



Selection of Evidence-Based Home Visiting Models in Alignment with CalWORKs Home Visiting Initiative Requirements

Summary Report

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EXECUTIVE SUMMARY

Early childhood educational and health care services have found to be effective in giving young children from disadvantaged backgrounds a healthy start in their life journeys. Parents of these children also benefit from participating in these services - improving their parenting skills, own well-being, and economic self-sufficiency.

As funding for the Paid Family Leave and Black Infant Health Programs has been recently increased, so too is more budgetary attention allocated to mothers and children, who are CalWORKs participants.

In support of the SACHS directors, this report features several models deemed evidence-based by the Department of Health and Human Services Home Visiting Evidence of Effectiveness (HomVEE) review, the California Evidence-Based Clearinghouse for Child Welfare, and other organizations. These models strive to serve the needs of low-income populations, have established minimum educational and visiting requirements for agency staff, and show evidence of efficacy in three to eight outcome domains as designated by the DHHS. For special consideration, this report highlights models that either show evidence of efficacy with specific subpopulations and cultures or were designed for specific subpopulations and cultures. Finally, a discussion of how these models align with additional CalWORKs HVI requirements is provided.

This report recommends the following evidence-based models as top contenders for the CalWORKs HVI:

- Healthy Families America (HFA)®
- Parents as Teachers (PAT)®
- Nurse-Family Partnership (NFP)®
- Early Head Start Home-Based Option (EHS-HBO)

BACKGROUND

A. The Importance of Preventive Intervention¹

- “A growing body of research points to the link between early childhood interventions and improved outcomes years or even decades into the future: higher education levels, better health, and stronger career opportunities. Investing in early childhood enables these outcomes in the future while strengthening families and reducing child poverty immediately.”²
- According to the National Conference of State Legislatures, “rigorous evaluation of high-quality home visiting programs has shown positive impact on reducing incidences of child abuse and neglect, improvement in birth outcomes such as decreased pre-term births and low-birthweight babies, improved school readiness for children and increased high school graduation rates for mothers participating in the program.”³
- The California Budget and Policy Center reached the same conclusion: “While later interventions can be successful, they also are likely to require more effort and public expenditures to address the harm.”⁴
- By putting families in touch with resources available in their communities, the visits also can increase parents’ employment and earnings.⁵
- “Cost-benefit analyses show that high quality home visiting programs offer returns on investment ranging from \$1.75 to \$5.70 for every dollar spent due to reduced costs of child protection, K-12 special education and grade retention and criminal justice expenses.”⁶

B. Increase in California Budgetary Funding for Home Visiting

- The 2018-19 California State Budget included a “first-ever statewide investment in voluntary, evidence-based home visiting” - originally proposed by Governor Brown as a three-year pilot program, limited to first-time parents under the age of 25 participating in CalWORKs.⁷
- CalWORKs, which is the California equivalent of the federal Temporary Assistance for Needy Families (TANF) program, will provide \$158.5 million to the new CalWORKs Home Visiting Initiative during Fiscal Years (FY) 2019-2022. This locally needs-focused initiative is apart from the federally funded California Home Visiting Program (CHVP), funded by the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.⁸
 - CalWORKs (California Work Opportunity and Responsibility to Kids) “provides temporary cash assistance to meet basic family needs, as well as education,

¹ <https://www.cdph.ca.gov/Programs/CFH/DMCAH/CHVP/Pages/default.aspx>

² <http://www.ebudget.ca.gov/2019-20/pdf/BudgetSummary/FullBudgetSummary.pdf>

³ <https://www.sacbee.com/opinion/california-forum/article223695075.html>

⁴ <https://www.sacbee.com/opinion/california-forum/article223695075.html>

⁵ <https://www.sacbee.com/opinion/california-forum/article223695075.html>

⁶ <https://www.sacbee.com/opinion/california-forum/article223695075.html>

⁷ <https://www.zerotothree.org/resources/2401-california-makes-historic-investment-in-home-visiting-for-low-income-families>

⁸ <https://www.zerotothree.org/resources/2401-california-makes-historic-investment-in-home-visiting-for-low-income-families>

employment and training programs to assist the family's move toward self-sufficiency."⁹

- CalWORKs eligibility criteria include:¹⁰
 - ✓ Age
 - ✓ Deprivation
 - ✓ Eligible Child
 - ✓ Income
 - ✓ Parenting/Pregnant status
 - ✓ Immigration Status
 - ✓ Property Residency / Citizenship
- Goal: To serve 16,000 Cal-WORKs eligible families in 2019-20 and around 15,000 families annually, starting in 2020.

C. CalWORKs Home Visiting Initiative / Program Requirements

- Home visiting "is an evidence-based, culturally competent, voluntary program model that pairs new parents with a nurse or other trained professional who makes regular visits to the participant's home to provide guidance, coaching, access to prenatal and postnatal care, and other health and social services."¹¹
- An "evidence-based" home visiting model has been evaluated using the criteria developed by the United States Department of Health and Human Services (DHHS).¹²

Note: Each county is permitted to use one or multiple evidence-based HV models.

- Program Goals:
 - "support positive health, development and well-being outcomes"
 - "expand opportunities for future education, economic and financial capability for participants, improving the likelihood they will exit poverty. The program will improve family engagement practices, support healthy development of young children living in poverty, and prepare parents for employment."
 - To decrease the chances/rates of:¹³
 - ✓ low birth weight
 - ✓ infant mortality
 - ✓ adverse childhood experiences (ACEs), including: abuse, neglect, and being a witness to crime, mental illness, and substance abuse

Note: These can negatively impact health (e.g., depression, heart disease), behavior (e.g., alcoholism, smoking), and learning throughout the child's life.¹⁴

⁹ <http://www.cdss.ca.gov/Portals/9/CalWORKs/HVI%20Fact%20Sheet.pdf?ver=2019-01-02-095720-637>

¹⁰ <https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/Communications/Issue-Brief-CHVP-CalWORKs.pdf>

¹¹ <http://www.cdss.ca.gov/Portals/9/CalWORKs/HVI%20Fact%20Sheet.pdf?ver=2019-01-02-095720-637>

¹² <https://homvee.acf.hhs.gov/Default.aspx>

¹³ <http://www.ebudget.ca.gov/2019-20/pdf/BudgetSummary/FullBudgetSummary.pdf>

¹⁴ <https://www.rwjf.org/en/library/collections/aces.html>

- To support children with:
 - ✓ immunizations
 - ✓ language development
- Participant Eligibility Criteria:¹⁵
 - pregnant and parenting women (including those who are considered to have high-risk factors), and infants born into poverty
 - a member of a CalWORKs assistance unit who is pregnant with no other children at the time of enrollment or a first-time parent or caretaker relative of a child (who's a member of a CalWORKs assistance unit) less than twenty-four months old at the time of enrollment in the HVI
 - Participants do not have to be in the Welfare-to-Work Program.
 - A county may serve additional individuals not described above so long as the county offers home visiting to all individuals in the target population.
- Services will include (but not be limited to):¹⁶
 - prenatal, infant and toddler care
 - infant and child nutrition
 - child developmental screening and assessments
 - parent education and training in parent/child interaction
 - child development and child care
 - job readiness and barrier removal
 - domestic violence and sexual assault services
 - mental health and substance abuse treatment and support

Note: Counties may provide up to \$500 per participant for materials related to above.
- Additional Requirements for County Applicants¹⁷
 - Undergo a competitive application process every two years
 - Encourage parents to enroll children in early learning setting or childhood enrichment activities
 - Provide up to 24 months of high-quality services
 - Submit written plan describing how they will accomplish program goals and collaborate with home visiting agencies on case management.
 - Provide data related to the outcomes of participants and children by race, ethnicity, national origin, primary and secondary language, and county
 - Please see tables below and Appendix A for all mandatory and additional criteria.

¹⁵ <http://www.cdss.ca.gov/Portals/9/CalWORKs/HVI%20Fact%20Sheet.pdf?ver=2019-01-02-095720-637>

¹⁶ <http://www.cdss.ca.gov/Portals/9/CalWORKs/HVI%20Fact%20Sheet.pdf?ver=2019-01-02-095720-637>

¹⁷ http://www.dof.ca.gov/Budget/Trailer_Bill_Language/documents/CalWORKsHomeVisitingInitiative.pdf

CalWORKs Home Visiting Initiative
Mandatory and Additional Criteria for HV Models¹⁸

Mandatory Criteria
Evidence-Based Home Visiting Model
Capacity to Serve Linguistic and Cultural Needs
Ability to Serve Target Populations
Home Visitor Qualifications (e.g., trained, certified, can provide culturally and linguistically appropriate services, completed background check)
Completed Specified Training
Services Implemented by Deadline
Service Duration of 2 Years Minimum
Six Outcome Domains Addressed in Collaboration with Other Service Providers
Case Management Plan Created with County
Standardized Screening and Assessment Tools to Track Progress
Data Collection for Evaluation Purposes

Additional Criteria
Three Years of Experience Serving CalWORKs Clients or CalWORKs-Eligible Clients
Ability to Maintain Model Fidelity
Recruitment and Outreach Strategies
Frequency of Service (Monthly or Weekly)
Plan to Minimize Attrition
Encourage Early Learning Setting
Resources for Immigrants
Plan for Funding Appropriate Supplies
Co-Location of HV Agency with a CWD
Participation in Multi-Disciplinary Group
Plan for Funding Sustainability

¹⁸ Adapted from CalWORKs HVI Request for County Plan – please see Appendix A for more details.

MODEL SELECTION CRITERIA

The models featured in this report are deemed evidence-based by the HomVEE review and the California Evidence-Based Clearinghouse for Child Welfare. These models aim to serve the needs of target populations, have minimum educational requirements for home visiting staff, and show evidence of efficacy in 3 to 8 outcome domains as designated by DHHS and fulfill at least some CalWORKs requirements. For further consideration, I noted models that demonstrate evidence of efficacy with specific subpopulations and cultures and/or were designed for specific subpopulations and cultures.

HomVEE Requirements for Evidence-Based Models

The Department of Health and Human Services (DHHS) launched the Home Visiting Evidence of Effectiveness (HomVEE) review¹⁹ to assess models that target families with pregnant women and children from birth to age 5.

To meet DHHS's criteria²⁰ for an "evidence-based early childhood home visiting service delivery model," models must have any of the following:

- At least one high- or moderate-quality impact study of the model finds favorable, statistically significant impacts in two or more of the eight outcome domains [to be discussed further in this report]
- At least two high- or moderate-quality impact studies of the model using non-overlapping analytic study samples with one or more favorable, statistically significant impacts in the same domain

In both cases, the impacts must either (1) be found in the full sample or (2) if found for subgroups but not for the full sample, be replicated in the same domain in two or more studies using non-overlapping analytic study samples. If the model meets the above criteria based on findings from randomized controlled trial(s) only, then one or more favorable, statistically significant impacts must be sustained for at least one year after program enrollment, and one or more favorable, statistically significant impacts must be reported in a peer-reviewed journal.²¹

For results from single-case designs to be considered towards the HHS criteria, additional requirements must be met:²²

- At least five studies examining the intervention meet the WWC's pilot single-case design standards without reservations or standards with reservations (equivalent to a "high" or "moderate" rating in HomVEE, respectively).
- The single-case designs are conducted by at least three research teams with no overlapping authorship at three institutions.
- The combined number of cases is at least 20.

¹⁹ <https://homvee.acf.hhs.gov/Default.aspx>

²⁰ <https://homvee.acf.hhs.gov/document.aspx?rid=4&sid=19&mid=6>

²¹ <https://homvee.acf.hhs.gov/document.aspx?rid=4&sid=19&mid=6>

²² <https://homvee.acf.hhs.gov/document.aspx?rid=4&sid=19&mid=6>

Descriptions of the outcome domains considered during the HomVee review are included in this report. For each outcome domain, both primary and secondary measures were used:²³

- Primary if data were collected through direct observation, assessment, or administrative records. Self-reported data are acceptable as primary only if collected using a standardized instrument.
- Other self-reported data are considered secondary.

Of the 46 models reviewed on the HomVEE site, twenty are deemed evidence-based using the U.S. Department of Health and Human Services criteria.

Additional Selection Criteria

I then narrowed the list of twenty models down to 10 evidence-based, MIECHV-grant-eligible²⁴ models by:

1. Target population
2. Having minimum education requirements for home visiting staff
3. Having minimum home visitation requirements
4. Domain outcomes (listed below) reported by DHHS as *Favorable* in high or moderate-quality studies:

Child development and school readiness

Child health

Family economic self-sufficiency

Linkages and referrals

Maternal health

Positive parenting practices

Reductions in child maltreatment

Reductions in juvenile delinquency, family violence, and crime

The following three pages include descriptions of these domain outcomes.

²³ https://homvee.acf.hhs.gov/homvee_executive_summary.pdf

²⁴ https://homvee.acf.hhs.gov/HRSA/11/Models_Eligible_MIECHV_Grantees/69/

Outcome Domains	Types of Evidence
Child Development and School Readiness ²⁵	<ul style="list-style-type: none"> • Engaging parents in activities designed to improve child functioning across developmental areas • Educating parents about child development and strategies to enhance school readiness (such as literacy activities) • Promoting positive parent-child interactions • Linking families to center-based early childhood care and education experiences.
Child Health ²⁶	<ul style="list-style-type: none"> • During a mother’s pregnancy: aiming to improve birth outcomes by linking mothers to prenatal health care and providing them with information about fetal development • Following the birth of the child: ensuring that children have access to health care, receive appropriate well-child care and immunizations, and receive appropriate medical care for illnesses and injuries • Providing information to parents about ways to support physical health, such as the importance of nutritious meals and physical activity
Family Economic Self-Sufficiency ²⁷	<ul style="list-style-type: none"> • Facilitating parents’ engagement in educational and training programs, and encouraging their pursuit of employment • Providing information about family support services in the community and linking families to self-sufficiency programs • Providing educational and training services (e.g., GED classes)
Linkages and Referrals ²⁸	<ul style="list-style-type: none"> • Coordinating with and referring participating families to places in their community where they can receive additional financial, in-kind, medical, or social support services

²⁵ <https://homvee.acf.hhs.gov/Outcome/2/Child-Development-and-School-Readiness/3/1>

²⁶ <https://homvee.acf.hhs.gov/Outcome/2/Child-Health/2/1>

²⁷ <https://homvee.acf.hhs.gov/Outcome/2/Family-Economic-Self-Sufficiency/7/1>

²⁸ <https://homvee.acf.hhs.gov/Outcome/2/Linkages-and-Referrals/28/1>

Outcome Domains	Types of Evidence
Maternal Health ²⁹	<ul style="list-style-type: none"> • Providing mothers with health information and guidance during pregnancy and after the child’s birth • Linking mothers to prenatal and postpartum health care providers • Linking mothers to treatment facilities for mental health and substance issues • Providing preventive mental health intervention or other services that promote their psychological well-being
Positive Parenting Practices ³⁰	<ul style="list-style-type: none"> • Providing didactic or experiential parenting education through a structured curriculum or addressing parenting needs identified during home visits • Integrating parenting interventions that have been found to improve specific parenting behaviors (e.g., responsive interactions and positive behavioral support) • Providing information to parents about child development or safety practices in the home
Reductions in Child Maltreatment (including abuse and neglect) ³¹	<ul style="list-style-type: none"> • Efforts to improve parental knowledge, skills, and behaviors to prevent child maltreatment • Efforts to decrease the number of stressors that may make families vulnerable to inappropriate parenting (e.g., improving child health and development, connecting families with community resources such as mental health and substance abuse services). <p>Note: Only health care encounters that may occur as a result of child maltreatment, such as treatment for injuries or ingestions, are included in the child maltreatment domain.</p>

²⁹ <https://homvee.acf.hhs.gov/Outcome/2/Maternal-Health/1/1>

³⁰ <https://homvee.acf.hhs.gov/Outcome/2/Linkages-Referrals/6/1>

³¹ <https://homvee.acf.hhs.gov/Outcome/2/Reductions-in-Child-Maltreatment/4/1>

Outcome Domains	Types of Evidence
Reductions in Juvenile Delinquency, Family Violence, and Crime ³²	<ul style="list-style-type: none"> Addressing parental mental health, self-efficacy, and self-sufficiency either directly or through linkages with other service providers - may affect families' long-term well-being and reduce the likelihood of adult criminal behavior and family violence) Providing parenting education and parent-child interaction activities - may improve parents' capacity to manage their children's behaviors and set children on a trajectory in which they are less likely to engage in later risky behaviors such as juvenile delinquency)

Of the 10 evidence-based models featured in this report, I've highlighted top contenders for CalWORKs HVI application in yellow (see table below) after considering research evidence, including the number of domain outcomes achieved. Furthermore, these top models have been shown to have statistically significant impact on certain ethnic subpopulations.³³ Models marked with an "*", including top contenders, have also appeared on the evidence-based-models list in the "CalWORKs Home Visiting Initiative (HVI) Request for County Plan (RFCP), January 1, 2019 – June 30, 2020." The Family Spirit® model deserves special attention due to its implementation in both tribal and non-tribal populations.

Models that target pregnant women and children from birth to 48+ months:	No. of Domain Outcomes Achieved
*Healthy Families America (HFA)®	8
*Parents as Teachers (PAT)®	4
Models that target pregnant women and children up to 23-24 months old:	No. of Domain Outcomes Achieved
*Nurse-Family Partnership (NFP)®	7
*Early Head Start Home-Based Option (EHS-HBO)	6
Health Access Nurturing Development Services (HANDS)	4
*Healthy Beginnings ³⁴	4
Family Spirit® (also targets tribal populations)	3

³² <https://homvee.acf.hhs.gov/Outcome/2/Reductions-Juvenile-Delinquency-Family-Violence-Crime/5/1>

³³ <http://homevisitingla.org/wp-content/uploads/2017/07/LACPECHVC-Comprehensive-Survey-of-HV-Outcomes-6-19-17-FINAL.pdf>

³⁴ This model does not have fidelity standards in place to insure staff adherence to model.

Models that target children from birth through 47 or more months:	No. of Domain Outcomes Achieved
SafeCare® Augmented	5
Child First	4
Early Start (New Zealand)	4

California Evidence-Based Clearinghouse for Child Welfare

The following models were rated as “well-supported by research evidence for a HV program on Child Well-Being” by the California Evidence-Based Clearinghouse for Child Welfare.³⁵

- Healthy Families America (HFA)®
- Nurse-Family Partnership (NFP)®

The following model is rated as “well-supported by research evidence for a HV program on Prevention of Child Abuse” by the California Evidence-Based Clearinghouse for Child Welfare:³⁶

- Nurse-Family Partnership (NFP)®

Evidence of Efficacy with Specific Subpopulations and Cultures

The following models have statistically significant impact on specific ethnic subpopulations.³⁷ Impact factors varied across models and included:

- rate of preventable child mortality
- parent knowledge and maternal involvement
- time spent with child
- effectiveness of mother-child interactions
- self-help development

Model	Sub-Population Impacted (Statistically Significant)
Healthy Families America (HFA)®	Indigenous
Nurse-Family Partnership (NFP)®	African-American
Parents as Teachers (PAT)®	Latino, Indigenous
Early Head Start Home-Based Option (EHS-HBO)	African-American

³⁵ <http://www.cebc4cw.org/topic/home-visiting/>

³⁶ <http://www.cebc4cw.org/topic/home-visiting-for-prevention-of-child-abuse-and-neglect/>

³⁷ <http://homevisitingla.org/wp-content/uploads/2017/07/LACPECHVC-Comprehensive-Survey-of-HV-Outcomes-6-19-17-FINAL.pdf>

Model Alignment with CalWORKs HVI Requirements

CalWORKs HVI Requirements	Model Alignment ³⁸
Mandatory Criteria	
Evidence-Based Model	All ten models featured in this report are evidence-based.
Capacity to Serve Linguistic and Cultural Needs	A few models specifically mention serving culturally diverse populations (Safecare Augmented, Healthy Beginning). Generally, local sites are permitted to adapt models to the specific populations (e.g., immigrants) that they serve, after obtaining approval from the licensing agencies (please see each model profile for more information on adaptations).
Ability to Serve Target Populations	A few models specifically target first-time moms (NFP, ES, ³⁹ HANDS, Healthy Beginning). Many models specifically mention serving low-income participants (PAT, NFP, EHS-HBO, Healthy Beginning, HANDS, Child First). Others (HFA, SafeCare Augmented, Child First, ES) aim to address adverse childhood experiences. Some models, such as HFA, give local agencies leeway to specify the populations that they wish to serve.
Home Visitor Qualifications (e.g., trained, certified, can provide culturally and linguistically appropriate services, completed background check)	Generally, these models require home visitors to have at least a high school diploma or GED (more often a bachelor's degree, if not a master's degree). Some models, including HANDS and Child First, require a degree or a license. A few of these models permit local agencies to determine educational requirements for home visitors.
Service Duration of 2 Years Minimum	All ten models featured in this report seem equipped to provide at least 2 years of service, if needed.
6 Outcome Domains Addressed in Collaboration with Other Service Providers	All models featured in this report seem equipped to address four domains as required by the HVI: (1) Prenatal, infant, and toddler care; (2) Infant and child nutrition; (3) Developmental screening and assessments; (4) Parent education, parent and child interaction, child development and care. Some models do not focus on: (5) Job readiness and barrier removal and (6) Domestic violence and sexual assault, mental health, and substance abuse treatment, but offer linkages and referrals to other community resources that do.

³⁸ According to https://www.nhvrc.org/wp-content/uploads/NHVRC_Yearbook_2018_FINAL.pdf
<https://homvee.acf.hhs.gov/models.aspx>

³⁹ The HomVee review site appears to not list Early Start as one of the models targeting pregnant women on the search results table; this discovery contradicts my findings on other sites.

CalWORKs HVI Requirements	Model Alignment ⁴⁰
Standardized Screening and Assessment Tools to Track Progress	Some models offer various initial, endpoint, or annual screenings (HFA, NFP, etc.). Based on published data reviewed, it's currently unknown whether they all have standardized tools to track progress throughout the service period.
Additional Criteria	
Frequency of Service (Monthly or Weekly) Provided Per Participant	All ten models featured in this report are equipped to provide weekly, monthly, more frequent, or less frequent service, depending on family needs.

⁴⁰ According to https://www.nhvc.org/wp-content/uploads/NHVC_Yearbook_2018_FINAL.pdf, <https://homvee.acf.hhs.gov/models.aspx>

MODEL PROFILES

Healthy Families America (HFA)⁴¹

(<https://www.healthyfamiliesamerica.org/>)

Domain outcomes reported by DHHS as *Favorable* in high or moderate-quality studies: All 8

Child development and school readiness

Child health

Family economic self-sufficiency

Linkages and referrals

Maternal health

Positive parenting practices

Reductions in child maltreatment

Reductions in juvenile delinquency, family violence, and crime

Theoretical Foundation

- Early, nurturing relationships are believed to be foundation for life-long, healthy development.
- Builds upon attachment and bio-ecological systems theories and tenets of trauma-informed care
- Interactions between direct service providers and families are:
 - relationship-based
 - designed to promote positive parent-child relationships and healthy attachment
 - strengths-based
 - family-centered
 - culturally sensitive
 - reflective

Target Outcomes

- Reducing child maltreatment
- Improving parent-child interactions and children's social-emotional well-being
- Promoting children's school readiness

Target Populations

- Pregnant women and children from birth - 48+ months
- Parents facing challenge(s), such as:
 - single parenthood
 - low income
 - childhood history of abuse and other adverse child experiences
 - current or previous issues related to substance abuse
 - mental health issues
 - domestic violence
- Sites must enroll families prenatally or within three months of the child's birth.

⁴¹ <https://homvee.acf.hhs.gov/Implementation/3/Healthy-Families-America--HFA--sup---sup-/10/1>

- Sites offer services to families until the child’s third birthday or up to the child’s fifth birthday.
- Sites select target population they plan to serve (e.g., first-time parents, parents on Medicaid, parents within a specific geographic region).

Model Features

- Includes:
 - screenings and assessments to determine families at risk for child maltreatment or other adverse childhood experiences
 - home visiting services
 - routine screening and assessment of parent-child interactions, child development, and maternal depression
 - parent support groups and father involvement programs (some sites only)
Note: HFA encourages local sites to implement additional services such as these that further address the specific needs of their communities and target populations.
- Frequency:
 - At least one home visit per week for the first six months after the child’s birth
 - After the first six months, number of visits may decrease.
Note: Visit frequency is based on families’ needs and progress over time.
- Each home visit generally lasts one hour.

Geographic Coverage

More than 550 affiliated sites across 38 states, the District of Columbia, American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands.

Parents as Teachers (PAT)⁴²

(<https://parentsasteachers.org/>)

Domain outcomes reported by DHHS as *Favorable* in high or moderate-quality studies: 4

Child development and school readiness
Family economic self-sufficiency

Positive parenting practices
Reductions in child maltreatment

Theoretical Foundation

- Idea that affecting parenting knowledge, attitudes, behaviors and family well-being impacts the child's developmental trajectory
- Grounded in Urie Bronfenbrenner's Human Ecology Theory and Family Systems Theory and also informed by additional theories, including developmental parenting, attribution theory, and self-efficacy theory
- Focuses on three areas of emphasis:
 - parent-child interaction
 - development-centered parenting
 - family well-being

Target Outcomes

- Increase parental knowledge of early childhood development and improve parenting practices
- Provide early detection of developmental delays and health issues
- Prevent child abuse and neglect
- Increase children's school readiness and school success

Target Populations

- Pregnant women and children from birth - 48+ months
- PAT affiliates select the specific characteristics and eligibility criteria of the target population they plan to serve. Criteria and characteristics might include:
 - children with special needs
 - families at risk for child abuse
 - parental income
 - teenage parents
 - first-time parents
 - immigrant families
 - low literacy among parents
 - parents with mental health or substance use issues

⁴² <https://homvee.acf.hhs.gov/Implementation/3/Parents-as-Teachers--PAT--sup--sup-/16/1>

Model Features

- one-on-one personal (or home) visits
 - Affiliates must offer at least 12 home visits annually to families with one or no high-needs characteristics and at least 24 home visits annually to families with two or more high-needs characteristics.

Note: Visit frequency may be gradually decreased as the family transitions out and into other services.

- Home visits last approximately 60 minutes.
- at least 12 group connections (or meetings) annually
- health and developmental screenings for children every year
- linkages and connections for families to needed resources
- Must offer services to enrolled families for at least two years

Adaptations

Affiliates can offer additional strategies (beyond the four core model components) or make model adaptations needed to best address families' needs at the local level, such as:

- culturally responsive
- directed to special populations
- offered in conjunction with other early childhood programs
- rural and/or indigenous populations

Geographic Coverage

All 50 states and the District of Columbia, as well as six countries internationally.

Nurse-Family Partnership (NFP)⁴³

(<https://www.nursefamilypartnership.org/>)

Domain outcomes reported by DHHS as *Favorable* in high or moderate-quality studies: 7

Child development and school readiness
Child health
Family economic self-sufficiency
Maternal health

Positive parenting practices
Reductions in child maltreatment
Reductions in juvenile delinquency, family violence, and crime

Theoretical Foundation

- Shaped by human attachment, human ecology, and self-efficacy theories
- Client-centered and driven by client-identified goals
- NFP nurse home visitors use input from parents, nursing experience, nursing practice, and a variety of model-specific resources coupled with the principles of motivational interviewing to promote low-income, first-time mothers' health during pregnancy, care of their child, and own personal growth and development.

Target Outcomes

- Improve prenatal and maternal health and birth outcomes
- Improve child health and development
- Improve families' economic self-sufficiency and/or maternal life course development

Target Populations

- Pregnant women and children from birth - 23 months
- First-time, low-income mothers and their children.
 - Mothers may invite fathers and other family members to participate in home visits.
- Client needs to enroll early in her pregnancy and receive a first home visit no later than the end of her 28th week of pregnancy.
- Services are available until the child is 2 years old.

Model Features

One-on-one home visits between a registered nurse educated in the NFP model and the client:

- NFP nurses conduct weekly home visits for the first month after enrollment and then every other week until the baby is born. After the child's birth, client need determines the visit schedule.

⁴³ <https://homvee.acf.hhs.gov/Implementation/3/Nurse-Family-Partnership--NFP--sup---sup-/14/1>

- Clients are assessed using the Strength and Risk Framework at enrollment, after the child’s birth, and regularly throughout the program. The results determine the visit schedule and where the visits will be held - the client’s home or another location.
- Home visits typically last 60 to 75 minutes.
- NFP NSO recommends that programs begin conducting visits early in the second trimester and requires programs to begin visits by the end of the 28th week of pregnancy. Clients graduate from the program when the child turns 2 years old.

Adaptations

- In some tribal communities, NFP has enrolled women with previous births.
- Dr. David Olds at the Prevention Research Center at the University of Colorado manages any requests for enhancements to the model.

Geographic Coverage

42 states, the U.S. Virgin Islands, and several tribal communities

Early Head Start Home-Based Option (EHS-HBO)⁴⁴

(<https://eclkc.ohs.acf.hhs.gov/programs/article/home-based-option>)

Domain outcomes reported by DHHS as *Favorable* in high or moderate-quality studies: 6

Child development and school readiness

Family economic self-sufficiency
Linkages and referrals

Maternal health

Positive parenting practices

Reductions in child maltreatment

Theoretical Foundation

A comprehensive, two-generation federal initiative aimed at enhancing the development of infants and toddlers while strengthening families.

Founded on the following principles:

- High-quality services
- Activities that promote healthy development and identify atypical development at the earliest stage possible
- Positive relationships and continuity, with an emphasis on the role of the parent as the child's first, and most important, relationship
- Activities that offer parents a meaningful and strategic role in the program's vision, services, and governance
- Inclusion strategies that respect the unique developmental trajectories of young children in the context of a typical setting, including children with disabilities
- Cultural competence that acknowledges the profound role that culture plays in early development
- Comprehensiveness, flexibility, and responsiveness of services that allow children and families to move across various program options over time as their life situation demands
- Transition planning
- Collaboration with community partnerships that allow programs to expand their services.

Target Outcomes

- Promote healthy prenatal outcomes for pregnant women
- Enhance the development of very young children
- Promote healthy family functioning

Target Populations

- Pregnant women and children from birth to 3 years of age
- Low income - Most families must be at or below the federal poverty level.

⁴⁴ <https://homvee.acf.hhs.gov/Implementation/3/Early-Head-Start-Home-Based-Option--EHS-HBO-/8/1>

- Ten percent of enrollees should be children with disabilities who are eligible for Part C services under the Individuals with Disabilities Education Act in their state.
- Each program is allowed to develop specific program eligibility criteria, aligned with the model's performance standards.

Model Features

- Weekly 90-minute home visits, with a minimum of 46 home visits per year
- Two group socialization activities per month for parents and their children, with a minimum of 22 group socialization activities each year

Geographic Coverage

All 50 states, the District of Columbia, and the U.S. territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands

Health Access Nurturing Development Services (HANDS) Program⁴⁵

[\(http://www.kyhands.com/\)](http://www.kyhands.com/)

Domain outcomes reported by DHHS as *Favorable* in high or moderate-quality studies: 4

Child health

Family economic self-sufficiency

Maternal health

Reductions in child maltreatment

Theoretical Foundation

Key assumptions:

- All families have strengths.
- Families are responsible for their children.
- Families are the primary decision makers regarding their children.
- Communities recognize their roles in children's lives.
- Communities recognize that all children must succeed.
- Public and private partnerships are vital to a successful program.
- Prevention and early intervention improve the community's well-being.

Target Outcomes

- Improve pregnancy and birth outcomes
- Enhance child growth and development
- Create safe homes
- Promote self-sufficient families

Target Populations

- Pregnant women and children from birth - 23 months
- First-time parents beginning during pregnancy or any time before a child is 3 months old.
- Eligible families face multiple challenges, including single-parent status, low incomes, substance abuse, and domestic violence.

Model Features

- Screening families for risk factors
 - Screening may occur prenatally or after birth until the child is 3 months old.
 - Risk factors include:
 - ✓ unemployment
 - ✓ isolation
 - ✓ substance abuse
 - ✓ unstable housing
 - ✓ low parental education
 - ✓ domestic violence
 - ✓ poor prenatal care
 - ✓ depression
 - ✓ single parenting
 - ✓ noncompliance with prenatal care
 - ✓ unsuccessful abortion

⁴⁵ <https://homvee.acf.hhs.gov/Implementation/3/Health-Access-Nurturing-Development-Services--HANDS--Program/37/1>

✓ use of tobacco

✓ prenatal and infant exposure to secondhand smoke

- A trained home visitor conducts home visits; frequency is determined on the basis of the family's needs.
- Home visitors use the Growing Great Kids™ (GGK) curriculum and provide services that focus on supporting the family, family-child interaction, child development, and personal responsibility.
 - Services include developmental and social-emotional screenings for children and domestic violence and perinatal depression screening for parents.
- Health prevention: Home visitors work with families to maintain up-to-date immunizations and well-child checks.
- A registered nurse or social worker provides quarterly visits to focus on:
 - signs of premature labor
 - labor and delivery
 - home safety
 - basic care
 - nutrition
 - exercise
 - safe sleeping
 - effects of smoking and secondhand smoke
 - stress
 - babies' cues
 - injury prevention
 - child development and temperament
 - adjustment to parenting
- The family support worker, supervisor, and family determine the intensity of services based on a family's progression through the HANDS program and their assessed need. As families progress frequency of visits drops from weekly to biweekly to monthly to every 3 months.
- Home visits average an hour in duration.

Adaptations for Special Populations

HANDS currently implements Moving Beyond Depression™ (MBD), a model that uses a 15-session treatment called in-home cognitive-behavioral therapy (IH-CBT), which focuses on alleviating symptoms of depression and increasing coping skills.

- A licensed and trained therapist travels to the mother's home to facilitate the IH-CBT sessions.
- The therapy concludes with a joint session in which the therapist and home visitor verbalize the mother's accomplishments, use of coping skills, and future recommendations for treatment and success.

Geographic Coverage

All 120 Kentucky counties

Healthy Beginnings⁴⁶

(<http://www.healthybeginnings.net.au/>)

Domain outcomes reported by DHHS as *Favorable* in high or moderate-quality studies: 4

*Child development and school
readiness
Child health*

*Maternal health
Positive parenting practices*

Theoretical Foundation

- Designed to prevent children from becoming overweight and obese
- Drew on research demonstrating the link between being overweight and obese during childhood and immediate and long-term adverse health and social-emotional effects
- Recognizing that a child's environment influences nutrition and physical activity, the program uses a family-focused approach to address risk factors associated with childhood obesity.

Target Outcomes

To prevent childhood obesity by:

- improving child and family eating patterns
- reducing sedentary activities, such as television viewing
- increasing physical activity

Target Populations

- Pregnant women and children from birth - 23 months
- First-time mothers of infants from socially and economically disadvantaged areas of South Western Sydney

Model Features

- Nurse home visitors address the following topics during each visit: infant nutrition and physical activity, family nutrition and physical activity, and family social support.
 - Using questions tailored to the child's age, the nurses initiate discussions and provide information on topics listed in a visit checklist.
- The home visitors offer referrals if the family had questions or concerns unrelated to the discussion topics. Telephone support is available between visits.
- Families receive eight home visits at the following stages: the prenatal period, and at 1, 3, 5, 8, 12, 18, and 24 months.

⁴⁶ <https://homvee.acf.hhs.gov/Implementation/3/Healthy-Beginnings/65/1>

- The visits are designed to coincide with early childhood developmental milestones related to feeding practices, nutrition and physical activity, and parent–child interactions.
- Each visit ranges in length from 45 to 90 minutes.

Geographic Coverage

South Western Sydney, Australia

SafeCare® Augmented

<https://safecare.publichealth.gsu.edu/training/safecare-augmented/>

Domain outcomes reported by DHHS as *Favorable* in high or moderate-quality studies: 5

Child development and school readiness
Linkages and referrals

Maternal health
Positive parenting practices
Reductions in child maltreatment

Theoretical Foundation

SafeCare offers intervention to parents at risk for child abuse and neglect, based on Project 12-Ways,⁴⁷ an ecobehavioral approach to the treatment and prevention of child abuse and neglect.

- Includes three modules:
 - Planned Activities Training, which focuses on parent-child/parent-infant interactions
 - Infant and child health
 - Home safety
- Model emphasizes learning in a social context and uses behavioral principles for parent training.

SafeCare Augmented, an enhanced version of SafeCare, adheres to the SafeCare model with additional training on Motivational Interviewing and domestic violence and ongoing consultation for providers from local experts in substance use and mental health.

Note: Only SafeCare Augmented meets DHHS criteria for an evidence-based model.

Target Outcomes

To prevent and address factors associated with child abuse and neglect by offering services targeting improved health care skills, including:

- identifying symptoms of illness or injury and seeking appropriate treatment
- safety of the home environment
- parenting skills (e.g., providing stimulating activities and positive parent-child interactions)

⁴⁷ <https://project12-ways.siu.edu/>

Target Populations

- Parents with children ages from birth to 5 years of age - program typically delivered between 18 and 22 weeks.
- Model has been used with culturally diverse populations.
- Model is designed for families with a history of child maltreatment or risk factors for child maltreatment, including:
 - young parents
 - parents with multiple children
 - parents with a history of depression or other mental health problems, substance use, or intellectual disabilities
 - foster parents
 - parents being reunified with their children
 - parents recently released from incarceration
 - parents with a history of domestic violence or intimate partner violence
- The model also serves parents of children with developmental or physical disabilities, or mental health, emotional, or behavioral issues.

Model Features

- One-on-one home visits between providers and families.
- Includes three modules:
 - 1) Planned Activities Training, which aims to teach parents to provide engaging and stimulating activities, increase positive interactions, and prevent troublesome child behaviors.
 - 2) Infant and child health, which trains parents to use health reference materials, record health information, use basic health supplies (such as a thermometer), prevent illness, identify symptoms of childhood illnesses or injuries, and provide or seek appropriate treatment.
 - 3) Home safety, which helps parents identify and eliminate safety and health hazards to children.
- A baseline assessment and observation of parental knowledge and skills, followed by four parent training sessions, and conclude with a follow-up assessment to monitor change.
 - Providers use a four-step approach during the parent training sessions to address target behaviors: (1) describe and explain the rationale for each behavior, (2)

model each behavior, (3) ask the parent to practice the behavior, and (4) provide positive and constructive feedback. This approach is designed to promote generalization of skills across time, behaviors, and settings.

- SafeCare providers conduct weekly or biweekly home visits for approximately 50 to 90 minutes each.

Adaptations

- SafeCare Augmented has also been adapted for use with high-risk, rural families who do not have a long history of involvement with child welfare services.
- Cellular Phone Enhanced Planned Activities Training is an add-on to SafeCare's Planned Activities Training module that incorporates cellular telephones to promote family engagement between home visits.
 - Providers send families daily text messages and occasional voice messages to encourage and remind them about newly learned parenting strategies.

Geographic Coverage

SafeCare providers in 25 states and abroad - in Australia, Belarus, Canada, Israel, Japan, Spain, Taiwan, and the United Kingdom

Project 12-Ways has been implemented in southern Illinois for more than 30 years.

Child First⁴⁸

(<http://www.childfirst.org/>)

Domain outcomes reported by DHHS as *Favorable* in high or moderate-quality studies: 4

Child development and school readiness
Linkages and referrals

Maternal health
Reductions in child maltreatment

Theoretical Foundation

Based on brain development research, which shows that:

- extremely high-stress environments (including poverty, maternal depression, domestic violence, abuse and neglect, substance abuse, and homelessness) are toxic to the developing brain of the young child
- the presence of a nurturing, consistent, and responsive parent-child relationship buffers and protects the brain from these stressors

Target Outcomes

- Aims to heal and protect young children from trauma and adversity
- Targeted child outcomes include: improved social-emotional development, mental health, language and cognitive development, and executive functioning
- Targeted parent outcomes include: reduced depression and other mental health problems, decreased parenting stress, and improved executive functioning
- Promote healthy child and family development by:
 - fostering a strong, nurturing parent-child relationship
 - decreasing involvement with child protective services
 - increasing connections to community-based services and supports for the child and other family members

Target Populations

- Child First targets pregnant women and families with children from birth through age 5 in which:
 - children have emotional, behavioral, or developmental challenges
 - family faces multiple environmental and psychosocial challenges that may lead to negative child outcomes, such as maternal depression, domestic violence, substance abuse, homelessness, or abuse and neglect
- Families are served without regard for their ability to pay, legal status, or number of children in the family.

⁴⁸ <https://homvee.acf.hhs.gov/Implementation/3/Child-First/42/1>

Model Features

- Each family is assigned a Child First team consisting of:
 - a licensed, master’s-level mental health/developmental clinician, who is responsible for assessment and therapeutic intervention,
 - a care coordinator, who is responsible for connecting families to community services and supports.

They provide the following services:

- ✓ *Assessment of child and family needs.* The clinician and care coordinator team uses an ecological approach to assess the child’s health and development, important relationships, and family challenges, and a protocol of standardized and informal measures.
 - ✓ *Observation and consultation in early care and education setting.* The clinician works with the teacher to develop classroom strategies to decrease challenging behaviors and enhance the child’s social-emotional development.
 - ✓ *Development of a child and family plan of care.* The Child First team collaborate with the family on a plan that reflects the parents’ goals, priorities, strengths, culture, and needs. Reviewed at least every three months, it is also a plan for intervention, supports, and community-based services for the child, parents, and other family members.
 - ✓ *Parent-child mental health intervention.* The home-based intervention incorporates both trauma-informed Child-Parent Psychotherapy (CPP; based on the work of Lieberman and Van Horn) and parent guidance. It is a two-generation approach, designed to strengthen the parent-child relationship and promote secure attachment so that the relationship serves both as a protective buffer to unavoidable stress and directly facilitates emotional, language, and cognitive growth.
 - ✓ *Care coordination.* The care coordinator provides intensive support during home visits to connect the family to comprehensive community-based services and supports and addresses barriers to access. The care coordinator aims to build parents’ capacity for executive functioning through goal setting, planning, prioritizing, and revising; and by connecting families to resources.
- The intensity and length of Child First services vary based on child and family needs.
 - Engagement/assessment phase (first month): Home visits are scheduled twice per week for 60 to 90 minutes, and clinicians and care coordinators visit families together. Thereafter, the individual needs of the child and family determine when visits are made together or separately.
 - Intervention phase: Each family is visited weekly, at a minimum. Visits can be more frequent if there is high need, with intensity of the visits determined by the unique goals of the family.

- Child and family needs determine the length of service, which is usually from 6 to 12 months. However, the intervention can be longer if there are significant challenges.

Geographic Coverage

15 sites across Connecticut; Palm Beach County, Florida; and 25 counties in eastern North Carolina

Early Start (New Zealand)⁴⁹

(www.earlystart.co.nz)

Domain outcomes reported by DHHS as *Favorable* in high or moderate-quality studies: 4

Child development and school readiness
Child health

Positive parenting practices
Reductions in child maltreatment

Theoretical Foundation

- Early Start aims to create a collaborative, problem-solving partnership between the home visitor and family to maximize child health, increase child and family well-being, build strengths, and eliminate deficiencies. Early Start recognizes that child well-being can occur only through the more general health and well-being of the family, although the target child is treated as the primary focus of services.
- Efforts aimed to create a universal model that can be delivered to both Māori and non-Māori families in a culturally responsive way.

Target Outcomes

- Improve child health
- Reduce child abuse
- Improve parenting skills
- Support parental physical and mental health
- Encourage family economic well-being
- Encourage stable, positive partner relationships

Target Populations

- Children from birth - 48+ months
- At-risk families (with substance abuse, family violence, child abuse and/or neglect) with newborn children up to age 5.
- Māori, an indigenous population of New Zealand.

Model Features

- Three-stage eligibility determination process. First, Early Start administers a short risk assessment containing items on maternal age, extent of family support, whether the pregnancy was planned or unplanned, substance abuse, family violence, and child abuse and neglect. Any family with two or more risk factors continues to the next stage of the process.
- One-month assessment period for families to become acquainted with the program and for Early Start to learn about the family

⁴⁹ <https://homvee.acf.hhs.gov/Implementation/3/Early-Start--New-Zealand-/38/1>

- In-depth needs assessment based on a modified version of the Kempe Family Stress Checklist
- Early Start provides home visitation services based on four established curricula:
 1. Partnership in Parenting Education (PIPE) “Listen, Love, Play,” which focuses on listening, trust, language, problem solving, feelings, and how babies learn
 2. Triple P (Positive Parenting Program), which focuses on positive parenting practices and means to address childhood behavior problems
 3. Getting Ready for School focused on 4-year-olds
 4. Incredible Years
- Additional services based on need:
 - Infant and child safety awareness
 - Linkages to supportive services in the community, including budget, health, and relationship services
 - Advice and support concerning healthy lifestyle choices, including family and child nutrition
 - Household and time management
- Includes four levels of service intensity, ranging from 3 hours per week to 1 hour per 3 months

Adaptations

Both a breastfeeding support group for young parents and services focused on the early years are available through Early Start Project Ltd.

Geographic Coverage

Christchurch area of New Zealand.

Family Spirit⁵⁰

(<https://www.jhsph.edu/research/affiliated-programs/family-spirit/>)

Domain outcomes reported by DHHS as *Favorable* in high or moderate-quality studies: 3

Child development and school readiness

*Maternal health
Positive parenting practices*

Theoretical Foundation

- Based on G. R. Patterson’s model that posits parenting as the critical link between parents’ personal characteristics and environmental context and children’s individual risks and outcomes.
- The model also incorporates traditional tribal teachings throughout the curriculum. The model developers believe that cultural teachings are protective factors that can improve maternal and child health in American Indian communities.

Target Outcomes

- Increase parenting knowledge and skills
- Address maternal psychosocial risk factors that could interfere with positive child-rearing, such as drug and alcohol use, depression, low education, unemployment, and intimate partner violence
- Promote optimal physical, cognitive, and social/emotional development for children ages birth to 3 years
- Prepare children for early school success
- Ensure children receive recommended well-child visits and health care
- Link families to community services to address specific needs
- Promote parents’ and children’s life skills and behavioral outcomes across the lifespan

Target Populations

- Pregnant women and families with children younger than age 3. Family Spirit recommends initiating the program by at least 28 weeks of gestation and continuing until the child’s third birthday.
- Native American communities
- Also used with non-Native populations with high maternal and child behavioral health disparities

Model Features

- Paraprofessional health educators visit families in their homes.
 - They try to establish a close rapport with families to facilitate delivery of the curriculum, which consists of 63 lessons within the following six domains:

⁵⁰ <https://homvee.acf.hhs.gov/Implementation/3/Family-Spirit-sup---sup-/60/1>

prenatal care, infant care, child development, toddler care, life skills, and healthy living. Lessons are intended to be taught sequentially over 52 home visits.

- The health educators also refer families to community resources to address specific needs.
- Home visits are more intensive in the prenatal and newborn stages and diminish in frequency as children age.
 - The model developers recommend weekly visits through the child's first 3 months, biweekly from 4 to 6 months, monthly from 7 to 22 months, and bimonthly from 23 to 36 months of age.
- Visits typically last 45 to 90 minutes.

Adaptations for Special Populations

- Family Spirit allows affiliates to make enhancements to the curriculum and model to meet program and families' needs at the local level.
 - Affiliates can incorporate cultural enhancements and add group sessions on Family Spirit lessons, such as basic infant and toddler care or life skills.
- The Family Spirit national office at the Johns Hopkins University Center for American Indian Health must approve adaptations to the model.

Geographic Coverage

Over 100 reservation-based and urban Native communities across 17 states, including two non-Native urban communities with high maternal and child behavioral health disparities

GAPS IN RESEARCH

- More high- or moderate-quality studies are needed to determine effectiveness of models across the board.
- In order to have larger sample sizes, more studies of families with different characteristics are needed.
- Little or no research has been conducted on the impact of these models on military families.

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ADDITIONAL RESOURCES

Lists of Research Studies on Each Model Profiled

Healthy Families America (HFA)®

- <https://static1.squarespace.com/static/55ccef2ae4b0fc9c2b64f3a1/t/56d9a0eaa3360cb115e290c0/1457103084618/HFA+Evaluation+Table+2015.pdf>
- <https://homvee.acf.hhs.gov/Studies/Healthy-Families-America--HFA--Study-Search/10>

Parents as Teachers (PAT)®

- <https://parentsasteachers.org/evidence-based-research>,
<https://homvee.acf.hhs.gov/Studies/Parents-as-Teachers--PAT--Study-Search/16>

Nurse-Family Partnership (NFP)®

- <https://www.nursefamilypartnership.org/about/proven-results/published-research/>
- <https://homvee.acf.hhs.gov/Studies/Nurse-Family-Partnership--NFP--Study-Search/14>

Early Head Start Home-Based Option (EHS-HBO)

- [https://homvee.acf.hhs.gov/Studies/Early-Head-Start-Home-Visiting-\(EHS-HBO\)/8](https://homvee.acf.hhs.gov/Studies/Early-Head-Start-Home-Visiting-(EHS-HBO)/8)

Health Access Nurturing Development Services (HANDS) Program

- <https://homvee.acf.hhs.gov/Studies/Health-Access-Nurturing-Development-Services--HANDS--Program/37>

Healthy Beginnings

- <https://homvee.acf.hhs.gov/Studies/Healthy-Beginnings-Study-Search/65>

SafeCare® Augmented

- <https://homvee.acf.hhs.gov/Studies/SafeCare-Study-Search/18>

Child First

- <https://homvee.acf.hhs.gov/Studies/Child-First-Study-Search/42>,
<https://www.childfirst.org/our-impact/research>

Early Start (New Zealand)

- <https://www.earlystart.co.nz/research/>
- <https://homvee.acf.hhs.gov/Studies/Early-Start--New-Zealand--Study-Search/38>

Family Spirit®

- <https://www.jhsph.edu/research/affiliated-programs/family-spirit/proven-results/publications/>,
- <https://homvee.acf.hhs.gov/Studies/Family-Spirit-Study-Search/60>

APPENDIX A: CalWORKs HVI Requirements

CalWORKs HVI Request for County Plan

4. Requirements for Home Visiting Models

To be determined eligible for funding, the home visiting model must have demonstrated evidence of effectiveness (See HomVEE in the Glossary of Terms). Evidence-based home visiting models that are not identified by HomVEE to meet United States Department of Health and Human Services (HHS) criteria for evidence-based home visiting programs must submit a copy of the model's evaluation of efficacy.

In addition to the evidence-based model criteria, approval of the county plan is contingent upon counties and each home visiting model's ability to implement the mandatory criteria outlined below and demonstrate the capacity to integrate additional criteria in the delivery of home visiting services. The Department will utilize the scoring criteria as referenced below.

Mandatory Criteria

Criteria	Description
Home Visiting Model <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	The home visiting model is identified by HomVEE to meet the HHS criteria for evidence-based home visiting programs or the home visiting model is an evidence-based model with an evaluation included with the RFCP. <i>Please note, home visiting models without an evaluation will not be considered for funding.</i>
Capacity <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	The home visiting model demonstrates capacity to serve the linguistic and cultural needs of the target population.
Ability to Serve Target Populations <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	The home visiting model demonstrates a plan to offer and continue to provide home visiting services to the target population of pregnant women with no other children, or first-time caretaker relatives of children less than twenty-four months old.
Home Visitor Qualifications <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Home visitors are registered nurses, nurse practitioners, social workers, or other persons able to provide culturally and linguistically appropriate services who are trained and certified, and have completed a background check.
Training <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Home visitors will complete all required trainings as outlined in the Part III - Assurances, prior to visiting homes.
Implementation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Home visiting services will begin being offered no later than April 1, 2019.
Duration <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	The home visiting model includes the provision of home visiting services for a minimum of 24 months.
Home Visiting Outcome Domains <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	The home visiting model includes collaboration with other service providers to leverage and expand resources and referrals relating to all of the following: (1) Prenatal, infant, and toddler care; (2) Infant and child nutrition; (3) Developmental screening and assessments; (4) Parent

CalWORKs HVI Request for County Plan

Criteria	Description
	education, parent and child interaction, child development, and child care; (5) Job readiness and barrier removal; and, (6) Domestic violence and sexual assault, mental health, and substance abuse treatment.
Case Management <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	The home visiting agency and the county have, or plan to establish, a collaborative case management plan.
Screening and Assessment Tools <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	The home visiting agency used standardized data collection tools (E.g. screenings, assessments, questionnaires, interviews), and procedures to evaluate the status and track progress in educational, developmental, health, and other domains for the child and the adult.
Data Collection <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	The home visiting model has policies, procedures, and systems in place to collect data for evaluation purposes.

If you answered “NO” to any of the above mandated requirements, please DO NOT complete the RFCP. All of the mandatory criteria listed above are required.

Additional Criteria

County plans will also be scored and evaluated considering the following criteria:

Criteria	Description
Experience	The home visiting agency has a minimum of three years of experience serving CalWORKs clients or CalWORKs-eligible clients.
Model Fidelity	Home visiting agency has the appropriate supervision and infrastructure to maintain fidelity to the model.
Outreach	Home visiting recruitment and outreach strategies are established.
Frequency	The home visiting agency has a demonstrated capacity to provide services to the same participant at least monthly and multiple times per month as needed.
Attrition	Home visiting agency has a plan to minimize attrition.
Early Learning Setting	Processes and procedures are in place to ensure home visitors encourage CalWORKs participants to engage in high-quality early learning settings.
Resources for Immigrants	Home visiting model has a comprehensive plan to ensure home visitors connect families with immigration services and resources.
Material Goods	There is an established procedure to allocate funds for health and safety related items.

CalWORKs HVI Request for County Plan

Criteria	Description
Co-location	The home visiting agency co-locates with a CWD or provides a feasible reason as to why they are unable to co-locate.
Collaboration	Participation in a multi-disciplinary group that focuses on home visiting.
Sustainability	The home visiting agency has a strategic plan for sustainability of funding for home visiting services to the CalWORKs populations. (E.g. funding from local sources, leveraging federal or other resources).

a. Home Visitor Qualifications

In the proposal, counties must describe how they will ensure that home visiting agencies recruit and retain home visitors that reflect the population of the CalWORKs program. Home visits must be provided by a registered nurse, nurse practitioner, social worker, or other person able to provide culturally appropriate services, who is trained and has completed a background check.

Counties are required to provide evidence of home visitor qualifications. (Information about required home visitor trainings can found in Part III - Assurances).

b. Co-location and Collaboration

Participating counties are strongly encouraged to co-locate home visitors and County CalWORKs staff in order to facilitate communication and coordination of services.

The county and home visiting agency are highly encouraged to participate in a local multi-disciplinary group that focuses on home visiting. The workgroup will have the opportunity to share best practices, improve service delivery, ensure systems integration, and develop solutions to issues that may arise.

Local home visiting workgroup partners may include, but are not limited to, local and state home visiting agencies; representatives of counties; CalWORKs clients; advocates; home visitors; home visiting experts; behavioral health organizations; family resource centers; local First 5 Commissions; and other interested partners.

5. Statewide Stakeholder Collaboration Meetings

The CDSS will convene counties with participating home visiting programs twice annually, beginning no later than April 1, 2019, to share challenges, lessons learned, and best practices. These meetings shall be maintained indefinitely to provide continuous quality improvement utilizing the data collected.

APPENDIX B: California Work Opportunity and Responsibility to Kids Home Visiting Initiative Letter to County Welfare Directors



STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov



July 31, 2018

ALL COUNTY WELFARE DIRECTORS LETTER (ACWDL)

TO: ALL COUNTY WELFARE DIRECTORS

FROM: TODD R. BLAND, Deputy Director
Family Engagement and Empowerment Division

SUBJECT: CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS
HOME VISITING INITIATIVE

The California Department of Social Services (CDSS) is seeking proposals from counties interested in implementing a new California Work Opportunity and Responsibility to Kids (CalWORKs) Home Visiting Initiative (HVI).

PURPOSE AND ELIGIBLE POPULATION

The purpose of the HVI is to support positive health, development, and well-being outcomes for pregnant and parenting women, families, and infants born into poverty, expanding their future educational, economic, and financial capability opportunities, and improving the likelihood that they will exit poverty.

Home visiting is an evidence-based, voluntary program model that pairs new parents with a nurse, or other trained professional who makes regular visits in the participant's home to provide guidance, coaching, access to prenatal and postnatal care, and other health and social services. The pairing of home visiting with CalWORKs provides an opportunity to connect parents with necessary resources, improve their parenting skills and household order, and ensure that their children have a safe and nurturing environment that allows them to thrive and grow.

Senate Bill 840 (Chapter 29, Statutes of 2018), or the Budget Act of 2018, appropriated approximately \$26.9 million for January 1, 2019 through June 30, 2019. Assembly Bill 1811 (Chapter 35, Statutes of 2018) codified the requirements for the HVI. Subject to appropriation in the annual Budget Act, the Department shall continue to award funds to participating counties who apply biennially and, at least, meet the minimum requirements established by the CDSS. The funds appropriated may be used in combination with funding from other sources.

Funding for the HVI will be used to provide counties with resources to offer home

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visiting services to a member of a CalWORKs assistance unit who is pregnant, with no other children at the time of enrollment, or a first-time parent or caretaker relative of a child less than twenty-four months at the time he or she enrolls in the HVI. A county may serve additional eligible CalWORKs participants as long as the county continues to offer and provide home visiting services to the target population noted above.

A member of the assistance unit does not need to be eligible for, nor is required to participate in, the Welfare-to-Work program in order to receive home visiting services.

PRIMARY PROGRAM COMPONENTS

Voluntary Evidence-Based Home Visitation

CalWORKs participants electing to participate in the HVI will receive coaching and guidance through regular, planned home visits. Participants will obtain information about strategies to improve their family's health and provide better developmental opportunities for their children. CalWORKs participants will also receive information that will connect them to an array of employment and other services. Home visitors will provide resources directly and refer families to services so that families can receive the support they need. If a family chooses to participate in this program, their participation shall not affect their application for aid nor eligibility for any other CalWORKs benefits, supports, or services.

Case Management Services

The county and home visiting agency shall establish a collaborative case management plan. These activities include assessing the family's needs, developing a case plan, monitoring progress in achieving case plan objectives, and ensuring the provision of all services specified in the case plan. The case plan should build on the strengths established during the home visiting period, and the family's associated connections to child care.

Coordination with County Staff

Home visitors shall coordinate closely with county CalWORKs staff. Close coordination and communication between home visitors and the county staff is essential to ensure that families have access to services without adding any additional burdens to the clients or duplication of processes and services by the county or home visiting agency. In order to promote collaboration between the two groups, counties are encouraged to co-locate home visitors and county CalWORKs staff.

Enrollment in Early Learning Programs

High-quality early learning programs have a demonstrated ability to improve both short-term and long-term outcomes for children with unmet needs. The home visitors will encourage families to enroll their child(ren) in high-quality early learning settings, participate in playgroups, or engage in other child enrichment activities. Parents will have an opportunity to select from high-quality early learning settings that may provide developmental screenings and assessments, and offer a core curriculum that is developmentally, culturally, and linguistically appropriate. If a parent volunteers in the

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early learning setting, these hours shall count towards their allowable activities under their Welfare-to-Work (WTW) plan. Children enrolled in an early learning setting through the HVI, may remain enrolled for 24-months regardless of the parent's participation in activities.

DATA COLLECTION AND PROGRAM EVALUATION

As a condition of funding, participating counties must provide data necessary to administer the program and demonstrate the outcomes of participants and children by race, ethnicity, national origin, primary and secondary language, and county. The data collection shall include program outcomes for the parents and children served in the program, models utilized, and measures specific to CalWORKs objectives.

Counties must develop a data sharing agreement with the home visiting agency and provide a copy of the agreement(s) to the Department. A sample data sharing agreement will be provided (Attachment C). Counties that are selected to participate in the HVI will also be required to participate in the evaluation.

INSTRUCTIONS FOR COUNTY APPLICATION

Criteria for Evaluation

Counties that choose to submit a Request for County Plan (RFCP) must use an evidence-based home visiting model. For this program, an evidence-based home visiting model means a home visiting model approved by the Department, which shall be evaluated considering criteria developed by the United States Department of Health and Human Services for evidence-based home visiting ([HomVEE](#)).

Applicant

The CDSS will accept one application per county from either the County Welfare Department (CWD) or county Department of Public Health (DPH). Counties should determine which department has the greatest capacity to meet the requirements of the program and deliver services effectively and efficiently. A Memorandum of Understanding (MOU) between the participating county agencies must be submitted prior to implementation. This agreement should include, but not be limited to, each agencies' specific roles and responsibilities, data sharing, and communication expectations. If the county DPH serves as the lead, the CWD must agree to participate and collaborate.

Regional Partnerships

Counties may choose to partner with other counties to deliver home visiting services regionally. Partnering counties must submit a joint RFCP by the due date. Additionally, a MOU between the counties, and an outline of specific roles and responsibilities in the implementation of the HVI shall be submitted to the CDSS prior to implementation.

Multiple Models May Be Utilized

Counties may choose to fund more than one home visiting model within their county. Each model must be outlined in the RFCP.

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Funding Allocations

The first cycle of funding is allocated for January 1, 2019 through June 30, 2019. The first application cycle will operate January 1, 2019 to June 30, 2020 (18 months). The next opportunity for application and funding cycle will be July 1, 2020 – June 30, 2022. Funding is subject to an appropriation in the annual Budget Act.

The services offered via the HVI are not entitlement services and participating counties may limit the number of families participating in the program to ensure that the costs do not exceed the amount of funds awarded to the county for this purpose. Funding awarded for the purpose of home visiting services provided under this article shall not supplant expenditures from any other existing funding sources subject to county control for home visiting services. Funding appropriated may be used in combination with funding from other sources, if the entirety of services provided meet the award requirements of the program.

Initial county allocations are based on the distribution of eligible cases per county, assuming statewide implementation, ensuring that each county has a minimum allocation of \$10,000. An amount of \$989,000 for Employment Services associated with the HVI will be included in the CalWORKs Single Allocation for counties participating in the HVI. After the approval of submitted plans, the CDSS will distribute any unallocated funds among participating counties. Final funding allocations and claiming instructions will be included in forthcoming County Fiscal Letters (CFLs).

Scoring

The nature of this application is a competitive process. It is possible that counties may not receive funding or may not receive the full amount of their request. In order for an application to be considered, the model selected must be evidence-based and meet the minimum requirements established on Page 4 of the RFCP. After demonstrating that the minimum requirements have been met, the application will be scored on criteria established by the CDSS (Page 5 of the RFCP).

A complete scoring rubric can be found in Attachment D.

TIMELINE

Please note the following timelines:

- Mandatory HVI Conference Call: August 10, 2018 from 1:30 PM – 3:30 PM
- Request for County Plan (RFCP) due: September 28, 2018
- Tentative Award Notification: October 2018
- Final Allocation letter for approved counties: November 2018
- Implementation Date of Program: January 2019

All RFCPs must be submitted to the Child Care Programs Bureau **by 5:00 p.m. on September 28, 2018**. RFCPs received after the deadline will not be reviewed or considered for funding.

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Please e-mail completed applications
(Subject line: FY 2018-19 HVI Request for County Plan) to:

CalWORKsHVI@dss.ca.gov

If you have any questions or are interested in applying for this program, please submit a request to CalWORKsHVI@dss.ca.gov. The application, along with any attachments, will be emailed to you.

OUR WHY:

REVOLUTIONIZE
THE WAY PEOPLE
WORK TO ENSURE
THE WORLD IS A
HEALTHIER PLACE.



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