US PARTNERSHIP ON MOBILITY FROM POVERTY

Scale Evidence-Based Home Visiting Programs to Reduce Poverty and Improve Health

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The ideas in this paper were shaped by discussions within the Partnership but do not necessarily represent the views of all members.

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ABOUT THE US PARTNERSHIP ON MOBILITY FROM POVERTY

With funding from the Bill & Melinda Gates Foundation, the Urban Institute is supporting the US Partnership on Mobility from Poverty. Led by chair David Ellwood and executive director Nisha Patel, the Partnership consists of 24 leading voices representing academia, practice, the faith community, philanthropy, and the private sector.

The Partnership's definition of mobility has three core principles: economic success, power and autonomy, and being valued in community. Our collective aspiration is that all people achieve a reasonable standard of living with the dignity that comes from having power over their lives and being engaged in and valued by their community.

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Executive Summary

Poverty does not determine one's destiny. However, it can make it more difficult for parents to provide the best options for their children, particularly when economic disadvantage is coupled with other behavioral or contextual challenges such as substance abuse, mental illness, family violence, or resource-poor communities. Evidence shows that providing the right supports in the home creates long-term, two-generation solutions for the parents and child.

No child born into poverty should be sentenced to live a life of poverty. Yet only 16 percent of persistently poor children are consistently working or in school as young adults and not poor later in adulthood, fueling a cycle of intergenerational poverty.[1] Although poverty strikes children of every race and ethnicity, and in every state across the nation, children who are black, Hispanic, American Indian or Alaska Native, or living in the South are most likely to live in poverty.

The long-term effects of poverty on very young children are well documented and egregious and can significantly limit a child's prospects. Impacts begin before birth. Children living in poverty are more likely than other children to have been born prematurely and at a low birth weight. Throughout childhood they are more likely to experience a level of stress researchers describe as "toxic," stemming from increased rates of abuse, violent crimes, and other traumas. Such extreme stress can impair brain development in areas important to succeeding as an adult, including setting goals, prioritizing tasks, and controlling impulses.

In the United States today, approximately one in five children under the age of 5—or 5.3 million children—live in poverty. An effective strategy to help break the cycle of poverty is to counteract the impact of poverty on the brain development of young children. Early childhood home visiting is an evidence-based approach that capitalizes on this critical period by connecting pregnant women and parents of young children with nurses, mental health clinicians, parent educators, and other trained professionals who regularly travel to the parents' home to provide the tools, guidance, and support necessary to promote healthy children, healthy parents, and family self-sufficiency.

As of 2017, 20 early childhood home visiting models have been designated as evidence based because of their proven track record. Participating mothers build the confidence they need to better provide for their children; they are more likely to return to school and work and have fewer closely spaced subsequent pregnancies, a key contributing factor to alleviating persistent family poverty. Home visiting motivates positive changes in parenting behaviors, leading to a lower incidence of child abuse and neglect. Children benefit from safer and healthier homes and have fewer language delays and behavioral problems.

Although home visiting for high-risk families in poverty receives support from federal, state, and local government and philanthropy, services reach only a 300,000 families and pregnant women in the United States—or about 4 percent of families in poverty.[2] We propose scaling up evidence-based home visiting programs to make them available to the remaining 96 percent of families currently unable to access them.[3] Recognizing the magnitude of this investment and the infrastructure needed to meet this goal, we propose an initial step of quadrupling the number of families served in targeted poor communities. This goal equates to one in five families and pregnant women with income below the federal poverty level.

Impact on Three Dimensions of Mobility

The Partnership's definition of mobility has three core principles: economic success, power and autonomy, and being valued in community.

Investment: We propose a $1.2 billion expansion in federal funds for home visiting, which would quadruple the number of families receiving services.

Impact:

- Economic Success: Cost-benefit analyses of home visiting programs find that the average return for taxpayers per $1.00 invested ranges from $1.35 to over $5 for the most at-risk families and children.
- Power and Autonomy: Parents will have healthy babies, fewer unintended or closely timed pregnancies, and support returning to work and school; manage stress better; and experience less depression. Children will have improved health, greater success in school, and fewer encounters with juvenile justice.
- Being Valued in Community: Parent-child bonds will strengthen. Families will experience less social isolation and have greater social capital.

The Problem: Poverty Limits Children's Chances to Thrive as Adults

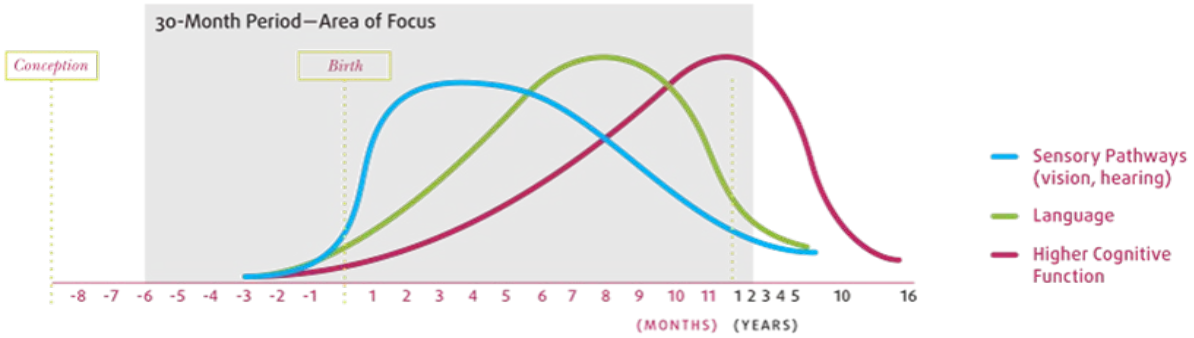
In the United States today, approximately one in five children under age 5, or 5.3 million children, live in poverty.[4] The very youngest—babies less than a year old—are the most likely to be poor.[5] Research shows that children are frequently exposed to stress levels so extreme researchers have deemed them "toxic." The volatile combination of toxic stress, poverty, and other adverse experiences associated with poverty, especially neglect, can profoundly impair a child's development in ways that carry into adulthood.[6] Although child poverty is prevalent nationwide, large racial and geographic disparities exist: children who are black, Hispanic, and American Indian or Alaska Native,[7] as well as children living in the South,[8] are disproportionately poor. Children in poverty are more likely to experience

- premature, low-weight births
- impaired brain development that can affect their ability to absorb and process knowledge, make decisions, and regulate emotions;
- abuse, violent crime, poor nutrition, and other trauma;
- poor mental health and behavioral and emotional problems;
- lower reading and math test scores, lower school attendance, and higher dropout rates;[9]
- risky behaviors leading to higher rates of premarital teen births and juvenile arrests; and
- job instability.[10]

Early childhood provides a brief window of opportunity to minimize or even prevent some of these effects. As figure 1 shows, basic vision, hearing, and language functions develop during a critical period that peaks in early infancy. The first 1,000 days of a child's life can influence his or her ability to learn, develop social skills, self-regulate, and respond to stress with resilience.[11] It is during this period that trained home visitors can have a huge impact on both parents and children. As Dr. Jack Shonkoff, a Harvard pediatrician and leader in the field, described, "You can modify behavior later, but you can't rewire disrupted brain circuits. We're beginning to get a pretty compelling biological model of why kids who have experienced adversity have trouble learning."[12]

FIGURE 1

Human Brain Development: Synapse Formation Dependent on Early Experiences



Source: Nelson, C.A., *From Neurons to Neighborhoods* (2000). Shonkoff, J. & Phillips, D. (Eds.)

The Solution: Evidence-Based Early Childhood Home Visiting Programs

Evidence-based early childhood home visiting programs are an effective strategy to promote mobility from poverty for low-income children and their families. These programs connect low-income pregnant women and low-income parents of young children with nurses, mental health clinicians, and other specialists. Providers travel to the parents' homes and offer tools, guidance, and support that promote healthy children, healthy parents, and family self-sufficiency. Parents can then break the cycle of poverty and create better lives for themselves and future generations.

Home visiting seeks to reduce health, educational, and income disparities faced by families and support them to become the best possible advocates for their children and themselves. This goal is accomplished through ongoing coaching on communication and problem-solving skills. Home visitors educate and connect families to other services they may need: they work with health care professionals to coordinate care, the local housing authority to find affordable housing, the public school system and career training programs to help parents continue their education and find jobs, and local human services agencies to obtain appropriate child care. Such links help parents return to school and work[13] and reduce child maltreatment, accidental injury, and infant mortality.[14]

Although home visiting models vary in their goals, services, and target populations, all share criteria that are critical to their success:

1. **Participation is voluntary.** Parents who sign up for home visiting services do so of their own accord, demonstrating an emotional buy-in that increases engagement and success. Research shows that voluntary participation encourages a sense of pride in adults, who know they are choosing to do something good for themselves and their family, as opposed to the stigma associated with court-ordered and other nonvoluntary programs. When offered as a family support and coaching program, early childhood home visiting does not carry the same social stigma often associated with welfare and other government assistance programs.[15]
2. **Services are provided in the home or wherever families are living, including homeless shelters, temporary housing, or foster homes.** Bringing the services to the participant instead of compelling the participant to come to an office has multiple benefits. First, it decreases barriers to participation because participants do not need to secure child care, identify transportation, or manage other logistical challenges associated with leaving the home. Second, the home visitor can assess the family's living situation to determine if issues may need to be addressed.

3. **Services target both the child and the parent(s).** Home visiting takes a two-generation, whole-family approach to strengthening families with young children. Services are tailored to each family, building on its strengths and addressing its unique challenges either directly or by connecting the family to other community resources.[16] By providing ongoing, therapeutic support to parents and their children, home visiting programs strengthen the parent-child relationship, build parents' self-confidence, and motivate positive changes in parental behaviors. For example, home visiting has been shown to improve birth spacing and reduce the number of subsequent pregnancies among low-income mothers,[17] a key contributing factor to alleviating sustained family poverty.
4. **Services help parents become better providers for their children.** One of the many challenges facing a new parent is figuring out how to get and keep a job while caring for a young child. This is especially true for the low-income, single mothers who constitute the bulk of home visiting clients. These mothers likely cannot afford outside child care and do not necessarily have a reliable partner or family member who can provide consistent, high-quality care. Yet these mothers need to work to support their families. Home visitors help parents secure safe, affordable child care and address other needs so parents can return to work or school. As part of this assistance, a home visitor helps parents set realistic goals and bolsters their confidence in their ability to reach those goals. Examples include avoiding or stopping risky behaviors, engaging in healthy behaviors, and coping with challenging situations. These changes can increase maternal employment and reduce reliance on government support programs such as Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP).

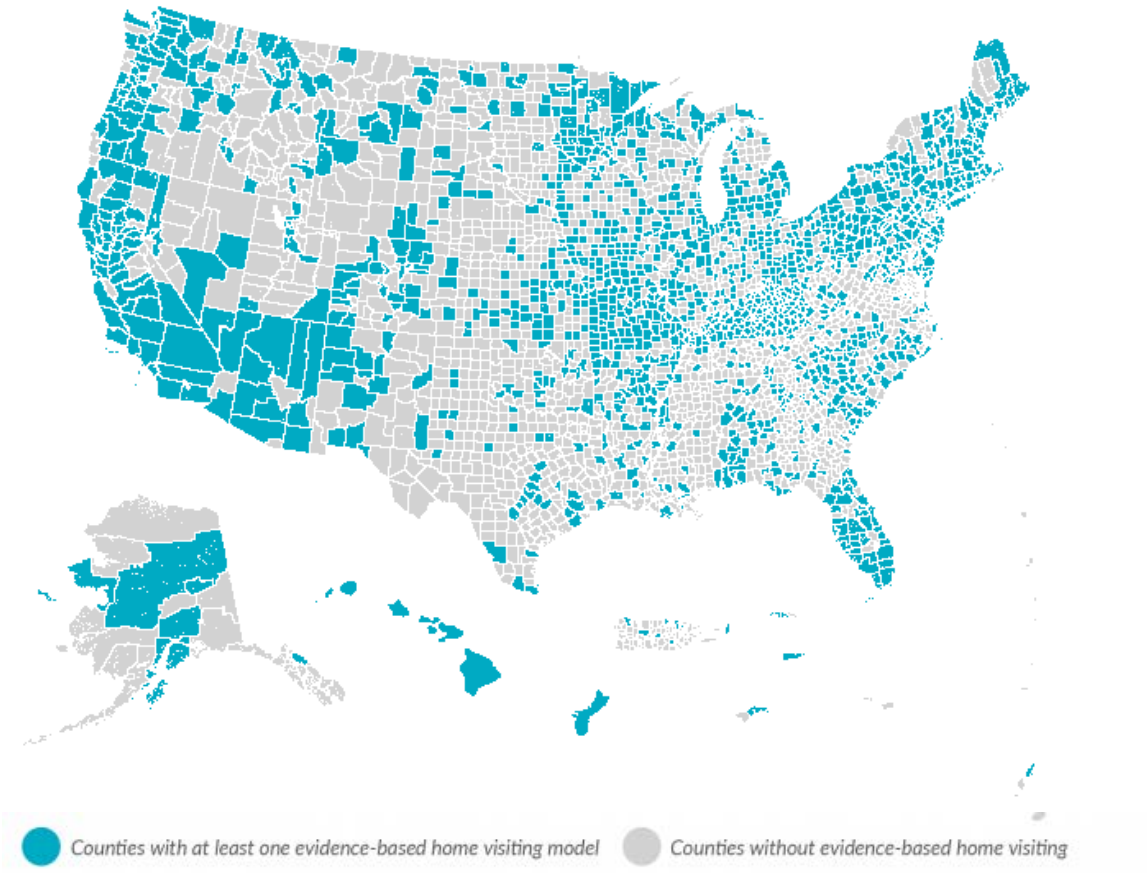
Despite these commonalities, evidence-based home visiting models vary programmatically. Although all are based on visiting a family in their home, some home visiting models also help build social networks, such as by organizing events where parents can share with and learn from one another, bringing together pregnant women due at the same time, or facilitating online communities through social media. Importantly, home visiting programs do not focus solely on the mother, who is frequently the custodial parent in low-income families. When appropriate, home visiting programs actively engage the father as well. For example, Parents as Teachers, a national evidence-based model, offers a toolkit about responsible fatherhood.[18] Engaging fathers as early as possible during pregnancy can lead to healthier birth outcomes[19] and, in turn, healthier child development. Home visiting can motivate young and first-time fathers to be role models for their children, better support their partners, and set and work toward their own personal goals.[20]

The Proposal: Expand Access to Evidence-Based Home Visiting Programs

All 50 states, 5 US territories, 24 Tribal Nations, and the District of Columbia currently implement evidence-based home visiting programs.[21] Although home visiting for high-risk families in poverty receives support from federal, state, and local government and philanthropy, services reach only an estimated 4 percent of pregnant women and families with young children living in poverty. Rates of unmet need vary geographically. Some high-poverty southern states, such as Mississippi, Georgia, and Texas, have the lowest reach; rural areas in states like West Virginia and Nevada also lack evidence-based programs.[22]

FIGURE 2

Evidence-Based Home Visiting by County, 2016



Source: National Home Visiting Resource Center, Data Supplement: *2017 Home Visiting Yearbook* (Arlington, VA: James Bell Associates, and Washington, DC: Urban Institute, 2017), https://www.nhvrc.org. Used with permission.

National estimates show about 301,000 families received services from an evidence-based home visiting model in 2016.[23] About three-quarters of these families had incomes below the federal poverty level, and the other quarter showed other needs. Most home visiting programs target services to low-income parents, teen parents, single first-time mothers, families with a history of child maltreatment, or families with children with behavioral or developmental problems. Most program participants are young women, many of whom are single mothers who have not finished high school.

Rosa, a 16-year-old mother from Lancaster, Pennsylvania, was just 14 when she became pregnant. She was unsure how she would care for her baby and finish high school. Like many teen mothers, Rosa felt stigmatized and disrespected by her peers. Beth, Rosa's nurse home visitor, helped Rosa gain the confidence she needed to overcome stress and take control of her life.

"It has meant so much to me to have a nurse at my side, someone who I could trust for advice," Rosa said before members of Congress. "Having a nurse like Beth, who I could trust with questions about my health when I was pregnant, breastfeeding when I was a new mom, child development as she grows, and life goals helped me to be a successful parent."

With her home visitor's support with goalsetting, Rosa has stayed in school and balances studying with caring for her young daughter.

A national profile of evidence-based home visiting programs shows the need for home visiting services extends across racial and ethnic groups. Participants are racially and ethnically diverse: 60 percent are white, 21 percent are black, 8 percent are multiracial, 4 percent are American Indian or Alaska Native, 2 percent are Asian American, less than 1 percent are Native Hawaiian or Pacific Islander, and 4 percent identify with another group.[24] Twenty-six percent are Hispanic or Latino.

We propose quadrupling the number of families served by evidence-based home visiting programs in high-poverty communities. This increase equates to 1.2 million families total and about one in five families and pregnant women with incomes below the federal poverty level. An additional $1.2 billion a year in federal funding would bring the annual allocation to $1.6 billion.[25] State funding and billing of education systems and Medicaid would enhance program reach and meet the match requirements, which can be as high as 25 percent. Philanthropic investment would be $160 million a year or 10 percent—the requirement for start-up and matching funds to ensure operations are viable—plus additional funds for targeted research and evaluation.

When offered communitywide in high-need areas to promote families' health, home visiting programs could produce systematic changes in population outcomes. When home visiting reaches enough families in a community, it can make parents feel they matter and are valued members of the community. Stronger communities contribute to structural change.

Program expansion at the community level will help address critical research questions, including the following: Can scaling up home visiting transform a community to better serve the long-term developmental interests of the child? And how does this approach compare to housing programs that relocate low-income families to higher-opportunity communities?

Evidence-Based Home Visiting Programs Help Low-Income Families Move Out of Poverty and Adopt Healthier Behaviors

Evidence-based early childhood home visiting is a cost-effective prevention and intervention strategy proven to improve both short- and long-term child outcomes. In 2009, the Home Visiting Evidence of Effectiveness project was launched to conduct a transparent review of the home visiting research literature and assess program models for evidence of effectiveness.[26] This annual review draws from the research literature to evaluate the quality and depth of evidence that underlie the impact of program models in eight areas critical to long-term stability and mobility: (1) maternal health; (2) child health; (3) positive parenting practices; (4) child development and school readiness; (5) reductions in child maltreatment; (6) reductions in juvenile delinquency, family violence, and crime; (7) family economic self-sufficiency; and (8) linkages and referrals.

As of 2017, 20 programs have met the Home Visiting Evidence of Effectiveness project criteria for an evidence-based home visiting model by demonstrating positive impacts in at least one of the eight areas, as documented in rigorous peer-reviewed studies.[27] Among the five largest program models (based on enrollment), impacts are observed in multiple domains (table 1). All evidence-based models have produced sustained impacts measured at least one year after program enrollment (see appendix table B.1 for age groups served by model). Nurse-Family Partnership (NFP) has conducted several longitudinal studies and has found positive life-course changes measured up to 15 years after a child's birth. Benefits to mothers include fewer subsequent pregnancies, less dependence on welfare, fewer verified reports of child abuse and neglect, less substance abuse, and fewer criminal behaviors leading to arrests.[28] Long-term benefits to children include improved academic achievement,[29] less criminal and antisocial behavior,[30] and lower rates of teenage pregnancy for girls.[31] These kinds of outcomes for mothers and children along the life course could disrupt intergenerational cycles of poverty, building stronger families, one at a time.

TABLE 1

Impacts of the Five Largest Evidence-Based Home Visiting Models

	Maternal health	Child health	Positive parenting practices	Child development and school readiness	Reductions in child mal-treatment	Reductions in juvenile delinquency, family violence, and crime	Family economic self-sufficiency	Linkages and referrals
Early Head Start–Home Visiting			◊	◊	◊		◊	◊
Healthy Families America	◊	◊	◊	◊	◊	◊	◊	◊
Home Instruction for Parents of Preschool Youngsters			◊	◊				
Nurse-Family Partnership	◊	◊	◊	◊	◊	◊	◊	
Parents as Teachers			◊	◊	◊		◊	

Yet the specific outcomes of any individual home visiting program vary at least in part because of participants' circumstances. Race, ethnicity, culture, gender, age, disability, socioeconomic status, and geographic location all contribute to a person's ability to achieve good mental, emotional, and physical health and make positive behavioral changes. For example, African American women are 2.5 times less likely to breastfeed than white women.[32] Given the documented positive impact of breastfeeding on the development of a child's immune system, this cultural difference can have far-reaching implications. Moreover, 31 percent of low-income children are obese or overweight before the age of 5, compared with 9 percent of preschoolers nationally, with highest rates among American Indian and Alaska Native and Hispanic children.[33] Childhood obesity is tied not only to adult disease but also bullying, social isolation, depression, and lower self-esteem.[34] And nearly 6 in 1,000 children in the United States do not reach their first birthday, with the rate nearly double for infants of black mothers.[35]

In its most effective applications, evidence-based home visiting explores the nature of variations in outcomes like these and adapts practices in a culturally sensitive manner to achieve better outcomes. Children who experience nurse home visiting are less likely to be obese because their mothers learn about the importance of a healthy pregnancy weight and breastfeeding.[36] Intensive home visiting decreases infant death dramatically among black children born into poverty.[37] A randomized controlled trial in Memphis, Tennessee, found that black children living in poverty who experienced home visiting were less likely than control group children to die by age 20 from preventable causes, such as sudden infant death syndrome, unintentional injury, and homicide.[38]

Home Visiting Programs Reduce Demand for Public Assistance

The body of evidence shows not only how home visiting can help families escape the intergenerational cycle of poverty, but how outcomes can produce substantial return on investment and reduce demand for public assistance. Reductions in preterm births, infant deaths, child injuries treated in emergency departments, child maltreatment and child welfare system involvement, youth substance abuse and arrests, intimate partner violence, and extended use of government safety net programs (e.g., TANF, SNAP, and Medicaid) all result in large cost savings. A 2005 analysis found that every $1.00 invested in the highest-need families served by NFP returned a net benefit of $5.70 to society, with most of this return on investment accruing to government.[39] Further, a 2015 study extrapolated outcomes from 30 evaluations of the NFP program and found substantial government savings for the 177,517 families enrolled between 1996 and 2013.[40] Because NFP families earn more and space the births of their children according to medical recommendations,[41] they use fewer resources from government safety net programs such as SNAP, TANF, and Medicaid.[42]

Cost-benefit analyses of other home visiting programs have found average returns on investment ranging from $3.39 for Parents as Teachers to $1.41 for Healthy Families America, and $1.35 for SafeCare.[43] Returns to society could be even higher when accounting for other important impacts that are harder to quantify, including improved health.

Because home visiting touches on so many aspects of children's development, the net impact on longer-term outcomes as children grow into adults is amplified. Using the social genome model, analysts simulated the expansion of the NFP program to all first-born children of single mothers living in poverty. The simulation found that annual household income for NFP participants at age 29 was $2,335 higher; at age 40, it was $3,845 higher. Accumulated over a lifetime, the difference in earnings was more than $35,000,[44] an amount suggesting the strength of such a model to lift families out of poverty.

Next Steps to Scale Up Evidence-Based Early Childhood Home Visiting Programs

The fact that highly effective, evidence-based home visiting programs reach so few of the families who could benefit from them makes a strong case for increasing program access and funding. Governments and private philanthropies both have important roles in successfully scaling these programs to improve the life chances of young children and their families.

Recommendations to Governments

Home visiting can provide significant benefits to society across different arenas and multiple generations. Unfortunately, with short-term budget deficits, election cycles, and other crises, policymakers are rarely able to focus on long-term cost savings or broader societal benefit. Changes are under way to encourage greater use of evidence-based programs, such as the gradual shift to paying for value over volume in Medicaid. But federal and state governments can accelerate these changes, particularly in scaling evidence-based home visiting programs to move families out of poverty. Governments can take the following steps to improve access:

1. **Expand the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.** MIECHV is a federal, data-driven program that provides formula and competitive grants to states for evidence-based home visiting services. The MIECHV program is one of a few federal programs that designates at least 75 percent of funding for approved evidence-based models; annual funding to states, territories, and tribal grantees depends on meeting continuous evaluation and accountability metrics. The program allows communities with concentrations of poor child health and other risk indicators to select among approved evidence-based models to focus on the outcomes most relevant to their community.[45] The MIECHV program was an early milestone in national efforts to advance evidence-based home visiting programs and continues to be an example of how to fund successful programs. In fiscal year 2016, MIECHV-funded programs served about 160,000 families nationally, of which 74 percent were poor. But although the number of families served increased nearly fivefold between 2012 and 2016,[46] MIECHV still serves only 27 percent of US counties and a small fraction of the nation's vulnerable families.[47] Quadrupling the federal investment would bring the annual allocation to $1.6 billion and bring home visiting to more counties nationwide.

2. **Facilitate access to state Medicaid funding for evidence-based home visiting programs.** The focus on evidence-based programs has also taken root in Medicaid, as state agencies pursue contracting mechanisms that reward providers for outcomes rather than the completion of a specific service. Home visiting programs supporting health outcomes targeted by Medicaid agencies can become a strong base for reduced cost, higher-quality efforts to improve population health. In fact, home visiting programs have had some success accessing Medicaid as a sustainable source of funding. For instance, NFP-implementing agencies in 25 of 42 states now access some form of Medicaid reimbursement, including targeted case management, enhanced prenatal services, and Medicaid administrative claiming. Other program models, such as Child First and Healthy Families America, have also drawn on a limited degree of Medicaid support. More than 90 percent of mothers participating in Kentucky's statewide, evidence-based model Health Access Nurturing Development Services were determined to be Medicaid eligible, thus encouraging the state's public health department and Medicaid agency to develop a collaborative agreement to cover costs.[48] In March 2016, the Centers for Medicare and Medicaid Services released guidance encouraging state Medicaid agencies to support home visiting programs through multiple categories of funding. Though home visits have traditionally received Medicaid reimbursement on a fee-for-service basis, state Medicaid programs are increasingly moving to systems that pay for value and outcomes.
3. **Remain responsive to ongoing efforts to reform the US health care system.** Reform efforts have produced a rapid evolution of funding streams and the organization of health care delivery. As stakeholders explore how Medicaid can more comprehensively fund programs (such as early childhood home visiting) that address underlying social determinants of health, they must likewise identify ways to embed these programs within new value-based payment initiatives such as accountable care organizations[49] and accountable health communities.[50] Examples include South Carolina's 1915(b) waiver to provide enhanced prenatal, postpartum, and infant care services using the NFP model, as well as proposed or implemented 1115 waivers to test innovative financing models for home visiting services in other states (e.g., Maryland, New York, and Texas). To complement this ongoing work, we propose two additions at the federal, state, and local government levels:
    - » Use evidence of program effectiveness on brain development, asset building, and alleviation of poverty to inform programmatic funding more broadly across health, education, criminal justice, and child welfare.
    - » Support state and local innovation, with targeted communities driving the testing and replicating of models with understudied populations to determine which models work best for different families.
4. **Grow the home visiting workforce.** Efforts to scale up home visiting are only possible with the presence of a qualified home visiting workforce. The demands of working with a high-risk

population can lead to high staff turnover, as seen in related fields such as early childhood education, nursing, and social work. Labor shortages in some high-need communities challenge recruitment efforts. Few students go to school to become a home visitor. The job is often an afterthought for graduates of nursing and social work programs. Other people are attracted to the job after participating in home visiting programs themselves or knowing someone who did. Supporting states and localities in developing and testing innovative approaches to build the home visiting workforce is a critical step to service implementation and expansion. The field needs clear career pathways to help recognize early childhood home visiting as a profession. Partnerships with local community colleges and professional training programs could be a valuable solution. Apprenticeship programs are gaining popularity and could place trainees in home visiting settings to gain necessary hands-on skills and knowledge from seasoned workers. Some universities are beginning to offer courses on home visiting; and, under MIECHV, several states are developing home visiting certification programs, written core competencies, and intensive trainings on sensitive issues like domestic violence and substance abuse. More investment in these innovations will pave the way for more successful implementation outcomes.

Recommendations to Private Philanthropy

Philanthropy's role has been and will continue to be critical in leveraging support for evidence-based home visiting programs. Specifically, philanthropy can continue to work to increase access to these critical programs in four ways:

1. **Mobilize strategic partnerships in priority states.** Many of the nation's poorest states have the fewest home visiting programs. Increasing the availability of home visiting services in these priority states can be helped through strategic partnerships with key organizations active in these communities. Philanthropic support can be used to identify and target high-needs communities where programs could be implemented and expanded to serve all eligible low-income families. Beyond looking at the availability and reach of existing services, a range of community indicators could be taken into account: socioeconomic factors, such as persistent poverty, chronic unemployment, and low housing affordability or quality; health indicators, such as opioid abuse or obesity; and shortage of medical and behavioral health providers. Once communities are identified, home visiting programs and stakeholders can develop a comprehensive approach in each community to identify and secure funding, build community support to engage and enroll families and ensure provider capacity, and establish policies to enhance program sustainability. Action-based learning networks could provide a structure for clinical and financing experts to examine how

different home visiting models might work together to ensure people are matched with the best program to address their particular strengths and risks.

2. **Invest in communitywide home visiting access to promote population-level change.** The limited federal funding targets a small share of high-risk families. But philanthropy can supplement funding to implement and test communitywide approaches so all families can experience the benefits of home visiting. In Guilford County, North Carolina, private funders, including The Duke Endowment, George Kaiser Family Foundation, and Blue Meridian Partners, are helping Family Connects and NFP implement a lighter-touch universal home visiting model and more intensive services for higher-risk families. Philanthropy is also helping home visiting programs in Tulsa, Oklahoma, collaborate on an integrated approach.
3. **Convene key stakeholders to identify additional sustainable funding solutions.** The home visiting community[51] should turn its efforts to (1) identifying and promoting successful funding strategies beyond MIECHV; (2) exploring options for complementary funding streams, such as coordinating resources from the Departments of Health and Human Services, Education, Defense, and Justice; and (3) establishing permanent, sustainable funding streams that leverage these strategies to further expand home visiting's reach nationwide. These efforts will require coordinated action across a range of local, state, and federal stakeholders. Convenings may bring together state Medicaid agencies with other public agencies, such as housing and criminal justice, to identify ways to support home visiting. In this convening role, philanthropy can set the expectation and help create an underlying structure for sustainable ideas. Establishing permanent funding streams may require legislation that clearly establishes home visiting as a social service priority. With the decentralized nature of US federal and state governments and the frequent movement of congressional and executive agency leadership and lower-level staff, stakeholders must engage repeatedly at multiple levels and sectors of government to generate enough support to achieve change. Convenings could facilitate dialogue and feedback from the staff central to these policy decisions and educate new and returning congressional members about the effectiveness of the program and its presence (or absence) in their states and districts.
4. **Fund research to support home visiting as a solution to intergenerational poverty.** Home visiting programs have spent close to a decade making measurable progress on building the evidence base. Philanthropy can support continued research and innovations. From the gaps in research already identified that could strengthen the field of practice to investments that increase the use of technology and enable innovation (while preserving outcomes), philanthropy can play a role that is not likely or easily occupied by government, and one that home visiting programs do not have the resources or potentially the expertise to undertake alone. In the short term, expert analysis and engagement is needed to understand how changes to the evolving US health care system might affect Medicaid financing of program services. In particular, it will be critical to clearly outline (1)

how home visiting programs can seek reimbursement under existing Medicaid coverage options; (2) how such reimbursement may be affected by reforms to health care coverage, such as block grant or per capita cap Medicaid funding strategies; and (3) what changes to federal Medicaid regulations might better support program sustainability. Commissioning this study from a nonpartisan research institution and engaging key federal policymakers would support bipartisan efforts to fund home visiting programs.

Closing

A critical strategy for improving children's life chances and breaking the vicious cycle of poverty is to establish adequate, sustainable funding for evidence-based early childhood home visiting programs and to enact policies that increase access to them. Home visiting programs target different populations at different developmental stages. With the right level of coordination between programs and the commitment from government and philanthropy that home visiting is a staple service in our communities, families like Rosa's can reach their full potential and give their children the future they deserve.

Appendix. Evidence-Based Home Visiting Programs and Populations Served

Program models	Pregnant women	Birth–11 months	12–23 months	24–35 months	36–47 months	48+ months
Attachment and Biobehavioral Catch-Up (ABC) Intervention		◊	◊			
Child FIRST		◊	◊	◊	◊	◊
Family Connects		◊				
Early Head Start–Home Visiting	◊	◊	◊	◊	◊	
Early Intervention Program for Adolescent Mothers	◊	◊				
Early Start (New Zealand)		◊	◊	◊	◊	◊
Family Check-Up for Children				◊	◊	◊
Family Spirit		◊	◊	◊		
Health Access Nurturing Development Services (HANDS)	◊	◊	◊			
Healthy Beginnings	◊	◊	◊			
Healthy Families America	◊	◊	◊	◊	◊	◊
Healthy Steps		◊	◊	◊		
Home Instruction for Parents of Preschool Youngsters (HIPPY)®					◊	◊
Maternal Early Childhood Sustained Home Visiting Program	◊	◊	◊			
Minding the Baby	◊	◊	◊			
Nurse-Family Partnership	◊	◊	◊			
Oklahoma's Community-Based Family Resource and Support Program	◊	◊				
Parents as Teachers	◊	◊	◊	◊	◊	◊
Play and Learning Strategies: Infant Curriculum		◊				
SafeCare		◊	◊	◊	◊	◊
Total number of programs	**10**	**18**	**14**	**9**	**8**	**7**

Source: "Home Visiting Evidence of Effectiveness Review (HomVEE)," US Department of Health and Human Services, Administration for Children and Families, accessed August 18, 2017, http://homvee.acf.hhs.gov. See website for additional details on each model, including eligibility criteria, program goals, and staffing requirements.

Notes

1 Caroline Ratcliffe and Emma Cancian Kalish, "Escaping Poverty: Predictors of Persistently Poor Children's Economic Success" (Washington, DC: US Partnership on Mobility from Poverty, 2017).

2 National Home Visiting Resource Center, *Data Supplement: 2017 Home Visiting Yearbook* (Arlington, VA: James Bell Associates, and Washington, DC: Urban Institute, 2018). Available at https://www.nhvrc.org.

3 We recommend investments in "evidence-based" early childhood home visiting programs, defined as those that meet the certification standards outlined in the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Researchers have rigorously evaluated these programs and can provide sufficient evidence of improved outcomes for participating parents and children. Recognizing the importance of distinguishing between MIECHV-certified programs and those that are not, we refer only to evidence-based home visiting programs throughout this paper.

4 Population Reference Bureau, analysis of data from the US Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2015 American Community Survey, accessed December 2016, http://datacenter.kidscount.org.

5 Yang Jiang, Maribel R. Granja, and Heather Koball, "Basic Facts about Low-Income Children: Children under 6 Years, 2015" (New York: National Center for Children in Poverty, 2017).

6 "Toxic Stress," Center on the Developing Child at Harvard University, accessed March 17, 2017, http://developingchild.harvard.edu/science/key-concepts/toxic-stress/.

7 Jiang, Granja, and Koball, *Basic Facts about Low-Income Children.*

8 US Department of Agriculture, Economic Research Service, using data from the US Census Bureau, American Community Survey 2015, accessed March 15, 2017, https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/child-poverty/.

9 Child Trends, *Children in Poverty: Indicators of Child and Youth Well-Being* (Washington, DC: Child Trends, 2016).

10 Caroline Ratcliffe, "Child Poverty and Adult Success" (Washington, DC: Urban Institute, 2015).

11 Jack P. Shonkoff and Deborah A. Phillips, eds., *From Neurons to Neighborhoods*: *The Science of Early Childhood Development* (Washington, DC: National Academy Press, Board on Children, Youth, and Families, National Research Council and Institute of Medicine, 2000).

12 Nicholas Kristof, "A Poverty Solution That Starts with a Hug," op-ed, *New York Times*, January 7, 2012, http://www.nytimes.com/2012/01/08/opinion/sunday/kristof-a-poverty-solution-that-starts-with-a-hug.html.

13 David L. Olds, Charles R. Henderson, Jr., Robert Tatelbaum, and Robert Chamberlin, "Improving the Life-Course Development of Socially Disadvantaged Mothers: A Randomized Trial of Nurse Home Visitation," *American Journal of Public Health* 78, no. 11 (1988): 1436–45.

14 Kimberly DuMont, Kristen Kirkland, Susan Mitchell-Herzfeld, Susan Ehrhard-Dietzel, Monica L. Rodriguez, Eunju Lee, China Layne, and Rose Greene, *A Randomized Trial of Healthy Families New York (HFNY): Does Home Visiting Prevent Child Maltreatment?* (Rensselaer: New York State Office of Children and Family Services, and Albany: University of Albany, State University of New York, 2010); Edward F. Donovan, Robert T. Ammerman, John Besl, Harry Atherton, Jane C. Khoury, Mekibib Altaye, Frank W. Putnam, and Judith B. Van Ginkel, "Intensive Home Visiting Is Associated with Decreased Risk of Infant Death," *Pediatrics* 119, no. 6 (2007): 1145–51.

15 Pew Charitable Trusts, *Family Support and Coaching Programs: Crafting the Message for Diverse Stakeholders, 2015* (Philadelphia: Pew Charitable Trusts, 2015).

[16] Schuyler Center for Analysis and Advocacy, *Home is Where the Start Is: Expanding Home Visiting to Strengthen All of New York's Families* (Albany, NY: Schuyler Center for Analysis and Advocacy, 2016).

[17] Olds et al., "Improving the Life-Course Development of Socially Disadvantaged Mothers."

[18] Parents as Teachers, "Promoting Responsible Fatherhood," accessed July 6, 2017, http://parentsasteachers.org/fatherhood-toolkit/.

[19] Maggie Redshaw and Jane Henderson, "Fathers' Engagement in Pregnancy and Childbirth: Evidence from a National Survey." *BMC Pregnancy and Childbirth* 13, no. 70 (2013). doi:10.1186/1471-2393-13-70.

[20] Heather Sandstrom, Maeve E. Gearing, H. Elizabeth Peters, Caroline Heller, Olivia Healy, and Eleanor Pratt, *Approaches to Father Engagement and Fathers' Experiences in Home Visiting Programs*, Report 2015-103 (Washington, DC: US Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation, 2015).

[21] National Home Visiting Resource Center, *Data Supplement: 2017 Home Visiting Yearbook*.

[22] National Home Visiting Resource Center, *Data Supplement: 2017 Home Visiting Yearbook*.

[23] National Home Visiting Resource Center, *Data Supplement: 2017 Home Visiting Yearbook* .

[24] National Home Visiting Resource Center, *Data Supplement: 2017 Home Visiting Yearbook*.

[25] Up to 30 percent would be allocated for state and federal research and evaluation and technical assistance from the Health Resources and Services Administration. An increased efficiency would be realized because the infrastructure is already in place, so expansion efforts would limit overhead for federal and state operations to an additional 10 percent.

[26] The Office of Planning, Research and Evaluation in the Administration for Children and Families, US Department of Health and Human Services, in collaboration with the department's Health Resources and Services Administration, contracted Mathematica Policy Research to conduct HomVEE.

[27] Emily Sama-Miller, Lauren Akers, Andrea Mraz-Esposito, Marykate Zukiewicz, Sarah Avellar, Diane Paulsell, and Patricia Del Grosso, *Home Visiting Evidence of Effectiveness Review: Executive Summary* (Washington, DC: US Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation, 2017).

[28] David Olds, John Eckenrode, Charles R. Henderson, Jr., Harriet J. Kitzman, Jane Powers, Robert E. Cole, Kimberly Sidora, Pamela Morris, Lisa M. Pettitt, and Dennis W. Luckey, "Long-Term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect: Fifteen-Year Follow-Up of a Randomized Trial," *JAMA* 278, no. 8 (1997): 637–43.

[29] Harriet J. Kitzman, David L. Olds, Robert E. Cole, Carole A. Hanks, Elizabeth A. Anson, Kimberly J. Arcoleo, Dennis W. Luckey, Michael D. Knudtson, Charles R. Henderson, Jr., and John R. Holmberg, "Enduring Effects of Prenatal and Infancy Home Visiting by Nurses on Children: Follow-Up of a Randomized Trial among Children at Age 12 Years," *Archives of Pediatrics and Adolescent Medicine Journal* 164, no. 5 (2010): 412–18.

[30] David Olds, Charles R. Henderson, Robert Cole, John Eckenrode, Harriet Kitzman, Dennis Luckey, Lisa Pettitt, Kimberly Sidora, Pamela Morris, and Jane Powers, "Long-Term Effects of Nurse Home Visitation on Children's Criminal and Antisocial Behavior: 15-Year Follow-Up of a Randomized Controlled Trial," *JAMA* 280, no. 14 (1998): 1238–44.

[31] John Eckenrode, Mary Campa, Dennis W. Luckey, Charles R. Henderson, Jr., Robert Cole, Harriet Kitzman, Elizabeth Anson, Kimberly Sidora-Arcoleo, Jane Powers, and David Olds, "Long-Term Effects of Prenatal and Infancy Nurse Home Visitation on the Life Course of Youths: 19-Year Follow-Up of a Randomized Trial," *Archives of Pediatrics and Adolescent Medicine Journal* 164, no. 1 (2010): 9–15.

[32] Katherine M. Jones, Michael Power, John T. Queenan, and Jay Schulkin, "Racial and Ethnic Disparities in Breastfeeding." *Breastfeeding Medicine* 10, no. 4 (2015): 186–96.

[33] Barbara Polhamus, Karen Dalenius, Holly Mackintosh, Bridgette L. Smith, and Lawrence Grummer-Strawn, *Pediatric Nutrition Surveillance 2009 Report* (Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2011); Cynthia L. Ogden, Margaret D. Carroll, Cheryl D. Fryar, and Katherine M. Flegal, "Prevalence of Obesity among Adults and Youth: United States, 2011–2014," Data Brief 219 (Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, 2015).

[34] M. van Geel, P. Vedder, and J. Tanilon, "Are Overweight and Obese Youths More Often Bullied by Their Peers? A Meta-Analysis on the Correlation between Weight Status and Bullying," *International Journal of Obesity* 38, no. 10 (2014): 1263–67; L. I. Griffiths, T. J. Parsons, and A. Hill, "Self-Esteem and Quality of Life in Obese Children and Adolescents: A Systematic Review," *International Journal of Pediatric Obesity* 5, no. 4 (2010): 282–304; White House Task Force on Childhood Obesity, *Solving the Problem of Childhood Obesity within a Generation* (Washington, DC: White House Task Force on Childhood Obesity, 2010).

[35] Infant Mortality Statistics from the 2013 Period Linked Birth/Infant Death Data Set, National Vital Statistics Reports 64 (9), https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_09.pdf.

[36] William Thorland, Dustin Currie, and Claire Colangelo, "Status of High Body Weight among Nurse-Family Partnership Children," *American Journal of Maternal Child Nursing* 42, no. 6 (2017): 352–57.

[37] Donovan et al., "Intensive Home Visiting Is Associated with Decreased Risk of Infant Death."

[38] David L. Olds, Harriet Kitzman, Michael D. Knudtson, Elizabeth A. Anson, J. A. Smith, and Robert E. Cole, "Effect of Home Visiting by Nurses on Maternal and Child Mortality: Results of a 2-Decade Follow-Up of a Randomized Clinical Trial," *JAMA Pediatrics* 168, no. 9 (2017): 800–06.

[39] Lynn A. Karoly, Rebecca Kilburn, and Jill Cannon, *Early Childhood Interventions: Proven Results, Future Promise* (Santa Monica, CA: RAND Corporation, 2005).

[40] Ted R. Miller, "Projected Outcomes of Nurse-Family Partnership Home Visitation during 1996–2013, USA," *Prevention Science* 16 (2015): 765–77.

[41] Very closely spaced subsequent births, such as within 18 months, increase risk for adverse birth outcomes and development delays in children.

[42] Miller, "Projected Outcomes of Nurse-Family Partnership Home Visitation."

[43] "Benefit-Cost Results," Washington State Institute for Public Policy, accessed March 17, 2016, http://www.wsipp.wa.gov.

[44] Urban Institute tabulations using the social genome model (available upon request).

[45] "Evidence-Based Models Eligible to Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Grantees," Home Visiting Evidence of Effectiveness, accessed August 18, 2017, http://homvee.acf.hhs.gov/HRSA/11/Models_Eligible_MIECHV_Grantees/69/.

[46] "The Maternal, Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed," Health Resources and Services Administration, https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/programbrief.pdf

[47] Although MIECHV is one of the largest single sources of funding for home visiting in the United States, programs also receive significant support through Medicaid, Title V funds (Maternal and Child Health Block Grant Program), TANF, federal grant programs such as Healthy Start and Early Head Start, and federal and state education funds. Some states pay for home visiting with state general funds, tobacco settlement funds,

and designated budget line items. Some communities are exploring pay for success projects as a financing tool; a pay for success home visiting project is under way in South Carolina, and others are in development in Michigan, Washington, and Tennessee.

48 Katharine Witgert, Brittany Giles, and Amanda Richardson, *Medicaid Financing of Early Childhood Home Visiting Programs: Options, Opportunities, and Challenges* (Washington, DC: Pew Center on the States, 2012).

49 An accountable care organization (ACO) was first described in 2006 by Elliott Fisher, director of the Center for Health Policy Research at the Dartmouth Medical School. An ACO "can be generically defined as a group of health care providers, potentially including doctors, hospitals, health plans, and other health care constituents, who voluntarily come together to provide coordinated high-quality care to populations of patients. The goal of coordinated care provided by an ACO is to ensure that patients and populations—especially the chronically ill—get the right care, at the right time, and without harm, while avoiding care that has no proven benefit or represents an unnecessary duplication of services." See https://www.healthcatalyst.com/what-is-an-ACO-definitive-guide-accountable-care-organizations.

50 The accountable health communities (AHC) model is "universal, comprehensive screening for health-related social needs of community-dwelling Medicare and Medicaid beneficiaries accessing health care at participating clinical delivery sites. The model aims to identify and address beneficiaries' health-related social needs in at least the following core areas: housing instability and quality, food insecurity, utility needs, interpersonal violence, and transportation needs beyond medical transportation." The AHC model will "test whether increased awareness of and access to services addressing health-related social needs will impact total health care costs and improve health and quality of care for Medicare and Medicaid beneficiaries in targeted communities." See https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-01-05.html.

51 The Home Visiting Coalition is a diverse group of organizations committed to the well-being of children that promotes continued federal support of home visiting to strengthen families in communities across the country. The Steering Committee of the National Home Visiting Coalition includes NFP, Healthy Families America/Prevent Child Abuse America, Parents as Teachers, Home Instruction for Parents of Preschool Youngsters, National Head Start Association, Center for Law and Social Policy, Council for a Strong America, First Five Years Fund, Association of State and Tribal Home Visiting Initiatives, Association of Maternal and Child Health Programs, Dalton-Daley Group, and First Focus. This collaboration has been critical to the demonstrated success in driving an expansion of public funding for home visiting services. Since 2004, national organizations including NFP, Parents as Teachers, Healthy Families America, and Home Instruction for Parents of Preschool Youngsters have partnered to cultivate strong federal and state bipartisan support for evidence-based home visiting. These efforts were instrumental to the 2008 creation of the $17 million federal Evidence-Based Home Visiting program under President Bush and the 2010 creation under President Obama of the $1.5 billion MIECHV program. The powerful evidence for the NFP model combined with the collective evidence of home visiting effectiveness drove policymakers in both administrations to create these grant programs supporting multiple home visiting programs. Today, members of the Steering Committee for the National Home Visiting Coalition continue to cultivate support for home visiting at the federal level and at the grassroots level where programs live.

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