Issue Brief

CHAPIN HALL
CENTER FOR CHILDREN
AT THE UNIVERSITY OF CHICAGO

September 2006

Implementation of Home Visitation Programs: Stories from the States

By Miriam Wasserman

Development of state-based home visitation programs[1]

In the early 1990s, the CEO of a company told the mayor of Hampton, Virginia, that he couldn't hire many of the kids from Hampton's schools because they were not prepared to enter the work force. After researching why high-school graduates were not employable, Hampton community leaders concluded that poor performance problems began before the children ever got to school.[2] Consequently, they began investigating strategies that would provide children a healthy start in life, beginning well before kindergarten, when a child was born or a woman became pregnant. At that time, Hawaii's Healthy Start program was attracting attention among child abuse prevention advocates with its early identification of new parents at risk and voluntary home visiting services provided by trained visitors. Drawing on Hawaii's experiences and on core findings emerging from the evaluations of numerous early intervention efforts, Prevent Child Abuse America (PCA)[3] initiated a national strategy to establish a system of universal support for all newborns and their parents called Healthy Families America (HFA). Hampton officials advocated starting a local Healthy Families America demonstration program. Soon, Alexandria wanted to start a program too. Fairfax County had also begun home visiting services for Hispanic families with a federal grant. Prevent Child Abuse Virginia, the PCA affiliate in Virginia, applied for a grant from the Freddie Mac Foundation to develop the capacity to coordinate the development of more of these programs in Virginia when communities chose to use this prevention approach. "That was the beginning of Healthy Families Virginia," says Johanna Schuchert, Executive Director of Prevent Child Abuse Virginia.

Today, there are thirty-eight sites across the state serving families in eighty-nine communities and it has become a very formalized network. A system is in place to connect sites with each other, evaluate outcomes, ensure the quality of services, provide training, disseminate information about the program, publicize positive outcomes, and further develop state funding. Multi-site committees deal with evaluation, training, technical assistance and quality assurance. The state

1 This article is based on interviews conducted with some of the largest home visiting programs that have statewide presences in particular U.S. states. It is not meant to be an exhaustive review of all home visiting programs present in U.S. states, but rather to illustrate through specific examples a range of the issues that many social service programs face as they are taken "to scale".

2 Information on Healthy Families programs in Virginia was provided by Johanna Schuchert, Executive Director of Prevent Child Abuse Virginia, through a conversation with the author on January 9, 2006.

3 Prevent Child Abuse America was formerly known as the National Committee to Prevent Child Abuse.

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has been divided into three regions, each with a coordinator that provides technical assistance and quality assurance to the twelve to fourteen sites in that specific region. The coordinators do an annual visit to each site to determine that it is adhering to the critical elements of the program, as laid out by the national Healthy Families America credentialing standards. They write a detailed report with recommendations for quality improvement, which helps to identify technical assistance and training needs for the coming year. In its private, nonprofit coordinating role, Prevent Child Abuse Virginia provides networking opportunities for all the sites by hosting meetings for directors, supervisors, home visitors, and assessment workers. Moreover, Virginia's Healthy Families network is also closely tied in with the Healthy Families America national network.

Although each home visitation state system has its unique story, the experience of Virginia exemplifies the way in which many state-based home visitation services have grown: A model that was developed in a different setting was brought into the state and, starting from a few local sites, evolved to become a fairly elaborate network.

The characteristics of state-based home visiting systems vary from one state to another and from one home-visiting program to another, depending on the way they were implemented, the state's particular administrative structure and political climate, and the home-visiting program's traits, among others. Despite differences in their initial implementation and context, state-based home visiting systems confront similar challenges with respect to sustainability: they have to secure funding that supports services and system functions without compromising quality or the model's design; they have to be able to demonstrate the efficacy of their model and its implementation; and they need to ensure that new programs are able to reproduce the model with quality, embracing those characteristics that have made programs successful in the past.

As was the case in Virginia, growing a state-based home visitation system requires the work and dedication of people at the "ground" level who start up the local sites, of people or organizations who can advocate for and coordinate the resources for a group of sites, and of champions from within state government who help channel resources for the growing system. The degree to which any of these groups of players predominate varies. The case of Virginia represents perhaps the most common growth path where services have evolved organically from the ground up. In these types of cases, typically there were a few sites up and running in a state, which led to greater awareness and familiarity with the program — as well as more entrenched local interests — eventually to acquiring a more secure federal or state funding stream, and, in time, to greater program proliferation. Although the grassroots level at the different local sites played a crucial role in Virginia, the system's development also depended on the strong support from key legislators who helped secure funds for the system.[4]

Local champions within state governments also were instrumental in implementing home visitation programs in many other states. The successful implementation of Healthy Families in Indiana, one of the first Healthy Families statewide efforts, owed much to the support and the groundwork laid by Governor Evan Bayh, who, in 1991, had launched "Step Ahead," an initiative designed to ensure that children start school ready to learn.[5] Likewise, there were three Nurse-Family Partnership sites operating in Pennsylvania in the late 1990s, and in 2001, governor Tom Ridge and his wife, Michele Ridge, obtained Temporary Assistance for Needy Families (TANF) money to expand the program. The funds, channeled through the Pennsylvania Commission for Crime and Delinquency, led to twenty new sites.[6] Similarly, Parents As Teachers (PAT) made its way to Idaho after Christopher "Kit" Bond, who as Missouri Governor was a key advocate of PAT, became a senator and served with Dirk Kempthorne from Idaho. Kempthorne subsequently became Idaho Governor and brought PAT into the state. Home Instruction for Parents of Preschool Youngsters (HIPPY) also achieved a very strong presence in Arkansas when state first lady Hillary Clinton saw one of the earliest programs in the country and decided to bring it back to Arkansas and institute funding for it.

Some states have implemented home visitation programs using a top down approach. This is the case of the initial development of PAT in Missouri, where it evolved from a pilot program financed in 1981 by the Danforth Foundation and the Department of Elementary and Secondary Education into a program implemented in all Missouri school districts

4 For many of the other states where Healthy Families America has programs, the initial pool of funding was the result of advocacy work by chapters of Prevent Child Abuse America. These grants are generally managed by a state agency and awarded to communities interested in starting Healthy Families programs through a competitive grant process, reports Johanna Schuchert.

5 Schorr, Lisbeth B. "Common Purpose: Strengthening Families and Neighborhoods to Rebuild America" Anchor Books, Doubleday, 1997 pp. 45.

6 Information reported by Geri Summerville, Vice President for Replication and Expansion Services for Public Private Ventures (an organization that has been working with Dr. David Olds and the Nurse-Family Partnership).

starting by 1985.[7] Such was also the case in Oklahoma's implementation of the Nurse-Family Partnership (NFP) between 1996 and 1998. There was a child abuse incident in the state that mobilized the state's legislature to act decisively. Children First, Oklahoma's NFP, was created by state statute in 1996 and funded with state appropriations. In February 1997, four pilot sites were created. By October 1998, services were available in all of Oklahoma's seventy-seven counties.[8]

In general, the particular home visiting model selected by a state was not chosen through a systematic evaluation of existing home visiting programs. Rather, in most cases, no other home visitation models were considered when states elected to implement home visitation programs. Most strategic decisions were based on what was popular at the time, what someone in a position of influence had learned about a particular model, or the presence of a model was already in place that was supported by local advocates.

In a few exceptional cases, a specific home visitation model was selected after evaluating and comparing different home visitation options or intervention programs. The way Nurse-Family Partnership programs took off in Colorado is an example of this deliberate approach. A member of the Colorado Lawyers Committee's subgroup focusing on children took a year to travel the country "on his own dime" looking for prevention strategies for at-risk children. The goal was not to have a home visitation program or to target any particular outcome (child abuse, school readiness, violence prevention, etc.), but rather to find proven prevention programs for low-income children ages 0 to 5. Conversations with the Carnegie Corporation led to Dr. David Olds, the originator of the Nurse-Family Partnership, who, as it happened, was working at the University of Colorado. After evaluating other programs, the Lawyer's Committee was convinced of the Nurse-Family Partnership program's cost effectiveness and, in 2000, the group formed a partnership with David Olds and founded a nonprofit organization called Invest in Kids. With support from the Colorado Trust and other private philanthropies in the state, Invest in Kids educated state and local leaders about the program. They found a champion in State Senator Norma Anderson who led the effort to fund and expand the program through the Colorado Nurse Home Visitor Act, which calls for gradually scaling up NFP over a 10-year period throughout the state using tobacco settlement dollars. "It helped a lot that by then we had six sites up and running," notes Lisa Merlino, Deputy Director of Invest in Kids, Denver, Colorado.[9] Even though they were recently established, these sites were able to exert pressure on their legislators for funds, she said.

Sustaining adequate sources of funding

The expansion of home visitation sites and the provision of services to families over a sustained period of time depend in large part on stable funding streams, lasting between 2 and 5 years, depending on the program model. Moreover, additional funding is necessary to support system functions beyond direct assistance to families. Funds are needed to oversee program quality across the state and, ultimately, to produce credible research in order to demonstrate positive results and a program's cost effectiveness. Programs also need resources to sustain a high level of public or strategic awareness and to cultivate and preserve key relationships.

Almost all state-based home visiting programs combine funding from several federal, state, local, and private sources, such as federal sources that are managed by the states such as Temporary Assistance for Needy Families (TANF), Federal Title V Maternal and Child Health Block Grants, Medicaid as well as state-generated funding streams such as Tobacco Settlement dollars, and general revenue funds, among others.[10] This dependence on varied sources of funding is often a product of necessity. However, diversification

7 PAT expanded more at a top-down level in the first few states where it was implemented (Missouri, Ohio, Texas, and Connecticut) under the direction of state government. However, PAT's expansion is now more typically from "the ground up": localities interested in the program acquire it and then a growing number of sites in the state eventually lead to the position of a state leader being created. Moreover, there is wide variation in the roles of state leaders within PAT: title responsibilities vary across states; being state leader is a full-time occupation for some but not for all state leaders; and, while some state leader positions are funded by not-for-profit organizations, others are housed and funded by state agencies (such as departments of education and health) and still other PAT state leader positions are funded by grants from the Parental Information and Resource Center (PIRC) program of the U.S. Department of Education. In fact, "PIRC grants have helped fuel the demand for state systems," explains Sue Treffeisen, State Systems Director for PAT. This is because PIRC grantees are required to use a minimum of 30 percent of their awards to establish, expand, or operate early childhood parent education programs such as Parents as Teachers, Home Instruction for Preschool Youngsters, and other early childhood parent education programs.

8 Mildred Ramsey, Director of Children First, conversation with the author, January 17, 2006.

9 Lisa Merlino, conversation with the author, January 2, 2006.

10 For more information see: Johnson, Kay A. "No Place Like Home: State Home Visiting Policies and Programs." The Commonwealth Fund, May 2001. "The Benefits and Financing of Home Visiting Programs" Issue Brief, NGA Center for Best Practices, June, 2002. "Chapter 8: Funding", State Systems Development Guide, Healthy Families America.

of funding sources is also a strategy pursued by many home visitation programs to ensure sustainability. Most programs face a constant struggle both to preserve the funding streams they have and to obtain new sources of funding. Some of these pressures could potentially be eased by pending federal legislation. The Education Begins at Home Act, initially introduced by Missouri Senator Kit Bond, would establish the first dedicated federal funding stream to support the expansion of quality home visitation programs.[11]

The Healthy Families programs in Virginia offer a good example of the amount of effort required to preserve financial support for home visitation. The programs depend on a patchwork of funding streams, and approximately 30 percent of the resources come from state revenue through budget amendments passed by the legislature.[12] Because being funded via budget amendments requires that an amendment be passed each year, maintaining funding requires constant contact with the legislature. In addition, Virginia has 4-year term limits for governors, which makes it difficult to maintain relationships with the governor's office.[13] Hence, the Healthy Families Virginia state system works very hard to keep the legislature involved. They target key legislators and maintain a core group of informed policymakers so that they do not have to start from scratch with every administration. They have formed a legislative advisory board co-chaired by legislators from both parties: an average of thirty-five legislators serve on the board annually. Members receive an annual report on the state of Healthy Families in Virginia, the latest evaluation results, and presentations from community leaders and parents about the impact of Healthy Families programs.

Finding the financial support to build a system's training and evaluation capacities is often more difficult than finding the support for direct services to families. However, state systems that have been able to provide consistent quality services, credibly demonstrate results, and provide cost effectiveness figures have felt that these abilities have helped them to defend their funding against cost-cutting campaigns. In Virginia, for instance, the need to justify the program's funding to the legislature on an annual basis has made maintaining the quality of the services and being able to demonstrate results key concerns of the system. "We have to prove that their investment is a good one," notes PCA Virginia Executive Director Johanna Schuchert. Outside evaluators from the College of William and Mary analyze information from all of the sites in the state and write a report that is distributed to the General Assembly at the annual advisory board meeting.[14]

Although the main concern for home visitation programs is obtaining funds, the characteristics of certain funding streams can have consequences for program fidelity and quality. "The reality is that not all money is good money for a health services program targeted to low-income, pregnant women," write Dr. David Olds and colleagues with respect to funding for Nurse-Family Partnership programs.[15] "If the funding stream tapped by a site, for example, does not support services during pregnancy, the program cannot be implemented successfully there. If funding streams do not allow nurses to address all of the families needs related to health, parental role, and life course, the program cannot be implemented as designed." Similarly, funding sources that reimburse sites on a per-visit basis may undermine the incentives for home visitors to persevere with hard-to-reach families, who may be precisely the ones most in need of services.

For Parents as Teachers (PAT), the realities of available funding have made the organization serve a more targeted popu-

11 The Senate bill, S.503 had 15 cosponsors and had been read twice and referred to the Committee on Health, Education, Labor, and Pensions as of the Summer Recess of 2006. The House bill, H.R. 3628, was sponsored by Illinois Representative Danny K. Davis, had 46 cosponsors and had been referred to the Committee on Education and the Workforce, and to the Committee on Armed Services.

12 The money appropriated for the Healthy Families programs is funneled through the Virginia Department of Social Services and distributed across sites through a formula created with Prevent Child Abuse Virginia. To qualify for funds, new sites must go through a community planning process facilitated by Prevent Child Abuse Virginia specialists and build their program according to the criteria of Healthy Families America. They must raise matching funds as a way of demonstrating community commitment and involvement. When established, they have to be working towards being credentialed by Healthy Families America.

13 Information provided by Johanna Schuchert, Executive Director of Prevent Child Abuse Virginia, in a conversation with the author, January 9th, 2006.

14 Virginia serves to illustrate the point that substantial efforts are required to sustain funding, but the specific strategies that states choose depend on their circumstances. In Arizona, for instance, Healthy Families programs have enjoyed the support of several governors in an environment where the legislature has tended to be more conservative and has tended to take the position that government should not play any role in family life. In order to sustain their funding (which includes a combination of general funds and TANF funds) the programs have had to work quietly and strategically, keeping a low political profile and avoiding becoming targets of dissent. They acknowledge the governors' support, but do not take the battle to the legislature. They work closely with key legislators and on occasion have taken legislators on home visits. "They don't go up against us" after that, says Becky Ruffner, Executive Director Prevent Child Abuse Arizona.

15 Olds, David L., Peggy L. Hill, Ruth O'Brien, David Racine, and Pat Moritz. "Taking Preventive Intervention to Scale: The Nurse-Family Partnership." Cognitive and Behavioral Sciences 2003, 10(4), 278-290.

lation than its founding philosophy envisioned. “While the belief that quality home visiting should be available to all families remains extremely strong,” remarks Susan Stepleton, President and CEO of Parents as Teachers National Center, “funding streams mandate a different picture.” Currently, almost half (45 %) of the PAT programs throughout the country are targeted to families such as low-income families, families with limited English proficiency, or adolescent parents.[16]

Paradoxically, sometimes when abundant funding becomes available, the speed required to absorb it can compromise program quality. In its impressive ramp-up of the Nurse-Family Partnership (NFP) into a statewide program, Oklahoma faced such issues. “By hiring nurses so quickly you might deplete the pool,” comments Mildred Ramsey, Director of Children First.[17] “You are advertising and filling slots, you don’t have as much time to go through each individual candidate and make sure they are a good match.” There are also challenges to establishing the labor hierarchy. As they were hiring nurses and supervisors at the same time, some of the staff nurses complained to Ramsey, saying “Well, she doesn’t know any more than I do.”

The issue is not unique to Oklahoma. The Healthy Families sites in Arizona have benefited from the election of Janet Napolitano, a governor who is a strong supporter of the program and took the position to expand Healthy Families statewide, obtaining a combination of general funds and TANF funds to double the program.[18] In 2006, the Healthy Families Arizona programs asked for another $8.7 million. Now, they face two major challenges. They have to obtain sustained support from the legislature, which is in conflict with the governor, and they have the challenge of absorbing the funds rapidly. “We don’t want to lose quality as we grow,” says Becky Ruffner, Executive Director Prevent Child Abuse Arizona. “It is not likely that we will have this kind of support when (the Governor) leaves, we have to take advantage of the time window we have,” she points out.

16 Susan Stepleton, presentation in: Challenges to Building and Sustaining Effective Home Visitation Programs: Lessons Learned from the States, May 3, 2006.

17 Mildred Ramsey, conversation with the author, January 17, 2006.

18 Becky Ruffner, Executive Director Prevent Child Abuse Arizona, conversation with the author, January 24, 2006.

Efficacy: How to demonstrate proven outcomes and the debate about the importance of randomized control trials

The capacity to demonstrate proven results has become increasingly important for defending funding streams, finding new sources of financing, and even for starting new home visitation programs. This is especially true after critical reports came out in the late 1990s that raised questions about the capacity of some home visitation programs to produce positive outcomes. It also is emblematic of broader trends towards implementing evidence-based social programs.

Although the national home visiting programs have employed accepted research methodologies to evaluate their outcomes, some states are experiencing growing pressures from funders for more specific types of research to back their outcomes. “The options for the kinds of research that is acceptable have shrunk,” comments Elisabet Eklind, Executive Director of HIPPY U.S.A.[19] Evaluations that are conducted with an experimental design that includes randomized control groups have increasingly come to be seen as the gold standard in assessing social service programs.

In this respect, the Nurse-Family Partnership has a unique trajectory. The program originated in the 1970s in an academic setting and was designed from the very beginning to be tested with randomized control methodology. Three separate trials were conducted with the first being in Elmira, New York, in 1978. As a result of these origins, the Nurse-Family Partnership is today in the exceptional position of being able to not only report outcomes from such experimental evaluations but also to provide evidence of long-term effects of the intervention. In a follow-up conducted 15 years after going through the Elmira program, children who participated had significantly more positive outcomes than those children from similar backgrounds who did not participate (Olds D., Henderson C.R. Jr., Cole R., et al. Long-term effects of nurse home visitation on children’s criminal and antisocial behavior: 15-year follow-up of a randomized controlled trial. JAMA. 1998;280:1238-44).

Among their findings, Olds and his team determined that the 15-year-old children of low-income, unmarried mothers who were visited by nurses during the Elmira trial had fewer arrests, convictions, lower measures of alcohol and cigarette usage, and fewer sexual partners than the children from similar families who did not receive home visits.

19 Elisabet Eklind, conversation with the author, January 23, 2006.

Other home visitation models are working to back their outcomes with similar research methods. "Our commitment to research is absolute," says Parents as Teachers' Susan Stepleton. "While we are pleased with positive results we can cite, we've made a strong organizational commitment to taking work begun by a blue ribbon scientific advisory committee and moving us towards a high-level, comprehensive, random assignment Gold Standard study of the effectiveness of (our home-visitation model) 'Born to Learn'."[20] Similarly, the Healthy Families New York program has recently released the first report of a 3-year randomized control evaluation, which found positive changes in parent self-reports of abuse and neglect and on some childbirth outcomes after the families had been participating in the program for 1 year.[21]

However, an over-reliance on results from randomized control trials also presents problems for home visitation programs. Such evaluations are very expensive, and the control group methodology is often antithetical to the philosophy and motivation of these organizations because they feel that they have to identify a group of families in need of help and then not provide them with assistance but rather sit back and watch how many children get hurt.

"People can put too much faith in randomized trials," says Erikson Institute associate professor Jon Korfmacher, who has worked on a number of randomized trials of home visiting programs.[22] Despite their strengths, many factors can go wrong with such evaluations. Randomized trials are the last step in a process of evaluations: before they can be conducted, researchers must be reasonably certain that the program model is sound and that implementation has been successfully achieved. The results of such evaluations tend to be very conservative, which, points out Korfmacher, raises the issue of "what does it mean if you see small program effects?"

In addition, randomized control trials set up conditions that do not normally occur in real-world settings. For example, the fact that investigators are involved may increase staff enthusiasm and their commitment to careful implementation. Moreover, the motivation of trial participants can differ from regular program participants in that trial subjects know that they may not be receiving anything "real" (if they are assigned to the comparison group) and they may be more motivated by the lure of monetary compensations or incentives often paid to research participants than by what a program offers in real settings (support, referrals, information, etc.).

Although evaluations of and research on home visiting programs can provide valuable information for maintaining and improving program quality, this requires that findings be translated into lessons that have relevance for practice. The Research-Practice Council, created by Healthy Families America, represents an attempt to bridge the gap between research and practice. The Council's objective was to examine implementation and quality issues within HFA, using an initial 3-year grant from the Packard Foundation. Researchers and practitioners began by examining together the differences in the definitions of service terms like "enrollment" and "retention" across Healthy Families sites. Subsequently, the Council developed strategies to review family retention and other implementation issues consistently across sites. The results of the study provided a comprehensive picture of program implementation focusing on key issues such as attracting and retaining families, intensity of services, and staff retention. The study also provided information on the degree of site variation and factors related to variation in implementation.[23] The Council issued its first report in 2004 and has recently been reconvened to plan a new research project looking at the special qualities of HFA's most highly successful sites in order to better understand what makes them work. "In addition to the actual 'product', the benefit of the collaborative efforts and the 'getting to know you' between researchers and practitioners was tremendous and the relationships established continue on today," says Lisa Schreiber, Director of Healthy Families America.

Ensuring program quality as the model is being replicated

No matter how carefully evaluated a program is, it will face the challenge of ensuring program quality as it is replicated in new settings. All of the national home visitation programs have had to find ways of making certain that new sites remain faithful to the program model and to assure that the program is implemented in a way that retains the quality standards required to reproduce the original model's positive results.

At the root of the strategy to ensure model fidelity, the na-

20 Susan Stepleton, presentation in: Challenges to Building and Sustaining Effective Home Visitation Programs: Lessons Learned from the States, May 3, 2006.

21 "Evaluation of Healthy Families New York (HFNY): First Year Program Impacts." February 2005 http://www.healthyfamiliesamerica.org/downloads/eval_hfny_2005.pdf

22 Jon Korfmacher, conversation with the author, January 31, 2006.

23 Initial Results of the HFA Implementation Study" National Center on Child Abuse Prevention Research, Prevent Child Abuse America, Chicago, IL. May 10, 2004

tional home visiting programs attempt to distill and spell out the specific elements of their models that are critical to achieving the programs' goals. With these crucial components identified, the organizations have designed different ways to monitor their implementation in each new site. These strategies range from self-assessment tools available to the new sites, optional site visits by outside observers, mandatory reviews, to practically constant oversight of defined performance measures through a unified data system.

In addition, important issues of program fidelity occur at the home visitor level, points out Erikson Institute professor Jon Korfmacher.[24] "How much home visitors know about the model they are implementing varies a lot," says Korfmacher. Having a precise manual for home visits helps in establishing model fidelity. This, however, can also raise questions as to how well a program can relate to and respond to local community settings.

The programs vary in the degree of flexibility they allow in implementation. The Nurse-Family Partnership, the organization that evolved from Dr. Olds' work, for instance, has very clearly spelled out the conditions for replication. Although there is a degree of individuality at the nurse-family level, the home visits are organized by guidelines that specify the structure of the home visit and the content to be covered. The Nurse-Family Partnership National Office looks for certain specific capacities in sites choosing to implement the program. "These capacities include having: an organization and community that are fully knowledgeable and supportive of the program; access to sustainable funding appropriate to the program's design; a staff that is well trained and supported in the conduct of the program model; and real-time information on program and benchmark outcomes to guide efforts in continuous quality improvement."[25] Every implementing organization develops a contract with the NFP National Office that lays out the organization's commitment to conduct the Nurse-Family Partnership in accord with the specific standards that characterize the model. In particular, organizations are required to enter data into a Clinical Information System that allows the National Office to monitor the performance of the program as it is implemented.[26]

Within HFA, there is a greater degree of variation in implementation from site to site — within certain guidelines — and the organization encourages debate and information sharing about strategies that work. Healthy Families America relies on a credentialing system, which was developed at the onset of the initiative, to ensure that the main elements of the intervention are addressed.[27] In order to receive certification, the programs have to demonstrate a commitment to implement twelve critical elements that HFA has identified as crucial to the success of the programs and that cover various service delivery aspects, program content, and staffing.[28] The credentialing process entails an application, a self-assessment that involves gathering input from all key personnel associated with the program, and a peer review site visit — to provide a comprehensive and objective review and validate a program's self-assessment and adherence to the critical elements. An objective panel then decides whether or not to award the credential based on the outcomes of the site visit and the evidence of quality presented.[29]

Parents as Teachers also has taken steps to safeguard the model's integrity as it is more widely implemented by spelling out how the different elements of the model are expected to lead to the desired outcomes for parents and children. "Quality standards, which speak to eight subject areas, have been developed and make very clear what constitutes model fidelity," notes Susan Stepleton, President and CEO of Parents as Teachers National Center.[30] The organization has

24 Jon Korfmacher, conversation with the author, January 31, 2006.

25 Olds, David L., Peggy L. Hill, Ruth O'Brien, David Racine, and Pat Moritz. "Taking Preventive Intervention to Scale: The Nurse-Family Partnership." Cognitive and Behavioral Sciences 2003, 10(4), 278-290.

26 Ibid.

27 The credentialing process was developed in partnership with the Council on Accreditation of Services to Families and Children (COA). Daro, D. (2000). Child abuse prevention: New directions and challenges. In: Hansen, D. (ed.). Motivation and Child Maltreatment Vol. 46 of the Nebraska Symposium on Motivation. University of Nebraska, Lincoln, pp. 161-220.

28 Information on the HFA Critical Elements is available at: http://www.healthyfamiliesamerica.org/about_us/critical_elements.shtml. In brief, these elements refer to: Initiating services prenatally or at birth; using a standardized assessment tool to identify families with highest risk factors for child maltreatment; service participation is voluntary; offer services intensively (i.e. at least once a week) with well-defined criteria for increasing or decreasing frequency of service and over the long-term (i.e. three to five years); services should be culturally competent; services should focus on supporting the parent as well as supporting parent-child interaction and child development; all families should be linked to a medical provider and they should be linked to other services depending on their needs; staff should have limited caseloads; staff should be selected because of their capacity, willingness, and skills to do the job; staff should have a framework for handling the variety of situations they may encounter when working with at-risk families including training in cultural competency, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and services in their community; service providers should receive intensive training specific to their role to understand the essential components of family assessment and home visitation; service providers should receive ongoing, effective supervision.

29 Taken from HFA web site at: http://www.healthyfamiliesamerica.org/network_resources/credentialing.shtml

30 Susan Stepleton, presentation in: Challenges to Building and Sustaining Effective Home Visitation Programs: Lessons Learned from the States, May 3, 2006.

set up a process of self-assessment and reinforcement that helps programs know how they are doing and provides a roadmap for improvement in areas of deficiency. Site visits to confirm program quality are also available. In addition, Parents as Teachers program sites complete a web-based annual program report describing service delivery and demographics. Summaries of this information can then be easily viewed, graphed, and charted to help programs make decisions about continuous quality improvement based on very current information.

As the national models have taken steps to maintain program quality, they have also been able to detect problem areas. The Nurse-Family Partnership, for instance, has found that replication sites have, on average, greater participant attrition and attenuated effects on both maternal and child outcomes relative to the original program trial sites.[31] The information they have collected through their integrated system has highlighted such implementation challenges as the fact that mothers are registering in the programs later in gestation than they did in the trials. Similarly, the information indicates that nurses in replication sites tend to spend less time on the promotion of competent parenting and more time on issues of physical health than the nurses in the trials. This type of information has helped the NFP National Office decide how to target technical assistance.

Other organizations have a less centralized way of addressing problem areas. In the case of Healthy Families America, the role of the national organization has been to learn what local programs have done to address problems, find out what is working well, and then disseminate that information to the field. For instance, evaluations have highlighted the fact that HFA programs are challenged in serving the highest-risk families who deal with such issues as domestic violence, substance abuse, and mental health concerns such as maternal depression. "Research reveals the good, bad, and sometimes the ugly," says Lisa Schreiber, Director of Healthy Families America.[32] Individual programs throughout the system have crafted their own innovations to grapple with these problems. The national organization has been helping to compile examples of best practices in addressing these problems. "The enhancements to the programs really run the gamut from improved training, adding clinical staff to their services, and improving referrals with other critical services for families," says Schreiber.

31 Olds, David L., Peggy L. Hill, Ruth O'Brien, David Racine, and Pat Moritz. "Taking Preventive Intervention to Scale: The Nurse-Family Partnership." Cognitive and Behavioral Sciences 2003, 10(4), 278-290.

32 Lisa Schreiber, presentation in: Challenges to Building and Sustaining Effective Home Visitation Programs: Lessons Learned from the States, May 3, 2006.

Future growth and development

Despite ongoing debate as to the program's ultimate efficacy, home visitation remains a core strategy to combat child abuse and to foster positive parent-child relationships. Although many home visitation models initially lacked sufficient infrastructure to support statewide or national expansion, their growth is now occurring with a much greater degree of formalization and strategic planning. The large, national organizations have greater capacity to assist, guide, and oversee new site development directly or through their state-system structures. They can also change and respond to demands from the environment as they detect new needs or implementation challenges. Moreover, they are collaborating and discussing ways to address issues that affect the field of home visitation more broadly. Although such conditions are not a panacea for all growth-related problems, they do provide a rational structure for building on existing efforts and knowledge to improve the strategy's ability to achieve its desired objectives.

Appendix

National home visitation models in brief

Home visiting programs that aim to prevent adverse effects in the lives of young children have expanded widely in the United States.[33] In addition to many small-scale programs that have developed locally, a number of home visiting program models have come to be recognized nationally and have developed the capacity to replicate across the country.

The four home visiting models cited in this paper have at least one state-based system in place and national headquarters to support and sustain their national expansion by helping start up new programs, train home visitors, maintain the quality of the programs across locations, improve program content, and conduct research. These programs differ to some extent in their specific goals, the populations they serve, the practitioners they hire to conduct the home visits (for instance nurses versus paraprofessionals), among others, but, they share "a focus on the importance of children's early years and on the pivotal role that parents play in shaping children's lives, and by the sense that one of the best ways to reach families with young children is by bringing services to them, rather than expecting them to seek assistance in their

33 "Home Visiting: Recent Program Evaluations." The Future of Children, Vol. 9, No. 1, Spring/Summer 1999.

communities."[34] Although they mostly serve different populations and aim for different goals, these programs are at times competing with one another as well as with other early intervention efforts for limited funds, particularly when a state considers statewide expansion of a single model.

We interviewed staff members at the national program offices of the four programs and, in the case of the largest programs, we also talked to staff members from several state offices who were intimately acquainted with the particular details of program expansion in their individual states. The four programs we surveyed are described below along with a listing of the states in which each model reports a statewide support system:

Healthy Families America (HFA) evolved from the experiences of Hawaii's Healthy Start program. HFA was launched in 1992 with the goals of promoting positive parenting, enhancing child health and development, and preventing child abuse and neglect. Currently, Healthy Families America exists in over 430 communities in the United States and Canada and serves over 85,000 families with assessment services and 50,000 families with home visiting services.[35] The population served consists mostly of first-time parents, two-thirds of whom are single and TANF-eligible. Services are initiated after the birth of the child and prenatally for about 40 percent of the families served.[36] Voluntary home visits are delivered by staff with varying qualifications and professional training, and the dosage of visits is based on family need.

The Nurse-Family Partnership (NFP) was developed by an academic research demonstration in Elmira, New York in the 1970s. In 1996, an effort to replicate the program nationally was launched. Since then, the program has grown to more than 150 sites serving more than 20,000 families annually in 21 states.[37] The main goals of the program are to improve pregnancy outcomes (through reducing smoking and improving prenatal care, for example), children's health and development (by promoting competent parenting), and families' economic self-sufficiency (by increasing spacing of subsequent pregnancies and encouraging maternal education and employment). The program works exclusively with low-income, first-time mothers who are recruited into the program before the twenty-eighth week of gestation. Home visits are conducted by nurses beginning during pregnancy and continuing until the child turns 2.

Parents as Teachers (PAT) was developed in Missouri in the early 1970s to address inequities in children's readiness to learn through greater parental awareness and involvement. Initial funding was provided by the Missouri Department of Elementary and Secondary Education and The Danforth Foundation. State funding was provided in 1985 to implement the PAT program in all Missouri school districts. Since 1985, the program has expanded to all fifty states and to other countries. In 2005, PAT reached over 320,000 children.[38] The program is designed to enhance child development and school achievement through parent education accessible to all families (it is a universal access model). Home visits are delivered by trained parent educators using an established curriculum called "Born to Learn". Families participate from pregnancy until their child enters kindergarten, usually age 5.[39]

The Home Instruction Program for Preschool Youngsters (HIPPY) was developed in Israel and came to the United States in 1984. The main goal of the program is to improve school readiness of children ages 3-5 years by providing parents with knowledge and materials to stimulate their children's early learning. The program model consists of a developmentally appropriate curriculum, with role play as the method of teaching, staffed by home visitors from the community, supervised by a professional coordinator and with home visits interspersed with group meetings as the delivery methods. In the 2003-04 program year, there were 157 HIPPY program sites in 26 states and the District of Columbia, serving over 16,000 children and their families.[40]

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34 "Home Visiting: Recent Program Evaluations." The Future of Children, Vol. 9, No. 1, Spring/Summer 1999.

35 Healthy Families America web site at: http://www.healthyfamiliesamerica.org/about_us/index.shtml

36 "2003 Annual Profile of Program Sites" Healthy Families America. December, 2004. Available at: http://www.healthyfamiliesamerica.org/downloads/hfa_site_survey.pdf

37 The Nurse-Family Partnership web site at: http://www.nursefamilypartnership.org/resources/files/PDF/Fact_Sheets/NFPOverview.pdf

38 Parents as Teachers National Center (2006). 2004-2005 Parents as Teachers Born to Learn annual program report summary. Retrieved September 6, 2006, from http://www.parentsasteachers.org/site/pp.asp?c=ekIRLcMZJxE&b=1343353

39 History and background available from the Parents as Teachers web site at: http://www.parentsasteachers.org/site/pp.asp?c=ekIRLcMZJxE&b=272093

40 History and background available from the HIPPY USA web site: http://www.hippyusa.org/About_HIPPY/about_HIPPY.html

Acknowledgements

I would like to express my gratitude to all the interviewees who contributed to this project by sharing their knowledge and time with me. I greatly appreciate the insights provided by: Deborah Daro, Elisabet Eklind, Gaylord Gieseke, Judy Jerald, Natasha Johnson, Phyllis Kikendall, Jon Korfmacher, Lisa Merlino, Mildred Ramsey, Becky Ruffner, Lisa Schreiber, Johanna Schuchert, Sue Stepleton, Geri Summerville, Kellie Teter, Sue Treffeisen, and Patricia Uris.

For More Information

Read Chapin Hall publications about home visitation:

An Evaluation of the Cuyahoga County Home Visitation Programs for New Parents
by Deborah Daro, Eboni Howard, Jennifer Tobin and Allen Harden

Engagement and Retention in Voluntary New Parent Support Programs
by Deborah Daro, Karen McCurdy and Carnot Nelson

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