



**WASHINGTON COUNCIL FOR
PREVENTION OF CHILD ABUSE & NEGLECT**
Children's Trust of Washington

Senate Bill 5830: Home Visiting Collaboration and Consolidation

Report to the Washington State Legislature

January 18, 2008

Background Information / Work Group Responsibilities

Engrossed Substitute Senate Bill (ESSB) 5830, passed during the 2007 legislative session, directed the Washington Council for Prevention of Child Abuse and Neglect/Children's Trust of Washington (WCPCAN/CT) to develop a plan with the Department of Social and Health Services (DSHS), the Department of Health (DOH), the Department of Early Learning (DEL) and the Family Policy Council (FPC) to coordinate or consolidate home visiting services for children and families.

A due date of December 1, 2007 was established for delivery of the report.

In July, WCPCAN/CT convened a work group of the agencies named in the bill to create the plan for coordination or consolidation and to develop recommendations for implementation of that plan. Input from national experts, community agencies and providers of home visiting services also informed the work group's recommendations. The work group held five meetings; a list of participants and contributors is available at the end of this report.

A Definition of Home Visiting

Home visiting is a modality for delivering an array of services administered in the home. Many of these services may be one-time visits, visits of convenience to administer a service typically delivered in another location, or a very specific type of home visit that impacts a very narrow outcome, such as home visits for children with asthma to help eliminate household allergens. However, there is a category of programs that serve children and families during the window of time from pregnancy to age five that are intended to improve maternal and child outcomes that, in turn, contribute to multiple benefits to the child during his or her lifetime. This report is focused on those types of programs, which are commonly referred to as “home visiting programs” by experts in the health, child abuse prevention, and school readiness fields both within the state and nationally.

Home visiting programs can be intensive and targeted to specific at-risk groups, or they can be universal and intended for any and all families who are choose to participate. According to the Center on the Developing Child at Harvard University in their report *A Science-Based Framework for Early Childhood Policy*, “Intensive family support through home visiting by skilled personnel can produce benefits for children and parents, especially when it is targeted to families at particular risk.”

Currently in Washington State, home visiting programs focus primarily on: assisting pregnant women in having healthy pregnancies; teaching parenting skills in their natural environment; identifying solutions to developmental or family problems; and using the parents, caregivers and extended family’s own experiences as the foundation for learning and improving. Pregnancy and early infancy have been shown to be times when parents (both mothers and fathers) are motivated to change behaviors and learn new skills. When home visiting services are provided as part of the transition to parenthood they can help lay the foundation for future parenting practices. Research clearly shows that infants are born learning and that brain development is most intense for children prenatal to age three, with continuing sensitive periods for brain development throughout childhood. For these reasons, home visiting services in Washington typically focus on children prenatally to age three and their families, though they may serve children up to age five.

While home visiting programs vary widely with respect to populations served and types of services provided, they commonly target high-risk pregnant women, families with infants, overburdened families at risk of abuse and neglect and children with special health care needs.

For the purposes of this plan, the work group has identified key components that contribute to making home visiting programs most effective. These criteria were culled from best practices among home visiting programs and research on the field. The work group agreed that expanding the definition of home visiting beyond what was written in the bill would be helpful for purposes of clarity and transparency and offers the suggested criteria below. These criteria are guidelines, and are not intended to be exclusive. The components are:

- Services are delivered at home.
- There is a program model that has a clear framework and utilizes standardized interventions that are evidence-based or research-based.
- Services are voluntary.
- Services are anchored by and based on an ongoing relationship between the visitor and the parent.
- Visits are regularly scheduled, happen at least monthly and often 2-3 times per month; and occur over a period of time.
- A specific population identified by demographic markers and/or risk factors is targeted for service.
- The program models typically begin serving parents prenatally or at the birth of a child but may begin as late as age two years.
- Services typically continue for a 2-3 year period.
- Services are implemented with fidelity as indicated in the framework of the model and as the research has indicated are most effective.

Existing Home Visiting Funded by State Agencies

In Washington, a number of state agencies currently support home visiting services. These services may be funded exclusively with state dollars, or with a combination of local funding and state and federal funds administered by the state agency. Since home visiting services impact a variety of positive outcomes, these services may be selected by one agency as a means of improving health outcomes and selected by another agency for improving safety, early learning or other outcomes. In each case, agencies choose program models best suited to advance their own mission and goals.

Because it is a program modality that addresses a variety of outcomes, a number of state agencies have employed home visiting services. There are home visiting programs that focus primarily on health outcomes, on literacy and school readiness outcomes, and on child abuse prevention and parenting skills outcomes. Since research shows that a single home visiting program can impact a variety of outcomes, a home visiting program may have health improvement as its primary goal, but also impact children's school readiness and parenting skills. However, since not all home visiting models achieve equal results in all outcome areas, nor are all programs of the appropriate intensity for a given family, Washington has developed an array of home visiting services.

The following is a brief description of home visiting services currently funded and/or administered by state agencies.

Department of Social and Health Services / Department of Health

DSHS and DOH jointly share the responsibility of managing the state's First Steps Program, designed to promote positive birth outcomes. Components of the program include Maternity Support Services (MSS) and Infant Case Management (ICM), both of which may offer home visits. MSS and ICM are available in every county. All pregnant women who receive Medicaid are eligible to receive MSS during pregnancy through two months postpartum. ICM is available for those Medicaid eligible infants and their families that meet the eligibility criteria anytime between 3 and 12 months after birth. MSS and ICM services may be administered in the home or in a clinic setting. First Steps utilizes research based practices and tools to deliver services, but it is not a home visiting model in the same way other programs such as Nurse Family Partnership are, with strict protocols and an outcome-based curriculum that is followed.

Home visits through First Steps include screening, assessment, education, brief interventions and case management, as well as referring and linking families to other appropriate services. In addition, First Steps dollars are used in some communities to specifically fund the Nurse Family Partnership program. The exact amount of the First Steps budget that is used for NFP is not clear because of how it is billed, but First Steps dollars are used in the 10 NFP sites in this state to fund that particular home visiting model. Each county uses their funding differently to pay for the NFP service, but typically First Steps is billed for approximately 9 hours of NFP services, which are usually used during the prenatal period and/or before the child is two months of age.

When First Steps dollars are exhausted, local health districts use funding from other sources (including other state agencies, local government, federal grants, or private dollars) to pay for the remaining years of NFP services. \$6.9 million of the MSS state funding and \$845,869 of the ICM state funding were spent on First Steps home visits in 2006.

Department of Social and Health Services:

DSHS is also spending approximately \$150,000 in the 07-08 fiscal year on the Promoting First Relationships home visiting model for families in the Children's Administration's Alternative Response System (ARS). The total ARS budget is \$2.1 million. Some other services provided by DSHS such as Family Preservation Services (FPS), Intensive Family Preservation Services (IFPS), and Functional Family Therapy (FFT) are family therapy models that happen to be delivered in the home, and are not truly voluntary services, so the work group agreed that they do not qualify as home visiting programs by the criteria it established.

Department of Health:

DOH provides federal Title V funding to 33 local health jurisdictions (LHJ's) and one hospital to improve the health of mothers, children and families in their communities. For Federal Fiscal Year 07, the total amount of Title V funding was \$5.4 million. This funding allows the LHJ's flexibility for activities responding to local needs in the maternal child health population. In most locales, a portion of the funding is used to support Public Health Nurse home visits, including partial funding for the Nurse Family Partnership program in 9 counties. There is no requirement that LHJ's use any specific home visiting program model. The exact amount of the total funding used for home visiting from this source is not known because that information is not required in reports received from counties.

In addition, the 2006 supplemental budget included \$150,000 for the Kitsap County Health District through the Department of Health for “Home Visits for Newborns”. The Kitsap Health District used this funding to support their Welcome Home Baby universal home visiting program, which provides one home visit for every newborn in the county. While continuation funding for this program was not included in the 07-09 budget, the county continues to operate Welcome Home Baby with other funding.

WCPCAN/Children’s Trust of Washington:

WCPCAN/CT is utilizing \$1.5 million of the new dollars appropriated in each of the 07-09 biennium fiscal years to support performance-based contracts with community-based agencies to provide evidence based home visiting services that promote optimal child development, support school readiness and prevent child abuse and neglect. The agencies funded by WCPCAN/CT implement a variety of home visiting models that include goals of supporting parent-child bonding, promoting maternal and child health and increasing parent knowledge of child development. Research shows that these strategies help prevent child abuse and neglect.

In addition to these state dollars, WCPCAN/CT receives approximately \$600,000 in federal dollars annually that it uses to fund capacity building grants to community-based agencies. Funding is determined through an annual competitive grant process. These grants made from federal dollars support both parent education and home visiting programs. The portfolio of funded programs changes each year; however, in the 07-08 fiscal year WCPCAN/CT’s federal dollars funded an additional \$40,000 in home visiting services.

Department of Early Learning:

The Department of Early Learning received approximately \$320,000 for the 07-08 state fiscal year to invest in culturally relevant parent and caregiver support and education. Since many communities have expressed interest in growing home visiting services as part of a desired spectrum of supports for families with young children and of a coordinated system of early learning supports, it is anticipated that some of the local projects seeking funding may include home visiting as a program strategy. However, the total amount of funding from that allocation that will go to home visiting services has not yet been released. DEL does not administer or oversee the home-based Early Head Start services funded with federal dollars through the Head Start State Collaboration Office. That money is allocated directly to grantee agencies in the state. However, the Department works collaboratively with Region X in supporting these programs. Home-based Early Head Start is entirely supported through the federal funding stream.

Family Policy Council:

Many Community Health and Safety Networks, the local affiliates of the Family Policy Council, have supported home visiting services as an important step in developing a comprehensive system for helping families improve health, safety, early childhood development and school readiness. However, the Family Policy Council Community Networks do not typically provide funding for home visiting for an extended period of time. Their investments in home visiting typically serve one of three purposes:

to demonstrate the effectiveness of home visiting services to a local funder that will sustain the services; to improve service quality through education and training of providers or by improving implementation fidelity; and to extend available resources by brokering local agreements about the match between models used in the community and population groups receiving services. This agreement allows a community to use a more expensive model (e.g. a model delivered by local public health nurses) for higher risk families and less expensive models for lower risk families without compromising desired outcomes.

One example of the investments a Network might make comes from the Thurston County Network. During the 1999-2001 biennium they funded a survey of home visiting programs in the county and found a need for improved professional standards, training and coordination. They then developed a cross-training curriculum and trained 50 providers in the area. They also convened a taskforce that decided to use two home visiting models, NFP and Parents as Teachers, to conduct home visits with new moms. The investment was \$7,500 for the biennium. In the 2001-2003 biennium they utilized research to convince the county government to invest in the continuum of home visiting services and helped support NFP directly with a total investment of approximately \$36,000 for the biennium. In 2003-2005 they provided grant writing services and staffed the collaborative that was working towards an integrated home visiting continuum for the county. Total investment during that biennium was about \$23,000. Their efforts helped to secure sustainable funding for the programs, and at that point the Network focused on providing technical assistance and helping to identify other funding sources for the continuum of services.

Total State Dollars Invested in Home Visiting

Given that some agencies and programs have not yet made funding decisions about the portion of their budget that will go to home visiting, or are providing support that is minimal and used only for start-up costs, it is difficult to provide a grand total of funding for home visiting services that comes from the state. However, the approximate amount is \$9.16 million in the current (07-08) state fiscal year, with an estimated total of \$18.3 million for the 07-09 biennium.

The accompanying chart provides detailed information about most of the home visiting services currently funded by state agencies. However, there are some limitations in terms of what the chart captures. It does not include the WCPCAN/CT federally funded home visiting programs or the \$350,000 that WCPCAN/CT is contracting to Thrive by Five for home visiting programs in the demonstration sites because the exact breakdown of which evidence based home visiting programs will be funded with those dollars has yet to be decided. The matrix also does not include the federal Title V funding because the amount that goes to home visiting cannot be determined. Finally, the matrix does not contain information about what, if anything DEL is funding with their parent support dollars or any fiscal support provided by the Networks (through the Family Policy Council).

	Program	State Investment	Other Investment	Target Population	Statewide Penetration	Age Range of Children	Service Intensity/ Duration	Program-Identified Outcomes	Identifying Characteristics/ Differences Between Models	Approx. Cost/ Family/ Year
Low Intensity, Moderate-High Frequency, Short Duration	First Steps - Maternity Support Services	HRSA administers this program through DOH, in FY 2006 approx. \$6.9 million for home visiting services	Federal dollars cover 51% of the program costs, so an additional approx. \$6.9 million was invested with federal dollars	All Medicaid eligible pregnant women in the state	In 2006, served 71.4% (28,853) of Medicaid eligible women (service varied by county with between 50 - 90% of eligible women being served)	Pregnancy through 2 months postpartum	Depends on pregnant moms needs. Max. of 60 units per pregnancy. One unit is equal to 15 minutes.	To enhance birth outcomes.	Services are provided by a multidisciplinary team: Comm. Health Nurse, Registered Dietician, Behavioral Health Specialists. This team may be assisted by a community health worker (paraprofessional) supervised by one of the clinician.	Calendar year 2006: Home visits cost 514.55 per person.
Low Intensity, Moderate-High Frequency, Short - Moderate Duration	First Steps - Infant Case Management	HRSA administers this program through DOH, in FY 2006 approx. \$571,000 for home visiting services	Federal dollars cover 51% of the program costs, so an additional approx. \$571,000 was invested with federal dollars	High-risk, Medicaid-eligible infants	Statewide penetration for 2006 is 22.2% (8,948) of Medicaid eligible infants	3 month to 12 month old infants	Depends on the severity of risk. Max. of 40 units per 9 - 10 months. One unit is equal to 15 minutes.	Linkage and referral to community resources to increase self sufficiency of parent/s	Services are provided by one of the multidisciplinary team members listed above or an ICM who has at least a two year degree and work experience in this field.	Calendar year 2006: Home visits cost \$233.91 per person.
High Intensity, High Frequency, Long Duration	Early Head Start	No state investment for home based services. No state agency oversight/ involvement in home based option.	Federal Early Head Start \$ provided directly to grantees	Low-income families. Priority given to high-risk families and children in foster care. Minimum of 10% of children need to be children with special needs.	22 sites in Washington. 934 families served through home-based services, 513 through center-based, and 178 families through combined home and center services	Pregnancy through 3 years	Weekly home visits by trained early childhood professionals. Minimum 32 visits a year. Minimum 1.5 hrs per visit. At least two group socialization meetings a month.	Increase parent knowledge of child development <ul style="list-style-type: none"> • Reduce parenting stress • Parents progress towards edu., literacy & employment goals • Enhance parent-child relationships • Improved child dev't • Early detection of dev't delays & health issues 	Services are comprehensive, covering family support, health, mental health and early intervention services. <p>Services offered in home, in center or combination of both based on families' needs.</p>	\$12,650 (not only home visiting. Also includes center-based care which may be full-day child care & combo models)

	Program	State Investment	Other Investment	Target Population	Statewide Penetration	Age Range of Children	Service Intensity/ Duration	Program-Identified Outcomes	Identifying Characteristics/ Differences Between Models	Approx. Cost/ Family/ Year
High Intensity, High Frequency, Long Duration	Nurse Family Partnership	WCPCAN/CT: approx. \$520K/yr DOH does NOT fund NFP directly. Local Public Health Districts MAY choose to invest. Currently 10 LPHD fund NFP, and they use some of their First Steps dollars to support the programs.	Medicaid dollars can be used to fund NFP. Typically 30% of NFP costs are covered by Medicaid.	First-time, low-income mothers	10 sites with capacity to serve approximately 900 families statewide	Early pregnancy through age 2 (families must enroll in early pregnancy)	Home visits occurring weekly to monthly by public health nurses for approximately 3 years.	<ul style="list-style-type: none"> • Improved prenatal health • Fewer childhood injuries • Fewer subsequent pregnancies • Increased intervals between births • Increased maternal employment • Improved school readiness 	<p>Implemented by local public health districts, and visits must be completed by a public health nurse</p> <p>Focus on health outcomes</p> <p>Families cannot have any other children (First-time mothers only)</p>	\$5,000
Moderate – High Intensity, Moderate – High Frequency, Long Duration	Parents As Teachers	WCPCAN/CT: approx. \$285,000 per year	Federal grants, state, counties, cities, health departments, social service orgs, foundations, school districts and others	Universal	26 sites statewide serving approximately 1,500 families	Pregnancy through age 5	Home visits weekly to monthly by trained paraprofessionals from pregnancy through age five. Families can enroll at any time during this period.	<ul style="list-style-type: none"> • Increase parent 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 	<p>Implemented by school districts and non-profit entities.</p> <p>Flexible model depending on who is implementing and population being served.</p>	\$2,000
Low Intensity, High Frequency, Moderate Duration	Parent-Child Home Program	WCPCAN/CT: approx. \$100,000 per year	Cities, local Educational Service Districts (ESDs), the Business Partnership for Early Learning, and federal Title IV funding	At-risk parents (single, low-income, teen parents, multiple risk factor families, etc.)	5 sites statewide serving approximately 280 families	16 mo. through age 4, but typically 2 and 3 year olds are the target	Home visits twice weekly for ½ an hour each visit for two years (23 weeks is minimum amount of weeks that constitute a program year).	<ul style="list-style-type: none"> • Early Literacy • Increased school readiness • Enhanced social-emotional development • Strengthen parent-child relationship 	<p>Home visitor brings a book or educational toy once a week for families to keep and model interaction with the item.</p>	\$2,400

	Program	State Investment	Other Investment	Target Population	Statewide Penetration	Age Range of Children	Service Intensity/ Duration	Program-Identified Outcomes	Identifying Characteristics/ Differences Between Models	Approx. Cost/ Family/ Year
Moderate Intensity, High Frequency, Low Duration	Promoting First Relationships	Children's Administration/ DSHS: \$150,000		Universal		Birth through age 3	Home visits weekly for ten weeks by a trained	<ul style="list-style-type: none"> • Increase children's healthy social-emotional development • Increase responsive, nurturing caregiver relationships 	Utilizes videotaping of parent-child interaction as part of instruction	\$2,500
High Intensity, High Frequency, Short Duration	Project SafeCare	WCPCAN/CT: approx. \$120,000		Families at risk for abuse and neglect		Birth to age 5	Bi-weekly or weekly home visits for 15 weeks by a trained paraprofessional.	<ul style="list-style-type: none"> • Prevention of child maltreatment, particularly neglect • Promote optimal child health and development • Increase parent's use of behavior mgmt skills • Improve parent-child bonding 	One of very few programs shown to be effective with neglectful families	\$2,000
Moderate Intensity, Low Frequency, Low Duration	Welcome Home Baby	None currently. \$150,000 in the 06-07 fiscal year was appropriated to the Kitsap Public Health District through DOH. However, if the mom is Medicaid eligible, the visit is covered under First Steps	Currently funded entirely by the Kitsap Public Health District. In 06-07 \$150K matching funds were required for state dollars	Universal	County wide in Kitsap County	Birth (within the first two weeks after a child is born)	One-time visit within the first two weeks of a child's life by a public health nurse.	<p>To ensure that every child/family in the county is seen by a professional at birth of child</p> <p>Linkage made to needed services</p> <p>Support for breastfeeding efforts</p>	Focuses on screening and assessing every newborn in the county and referring families to appropriate services as needed	Not Available

Availability of Home Visiting Services

The complete picture of home visiting services in Washington is bigger than just those that are funded by state agencies. Local communities may provide and fund home visiting programs that are not supported by state funds or that supplement state funds with local resources. As noted above, the matrix of state funded home visiting programs provided is incomplete, as it does not include all federally funded services or the substantive and important investments of local government or non-public entities. A full inventory of home visiting programs and the reasons that they are funded may be necessary in order to retain incentives for non-state investments in home visiting. Detailing the full capacity and availability of home visiting programs throughout the state was understood to be outside the scope and charge of this plan.

Currently, in order to support evidence-based, quality services of sufficient intensity and duration, community entities find that it may be necessary to utilize or blend funding from multiple state agencies as well as from other funders, public or private. Community providers often work together to monitor the mix of funding to ensure that overlap or duplication of services is not occurring and that resources are used in the most effective way possible.

Plan for Creating a Coordinated or Consolidated System of Home Visiting

The work group has established short term and long term objectives that will help move Washington towards a coordinated and consolidated system of home visiting. It is the recommendation of this group that the state agencies continue to meet on a regular basis in order to come to agreement on and ultimately implement the objectives outlined. The challenge that exists in our current system that each element is intended to help resolve is noted within the discussion of each objective.

Short term objectives are the first steps in creating a well integrated and effective system for home visiting and will immediately help to ensure better coordination between agencies funding these types of services. It is our best estimate that reviewing and coming to a decision about each of these short term objectives could be completed over the next two years. The long term objectives will take more time to address, are less concrete in some cases, and may require additional investment from the state to fully accomplish them; many need to be fleshed out to determine if they are appropriate for our state system. However, long term objectives are important to discuss and carefully consider to ensure that we have taken advantage of every avenue to create the best system possible. While these items may be part of the discussion as we address the short term objectives, we estimate that they may take as much as five or ten years to fully come to fruition.

While some agencies may be able to meet some or all of the objectives within existing resources, some agencies clearly will not. The work group felt strongly that addressing all of these objectives will cost something, and some may indeed be very expensive to undertake.

It is important to note that in both the short and long term objectives, the information provided is intended to describe the purpose of the task. This description clearly does not cover all of the intricacies each topic encompasses, which cannot be accurately reflected until it each item has been fully explored.

Short Term Objectives

- **Ongoing Agency Communication and Coordination**

Challenge:

Lack of coordination or consolidation of home visiting services among state agencies

The home visiting workgroup has made considerable progress and has identified a need to continue meeting beyond the due date of this report. Quarterly meetings would allow the work of the group to continue to move forward. Missing contributors to the group should be identified, including but not limited to: philanthropic partners, Thrive by Five, local public health jurisdictions, other state or public agency funders, community agencies and others who are investing in home visiting. This will provide the most complete picture of what is being funded across the state, how home visiting manifests in particular communities and help to identify unmet needs.

- **Inventory of Home Visiting Programs Across the State**

Challenge:

Lack of clarity about what home visiting programs currently exist in the state, what entities fund those programs and how many families are served

While the matrix included with this report begins to inventory the home visiting programs supported by state investment, a more detailed inventory is desirable. An inventory may include: where a program is located, what funding sources they utilize (private, public, and other); how many families are served; program models adhered to (or variations funded); eligibility criteria for acceptance to the program; and contact information, to name a few components. The inventory may also include information about the system of family support, early intervention and early learning services available to children prenatally through age five and their families, which is the context for the home visiting services delivered in each local area.

An inventory may be taken as a snapshot in time to get a sense of the current home visiting services in our state and to identify gaps in service, or it may be compiled into a database that is updated on an annual basis. In considering this project, we would plan to consult with both 2-1-1, WithinReach, Family Policy Council Community Networks and other entities that develop service inventories to ensure that we are not duplicating work that is already in place.

- **Streamlined or Common Methods of Screening and Assessment**

Challenge:

Families who might benefit from or want to access home visiting services are not always aware of the availability of programs in their area and home visiting providers do not always receive appropriate referrals for their programs

Identifying components of a universal assessment tool or a menu of assessment tools communities can choose from to help ensure that families are referred to the appropriate home visiting program may be a useful contribution to coordination and integration of client

driven services, according to one national expert who spoke to the workgroup. This effort need not replace assessments currently used by programs or evidence-based models, but rather could be used as a triage tool to best match families with appropriate home visiting services available in their community. Common screening and assessment, coupled with a means for tracking community-wide referrals and unmet needs over time, can help to identify gaps in service as well as any overlapping services. Thurston, Whatcom and Clark counties and Thrive by Five are all using or developing versions of a common screening or assessment tool and may inform the statewide work. However, the implications of using such a system for populations that are distrustful of organizations and people they do not know (such as many immigrant and refugee communities) will need to be considered as well. To start with, this tool will most likely utilize assessment tools that already exist or use components of existing assessment tools. Ideally this would be an automated system, if it is established, but that is a longer term goal and will not be possible to accomplish in two years.

- ***Shared Outcome Reporting Requirements***

Challenge:

Local communities often have to braid funding from multiple agencies and then report different information out separately to each individual agency or multiple state agencies request similar information from funded programs for a variety of program models but do not ask for the information in exactly the same way

Shared outcome reporting requirements for state funded programs can support a more integrated system. This is an important issue for local programs, who express concern about spending too much time completing paperwork and reports. Evaluation requirements that agencies are held to because of federal grant requirements cannot be negotiated. If multiple state agencies are funding the same home visiting model or are requesting similar data of funded programs across models, it may be possible to identify common evaluation questions and strategies. A potential outcome of this effort may be the ability to begin to collect and compare aggregate data across the state and draw conclusions about the effectiveness of the interventions on a broader scale. However, each home visiting program is designed to produce specific outcomes based on the research, so it may not be reasonable to request common outcome measures across all programs. This strategy is not intended to change the evaluation components built into evidence-based program models, nor is it intended to eclipse outcome evaluation that is a necessary part of a single agency promoting its unique mission or goals. This strategy is intended to align and streamline reporting of data required by multiple funders where possible.

- ***Cross-Cutting Training Components or Curriculum for Home Visitors***

Challenge:

Lack of cohesion across the continuum of home visiting services

Training for home visitors that cut across models is an idea that a number of states and localities have considered as a way to tie programs together. To be clear, this is not suggested as training in lieu of the training that evidence based programs require as part of their model fidelity. It would be additional training applicable to all types of models. Determining components that would be useful across program types could prove a difficult task because of the specific research-based design of each individual program model, so

this effort needs to be carefully considered. Thurston County developed a common training for all home visitors as part of their system development in the 01-03 biennium that may serve as a useful example.

- ***Incentivizing Local Communities***

Challenge:

Coordination or consolidation at the state level alone will not create an integrated and coordinated system

A goal of this system needs to be supporting and making it easier for partners and providers to have a cohesive continuum of services at the local level. Coordination of some components at the state level is not the entire solution; coordination or consolidation must also occur locally. As funders, state agencies can help to incentivize communities to better communicate, coordinate and consolidate. Funding and incentives may help communities come together and develop or further their own plans for coordination.

Long Term Objectives

- **Consolidated Contracts or Interagency Agreements**

Challenge:

Local communities often have to braid funding from multiple agencies and then report different information out separately to each individual agency

At the local community level, providers are continually blending and braiding funding from a variety of sources to fully support their programs. To ease requirements placed on programs and reduce the paperwork they are required to complete, both in applying for funding and in reporting on the use of dollars, contracts that cover funding from multiple agencies may be a feasible way to coordinate funding. Another way to address this issue may be developing interagency agreements that specify the criteria for funds to transfer to a central point in order for one contract to be produced and monitored, with the central entity reporting to all state funders. The Family Policy Council has provided this service in the past.

- **Coordinated Information Systems**

Challenge:

It is difficult to determine if multiple state agencies or programs funded by state agencies are serving the same families

Among the larger, longer term issues to be addressed or considered is the fact that there is no state central database detailing services received across systems. Some states are making progress in allowing agency information systems to communicate to one another. This is most likely a very expensive and time intensive process and would require thoughtful consideration to move forward. Both Whatcom County and the demonstration sites funded by Thrive by Five are experimenting with issues related to coordination of information systems; their efforts would serve to inform this process.

- **Finance Models / Funding “Portal”**

Challenge:

Local communities often have to apply for funding from multiple agencies in order to fully fund a particular program model or to serve more families and the applications can be time consuming and paperwork intensive

It will be imperative to study other state and local systems for funding home visiting services in a coordinated manner. This may include exploring opportunities to maximize federal funding streams. Related to this is the desirability of creating a single place or resource where communities apply for home visiting dollars in which all of the coordination of state funds is done behind the scenes. This would be a major undertaking, but may deserve consideration. Because home visiting is a service delivery mechanism rather than a system of services within a sector, this approach may not be a good fit. In addition, addressing this challenge will require exploration of whether it is feasible and desirable to have all home visiting funding concentrated at one agency. The differing requirements of home visiting models regarding specific professional training and credentials, such as local

public health nurses, would need to be addressed in exploring the feasibility of having a single agency serve as the funder for all home visiting.

- **Federal Funding Barriers**

Challenge:

Requirements related to serving populations and reporting outcomes that are attached to federal funding streams can create barriers to coordination amongst state agencies

Defining and addressing the barriers that exist with many of the federal funding streams for home visiting will help ensure that coordination can exist at the state level. There are multiple grants and funding streams coming from a variety of federal agencies, all of which have their own evaluation and reporting requirements as well as expectations for the types of investments made with their dollars. Identifying and developing a coordinated system will require consideration of some of these federal requirements. The Health Care Authority is taking the state agency lead on Electronic Health Records and should be included in future meetings.

A review of other state systems showed no state with a completely integrated, coordinated home visiting system. Washington is often on the cutting edge of efforts around early learning and evidence-based practice, and is a leader in efforts to coordinate services and systems as well. While commendable, being ahead of the curve does decrease the likelihood of being able to replicate or adapt a model used successfully elsewhere. Designing a thoughtful and effective model for coordinated home visiting services will take some time and dedicated efforts.

Current and ongoing efforts and evaluations, including but not limited to the early learning demonstration sites (White Center and East Yakima) funded by Thrive by Five, will help inform statewide attempts to build effective, community responsive home visiting systems. An additional factor for consideration as such a system is conceived and developed is that home visiting services are usually part of a larger system of services to children and families, and must ultimately be coordinated with other social service, health, and early learning and education systems in order to advance individual and collective learning.

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To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).

5830 Workgroup Participants

WCPCAN/Children's Trust, DSHS, the Department of Health, the Department of Early Learning, and the Family Policy Council were all named specifically in the bill to participate in the creation of this plan. The workgroup discussing the plan was open to any and all individuals who wanted to be a part of the planning process. Below are the participants for the agencies and additional stakeholders who contributed to this report.

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State Agency Participants:

Kristen Rogers, MSW
Director, Policy & Practice
WCPCAN/Children's Trust (convener)

Kathy Chapman, RN, MN
Manager, Maternal and Infant Health
Office of Maternal and Child Health
Community and Family Health
Washington State Department of Health

Aurea Figueroa
WorkFirst Program Manager
Economic Services Administration
Division of Employment & Assistance Programs
Department of Social and Health Services

Judy King, MSW
Parent Support and Programs
Department of Early Learning

Cindy Mund
Chief, Field Operations
Economic Services Administration
Division of Employment & Assistance Programs
Department of Social and Health Services

Dana Phelps, M.Ed.
Evidence Based Practice Manager
Children's Administration/DSHS

Laura Porter
Staff Director
Family Policy Council

Judy Schoder, RN, MN
Manager, Child and Adolescent Health
Office of Maternal and Child Health
Community and Family Health
Washington State Department of Health

Joan Sharp
Executive Director
WCPCAN/Children's Trust

Casey Zimmer, RN
Section Manager
Family Healthcare Services Section
Health and Recovery Services Administration
Department of Social and Health Services

Community Participants:

Cathy Garland
Director of Early Learning
Children's Home Society of Washington

Laurie Lippold
Director of Public Policy
Children's Home Society of Washington

Lois A. Schipper, BSN, MPH
Program Manager
Parent Child Health Services
Public Health – Seattle & King County

Laura Wells
State Director
Fight Crime: Invest in Kids Washington State

**For any questions or comments on this report contact
David Beard, WCPCAN/CT Director of Policy and Practice
beardd@wcpcan.wa.gov | 206.518.0236.**