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Community-Based Home Visiting: Fidelity to Families, Commitment to Outcomes

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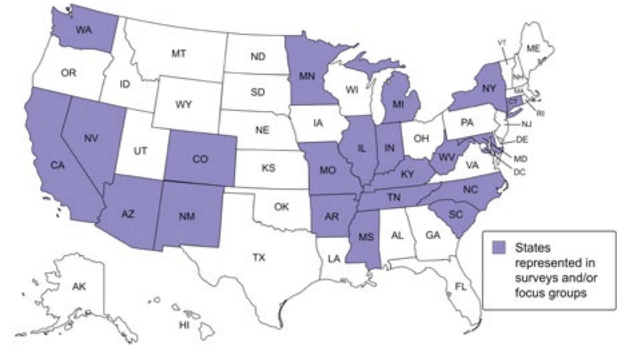
Executive Summary

- **Total individuals contributing**: 48
- **Total models represented**: 34
- **Total states represented**: 21 (Arizona, Arkansas, California, Colorado, Connecticut, Illinois, Indiana, Kentucky, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Mexico, New York, North Carolina, South Carolina, Tennessee, Washington, West Virginia)



Key Themes:

- **Family-Centered Design Yields Continuous Quality Improvement**: A common trait of many models that contributed to this report is an emphasis on a human-centered design process that employs rapid feedback from families to improve offerings throughout the program year and in annual planning. While many home visiting models across the country collect family feedback, community-based models are set apart by their ability to quickly make changes to their format and content in response to that feedback.
- **Research, Data, and Outcomes Must Be More Effectively and Inclusively Defined**: All the models in this report value research, data, and outcomes, and define and collect them in ways that are meaningful to families and paint a more complete picture of their needs, goals, and experiences. They feel that a narrow, solely quantitative definition of research omits significant, meaningful indicators of effectiveness.

Flexibility allows community-based models to meet families' expressed needs.

- **Reclaiming Culture and Advancing Language Access to Improve Family Experiences and Outcomes**: Because of their rapid feedback mechanisms, ability to make real-time changes to content/curriculum and delivery methods, and strong relationships with their community, community-based home visiting models are uniquely positioned to quickly develop and implement programming that emphasizes cultural resonance as well as language access.
- **Flexibility Is Necessary to Serve the Community and Enhance Outcomes**: The flexibility valued by community-based models serves multiple purposes, including the ability for models to meet the specific needs expressed by families in their communities, define research outcomes that are meaningful to the families they serve, and design research studies in ways that honor community members' expertise and contributions.
- **Structural Barriers to Funding Impact Sustainability and Accessibility**: The community-based

home visiting models in this report blend and braid private philanthropic funding and public local and state funding. The sustainability of each of these funding sources varies widely among models, leaving some organizations uncertain about their ability to continue providing services to their community. This is further exacerbated by the current design of the Home Visiting Evidence of Effectiveness (HomVEE) evaluation process, which determines eligibility for federal Maternal, Infant, Early Childhood Home Visiting (MIECHV) funding and is largely inaccessible to community-based models.

Overview and Background

About Home Visiting

Home visiting connects expectant parents, new caregivers, and their young children with a support person, called a home visitor, who meets regularly and develops a relationship and connection with a family in order to support that family in achieving their goals and meeting their needs. Home visitors and families meet in a family's home or a location of a family's choice and focus on strengthening the well-being of caregivers and children and connecting families to community resources. There are numerous positive outcomes of home visiting, including improved maternal/caregiver physical and mental health, infant mortality, caregiver confidence, school readiness, child development, safety, and many others. Home visiting can be provided by infant and early childhood professionals, social workers, peers, doulas, nurses, mental health professionals, parents, community health workers, promotoras, and other trained individuals. Home visiting models vary in the ages of children served but can start prenatally and generally end by school entry.

In the United States, there are two main pathways for home visiting models to be developed and implemented:

1. **MIECHV-eligible home visiting models**: This group is composed of home visiting models that have been developed and researched in alignment with the standards set forth in the statute authorizing the federal Maternal, Infant, Early Childhood Home Visiting (MIECHV) program and its standards for review, the Home Visiting Evidence of Effectiveness (HomVEE) review. This includes meeting a federally defined standard of what is "evidence-based," which requires a "grounding in relevant empirically-based knowledge," an association with a national organization or institution of higher education, and ongoing measurement of the specific data points prioritized by the MIECHV program/HomVEE process. These models are eligible for federal funding through MIECHV.
2. **Community-based home visiting models**: Home visiting models use a design and measures of success that center community goals and perspectives and the needs identified by members of a local community. These models are developed by organizations that are based in the community, local government, medical systems, or higher education institutions and intentionally center

the perspectives of the families they serve and community members. This category may include community-based models that pursue MIECHV "Promising Practices" funding, but as noted below, successfully accessing that funding is rare, and these models are not eligible for other MIECHV funding.

Many communities have innovative ideas about how to design and implement their own home visiting models.

Home visiting models that pursue each of these pathways are highly impactful. Though it has a significant basis in research, the home visiting field as a whole continues to build on that foundation to better understand how to center clients' voices and goals in measures of effectiveness and what specific practices are most effective for particular priority populations. In pursuit of those goals, a number of MIECHV-eligible models work to adapt their work in ways that are more relevant to particular communities or populations. At the same time, many communities have innovative ideas about how to meaningfully and effectively design and implement their own home visiting models. Programs pursuing each pathway are currently optimizing the funding sources available to them, with community-based models facing significant challenges in accessing public funding because of a lack of funding opportunities that are inclusive of models that have been co-created and evaluated by families and community members.

Without significant additional public and private investments in home visiting, there continues to be significant unmet need across the country. In order to support the thousands of additional families who could benefit from home visiting, all options for increasing support for critical, culturally relevant and family-centered models must be explored. To that end, this report delves into the unique strengths and challenges of community-based home visiting models and makes policy and funding recommendations that would improve support for these models and therefore families' access to home visiting that best meets their goals.

About Community-Based Home Visiting Models

This report focuses on **community-based home visiting models**, which are home visiting models whose design and measures of success center community goals and perspectives and the needs identified by members of a local community. These models are developed by organizations that are based in the community, local government, medical systems, and higher education institutions and intentionally center the perspectives of the families they serve and community members. **They are often developed by those with lived experience with the unique cultures, strengths, and solutions that make up the fabric of the community they live in and aim to serve, and reflect great racial, ethnic, and linguistic diversity**. They also endeavor to address any systemic biases and barriers that particularly target and affect their community or their model's target populations. This often includes those who face multiple barriers to accessing the types of prenatal care they desire, such as people living in rural areas, immigrant and refugee populations, Black

and brown expectant parents, people speaking languages other than English, families from specific cultures and countries of origin, families experiencing economic disparities, and others.

Community-based home visiting models often prioritize members of the community or families formerly served by home visiting becoming home visitors and home visiting supervisors themselves. Many of these models are designed with a strong emphasis on supporting their workforce through adequate pay and benefits, mental health services, ongoing training and professional development, and rightsizing caseload levels. They rely heavily on building trust between home visitors and families as well as communities and service providers; this is the foundation on which many of these models are built. Deborah Young, with Empowering Communities Globally: For the Care of Children, based in Colorado, summed up community-based home visiting models this way:

> **"Anyone who benefits is in the best position to create a model that serves them."**

Community-based home visiting models are often designed by the community being served in response to a gap in services (such as a lack of pre- or postnatal care, culturally resonant programming, or school readiness) or data that highlights the needs of specific local populations (such as high rates of maternal or infant mortality). Some models are developed as a bridge between the offerings of existing home visiting models or used as a referral to existing models, and some are created based on the feedback and data received about local needs and preferences that show an existing model is not the right fit for a community. Community-based models often have a diverse array of partnerships, including with local, state, and county governments, schools, mental and physical health providers, hospitals, and other community service providers and leaders. As stated by SaRonn Mitchell from Save the Children's Early Steps to School Success model:

> **"What our program has done is to be able to reach those families that otherwise ... would have never had any intervention whatsoever. The communities that we serve are some of the most resource-poor communities in America."**

While community-based models have demonstrated significant benefits for those they serve, their efficacy is defined by a different set of criteria than many of the models currently receiving federal funding. **The models discussed in this report believe strongly in the power of research evidence to demonstrate their impact on their communities and follow a model or curriculum with fidelity, two main requirements of federal MIECHV funding. But because their processes of showing outcomes do not always align with those required to receive federal funding, they face unique challenges in implementing and sustaining their programming**.

Home visiting is supported through a variety of means in states, including federal, state, local, philanthropic, and grant funding. The largest federal source of home visiting funding is the MIECHV program. Under

MIECHV, the Health Resources and Services Administration (HRSA) determines which home visiting models qualify for federal funding based on congressionally determined benchmarks and research-evidence requirements. Those models are included in the HomVEE list that states, tribes, and territories can choose from to use their MIECHV funding on. The community-based models discussed in this report do not currently qualify for MIECHV funding because they collect data and measure success in ways that are tailored to their local context rather than with the criteria set forth in the federal MIECHV definition of "evidence-based." Models on the HomVEE list are often referred to as "evidence-based" in the home visiting field, but this report will use the term "MIECHV-eligible" to describe these models. Community-based models, too, have extensive evidence to document their effectiveness and outcomes even though their methods of measuring those outcomes do not align with the requirements of the HomVEE review process.

Community-based models, too, have extensive evidence to document their effectiveness.

Under MIECHV, states have the option to use up to 25 percent of their award for "promising practices" to fund models that do not currently qualify for MIECHV funding through the HomVEE list. Only a small handful of states currently use the "promising practices" pathway, and the criteria and process required by HRSA to use this option are not clearly defined. This option is not viable for most community-based home visiting models because they still have to meet many of the requirements of MIECHV-eligible models and find the resources to pay for them, including being evaluated through a randomized controlled trial and being developed or endorsed by a national organization or institution of higher education.

Methods

We connected with many community-based home visiting models in the production of this report, but these models are part of a much larger landscape. There are many additional community-based home visiting models providing vital services and connections throughout the country, and we look forward to seeing further research of, learning from, and outreach to more models and communities in the future.

Between June 2022 and December 2023, Start Early and First Focus on Children hosted virtual listening sessions with representatives from community-based home visiting models. The purpose of the listening sessions was to gather information from a diverse group of community organizations to better understand what types of services are being provided in communities, the success those organizations are achieving, and what barriers and challenges exist for them to access funding and resources to sustain the critical services they provide to their communities. Those who were interested in contributing to the listening sessions but unable to attend had the opportunity to share their expertise via a written survey in January 2024. Forty-eight individuals representing 34 community-based models from 21 states (Arizona, Arkansas, California, Colorado, Connecticut, Illinois, Indiana, Kentucky, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Mexico, New York, North Carolina, South Carolina, Tennessee, Washington, West Virginia) responded to these opportunities to provide input.

Listening-session and survey participants had the opportunity to review this report in draft form, and edits were made based on their feedback. Permission was received from anyone quoted in this report, and all participants were given the option to remain anonymous in order to promote an open and honest dialogue. They were also given the option for their contact information to be included in the Appendix of this report. Listening-session participants were compensated for the generous sharing of their time and expertise.

We connected with many community-based home visiting models in the production of this report, but these models are part of a much larger landscape. There are many additional community-based home visiting models providing vital services and connections throughout the country, and we look forward to seeing further research of, learning from, and outreach to more models and communities in the future.

Key Theme 1: Family-Centered Design Yields Continuous Quality Improvement

While many home visiting models across the country collect family feedback, community-based models are set apart by their ability to quickly make changes to their format and content in response to that feedback. The type and format of feedback collected from families varies within and across models and includes one or both of the following:

- **Ongoing, In-the-Moment Feedback Collection**: Several community-based home visiting models indicated that they gather feedback on their services verbally, whether during home visits or other touchpoints or when they see their clients out in the community. Representatives from models that use this approach emphasized that trust and a strong presence in the community were key to ensuring that families could be candid with their feedback and feel confident that program staff would use that feedback to inform services. In particular, representatives from several models shared that community members being willing to refer friends and family to a service is a major indicator of trust and satisfaction with the model that is not captured by more-formal research practices. As shared in a listening session for home visiting providers from Washington state: **"There are multiple ways of knowing services are working for families, and it is not always a Randomized Control Trial or a required assessment. Families vote with their feet."** Although it is not a data point that is often recognized in determining effectiveness of home visiting services, families will choose — and encourage their friends and family members to choose — home visiting models that align with their values, goals, and needs.
- **Scaffolded Family Feedback Collection**: In other instances, models opted for a more structured approach to gathering families' input, including administering written surveys and hosting family advisory councils. Representatives from at least one model shared that family engagement was

centered in the broader initiative that gave rise to their home visiting model itself, thus family voice is embedded in its structure and design.

Gathering feedback in these ways allows models to increase their alignment with families' cultural norms, goals, and preferred service formats (e.g., meeting frequency or location). **As families and communities evolve, community-based home visiting services rapidly evolve in response, which advances the trusting relationship between a model and its clients and ensures that the model remains impactful**.

Representatives of several models conveyed that participating in the same research processes as MIECHV-eligible models would limit their ability to quickly gather client feedback and adjust programming to recenter families' expressed needs. **For these models, their ability to be responsive to families and support them in meeting their current goals and needs is meaningful evidence of effectiveness that they strongly believe should be more widely recognized in federal funding opportunities**. Some cited the desire to conduct this type of continuous quality improvement as part of the rationale behind selecting a community-based approach to home visiting instead of opting for a MIECHV-eligible model, or for transitioning from using a MIECHV-eligible model to a community-based model. One listening-session participant offered:

> **"[The state agency] wants us to have this stamp that says … that [we're using] an evidence-based model. … But really, what that means is, it's like 20 years outdated. And I think that's the problem with some of these research-backed curricula: … it takes so long to make changes [that] they're no longer congruent with what our broader community needs."**

Staff from one of the models with particularly strong continuous quality improvement practices host an ongoing formal working group on parent voice for the community-based and MIECHV-eligible model-based programs in their county to come together to engage in peer-to-peer support on using family feedback to inform model implementation. This type of ongoing feedback gathering, analysis, and collaboration would benefit many communities and could be replicated with adequate funding and staffing support.

Key Theme 2: Research, Data, and Outcomes Must be More Effectively and Inclusively Defined

All of the models included in this report value research, data, and outcomes — but those things look different across models and often do not conform to the narrowly defined requirements of the HomVEE review. **Leaders from many community-based models emphasized that there are multiple meaningful ways to collect data and evaluate outcomes and that the HomVEE process favors quantitative data, unintentionally creating little opportunity for the essential learnings that qualitative data have to offer about model effectiveness and family outcomes**. One model representative said:

> **"I think we all can agree that data is the thing. You know, everybody's got it collected. Everybody's got to aggregate it. Everybody's got to pay attention to it. But what information are we really getting out of it? I think sometimes what my frustration is, it puts our focus on the wrong thing. ... And I think the actual family story gets put to the side. Nobody is interested in the qualitative data. ... [A parent] said her home visitor changed her life. Those were her exact words, and she doesn't know what she would have done without her home visitor being there for her. So what that says to me is, we met that family exactly the way that that family needed to be met, which might not show so great in your quantitative data. So I guess that's always kind of my frustration. I'm hoping that ... the decision-makers take the time to actually listen to what the families want, and not ... how they think you should be spending the money."**

Shannon Shallenberger, Early Childhood Director, Shelbyville Community Unit School District (CUSD) No. 4 in Illinois, said, **"What I would hope is that national funders would give some credit to ... just the informal, more of the soft data, the stories."**

Community-based models collect qualitative and quantitative data on numerous outcomes and indicators, including:

- Adequate and thriving wage compensation for and retention of home visitors
- Better results at hospitals
- Breastfeeding rates
- Connections made between families and the community resources they need
- Cesarean section rates
- Families' access to children's books
- Family empowerment
- Family satisfaction with home visiting and doula programming
- Improved early relational health (the role that early relationships and experiences play in health and well-being throughout a person's lifetime)

- Increased positive pregnancy and birthing experiences and improved mental health of expectant parents
- Maternal and infant mortality rates
- Members of the community seeking out home visitors
- Numbers of infant/early childhood professionals a site has put into the field in their own communities
- Positive shared emotional interactions between caregivers and children
- Home visiting participation rates and school attendance
- School readiness

Many of these indicators are closely aligned with the goals of the MIECHV statute and HomVEE review process but are not themselves recognized as acceptable indicators of a model's effectiveness under the requirements of MIECHV.

Representatives from many models emphasized that the relationships between families and home visitors are the key to successful outcomes, and these can be overlooked when an evaluation is too focused on the evidence base as it is currently defined by the HomVEE criteria.

Leaders from multiple models stressed that many outcomes — particularly qualitative outcomes — are devalued in the federal review process for MIECHV eligibility. They shared that the HomVEE process, as required by the MIECHV statute, excludes many other valid ways to prove the effectiveness of a model and the process of developing outcomes that resonate with families. They would like the process of determining whether a model is "evidence-based" or MIECHV-eligible to look at models in ways that are meaningful to families and represent a more complete picture of their needs, goals, and experiences, rather than making everything contingent on a specific set of indicators.

Community-based models emphasize measures of effectiveness that are meaningful to families.

Leaders of a model in New Mexico gave an example of the additional training it does for home visitors to limit their burnout and provide constant learning and continuous education. These factors cause home visitors to stay in their field and provide continuity for families, which results in better care and outcomes for those families. Though they enhance model impact and client outcomes, the effects of supports like these are not often captured in a formal review process or the types of research and indicators currently used to determine MIECHV funding eligibility. Staff from another model said,

> "We are still doing good work, metrics are still showing that we're making change, that there is impact, that there is improvement in these families' lives — while you somewhat understand why there needs to be some framework around the goals of home visiting ... there's more than one way to get to that point."

Key Theme 3: Reclaiming Culture and Advancing Language Access to Improve Family Experiences and Outcomes

Developers of many of the models included in this report have centered cultural resonance as a core feature and have built on that strong foundation as new families from a diverse array of ethnic groups have joined their communities. Most home visiting models across the country recognize the importance of cultural humility skills for their staff and recruit staff who reflect the racial and ethnic backgrounds of their clients. **Because of their rapid feedback mechanisms, ability to make real-time changes to content or curriculum and delivery methods, and strong relationships with their community, community-based home visiting models are uniquely positioned to quickly develop and implement programming that emphasizes cultural resonance, reclamation, and healing, as well as language access**. This has allowed many community-based models to quickly and effectively adapt their offerings to serve immigrant, refugee, and other historically disenfranchised populations that are disproportionately affected by the maternal health crisis and not being reached in a culturally responsive way by other services in their communities.

Community-based home visiting models are uniquely positioned to quickly implement programming.

Culture

Many of the models we spoke with have pivoted and/or been called on to fill gaps in services for Indigenous as well as immigrant and refugee families. **This has included work to place culture at the center of model design by defining home visiting services and family success using culturally relevant concepts**. For example, a model serving an Indigenous community in Washington state relies on Indigenous parenting knowledge, traditions, and family/community relationship structure, serving as additional or stand-in "Aunties" for its clients. A model in Colorado recognizes the need to connect expectant and new mothers with job skills and professional opportunities that align with their cultural values around caregiving and gender roles. As a result, the model has helped place approximately 150 multilingual people in early-care-and-learning roles in their community, which in turn creates new opportunities for families engaged with the model to continue experiencing cultural resonance, representation, and belonging in child care and other early childhood settings. Multiple community-based models noted that the redefining of their services in culturally resonant terms is in direct contrast to many other institutions in the community, such as schools, hospitals, or other family support institutions. Rather than designing programming and defining measures of success in terms that are not part of their service population's cultural norms (e.g., "school readiness"), community-based home visiting models embrace their clients' cultural knowledge and concepts and help them navigate systems that are not as flexible.

Models that center cultural resonance in their content also reflect this core value in their measures of success. Some cited specific success stories of reconnecting expectant parents with cultural knowledge and experiences, leading them to include metrics around joy and quality of birthing experience in their evidence of effectiveness. A representative from one community-based model in California also engaged in a countywide continuous quality improvement workgroup for models to discuss engagement of African American home visitors and clients and identify shared best practices.

Prioritization of cultural humility has yielded trusting relationships with families for community-based models.

Community-based model developers indicated that their prioritization of cultural humility among home visitors and their intentional centering of families' unique values, goals, and needs have yielded trusting relationships with families that often spread via word of mouth among community members. This emphasis on cultural resonance is cited as a driving force behind both the need and desire for members of these diverse communities to transition from home visiting client to home visitor. In order to be sustainable, these culturally resonant and welcoming models need home visitors with lived experience in the cultures they serve; because the enrolled families feel welcomed and trust the model, they want to serve their communities as home visitors. To this end, many of the community-based models included in this report hire home visitors based on lived-experience-related qualifications rather than formal degrees and training programs. Deborah Young, with Empowering Communities Globally: For the Care of Children, in Colorado said:

> **"We really are incorporating reading books to children, bringing in their culture, bringing in their grandparents, bringing in what happens in [their home country]. ... And we're trying to get to the memories with the positive, shared emotional interactions. [N]ot [about] when you had to flee in the war, but what was it like when you were a little kid? Where did you play? Where did you run? And can you build that into the story so that you're not only sharing your family's history [but also] historical and cultural things."**

Language

Because community-based models are often co-created with community members themselves, they reflect the norms, values, and language needs of the community. Staff from several models that contributed to this report also shared the importance of understanding and continually monitoring the language needs of their communities to ensure they are providing services, educational materials, and outreach materials that are highly accessible. This has allowed them to ensure that groups that have been historically disenfranchised and divested from have access to critical maternal health and child development information and assistance navigating other institutions in their community (e.g., schools and hospitals) that may not provide

translation services. Leaders of a community-based model in California shared that their client-recruitment materials undergo a "rigorous" review process for readability and accessibility in addition to being translated into other languages and tailored specifically based on the interests and needs of several diverse populations in the community.

A handful of community-based models have gone even deeper to use language to enhance their clients' experience of home visiting and other services in their community. For example, models that emphasize Indigenous languages use them as a point of connection with culture and a means of engaging in cultural reclamation and the reclamation of Indigenous parenting practices and knowledge. Another model that specifically serves refugee populations has supported its clients in accessing higher education programs and has advocated with local institutions to ensure that their clients receive the translation services and other accommodations to which they are entitled.

Representatives from multiple models reported that their translation and language access efforts presented logistical and financial challenges to their organizations. This work has required them to support on-staff translators or rely on third-party translation services (e.g., LanguageLine Solutions) that sometimes do not fully meet the needs of their clients due to cultural norms/values (i.e., differences in dialects, the need for male/female translators for specific situations) or a gap in health or child-development-related vocabulary. In order to ensure that clients are able to express themselves in their native language, some models have engaged former clients as home visitors who can help meet that need. Greater access to more-sustainable funding is needed for these models to continue providing critical language services that can help narrow the maternal health equity gap for underserved populations.

Key Theme 4: Flexibility Is Necessary to Serve the Community and Enhance Outcomes

In Serving the Community

The flexibility valued by community-based models serves multiple purposes, including the ability for models to better meet the specific needs expressed by families in their communities. Leaders of several models reported that they previously used a MIECHV-eligible model but transitioned to a community-based model when they realized the needs of families in their communities would be best served through more flexibility than they could provide under the MIECHV-eligibility criteria. Others decided from the start that their communities needed flexibility and adaptability to best serve them. The ability to have local control is paramount for these models because every community is different. Shannon Shallenberger, Early Childhood Director, Shelbyville CUSD No. 4 in Illinois, said, **"You can't have a one-size-fits-all approach to home visiting — it needs to be what works best for local families."**

These flexibilities are evidenced by multiple components of a community-based model. Some models highlighted the flexibility needed in family eligibility requirements. Representatives from multiple models shared that they are able to accept families starting at all stages of pregnancy and ages in early childhood, which is different from some MIECHV-eligible models that limit the start time or age for their home visiting services because their model has only been approved for specific times and ages. Others adapt to meet the needs of new populations in a community that must be met quickly and cannot wait for the years and resources it takes for changes in a curriculum to be evaluated and approved in alignment with the HomVEE process. Staff from at least two models shared the importance of the ability to offer virtual home visits. One model from California was designed to provide services only through the use of virtual visits even prior to the COVID-19 pandemic because that best met the needs of its families and allowed more families to access services. A model in Missouri found success with virtual visits during the pandemic and is continuing this option of service delivery after receiving feedback from families that they prefer it. Representatives from many models shared that the frequency and dosage of home visits — and communication or re-enrollment between visits — intentionally varies based on what the family needs and can be more or less frequent depending on what is most helpful for each individual family, unlike in many MIECHV-eligible models that may have a prescribed number and frequency of visits based on what that model is approved for under the HomVEE process.

Community-based models' flexibility is critical to their ability to be responsive to the community's needs.

A representative of a model from Washington state emphasized that the purpose of flexibility is to allow providers to follow the goals and desires of a family and that this ability to be responsive builds the rapport and relationship that is key to success in home visiting. **These successful models were not the result of one moment in time; rather, they have evolved and will continue to evolve based on community needs**.

In Generating Outcomes and Evidence

In some instances, the unique flexibility and relationships of community-based home visiting models have yielded important gains for the home visiting field toward developing outcome measures and research evidence that is both high quality and meaningful to the community they serve. Representatives from multiple community-based models emphasized the importance of identifying relevant and meaningful model outcomes until program staff begin to build trust with the community and learn more about local families' goals and needs. They cited this flexibility as critical to their ability to be responsive to the community's needs, create programming that resonates with families, think innovatively about the quantitative and qualitative data that best represents the unique strengths of their model, and engage families and staff as equal partners in the model-evaluation process.

The resulting measures and data are not only representative of the quality of their services but also the quality of their relationships with the community. The models included in this report use methods like community-based participatory action research methods and impact studies that help them understand their effect on data that is of high local importance (e.g., local maternal mortality rates). The ability to collect data that is particularly meaningful to the populations they serve (e.g., quality of birth experience and C-section rate for Black expectant parents, who experience medical discrimination at higher rates than their white peers) is also essential to their approach to research. In these instances, successfully and meaningfully conducting the research in partnership with home visiting clients and other community members is considered part of the model's outcomes and impact. Additionally, for some models, this approach gave rise to broader continuous quality improvement and peer learning efforts, including a countywide data collaborative and a nationwide data consortium that elevate best practices and recommendations for model improvements.

A new approach from both public and private funders has the potential to yield data that is both high quality and responsive to families' and communities' goals.

Contributors from several models noted that this approach of placing community needs and trust building before assessment was possible specifically because it was approved by the private funders who support their work. They noted that the opportunity to co-develop outcome measures with the community would not have been possible under the current MIECHV statute or other federal funding requirements. **This indicates that a new approach from both public and private funders has the potential to yield data that is both high quality and responsive to families' and communities' goals**.

This approach is also particularly relevant for communities — including Black and Indigenous communities — that have historically been exploited by researchers and thus have low trust in assessments like those required as part of processes that allow models to secure federal home visiting funds. In this respect, placing community needs, goals, and trust at the beginning of the research and evaluation process has the potential to help reinforce the trusting relationships held by home visiting programs in communities. This generates richer data and ensures that community members feel like valued, equal partners in the evaluation and data utilization process. A representative from one model said,

> **"Flexibility is essential in being able to provide culturally relevant services. There is a need for co-creating the rhythm and the focus that is following the goals of the family. We use a guide, or have an approach or resources to support staff, but it is essential to embed flexibility in community-based work because not every family, culture, or region is the same."**

And a contributor from another model added, **"Goals of the family should be more important than goals of the funder."**

Key Theme 5: Structural Barriers to Funding Impact Sustainability and Accessibility

Sustainability

The community-based home visiting models included in this report blend and braid private philanthropic funding and public local and state funding. For models that serve communities in multiple states, their funding sources and amounts vary widely by state based on the interests of local private funders and government officials. **The sustainability of each of these funding sources varies widely among models, leaving some uncertain about their ability to continue providing services to their community**.

Representatives from multiple models indicated that shifting city/municipality and county politics has affected their ability to obtain sustainable funding and provide the types of services requested by the community. For example, a program in the Midwest shared that a change in county government leadership led to a deprioritizing of maternal health for the public health department, and therefore less county funding was available for home visiting. A representative from another model shared that it was largely supported by a state tobacco tax and that as additional restrictions are placed on tobacco sales in the interest of public health, the program's budget will be cut in half by 2029. It is seeking other state and federal funding sources to close that gap. A contributor from another model shared,

> **"Taking away choices for families to get matched up with the best educational program for them, I think, is a mistake. And for us, you know, being small, we don't need another [one of the existing MIECHV-funded models] in our community. ... So I feel like some of us who have models that are not federally funded... we're just gonna go away. And you know that's scary for our staff. It's scary for us."**

Representatives from some models offered innovative approaches to maintaining their services even as they struggle to identify new funding sources. For example, in California, a countywide home visiting initiative has intentionally created its community-based model as a complement to the services provided — and funding used — by two MIECHV-eligible models serving the same community. By situating its community-based model alongside MIECHV-eligible models, the initiative uses this community-based model as a universal home visiting service that all families in the county are eligible for and a referral source to the MIECHV-eligible models that may serve specific groups or have more-targeted services. The initiative's leadership notes this as a win-win: all families, including those who do not initially qualify for one of the two MIECHV-eligible models, receive the impactful and effective services provided by their community-based model, and families who need additional services are easily identified and gain access to them through the complementary services of the MIECHV-eligible models serving their community.

This approach has been especially helpful as the two MIECHV-eligible models quickly ran out of capacity to meet the community's full needs. While local leaders continue to search for sustainable funding sources for their universal, community-based model, their approach of using these models as complementary means that at least two of their three models have stable and secure funding. Sharlene A. Gozalians, director of LA Best Babies Network at California Hospital Medical Center, said,

> **"While we have the national evidence-based programs, we've also got this really successful [community-based] model that is working. How do we continue to support this program to sustain and continue to grow, knowing the need is continuing? We estimated that in [our county] for children 0 to 5 years old, that we need 735,000 slots for home visiting, and as of right now we have less than 35,000 funded slots. But if we can at least get the [community-based] universal model to provide that support in the first 9 months of life ... we believe that there is a difference in outcomes. When this child turns 3, 4, and 5, there is a better sense from the parents, higher self-efficacy, empowerment, [confidence]. ... But we want to go forward. We don't want to go backward because somebody didn't give us the stamp that said, we're evidence based right? But it's working right? They're serving families, it's working, it's great. ... How do these sites get to tap into these dollars and continue the great work they're doing?"**

Accessibility

Many of the individuals consulted for this report felt the sustainability of their community-based home visiting model would be strengthened with greater access to federal funding, including through MIECHV, the Family First Prevention Services Act (FFPSA), and Medicaid. However, almost all had experienced several structural barriers that have discouraged them from pursuing federal funding to support their work.

Medicaid reimbursement for home visiting is challenging for all types of home visiting models, including MIECHV-eligible models, to access. The Centers for Medicare and Medicaid Services and HRSA have given some guidance to states on how to pay for home visiting services with Medicaid, but many states still do not have the guidance they need in order to combine federal funding streams. Medicaid financing is even more difficult to access for community-based home visiting models. One model reported that it previously leveraged Medicaid funding but lost access to it when its state deprioritized use of Medicaid for home visiting.

The most commonly mentioned barrier was the highly specific outcomes and research studies required through the HomVEE model approval process, which dictates which models are eligible for MIECHV funding. As stated earlier, the community-based models included in this report strongly support data

collection and showing evidence of effectiveness. The types of research used to evaluate models through the HomVEE process typically require more resources than are available to community-based models. Additionally, several of these models that have attempted to achieve HomVEE status have found the process to be opaque and not clearly defined. A representative from one model shared that they were approached by HRSA and asked to submit information for review, which is unusual, but their application was not approved. A contributor from another model reported that they have been in the process of applying for HomVEE status since 2018. They completed the research required several years ago but the model still has not been approved. They now have a peer-reviewed journal article detailing the model's effectiveness, but it most recently was rejected from HomVEE status because its application was not reviewed. Some models, like this one, have research practices that are largely aligned with the goals of MIECHV and HomVEE, but the HomVEE standards are so narrow that they are still unintentionally disqualified. Barb Lunneman with Save the Children added, **"There are a lot of hoops we have to jump through ... there's always one more thing we haven't done."**

A representative from a model in California said that models need resources and must be well-known in the home visiting field in order to achieve an "evidence base" as defined by MIECHV. **However, that status is not an affordable or achievable goal for countless models, even though they have evidence that shows their program is producing results**. Several participants suggested that MIECHV should be improved to make it more inclusive and welcoming to a diverse array of models, and another said many models work within unique communities and wondered whether the MIECHV-eligible models have been proven to work in all of these communities or if their evidence only shows that they work in certain places and populations. The specific evidence base required by the MIECHV statute was created to ensure that families would receive high-quality home visiting and that federal money was being well-spent. But it has had the unintended consequence of limiting choice and access for some families to the home visiting models that work best for them and their communities.

> [The HomVEE review process] has had the unintended consequence of limited choice and access for some families.

There are negative consequences to not being included on the HomVEE list in addition to the obvious one of not being eligible to receive MIECHV funding. Representatives from multiple models shared that not being on HomVEE list negatively impacts their ability to access non-federal funding as well. A contributor from one model shared that it lost a non-federal funding opportunity because the funder decided to choose from the list of MIECHV-eligible models instead of looking at community-based models. Representatives from some models said they are not taken as seriously in the home visiting field because they do not have the MIECHV "stamp." **A lack of funding through MIECHV, FFPSA, and Medicaid creates unpredictability for models and harms their ability to grow their evidence base, which in turn**

eliminates their access to federal funds. One model said this exclusion "has felt very defeating." Another shared, "We have to leave room for how we're … evolving, and then how we're moving forward in the future and give credit to those programs that, because of a lack of funding, haven't been able to get on the playing field to show [they are] evidence-based. But we have [an] evidence base."

Conclusion and Policy Recommendations

Home visiting programs are highly impactful, and both MIECHV-funded and community-based models are maximizing the current funding available to them; however, there are thousands more families across the country who could be supported through home visiting with increased access to funding. **Policy changes are needed to address the specific concerns that community-based models have about their financial sustainability and a need for greater access to local, state, and federal public funds and private funds**.

One focus group participant, Dr. Twylla Dillion from HealthConnect One in Chicago, posed a challenge and an invitation to the home visiting field:

> "Do we have every bit of evidence in the way that they want it? No. Do we have a lot of anecdotal evidence? Absolutely. Do we have a lot of evidence specifically from Black and brown communities? Yup. If they want more, do they know where to come get it? Come talk to me and my friends. There's a lot of information."

In this spirit, below we offer a set of recommendations intended to encourage policymakers, researchers, funders, and others to engage with the research evidence and innovative practices of community-based models to help sustain their impact on the communities they serve and ensure that the option of creating such models is a viable option across the country.

As noted above, federal MIECHV funding is inextricably tied to a set of narrow research evidence standards that are costly for smaller models to carry out and do not allow for communities' priorities to determine how a home visiting model's effectiveness is defined. The following are recommendations developed based on the information shared by the community-based models included in this report. These recommendations would improve the sustainability of community-based models and their access to needed resources, and would move the home visiting field closer to becoming a more diverse, equitable, and inclusive space that celebrates the cultures, goals, and contributions of families and providers.

Policy Recommendations

For Federal Administrators and Elected Officials

Equity and Family Voice

- Include in the MIECHV statute a requirement for each state to create a parent-community leadership council to ensure that home visiting programs serve diverse families and communities in ways that are responsive to and informed by the needs of those families and communities. Models for these councils can be found in Healthy Start's use of Community Consortia and in Head Start's use of Policy Councils, in addition to the models included in this report that embed parent and community voice into their program design and decision-making.
- Leverage President Biden's Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government to support the maternal and infant health equity goals of home visiting, inclusive of community-based models.

Funding

- Increase funding for home visiting -- inclusive of community-based home visiting -- through various funding streams and the complementary programs and professionals that support families, including MIECHV, Healthy Start, Early Head Start, and the provision of doulas, community health workers, and other professionals for families.
- Consult with community-based models as policy decisions are made in order to understand how potential changes would affect their ability to access that funding.
- Provide administrative guidance about how innovative models and state MIECHV administrators can work together to include community-based models in "promising practices" funding.
- Create formal and inclusive criteria for which models qualify as "promising practices" and a process through which community-based models can actively apply to be considered for this funding.
- As states opt in to using a portion (up to 25%) of their MIECHV funds to support "promising practices," encourage or require administrators to account for the costs of the evaluations required for programs in this category. Community-based models are often unable to pursue "promising practices" funding, as the amount available is often inadequate to both continue delivering services and fund the evaluations that are required for "promising practice" models. Requiring states to demonstrate that they have planned for evaluation funding would help ensure that "promising practices" can serve as a meaningful pathway to accessing MIECHV funding for community-based models.
- Increase the amount of funding available for states to use for "promising practices" to help account for research costs, and create incentives for states to engage with the "promising practices" pathway

(e.g., through a slightly higher federal funding match rate for state and philanthropic money that is used for "promising practices", or creation of a new funding set-aside specifically for research and evaluation for "promising" programs).

- Change the title of the "promising practices" funding pathway to better reflect the extensive expertise of community-based models and their potential to inform future directions of the home visiting field. The term "promising" indicates that the practices under this umbrella have yet to produce research evidence that they are effective for the communities they serve. The majority of the community-based models included in this report have already conducted extensive evaluations of their programs and demonstrated impact in the communities they serve. Though that research evidence does not align with the current set of standards for MIECHV funding, it can and should serve as an important source of innovative programmatic and research ideas that can inform the field. Renaming "promising practices" to "innovative" or "community-based practices" would help elevate community-based models' expertise, experience, and new contributions to the field.
- Make additional funding available to home visiting models — including community-based models — to cover the significant and unique costs associated with serving language-diverse families (e.g., live and asynchronous translation, training, cultural competency). This will ensure that programs can continue doing the critical work of reaching families who experience many barriers to accessing prenatal and early childhood services without compromising the financial sustainability of their program overall. As climate change progresses and people across the world seek to migrate to safer areas of the globe, this need is likely to increase for home visiting programs in the United States, particularly the Midwest.
- Allow state, local, and philanthropic funding being spent on community-based models to count toward a state's contribution to its MIECHV federal match funding. The most recent reauthorization of MIECHV includes a new state match option, and HRSA has stated that only money spent in a state on HomVEE-approved models will count toward the state portion of the match. This is a disincentive to states to fund community-based models in their communities and could result in current funding to them being cut and instead used on models that would count toward the match.
- Provide additional encouragement and guidance to states detailing how they can use Medicaid reimbursement for home visiting, and allow Medicaid reimbursement for community-based home visiting models in addition to those on the HomVEE list.
- Pass legislation making home visiting a required Medicaid benefit; include community-based models as providers and do not limit reimbursable models to those on the HomVEE list.
- Allow the Family First Prevention Services Act to use community-based models in its prevention efforts, in addition to those on the HomVEE list.

Research

- Change the HomVEE standards to allow for all research methods and data that convey results that are aligned with the goals and needs of home visiting clients and that convey the effectiveness of community-based models. This includes:
  - Centering families' input in defining and prioritizing program outcomes.
  - Placing value on data that describes clients' perceptions of the effectiveness of services, including qualitative data, stories, and formal and informal feedback mechanisms alongside quantitative data.
  - Placing value on research methods other than randomized controlled trials, which are expensive to carry out and would require models to withhold services from a segment of their community in order to create a comparison population. Allowable research methods should include community-engaged research (formerly known as community-based/participatory action research), and research conducted internationally should be eligible for review.
- Update the MIECHV statute to eliminate the requirement that in order to be considered a "promising practice" models must be developed or identified by a national organization or institution of higher education. Adapt the evaluation requirement to allow for additional research methods and data that convey results aligned with the goals and needs of home visiting clients to show model effectiveness. Through these changes, the "promising practices" pathway can help serve as a source of innovation and provide examples of how a broader array of research methods can be used by the field a whole.
- Update the HomVEE process to clarify how home visiting models can be considered for review, what materials they will need to provide for review, what additional funding and supports are available to help them align with the HomVEE standards, and a reasonable timeline for that review to be completed. These changes would make the process easier and more transparent for all home visiting models and would be beneficial to community-based models that often have a small number of staff and limited time to manage the review process, which can include multiple extensive requests for information from models and can span years.
- Update the HomVEE process to give priority points, or add a separate review process or designation, to models that demonstrate active use of family and community input for continuous quality improvement in their research methods and model design. This will ensure that states and communities that seek to prioritize this approach are able to quickly identify which models offer it.
- Include identifying learnings from community-based home visiting models as an activity of the next MIECHV Learning Agenda, with the goal of creating greater opportunities for lifting up the research and programmatic innovations advanced by these models and increasing their access to MIECHV funding.
- Examine how community-based models are playing a role in helping expand access to home visiting in the communities they serve.

- Conduct a nationwide landscape review on community-based models' research methods and how they can be used to inform revisions to the MIECHV benchmarks and HomVEE review process. Many of the models that contributed to this report have decades of experience in blending rigorous research practices with outcome measures and data that are rooted in the voices of community members and home visitors themselves. Additionally, many of the indicators they use align with the goals of MIECHV but are not recognized in the statute or in the HomVEE process. The lessons learned from that work represent a rich but untapped source of knowledge that can help guide the home visiting research field and help ensure that models that center community voices are not placed at a disadvantage as they pursue federal funding.

For State and Local Administrators, Elected Officials, and Advocates

- Explore the community-based home visiting models that are available across states and the many strengths they offer. MIECHV administrators should consider leveraging "promising practices" funding to support community-based models in their state and inquiring with HRSA regarding how these models can engage in the HomVEE review process. Local public health and education administrators interested in exploring MIECHV "promising practices" funding for a program in their community should reach out to their state's MIECHV administrator to share more about the community-based model(s) serving their area. Please see the Appendix for a state-by-state list of community-based models that participated in this report and have opted to share their contact information.
- Ensure that community-based home visiting models are eligible for and included in state and local funding that is directed toward maternal and infant health or other public health initiatives. Although for some state and local initiatives it is common practice to adopt HomVEE status as a criteria for funding, we encourage administrators to broaden their criteria so community-based models are included.
- Ensure that state advocacy coalitions are welcoming and inclusive of community-based models. In addition to their strong relationships with their clients and communities, these models often bring decades of experience in program design and delivery, research design and implementation, and developing culturally relevant practices. When community-based models are included in statewide advocacy and peer learning opportunities, they are likely to strengthen other communities' home visiting systems and the state as a whole. In many cases, representatives from community-based models are eager to share their experience and expertise through opportunities to advocate for home visiting at the state and local levels.
- Promote systems building and collaboration among community-based home visiting models and other local early care and learning resources, including child care and early intervention programs.

For Philanthropy

- Support an ongoing peer learning cohort for community-based models across the country. Nearly all individuals who contributed to this report indicated a desire to continue engaging with their peers in shared federal advocacy efforts that would support the success of their models and peer-to-peer learning to inform their model design and programmatic offerings. Community-based programs have a desire to be at tables where decisions are made and have extensive experience and expertise to offer to their peers and decision-makers.
- Use funding criteria that reach beyond the list of models designated as "evidence-based" through the federal HomVEE process. While some funders adopt the list of MIECHV-approved models in an effort to deepen the impact of their investments, doing so perpetuates the inaccessibility of funding for the community-based models in their state or community.

Appendix

Community-Based Model Directory

Model information is included with permission.

Models Serving Individual States		
Model/Organization Name	**State**	**Contact Information**
LA Best Babies Network at California Hospital Medical Center (Overseeing Welcome Baby and other home visiting models)	California	**Contact Name**: Sharlene A. Gozalians, Dr.P.H., M.P.H., C.H.E.S. **Title**: Director of LA Best Babies Network, Dignity Health — California Hospital Medical Center **Phone**: 213-250-7273, ext. 111 **Email**: sgozalians@labestbabies.org **Service Area**: Los Angeles County, CA
MOMS	California	**Contact Name**: Sarah O'Rourke **Title**: Chief Program Officer **Phone**: 714-972-2610 **Email**: sorourke@momsorangecounty.org **Service Area**: Orange County, CA
Empowering Communities 5-Step Home Visiting Model	Colorado	**Contact Names and Titles**: Deborah Young, Executive Director, and Fateme Jafari, Home Visiting Project Supervisor **Phone**: 303-527-2742 **Email**: info@empoweringcommunitiesglobally.org **Service Area**: Arapahoe, Denver, Adams, and Weld counties
Baby TALK — Lee, Ogle, and Dekalb Counties (Illinois)	Illinois	**Contact Name**: Jodie Thunder **Title**: Family Enrichment Program Manager, Community Coordinated Child Care **Email**: jodiet@four-c.org **Service Area**: Lee, Ogle, and DeKalb counties
Best Starts for Kids (Coordinating organization for multiple community-based models)	Washington	**Contact Name**: Adrian Lopez **Title**: Best Start for Kids Prenatal to Five Team Lead **Email**: alopezromero@kingcounty.gov **Service Area**: King County, WA

Models Serving Multiple States

Model/Organization Name	State	Contact Information
All Babies Initiative	Illinois, Indiana	**Contact Name**: Heather Anderson **Title**: Program Manager **Phone**: 812-238-8171 **Email**: heaanderson@union.health **Service Area**: West Central Indiana and East Central Illinois
HealthConnect One Community Based Doula Model	Illinois, Mississippi, New Jersey, New York, Texas, Utah	**Contact Name**: Jacqueline Lambert **Title**: Community Based Doula Manager **Phone**: 662-402-6611 **Email**: jlambert@healthconnectone.org
First Born And More	Minnesota, New Mexico	Santa Fe Community College **Email**: firstborn@sfcc.edu
Early Steps for School Success	Arkansas, California, Kentucky, Mississippi, New Mexico, South Carolina, Texas, Washington, West Virginia	**Contact Name**: Barbara Lunnemann **Title**: Save the Children Advisor — Kindergarten Readiness **Phone**: 618-972-4387 **Email**: blunnemann@savechildren.org