

NATIONAL ALLIANCE

of home visiting models

Lessons from the Field:

Learning to Replicate and Take Quality Home Visiting to Scale January, 2019

INTRODUCTION

We (the National Alliance of Home Visiting Models) have been providing home visiting services to pregnant women and young families for many years. For the past six years, we have been operating within the context of a Federal Initiative that has provided expanded opportunities to replicate our programs, particularly in under-resourced communities and with populations at high risk for poor parent and child outcomes. Repeated evaluations of our efforts have found that we have many positive impacts. Our experience, however, has also determined that we need to further adapt and improve our work to achieve and sustain all desired objectives. Independent of any specific evaluation or research study, the totality of our experiences suggest the following:

- Early childhood home visiting is valuable – it can make a measurable difference in the ability of many parents to care for their children and ensure optimal child development.
- Our implementation varies – it is hard to replicate programs consistently and to always deliver what families most need. Limited resources in many communities and the growing challenges families face impedes our progress, but we are constantly looking for ways to address these challenges.
- We are learning how to deliver services more effectively and how to operate in a layered management environment in which operations are influenced by our practices, state priorities, Federal guidelines, and funder requirements.

This brief reflects on the changes we have made in our practice and how our operations have been impacted by the current policy context.

MIECHV OVERVIEW

The passage of the Federal Maternal, Infant, and Early Childhood Home Visiting program (MIECHV), authorized as a part of the Affordable Care Act of 2010, solidified home visiting's central role in supporting parents and promoting child wellbeing. While not the first attempt to direct significant Federal resources into early home visiting, MIECHV's initial \$1.5 billion investment, and its subsequent reauthorization in 2018, established a sizable and stable funding stream for early home visiting and identified a specific entity in each state to manage the program. A greater number of communities now

offer early home visiting as part of their prevention continuum and nearly 70% of the states are replicating multiple models, offering new parents greater opportunities to access early support.

MIECHV's emphasis on replicating proven, evidence-based programs and setting common performance standards has ushered in a new level of rigor and expectations for the prevention field. MIECHV grantees are required to report common aggregate information on the number of parents and children served, the demographic characteristics of program participants, and various service characteristics (e.g., the model provided, the proportion of families successfully completing the program). In addition, MIECHV has extended the mission of early home visiting far beyond the notion of preventing child maltreatment and strengthening parental capacity. Home visiting is increasingly viewed as a strategy to address a range of child and maternal health and behavioral issues. States, through the implementation of home visiting, are expected to improve maternal and newborn health; reduce child injuries, abuse, and neglect; improve school readiness and achievement; reduce crime or domestic violence; improve family economic self-sufficiency; and improve coordination with and referrals to other community resources and supports.

Many of the national models identified as "evidence based" have been operating for many years – in some cases we have been providing services for more than three decades. While MIECHV has greatly expanded the reach of our models, less than a third of any of our local affiliates exclusively depend upon these Federal dollars. Most of our programs continue to operate with public funds provided through state and local initiatives or private, philanthropic resources. Our long-standing focus on quality improvement has continued and expanded under MIECHV. To support our networks, we have refined our training protocols, supervisory structures, fidelity monitoring systems, and data collection efforts. In contrast to the pre-MIECHV days, however, monitoring program implementation and documenting impacts is now a shared management responsibility among ourselves, state grant managers and Federal staff. This layered accountability and decision-making system has been a mixed blessing. It has accelerated the rate of change and, at times, confounded the ability to achieve consistent implementation across communities.

WHAT ARE WE LEARNING?

Rapid expansion of home visiting under MIECHV complicates an already complicated implementation process

Supporting program replication is a complex, labor intensive, and time-consuming task. Even with a well-resourced national office to oversee new applications for program expansion and to manage ongoing training and implementation for our current network, a spike in interest among even a small number of states or communities has, at times, stressed our operations. MIECHV's implementation across all 50 states, U.S. territories, and several tribal communities within a 12-month period uniquely complicated our replication and training activities in several ways. Our resources needed to be spread across a significantly higher number of programs, many of whom were located in new communities and, in some instances, served new populations.

To address these challenges, we accelerated many of the reforms we had already initiated to enhance our internal monitoring and accountability systems. These reforms included such activities as:

- Enhanced fidelity training – we provided home visitors and agency managers tools to track the service delivery process, document participant characteristics, and assess outcomes. These systems help workers understand when they are off track in terms of key implementation goals.
- Provided more intensive training sessions around reflective supervision – we placed high priority in designing and fielding advanced training for all supervisors to improve their capacity to offer home visitors robust support, including additional hours of reflective supervision.
- Improved training on the use of technology – we encouraged home visitors to text participants to remind them of appointments and to suggest age appropriate activities to improve parent-child engagement. One of us is testing a virtual version of our efforts, increasing our ability to deliver home visiting to rural or isolated areas.
- Added emphasis on monitoring outcomes – we enhanced our information systems to monitor performance and assess outcomes in a more standardized manner. For example, this included the adoption of standardized measures with all participants to monitor changes in parenting skills, parent-child interaction, and child development.
- Capitalized on the use of rapid testing strategies supported under MIECHV to assess potential practice reforms -- MIECHV introduced us to new tools, such as the HRSA-supported rapid cycle quality improvement strategies (HV CoIIN), for identifying and integrating new, more effective strategies into our service delivery system.
- Changed the way in which curriculum elements were selected and used by home visitors – we help direct service providers tailor their services in ways that reflect a family’s “in the moment” reality by offering added training in the use of observational skills and responsiveness.
- Established or expanded a dedicated “implementation team” within our national offices – these teams ensure prospective applicants are a good fit with our program and have the financing and other resources necessary to provide initial and ongoing high quality service delivery.
- Operated “help desks” to address affiliates’ questions in a timely manner and then used these questions to flag needed reforms in our ongoing operations -- we increasingly use feedback from our affiliates to identify areas of unmet need and plan program improvements.
- Raised the bar with respect to data collection – we are standardizing our data collection requirements, including collecting participant level data on a regular basis from all or a subset of our affiliates. We are getting better at using data to provide “real time” feedback to individual programs as well as refine our national priorities. We are also improving our ability to integrate data collection with state health care providers and other partner systems to track and improve overall family outcomes.
- Committed to collectively learning from each other – we are finding new ways to learn from each other on how best to respond to changes in the practice and policy landscape.

MIECHV has had several direct and indirect impacts on program operations.

Federal investment in early home visiting brought with it a new level of Federal oversight and performance guidelines. In addition, the legislation identified an entity in each state to determine specific investment strategies at the local level, including the selection of specific models and target communities. State MIECHV grantees also are charged with creating mechanisms to manage these investments in ways that maximize the state’s ability to achieve MIECHV’s overall objectives. In fulfilling these Federal and state objectives, the initiative altered the ways in which we relate to our affiliates and replicate our services in ways that continue to challenge our operations.

- Increased service demand – MIECHV raised awareness of home visiting among policy makers as well as the general public. Meeting this growing demand has required rapid hiring of staff in many communities and has impacted our existing affiliates as well as new programs. In one case, a model had to scale up a new version of their program in order to comply with MIECHV’s determination of its “evidence-based” components.
- Increased training demands for home visitors – in addition to our model specific training, our home visitors are now required to participate in training designed by state grantees. In many cases, this training augments what models are providing, offering home visitors more contextual information on the nature of local laws, expectations, and resources. However, in other cases, home visitors are required to attend trainings that are duplicative of what they are receiving from the models themselves. In a few instances, these training options are unrelated to core components of a model’s service delivery processes.
- More centralized approaches for linking families to services – the development of centralized intake systems operating in many communities altered our relationships with many referral sources. In some cases, our relationships with referral sources are less direct than in the past, with potential participants being screened and referred to our programs by a third party. In such instances, the most appropriate families may not be referred, and there may be a delay from initial referral to service engagement. Furthermore, we have been told that some of the most vulnerable families are hesitant to engage with these centralized intake systems. All of these issues mean that we have less control over who arrives at our doorstep.
- Changes in our caseload characteristics – MIECHV’s focus on locating services in high risk communities and engaging parents facing the greatest challenges has, in some instances, resulted in our programs serving a higher proportion of complex cases. This has required us to alter our caseload standards and reconsider the duration and dosage levels we offer families. In other cases, a counter trend has occurred. At least one model reports a referral pool of families with fewer risks factors than in the past, in part because centralized intakes often place greater emphasis on demographic characteristics (such as young maternal age, single parent status, and poverty) when defining the “at risk” population than on conducting more systematic psychological or social assessments.
- A more educated and “professionalized” work force – local home visiting programs are hiring a higher proportion of college graduates to serve as home visitors, a trend which began before MIECHV implementation. However, in some cases, this trend has required models to develop more innovative recruitment strategies to field a work force reflective of the racial and ethnic diversity we find in the communities in which we work. Challenges also exist in filling positions and retaining staff in both rural communities as well as urban areas with an extremely high cost of living (e.g., New York and the Bay Area). Those home visiting models that place specific emphasis on hiring former clients find they are able to offer services in more languages and struggle less with issues of diversity.
- Program longevity is not always a function of “quality” – under MIECHV, several of our affiliates with a strong record of performance have been defunded. State grantees that utilize an annual RFP process to identify those providers that will receive funding each year can result in programs being funded or defunded not based on performance but on a state’s interest in reaching a new population or a new community.
- Transparency remains a problem – we often are not fully aware of why decisions are being made with respect to funding priorities, new training demands, or reporting requirements. This lack of clarity can lead to frustration in understanding how best to support our local affiliates.

- Screening does not always result in families receiving needed services – our home visitors are conducting more screenings around a range of core issues such as mental health, substance abuse, and domestic violence. However, the absence of sufficient service capacity to address these needs in many communities is frustrating and difficult for home visitors. It is painful to see a problem with little capacity to fully address it.

We continue to believe that our home visitors and their supervisors are the linchpin to our current and future success.

Although we have not altered our educational requirements for our home visitors, we are seeing an increasingly better educated and skilled group of direct service providers. To ensure that our home visitors continue to demonstrate the skills necessary to effectively engage and service our participants, we continue to place particular emphasis on the intangible characteristics we think make for an effective home visitor.

- We are seeking relationship builders – we are consciously screening for individuals that have “relational skills” and are comfortable communicating with a range of new parents. We can communicate skills and content in our trainings; we cannot create an empathetic, nurturing, reflective individual.
- We are seeking experience and building knowledge in core problem areas – we are more intentional in ensuring that our affiliates are capable of educating and supporting home visitors in identifying and addressing participant needs in the areas of mental health, substance abuse and domestic violence.
- We are offering our staff opportunities for growth – we are building a pipeline for professional growth and workforce development. Some of us have long hired former participants as home visitors, providing them access to employment and a new career. However, across all models we are seeing more of our support staff seeking out additional education so they can aspire to be home visitors or current non-degreed home visitors seeking out BA or AA degrees. And in other instances, home visitors are obtaining advanced degrees so they can go on and become mental health clinicians or supervisors.

CONCLUSION

Early home visiting is a core component of a community’s collective effort to support parents of young children, enhance parental capacity, and promote positive child development. We are getting better at what we do in part because we are now collectively learning from each other both across models as well as with our state and Federal partners. We also are cognizant of the fact that home visiting programs, even when well implemented and staffed, are not able to meet the needs of all families under all circumstances. Achieving MIECHV’s long term outcomes will require attention to a number of other concerns.

- Addressing the impacts of poverty on parental choice and personal capacity – efforts are needed to improve the quality of housing, access to medical care, child care, and other primary supports to reduce parental stress and create new opportunities for parents beyond what a home visitor can provide.
- Expanding the availability and quality of therapeutic interventions – the limited availability of treatment programs to address the psychosocial and behavioral issues facing a growing

proportion of home visiting participants limit program impacts. Adequate service levels to address mental health concerns, substance abuse issues, and domestic violence need to be available as part of a continuum of services to maximize the benefit of screening for these conditions as part of the home visiting process.

- Strengthening community context – strong communities reinforces parental capacity. Communities which provide the basics for their residents – available primary health care services, housing, safety, education options including high school diploma programs and certifications for non-traditional students, mentoring, job training, and shared resources such as parks, child care, and family resource centers – create opportunities for parents to help themselves as well as help each other to nurture their children. Such communities also offer human service programs like home visiting a list of partners to augment their individual resources and deepen their capacity to achieve maximum outcomes with diverse families.

In the absence of such changes, early home visiting will have limits on what it can achieve with young families in both the short and long term. We look forward to working collaboratively with each other and those engaged in these reforms to build communities in which all parents and children receive the support they need to realize their best outcomes.

