concerns and problems as they occur.

⁵⁰ See, for example, <https://www.mdrc.org/centralized-intake-innovation-field> and state home visiting reports for 2016 available through HRSA (the Health Resources and Services Administration).

- Remain open-minded and committed to moving forward.
- Maintain the ability to see the bigger picture of how the system benefits the entire community, even if some decisions may not benefit their programs directly.
- Maintain support from all organizational levels, from managers to the personnel making home visits⁵¹.

⁵¹http://www.state.ia.us/earlychildhood/files/state_system/quality_services_programs/central_intake.pdf

FUNDING SOURCES

Most home visiting programs/initiatives utilize braided sources of funding from federal and state sources to support the services they provide to families.

Federal Sources

From 1985 to 2008, the primary federal source of home visiting funding was distributed via the Healthy Start Programs, but program funding was severely reduced due to economic concerns at the federal level. States were left without significant levels of federal support until 2010 when the Affordable Care Act authorized the Maternal, Infant, and Early Childhood Home (MIECHV) program to (1) strengthen and improve the programs and activities carried out under Title V of the Social Security Act; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. The program (which was reauthorized for five years as part of the Bipartisan Budget Act of 2018) is intended to promote evidence-based home visiting practices, with state innovation and flexibility in implementing programs. MIECHV requires that 75% of grant funds be used to support the implementation of evidence-based practices with rigorously evaluated results and well-documented evidence of success. States can invest up to 25% of grant funds to implement and rigorously evaluate promising and new approaches or significant innovations with the goal of continuing to build the research base for effective home visiting and leading to more types of effective programs, especially for previously underserved groups for which no or few evidence-based models exist.

Key features of MIECHV include the following⁵²:

- The targeting of vulnerable families with very young children residing in at-risk areas. Targeted families include those at risk for negative child outcomes, pregnant adolescents from underserved minority groups, and families at risk for maltreatment, among others.
- The requirement that grantees demonstrate improvement among eligible families participating in the program in six benchmark areas:
 1. Improved maternal and newborn health.
 2. Prevention of child injuries, child abuse, neglect or maltreatment, and reduction of emergency department visits.
 3. Improvement in school readiness.
 4. Reduction in crime or domestic violence.
 5. Improvements in family economic security.

⁵² <https://www.cbpp.org/research/effective-evidence-based-home-visiting-programs-in-every-state-at-risk-if-congress-does-not>

6. Improved coordination and referrals for other community resources and support.
- Requirement that grantees increase coordination of services in at-risk communities and promote greater intra-agency collaboration. In their MIECHV plans, states must demonstrate how they will achieve greater coordination and develop benchmarks for measuring their progress.

Another federal funding source for home visiting is the Title V (of the Social Security Act) Maternal Child Health Block Grant program. Title V support is targeted toward improving the health and well-being of mothers and children, including children with special needs, and their families. Through federal and state partnerships, Title V grants fund the following:

- Access to quality health care for mothers and children, especially for people with low incomes and/or limited availability of care.
- Health promotion efforts that seek to reduce infant mortality and the incidence of preventable diseases, and to increase the number of children appropriately immunized against disease.
- Access to comprehensive prenatal and postnatal care for women, especially low-income and/or at-risk pregnant women.
- An increase in health assessments and follow-up diagnostic and treatment services, especially for low-income children.
- Access to preventive and child care services, as well as rehabilitative services for children in need of specialized medical services.
- Family-centered, community-based systems of coordinated care for children with special health care needs.
- Toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

According to the HRSA's Maternal and Child health website, maternal and child health agencies, which are usually located within a state health department, apply annually for Title V funding. States are required to submit Annual Reports and complete a statewide, comprehensive needs assessment every five years⁵³.

In addition to MIECHV and Title V funding, states may also seek federal dollars through Medicaid and Temporary Assistance for Needy Families (TANF). The Michigan Home Visiting Initiative identified the following possibilities for accessing Medicaid and TANF funds:

Medicaid Billable Services

- Services provided by home visitors are potentially reimbursable by Medicaid, including the completion of health assessments. Other services that could

⁵³ <https://mchb.hrsa.gov/maternal-child-health-initiatives/title-v-maternal-and-child-health-services-block-grant-program>

potentially be billed to Medicaid can be identified in cooperation with the state Medicaid office.

Medicaid Health Plans

- Managed care plans providing health care coverage and services to Medicaid beneficiaries have the option to provide home visiting services directly or to contract with providers to offer services. All of Minnesota's managed care plans have agreed to cover the costs of home visiting services. They elected not to provide those services directly, but rather have contracted with local health departments to provide home visiting services. Each plan negotiates contracts individually with local health departments in its service area. Further, some managed care plans offer financial incentives for clients receiving services.

Temporary Assistance for Needy Families (TANF)

- While TANF primarily provides cash assistance to families in poverty, federal law permits the funding of other benefits and services to low-income families with children and/or other activities that support program goals of reducing out-of-wedlock pregnancies and promoting two-parent families.
- The purpose of TANF is to increase state flexibility in meeting the following program goals:
 1. Provide assistance, so that needy families with children can live in their own home or with relatives.
 2. End dependency of needy parents on governmental benefits through work, job preparation and marriage.
 3. Reduce the incidence of out-of-wedlock pregnancies.
 4. Promote the formation and support of two-parent families. States can use TANF in ways that achieve any of these goals. Washington state, through its Thrive by Five initiative, is an example of a program that used TANF funding to expand evidence-based home visiting⁵⁴.

⁵⁴https://www.michigan.gov/documents/homevisiting/HV_Potential_Financing_Strategies_July_2015_496192_7.pdf

Funding for Home Visiting in Missouri

In the state of Missouri, home visiting services are funded through three separate agencies: the Missouri Department of Health and Senior Services, the Missouri Department of Social Services, and the Department of Elementary and Secondary Education.

Missouri Department of Health and Senior Services (DHSS)

- Missouri DHSS contracts with local agencies that provide voluntary early childhood home visiting services, supporting families' abilities to help young children grow up healthy, safe, and ready to learn, and eventually become successful adults.
- Funding for the program is provided through the federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program Grant (first received in 2010) and the Title V Maternal and Child Health Services Block Grant (MCH) utilizing four evidence-based, nationally known models: Early Head Start Home Based Option, Healthy Families America, Nurse Family Partnership, and Parents as Teachers.
- In order to access the MIECHV grant, DHSS was required to conduct a statewide Needs Assessment that identified the top 10 counties (shown below) most in need based on indicators related to infant health, poverty, child maltreatment, substance use, crime, and unemployment (among others)[1]. The five most at-risk counties respectively, receiving funding for home visiting through the MIECHV grant program and the models implemented are shown in the table below[2].

MIECHV	
County Served	Home Visiting Model(s)
Pemiscot County	Early Head Start Home-Based Option Nurse Family Partnership
Dunklin County	Early Head Start Home-Based Option Nurse Family Partnership Parents as Teachers
Butler County	Early Head Start Home-Based Option
Ripley County	Early Head Start Home-Based Option
St. Louis City	Parents as Teachers
The MIECHV Needs Assessment also identified the following five counties in order of need as: Mississippi, New Madrid, Washington, Crawford, and Scott counties. These counties are currently not funded for MIECHV supported home visiting.	

- Goals for MIECHV-funded home visiting include:
 1. Improvements in maternal and newborn health.

2. The reduction of child injuries, maltreatment, and reduction in emergency department visits.
 3. Improvements in school readiness and achievement.
 4. Reduction in crime or domestic violence.
 5. Improvements in family economic self-sufficiency.
 6. Improvements in coordination and referrals for other community resources and supports for families.
- Missouri DHSS applies these same goals to the MCH-funded home visiting. The models implemented and the counties contracted to be served with MCH funding are shown in the following table.

MCH	
Home Visiting Model	Counties Served
Healthy Families America	Boone, Greene, Maries, Phelps, Randolph
Nurse Family Partnership	Bollinger, Cape Girardeau, Cass, Clay, Jackson, Johnson, Lafayette, Mississippi, New Madrid, Perry, Platte, Ray, Scott, St. Louis, Ste. Genevieve, Stoddard

Missouri Department of Social Services (DSS)

- Missouri DSS-Children's Division: The Home Visiting Program of Missouri Children's Division within the Department of Social Services is an in-home service designed to assist with the prevention of child abuse and neglect by offering additional in-home support for at risk families. This is a voluntary program providing services to eligible parents whose family income does not exceed the federal poverty level, are currently pregnant, and/or have a child under the age of 3 years. The Home Visiting program provides parents with hands-on training and modeling of appropriate behaviors, educational support groups, developmentally appropriate books and toys for children, as well as various incentives for parents to keep them engaged in the program.
- The Home Visiting program is located in 11 regions across the state, spanning 57 counties, with 8 Partnership Agreements and 11 Competitive Contracts providing Home Visiting services. Contractors and Partnerships are required to serve 70% of Children's Division referred families; funding for the contracts comes from the state's general revenue.

Missouri Department of Elementary and Secondary Education (DESE)

- DESE funds the statewide implementation of Parents as Teachers, an evidence-based early childhood home visiting program. Trained parent educators screen children for delays and support families in positive parent-child interaction,

awareness and caregiver support of healthy child development, and overall family well-being. Targeted goals and outcomes include:

- Increased parent knowledge of early childhood development and improvement of parent practices.
- The prevention of child abuse and neglect.
- Early detection of developmental delays and health issues.
- Increased school readiness and success.
- Early establishment of positive partnerships between home and school.
- Programs are implemented through partnerships that include the DESE – Early Learning Section, the Parents as Teacher National Center, and local school districts, which also provide funding to implement the program for their families^[1]. DESE allocates funds to school districts in alignment with state-level priorities; “high needs” families with children ages prenatal to 3 are at the top of the list.

Funding Models in Other States

According to the National Home Visiting Resource Center, a number of states (other than Missouri) allocate money from their state general fund or use dedicated funds while seeking federal funding through Medicaid, TANF, and Title IV of the Social Security Act in addition to grants provided through the MIECHV program.

For instance, some states (other than Missouri) allocate money for home visiting from their state general fund or use dedicated funds, such as lottery proceeds, tobacco settlement dollars, tobacco taxes, and birth certificate fees. The National Conference of State Legislatures (NCSL) identified a number of state practices in securing home visiting funding. Highlights from four states are listed below:

- **Colorado:** In Colorado, most home visiting funding comes from the state’s Tobacco Master Settlement fund, a 25-year agreement through which major tobacco companies offset costs arising from health problems incurred by tobacco use. Colorado increased its use of dedicated funds to support home visiting by more than 60% between fiscal years 2015 and 2017, rising from \$14 million to \$23 million.
- **New Jersey:** New Jersey has invested nearly \$4.3 million in general funds to support home visiting in recent years. In terms of federal dollars, New Jersey allocates both TANF and Title IV-B (i.e., child welfare prevention) funding to support home visiting programs.
- **Oregon:** Oregon appropriated \$14 million in general funds for home visiting in fiscal year 2017, nearly double the \$7.6 million spent in fiscal year 2015. The state also allocates federal MIECHV, Medicaid, and Title IV funds, and received a grant from the

^[1] <https://dese.mo.gov/quality-schools/early-learning/parents-teachers>

Ford Foundation to provide training and technical assistance to enhance parent education delivered by home visitors.

- **Tennessee:** Tennessee's home visiting services are funded nearly evenly by state and federal funding sources. The state allocated about \$2.5 million from its general fund to support home visiting programs in fiscal years 2015, 2016, and 2017.

Private Funding Sources

States, local agencies, non-profit organizations, and research institutes also leverage private dollars to develop, implement, and expand home visiting services. Examples of organizations that support or have supported home visiting include the March of Dimes, and philanthropic partners, such as the Robert Wood Johnson Foundation, Heising-Simons Foundation, W. K. Kellogg Foundation, Richard W. Goldman Family Foundation, Pew Charitable Trusts, and others.

Local/regional United Ways also provide funding for home visiting initiatives in numerous communities/regions throughout the U.S., including the United Way of Greater Kansas City (which supports Promise 1000), the United Way of Greater Cincinnati (Every Child Succeeds), and the United Way of Greater Atlanta (PACE, the Partners Advancing Childhood Education program).

RESOURCES FOR ADDITIONAL INFORMATION ON HOME VISITING

National Home Visiting Resource Center⁵⁵ (NHVRC)

Maintained by James Bell Associates in partnership with the Urban Institute with funding from the Heising-Simons Foundation and the Robert Wood Johnson Foundation. The 2017 Home Visiting Yearbook collected by the NHVRC compiled key data on home visiting programs across the country (<https://www.nhvrc.org/yearbook/2017-home-visiting-yearbook/>). The NHVRC also disseminates home visiting research and evaluation information, briefs on new developments, summaries of evidence-based models, and lists of other home visiting resources.

Home Visiting Evidence of Effectiveness (HomVEE)

This project was launched in 2009 by the U.S. Department of Health and Human Services to conduct thorough and transparent reviews of the home visiting research literature. HomVEE provides an assessment of the evidence of effectiveness for home visiting models that target families with pregnant women and children from birth to kindergarten entry (that is, up through age 5). To carry out the HomVEE review, each year Mathematica Policy Research¹ conducts a thorough search of the research literature on home visiting. Mathematica also issues a call for studies to identify additional research, reviews the literature, assesses the quality of research studies, and evaluates the strength of evidence for specific home visiting models. The review for 2017 is available at: https://homvee.acf.hhs.gov/homvee_executive_summary_august_2017_final_508_compliant.pdf.

Pew Charitable Trusts' Home Visiting Project (which ended in 2015)

Developed to “promote cost-effective investments in high-quality, home-based family support and coaching programs for new and expectant families”⁵⁶. In addition to their work in identifying effective language for eliciting home visiting enrollment and the support of voters and policymakers (referred to earlier in this report), the project focused on the following:

- **Policy Advocacy at the State and Federal Levels:** The project provided technical assistance to state campaigns to advance policy change and increase state investments in home visiting. The project also advocated for data-driven federal policies and investments in the state home-based family support and coaching programs, with work to reauthorize the Maternal, Infant, and Early Childhood Home Visiting program.

⁵⁵ <https://www.nhvrc.org>

⁵⁶ <http://www.pewtrusts.org/en/projects/archived-projects/home-visiting-campaign>

- **A New Body of Home Visiting Research:** Pew commissioned research on the relationship between home visiting and gains in education, health and future. The studies explored the importance of program quality and target populations – and the interactions between them – in determining ultimate outcomes for children and families.
- **Information Sharing:** The project hosted webinars, events, meetings, and communications to facilitate a national conversation on the significance of home-based family support and coaching programs. In doing so, the project was an important resource for state policymakers and administrators making data-driven policy investments.

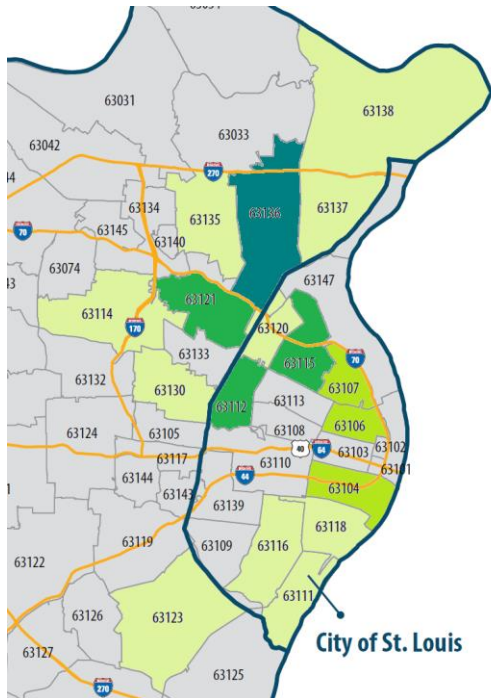
One of the project's products was the Home Visiting Data for Performance Initiative materials, which were designed to support states in collecting, analyzing and using data to improve practice and to provide a way for states to "document the impact of public investments in home visiting in a clear, consistent, and compelling manner." These materials include recommended process indicators, focused on the extent to which program participants make use of relevant services, like postpartum or well-child visits, and outcome indicators reflecting the well-being of mothers and children in areas, like breastfeeding, smoking cessation and educational attainment. More information is available at: <http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2015/05/using-data-to-measure-home-visiting-performance>.

Other resources listed in the 2017 Home Visiting Yearbook⁵⁷ include the following:

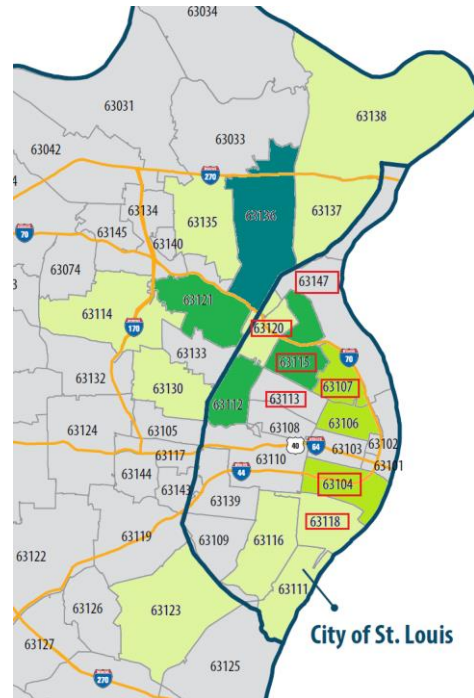
- **Home Visiting Applied Research Collaborative (HARC):** Defines and advances the national home visiting research agenda. Established in 2012 and supported by MIECHV funding, HARC uses their research to inform home visiting policy and practice.
- **Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN):** Connects select MIECHV grantees and local implementing agencies (LIAs) to pursue improvements in the field. The network is a cooperative effort between HRSA and Early Childhood Systems.
- **Home Visiting Coalition:** Works to promote continued federal support of home visiting to strengthen families in communities across the country.
- **Association of State and Tribal Home Visiting Initiatives:** A member-driven organization that helps states, territories and tribes effectively implement and improve home visiting programs. Members provide peer-to-peer support and communication to help each other learn from their experiences.

⁵⁷ <https://www.nhvrc.org/yearbook/2017-home-visiting-yearbook/>

1: Additional Maps



This map duplicates the data in Figure 1 (Number of programs reporting each ZIP code that is in their top 5 served), zooming in on the areas of St. Louis City and County where providers are working.



This map shows the same ZIP codes in providers' Top 5 above, and overlays the "high impact" ZIP codes mentioned on page 21, highlighted in red.

2. Target Population and Program Goals of Evidence-Based Models

Appendix

Target Population and Program Goals of Evidence-Based Models

Model	Target Population	Program Goals
Child FIRST	Pregnant women and families with children from birth to age 6.	The goal of the program is to decrease the incidence of emotional and behavioral disturbance, developmental and learning problems, and abuse and neglect among high-risk young children and their families.
Early Head Start-Home Visiting (EHS-HV)	Low-income pregnant women and families with children birth to age 3. Most families must be at or below the federal poverty level.	The program is a comprehensive, two-generation federal initiative aimed at enhancing the development of infants and toddlers while strengthening families.
Early Intervention Program for Adolescent Mothers	Pregnant adolescents (ages 14-19) from underserved minority groups who are referred to the county health department or another health services agency for nursing care.	The program is designed to help young mothers gain social competence and achieve program objectives by teaching self-management skills, techniques for coping with stress and depression, and skills to communicate effectively with partners, family, peers and social agencies.
Early Start (New Zealand)	The program targets at-risk families with newborn children up to age 5.	The program is designed to improve child health, reduce child abuse, improve parenting skills, support parental physical and mental health, encourage family economic well-being, and encourage stable, positive partner relationships.

Appendix

Target Population and Program Goals of Evidence-Based Models

Model	Target Population	Program Goals
Family Check-Up	Families (with children ages 2 to 17) with risk factors, including socioeconomic; family and child risk factors for child conduct problems; academic failure; depression; and risk for early substance use.	The program is designed as a preventative program model to help parents address typical challenges that arise with young children before these challenges become more serious or problematic.
Healthy Families America (HFA)	The program is designed for parents facing challenges (single parenthood; low income; childhood history of abuse; and adverse child experiences, for example). HFA requires that families be enrolled prenatally or at birth.	The program goals include reducing child maltreatment, increasing utilization of prenatal care, improving parent-child interactions, and promoting children's school readiness.
Healthy Steps	The program is designed for parents with children from birth to age 3.	The program is designed to support the physical, emotional and intellectual development of the child by enhancing the relationship between health care professionals and parents.
Home Instruction for Parents of Preschool Youngsters (HIPPY)	The program is designed for parents, with children ages 3 through 5, who have doubts about or lack confidence in their ability to instruct their children and prepare them for school.	HIPPY aims to promote preschoolers' school readiness and support parents as their children's first teacher by providing instruction in the home.

Appendix

Target Population and Program Goals of Evidence-Based Models

Model	Target Population	Program Goals
Maternal Early Childhood Sustained Home-Visiting Program (MECSH)	The program targets disadvantaged, pregnant women at risk of adverse maternal and/or child health and development outcomes.	The MECSH program is designed to enhance maternal and child outcomes by providing antepartum services in addition to the traditional postpartum care.
Nurse Family Partnership (NFP)	NFP is designed for first-time, low-income mothers and their children.	NFP is designed to improve (1) prenatal health and outcomes, (2) child health and development, and (3) families' economic self-sufficiency and/or maternal life course development.
Oklahoma's Community-Based Family Resource and Support (CBFRS) Program	Oklahoma's CBFRS program targets first-time mothers living in rural counties.	The CBFRS program, which targeted first-time mothers, was developed to improve maternal and child health and child development.
Parents as Teachers (PAT)	Eligibility criteria, selected by affiliates, might include children with special needs, families at risk for child abuse, and income-based criteria, among others. The model is designed to serve families throughout pregnancy through kindergarten entry.	The goal of the program is to provide parents with child development knowledge and parenting support, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness.

Appendix

Target Population and Program Goals of Evidence-Based Models

Model	Target Population	Program Goals
Play and Learning Strategies (PALS)	Families with children ages 5 months to 3 years.	The program is designed to strengthen parent-child bonding and stimulate children's early language, cognitive and social development.
Project 12-Ways/SafeCare	SafeCare is designed for families with a history of child maltreatment or risk factors for child maltreatment.	SafeCare aims to prevent and address factors associated with child abuse and neglect among the clients served.

Source: U.S. Department of Health and Human Services, Administration for Children & Families, "Home Visiting Evidence of Effectiveness," <http://homvee.acf.hhs.gov/>.

3. List of Partnering Agencies for Every Child Succeeds

- Beech Acres Parenting Center
- Brighton Center
- Butler County Educational Service Center
- Children Inc. (NKY)
- Greater Cincinnati Behavioral Health Services
- Pathways to Home
- Santa Maria Community Services
- St. Elizabeth (NKY)
- The Children's Home of Cincinnati

4. Descriptions of Program Models Utilized by Every Child Succeeds

SafeCare®

From the SafeCare website⁵⁸: SafeCare is an in-home parenting curriculum in which parents are taught how to interact in a positive manner with their children, recognize hazards in the home, and recognize and respond to symptoms of illness and injury. Certified SafeCare professionals provide in-home, module-based skills training targeting the areas of parent-child interaction, home safety, and child health. SafeCare is provided in weekly home visits that last up to 60 minutes, and the duration of the program is typically 15-20 weeks for each family. Each module includes a baseline assessment, intervention (training) sessions, and a follow-up assessment to monitor changes and progress in parenting skills over the course of the program. SafeCare was implemented by the Humboldt county Georgia Department of Health and Human Services (DHHS) in January 2013 [and now maintains a national training and research center for program replications across the U.S. and internationally at Georgia State University].

[Evaluation] research has shown that when SafeCare is presented with fidelity, expected results include:

- Increased children's safety.
- Improved parental knowledge of health treatment.
- Improved parent-child communication and problem-solving.
- Reduced physical abuse and neglect.

HANDS (Health Access Nurturing Development Services)

From the HomVee model descriptions of evidence-based home visiting models⁵⁹: HANDS is a voluntary home visiting program designed to prevent child maltreatment, improve family functioning, facilitate positive pregnancy and child health outcomes, and maximize child growth and development. The program targets first-time pregnant mothers or parents with children up to 3 months old, who have multiple challenges, such as single parenthood, low income, substance abuse problems, or being victims of abuse or domestic violence. A trained paraprofessional or professional home visitor, such as a social worker, conducts prenatal and postnatal home visits with parents; provides parenting information, problem-solving techniques, parenting skill development; and addresses basic needs. The level of services offered to families varies and is based on the needs of the family and the pace at which they progress through the program.

The HANDS program is administered by the Kentucky Department for Public Health (DPH) through local health departments and contracted sites. Within DPH there is a central office

⁵⁸ <https://safecare.publichealth.gsu.edu/files/2016/12/Humboldt-Co.-June-2016-Report.pdf>

⁵⁹ <https://homvee.acf.hhs.gov/Model/1/Health-Access-Nurturing-Development-Services--HANDS--Program-In-Brief/37>

team consisting of a program administrator, quality assurance coordinator, training coordinator, technical assistance coordinator, data coordinator, epidemiologist, Maternal, Infant and Early Childhood Home Visiting (MIECHV) grant administrator, system of care coordinator, Moving Beyond Depression coordinator, quality assurance specialists, technical assistance specialists, and administrative staff. In addition, six Growing Great Kids™ certified trainers provide training to HANDS staff throughout the state of Kentucky⁶⁰.

⁶⁰ <https://homvee.acf.hhs.gov/Implementation/3/Health-Access-Nurturing-Development-Services--HANDS--Program-Model-Overview/37>

5. Ohio's Help Me Grow Program

Zero to Three

From the Zero to Three website⁶¹: Ohio's Help Me Grow Home Visiting program is a statewide effort to provide expectant or new parents with health and child development information. The Help Me Grow Home Visiting program has been in existence for several years. Following an increase in state general revenue funding for this program, a team of stakeholders undertook a revision of key aspects of the program.

The goals of the program, drawn from home visiting research and evaluation studies, are to:

1. Increase healthy pregnancies.
2. Improve parenting confidence and competence.
3. Improve child health, development and readiness
4. Increase family connectedness to community and social support.

Eligibility has been defined to focus on the most vulnerable families: first-time pregnant women, and first-time parents with a child less than 6 months of age. These families must meet income guidelines of 200% of the federal poverty level. In addition, eligibility also includes children under the age of 3 who are referred from child protective services or with at least one parent in active military duty.

There are four key components to the Home Visiting program: evidence-based parenting education curricula, ongoing screenings and assessments, family need-based referral/resource linkage, and transition to a development-enhancing program/early care and education center. The program utilizes an enhanced centralized intake process in coordination with the Department of Developmental Disabilities; the central intake serves as a single point of access for all families.

According to evaluation information available for 2016, home visiting programs in Ohio:

- Made 18,798 home visits to 3,691 parents and children in 1,830 families.
- Served families living in communities in 27 counties across the state, or 31% of all Ohio counties.
- Reported that 97% of children who participated in home visiting programs either showed improvements in their developmental screenings between the time of their initial screen and follow-up screen, or their screenings did not identify any concerns⁶².

⁶¹ <https://www.zerotothree.org/resources/903-ohio-s-help-me-grow-statewide-home-visiting-program>

⁶² <https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/oh.pdf>

6. Description of the Moving Beyond Depression Program

Moving Beyond Depression

From the Moving Beyond Depression website: First, mothers enrolled in home visitation are screened by the home visitor using a self-report depression screen. Mothers with elevated scores are referred to Moving Beyond Depression. After receiving the referral, the therapist schedules an eligibility assessment to determine if the mother meets diagnostic criteria for Major Depressive Disorder. Mothers will receive 15 weekly treatment sessions and a booster session one month following the 15th session. IH-CBT is provided by a licensed master's-level mental health clinician. Treatment is standardized and is based on the core elements of Cognitive Behavioral Therapy, with substantial adaptations for in-home treatment in the context of ongoing home visiting services that enhance feasibility, engagement and impact.

The program is designed to establish strong working relationships between home visitors and therapists, who collaborate closely through treatment. Doctoral-level team leaders also provide weekly support to therapists. Through this team approach, Moving Beyond Depression has the potential to help mothers overcome their depression and focus their love and attention on their child.

After treatment, mothers receiving IH-CBT reported:

- Fewer and less severe depressive symptoms.
- Decreased anxiety and other symptoms of psychological distress.
- Improved coping with stress.
- Fewer relationship difficulties.
- Increased social support.
- More satisfaction in the parenting role.

Mothers who recovered from depression reported:

- That they coped better with stress related to the parenting role.
- Their children improved in social and emotional health.
- They had more nurturing and stimulating interactions with their children⁶³.

A clinical trial funded by the National Institute of Mental Health found that: **compared to controls, mothers receiving IH-CBT:**

- Had substantial drops in symptoms of depression.
- No longer met criteria for major depressive disorder (70% recovery) at the end of treatment.

⁶³ http://www.movingbeyonddepression.org/?page_id=2363

- Reported improved coping with stress, fewer relationship difficulties, increased social support, and more satisfaction in the maternal role.
- Reported substantial drops in self-reported psychological distress and increased social support.
- Reported greater ability to function effectively at home, school, work and in relationships.
- Had an average of 11.2 treatment sessions, in contrast to the average of 4.3 in adult outpatient clinics.

In addition:

- Mothers who had the biggest gains were younger and received more IH-CBT sessions and home visits.
- Mothers who were maltreated in childhood showed particularly large gains in the number of people in their social networks following treatment.
- Mothers who recovered from depression reported that they coped better with stress related to the parenting role, their children improved in social and emotional health, and they had more nurturing and stimulating interactions with their children.
- Mothers receiving IH-CBT had an average of 3.2 additional home visits during the treatment phase relative to controls.
- Mothers who fully completed IH-CBT treatment remained in home visiting up to 4 ½ months longer in contrast to mothers who did not receive treatment⁶⁴.

⁶⁴ http://www.movingbeyonddepression.org/?page_id=2401