WASHINGTON STATE
Department of
Children, Youth, and Families

Report to the Washington State Legislature

OPPORTUNITIES AND CONSIDERATIONS FOR EXPANDING HOME VISITING SERVICES IN WASHINGTON STATE

In Response to HB 2779

"Improving access to mental health services for children and youth"

Presented March 8, 2019

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CONTENTS

ABBREVIATIONS

ACES	adverse childhood experiences
AIHC	American Indian Health Commission
CEBCCW	California Evidence-Based Clearinghouse for Child Welfare
DCYF	Washington State Department of Children, Youth, and Families
CPP	Child-Parent Psychotherapy
DEL	Washington State Department of Early Learning
DOH	Washington State Department of Health
DSHS	Washington State Department of Social and Health Services
ECEAP	Early Childhood Education and Assistance Program
EHS	Early Head Start – Home Based Services
ESSS	Early Steps to School Success
FAN	Facilitating Attuned Interactions
FFPSA	Family First Prevention Services Act
HCA	Washington State Health Care Authority
HomVEE	Home Visiting Evidence of Effectiveness
HVAC	Home Visiting Advisory Committee
HVSA	Home Visiting Services Account
LIAs	local implementing agencies
MIECHV	Maternal, Infant, and Childhood Home Visiting Program
MCO	managed care organization
NEAR	Neuroscience, Epigenetics, Adverse Childhood Experiences, and Resilience
NFP	Nurse-Family Partnership
PAT	Parents as Teachers
PCAP	Parent-Child Assistance Program
PCHP	Parent-Child Home Program
SBSM	Safe Babies, Safe Moms
STEEP	Steps Toward Effective, Enjoyable Parenting
SAMHSA	Substance Abuse and Mental Health Services Administration
SQL	Structured Query Language
TANF	Temporary Assistance for Needy Families
WSIPP	Washington State Institute for Public Policy

EXECUTIVE SUMMARY

PURPOSE AND CONTEXT

Home visiting is a voluntary, family-centered service offered to expectant parents and families with new babies and young children to support the physical, social and emotional health and development of the child. It is recognized as a very effective strategy for improving child health and development, especially in populations with limited resources. Research has found that benefits of home visiting services range from healthier births and improved school readiness to increased self-sufficiency for families.[1]

Washington State's capacity to provide these valuable services has steadily expanded since the creation of the Home Visiting Services Account (HVSA), significant private investment, and establishment of the federal Maternal, Infant, and Childhood Home Visiting Program (MIECHV) in 2010. MIECHV provided the first significant federal funding for home visiting — and marked a growing understanding of the effectiveness of home visiting to address new families' needs.

Today, Washington has capacity to deliver intensive home visiting services to 7,323 families. However, there are still more than 100,000 eligible families (at or below 200 percent of the federal poverty level, with a child younger than three years) that the state does not yet have capacity to serve. In response to this need, the Washington Legislature, through HB 2779 ("Improving access to mental health services for children and youth"), directed the Department of Children, Youth, and Families (DCYF) to explore expansion of home visiting services in Washington.

Since its inception, the HVSA has been managed by DCYF in partnership with Thrive Washington (Thrive). Federal and state funding flows through the account to fund long-term, early childhood home visiting programs – in fiscal year 2019 approximately 2,400 Washington families were served. Additional funders, with King County's Best Starts for Kids and the Federal Head Start/Early Head Start Home Based Program being the two largest, provide resources to serve another approximately 5,000 families.

Washington has a nearly decade-long track record of success in expanding home visiting services, and home visiting programs are currently operating in all but seven counties. The state is well positioned to expand home visiting services funded through the HVSA and to improve coordination across all entities supporting home visiting in Washington. There is an opportunity to build on the effective systems that have been created to support service delivery, technical assistance, data management and evaluation, and quality assurance.

Expansion will also come with challenges. The home visiting system has a highly diffuse governance, funding, delivery and evaluation landscape. For example:

- The HVSA currently funds approximately one-third of the intensive home visiting services in the state. DCYF and Thrive play a coordinating role for HVSA-funded programs, but they do not have oversight of non-state-funded service delivery.

[1] National Home Visiting Resource Center (2017). *2017 Home Visiting Yearbook.* Available at: https://www.nhvrc.org/.

- Funding comes from a broad range of federal, state and local sources, each of which has different criteria for the types of services that can be delivered using the various funding streams. This requires complex braiding and/or blending of funding.
- Home visiting services are delivered through multiple standardized models that address different outcomes, rely on different methodologies and demonstrate effectiveness in different ways. These differences affect availability of funding; coordination and quality assurance; monitoring and evaluation; and the ability of communities to select models that are most appropriate to their needs. The implications for expansion planning are significant.

This report provides an expansion scenario that responds to this complex landscape and would dramatically increase the amount of home visiting services provided by the state. It also identifies the core considerations that must be balanced with a large-scale expansion strategy.

APPROACH

To identify a strategic expansion scenario and the most important considerations for expansion of home visiting services in Washington, DCYF:

- Assessed factors that affect the distribution of funding for home visiting, especially the implications of requirements related to evidence of effectiveness.
- Analyzed the *Washington State Home Visiting Needs Assessment: 2017 Report* to prioritize communities and populations for expansion.
- Updated the *Home Visiting Scan: Fall 2017* to create a picture of the breadth and reach of services across the state.
- Analyzed cost considerations and funding options for expansion.
- Gathered information from stakeholders through interviews and a series of listening sessions and workshops.

The following findings were most significant for expansion.

- The need for home visiting services far exceeds the current resources available statewide. Only four counties in Washington State have capacity to offer services to more than 15 percent of families who would qualify — leaving a very large proportion of eligible families without coverage. Statewide, home visiting programs currently serve an estimated 6 percent of births to low-income families.
- Current sources of funding do not provide ready opportunities to support expansion of services — either because the potential for those funds to increase is limited, or because of restrictions on how funding may be used.
- The communities that can benefit most from home visiting services are rural communities that have little or no access to services, and low-income communities that have been identified by the state needs assessment as most vulnerable (as measured by risk factors such as infant deaths, teen pregnancies, kindergarten readiness, etc.), particularly African-American/Black, American Indian and Alaska Native, and Hispanic communities. Families facing homelessness, those involved in the child welfare system, those with mental health and/or substance use disorder challenges, and those who have experienced domestic violence could also benefit from services.
- To maximize the impact of home visiting, communities need greater access to approaches that are tailored to their needs. This includes approaches that, while not

meeting standard definitions for evidence of effectiveness, have demonstrable impact in the communities where they are used.

- Expansion will require continued building of the infrastructure needed to support high-quality home visiting services at the state and local level.

EXPANSION SCENARIO

Using the information gathered through these activities, DCYF developed an expansion scenario to help the legislature and policy makers begin the conversation about the best approach for serving more families across the state. The scenario assumes that expansion will occur in three phases and by the conclusion of the third phase will provide new home visiting services for more than 20,500 families. This will nearly triple the number of families currently served.

The expansion scenario focuses new resources first on communities with the highest levels of risk (based on the state needs assessment produced by the Washington State Department of Health). The priorities for expansion were created using sixteen risk factors across five domains (maternal and child health, socioeconomic status, education, home environment, and drug and alcohol use) and with consideration for the size of the population. Communities with higher risk would receive new services first, communities with moderate risk and large populations next, and finally communities with lower risk levels.

The following table provides a summary of the number of slots that would be added in this scenario, the cost per slot, and the cost of each new phase of expansion. Overall, this scenario would more than triple the home visiting capacity to serve families in low-income households in Washington, with the greatest expansion focused on the locales with the greatest need. By the end of phase 3, every county would have some capacity to provide home visiting services.

Table 1: Expansion Slots

	Phase 1	Phase 2	Phase 3	Total
Additional slots	5,000	8,000	7,500	20,500
Cost per slot	$8,600	$8,200	$7,800	---
Tribal carve-out	500	500	1,000	2,000
State home visiting capacity	10%	16%	22%	22%
New cost	$43 million	$65.6 million	$58.5 million	$167.1 million
No. of counties receiving additional slots	29	32	39	---

The cost of providing 20,500 families with new home visiting services is estimated to be $167 million annually in new funds. At the conclusion of the three phases of expansion, the cumulative cost to support the new services as well as the existing home visiting services funded through the HVSA would be $179.4 million per year.

By phasing the expansion, the state will be able to build local capacity and the statewide supports necessary to maintain high-quality services as the home visiting system grows. The scenario assumes that the expansion will occur over three or more biennia.

CONSIDERATIONS FOR EXPANSION

As mentioned above, there are a number of considerations critical to the development of a successful expansion strategy. The following provides a brief overview, with more detailed explanations in the body of the report:

- A specific approach to support less-established, innovative models as well as established models (a portfolio approach) can improve service to vulnerable communities, with additional support to maintain quality and efficiency.
- With limitations to the current sources of funding for home visiting, both in terms of the volume of funds available and what existing sources do and do not cover (e.g., evidence-based models vs. promising practices), any significant expansion will require alternate approaches to funding, and exploration of potential changes to reimbursement approaches as well.
- Universal voluntary in-home screening combined with a coordinated entry approach could increase the use of — but does not replace — longer-term, more intensive home visiting services. This approach would meet the need for coordinated intake and referral, though that need can also be met independently, as part of the expansion strategy.
- Community planning, leadership and organizational capacity development are critical to expansion. Capacity at the local implementation level will need to grow, which means an expansion strategy must consider current challenges to workforce development.
- Expansion will require state administrative capacity and funds dedicated to continuing long-term data system planning.
- To be effective at scale, state agencies need enhanced coordination and governance both within and beyond the HVSA-funded home visiting system.
- Appropriate public outreach and engagement of families' voices are both necessary to shift attitudes and practices and to ensure the impact of expanded services.

CONCLUSION

Over the past decade, the federal government, Washington policy makers and local communities have all recognized that home visiting services are a proven and important investment in the lives of children and families. Given the dramatic unmet need for these services, the Washington state legislature requested an analysis of how home visiting services could expand. This report provides an initial concept describing a phased expansion. The approach focuses on the most vulnerable families first. This includes many who would particularly benefit from services – rural communities with few existing services, African-American/Black and American Indian/Alaska Native families, and families struggling with issues such as child welfare involvement, domestic violence, substance use disorder or mental illness. By the end of the final phase of expansion, some home visiting capacity would be provided in every county in the state.

Potential expansion at this scale will also present some challenges. But with careful planning, technical assistance, and administrative and infrastructure supports, Washington has the

opportunity to be a national leader in the continued development of a robust statewide home visiting system.

Opportunities and considerations for expanding home visiting services in Washington

PURPOSE AND CONTEXT

RATIONALE FOR EXPANSION

Home visiting is recognized as a very effective strategy for improving child health and development, especially among vulnerable populations.[2] Benefits include reduced need for child welfare services, reduced child abuse and neglect, healthier births, better readiness for school, reduced involvement in criminal activity, reduced domestic violence, improved family self-sufficiency, and improved coordination and referral for other community services.[3,4] The Washington State Institute for Public Policy (WSIPP) has found home visiting to be cost-beneficial across a range of behavioral and health outcomes.[5]

However, there are still a great many families and children in Washington who could benefit from, but do not have access to, home visiting services. As of 2018, the total number of home visiting slots funded by all federal, state and local sources was 7,323, which is considerably less than the state's 125,800 eligible families (defined as families at or below 200 percent of the federal poverty level, with a child younger than three years). That leaves a projected 118,500 families still unserved.

The state's home visiting system, with its diverse funding, broad geographic range, and emphasis on meeting the needs of a wide range of vulnerable populations, is

From Lydia Place
Donna was forced to leave her home with her seven-month-old daughter when her partner's drug abuse escalated. Donna had a good job, a reliable vehicle and a stable home, and she was elated to be a new mom — until the pieces began to crumble around her.

At Lydia Place, Donna found supportive care and a warm community. Committed to learning all she could about parenting and child development, she enrolled in a home visiting program that provides education and guidance for new parents. Working with a parent educator, Donna learned about developmental milestones and activities and strategies to promote healthy development. Regular assessments let her know her daughter was on track.

Donna is now re-entering the workforce and moving into an apartment of her own. Home visiting gave her the tools and resources she needed to thrive during a very tough time. She will continue to work with her parent educator until her daughter reaches kindergarten, knowing she has support every step of the way. As she explains: "I know these early years are few and I don't want to have any regrets. I want to do everything to give my daughter the best life."

[2] National Home Visiting Resource Center (2017). *2017 Home Visiting Yearbook.* Available at: https://www.nhvrc.org/.
[3] Billings, K. and Baizer, S. (2018). *Parenting Works: The Public Safety and Economic Benefits of Home Visiting.* Available at: https://www.strongnation.org/articles/413-parenting-works-the-public-safety-and-economic-benefits-of-home-visiting.
[4] U.S. Department of Health & Human Services, Administration for Children and Families. *Outcomes*. Available at: https://homvee.acf.hhs.gov/outcomes.aspx.
[5] Washington State Institute for Public Policy (2018). *Benefit-Cost Technical Documentation*. Available at: http://www.wsipp.wa.gov/TechnicalDocumentation/WsippBenefitCostTechnicalDocumentation.pdf.

uniquely suited to lead an expansion of home visiting to better meet the needs of Washington families. In 2018, the Washington Legislature, through HB 2779 ("Improving access to mental health services for children and youth"), directed the Department of Children, Youth, and Families (DCYF) to explore potential expansion of home visiting services in Washington. This directive included three components:

- Develop a common set of definitions to distinguish between evidence-based, research-based, and promising home visiting and other home-based programs and services.
- Develop a plan to expand home visiting programs statewide.
- Collaborate with the Health Care Authority (HCA) to identify how to maximize Medicaid and other federal resources for home visiting.

This report responds to the legislature's request by cataloging definitions of different tiers of evidence and identifying the core considerations that underlie an expansion strategy. These considerations include identification of priority populations, development of a finance and cost model, the need for a diverse range of home visiting services, local and regional readiness, the capacity of the state system to support expansion, governance, and family and community engagement.

The report presents one possible expansion scenario. This preliminary scenario is based on extensive stakeholder input and was developed to provide a starting point for discussion of key decisions required to move forward with expansion, including a rough estimate of costs for service provision and infrastructure development.

CONTEXT FOR EXPANSION

In developing this report on the potential for expansion, DCYF considered the following existing landscape.

Description of home visiting

For the purposes of this report, and for the state's home visiting program, "home visiting" refers to voluntary, family-centered services offered to expectant parents and families with new babies and young children to help families and support the physical, social and emotional health of the child. Either before their child's birth or during their child's first years of life, families are matched with trained staff who visit them in their homes or in community settings to provide information related to healthy child development and early learning, support parent-child relationships, and offer connections to other information and services in the community. These visits typically continue over the course of several months or even years (on average, home visiting programs seek to serve families for two years). In this report, use of the term “home visiting” also means intensive home visiting programs, that make use of an evidence-based or promising practices model with accompanying service and quality standards.

Other services have some similar characteristics, such as the setting in which they are delivered or the type of service provided. However, there are important distinctions between these services and home visiting: for example, services may be offered in the clinic instead of the home, may not be voluntary, or may be shorter term. These can be important allied or ancillary services but are not considered "home visiting" in this report.

The focus on the delivery of home visiting services to expecting or new parents is important. Brain research shows this as a critical window for support, during which a parent's brain is in

development (regardless of whether it is a first, second, or subsequent birth).[6] Home visiting is a useful intervention for parents who are experiencing vulnerability (e.g., housing instability) and could benefit from additional support. For both mothers and fathers, home visiting offers access to new information and guidance during a time when the potential for developmental change for caregivers is particularly strong. Thus, home visiting is not only an effective intervention for child health and development, but one with potential for overall stability of families as well.

History and current status of home visiting in Washington State

In the past ten years, there has been significant public and private investment in home visiting in Washington and nationally. The establishment of the federal Maternal, Infant, and Childhood Home Visiting Program (MIECHV) in 2010, resulted in an expansion of home visiting services both nationally and within Washington. This influx of investment has created tremendous visibility, research, evaluation and learning about what it takes to scale up home visiting across the nation.[7] Today, home visiting programs reach more than 7,300 families in all but seven counties across Washington, with measurable impact on health, child development and educational outcomes.[8]

In 2010, the Washington Legislature established the Home Visiting Services Account (HVSA), a private-public partnership between the DCYF (at that time, the Department of Early Learning [DEL]) and Thrive Washington. The HVSA (1) braids state, federal and private dollars to fund high-quality home visiting programs across the state and (2) provides other types of support and assistance for those home visiting programs. In this report, because of these two roles, the HVSA is referred to as both a financial account and a statewide initiative that contributes to Washington's home visiting system.

From 2010 to 2016, the HVSA has received steady increases in funding, both for service provision and for infrastructure. This increased investment from federal and state sources has supported a rapid expansion of capacity to provide high-quality home visiting services from approximately 100 slots (defined as the capacity to serve a single household for a home visiting model's full duration) in 2010, to more than 2,400 slots in fiscal year 2019. There have also been increases in local funding outside the HVSA, such as through local levies.

Today, the HVSA funds nearly one-third of all home visiting programming in Washington. (See "Summary of home visiting landscape" below for an overview of HVSA and non-HVSA funding.) The HVSA's infrastructure and governance team also plays a broad coordination and leadership role, providing capacity building, technical assistance, help with workforce recruitment and retention, and quality assurance support to the programs funded by the HVSA account.

Who receives home visiting services

Demographic data of families served by HVSA-funded home visiting between October 2017 and September 2018 provide a snapshot of HVSA clients. This snapshot shows that 2,609 adults (here, "adult" refers to parents or caregivers, regardless of age) and 2,486 children received HVSA-funded home visiting services during this time. In general, the majority served were very

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[6] Swain, J. (2011). *Becoming a Parent — Biobehavioral and Brain Science Perspectives*. Curr Probl Pediatr Adolesc Health Care. 2011 Aug; 41(7): 192–196. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4317258/.

[7] Mother and Infant Home Visiting Program (2018). Implementation of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation. Available at: https://www.mdrc.org/sites/default/files/mihope_implementation_report_2018_10_26_508b.pdf/.

[8] This report includes assessments of home visiting capacity from several sources, including a statewide scan in 2017, an updated scan in 2018, and additional slots just released for 2019. Numbers will vary slightly in this report, reflecting changes in model requirements, local decisions about number of slots, and local capacity to utilize services.

young children of young parents, adults who had a high school education or less, and/or were unemployed. (See appendix A for detailed demographic data.)

Age

Among adults served by HVSA-funded programs, 5 percent were 17 years old or younger, 9 percent were 18 to 19 years old, and 32 percent were between 20 and 24 years (figure 1). Among children served, 32 percent were younger than 1 year, 52 percent were between 1 and 2 years, and 15 percent were between 3 and 4 years (figure 2). Fewer than 6 percent of births in Washington State are to teens.[9] Thus, the significant proportion of teens (19 years or younger) –15 percent – among adults served by HVSA-funded programs is a strong indicator that programs are successfully reaching one of the intended populations.

Figure 1: Percentage of adults served by the Home Visiting Services Account, by age in years (Oct. 2017 through Sept. 2018)

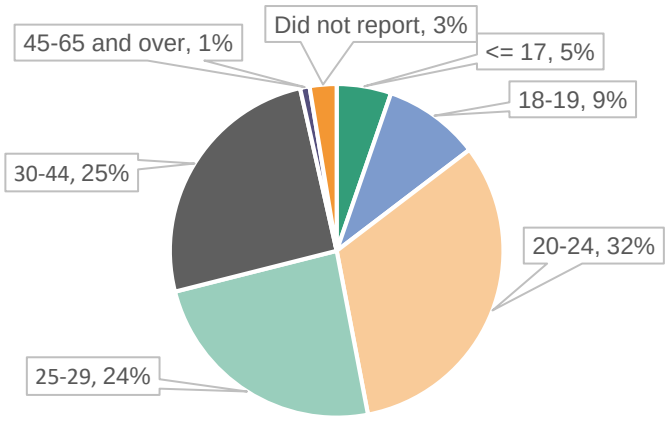
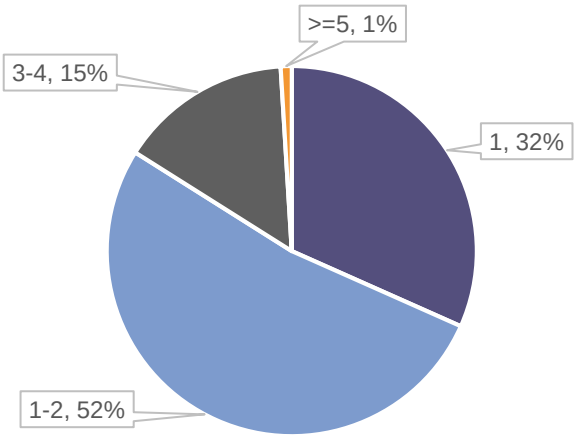


Figure 2: Percentage of children served by the Home Visiting Services Account, by age in years (Oct. 2017 through Sept. 2018)

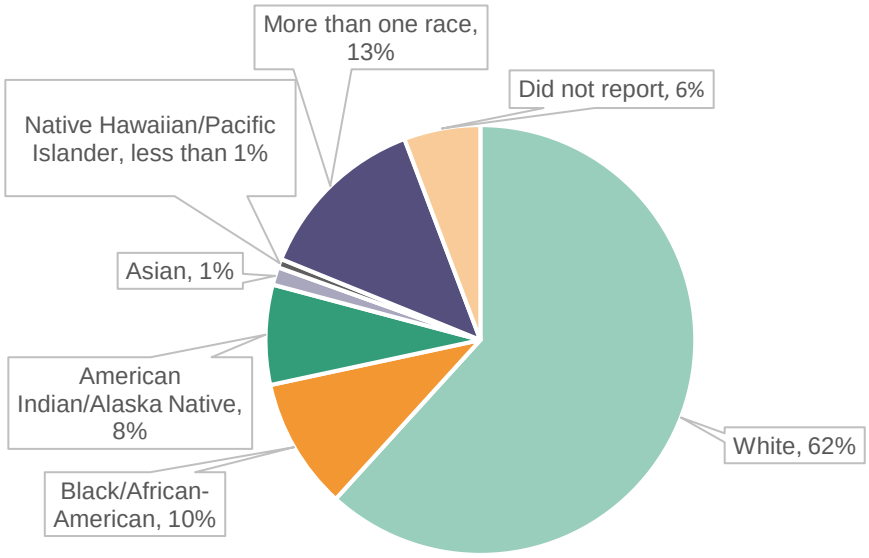


[9] Washington State Department of Health. "Birth tables by year." Available at: https://www.doh.wa.gov/DataandStatisticalReports/HealthStatistics/Birth/BirthTablesbyYear.

Race/ethnicity

HVSA-funded programs collect data on race and ethnicity separately. The majority of the adults served self-reported as white (62 percent), African-American/Black (10 percent), or American Indian/Alaska Native (8 percent) (figure 3). The remainder reported as Asian (1 percent), Native Hawaiian/Pacific Islander (less than 1 percent), more than one race (13 percent), or did not report (6 percent). Thirty-nine percent of adults self-reported ethnicity as Hispanic/Latino. The distribution of race and ethnicity among children was similar to that for adults, with a somewhat higher percentage of families self-reporting children of multiple races. Overall, HVSA serves a higher proportion of African-American/Black, American Indian/Alaska Native and multi-race populations than the state distribution of births for those groups.

Figure 3: Percentage of adults served by the Home Visiting Services Account, by race (Oct. 2017 through Sept. 2018)



*Thirty-nine percent (39%) of adults self-reported as Hispanic/Latino.

Education and employment

Just over one-half of the adults had a high school diploma or less (23 percent had less than a high school diploma, and 28 percent had a high school diploma or GED) (figure 4). Fifty-three percent of the adults were not employed, 37 percent were employed full time or part time, and the remainder did not report (figure 5).

Figure 4: Percentage of adults served by the Home Visiting Services Account, by educational attainment (Oct. 2017 through Sept. 2018)

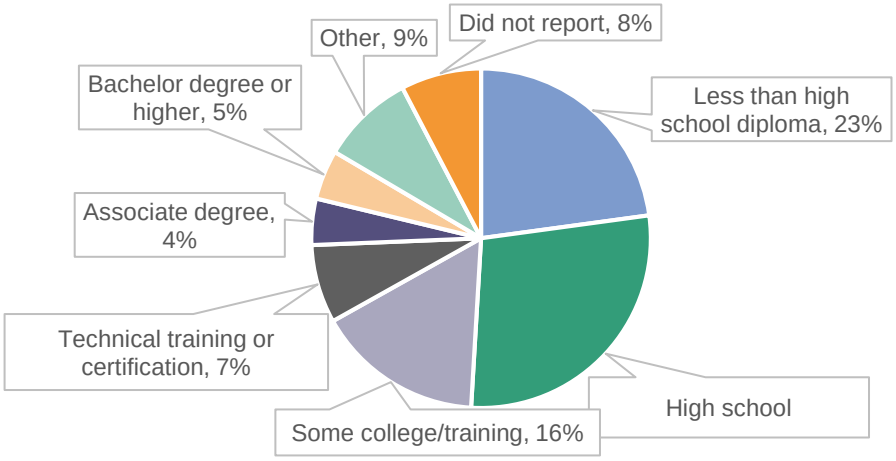
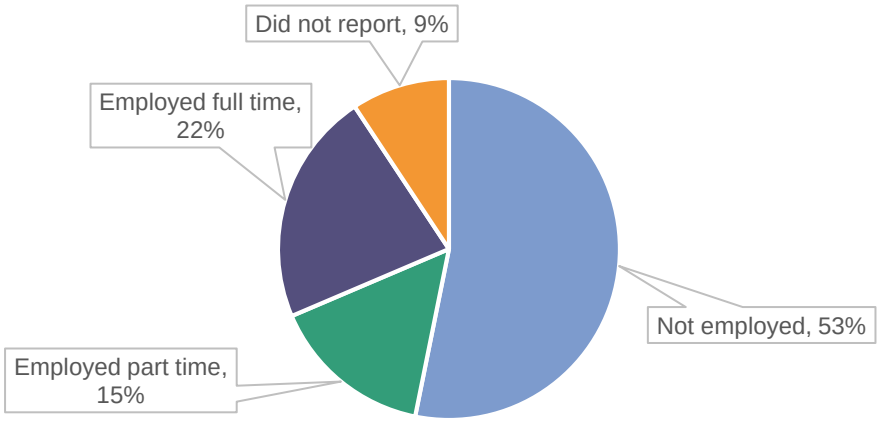


Figure 5: Percentage of adults served by the Home Visiting Services Account, by employment status (Oct. 2017 through Sept. 2018)



Number of slots vs. number served

These demographic data show that 2,609 adults and 2,486 children received services through the 2,154 HVSA-funded slots in Washington State in fiscal year 2018. Since "slot" refers to the capacity to serve a single household for a home visiting model's full duration, a single slot may serve multiple families over the course of a year, if one family's retention in a program is short and another family is enrolled to use that "slot."

Key players

Governance

Governance for home visiting is unique, with authority and accountability dispersed across the funding landscape.

DCYF, established as a new agency in 2017, is the lead for state-funded services that support children and families. DCYF brings together a number of programs and services previously managed through the Department of Social and Health Services (DSHS) and the Department of Early Learning (DEL), including oversight of the HVSA, and is the primary coordinator for the state's home visiting system.

The DCYF Family Support Programs Division manages all grants, contracts, reports and data collection regarding HVSA home visiting programs. The division works closely with the other state agencies and Thrive Washington to coordinate roles in the home visiting system.

Thrive Washington (Thrive), a private, nonprofit organization focused on early learning in Washington, is DCYF's private-entity partner for the HVSA. DCYF is required to engage a private partner to implement the HVSA by RCW 43.216.130. Thrive provides a hub of support to programs funded and not funded through the HVSA. Thrive leads in supporting local implementing agencies (LIAs) with start-up of their programs, then supports service delivery by providing training, technical assistance and capacity building for home visiting services. Thrive as an organization will be closing as of July 1, 2019, and is undertaking a planning process, in partnership with DCYF, to determine where their home visiting work will be best situated to support existing and expanded home visiting services.

The **Washington State Department of Health** (DOH) is responsible for the needs assessment required by MIECHV, for collecting and managing program data from LIAs receiving HVSA funding, and for producing the reports required for federal and state accountability. Additionally, DOH supports significant infrastructure development to ensure data quality, performance measurement, and program evaluation and maintains the cross-model structured query language (SQL) data warehouse.

Other state agencies play a central role in the planning, delivery and monitoring of home visiting services. In addition to DCYF, DSHS funds home visiting services to families receiving other DSHS support (see "Funding landscape," below). The Washington State HCA has been engaged in discussions about the potential use of Medicaid funding to support home visiting services. In addition, HCA and DOH provide a small amount of specific grant funding for investment in home visiting services.

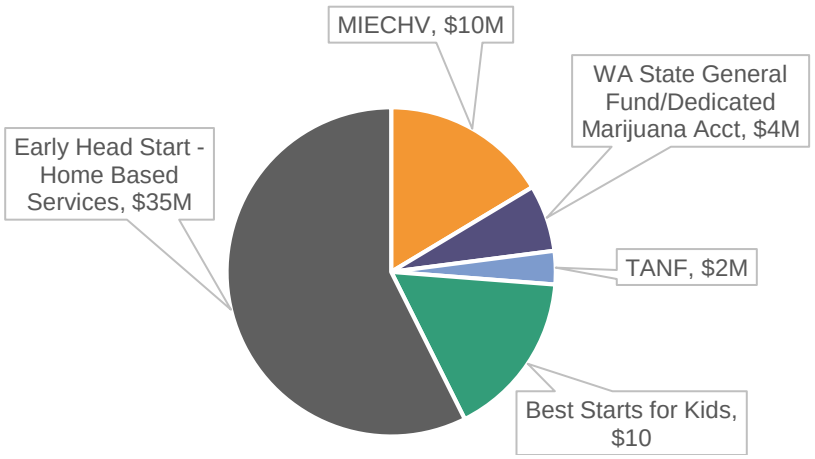
The **Home Visiting Advisory Committee (HVAC)**, coordinated by Thrive and DCYF, provides advice and strategic direction to the HVSA with regard to research and the distribution of funds from the account to eligible programs as required by RCW 43.216.130. Membership includes partners from organizations such as the LIAs, DSHS, HCA, the Washington Association for Infant Mental Health, and leaders from other critical programs that support families in the earliest years.

Funders

The three most significant funders of home visiting services in Washington are the **HVSA** ($15.2 million in FY 2018 and $18.8 million in FY 2019), which is funded by a mix of federal and state sources; **Best Starts for Kids** ($10 million), which is funded by a King County tax levy and funds services exclusively in that county; and **Early Head Start — Home Based Services (EHS)**, which provides more than $35 million in federal funding for home visiting in 26 counties across the state, with funds allocated directly to local organizations. A small proportion of services are also funded by other local levies and taxes or by private funders.

The HVSA benefits from funding from a number of sources, including the federal government's **MIECHV program** (approximately $10 million per year) and several state government sources, including the Washington **General Fund** and the **Dedicated Marijuana Account** (approximately $4 million per year together) (figure 6). **Temporary Assistance for Needy Families (TANF)** provides an additional $2 million annually.

Figure 6: Funder distribution for all home visiting services in Washington State, in millions of dollars (2018). MIECHV, Maternal, Infant, and Early Child Home Visiting Program; TANF, Temporary Assistance for Needy Families



Home visiting models

Home visiting services are most commonly delivered under one of several standardized models that outlines program goals, priority populations, what services are delivered, how services are delivered, and who may deliver them. These models are delivered by LIAs or partners in local communities, with financial and other types of support (capacity building, technical assistance) from the HVSA and other funders. Models may be considered either "evidence-based" or "promising practices," definitions reflecting evidentiary standards defined by federal funders, WSIPP and others.

There are eight home visiting models supported by HVSA funds, with two additional models in use in Washington (non-HVSA funded). DSHS, DOH and HCA also have programs offering short-term or specialized home-based services related to, but not considered to be, home-visiting services as defined in this report.[10] These offer a range of options for different community and family needs, including variations in outcomes, population focus, duration and frequency of services, and training requirements for the home visitor.

The majority (more than half) of all home visiting services in Washington State are delivered through one of four models:

[10] Washington State Department of Early Learning (2017). *Home Visiting Scan – Fall 2017*. Available at: https://del.wa.gov/sites/default/files/public/HV%20Scan%20DRAFT%20v6.pdf.

- Early Head Start – Home Based Services (EHS) is a home-based model that focuses on children's physical, social, emotional and intellectual development; prioritizes low-income pregnant women and children up to age three years; and is delivered by trained home visitors.
- Nurse-Family Partnership (NFP) focuses on pregnancy outcomes, child health and development, and economic self-sufficiency, prioritizes women with low incomes who are pregnant with their first child, and requires that the home visitor be a nurse, with a preference for nurses with a Bachelor of Science in Nursing.
- Parent-Child Home Program (PCHP) focuses on parent-child interaction and early literacy, prioritizes at-risk parents and children between two and four years old, and is delivered by trained home visitors, with a focus on matching the home visitor to the family's culture.
- Parents as Teachers (PAT) focuses on parenting skills and school readiness, early detection of health issues, and prevention of child abuse and neglect; prioritizes families with children between prenatal and kindergarten; and is delivered by parent educators.

Other models funded by the HVSA are Child-Parent Psychotherapy (CPP) and Steps Toward Effective, Enjoyable Parenting (STEEP), both of which focus on the parent-child relationship, and several community-designed models and services, including Family Spirit, a culturally tailored model developed with tribal communities, and the Outreach Doula Program, which links trained doulas with families of the same community, bridging language and cultural barriers. Other models in use in Washington State, but not funded by the HVSA, include Early Steps to School Success (ESSS), which focuses on school readiness; and Cherish, which promotes social-emotional well-being of children in out-of-home care.

Two programs that support families experiencing substance use, the Parent-Child Assistance Program (PCAP) and Safe Babies, Safe Moms (SBSM), include some elements of home visiting services but do not focus on parent-child interactions or child development, and thus do not meet the definition of home visiting used in this report.

For a more detailed review of key differences between models, see appendix B.

Additional stakeholders

The **Washington State Home Visiting Coalition** is committed to supporting increased investments in the HVSA for a portfolio of home visiting models, primarily through advocacy for funding and policy change. Members include home visiting programs; national home visiting models; nonprofit organizations; community-based organizations; and representatives from city and county government, among others.

The **American Indian Health Commission (AIHC)** has been a close partner with DCYF in planning and management of the state's home visiting system to ensure the inclusion of home visiting and other critical maternal and child health services that are culturally appropriate for American Indian populations.

ADDITIONAL FACTORS IMPORTANT TO EXPANSION

Although there was ample change during the first decade of the HVSA, the pace of change and range of contextual factors has intensified and will undoubtedly affect home visiting programming during this phase of expansion planning and subsequent implementation. The

transition of DEL to DCYF and fulfilling the requirements and promise of the new Department will require examination of how home visiting programs scale up, the capacity of the Department to support expansion, and integration with other DCYF services.

DCYF is taking on the following initiatives, as required by its enabling legislation (HB 1661):

- Defining child- and family-level outcomes and DCYF performance measures.
- Adopting performance-based contracting. (Home visiting will be included in both the fiscal year 2020 and 2021 contracting cohorts to implement outcomes-oriented performance-based contracting.)
- Integrating family support, early learning, and child welfare programming.

In addition, new federal legislation enacted in 2018, the Family First Prevention Services Act (FFPSA), has the potential to increase support for expansion of home visiting services for child welfare-involved families.

APPROACH

This report outlines the context for expansion, describes a planning approach to estimate the costs associated with a potential expansion scenario, and identifies key considerations that should be taken into account in developing an expansion plan. To identify these considerations, the DCYF team carried out the following activities:

- Analyzed definitions and criteria that affect funding for home visiting models.
- Identified key considerations used by the Washington State Home Visiting Needs Assessment: 2017 Report to prioritize communities and populations.
- Created a summary of the home visiting landscape, based on the Home Visiting Scan: Fall 2017, with November 2018 updates to data where possible.
- Interviewed 25 stakeholders and engaged many additional stakeholders in five large-group listening sessions and workshops.
- Analyzed cost considerations and options for expansion.

ANALYSIS OF DEFINITIONS AND CRITERIA THAT AFFECT FUNDING FOR HOME VISITING MODELS

HB 2779 tasked the DCYF to "Develop a common set of definitions to clarify differences between evidence-based, research-based, and promising practices home visiting programs and discrete services provided in the home." This analysis focused on definitions related to evidence of effectiveness (see continuum of evidence; appendix C), with two goals:

1. Understand how commonly used criteria and definitions affect the funding available for different types of models and the implications for expansion.
2. Assess how the HVSA's application of these terms influences funding, efficiency and ability to reach the communities with greatest risk and least access to services, in culturally diverse populations.

DCYF reviewed and compared the following sources of terms and definitions:

- **Washington statute RCW 43.216.130** sets out definitions for the key terms home visitation, evidence-based and research-based.

- **Home Visiting Evidence of Effectiveness (HomVEE)** was launched by the US Department of Health and Human Services to assess evidence of effectiveness of home visiting models for the federal MIECHV program. HomVEE only identifies models considered "evidence based"; all other models are considered a "promising approach."
- **HVSA** aligns with the HomVEE/MIECHV definition for identification of evidence-based models and uses the terms “researched-based” and "promising practices" for all other models.
- **The Washington State Institute of Public Policy (WSIPP)** has been tasked by the Washington State legislature to identify "evidence-based" public policies and practices. WSIPP classifies various services and program models as "evidence-based," "research-based" and "promising practice." WSIPP regularly reviews some home visiting models but has not reviewed all home visiting models implemented in Washington State or funded by the HVSA. DCYF currently does not use WSIPP classifications to determine whether models meet the criteria for funding through the HVSA as evidence based.
- **Best Starts for Kids**, a King County voter-approved initiative, is a major funder of home visiting services in King County. Best Starts for Kids provides funding for home visiting within the following classifications: "evidence-based" or "evidence-informed" and "community-informed."
- The **California Evidence-Based Clearinghouse for Child Welfare (CEBCCW)** of the Chadwick Center for Children and Families at Rady Children’s Hospital in San Diego has been tasked by the California Department of Social Services with identifying evidence-based child welfare practices. Rather than classifying practices as "evidence-based" or "not evidence-based," CEBCCW describes five tiers of practices, ranging from "well-supported by research evidence" to "concerning practice." These tiers mirror the evidentiary standards outlined in the FFPSA.

Separately, DCYF reviewed key definitions related to evidence of effectiveness from the US Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), the Pacific Institute for Research and Evaluation, and the Oregon State Evidence-Based Registry. These provided valuable insights but play a much smaller role in funding for home visiting broadly and are not included in detail here.

There is general agreement on certain aspects of the continuum of evidence. For example, "evidence-based" mostly refers to a model that has been tested through some number of randomized, controlled studies. And, although funders and evaluators rely on a variety of terms (e.g., "evidence-informed" vs. "research-based"), in general, these groups are in agreement about the hierarchy of the continuum of evidence:

- **Evidence-based** models and practices are those that have strong evidence based on rigorous scientific methods (typically two or more randomized, controlled trials) and are effective in achieving a specific set of outcomes.
- **Research-based** or **evidence-informed** models and practices have moderate evidence (only one published, peer-reviewed study) from randomized, controlled trials that they are effective in achieving a specific set of outcomes.
- **Promising practices** are those models and practices that do not yet have published evidence from a randomized, controlled trial but are believed to be on track for achieving outcomes to establish a level of evidence of effectiveness based on formal evaluation studies.

- The term **community-informed/community-designed practices** describes models and practices that have demonstrated effectiveness based on evidence from the communities in which they are implemented, although not from formal scientific studies.

With no single standard or set of definitions in use across the field of home visiting, major funders, like MIECHV, have a compelling influence on how these terms are generally applied in the field. Because this continuum of evidence affects the availability of funding, it is useful to consider the criteria used by the following sources of funding:

- **MIECHV** requires that 75 percent of funding be directed toward models considered evidence-based, and no more than 25 percent of funding directed toward promising practices. MIECHV relies on HomVEE to assess which models meet the criteria for evidence-based. Funding requests for promising practices must include funding for a rigorous evaluation to build evidence of the model.
- **Dedicated Marijuana Account** requires that 85 percent of funding be directed toward models that are considered "evidence-based", and no more than 15 percent directed toward promising practices. The administrators of the Dedicated Marijuana Account work with the University of Washington and SAMHSA's Center for the Application of Prevention Technologies to identify evidence-based home visiting programs with outcomes in marijuana use prevention or reduction among twelve- to eighteen-year-olds. WSIPP review is used to confirm evidence of effectiveness.
- Although **Best Starts for Kids** does not provide funding to the HVSA, they are a significant funder of home visiting services in Washington and a major recent influence on what models are implemented in King County. Best Starts for Kids funds both "evidence-based/evidence-informed" and "community-designed" programs, providing about $2.76 million for the former, and about $5.83 million for the latter — reversing the trend of other funders.

From Whatcom County:
Michael and Patricia had been told they would be unable to conceive, so when they learned they were expecting a child, they were thrilled. However, they had a difficult road: complications during pregnancy, a premature birth, and months in neonatal intensive care. Their daughter survived, but with ongoing medical and developmental concerns.

At an early prenatal visit, the family was connected with a trained nurse home visitor. Throughout their journey, the home visitor was on hand to provide advice and support. The home visitor also connected them to resources for financial assistance, mental and physical health services, affordable housing, and support for healthy child development.

Both parents were eager to learn and draw on the resources offered. Today, their daughter is free of health concerns and on track in all areas of development. The family is proud to have overcome the challenges they faced and says that the NFP program made a significant difference in their lives.

The large majority of funding available in Washington State, and in particular for HVSA, is required to be allocated toward evidence-based models — those that meet the highest bar. The strength of this approach is that it prioritizes models proven to be effective by commonly agreed

criteria. Organizations that implement these models, and that do so with fidelity, can have relative confidence of positive outcomes and intended results.

However, there are limitations to using most of the available funding to support the top tier of evidence. One limitation is that this approach relies on findings from randomized, controlled trials. To establish outcomes for a long-term intervention is an extensive process, often requiring years to design interventions, conduct evaluations and publish research. In addition, beyond the extensive research necessary to establish outcomes for a particular intervention, it is necessary to ensure that the model or program has the elements necessary to scale up the intervention in various different communities. There are valid reasons that effective home visiting practices might not meet these criteria.

These limitations must be considered in expansion planning for the following reasons:

1. Regardless of the level of evidence established for a home visiting program, strong implementation requires support. However, the type of support differs for models at different points on the continuum of evidence. Evidence-based home visiting models primarily need support for high-quality implementation; other models need support for program development, strong implementation, *and* the development of data systems which help in the evaluation of program outcomes.
2. The models that may be the best fit for high-risk communities may not be eligible for the largest pools of funding. That may limit the ability of such communities to choose the home visiting services that will best meet their unique needs. For example, models with less rigorous credentialing or pre-service training requirements for home visitors have more flexibility to employ members of the community as home visitors to bridge cultural and language barriers.

It is also important to consider challenges associated with delivering evidence-based models to larger populations. As evidence-based policymaking has expanded nationally and internationally, so has understanding of what it takes to scale evidence-based models and practices. The field of implementation science supports bringing these practices to communities and populations beyond those included in the initial research.[11] The HVSA has embraced implementation science through the Implementation Hub, which supports strong implementation and helps prevent drift (changes to an evidence-based model that alter the core components related to program outcomes), which can impair fidelity and undermine the program's effectiveness in ways that are not consistent with program requirements.

At the same time, as evidence-based programs are broadly scaled up, there is opportunity for adaptation and innovation within the model, while still ensuring that the model is delivered with precision. These adaptations and innovations are typically considered "model enhancements" and they should be evaluated and approved by the national model developer to ensure that the model's core components are sustained even as adaptations or innovations are tested to determine their impact for specific populations or issues (e.g., maternal depression, attachment, executive functioning). An emerging research initiative called "precision home visiting" is exploring the application of refined approaches to home visiting, building from knowledge and experience in precision medicine and precision public health.[12]

[11] National Implementation Research Network: https://nirn.fpg.unc.edu/
[12] https://www.hvresearch.org/introduction-to-precision-home-visiting/

KEY CONSIDERATIONS IN THE USE OF THE NEEDS ASSESSMENT

Methodology and outcomes

DOH completed a needs assessment in 2017 as an update to the 2010 *Washington State Home Visiting Needs Assessment*, [13] as required by the federal MIECHV program. The most recent needs assessment presents individual risk factors that may be associated with poorer health and education outcomes, including factors associated with the domains of maternal and child health, socioeconomic status, education, home environment, and alcohol and substance use. The needs assessment estimates the distribution of need across the state for home visiting services by comparing the number of low-income births in 2013–2015, with the number of funded home visiting slots. Data on the number of funded home visiting slots were updated in November 2018 for this report.

The needs assessment examined distribution of risk through the lens of two geographic units (counties and school locales) and one demographic unit (race/ethnicity). School locales are a district or a grouping of adjacent school districts with similar population characteristics that have at least 20,000 residents. This multi-dimensional approach supports a more nuanced analysis when using these data to plan for programs and services. Each of the methodologies has strengths and limitations.

For **geographic** distribution of risk, the needs assessment uses a quintile approach – evaluating risk in each county and school locale across five levels: highest, high, neutral, low, lowest. The following summarizes the results based on this approach:

- The **counties** in the highest quintile of risk included Adams, Ferry, Franklin, Grant, Grays Harbor, and Yakima. Two of these, Adams and Ferry, had fewer than 1,000 low-income births between 2013 and 2015, so although in the highest-risk category, the depth of need in those counties is relatively small. Of the six counties with the highest risk scores, only Yakima is also in the highest quintile for number of low-income births.
- The **school locales** in the highest risk quintile include the Spokane metro area, South King County, and Pierce County along the I-5 corridor; coastal regions, including Grays Harbor and Pacific County; and large portions of central and eastern Washington, including areas of Okanogan, Douglas, Grant, Franklin, Yakima, Klickitat, Benton, and Asotin counties. Of the 24 highest-risk school locales, nine are also in the highest quintile for number of low-income births, including Yakima, Toppenish, Tacoma, Sunnyside, Clover Park, Spokane, Franklin Pierce, Pasco, and Highline.

Through a **race/ethnicity lens**, the assessment identifies non-Hispanic Native Hawaiian and other Pacific Islanders as the highest-risk group. Non-Hispanic American Indian and Alaska Natives, Hispanics, and non-Hispanic African-American/Black communities were also at high risk compared to the Washington State average.

A key finding from this report, which was echoed universally in stakeholder interviews and workshops, is that the need for home visiting services far exceeds the current resources available statewide. Among counties with a significant number of low-income births (more than

[13] Washington State Department of Health (2018). *Washington State Home Visiting Needs Assessment – 2017 Report*. Available at: https://del.wa.gov/sites/default/files/public/OFCHI_HVNA_2017_Report_FINAL_2018_04_17.pdf.

500), none had slots available for more than 11 percent of low-income families, and the large majority were between 0 and 6 percent.

The needs assessment offers three helpful lenses for thinking about the highest-impact expansion strategy:

- First, because the assessment includes data sorted both by county and school locale, it is possible to identify the areas within each county where there are a high number of families who would benefit from services and where there are families at highest risk. This is significant because some counties overall may show relatively low need but have pockets where the need is very deep. For example, some of the more populous counties (Pierce, King, Clark, Spokane) have such large populations that their overall level of risk may be rated low, despite pockets of high need in those counties.
- Second, the assessment provides a measure of risk for each county and locale, which can be used as a rough guide to where home visiting services may have the greatest impact qualitatively (vs. quantitatively).
- Third, because the assessment uses a race/ethnicity model to examine risk factors by different racial and ethnic groups, it allows the state to identify needs across county or school locale boundaries.

The state home visiting needs assessment has some limitations. Data for some of the risk factors it includes (infant mortality and teen births) are tracked at the county level and across racial/ethnic groups but not at the school locale level. Because school locales have different boundaries — including occasionally crossing county boundaries — it was not possible to use some population-based data collected only at the county-level. School locale data is not disaggregated by racial/ethnic subgroup, which would be helpful.

Regardless, the assessment is a very useful tool for identifying the state's areas of most critical need. In the scenario presented in this report (see "Expansion scenario," below), data provided by the needs assessment are used to identify the level of need and risk in school locales across Washington State as a method for setting targets for expansion.

Priority populations for expansion

Based on the needs assessment, and on input from stakeholders, the following populations rise to the top as priorities for home visiting expansion.

- **Racial and ethnic populations with the highest prevalence of risk factors.** These groups not only are at higher risk but may face equity-related challenges in accessing health services and other support**.** Stakeholders echoed these priorities closely.
- **Geography-based populations with the highest prevalence of risk factors.** The expansion scenario described below in this report identifies several geographic areas as priorities for home visiting services.
- **Rural and remote (or frontier) communities that currently have no or minimal access to home visiting services.** Access to health services is often limited in rural areas, which means that home visiting services are both more valuable and difficult to deliver. Unless prioritized and supported for capacity development or until regional approaches are available, these areas may continue to go unserved.
- **Immigrants and refugees.** This group was not evaluated uniquely in the state needs assessment but was mentioned by a number of stakeholders as having high needs for home visiting services. (The needs assessment included all women who delivered

babies in 2013–2015, regardless of immigration status, and does not differentiate this group.)

Some families are at risk across multiple factors. These families should be further prioritized for recruitment and engagement.

SUMMARY OF HOME VISITING LANDSCAPE BASED ON HOME VISITING SCAN

In fall 2017, DCYF conducted an in-depth assessment of all home visiting services across Washington to identify what models are in use, in what proportions, and their scope (both who they serve and what risk factors they address). This *Home Visiting Scan – Fall 2017*[14] described program capacity from 2015 through 2017.

In preparation for this report, DCYF surveyed both HVSA- and non-HVSA–funded home visiting programs to update the 2017 scan. This update included models that:

- Provide voluntary home-visiting services to families as the primary intervention.
- Focus on supports that span from prenatal up to transition to school (ages 0 to 5 years), focusing on prenatal to age 3.
- Require a range of credentials and training for home visitors to provide intensive supports.
- Focus on one or more outcomes such as child development and parenting; child abuse, neglect and injury prevention; reduction of domestic violence; coordination of community resources and supports; and/or economic self-sufficiency.

The update assessed current home visiting coverage by county and by model. DCYF contacted model representatives for all nationally implemented models, major funders and local home visiting programs to determine the number of slots funded in the most recently completed program year, adding numbers for 2016 through 2018.

Most tribal home visiting services are not included in either the initial or updated scan because of differences in the way data for those services is collected and tracked. However, a new model that serves tribal needs, Family Spirit, is included in the 2018 numbers. Models that are in use but do not fit the DCYF's definition of home visiting are also not included in the updated scan (e.g., PCAP and SBSM).

As of November 2018, there were 7,323 home visiting slots funded in Washington State, which reflects a slight reduction from the fall 2017 total of 7,823.

Service distribution across funding sources

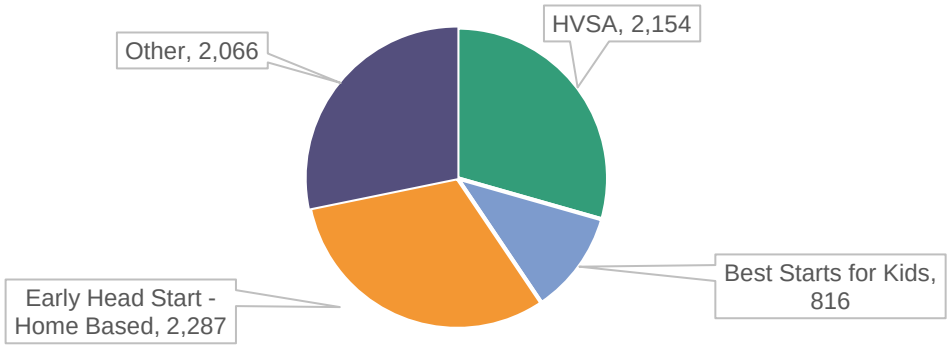
Of the 7,323 funded slots, 2,154 are funded through the HVSA, and 5,169 are funded through non-HVSA sources (figure 7). Among non-HVSA sources, Best Starts for Kids funds 816 slots, EHS funds 2,287 slots, and 2,066 slots are funded by other sources, including local levies and taxes or private funders.

The HVSA is the only centralized, coordinated body providing support across many models and programs throughout the state. The proportion of home visiting slots supported through this

[14] Washington State Department of Early Learning (2017). *Home Visiting Scan – Fall 2017*. Available at: https://del.wa.gov/sites/default/files/public/HV%20Scan%20DRAFT%20v6.pdf.

state fund is remaining relatively stable. However, the State's opportunity to influence the quality and prioritization of all services provided (including non-HVSA funded slots) may wane if the HVSA continues to be a relatively small portion of the total number of slots funded.

Figure 7. Number of funded slots for all home visiting services in Washington State, by funder (2018). HVSA, Home Visiting Services Account.



Service distribution across models

The four most commonly used models account for 7,007 (96 percent) of the state's 7,323 slots. Allocations for all models included in the updated scan are as follows:

- EHS: 2,286 slots.
- NFP: 2,236 slots.
- PAT: 1,470 slots.
- PCHP: 1,015 slots.
- Outreach Doula Program: 102 slots.
- CPP: 78 slots.
- STEEP: 34 slots.
- Family Spirit: 12 slots.

Allocations for models that are not funded by the HVSA are:

- Cherish: 50 slots.
- ESSS: 40 slots.

These numbers are based on reports from each model for the most recently completed program year. Thus, there is some fluctuation between years (and throughout the year, as a result of varying funding cycles), especially because the home visiting models do not all use the same program year. The PCAP and SBSM models (now combined) account for an additional 1,409 slots but were removed from the analysis for purposes of this report.

This distribution of models closely mirrors the distribution in funding for evidence-based versus promising practices (e.g., the MIECHV requirement, mirrored by the HVSA, that 75 percent of MIECHV program funding be directed toward evidence-based models). For all of the home visiting slots currently funded, 7,085 (97 percent) are delivered through evidence-based models, and only 238 (3 percent) are delivered through research-based or promising practice models.

The mix of models and funding sources is likely to change with expansion, particularly as communities are engaged to design and choose models that fit their needs.

ENGAGEMENT WITH STAKEHOLDERS IN LISTENING SESSIONS AND WORKSHOPS

Between September and December 2018, the DCYF team, with support from Cedar River Group, talked with a wide range of stakeholders to solicit input on the potential expansion of home visiting services, asking about both challenges and opportunities.

Interviews with individual stakeholders

Twenty-five individuals were interviewed, including representatives from Thrive Washington, DCYF, other state departments (DOH, DSHS, HCA), the AIHC, United Indians of All Tribes Foundation, home visiting advocates, and a representative of the Washington State Legislature. Interview questions ranged from topics about greatest unmet needs to preferred strategies for expansion. For a list of interviewees, their titles, and questions asked, see appendix D.

Workshops

Workshops and listening sessions held during previously scheduled gatherings of home visiting leaders and program managers in October, November and December yielded additional input. Leveraging already-scheduled meetings offered access to the greatest number of viewpoints in a setting already geared to discussions about home visiting. These sessions included a meeting of the HVAC; the Washington State Home Visiting Coalition; the HVSA All LIA Programs Meeting, which brings together representatives from implementing partners; the Tribal Home Visiting and Maternal Health Summit; and the Indian Policy Early Learning Committee.

Themes and findings

The following are major themes and findings from the interviews and stakeholder group discussions.

Timing for expansion

There was broad consensus that the time is right to expand home visiting services in Washington. Those interviewed felt that home visiting is an effective, cost-beneficial service; that the state has a successful eight-year track record in expanding home visiting services; and that there continues to be a high unmet need for additional home visiting services. There was also a strong sentiment that expansion should include the necessary supports for communities and agencies to ensure success (see "Challenges and obstacles to expansion," below).

Greatest unmet needs

Asked about where the greatest unmet need for home visiting services is, stakeholders universally identified two populations: rural communities that have little or no access to services, and low-income communities that have been identified as high-risk, particularly African American/Black, American Indian and Alaska Native, and Hispanic communities. Stakeholders agreed that the 2017 needs assessment provides a good starting point for prioritization. Stakeholders strongly prioritized culturally appropriate and customized services that meet communities where they are. DCYF will continue to use the process and lessons learned in the Thrive-led rounds of community planning in 2013 and 2015, two of which focused on rural

capacity development. Results of the rural community planning work are highlighted in the *Researching Implementation Supports Evaluation Study*.[15]

Priority populations for expansion
Most stakeholders placed priority on ensuring that home visiting services are available in all counties in the state, as well as a focus on families at highest risk for poor maternal and child health outcomes. Specific populations mentioned most often by stakeholders included those racial and ethnic groups mentioned above and families facing homelessness, mental health and substance use issues, and domestic violence.

Challenges and obstacles to expansion
While eager to pursue the opportunities that expansion would bring, stakeholders were also direct about the potential challenges, including the need for training and support for local workforces, the importance of programs and staff that are culturally diverse, and identifying sufficient staff to expand where the need is greatest. Similarly, they said that communities would need support to develop the infrastructure and capacity to support expanded services, and linked each of these issues to the strong need for community-driven planning in the regions or among the populations where expansion will occur. Many stakeholders who work for state agencies also acknowledged that, given the recent restructure of DCYF, expansion would also require infrastructure and additional support and/or capacity for staff at the state level.

Preferred service delivery model
Stakeholders voiced a strong sentiment supporting a portfolio approach that offers multiple programs to meet diverse community needs, including promising approaches and other models that may not be evidence based. They noted that the current funding streams are not aligned with that goal. They emphasized the importance of matching communities with the right model to ensure that the unique needs of vulnerable populations are met.

A number of stakeholders also suggested that some form of universal screening and referral – or coordinated pathway into home visiting – would be an important aspect of an expansion strategy. They stated that universal screening would help ensure that all families receive an initial visit and that referrals to longer-term home visiting services reach those who would benefit most. Given finite resources, some expressed concern about finding the right balance between investment in a universal approach and expansion of long-term slots for priority populations.

Scale of expansion
While everyone supported expansion, especially in communities at highest risk, several stakeholders cautioned that given limits on both state and community capacity, expansions should be scaled appropriately to continue to deliver high-quality and effective programming. In addition, others stated that scaling or phasing of expansion should be guided by creation of an ultimate goal for full build out of the home visiting system using data to inform the initial expansion goal.

Funding options for expansion
Since current funding sources prioritize investment in evidenced-based models, stakeholders suggested that funds for expansion are needed to support models that are effective in meeting the needs of high-risk communities, regardless of whether they meet standard definitions for

[15] SRI International (2017). *RISE Home Visiting Evaluation Rural Case Study Brief Report.* Available at: https://del.wa.gov/sites/default/files/public/RISE_RuralCaseStudy_Brief_FINAL_9-20172.pdf.

"evidence-based." Stakeholders believed that the Washington State General Fund was an extremely important source of flexible funding, especially for expansion. Some of those interviewed also mentioned that Medicaid and the FFPSA may provide opportunities for additional funding for expansion.

EXPANSION SCENARIO

To inform the Legislature's thinking about scope, direction and resources needed to expand Washington's home visiting services, DCYF developed an expansion scenario. It identifies the ways in which expansion could be scaled up in size, gauges the costs associated with expansion, and identifies the key considerations and decisions that would need to be addressed in planning for expansion. This scenario took into account stakeholder input and data from both the home visiting scan and the home visiting needs assessment.

One of the key questions in expansion planning is how to balance the differing needs for home visiting services across the state. In other words, should expansion focus on reaching the largest number of families in need of home visiting services? Or should the focus be on reaching the families at greatest risk of poor birth or child health outcomes? Or should the focus be on ensuring that there is at least some base level of service in all parts of the state? This scenario attempts to balance these needs.

The scenario describes three possible phases of expansion that could occur over three or more biennia, depending on capacity and readiness for expansion (see appendix E). During that time, approximately 20,500 new home visiting slots would be created to serve families. As a result, home visiting services in Washington would grow from the current level – capacity to serve 6 percent of all births in low-income families – to capacity to serve 22 percent of all births in low-income families.

Developing an overall goal for full build-out is challenging. There are very few data available to evaluate community- or population-level outcomes where long-term home visiting has been implemented at this scale. It has simply not been done. However, one possible example comes from Virginia, where the city of Hampton commissioned a study published in 2007 on the citywide impact of the home visiting program called the Healthy Families Partnership.

That study, called the *2007 Hampton Healthy Families Partnership Benchmark Study*, examined the citywide impacts of scaling up a home visiting program between 1998 and 2002 and operating at scale between 2002 and 2005 (1,000 participants per year) compared to other cities in the state.[16] In most domains, Hampton, a city of approximately 135,000 residents, 6 percent of whom are under age 6, outperformed comparison cities without citywide home visiting programs on population-level indicators including child abuse and neglect, infant mortality, and births to teens (as well as others). This program was not sustained at scale because of the economic downturn. However, researchers involved in this study suggest that 35 percent to 50 percent of eligible families accessing home visiting may create a tipping point for community-level change.

[16] Galano, J. and Huntington, L. (2007). *2007 Hampton Healthy Families Partnership Benchmark Study: Measuring Community-Wide Impact*. Available at: https://hampton.gov/DocumentCenter/View/187/2007-Benchmark-Study?bidId=

Beyond this study, there is very little published evaluation on outcomes expected or seen when home visiting is implemented at full scale. The expansion scenario goal of reaching 22 percent of low-income families far exceeds the current program reach, and it is very close to the estimated proportion of eligible families (25 percent) that will utilize home visiting services when such services are available (though expansion planning should also include strategies to increase utilization among all families that can benefit — and to reach families furthest from opportunities).

The target level of coverage is ambitious but has potential to deliver major family and community impact, and it represents significant progress toward the tipping point suggested by the Hampton study. Ongoing evaluation of program scale-up would be necessary to calibrate the ultimate goal.

The total annual cost to the HVSA account of supporting 20,500 new slots – the cumulative total of new slots added by the end of phase 3 – would be $167 million in new funding. To support both expansion *and* existing HVSA-funded slots would require $179.4 million per year.

This scenario is imperfect, but using the highest-quality data available, it provides a good starting point for discussions about expansion.

FRAMING ASSUMPTIONS

The expansion scenario is based on the following framing assumptions.

Phased expansion, with a focus on high-risk communities first

The need for home visiting services is substantial, as both the state needs assessment documents and stakeholders confirm. However, expansion should build on the success and strengths of the current system of services and should be phased. Phasing will enable the growth to be well supported by planning, technical assistance, community engagement and sound systems developments. The expansion scenario explores a three-phase approach that reaches the families with the deepest needs immediately while expanding in communities with moderate and lower risks in later phases. There are also guardrails to ensure that locales that have comparatively lower risk, but a significant number of low-income births, receive some priority in expansion.

Blended "cost per home visiting slot"

There is wide variation in the cost per slot between and among home visiting models (the reasons for this variation are described in "Financing and Sustainability," below). To accommodate this variation, DCYF is using a blended rate in planning for expansion (averaging cost data from all home visiting models). This facilitates planning for counties and locales in which multiple models may be required to meet the needs of different populations and communities.

The “fully burdened” blended rate used for phase one of expansion is $8,600 per home visiting slot per year. The rate is projected to decrease to $7,800 per slot per year by phase 3, based on the assumption that some economies of scale will be achieved. However, it should be noted that the projections do not include cost of living increases for payment of direct services. This fully burdened rate includes payments to LIAs for direct services, as well as the cost of infrastructure and capacity building needed to support expansion. The rate includes necessary funding for the initial community planning process, technical assistance, data management and evaluation,

contract management and administration of the program, quality assurance, training and workforce development, and other services needed to support expansion. The rate also includes implementation of performance-based contracting. (See appendix F for a breakdown of the fully burdened cost estimates for each of the three phases and appendix G for a breakdown of administrative costs.)

School locale vs. county

To ensure that the analysis takes into account diversity across regions and pockets of high need within lower-need counties, the planning scenario uses school locale data rather than county data to identify levels of risk.

RISK SCORING

To establish areas of greatest priority and identify locales with the greatest concentration of high-risk factors, DCYF used the 2017 home visiting needs assessment data to create a risk index (see appendix H). The index is based on the weighted average of multiple risk indicators across five domains (maternal and child health, socioeconomic status, education, home environment, and drug and alcohol abuse). Each domain is weighted equally so that domains with more indicators do not have a larger impact on the risk index. The scenario then assigns priority ranking from 1 (highest risk) to 5 (lowest risk). Overall, 66 percent of low-income births identified between 2013 and 2015 fall into the higher priority categories (1, 1.5, 2, and 2.5) according to this methodology.

SETTING PRIORITIES FOR EXPANSION

A target level of home visiting services coverage was assigned for each level of risk.

- For tribal communities, the highest-risk demographic identified in the needs assessment, the target is serving 40 percent of all births in low-income families.
- For non-tribal, highest-risk communities (a priority ranking of 1 to 1.5), the target is serving 35 percent of all births in low income families.
- For non-tribal, medium-risk communities (a priority ranking of 2 to 2.5), the target is serving 25 percent of all births in low income families.
- For non-tribal, lowest-risk communities (a priority ranking of 3.0 to 5.0), the target is serving 20 percent of all births in low-income families.

For example, in the Moses Lake school locale, which had 1,385 low-income births in 2013-2015, a priority ranking of 1.5, and a target of 35 percent coverage, 485 slots would be needed to achieve that target. In the Cle Elum/Roslyn school locale, which had 961 low-income births in 2013-2015, a priority ranking of 2, and a target of 25 percent coverage, 240 slots would be needed.

Considering feasibility and cost, and to ensure that expansion would not be concentrated only in the largest population centers, additional guardrails were put in to cap the number of slots that could be added depending on the size of the locale.

The expansion scenario provides a carve-out for working with American Indian and Alaska Native populations and implementation should consider the unique nature of government-to-government relationships. It would be DCYF's intention to support tribes to expand services by

hiring, recruiting and retaining home visitors to focus on tribal populations within their service area/jurisdiction.

PHASED APPROACH

The scenario uses the above methodology to create a three-phase expansion process:

- **Phase 1** focuses on locales with priority rankings of 1 to 2.5. Each locale is allotted a number of new slots based on achieving a portion (one-quarter to one-third) of the overall target for that locale (e.g., a locale with a target of 1,000 slots would receive 250 new slots in this round; a locale with a target of 75 slots would receive 20). Phase 1 adds approximately 5,000 slots across locales, with 500 of these additional slots for tribal communities. The cost for this first phase of expansion would be $43 million per year.
- **Phase 2** focuses again on locales with the highest priority rankings but adds two new groups: locales with a priority ranking of 3.0, and locales with at least 1,000 low-income births in 2013-2015, regardless of risk score. Phase 2 adds approximately 8,000 slots across locales, with 500 of these additional slots for tribal communities. An additional $65.6 million per year would be required to support the second phase of expansion.
- In **Phase 3**, sufficient slots are added in every locale to meet their targets, with adjustments for existing met need: to account for existing home visiting capacity (which is known at the county level, but not at the locale level), the number of new slots assigned in phase 3 is reduced by 50 percent across the board. Phase 3 adds approximately 7,500 slots across locales, with 1,000 of these additional slots for tribal communities. An additional $58.5 million per year would be required for Phase 3.

The following table provides a summary of the number of slots that would be added in this scenario, the cost per slot, and the cost of each new phase of expansion. Overall, this scenario would more than triple the home visiting capacity for low-income families in Washington, with the greatest expansion focused on the locales with the greatest need. By the end of phase 3, every county would have some capacity to provide home visiting services.

Table 2: Expansion Slots – Phased Approach

	Phase 1	Phase 2	Phase 3	Total
Additional slots	5,000	8,000	7,500	20,500
Cost per slot	$8,600	$8,200	$7,800	---
Tribal carve-out	500	500	1,000	2,000
State home visiting capacity	10%	16%	22%	22%
New cost	$43 million	$65.6 million	$58.5 million	$167.1 million
No. of counties receiving additional slots	29	32	39	---

ADDITIONAL CONSIDERATIONS FOR EXPANSION

While the scenario above provides an option for potential expansion of the state's home visiting system, there are a number of factors that will need to be considered in deciding the appropriate

size and rate of expansion. Based on conversations with stakeholders and the research and analysis represented above, DCYF believes the considerations below are critical to the development of a successful expansion strategy.

In addition, the HVSA is guided by a set of core values that support planning and decision-making for home visiting services:

- **Portfolio approach:** HVSA is invested in using a portfolio approach to fund a range of models and programs, supporting home visiting that will meet the needs of diverse communities and populations.
- **Diverse representation:** HVSA is invested in ensuring the portfolio of funded programs includes representation from diverse geographic, racial and cultural communities.
- **Funding a range of capacity:** HVSA is invested in granting funds to programs and organizations with a broad range of capacity, including high-capacity, moderate-capacity, and low-capacity programs.
- **LIA participation:** HVSA fosters participatory engagement with LIAs related to technical assistance and evaluation processes.

These core values are an essential backdrop to expansion planning and reflect the state's desire to deliver the greatest impact.

SERVICE DELIVERY AND ACCESS

A specific approach to support less-established, innovative models as well as established models (a portfolio approach) can improve service to vulnerable communities, with additional support to maintain quality and efficiency.

An expansion strategy must consider which models best meet an individual community's needs and the community's capacity to implement the model. Ideally, models will also reflect the communities they serve, including some models that require home visitors to be of and from the communities they serve. This is especially important in underserved communities, which tend to have a complex range of needs and fewer resources for implementation. However, the models that are the best match for such communities do not always meet the highest bar for evidence of effectiveness.

Currently, due to funding restrictions and other reasons, 95 percent of HVSA-funded slots are for evidence-based home visiting models. To maximize access to services in the hardest-to-reach communities, the state will need to strengthen support for promising practices and community-defined models and identify creative approaches to funding. The expansion scenario described above assumes that 80 percent of the new slots added will be evidenced-based, while 20 percent will be for promising practices.

It should also be noted that a portfolio approach can help ensure equity and meet the state goals of serving vulnerable populations. However, increasing the number of models used could come at the cost of efficiency and put achieving economies of scale at risk. Each new model requires new capacity, data systems, training and more that can add to the cost of a statewide system. New models require more intensive technical assistance and more support for evaluation.

New approaches, such as regional and virtual models, may help maximize the impact of expansion.

One of the challenges in serving rural communities is that there are fewer LIAs to deliver home visiting services. DCYF has recently started funding a small number of LIAs that provide services to multiple counties. This could be a way to overcome the lack of local capacity in some communities, and it could also achieve some economies of scale, including fewer contracts and reduced need to recruit and retain staff in sparsely populated locations. DCYF will review this approach for potential use in expansion.

Another challenge in making sure rural communities have access to home visiting services is the long distances home visitors must travel to reach families. Virtual home visiting (e.g., by telephone or computer) may be useful for expanding the reach of home visiting services to these communities. Currently NFP has approved the use of some telehealth encounters to support activities in home visits, and PAT is piloting a virtual home visiting program in southern California, with evaluation results expected in the coming year. DCYF is committed to exploring the potential of using these and other new, effective approaches as they emerge.

UNIVERSAL HOME VISITS AND SCREENING

Universal in-home screening with coordinated entry can increase the use of — but does not replace — longer-term home visiting services.

One way of providing access to the greatest number of families would be to establish a universal "light touch" in-home screening and referral program for all new mothers. This approach would offer one to three voluntary in-home visits for all new mothers after birth, with screening for family needs and risk factors and referral to more intensive services (including longer-term home visiting) if needed.

Some stakeholders expressed interest in creating coordinated screening and referral services as a means of identifying the highest-risk families at the time of birth and matching them with the most appropriate services to meet those needs. It was also suggested that this approach could reduce any stigma associated with home visiting by establishing an initial home visit as the norm for all families. This approach is complementary to, but not a substitute for, traditional home visiting services that support families more intensively and over an extended period of time.

As part of expansion planning, DCYF explored Family Connects, one potential model for universal screening with coordinated entry and referrals that has been implemented effectively in several states.

Family Connects

Family Connects is a national nurse home visiting model for parents of newborns. It began in Durham, North Carolina, and has been used in other communities across the country. Research for this report focused on the Family Connects pilots in Illinois at two locations — in urban Peoria and rural Stephenson County.

Family Connects in Illinois provides both coordinated entry and light-touch home visiting services. A nurse meets with all new parents in the hospital, before discharge, for intake into the program. For those who accept, a nurse follows up with a home visit in two to four weeks to

carry out a physical assessment of the baby and mother, screen across a number of areas of risk, and make referrals as needed.

The Family Connects model initiates contact with families at or after birth, whereas many home visiting models, including those prevalent in Washington, require that families begin home visiting services prenatally and can remain in contact with families for several years. Prenatal-based programs need to recruit families through various means, while Family Connects recruits families based on the birth of a child, and serves as a useful way to link additional families to home visiting and other appropriate services.

Through the Family Connects pilots, the state of Illinois has been better able to reach the hardest-to-reach families. Because the model is universal, staff report that it tends to reduce the stigma often associated with participation in a service that is only provided to low-income families.

To date, results have been positive. Over the course of the two pilots (17 months for Stephenson County, and 15 months for Peoria), coverage has increased to 100 percent for the initial hospital visit. The large majority of women agree to participate in the program (93 percent in Stephenson County and 76 percent in Peoria), and its reach for the follow-up visit is 77 percent in Stephenson County and 44 percent in Peoria. The City of Chicago is planning to pilot Family Connects in 2019.

Family Connects does not replace Illinois' existing home visiting program (or other services); rather, it connects families to the home visiting and other resources they need. However, it does draw on a similar set of funding sources, including MIECHV and the State Board of Education, which is the largest funder of home visiting in Illinois. Medicaid has not yet proven to be a viable funding option in Illinois, but Family Connects is still assessing its potential.

The cost per family is approximately $750-$800 per year.

First Steps

Some families in Washington receive similar short-term interventions. Washington's Medicaid First Steps program includes full medical coverage, maternity support services, infant case management and childbirth education. Maternity support services can be offered in a home setting to provide Medicaid-enrolled pregnant women, or mothers and infants up to 60 days after birth, access to case management, short-term preventive health and education services, and short-term interventions provided by an interdisciplinary team that includes a nurse, a nutritionist and a social worker. Infant case management continues through the infant's first year of life and can be an important pathway for families to access more intensive, longer-term home visiting services.

Implications of universal approach for home visiting expansion

In the long term, providing some form of universal light-touch home visiting services to families in Washington may be an effective way to identify and engage the families who can most benefit and help ensure they are matched with the most appropriate home visiting or other services. It aligns with DCYF's goals (described above) and vision of ensuring services are allocated to the most vulnerable families.

However, building such a program requires not just resources greater than those currently available, but significant infrastructure. Moreover, a coordinated entry system that refers families

to services – including and beyond home visiting – will ultimately increase usage of those services, which implies the need for additional funding. Expansion planning should consider both the benefits of and the resources required to implement either a universal access approach or a coordinated entry system. Developing a universal light-touch approach is outside the scope of this report but should be done in phases to learn how to best introduce and support the program in various communities with different needs, starting with the highest need communities. It will also be important to consider how such a program could integrate with existing services (e.g., referrals to longer-term home visiting services) and what new needs for services would be created.

DCYF's exploration of Family Connects and other universal screening options was conducted as the same time as the HCA's assessment of the potential use of Medicaid funding to support home visiting services; thus, that option has not yet been fully explored. A more detailed investigation would be useful to expansion planning that includes universal screening and coordinated entry.

INTAKE AND REFERRAL PROCESSES

An effective expansion strategy will support strong systems of referral to home visiting that (1) identify all families in need of home visiting and (2) match those families to the right program based on their individual circumstances. Identification of eligible families can be improved by outreach, training for providers and case managers, and building partnerships with related services that can cross-refer (for example, services for substance use, domestic violence, mental health or family homelessness).

Once families are identified, communities could benefit from a system of “coordinated entry” that assesses each family and matches them to the right program for their needs. This supports families in accessing services based on their strengths and needs at the time. Coordinated intake and referral is an important consideration, whether as an independent component of the expansion strategy or as an element of universal screening.

FINANCING AND SUSTAINABILITY

Variation in cost between (and within) home visiting models will affect budgeting for expansion.

The current payment structure for HVSA-funded home visiting services is a cost reimbursement approach, which means that actual (vs. budgeted) costs are reimbursed. This approach has both strengths and limitations. Because only costs and services that are incurred are reimbursed, it is a cost-efficient approach — for example, when staff transition, contractors cannot bill for time not spent on the contract. On the other hand, variability in costs across programs and models is a challenge to accurate projection and planning. DCYF will need to ensure ongoing administrative capacity to braid resources with expanded funding.

DCYF has relied on this approach to ensure the agency can meet the requirement for braiding (tracking the dollar to the family served for each funding source) various funding sources for home visiting. However, DCYF is also examining how costs vary within and across home visiting models and programs. This exploratory analysis is building a baseline of information to examine the possibility of developing an alternate payment structure, such as a rate-based payment structure. (See "Alternate models for reimbursement," below.)

As required by RCW 43.216.130, DCYF (and Thrive before DCYF) use a competitive application process to select home visiting service providers (LIAs). Applicants submit proposed budgets, which are reviewed to select LIAs to provide services. Once LIAs are selected, DCYF refines the budgets and re-examines the budgets annually. LIAs bill against the contracts, using a cost reimbursement method described above. As such, there is variation across the state in the cost to serve families. There are valid reasons for these variations, such as differences in frequency of service across models, training and education requirements for different models (e.g., NFP prefers nurses with at least a Bachelor of Science in Nursing as home visitors), or the differences in wage rates in different parts of the state. There is also some potential, based on further analysis, to reduce this variation. The variation adds complexity to future planning and, more important, to the efficiencies needed to be successful at scale.

DCYF is currently conducting a cost analysis (see appendix I for a brief summary) to explore cost data and the potential for creation of another payment methodology while maintaining high-quality services. Nonetheless, expansion planning must account for the existing variation in costs among the home visiting models as well as differences in how much individual programs (even those using the same model framework) spend per family served. Therefore, as described earlier in the report, DCYF has used a blended rate to project costs for expansion planning.

Alternate models for reimbursement for home visiting are being explored.

At the HVSA's inception, the HVSA statute directed DCYF to work with its private-public partnership (currently Thrive Washington) to administer LIA contracts and provide technical assistance to LIAs, leveraging private funds to support both aspects of the work. In 2017, the administration of the LIA contracts was transferred to the state Department of Early Learning (now DCYF).

DCYF has considered using a rate-based method of payment for LIAs. DCYF will continue to explore development of a rate approach, although much more cost data and study will be needed. In addition, the rate approach must also fit within DCYF's performance-based contracting and equity goals. Some potential benefits of implementing a rate-based payment approach include that it may align with the use of Medicaid funds (described below) which may require a rate- or value-based payment methodology and it could reduce some variation across programs. On the other hand, other significant funding sources (e.g., MIECHV) require that funds be braided, not blended, which is much more challenging when using a rate-based methodology. Further analysis of a potential change in how payments are made would require substantial work by DCYF. At this time, DCYF will continue to use cost reimbursement payment methodology for LIAs while exploring other methods.

Local implementing agencies face other budget considerations.

For the most part, LIAs have received very limited annual adjustments to their budgets, with the exception of a modest cost of living adjustment in fiscal year 2019 and some special circumstances (e.g., when an agency takes over a contract from another LIA). Flat budgets place increasing pressure on LIAs, especially in terms of attracting and retaining staff and maintaining quality, which will only increase in an expansion environment. Over time, many LIAs have sought additional fund sources to round out their budgets to maintain high quality services.

Based on DCYF's initial analysis, HVSA is on average paying for 90 percent of all program costs in LIA budgets, with a range from 66 percent to 100 percent (depending on the model).

The legislation that established DCYF (HB 1661) requires DCYF to implement performance-based contracts (defined as "results-oriented contracting that focuses on the quality or outcomes that tie at least a portion of the contractor's payment, contract extensions, or contract renewals to the achievement of specific measurable performance standards and requirements"). The HVSA contracts currently embed performance incentives for meeting specific service delivery targets for dosage, enrollment and screening. As of fiscal year 2020, DCYF will implement more rigorous standards for outcomes-oriented, performance-based contracting.

As DCYF continues to roll out the outcomes-oriented, performance-based contracts initiative, the home visiting contracts will continue to refine the approach to performance-based contracts to meet the agency standards, currently in development. This is another consideration that will affect scale-up and rates for an expanded home visiting system. Some portion of payments for LIAs would be based on meeting performance measures. The expansion scenario includes 1.5 percent of the blended rate per slot (for direct services) for a performance payment as a contingent reward – a payment beyond the base budget for meeting or exceeding a performance target.

Current sources of funding for home visiting are limited.

Opportunities to expand support for home visiting within the current funding landscape are limited. Most of the existing fund sources for home visiting do not provide ready opportunities to support the expansion of services. The following provides a summary of current and potential funding sources.

MIECHV
The State is currently accessing and using all federal MIECHV funds available. The federal MIECHV program was reauthorized in 2017 for five years at level funding – $1.5 billion available nationally. Given that the U.S. Department of Health and Human Services, Health Resources and Services Administration has administered the grants using a formula and competitive grants, it is highly unlikely that those funds will increase in the near term.

Temporary Assistance for Needy Families and the Dedicated Marijuana Account
These sources offer limited funds. They are restricted to specific uses, and at this time do not provide opportunities to support significant expansion of home visiting services. Funding for home visiting through the Dedicated Marijuana Account is a specific line item in that budget, and this would be required again for funding to increase. TANF-funded clients must be engaged in the TANF WorkFirst Program with a priority on families participating in the Pregnancy to Employment Pathway.

Medicaid
The Washington State HCA has been exploring the potential to use Medicaid funds to support home visiting services. Their August 2017 report, Washington State Home Visiting & Medicaid Financing Strategies, suggested four potential options,[17] which are further explored as required in Section 4 of ESSHB 2779 (2018) in the January 2019 legislative report *Medicaid Financing*

[17] Washington State Health Care Authority (2017). *Washington State Home Visiting and Medicaid Financing Strategies — Submitted to the Department of Early Learning, August 22, 2017.* Available at: https://www.hca.wa.gov/assets/program/home-visiting-medicaid-financing-strategies.pdf.

and Home Visiting Services: Recommendations to Leverage Medicaid Funding for Home Visiting (see Appendix J for an initial summary of the recommendations made in this report):

- **Medicaid administrative claiming**, under Sec. 1903 [42 U.S.C. 1396b] (w)(6)(a), allows reimbursement for qualified administrative activities provided by governmental entities and their sub-contracted vendors.
- **Managed care contracting**, under Sec. 1932 [42 U.S.C. 1396u—2](a)(1)(A), allows reimbursement for discrete home visiting services as part of the managed care organization (MCO) benefit package.
- **Targeted case management**, under Sec. 1905 [42 U.S.C. 1396d] (a)(19), allows reimbursement for helping clients access medical, social, educational or other services during a home visit, including activities such as screenings, assessments, referrals and care plan development.
- **Medicaid waiver development**, under Sec. 1915 [42 U.S.C. 1396n](b)(1-4), allows reimbursement for home visiting services by waiving certain Medicaid program requirements; these waivers can support braiding Medicaid, state match, and private funds with a selective contracting process prioritizing specific populations and providers.

The additional analysis suggests that the best options for the state to pursue are (1) develop a Medicaid home visiting state plan amendment for case management and (2) contract with managed care organizations for discrete home visiting services. (Note that these reports were evolving simultaneous with conversations about universal screening and coordinated entry, so the potential for Medicaid to support these options has not yet been fully explored.)

According to the January 2019 HCA report, DCYF and HCA could develop a proposed State Plan Amendment to reimburse LIAs for case management services to assist families with access to medical, social, educational or other services during home visits. These could include screenings, assessments, referrals and care plan development funded through the HVSA.

For contracts with MCOs, HCA would work with MCOs to support contracting with DCYF for home visiting services funded through HVSA programs. The services covered could include clinical, behavioral health and case management services.

Neither option offers a quick opportunity to secure new funding. Medicaid does not have the potential to fully fund home visiting services because coverage is limited to medically necessary, allowable services as approved by the federal Center for Medicare and Medicaid Services.

Medicaid options also require an allocated state match. Washington's federal medical assistance percentage is 50 percent; the Medicaid match may include unmatched state funds or, in some cases, private funds. Funds from other federal agencies cannot be used. State funds already used as match or as maintenance of effort are also not eligible.

States that access Medicaid to help support home visiting services report that 2 percent to 40 percent of specific home visiting services are Medicaid reimbursable. The amount varies by model, provider type, specific services, and Center for Medicare and Medicaid Services approval. The larger reimbursement generally includes home visiting services that are more clinical in nature. States also tend to use more than one Medicaid Authority in order to more fully maximize reimbursement potential.

Thus, Medicaid could and should be part of an expansion strategy, but it will not be the sole source for expansion funding. Until further analysis and a fiscal impact are jointly completed by HCA and DCYF, it is unclear what proportion of home visiting services could be covered by Medicaid funds with either option.

Private funding
The state has a history of using a modest level of private or philanthropic funding to support HVSA services, including a $10 million grant over five years from 2012 to 2017. While there continue to be home visiting models supported by private and philanthropic sources, in general, Thrive found their private partners were not interested in funding ongoing service delivery. However, private funding might be secured to support innovation, workforce needs, quality assurance, and other enhancements to programs. Once there is stability in securing a new home for the support services that Thrive provides to home visiting models (the Home Visiting Hub), there is an opportunity to explore this potential funding source. In addition, the Thrive Home Visiting Hub is partnering with Best Starts for Kids to provide model-specific support to LIAs funded by Best Starts.

Family First Prevention Services Act
The FFPSA became federal law in February 2018. It may offer a new source for funding evidence-based home visiting services. FFPSA offers states the opportunity to receive reimbursement for services that can aid in preventing children from entering foster care. However, it is too soon to assess its full potential for home visiting, especially given early definitions of who might be considered a candidate for funding (e.g., only children at imminent risk of entry or re-entry into foster care). DCYF plans to submit its FFPSA prevention services plan by June 30, 2019, with initial implementation as early as November 2019. The FFPSA uses evidence criteria and categories similar to those of the CEBCCW, though a new clearinghouse will be developed at the federal level to guide FFPSA implementation. DCYF will track the development of the new clearinghouse and guidelines to determine whether this is an opportunity for funding of home visiting expansion.

Washington State General Fund
Washington State General Fund resources offer flexibility for funding a full continuum of home visiting services for an expansion. An increase in support from the General Fund would make it possible to support models that are effective and valid but not funded by other sources – e.g., promising practices models that are effective in the communities with the greatest need. DCYF recently received an increase of $1.5 million in funds to expand services funded by the HVSA for fiscal year 2019. DCYF awarded contracts with service providers for $1 million to expand existing services and $500,000 to start-up home visiting programs starting in December 2018. DCYF received high-quality applications requesting services for more than double the available funds.

Non-HVSA funders of home visiting services
Other significant funders (beyond the HVSA) include EHS, at $35 million per year, and Best Starts for Kids, at $10 million per year. DCYF will need to continue to ensure these funders stay at the table in expansion strategy discussions, to ensure that impact is optimized across all available resources (HVSA and non-HVSA home visiting services).

From Centralia College
Louisa was the mother of a rambunctious 2-year-old when she encountered home visiting for the first time. Through the program, she learned how to channel her son's energy through educational activities and play – and how to respond when difficult situations come up. The confidence she built by working with her home visitor laid the groundwork for her to enroll for classes at Centralia College. Now she's a happy college student and a very proud mom: "All of the information and fun books have really helped progress my kiddo big time. This program is so helpful for first-time moms and all the moms out there."

LOCAL AND REGIONAL READINESS FOR EXPANSION AND WORKFORCE CAPACITY

Community planning and organizational and leadership capacity development are critical to expansion.

Successful implementation of home visiting programs demands significant organizational capacity. Home visiting programs funded by the HVSA are subject to strict data collection and reporting requirements, require rigorous adherence to model curricula, and rely on trained staff and supervisors and strong, adaptive organizational leadership.

As described earlier in the report, different models work more effectively in specific communities and in filling gaps in existing resources. Therefore, expansion should be guided by community planning to ensure new services fit gaps in existing resources and can effectively meet the needs of families furthest from opportunity. Likewise, it is essential to support LIAs in identifying the resources and capacities needed to effectively connect with families and implement models with quality and fidelity.

Funders have found that communities have different levels of preparedness for the planning and implementation associated with the start-up or expansion of a high-quality home visiting services. Some communities have many potential LIAs that have a large number of well-trained staff and are configured to implement one or more models appropriate to the communities they serve. Others need more support to choose the right mix of home visiting services to meet the community's needs, coordinate with existing programs and services, identify the organization(s) most suited to implementing home visiting, and then build the necessary capacity for implementation. Capacity building takes time, staging, strong leadership and dedicated funding. Even in the best-prepared communities, recruitment, training and credentialing for home visitors are potential challenges.

Currently, Thrive Washington's Home Visiting Hub provides support for LIAs, including capacity building and technical assistance on the implementation of a variety of models – a role that has been critical in the ramp-up of home visiting services since 2010 (see appendix K for a fuller description of the Hub). They have also supported community planning initiatives to help communities identify the best home visiting model for their community and then prepare for program implementation. In 2019, the Thrive organization will step out of its role as a partner to DCYF in home visiting services. However, the staff that provide support through the Home Visiting Hub will continue their work within a new organization. There are active conversations under way to find a new organizational home for the Home Visiting Hub, and DCYF and Thrive will transition the Hub to a new organization by July 1, 2019.

Once the Home Visiting Hub finds a new home, it will be poised to continue providing technical assistance, capacity building and community planning to support expansion. However, expansion of home visiting services will require increasing the staff capacity at the Hub.

Attrition and compensation are challenges to workforce development.

In 2017, DCYF began participating in a grant-funded project from the federal MIECHV program focused on recruitment and retention of a high-quality home visiting workforce in Washington and across the federal Region X (Alaska, Idaho, Oregon and Washington). This Innovation Grant represents a unique opportunity as expansion planning moves forward. It provides a chance to identify and address some of the core issues that are restricting both the capability and the capacity of the home visiting workforce.

Among the first activities completed under the Innovation Grant was a study of the home visiting workforce across Region X, with the goal of identifying strengths, gaps and unmet needs to inform workforce recruitment, retention and professional development efforts. The findings from the study are extremely relevant and timely for expansion planning.[18]

To achieve expansion at the scale articulated in the home visiting expansion scenario, there are several facets of workforce and professional development that need to be addressed.

Size of workforce, recruitment and retention
In recent evaluations supported by DCYF, evaluators found that within a 2.5-year period there was approximately 35 percent turnover of home visiting staff (figures 8 and 9), with the highest rates of turnover in rural programs.[19,20] To provide staff resources at the level required by the expansion scenario, the workforce would need to grow substantially over the three phases.

Assuming an average caseload of 18 families per home visitor and 8 home visitors per supervisor, the scenario would require approximately the following number of additional home visitors and supervisors:

- Phase 1: 278 home visitors, 35 supervisors.
- Phase 2: 417 home visitors, 52 supervisors.
- Phase 3: 417 home visitors, 52 supervisors.

Many strategies will need to be identified to grow and retain the workforce. For example, one possible (partial) solution would be provision of scholarships to build a pipeline for home visiting jobs. For example, scholarships might support nurses in completing the Bachelor of Science nursing degree required by some models. This is currently a very costly degree to obtain, and there is a very high demand (and often higher pay) for nurses with Bachelor of Science Nursing degrees in health care.

Current workforce within five years of retirement
Currently, there are a number of leaders, administrators and supervisors in the field of home visiting who are less than five years from retirement. It is necessary to build a pathway for development of leaders and supervisors at the local and state levels to step into these roles in the coming years.

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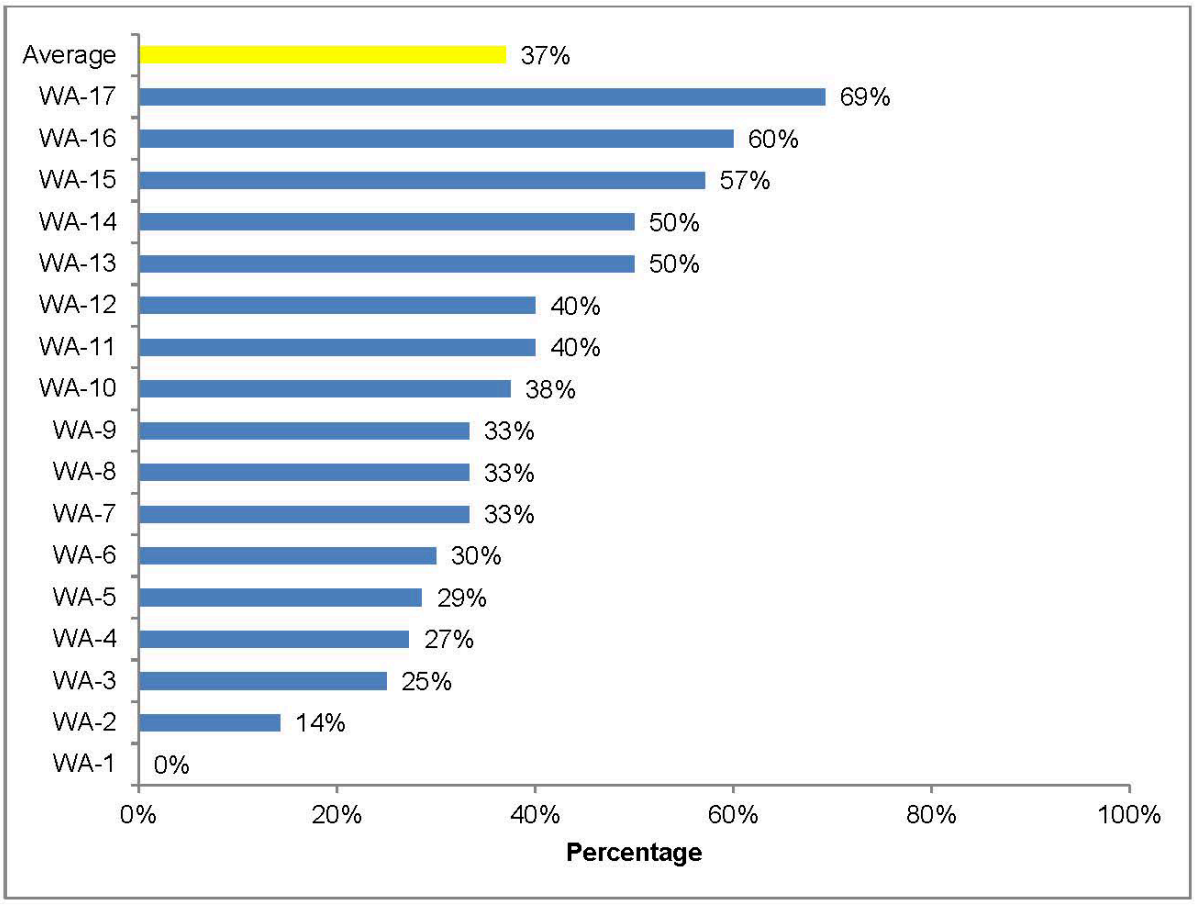
[18] Region X Innovation Grant (2018). *Region X Home Visiting Workforce Study*. Available at: https://www.dcyf.wa.gov/sites/default/files/pdf/RegionXWebinarPPT-Nov18.pdf.
[19] Schachner, A., Gaylor, E., Chen, W-B., Hudson, L., and Garcia, D. (2017). *RISE Home Visiting Evaluation: Final Evaluation Report — Select Findings from Years 1 and 4 of the Evaluation.* https://www.dcyf.wa.gov/sites/default/files/pdf/RISE_Final_Eval_Report_FINAL_2017_send.pdf.
[20] SRI International (2017). *RISE Home Visiting Evaluation Rural Case Study Brief Report.* Available at: https://del.wa.gov/sites/default/files/public/RISE_RuralCaseStudy_Brief_FINAL_9-20172.pdf.

Workforce capacities and skills

Among other critical skills and capacities for the home visiting workforce, DCYF also will need to ensure that supervisors and home visitors have access to high-quality reflective supervision. The *Reflective Supervision Guidelines* developed under the MIECHV Innovation Grant provide common language and guidance.[21] Beyond reflective supervision, DCYF will use the home visiting workforce study, examine national resources such as the Institute for the Advancement of Family Support Professionals and the Ounce's ACHIEVE OnDemand training institute, and engage HVAC and other home visiting practitioners in Washington to design a workforce development plan.

Figure 8: Percentage of staff turnover in Washington State home visiting programs from 2013 through 2015

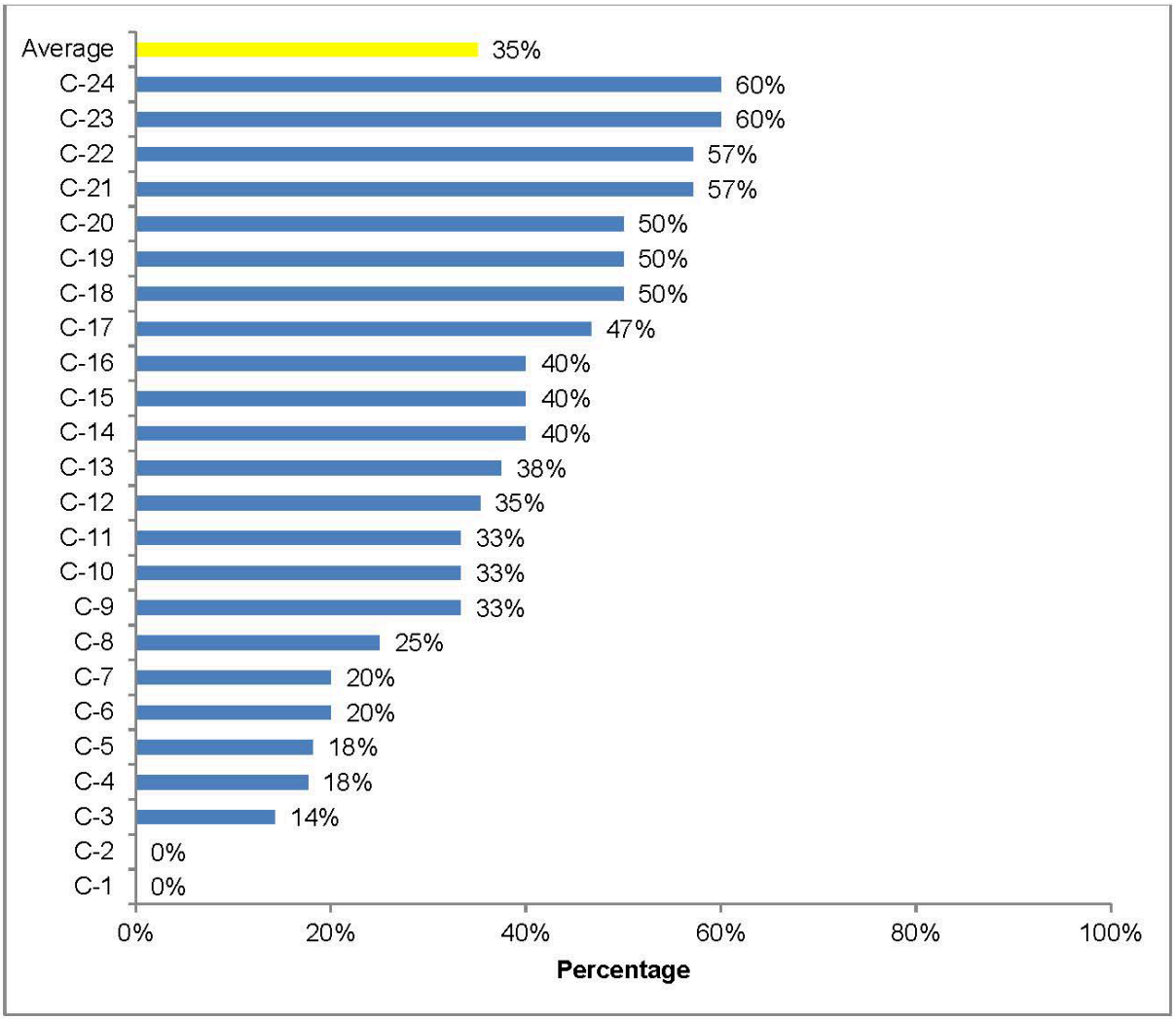


Source: Staff lists provided for 2014, and 2017 Program Practices Survey.

Note: Program numbers were assigned randomly based on the rank order of programs on the variable of interest. Program numbers are *not* associated with a given program and are not held constant on program-level charts throughout the report.

[21] Region X Innovation Grant (2018). *Reflective Supervision: A Guide from Region X to Enhance Reflective Practice Among Home Visiting Programs*. Available at: https://www.wa-aimh.org/rs-guidelines?mc_cid=faa1d96d3d&mc_eid=a946c74892.

Figure 9: Percentage of staff turnover in comparison programs from 2013 through 2015



Source: Staff list provided for 2014, and 2017 Program Practices Survey.

Note: One program participated only in data export activities and is not represented in this data. Program numbers were assigned randomly based on the rank order of programs on the variable of interest. Program numbers are *not* associated with a given program and are not held constant on program-level charts throughout the report.

Support to serve and prevent burnout for home visitors working with families experiencing trauma

The workforce study provided new insight into the rate of attrition by home visitors. More than one-third of home visitors have been in the field for less than two years; more than one-half have been in their current jobs for less than two years. The study also suggests that this high turnover strongly correlates with the increase in trauma-related work responsibilities. More than 30 percent of the home visitors responding to the workforce study reported working with families with four or more adverse childhood experiences (ACEs) – significantly higher than in the general population. These families are dealing with a variety of challenges, including issues related to mental health, substance and alcohol use, and domestic violence.

Working with vulnerable populations, such as these, requires a special set of skills, including trauma management for both families and home visitors. Families respond best to sensitive and supportive communication, and home visitors need tools to manage their own responses to the trauma to which their jobs expose them. As a part of the MIECHV Innovation Grant, Washington – along with Alaska, Idaho and Oregon – is testing out innovative professional and skill-building approaches using the NEAR (Neuroscience, Epigenetics, Adverse Childhood Experiences, and Resilience) @Home Toolkit and *Facilitating Attuned Interactions* (FAN).[22,23] Both approaches are being very well received in the initial implementation by home visitors and supervisors.

Access to competitive compensation and opportunities for professional development
A significant number of home visitors and supervisors who participated in the workforce study survey reported working more hours than they were paid. In addition, while average salaries are above minimum wage (between $19 and $26 per hour), many home visitors were employed for fewer than 40 hours each week, which reduced their overall take-home pay. A high percentage of home visitors are receiving public assistance, and more than one-quarter who had been in the field for more than a year had gone more than a year without a salary increase. Among benefits offered to home visitors, tuition reimbursement was rare. These factors make it difficult for current Washington home visiting services to compete with related industries for experienced staff or to recruit, train and retain staff.

Need for culturally matched home visitors for families from vulnerable populations
Fewer than half of home visitors reported sharing common racial, ethnic or cultural traits with the families they serve. Approximately one-third speak a different language than those they serve. Cultural match enhances the opportunity to build trust and deliver services that are tailored and acceptable to families and communities. For this reason, there is interest among stakeholders in funding specifically dedicated to models that allow for a workforce that culturally matches families served.

As the work on the MIECHV Innovation Grant continues through September 2019, it will be important to use the findings and results from this work to inform expansion planning. For example, DCYF has included workforce and professional development in the infrastructure costs associated with the expansion scenario cost model. With these funds, DCYF would continue to grow the innovative strategies that began with the MIECHV Innovation Grant, such as increasing access to FAN and the NEAR@Home Toolkit, and reflective supervision. DCYF would also conduct another workforce study in three to five years to continue to build a longitudinal understanding of the home visiting workforce.

STATE SYSTEMS STRUCTURE AND CAPACITY FOR EXPANSION

Capacity at the implementation level should grow to support expansion.

In partnership with Thrive, DOH, DSHS and HCA, the staff at DCYF manage, direct and oversee the HVSA-funded home visiting services in Washington. The Department's roles include planning and governance, contract development, monitoring and compliance, data

[22] Thrive Washington. *Near@Home Toolkit*. Available at https://www.nearathome.org/download/. [Accessed 2 Jan 2019.]
[23] Erikson Institute. *Facilitating Attuned Interactions.* Available at: https://www.erikson.edu/professional-development/facilitating-attuned-interactions/. [Accessed 2 Jan 2019.]

management and evaluation, training and assistance, grant writing and reporting, public outreach and engagement, systems development and integration, and workforce development.

Given the growth of home visiting services since 2010, DCYF and staff at other state agencies have identified a need for additional resources to manage a larger system. Expansion at the scale proposed in the scenario described in this report would require new resources to plan, manage and evaluate the larger home visiting system. For example, additional staff would be required to monitor and provide direct technical assistance to LIA contracted partners on the development, administration and oversight of their home visiting program.

DCYF is still in the process of determining the maximum caseload of DCYF staff to LIA contractors. This work has only been managed by DCYF for 18 months. The caseload also depends on the capacity of the LIA and whether the program is starting up or in full implementation. Currently, contract monitors have between fifteen and eighteen LIA contracts to monitor, which includes annual on-site monitoring (programmatic and fiscal).

Similarly, most LIAs funded by the HVSA are also at full capacity to deliver on the slots for which they are currently funded and for administration of their programs. There are several options for managing this, including (1) providing resources to expand capacity; (2) prioritizing expansion where the existing capacity is strongest (though this might limit delivery of services in high-risk locales), and/or (3) looking at options for sharing administrative responsibilities across contractors, which the Early Childhood Education and Assistance Program (ECEAP) adopted and has been effective.

DATA SYSTEMS INFRASTRUCTURE

Expansion will require administrative capacity and funds dedicated to continuing long-term data system planning.

Accurate, reliable data are essential to the functioning of Washington's home visiting system. Information about who receives home visiting, the types of services they receive and where they are referred to, and goals and outcomes achieved all affect financial planning, eligibility for funding, service provision, quality improvement, and almost every aspect of program management and service delivery.

Currently, there is variation in data collection strategies and tools across models and LIAs, because each model has specific requirements. For example, some of the more established models require that all LIAs use a national data system; for others, the LIA may (or may not) develop its own practices around collecting and maintaining data. Some models have established fidelity standards, and some do not. LIAs using promising practices models have less-structured data collection requirements and thus less-structured data management systems, though still collecting data for all of the aligned measures required by DCYF.

To create greater data standardization and quality, DCYF has worked to integrate data from the various systems across models into a single database that DOH has developed and managed using SQL Server. To date, more than 80 percent of LIAs are using systems that allow integration into the SQL Server database system, and DOH is working with the remaining 20 percent to streamline their data reporting by 2020. This structure allows the LIAs to continue to use the model or a locally developed data system (avoiding duplicate data entry) and uses raw data from transfers and transformation/standardization from each system's data. DOH, with

DCYF, has begun a long-term data system planning process to guide development of the next stages of expansion and necessary data management.

Support for ongoing data systems infrastructure development is a critical element of an expansion strategy, especially if expansion brings new models into the system. Funding will be needed for both staff time and tools to design and implement data management systems for an expanded home visiting system, including:

- Developing a roadmap for data collection and management across a wide range of models and LIAs.
- Database development and information technology support to align and import data from a broad array of disparate systems.
- Designing new workflows to serve the new comprehensive system.
- Data quality assurance and training for LIAs.

If the state elects to implement a universal approach with coordinated referrals, alongside the existing or expanded intensive long-term home visiting services, the approach to data collection, management and evaluation will need to be explored.

As decisions regarding scope and pace of expansion are made, the implications for a robust data system must be considered. The complexity and quantity of data will require additional resources either to support and expand the existing system and features, or to explore other data system opportunities. Ideally, expansion offers an opportunity for the state to position itself as a lead data manager and broker, potentially offering data services to additional home visiting programs outside of the HVSA.

DESIRED OUTCOMES

To guide the next two to three years of strategic and program development and administration, considering the various different funding requirements, DCYF has developed a theory of change, which is built on *2010 Home Visiting Goals and Objectives*, developed by a broad group of stakeholders (see appendix L). DCYF's high-level goal is to achieve high-quality home visiting services, integrated across state and local early learning programs.[24] There are five systemic outcomes associated with this goal that align with DCYF's child, family and performance outcomes and should be prioritized in expansion planning:

1. Family needs met.
2. Effective workforce.
3. Strong partnerships.
4. Robust home visiting community organizations.
5. Engaged public.

Beginning in fiscal year 2018, DCYF began to implement seven performance measures (called "aligned measures," because they are used across models and programs) to assess the performance of home visiting services provided by different LIAs. These performance measures were developed considering funder requirements, and varying model objectives:

[24] Washington State Department of Children, Youth, and Families. *Policy — Child Outcome Goals and Analytic Framework; Baseline Performance Assessment.* Available at: https://www.dcyf.wa.gov/practice/oiaa/policy. [Accessed 2 Jan 2019.]

From Yakima Valley Memorial Hospital:
"My best memories are him falling asleep on me, hearing him laugh for the first time and watching him take his first steps," said Randall at the end of his first year as part of a home visiting program at Yakima Memorial Hospital. His partner, Nadine, was a first-time mom who wasn't sure how involved her child's father would be.

But when she enrolled in a home visiting program, she and the home visitor were able to engage him during visits. He quickly became an avid learner and participant, doing all the assigned homework – including documenting the first year of his child's life. Today, Randall and Nadine parent together and are a closer couple than before their son was born. At 1-year-old, their son is healthy, and the family has set a new goal: to save a down payment on a house. They're already partway there, thanks to the new stability they've gained for themselves through working with their home visitor.

- **Breastfeeding at six months:** Percentage of infants (of mothers enrolled prenatally) who were breastfed any amount at six months of age.
- **Depression screening:** Percentage of primary caregivers enrolled in home visiting who are screened for depression within three months (90 days) of the child's birth (if the family was enrolled prenatally) or within three months (90 days) of enrollment (if the family was enrolled after birth).
- **Last well-child visit received:** Percentage of children enrolled in the home visiting program who received the last recommended well-child visit based on the American Academy of Pediatrics schedule.
- **Parent-child interaction observed:** Percentage of primary caregivers enrolled in home visiting who were observed during a caregiver-child interaction.
- **Daily literacy activities reported:** Percentage of children enrolled in home visiting with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with their child every day.
- **Child development screening completed:** Percentage of children enrolled in home visiting with a timely screen for developmental delays.
- **Intimate partner violence screening completed:** Percentage of primary caregivers enrolled in home visiting who are screened for intimate partner violence within six months of enrollment.

These measures are important considerations in expansion planning, especially when determining which models to bring into the system at which points in time. DCYF is currently establishing a baseline for these measures with fiscal year 2018 data that will serve as metrics for success as an expansion plan is rolled out. In the first year of data collection, nearly 70 percent of caregivers were screened within the timeframes required for depression and intimate partner violence. Some of these measures are being considered for performance-based contracting metrics as well.

GOVERNANCE AND FAMILY ENGAGEMENT

To be effective at scale, state agencies need enhanced coordination and governance both within and beyond the state home visiting system.

The HVSA-funded home visiting system is guided by an executive leadership group (the Home Visiting Leadership Forum) that includes senior executives from four state departments (DCYF, DOH, DSHS and HCA) and Thrive. These leaders meet annually to provide strategic direction

and discuss opportunities for greater coordination among state services. Stakeholders cited the importance of departmental directors continuing to play a leadership role in home visiting.

In addition, there is a managers group (the Home Visiting Partnership Group) that includes staff from each of those departments and the Thrive Hub staff. This group meets quarterly to discuss grant opportunities and development of, or revisions to, the needs assessment and the home visiting scan, and works to carry out the guidance provided by the leadership group. Thrive, DOH and DCYF also have a management team that meets at least monthly to ensure regular communication about planning and administration of the HVSA.

Given the complexity of this governance structure, any expansion must invest in ensuring continued alignment among the key state agencies – and with important private sector and community partners. As the system expands, there should also be consideration of enhancing these structures to more effectively integrate state-funded and non-state-funded programs, which, although funded separately, share the same workforce and serve the same communities. A governance structure that engages with non-state-funded programs on decisions about policy, funding and strategic direction could build capacity and bring promising practices to the table.

The Home Visiting Advisory Committee has been an effective leader, and there is good potential to build on the strength and membership of the group.

The HVAC, created by state statute, provides strategic advice to the HVSA partnership and the Washington home visiting system. The group has been led by Thrive, with support from DCYF and DOH, and includes between 20 and 30 members at any given time, including a wide variety of home visiting experts: liaisons from tribal communities, service providers, representatives from home visiting programs, research and evaluation experts, government and health department officials, and other early learning and family support stakeholders and experts. The HVAC is the primary point of coordination among groups working to deliver high-quality home visiting programming in Washington. Its work supports the goal of ensuring access to home visiting services for families who can benefit most.

The HVAC has been a useful source of advice during the steady growth of Washington's home visiting services over the past eight years. As the state identifies priorities for a next phase of expansion, it's an opportune moment to think about the composition of the HVAC. Thrive has been the leader in the recruitment and growth of the group, and that role will need to be replaced if not carried on by the Home Visiting Hub in its new home.

It may also be valuable to add new stakeholders, depending on the expansion strategy the state selects. For example, organizations that reach communities of special interest who are not currently represented, or representatives from LIAs that are implementing promising practice models, could be considered for participation on the HVAC.

Family engagement in planning is important to ensure that expanded services meet family needs.

While there is a strong desire among HVAC members and state agencies to engage families in decisions about home visiting services (e.g., which model is the best fit for a community, recruitment of families, or how to improve or enhance service delivery), most families in need of services face barriers to participating in planning meetings. DCYF has opportunities to enhance family engagement with an expansion of services. For example, some stakeholders suggested that the state could invest in soliciting feedback from families on a regular and systematic basis.

Others suggested that stipends could be made available to compensate parents for participation in meetings or to access childcare services that would enable parents to attend meetings.

COMMUNICATION, MESSAGING, AND MARKETING NEEDS

Appropriate public outreach and engagement of families' voices are both necessary to shift attitudes and practices and to ensure the impact of expanded services.

The 2010 Washington State Home Visiting Plan calls for investment and action to "build community and public will for a home visiting system that provides high-quality services to families in local communities."[25] Under this goal, DCYF focuses on four objectives:

1. Educate the public about home visiting services and provide information about home visiting services offered in Washington.
2. Cultivate champions to support local home visiting services and programs and provide information about ways to get involved.
3. Build off of existing public awareness campaigns that focus on early childhood health, development and learning, in order to inform parents, families and communities about home visiting.
4. Ensure that public engagement efforts are informed and influenced by families, consumers and stakeholders, and aim to reflect the diversity of communities served at the local, regional and state levels.

Expanding home visiting is only valuable if those services are available to and used by the families that need them. While some families actively seek services, stigma, mistrust and fear are significant issues for many families in high-risk groups. For example, some parents associate home visiting with child protective services and worry that accessing services will result in the loss of their child. Strong referral networks are also essential, which requires education of physicians, teachers and others who have contact with children and their families.

An expansion strategy should include public outreach that targets these and other key audiences to help shift understanding and attitudes among those who work within and use the system to maximize its impact.

CONCLUSION

In the past 10 years, home visiting services have been recognized nationally as a proven and important investment in enhancing the lives of children and families. Today ,Washington has the capacity to serve over 7,000 families, across all funders and all home visiting models, with programs in all but seven counties. But the need for more long-term home visiting services remains profound — there are still more than 100,000 eligible families that the state does not have capacity to serve. This includes many who would particularly benefit from services – rural communities with few existing services, African-American/Black and Native American/Alaska Native families, and families struggling with issues such as domestic violence, substance abuse or mental illness. While this is a challenge, it also presents an enormous opportunity.

[25] Washington State Department of Health (2011). *Washington State Home Visiting Updated State Plan.* Available at: https://del.wa.gov/sites/default/files/imported/publications/development/docs/HVUpdatedStatePlan.pdf.

With growing consensus around the value of home visiting, the state has developed the infrastructure and statewide network to help ensure expansion is done well. Successful expansion should: develop a diverse portfolio of models to best serve all communities; identify new flexible funding; support communities to develop local programs that serve local families with a trained workforce and organizational capacity; and continue to develop a statewide infrastructure to ensure high-quality services for all families.

Given the challenges, expansion should be done in phases and the state will need to work on multiple fronts – identifying where Medicaid or other federal or state funding can support expansion, looking at whether virtual or regional models can expand the impact, and potentially launching universal in-home screening, which can play an important role in increasing the use of, but not replace, longer-term home visiting services. With a deliberate equity focus on meeting the needs of all Washington's families, the addition of 20,500 new home visiting slots could serve as an important tool in the state's effort to ensure lasting impact for the youth and families in Washington for generations to come.

GLOSSARY

Administrative expenditures

Administrative costs associated with delivery of home visiting services that are not carried by local implementing agencies, including technical assistance, data/evaluation, administration, governance, workforce and others.

At-risk

At-risk communities are those for which indicators, in comparison to statewide indicators, demonstrate that the community is at greater risk than the state as a whole. Specific risk factors differ at the federal, state and county level. For example:

- The Maternal, Infant and Early Child Home Visiting Program defines at-risk communities as those with concentrations of premature birth, low-birth weight infants and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn or child health; poverty; crime; domestic violence; high rates of high-school dropouts; substance abuse; unemployment; or child maltreatment.
- DCYF defines at-risk communities as those with high concentrations of risk factors in five different domains, including maternal and child health, socioeconomic status, education, home environment, and drug and alcohol abuse.

Sources: Maternal, Infant, and Early Child Home Visiting Program, Washington State Home Visiting Needs Assessment: 2017 Report*.*

Capacity building

A process through which individuals, programs, organizations and systems obtain and/or strengthen assets and capabilities they need to effectively and equitably provide services to, and improve outcomes in partnership with, families and communities.

Source: Best Starts for Kids.

Capacity-building supports

An individualized, hands-on approach to building capacity within individuals, organizations and/or communities to design and implement practices or programs drawing upon best practices. This encompasses collaborative design, dosage and mode of delivery and addresses variables such as leadership development, funding/resource development and access to resources, practitioner empowerment, competence and capacity for future efforts.

Also: The provision of information, tools and resources on best practices along with the individualized, responsive and ongoing coaching and support to strengthen programs, organizations and systems capabilities.

Source: Best Starts for Kids.

Community

A subpopulation defined by shared geography, demographics, risk exposure or other characteristics.

Continuous quality improvement

A systematic approach to specifying the processes and outcomes of a program or set of practices through regular data collection and the application of change strategies that may lead to improvements in performance.

Source: Maternal, Infant, and Early Child Home Visiting Program.

Disparity

Unequal treatment and outcomes between privileged and marginalized groups.

Source: Best Starts for Kids.

Early childhood comprehensive system

A system of service strategies and supports to promote maternal, infant and early childhood health, safety and development and strong parent-child relationships. In Washington, strategies and organizations that participate in this system include the state home visiting program; the Department of Child, Youth, and Families; Thrive Washington; Project LAUNCH; Essentials for Childhood; Department of Health; Washington Association for Infant Mental Health; and Help Me Grow, among others.

Economies of scale

Reduced costs at higher volume of service provision, achieved through greater efficiency and the ability to share infrastructure and other costs among multiple entities.

Effective implementation

Implementation of a home visiting model that achieves the outcomes, measures, or impacts outlined by the national model or funder.

Eligible family

Families at or below 200 percent of the federal poverty level with a child younger than three years are considered eligible for home visiting services in Washington State.

Source: Washington State Department of Children, Youth, and Families.

Fidelity

A program is considered to be implementing a model with fidelity when program delivery adheres to the key elements of the model shown through research to be effective, for example:

- Recruiting and retaining clients.
- Providing initial and ongoing training, supervision and professional development for staff.
- Establishing a management information system to track data related to fidelity and services.
- Developing an integrated resource and referral network to support client needs.

Sources: Maternal, Infant, and Early Child Home Visiting Program, Washington State Department of Children, Youth, and Families.

High-quality service delivery

Services delivered in fidelity with the home visiting model on which implementation is based.

Home visitation

Services provided in the permanent or temporary residence, or in other familiar surroundings, of the family receiving such services.

Source: RCW 43.216.157.

Home visiting

Voluntary, family-centered services offered to expectant parents and families with new babies and young children to help families and support the physical, social and emotional health of the child. Trained practitioners visit families in homes or community settings to provide information related to healthy child development and early learning, support parent-child relationships, and offer connections to other information and services in the community. These visits typically continue over the course of several months or even years. On average, home visiting programs seek to serve families for two years.

Source: Washington State Department of Children, Youth, and Families.

Home-based services

Home-based services are a type of relationship-based support provided to expecting parents, and parents of children birth to age 5, in the places where they live.

Source: Best Starts for Kids.

Outcomes-oriented contracting

A contracting model in which service providers agree to performance deliverables which are expected to achieve specific outcomes or impacts desired and defined by the funder. Sometimes reimbursement for service provision, in whole or in part, is dependent upon achieving these contractually defined deliverables or outcomes.

Performance measures/aligned measures

Seven performance measures used by the Home Visiting Services Account to assess the performance of home visiting services provided by different local implementing agencies. Called "aligned measures" because they are used across models and programs, these include:

- Breastfeeding at six months: Percentage of infants (of mothers enrolled prenatally) who were breastfed any amount at six months of age.
- Depression screening: Percentage of primary caregivers enrolled in home visiting who are screened for depression within three months (90 days) of the child's birth (if the family was enrolled prenatally) or within three months (90 days) of enrollment (if the family was enrolled after birth).
- Last well-child visit received: Percentage of children enrolled in the home visiting program who received the last recommended well-child visit based on the American Academy of Pediatrics schedule.
- Parent-child interaction observed: Percentage of primary caregivers enrolled in home visiting who were observed during a caregiver-child interaction.

- Daily literacy activities reported: Percentage of children enrolled in home visiting with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with their child every day.
- Child development screening completed: Percentage of children enrolled in home visiting with a timely screen for developmental delays.
- Intimate partner violence screening completed: Percentage of primary caregivers enrolled in home visiting who are screened for intimate partner violence within six months of enrollment.

Priority population

For contracting with the Washington State Home Visiting Services Account, priority populations are defined as: poverty/low income/economic insecurity, homeless/unstable housing, parent mental health/behavioral health illness, racial and ethnic groups experiencing disproportionality, enrolled in WorkFirst/Temporary Assistance for Needy Families, prior involvement in the child welfare system, intimate partner violence, non–English-speaking or recent immigrant families, current/previously incarcerated parents, teen parents, history/current substance use (including tobacco), parents with low education, parents and/or children with disabilities, and currently or formerly in the military.

Source: Washington State Department of Children, Youth, and Families.

Reflective supervision

Support to enhance the reflective practice of home visitors and/or supervisors that is provided by someone who is employed by the agency or program and for whom the provision of reflective supervision is included in their job description. Reflective supervision is a form of ongoing, intentional, scheduled professional development that focuses on enhancing the reflective practice skills of home visitors for purposes of program quality, including staff wellness and retention.

Source: Reflective Supervision: A Guide from Region X to Enhance Reflective Practice Among Home Visiting Programs.

Start-up/expansion funds

Funding for community-based organizations to acquire resources and build infrastructure necessary to implement a new program, or to expand an already-existing one.

Source: Best Starts for Kids.

Voluntary service provision

Provision of home visiting services at the discretion of the receiving family.

Well-defined programs

Strategies or interventions that are supported by evidence, feasible to implement, fit the needs of the community, and are well defined. Innovations must be “teachable, learnable, doable, and assessable."

Source: Best Starts for Kids.

APPENDICES

A. Demographic data from families served by HVSA-funded home visiting between October 2017 and September 2018

B. Comparison of HVSA-funded home visiting models

C. Evidentiary requirements for home visiting models, compared across funders and influencers

D. List of stakeholders engaged and interview questions

E. Changes in home visiting need met, by county, during a three-phase expansion scenario

F. Expansion scenario overall budget projections

G. Cost analysis, administrative expense by budget category, at current level of service and with expansion

H. Home visiting expansion proposed methodology

I. Cost study notes for expansion

J. Medicaid financing for HVSA-funded programs

K. Description of Thrive Home Visiting Hub

L. Department of Children, Youth, and Families 2010 goals and objectives

APPENDIX A: Demographic data from families served by HVSA-funded home visiting between October 2017 and September 2018

	Population (no.)						
	Adult participants				Child participants		
Variable	Pregnant women	Female caregivers	Male caregivers	All adults	Female children	Male children	All children
Unduplicated count of participants							
Newly enrolled in home visiting	665	439	22	1,153	447	440	902
Continuing enrollment in home visiting	229	1,188	12	1,456	785	769	1,584
Total	**894**	**1,627**	**34**	**2,609**	**1,232**	**1,209**	**2,486**
Adult participants by age							
<=17 years	83	55	0	138			
18-19 years	145	97	1	244			
20-21 years	154	197	5	359			
22-24 years	181	296	4	485			
25-29 years	205	405	5	628			
30-34 years	72	274	5	359			
35-44 years	46	238	10	304			
45-54 years	0	17	1	18			
55-64 years	0	5	1	6			
>=65 years	0	0	0	0			
Unknown/did not report	8	43	2	68			
Total	**894**	**1,627**	**34**	**2,609**			
Child participants by age							
<1 years					379	390	787
1-2 years					662	616	1,300
3-4 years					180	190	375
5-6 years					11	13	24
Unknown/did not report					0	0	0
Total					**1,232**	**1,209**	**2,486**
Participants by race							
American Indian/Alaska Native	63	127	6	196	81	96	177
Asian	18	17	0	35	17	8	25
Black/African American	103	120	3	258	81	110	191
Native Hawaiian/Pacific Islander	9	7	1	17	6	8	14
White	499	1,082	22	1,611	775	731	1,506
More than one race	106	234	2	342	236	228	464
Unknown/did not report	96	40	0	150	36	28	109
Total	**894**	**1,627**	**34**	**2,609**	**1,232**	**1,209**	**2,486**
Participants by ethnicity							
Hispanic/Latino	274	722	14	1,018	556	543	1,099
Not Hispanic/Latino	567	890	20	1,509	646	642	1,288
Unknown/did not report	53	15	0	82	30	24	99
Total	**894**	**1,627**	**34**	**2,609**	**1,232**	**1,209**	**2,486**
Primary language spoken at home (per child)							
English							1,825
Spanish							509
Other							125
Unknown/did not report							27
Total							**2,486**
Marital status							
Never married (excludes those living with partner)	417	612	11	1,040			
Married	166	497	5	668			
Not married but living with partner	167	230	7	404			
Separated, divorced, or widowed	24	83	4	111			
Unknown/did not report	120	205	7	386			
Total	**894**	**1,627**	**34**	**2,609**			
Educational attainment							
Less than high school diploma	158	413	9	596			
High school diploma/GED	248	464	15	733			
Some college/training	122	284	4	416			
Technical training or certification	77	113	2	195			
Associate's Degree	27	85	2	115			
Bachelor's Degree or higher	36	86	0	123			
Other	131	96	1	231			
Unknown/did not report	95	86	1	200			
Total	**894**	**1,627**	**34**	**2,609**			
Educational status							
Student/trainee	96	216	4	316			
Not a student/trainee	515	1,170	28	1,724			
Unknown/did not report	283	241	2	561			
Total	**894**	**1,627**	**34**	**2,609**			
Employment status							
Employed full time	132	431	9	575			
Employed part time	147	247	6	401			
Not employed	516	850	18	1,383			
Unknown/did not report	99	99	1	242			
Total	**894**	**1,627**	**34**	**2,609**			
Housing status							
Not homeless							
Owns or shares own home/condominium/apartment	96	256	2	354			
Rents or shares own home or apartment	377	847	17	1,234			
Lives in public housing	19	72	1	92			
Lives with parent or family member	218	251	7	476			
Some other arrangement	56	39	4	99			
Subtotal	766	1,465	31	2,262			
Homeless							
Homeless and sharing housing	17	13	1	31			
Homeless and living in an emergency or transitional shelter	10	38	0	47			
Some other arrangement	10	24	1	35			
Subtotal	37	75	2	114			
Unknown/did not report	91	87	1	233			
Total	**894**	**1,627**	**34**	**2,609**			

Notes:

Data include families that received at least one home visit during the report year.

No demographic data are available for the two Parent-Child Home Program sites (31 funded slots).

Some sites did not report data by gender for either children or adults. For these sites, the counts were reported under "total adults" or "total children." Thus, numbers reported under "all adults" and "all children" may exceed the sum of the numbers reported by gender.

COMPARISON: HOME VISITING MODELS

The Home Visiting Services Account invests in and uses a portfolio approach to fund a range of models and programs, supporting HV that will meet the needs of diverse populations. The continuum of programs funded by the HVSA includes not only evidence-based practices but also research-based and promising practice models.

Model		Description
Child-Parent Psychotherapy	Promising practice	Support and strengthen the relationship between a child and caregiver as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning after a traumatic event
Early Head Start - Home Based	Evidence-based	Through home visits and group socialization activities, enhance the development of infants and toddlers while strengthening families, with a focus on child development and early childhood education; principles of child health, safety, and nutrition; adult learning principles; and family dynamics
Family Spirit	Evidence-based	Through the use of paraprofessionals from the community as home visitors and a culturally focused, strengths-based curriculum, support young parents from pregnancy to 3 years post-partum. Parents gain knowledge and skills to promote healthy development and positive lifestyles.
Nurse-Family Partnership	Evidence-based	Through a therapeutic relationship, promote a mother's abilities and behavior change to protect and promote her health and the well-being of her child, allocating time in each activity to address individualized goals and needs
Parents as Teachers	Evidence-based	Parent-child interaction using activity and book-sharing; development-centered parenting; family-centered assessment and goal-setting; resource network for family well-being; health, vision, hearing, developmental screenings
Parent-Child Home Program	Research-based	Through modeling, demonstrate and encourage parent-child interactions and literacy skills, focusing on building meaningful relationships with the families and supporting parents in their role as their children's first and most important teachers
Community Doula/ Partnering with Families for Early Learning	Promising practice	Offer information on health education and childhood development to enhance the parent-child relationship, maternal and child health, healthy birth outcomes and build children's language, literacy and social-emotional skills
Steps Toward Effective, Enjoyable Parenting	Promising practice	Build a secure attachment between parents and children by working alongside parents to help them understand their child's development, respond sensitively and predictably to their child's needs, identify and strengthen support networks for themselves and their child, reflect on their own relationship history and make decisions that ensure a safe and supportive environment for their child and the whole family

APPENDIX C: Evidentiary requirements for home vising models, compared across funders and influencers

Term	Washington statute RCW 43.216.157	MIECHV*	Dedicated Marijuana Account	WSIPP	Best Starts for Kids	CA Evidence Based Clearing House for Child Welfare
Evidence-based model or practice	• Multiple-site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.	• At least one high- or moderate-quality study with favorable, statistically significant impact in two or more of eight outcome domains. • At least two high- or moderate-quality studies with one or more favorable, statistically significant impact in the same outcome domain.	• At least two published studies demonstrating impact in intended outcomes. • Listed in SAMSHA/NREPP; Oregon State Evidence-Based Registry; or "Scientific Evidence for Developing a Logic Model on Underage Drinking: A Reference Guide for Community Environmental Prevention" (PIRE).	• Multiple (or one large, multiple-site) randomized and/or controlled trials demonstrating sustained improvements in at least one of five outcomes. • Can be successfully replicated in Washington and, when possible, has been determined to be cost beneficial (monetary benefits exceed costs).	• Rigorous research design demonstrating effectiveness when model is implemented with fidelity.	Uses "well-supported by research evidence," defined as: • At least two randomized, controlled trials published in peer-reviewed literature demonstrating the practice to be superior to an appropriate comparison. • At least one randomized, controlled trial showing a sustained effect at least one year beyond the end of treatment. • No data suggesting risk of harm.
Research-based model or practice	• Some research demonstrating effectiveness, but does not yet meet the standard of evidence-based practices.	NA	NA	• A single randomized and/or controlled study demonstrating sustained desirable outcomes *or* • A systematic review supporting sustained desirable outcomes (though not meeting the full criteria for "evidence-based").	Uses "evidence-informed," defined as: • At least one comparison study showing positive outcomes.	Uses "supported by research evidence," defined as: • At least one randomized, controlled trial published in peer-reviewed literature demonstrating the practice to be superior to an appropriate comparison and showing a sustained effect of at least six months beyond the end of treatment. • No data suggesting risk of harm.

Term	Washington statute RCW 43.216.157	MIECHV*	Dedicated Marijuana Account	WSIPP	Best Starts for Kids	CA Evidence Based Clearing House for Child Welfare
Promising practice	NA	• Conforms to a promising and new approach to achieving the MIECHV benchmark areas and participant outcomes • Has been developed or identified by a national organization or institution of higher education. • Will be evaluated through a well-designed and rigorous process.	NA	• Statistical analyses or a well-established theory of change shows the potential to meet the criteria for "evidence-based" or "research-based."	Uses "community-informed," defined as: • Designed for a specific community. • Valued by that community, embedded in cultural and social conditions, and/or address populations for which evidence-based practices or evidence-informed practices have not been developed.	Uses "promising research evidence," defined as: • At least one study in peer-reviewed literature using some form of control establishing the practice's benefit over the control or demonstrating that it is comparable or superior to a practice that is well-supported or supported by research. • No data suggesting risk of harm.
Outcomes, indicators, or domains against which effectiveness is assessed	NA	Child development and school readiness; family economic self-sufficiency; maternal health; reductions in child maltreatment; child health; linkages and referrals; positive parenting practices; reductions in juvenile delinquency; family violence, and crime	Must include "substance abuse prevention" as an area of interest	Child abuse, neglect, or the need for out of home placement; crime; children's mental health; education; employment	Health and development, prenatal to five years; health and development, including educational and employment outcomes, five to twenty-four years; youth and family homelessness prevention; Communities of Opportunity	NA (defined by model or practice)

Term	Washington statute RCW 43.216.157	MIECHV*	Dedicated Marijuana Account	WSIPP	Best Starts for Kids	CA Evidence Based Clearing House for Child Welfare
Source of definitions	NA	HomVEE	WSIPP, SAMHSA/NREPP, PIRE, Oregon State Registry	NA	FRIENDS National Resource Center for CBCAP Evidence-Based and Evidence-Informed Programs	NA

* In addition to the criteria above, if evidence of a model's effectiveness is from randomized controlled trial(s) only, then impact must be sustained for at least one year after program enrollment and research must be reported in a peer-reviewed journal for the model to be considered "evidence-based." All models used by MIECHV grantees, regardless of level of evidence of effectiveness, must be implemented with fidelity.

Abbreviations: CA, California; CBCAP, Community-Based Child Abuse Prevention; HomVEE, Home Visiting Evidence of Effectiveness review; MIECHV, Maternal, Infant, and Early Child Home Visiting Program; PIRE, Pacific Institute for Research and Evaluation; SAMHSA/NREPP, Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices; WSIPP, Washington State Institute for Public Policy.

APPENDIX D: List of stakeholders engaged and interview questions

Washington State Department of Children, Youth, and Families
Tleena Ives, Director of Tribal Affairs
Tim Kelly, Program Manager
Judy King, Director of Family Support Programs
Kasondra Kugler, Prevention Program and Data Specialist
Minnette Mason, Strengthening Families Prevention Program Specialist
Frank Ordway, Director of Government Affairs and Community Engagement
Genevieve Stokes, Government Affairs and Community Relations Specialist
Rene Toolson, Community Prevention Services Contracting Team Lead Strengthening Families Washington
Kathy Tan, Home Visiting Program Specialist,
Ivon Urquilla, Program Specialist
Vickie Ybarra, Director, Office of Innovation, Alignment, and Accountability

Washington State Department of Health
Lacy Fehrenbach, Office of Family and Community Health Improvement Director
Martha Skiles, Home Visiting Supervisor

Washington State Department of Social and Health Services
Spring Benson, Children and Family Support Program Manager
Susan Kavanaugh, Frontiers of Innovation Public Assistance Program Manager

Washington State Health Care Authority
Shannon Blood, Medicaid Early Learning and Home Visiting Program Manager, Washington State Health Care Authority

Thrive Washington
Liv Woodstrom, Vice President of Capacity Building, Thrive Washington
Catherine Blair, Manager of Program Administration, Thrive Washington

Best Starts for Kids
Melanie Maltry, Home-Based Services Manager
Marcy Miller, Strategic Advisor, Help Me Grow

Other Individual Stakeholders
Erica Hallock, WA State Dir, Fight Crime: Invest in Kids; Member, Home Visiting Coalition
Katie Hess, Ina Maka Program Manager, United Indians of All Tribes Foundation
Laurie Lippold, Director of Public Policy, Partners for Our Children
Jan Ward Olmstead, Member American Indian Health Commission for Washington State

Other Group Stakeholders
Home Visiting Advisory Committee
HVSA All LIA Programs Meeting
Indian Policy Early Learning Committee
Tribal Home Visiting and Maternal Health Summit
Washington State Home Visiting Coalition

Draft Interview Questions
Home Visiting Expansion Study
October 2018

1. Do you think this is an appropriate time to expand Home Visiting services in Washington State? If so why? If not why not?

2. What do you consider the biggest unmet needs for Home Visiting services in Washington State – both geographically and by populations?

3. What would you suggest the priorities should be for possible expansion of Home Visiting services?

4. What challenges or obstacles will need to overcome if home visiting services are expanded? In other words, what might get in the way of expanded services?

5. Do you have suggestions for strategies to overcome those obstacles?

6. Is there a service delivery model that should be prioritized if expansion occurs? Why?

7. Do you have preferred funding options for future expansion (either overall funding support or different reimbursement models)?

8. What issues/considerations should be taken into account in exploring potential expansion of Home Visiting services?

9. What is the scale of expansion that would make sense, and on what timeline? If expansion were successful, what would it look like in communities?

10. What goals should be set for possible expansion of Home Visiting services?

11. Who are the key stakeholders we should be sure and touch base with for this report development?

12. Is there anything we should discuss with respect to possible expansion of Home Visiting services?

APPENDIX E: Changes in home visiting need met, by county, during a three-phase expansion scenario

County	Existing capacity (no. of slots)	Low income births 2013-2015	Need met before expansion	Risk index	Slots added - Phase 1	Slots added - Phase 2	Slots added - Phase 3	Total slots (existing plus new after three phases)	Need met at end of Phase 3
Adams	93	956	10%	1.5	50	50	47	240	25%
Asotin	0	442	0%	2	50	50	27	127	29%
Benton	110	4494	2%	3	200	300	236	846	19%
Chelan	50	1918	3%	3	150	175	100	475	25%
Clallam	124	1249	10%	2	100	100	63	387	31%
Clark	179	7705	2%	3.5	150	400	439	1168	15%
Columbia	0	60	0%	4	0	0	0	0	0%
Cowlitz	137	2098	7%	2	150	200	134	621	30%
Douglas	14	1049	1%	2.5	75	75	26	190	18%
Ferry	0	136	0%	1.5	20	20	15	55	40%
Franklin	127	3383	4%	1.5	300	300	292	1019	30%
Garfield	0	40	0%	4	0	0	17	17	43%
Grant	87	3332	3%	1.5	275	275	244	881	26%
Grays Harbor	124	1245	10%	1.5	125	125	87	461	37%
Island	11	1075	1%	3.5	0	75	57	143	13%
Jefferson	20	337	6%	2.5	20	20	14	74	22%
King	2881	25750	11%	4	800	975	1467	6123	24%
Kitsap	261	3597	7%	4	100	275	274	910	25%
Kittitas	38	599	6%	3.5	0	50	14	102	17%
Klickitat	18	399	5%	2.5	25	25	19	87	22%
Lewis	119	1700	7%	2	150	150	89	508	30%
Lincoln	0	149	0%	5	0	0	27	27	18%
Mason	68	1248	5%	2	100	100	46	314	25%
Okanogan	100	1134	9%	2	100	100	50	350	31%
Pacific	20	338	6%	2	20	20	6	66	20%
Pend Oreille	116	244	48%	2	0	0	0	116	48%
Pierce	400	16963	2%	2.5	750	900	1035	3085	18%
San Juan	0	179	0%	5	0	0	18	18	10%
Skagit	84	2668	3%	2.5	250	275	125	734	28%
Skamania	10	168	6%	2.5	0	25	14	49	29%
Snohomish	539	11113	5%	3.5	400	700	575	2214	20%
Spokane	345	10463	3%	2.5	325	575	551	1796	17%
Stevens	0	808	0%	2.5	25	25	16	66	8%
Thurston	263	4131	6%	3.5	50	425	191	929	22%
Wahkiakum	25	48	52%	3.5	0	0	0	25	52%
Walla Walla	127	1136	11%	2	95	95	60	377	33%
Whatcom	194	3449	6%	3	50	300	187	731	21%
Whitman	16	573	3%	4	0	0	40	56	10%
Yakima	623	9781	6%	1.5	550	700	597	2470	25%
Totals	**7,323**	**126,157**	**6%**		**5,455**	**7,880**	**7,199**	**27,857**	**22%**

* Note: Some school locales overlap county boundaries (e.g., Columbia and Walla Walla). For purposes of this planning scenario slots for the locales were alloted to just one county.

APPENDIX F: Expansion scenario overall budget projections

	Current *(B)*			Projected expansion			
Variable	**HVSA-funded**	**Non-HVSA-funded**	**Total**	**Phase 1**	**Phase 2**	**Phase 3**	**Total**
No. of slots used for budget projection (*rounded to the nearest 500)*							
Added capacity				5,000	8,000	7,500	20,500
Tribal carve-out				500	500	1,000	2,000
Total capacity *(A)*	2,443	4,880	7,500	12,500	20,500	28,000	
Projected home visiting capacity statewide			**6%**	**10%**	**16%**	**22%**	
Cost per slot (rounded to the nearest $100)							
Direct service (LIA)			$6,547	$6,500	$6,600	$6,600	
Administrative support index (non-LIA)			$2,070	$2,000	$1,500	$1,100	
Performance-based contracting			$110	$100	$100	$100	
Costs for projection			$8,727	**$8,600**	**$8,200**	**$7,800**	
Budget projection (for new slots, by phase)				**$43,000,000**	**$65,600,000**	**$58,500,000**	**$167,100,000**
Estimated budget							
Cumulative total (HVSA) *(C)*	**$19,000,000**		**$19,000,000**	**$64,500,000**	**$127,100,000**	**$179,400,000**	
Direct service (LIA)	$13,500,000		$13,500,000	$48,750,000	$102,300,000	$150,190,000	
Performance-based contracting	$200,000		$200,000	$750,000	$1,550,000	$2,300,000	
Administrative support (non-LIA)			$5,300,000	$15,000,000	$23,250,000	$26,910,000	
Home visiting slots, cumulative (HVSA-funded only)	2,500			7,500	15,500	23,000	
	% of budget - LIA costs		71%	77%	82%	85%	
	% of budget - non-LIA		29%	23%	18%	15% *(D)*	

(A) Total capacity is the cumulative sum of existing and additional slots in each phase.
(B) Current capacity totals reflect the total service cost per slot reported by programs, including costs covered by non-HVSA sources.
(C) Annual cost to fund all currently existing slots and all new slots at end of each phase.
(D) A floor of 15% administrative cost was applied to phase 3.

Abbreviations: HVSA, Home Visiting Services Account; LIA, local implementing agency; PBC, performance-based contracting.

APPENDIX G: Cost analysis, administrative expense by budget category, at current level of service and with expansion

Administrative cost estimate at current level of service through HVSA-funded capacity

	FY2015	FY2016	FY2017	FY2018	FY2019	Four-year total (FY2015-2018)
LIA direct service	$9,056,845	$8,951,729	$10,727,314	$11,250,477	$13,756,841	$39,986,365
Technical assistance	2,627,824	2,118,662	2,054,936	1,196,823	1,516,331	7,998,245
Data/evaluation	802,366	1,126,566	1,261,311	847,406	1,051,381	4,037,649
Administration	379,531	601,247	740,743	1,195,770	1,595,234	2,917,291
Governance	175,000	60,588	44,627	11,936	36,714	292,151
Other	141,759	103,715	177,884	131,481	21,993	554,839
Workforce	0	44,994	91,810	634,296	836,298	771,100
TOTAL	$13,183,325	$13,007,502	$15,098,625	$15,268,189	$18,814,792	$56,557,641

Administrative cost estimate for expansion scenario

	Four-year total (FY2015-2018)	% of non-LIA	FY2022 (Phase 1)	FY2025 (Phase 2)	FY2028 (Phase 3)
LIA direct service	$39,986,365		$48,750,000	$102,300,000	$150,190,000
Non-LIA administrative support:					
Technical assistance	$7,998,245	48%	$7,239,858	$11,221,779	$12,988,305
Data/evaluation	$4,037,649	24%	$3,654,802	$5,664,944	$6,556,716
Administration	$2,917,291	18%	$2,640,676	$4,093,047	$4,737,372
Governance	$292,151	2%	$264,449	$409,897	$474,422
Other	$554,839	3%	$502,229	$778,456	$901,000
Workforce	$771,100	5%	$697,985	$1,081,877	$1,252,186
Total*	**$56,557,641**		**$63,750,000**	**$125,550,000**	**$177,100,000**

Abbreviations: FY, fiscal year; HVSA, Home Visiting Services Account; LIA, local implementing agency.

* Totals do not include funding for performance-based contracting.

HV Expansion Proposed Methodology

1-5-2019

Creating a slots target for each locale

Next, the risk index was used to create a targeted % home visiting capacity for each locale

Priority Score	Target HV Capacity
1.0, 1.5	35%
2.0, 2.5	25%
3.0 - 5.0	20%

LOCALE	# Low income births 2013-2015	County, primary	LOCALE INDEX	% target	35%/25%/20%, target based on risk
Goldendale	566	Yakima	1.50	35%	198
Grand Coulee Dam	558	Adams	1.50	35%	195
Omak	508	Okanogan	1.50	35%	178
Ferndale	690	Whatcom	2.00	25%	173
Shelton	672	Mason	2.50	25%	168
Kelso	632	Cowlitz	2.00	25%	158
Clarkston	442	Asotin	1.50	35%	155
East Valley (Spokane)	611	Spokane	2.50	25%	153
Lake Chelan	602	Chelan	2.00	25%	151
Prosser	603	Benton	2.00	25%	151

The percentage corresponding to that locale's risk index was multiplied by the number of low income births to create a "target home visiting slots" for each locale

Example, **Goldendale**:
Locale Index = 1.5; corresponds to 35% target
low income births * % target =
566 low income births * 35% target =
198 target home visiting slot capacity

Target Cap

Because some locales were quite large, we installed a "cap" to ensure expansion wouldn't be concentrated in only the largest population centers

- Additionally, it was considered that the large population centers were more likely to have existing home visiting service from earlier funding rounds and/or local resources

Added slots target		VOLUME CAP
1,501	3,000	1000
1,001	1,500	750
600	1,000	600
0	599	500

LOCALE	# Low income births 2013-2015	County, primary	LOCALE INDEX	% target	35%/25%/20%, target based on risk	VOLUME CAP	TOTAL ADDED SLOTS target
Spokane	5746	Spokane	1.50	35%	2011	1000	1000
Tacoma	5033	Pierce	1.50	35%	1762	1000	1000
Yakima	3617	Yakima	1.00	35%	1266	750	750
Clover Park	3154	Pierce	1.50	35%	1104	750	750
Pasco	3002	Franklin	1.50	35%	1051	750	750
Highline	3676	King	1.50	35%	1287	750	750
Sunnyside	2131	Yakima	1.50	35%	746	600	600
Kennewick	2746	Benton	2.00	25%	687	600	600
Kent	3802	King	2.50	25%	951	600	600
Auburn	2481	King	2.00	25%	620	600	600
Federal Way	3313	King	2.50	25%	828	600	600
Renton	3013	King	2.50	25%	753	600	600
Vancouver	3080	Clark	2.50	25%	770	600	600
Toppenish	1644	Yakima	1.00	35%	575	500	500
Franklin Pierce	1540	Pierce	1.50	35%	539	500	500
Mukilteo	2263	Snohomish	2.00	25%	566	500	500
Bethel	2124	Pierce	2.50	25%	531	500	500
Everett	2237	Snohomish	2.50	25%	559	500	500
Moses Lake	1385	Grant	1.50	35%	485	500	485
Othello	1248	Franklin	1.50	35%	437	500	437

Phase 3 Expansion

For the third and final "phase" of expansion, we assigned the remainder of target slots to each locale and then *reduced all locales slots total for Phase 3 proportionally by 50% (to account for current HV capacity)*

- The remainder was calculated by taking the "TOTAL ADDED SLOTS target" and subtracting any slots assigned in phases 1 and 2
- The proportional reduction was to "assign" current HV service capacity equally across all locales
  - This was determined to be the most equitable approach given the inability to assign current home visiting slots at the school locale level (currently only able to track at the county level).
  - We reviewed the county before and after service capacity as a check on this model – these results discussed in a later slide

This means Phase 3 slots are an estimate, to be refined once Phases 1 and 2 are completed and locale needs can be assessed more accurately

Phase 3 Expansion, results sample

LOCALE	# Low income births 2013-2015	County, primary	LOCALE INDEX	% target	35%/25%/20%, target based on risk	VOLUME CAP	TOTAL ADDED SLOTS target	PHASE 1	PHASE 2	PHASE 3*
Goldendale	566	Yakima	1.50	35%	198	500	198	50	50	49
Grand Coulee Dam	558	Adams	1.50	35%	195	500	195	50	50	47
Omak	508	Okanogan	1.50	35%	178	500	178	50	50	39
Clarkston	442	Asotin	1.50	35%	155	500	155	50	50	27
Tonasket	351	Okanogan	1.50	35%	123	500	123	50	50	11
Ocosta	274	Grays Harbo	1.50	35%	96	500	96	25	25	23
Seattle	5483	King	3.50	20%	1097	750	750	0	150	299
Evergreen (Clark)	2710	Clark	3.00	20%	542	500	500	0	150	174
Puyallup	2321	Pierce	3.00	20%	464	500	464	0	150	156
Edmonds	2120	Snohomish	3.00	20%	424	500	424	0	150	136
North Thurston	1744	Thurston	3.00	20%	349	500	349	0	150	99
Central Valley	1505	Spokane	3.50	20%	301	500	301	0	150	75
Woodland	470	Cowlitz	3.00	20%	94	500	94	0	50	22
Ellensburg	390	Kittitas	3.00	20%	78	500	78	0	50	14
Cascade	337	Chelan	3.00	20%	67	500	67	0	25	21
Enumclaw	291	King	3.00	20%	58	500	58	0	25	17
Washougal	270	Skamania	3.00	20%	54	500	54	0	25	14
Anacortes	252	Skagit	3.00	20%	50	500	50	0	25	13
Lake Washington	852	King	5.00	20%	170	500	170	0	0	85
Mead	747	Spokane	3.50	20%	149	500	149	0	0	74
University Place	717	Pierce	3.50	20%	143	500	143	0	0	71

Cost of expansion

With this expansion structure, the cost for each round is as follows:

Before expansion: ~6% HV service capacity	PHASE 1	PHASE 2	PHASE 3*
Total slots added:	5,455	7,880	7,199
TRIBAL carve-out	500	500	937
% state HV capacity	10%	16%	22%
counties	29	32	
	78%	86%	

OVERALL EXPANSION PLAN		
ADDED CAPACITY	TRIBAL carve-out	
20,534 slots	1,937 slots	9.4%

Counties excluded in Phase 1 of expansion (*COULD* be included with locale overlap):

- Garfield, Island, Kittitas, San Juan, Lincoln, Skamania, Whitman
  - ***Note: we can add these into the previous rounds (if not until R2, add in R1… R3, R2)***

HV Service Capacity Estimates, county

After Phase 3, all **counties** have a minimum of 15% of needs met, EXCEPT the counties shown:

County Name	Existing Capacity	Low Income Births 2013-2015	Percentage Need Met before exp.	*Risk Index - County*	Round 1 Add	Round 2 Add	Round 3 Add	% Need Met after Round 3
Columbia	0	60	0%	4	0	0	0	0%
Island	11	1075	1%	3.5	0	75	57	13%
San Juan	0	179	0%	5	0	0	18	10%
Stevens	0	808	0%	2.5	25	25	16	8%
Whitman	16	573	3%	4	0	0	40	10%

- Again, this is an estimate, because locales cross county boundaries, so these counties could actually receive higher % of needs met than the table indicates
- We could consider situational carve-outs, if desired, to address this unmet need
- EX: Columbia overlaps with Walla Walla; if you moved 12 slots from Walla Walla to Columbia, Columbia would move to 20% HV service capacity (or, “needs met”) and Walla Walla would only drop to 32%

HV Service Capacity Estimates, locale

After Round 3, the **minimum ADDED capacity for a locale** as a result of the expansion model **is 8%**

LOCALE	# Low income births 2013-2015	County, primary	LOCALE INDEX	% target	35%/25%/20%, target based on risk	VOLUME CAP	TOTAL ADDED SLOTS target	PHASE 1	PHASE 2	PHASE 3*	TOTAL SLOTS ADDED, By Locale	% UNMET need addressed in this expansion scenario
Seattle	5483	King	3.50	20%	1097	750	750	0	150	299	449	8%

For locales with a priority-risk value between 1 and 3, 12% is the minimum ADDED capacity

LOCALE	# Low income births 2013-2015	County, primary	LOCALE INDEX	% target	TOTAL SLOTS ADDED, By Locale	% UNMET need addressed in this expansion scenario
Kent	3802	King	2.50	25%	449	12%
Evergreen (Clark)	2710	Clark	3.00	20%	324	12%

Exception is Newport, Pend Oreille, which was not assigned any slots due to its current estimated HV capacity of 48%

School Locale-to-County Roll Up

- Because school locales sometimes cross county boundaries, a county was “assigned” to a locale, based on geography, with a single “primary county” matched to each locale.
- Once slots were allotted to each locale (by phase), the slots were summed by county based on which county was “assigned” to each locale. The estimate of capacity added via expansion was then done on a county level.
- This approach as a methodology is limited because only one county is associated with each locale in the analysis and slots cannot be divided across counties within locales.
- However, it does provide a method with which to evaluate overall allocation distribution and these known limitations will be considered when conducting expansion to ensure counties receive adequate coverage.

Cost Study Notes for Expansion

FINAL 12-13-2018

Background

The information provided in these slides was gathered and analyzed as part of a larger ongoing cost-study conducted by the DCYF Home Visiting Services team

Data availability and reliability is a known issue that is being continually investigated and solutions pursued to bridge data gaps and concerns

In pursuit of evaluating costs and payment approaches, we researched and reviewed internal and national cost studies related to home visiting service, consulted with federal Technical Assistance provider to get connected to other states that may have engaged in similar cost analysis/rate development, and gathered and analyzed HVSA-funded LIA financials for the current and past fiscal year.

The findings presented here are in no way complete or final as this work is in development and further data is pursued.

COST FINDINGS

Estimated cost per slot (blended rate)

Analyzing the full reported cost of home visiting service by the LIAs for SFY19, DCYF determined average costs of home visiting by model. This cost model was developed based on review of historical data as an sound approach for program planning.

To develop a blended rate, DCYF assumed a projected portfolio of 40% NFP, 40% PAT, and 20% Promising Practices. (current breakdown is 44%, 50%, and 6%, respectively). DCYF also modeled that payment of 100% of program costs, though we estimate current share of LIA budgets is on average 90% (range 40%-100%).

To calculate a composite/blended cost per family, DCYF multiplied the weighted-average reported cost per slot by the corresponding portfolio percentage to calculate a blended rate.

Then, the administrative cost, calculated at 25% of service cost (based on historical administrative cost as % of spend, with slight reduction for anticipated economies of scale) was added to the service cost per slot, as well as 1.5% to cover the performance based contracting requirements for securing outcomes-based payments.

Home Visiting $/Slot Estimate

The result was a total home visiting $/slot cost of:

- **Phase 1: $8,656 (Rounded to $8,600)**
- **Phase 2: $8,190 (Rounded to $8,200)**
- **Phase 3: $7,857 (Rounded to $7,800)**

NFP AVG TOTAL COST REPORTED			$ 7,200	$ / Slot, rounded
PAT AVG TOTAL COST REPORTED			$ 5,400	$ / Slot, rounded
PP AVG TOTAL COST REPORTED			$ 7,600	$ / Slot, rounded
		100%	of TOTAL $	
NFP	40%	$ 7,200	$ 2,880	
PAT	40%	$ 5,400	$ 2,160	
Portfolio	20%	$ 7,600	$ 1,520	
			$ 6,560	Service Cost, projected

	Phase 1	Phase 2	Phase 3	
Service $	$ 6,560	$ 6,560	$ 6,560	
Support $	$ 1,968	$ 1,509	$ 1,181	
PBC $	$ 128	$ 121	$ 116	*$110/slot is SFY19 actual; 1.5%*
FULL COST	**$ 8,656**	**$ 8,190**	**$ 7,857**	

Please note that historically MIECHV has been the largest funder within the HVSA, these numbers are skewed towards implementa tion as MIECHV has required (heavy on data, evaluation, CQI and technical assistance to meet federal MIECHV program requirements and stringent sub-recipient of federal awards requirements). If we scale with state funds, the ratio by different because the nature of the funds are different and don't have as many requirements. We did not assume different requirements in the projections because we have worked hard to have a standard, single contract with high standards of service (using MIECHV as baseline). Additionally, there were no rate or cost of living increases or adjustments included in the projections.

Administrative Cost Calculation

In SFY18, administration of LIA contracts transitioned to DCYF (then "DEL") from partner/contractor Thrive Washington.

The 4-year average of ADMIN COSTS AS A % OF TOTAL COST is 29%

- DCYF came in at 26% in SFY18, the first year of directly monitoring LIA contractors
- With the expansion scenario, DCYF is projecting a 23% administrative cost in the first phase of expansion and lower costs in both subsequent phases

	SFY15	SFY19	SFY22	SFY25	SFY28
LIA	$ 9,056,845	$ 13,756,841	$ 48,750,000	$ 102,300,000	$ 150,190,000
PBC			$ 750,000	$ 1,550,000	$ 2,300,000
Non-LIA	$ 4,126,480	$ 5,057,951	$ 15,000,000	$ 23,250,000	$ 26,910,000
	31%	27%	23%	18%	15%
		Current Rate			FLOOR APPLIED

3 Central Findings

Variability is prevalent between home visiting models, but even within service models

- Between models is not surprising given differences in service expectation (number of home visits per family, education/training requirements of home visitor staff, caseloads of home visitors / supervisor, model-specific annual fees)
- Within models is expected as well due to salary differences for staff in different regions (King county vs Yakima), variable mileage/program travel distances, and rent costs, caseload differences, to name a few
- Would like to understand this variability more if rates were developed, so as to responsibly and sustainable fund service

Personnel is the bulk of program costs

- This includes home visitors, supervisors, specialty staff and support staff
- This also means regional salary differences need to be factored in future funding decisions

Data gaps and inconsistencies must be addressed in order to truly understand full service cost

- Based on the data collection approach, thee are gaps in the completeness of data
- Unknown whether HVSA-funded programs are representative of service providers state-wide

Limitations of Current Data

Our sample set for financials is small

- 39 total LIAs across 8 different home visiting models (11 NFP, 19 PAT, 6 Promising Practices)
  - Note: Two of three HVSA-contracted tribal LIAs are not included in this data set as they are newly operational

The small sample set also means limited ability to understand regional (or other) cost variation

- Promising practices, in particular, as there is only one model that has more than 1 provider currently funded by HVSA

Because organizations offer a variety of services, it is difficult to ascertain how some costs are divided across departments/operations

Some organizations interpret cost categories differently, or don't detail certain line items (model fees, overhead expenses, etc.), making it hard to compare cost categories across organizations

Actual expenses are not invoiced in as much detail as budget submissions, therefore some cost data relied on budgets rather than expenses to analyze program costs

Other Studies

Cost studies and payment proposals reviewed:

- 3SI (internal report, 2014) – reviewed, limited consultation
- ESIT (internal report, 2012) – reviewed, interviewed
- Mathematica (national study, 2014) – reviewed, interviewed
- MiHope (national study, ongoing) – reviewed, waiting for report (estimated publication Jan/Feb 2019)
- Note that many states were consulted but uncovered no available cost study work from these conversations

Conclusions:

- The ESIT and both national studies conducted **time studies to develop service costs/rates**
- These could potentially be applied to home visiting, particularly the MIHOPE study when it is released, rather than requesting a time study done for the LIAs currently contracted with HV
- The Mathematica report was outdated (for use of costs) and **could not conclusively identify the causes of variability** (possibly because of small sample set and national scope of data participants)
- 3SI reported findings in cost variation geographically among HVSA-funded LIAs, but these do not seem to track to current data (and similar data gaps noted in that study persist today)
- ESIT mostly noted **professional class of service provider** (nurse vs therapist, etc) **as a central component of cost variation**; our data of HVSA funded LIAs seems to support clear salary differences across LIA models

Medicaid Financing for HVSA-Funded Programs

Summary for HCA and DCYF Executive Leadership, Dec. 17, 2018

Local HVSA-funded programs and other stakeholders reviewed shorter- and longer-term options for accessing Medicaid funds. They preferred the longer-term options because these options best address key criteria they identified (shown on right), and they want DCYF and HCA to take the time needed to get the details right and to continue to work with them to do so. Based on this input and consideration for state agency administrative workload, HCA and DCYF staff recommend pursuing **two Medicaid financing strategies including conducting cross-agency fiscal analyses,** seeking **funding in 2019**, and determining next steps for **managed care contracting and a State Plan Amendment in 2020**.

Stakeholder-developed Criteria for Planning

HVSA-funded programs want Medicaid financing plans to:

- Promote high levels of coordination
- Promote sustainability
- Increase care continuity
- Expand services to families with kids up to 5 years old
- Serve more families
- Enable flexibility for rural/urban, cultural variations

Preferred Options: MCO + TCM

	Managed Care Plan Integration	Targeted Case Management
Recommendations	Pursue contracts between DCYF and Apple Health managed care organizations (MCOs) for allowable services provided by HVSA-funded home visiting programs.	Develop a State Plan Amendment to reimburse targeted case management services provided by HVSA-funded home visiting programs.
Models Included	All HVSA-funded models; but some models may provide more allowable services by qualified providers than other models.	All HVSA-funded models; some models may provide more or fewer allowable case management services.
Funding Considerations	May increase use of behavioral health and/or clinical services, as well as case management, which would require an increased per member/per month capitated rate.	• 50/50 FMAP • FQHC eligible • Reimbursement for case management services only • Undocumented persons require state funding only
Alignment Considerations	• Cross-agency fiscal analysis needed • Cross-agency policy and program coordination • Continued engagement with HVSA-funded programs	• Cross-agency fiscal analysis needed • Cross-agency policy and program coordination • Continued engagement with HVSA-funded programs

Process to arrive at preferred options and next steps…

Cross-agency Collaboration

HCA-DCYF-Thrive monthly meetings: refined options to explore with stakeholders, reviewed workshop results, developed recommendations

Stakeholder Consultation

7 workshops (74 participants)

- Spokane
- Tukwila
- Sequim
- Lacey
- Burlington
- Yakima
- Vancouver

1 legislative information session (26 participants in Olympia and via web conference)

EXPLORING THE OPTIONS AND IMPACTS AT THE LACEY WORKSHOP
SEPTEMBER 12, 2018

Recommended Next Steps

1. **DCYF and HCA: Ensure sufficient staffing to complete next steps**
2. **DCYF and HCA: Develop coordinated funding proposal for 2019 legislative session**
   a. HCA: ensure resources are available to complete a fiscal analysis that determines state and federal financial participation as well as administrative workload (add FTE if needed)
   b. DCYF: ensure resources are available to complete fiscal analysis (add FTE if needed)
3. **DCYF and HCA collaborate to develop proposed MCO contracting and State Plan Amendment details**
4. **DCYF continue to involve HVSA-funded program providers in developing Medicaid financing proposals**

Leadership Questions/Requests

1. **Which Medicaid authority do you want to pursue?**
   a. MCO reimbursement for allowable services?
   b. TCM SPA?
   c. Both?
2. **Will you assign staff in both HCA and DCYF to complete the next steps listed above?** Some or all?
3. **What fiscal impacts should cross-agency fiscal staff project/complete before the legislative session?**

Dream big! Take time! Work with us!

--Key message from HVSA-funded program representatives that participated in stakeholder workshops, September 2018

THRIVE WASHINGTON

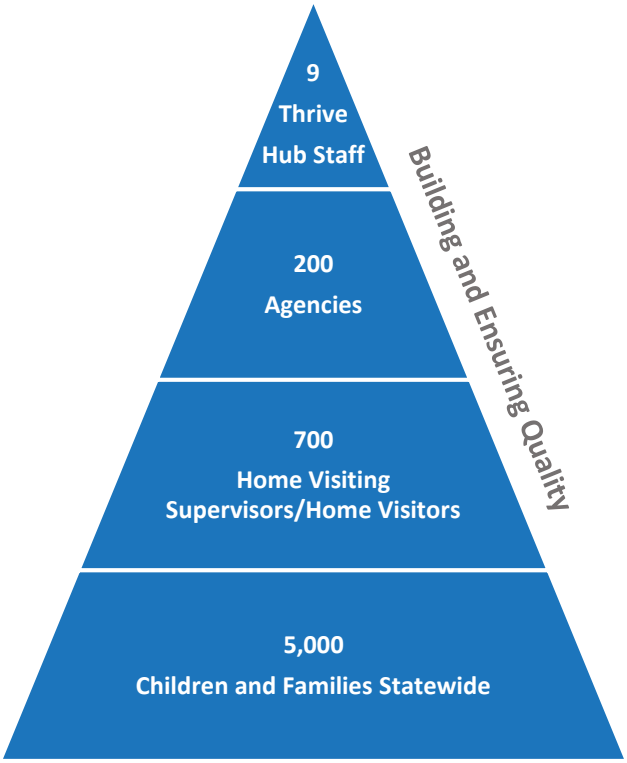
Early Learning. Every Child. Our Future.

Home Visiting Implementation Hub

Since 2010, Thrive Washington has helped lead and shape the state's home visiting work to ensure funding and the highest-quality resources reach the communities and families who need them most.

To create a home visiting system that works for many families, Washington state leverages federal, state and private funds through the Home Visiting Services Account (HVSA).

Working in close partnership with the state Department of Children, Youth and Families (DCYF), and local county and city governments, Thrive's Home Visiting Implementation Hub (the Hub) prepares communities to offer home visiting and, through coaching and supports, helps home visitors provide high-quality services to thousands of babies, children and families statewide.



The Hub supports:

Home visiting professionals, elevating the field with high-quality training, technical assistance, best practices and innovative ways to better support families, and ensuring fidelity to various home visiting models.

Communities considering a home visiting program, helping them identify gaps in existing resources and the populations that could benefit most, select a home visiting model to match community needs, and choose a lead agency.

State systems building and advocacy, collaborating with state agencies and stakeholders that use home visiting, staffing the legislated Home Visiting Advisory Committee, and leading the request for more state funds to support more families by coordinating the *Home Visiting Advocacy Coalition*.

A National Leader

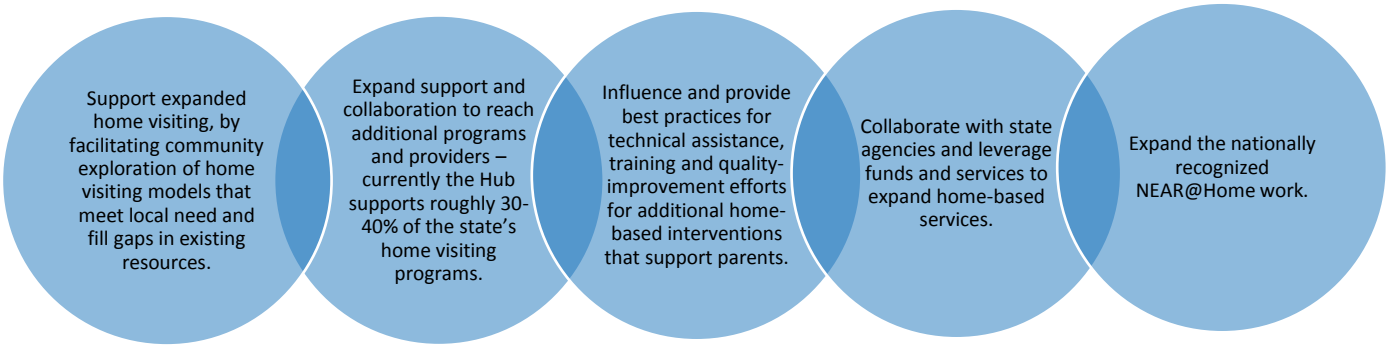
The Hub Team currently includes nine staff members. It is comprised of experts in model fidelity, home visiting implementation, and continuous quality improvement as well as public policy, and systems building.

The Implementation Hub:

- Uses the Implementation Science framework to help programs grow and maintain quality.
- Houses the state model leads for multiple home visiting models – Nurse-Family Partnership, Parents as Teachers and Parent-Child Home Program.
- Supports programs with two primary technical assistance providers: one who knows the home visiting model and one focused on quality improvement.
- Shows the power of having a portfolio of high-quality home visiting programs to share best practices and meet the needs of diverse communities and families.
- Values strengths-based, client-centered, reflective, trauma-informed and culturally responsive practices.
- Provides cross-model trainings and opportunities for peer connection and serves as a key collaborator in both state and national home visiting governance systems.
- Holds the internationally used NEAR@Home process and toolkit developed to help home visitors respectfully and effectively address Adverse Childhood Experiences (ACEs) with families.
- Includes expert staff who are regularly featured presenters at national conferences.

Looking Ahead

Over the next 2-3 years, the Hub aims to:



Washington State Home Visiting Goals and Objectives

Excerpted from the Washington State Home Visiting Updated State Plan, June 2011

The State Plan for a Home Visiting Program provides **high-level goals** and a set of clearly prioritized, feasible and **actionable objectives** that are necessary to foster a home visiting system in Washington. These priorities were identified through a collaborative process that involved stakeholders who are the most knowledgeable about the needs of at-risk populations and communities in our state. These goals and objectives are the critical next steps our system must take to continue building a comprehensive home visiting system, as well as contribute to the development of Washington's comprehensive early learning system.

The goals and objectives for Washington's State Plan for a Home Visiting Program fall within five strategic "buckets": Governance and Planning; Finance and Sustainability; Service Delivery and Access; Quality and Accountability; and Public Engagement.

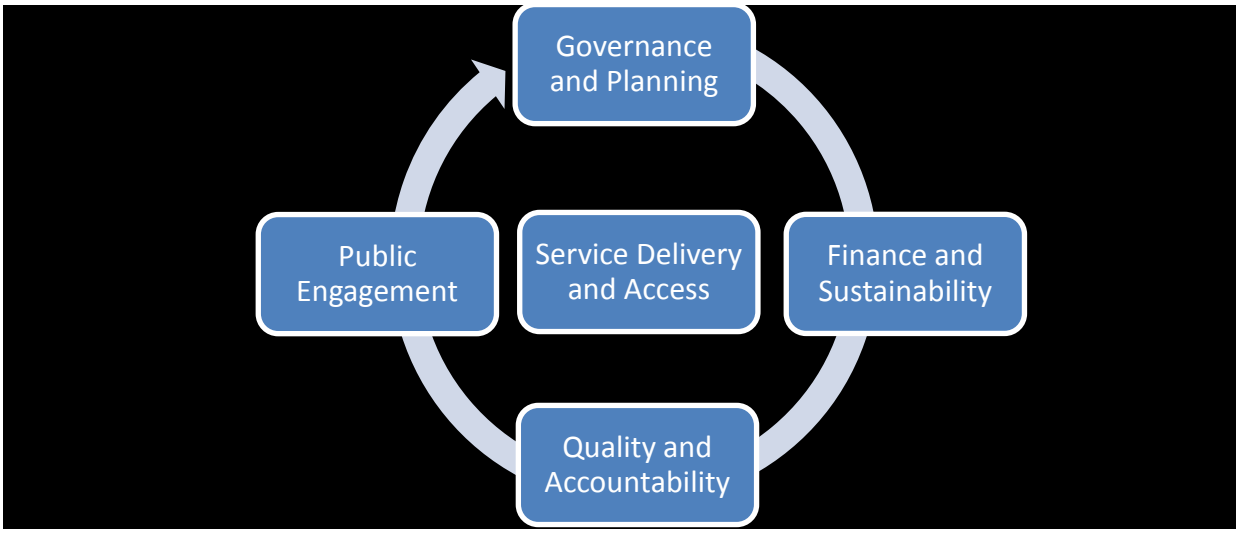


Figure 4: The Five Strategic "Buckets" for the Goals of the State Home Visiting Program.

1. GOVERNANCE AND PLANNING

Washington is in the process of developing a collaborative governance structure over the next two to three years, as outlined in the state Early Learning Plan. A federal grant for continued development of the Early Learning Advisory Council (ELAC) will be used to build a long-term, integrated governance and planning structure at both the state and local levels. Over the long-term, home visiting will be integrated into the broad early learning governance structure.

Goal 1: Integrate the home visiting system as part of the broader early learning planning and governance structure, encourage collaboration at the state and local levels, and engage and reflect the communities served.

Objectives:

A. Use the current home visiting planning structure to provide ongoing input and strategic direction in the development of the home visiting system. This structure includes ELAC, the Home Visiting Advisory

Committee, the Home Visiting Partnership Group, and the Home Visiting Executive Team (formerly the Cross Agency Governance Structure or CAGS).

B. Encourage strong local planning structures.

C. Link with partners in health, human services and K-12 to plan for a comprehensive approach to home visiting and linkages to other services and supports for families.

D. Listen to diverse local communities' views about culturally competent home visiting services, and use their input and local programs' expertise to assess the cultural competency of promising, research-based and evidence based home visiting models.

E. Ensure that home visiting work is informed and influenced by families, consumers and stakeholders, and aims to reflect the diversity of communities served at the local, regional and state levels.

2. FINANCE AND SUSTAINABILITY

To enhance and expand home visiting benefits prenatal through age 5 requires alignment of current funding and development of new funding resources. Many young children in Washington are living in families that are low-income or living in poverty, as described in our ELP. Funding for home visiting services is not commensurate with the demonstrated need. The 2010 Legislature created a Home Visiting Services Account (HVSA) to align and leverage public funding with matching private funding to increase the number of children and families being served by home visiting.

Goal 2: Build finance strategies and generate resources to sustain and grow the home visiting system in Washington state.

Objectives:

A. Seek funding from current sources, and new public (including local government) and private sources. Explore opportunities for leverage and to braid and blend funding sources through the HVSA.

B. Build finance strategies to support evidence-based, research-based and promising practice home visiting programs.

C. Secure resources to fund home visiting services and the infrastructure to support quality in local programs and at the state level.

D. Develop strategies to build long-term sustainability of high-quality home visiting programs.

E. Ensure that the finance strategies are informed and influenced by families, consumers and stakeholders, and aim to reflect the diversity of communities served at the local, regional and state levels.

3. SERVICE DELIVERY AND ACCESS

The Washington State Home Visiting Needs Assessment identified 32 geographic areas and five racial/ethnic groups as being at-risk compared to the state. The needs assessment found that four evidence-based and nine other home visiting programs are in use in the state, but only an estimated 2 to 11 percent of at-risk children and families are receiving these services. Through the U.S. Census and Washington Kids Count, there is ample evidence that to develop an early learning system that meets the

needs of all children requires explicit attention to a number of current gaps that exist—by income, race/ethnicity, language, and culture—both in child outcomes and opportunities and system capacity and response. Washington continues to build off a strong foundation of work that has been done at the state and local level to provide high-quality home visiting programs and models to support families with young children get a good start in life.

Goal 3: Ensure that high-quality, culturally competent home visiting services that meet the needs of local communities are available and accessible to at-risk families across the state.

Objectives:
A. Make evidence-based, research-based and promising program models more widely available and accessible to local communities.

B. Build capacity to increase access to home visiting services in rural, tribal and other underserved communities.

C. Identify and support effective intake and referral processes at the community, regional and state levels with organizations/entities that work closely with families.

D. Conduct culturally competent outreach to recruit and retain families in home visiting programs in underserved communities.

E. Work with communities and developers/representatives of evidence-based, research-based and promising home visiting models to ensure the cultural competency of home visiting services.

4. QUALITY AND ACCOUNTABILITY
Funders and policymakers want their investments to improve children's outcomes and overall readiness for school. This calls for programs to be accountable. In Washington, we are responding to accountability in diverse ways as outlined in our Early Learning Plan. For home visiting there is an emphasis on continuous quality improvement of the home visiting programs. Efforts also are under way in Washington to evaluate evidence-based home visiting programs in terms of the outcomes for healthy parenting and child development, early literacy and children's school readiness.

Goal 4: Ensure high-quality services and effective implementation of home visiting models and programs.

Objectives:
A. Increase the capacity to collect and analyze meaningful data at the program, model and systems levels for use in home visiting program improvement efforts.

B. Support communities in using these data for continuous quality improvement and on-going learning in their organizations.

C. Support communities in ongoing evaluation of promising/innovative practices to develop stronger evidence of effectiveness.

D. Ensure that the processes for assuring the quality of home visiting are informed and influenced by families, consumers and stakeholders, and aim to reflect the diversity of communities served at the local, regional and state levels.

E. Build professional development opportunities, training, and technical assistance for specific models/programs to support quality implementation of home visiting services.

F. Identify opportunities to share information and collaborate across home visiting programs and with partners in health, education and human service systems.

G. Build an integrated accountability system that meets local, state and federal needs, is consistent with program models and is cost-effective.

5. PUBLIC ENGAGEMENT

Nationally and in Washington, interest has been growing in using home visiting to enhance parenting, and promote the optimal growth and development of young children. Research has shown the effectiveness of home visiting to buffer the effects of multiple risk factors and benefit children's health and development. Organizations and agencies supporting children and families are engaging the public in support of home visiting and building a coordinated early learning system.

Goal 5: Build community and public will for a home visiting system that provides high-quality services to families in local communities.

Objectives:

A. Educate the public about home visiting services and provide information about home visiting services offered in Washington.

B. Cultivate champions to support local home visiting services and programs, and provide information about ways to get involved.

C. Build off of existing public awareness campaigns that focus on early childhood health, development and learning, in order to inform parents, families and communities about home visiting.

D. Ensure that public engagement efforts are informed and influenced by families, consumers and stakeholders, and aim to reflect the diversity of communities served at the local, regional and state levels.