Coordinated Funding Home Visiting Systems

Why It Matters, and Examples of How It is Done

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START EARLY | Consulting

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Purpose of Memo

The purpose of this memo is to provide Oregon's Early Learning Council with information to support greater understanding of the role, structure and management of funding in a coordinated home visiting system. While a fully coordinated system requires weaving together multiple funding sources to support high quality programming, significant attention must also be paid to the other components of the system. We can think of the funding as the fuel that runs the car, while the infrastructure of a system represents the engine, steering and navigation. Without the infrastructure, fuel alone will not get you to your destination.

Memo Structure

Part I of the memo provides context for the components of a well-designed coordinated home visiting system, and the reasoning for why this is important for the delivery of accessible, family centered services that will support the attainment of larger statewide goals for Oregon's young children and their families. Part II of the memo provides examples of how other states coordinate funding as well as other aspects of their home visiting systems. Lastly, the appendices provide a brief history of home visiting in Oregon, and profiles of four states, informed by interviews with home visiting systems leaders of each state.

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Part I: Key Elements of a Coordinated Home Visiting System

A well-designed coordinated home visiting system reduces duplication by aligning workforce policies, intake/referral, outcomes/data systems, and braided funding across models and agencies, and by evaluating both program and system effectiveness toward realizing two-generational health, economic, educational, and early learning goals [1] System governance and decision making is a formal, consensus-oriented approach where state agencies, local governments, and non-state actors (such as community-based organizations, private entities, and residents) jointly engage in decision-making and policy implementation.[2] Coordination of the system is supported by a neutral state-level organization that convenes and facilitates the feedback loops between the state and regional implementors, conducts access gap analysis and provides data and data dialogue protocols for successful shared governance.[3]

When building coordinated systems, it is important to pay attention to the standardization paradox: the more rigid a system becomes in pursuit of quality and consistency, the more likely it is to exclude the communities it aims to serve.[4] The most effective way to balance standards with equity is to distinguish between core components and adaptable peripheries. Core components are the minimum, non-negotiable elements of a program or intervention. These are the active ingredients that are scientifically or theoretically linked to the desired outcomes. The adaptable periphery consists of the structures, delivery methods, and organizational features that can be modified to fit local community needs without undermining the core components.[5] Each of the components listed below can be designed with both core components and adaptable peripheries represented.

Workforce: A skilled workforce is built and supported through reflective supervision, secondary trauma supports, respectful compensation, unified professional learning under a

[1] Center for Coordinating Oregon's Home Visiting Systems Home Visiting Systems Theory of Change Portland, Oregon, Portland State University 2024. Retrieved May 5, 2026.

[2] How States Structure Early Childhood Governance and Why It Matters, Prenatal to Three Policy Impact Center, blog, 03/18/25. Retrieved May 5, 2026.

[3] Turner, et al., "Understanding the Value of Backbone Organizations," Stanford Social Innovation Review, July 2012.

[4] Equity at the Center of Implementation, Center for the Study of Social Policy., 10/10/2019. Retrieved May 12, 2026.

[5] Miles, E., Mefferd, E., Schilder, D., Lucas, K., & Norwitt, J. (2024). Coordinating Services for Families with Children from Birth to Age 5. Urban Institute.

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shared core competency framework, and a career lattice with a corresponding compensation scale.[6]

Intake and Referral: A no-wrong-door intake and referral system has clear processes with standardized tools, shared technology for eligibility/enrollment/transitions, and closed-loop follow-up to confirm connection to services and to inform gap and performance evaluation.

Outcome Measures and Evaluation: Transparent reporting requirements are aligned with evidence-based services. Cultural, linguistic and geographic responsive program options are verified through landscape analyses and parent surveys. Data is used to guide scaling, identify gaps, allocate resources, and measure coordination and long-term outcomes.[7]

Braided Funding: Multiple distinct funding streams are directed toward shared goals and woven together in contracts while maintaining each source's rules and reporting requirements, improving adaptability to local changes, and shifting the administrative burden of harmonizing policies and procedures upstream to state agencies so providers can focus on service delivery.[8]

Governance: Collaborative decision-making structures are established with diverse representation, accountability, and institutional support to rebalance power, align funding and resources to community needs, and improve efficiency, effectiveness, and equity across programs.[9]

Coordination: A neutral convenor or backbone organization connects disparate home visiting programs by convening cross-sector partners to unify funding and implementation

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[6] National Home Visiting Resource Center, Home Visiting Yearbook, 2024. Retrieved May 10, 2026.

[7] Health Resources and Services Administration. "Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Oregon State Profile." U.S. Department of Health and Human Services. Retrieved May 2, 2026.

[8] Hubbard, A. and Wallen, M. Blending and Braiding Early Childhood Program Funding Streams Toolkit: Enhancing Financing for High-Quality Early Learning Programs., The Ounce of Prevention, 2013.; Health Resources and Services Administration. "Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program" Managing Multiple Funding Sources to Support Home Visiting Programs, U.S. Department of Health and Human Services.

[9] Liss, E. (2025). Maximizing impact under any structure: Governance lessons from local early childhood programs. New Practice Lab. https://files.eric.ed.gov/fulltext/ED676657.pdf

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strategies, facilitate effective data sharing, align policies for improved service delivery, and support development and training of a diverse home visiting workforce.[10]

Part II: State Examples of Early Childhood Home Visiting Funding Coordination

Start Early conducted a desk review of state home visiting systems, reviewing state plans, implementation guides and legislative reports. Fourteen (14) states that engage in various aspects of a coordinated early childhood home visiting system were identified as viable examples for Oregon to review. A series of charts provides information on how these states approach the coordination of early childhood home visiting systems with a focus on the components described in Part I of the memo.

[10] Samari, D. and Schmitz, P., Backbone Leadership Is Different: The Skills and Mindset Shifts Needed for Collective Impact, Collective Impact Forum, August 2024

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1. State Home Visiting Governance and Funding Strategy

This chart shows how 14 states structure governance, and finance early childhood home visiting systems. Across the states, common patterns include centralized oversight through health or early childhood agencies, regional or local coordination structures, and braided funding models that combine federal MIECHV funds with state funds, Medicaid, TANF, or other sources.

Regional/Local Control: Colorado, North Carolina, and Iowa utilizes local boards, councils or regional hubs to manage planning and implementation.

Centralized Oversight: Connecticut, Kentucky, New Mexico, and Michigan lean toward centralized, state-level accountability and legislative oversight.

Finance Models: Iowa, Minnesota, Washington and Wisconsin braid funding at the state level to reduce the administrative burden for individual programs.

State	Lead Governance Agency	Key Governance Features	Fiscal & Funding Strategy
Colorado	CO Department of Early Childhood	Mandated regional Early Childhood Councils (31 councils) manage local implementation.	Braids MIECHV, State General Funds, and Child Care Development Block Grants (CCDBG).
Connecticut	Office of Early Childhood (OEC)	Centralized cabinet-level agency oversight birth-to-five; mandated accountability legislation.	Utilizes MIECHV and State General Funds.
Illinois	Department of Early Childhood (July 1, 2026)	State general fund IDHS line item; MIECHV funds are currently aligned under the Bureau of Home Visiting. As of July 1, all home visiting will be under the same agency, with anticipated alignment of program standards and funding	Braids MIECHV and state funding; developed specific cost models for braided funding managed at the local level by individual programs.
Iowa	IA Dept. of Health and	Early Childhood Iowa (ECI) local boards represent all 99 counties for planning.	Managed through MIECHV and State General Funds.

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	Human Services (HHS)		
Kentucky	Cabinet for Health and Family Services (CHFS)	Operates the HANDS program under state-level accountability legislation.	Funded by MIECHV, Medicaid and state dollars for universal outreach to first-time parents.
Michigan	MI Dept. of Health and Human Services (MDHHS)	Strong emphasis on state-level legislative oversight and accountability reports.	Primarily MIECHV and state general funds.
Minnesota	Minnesota Dept. of Health (MDH)	Consolidates multiple grants into a single grant program.	Blends MIECHV, TANF, and state grants (NFP, EBHV) into a unified fiscal stream. Programs that are eligible to bill Medicaid are required to do so.
New Mexico	Early Childhood Education and Care Dept. (ECECD)	Fully integrated department with a centralized intake and referral portal.	Braids MIECHV, State General Funds, and Medicaid reimbursement.
New York	Council on Children and Families (CCF) / Dept. of Health	Interagency coordination focused on health and early learning data sharing.	MIECHV, state funds, and the First 1000 Days on Medicaid fiscal initiative
North Carolina	NC Dept. of Health and Human Services (NCDHHS)	Multi-sector governance involving local Smart Start public-private partnerships.	MIECHV and state-funded Smart Start initiative.
Pennsylvania	Office of Child Development and Early Learning (OCDEL)	Joint administration between Dept. of Education and Dept. of Human Services.	Integrated state-level office managing education and social service funding streams.

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South Carolina	SC First Steps / Children's Trust of SC	Hybrid governance: non-profit leads federal funds; state agency leads local partnerships.	Split fiscal management between SC First Steps (PartC/EI) and Children's Trust (MIECHV).
Washington	Dept. of Children, Youth, and Families (DCYF)	Cross-system data integration, specifically identifying children with special health needs.	MIECHV and State General Funds.
Wisconsin	Dept. of Children and Families (DCF)	Strong partnership with public health (DHS) for alignment on maternal health.	Combination of federal MIECHV and state Family Foundations dollars.

2. State Home Visiting Financing (2025–2026)

This chart shows how the 14 highlighted states currently finance home visiting programs using a mix of federal, state, Medicaid, and other dedicated funding sources. Across the states, common funding foundations include MIECHV, TANF, Title V, and state appropriations, while Medicaid is used in a variety of ways.

Dedicated Revenue Streams*:* Washington and Colorado stand out for using non-traditional taxes and specialized trust funds to insulate home visiting from general budget fluctuations.

The Medicaid Shift**:** States like Connecticut and South Carolina are updating reimbursement rates in 2026 to align with the actual cost of high-quality service delivery.

Private-Public Leverage: North Carolina is unique in its statutory requirement for a 10% local private match, which can contribute to community buy-in and fiscal diversification beyond state and federal grants.

Performance-Based Funding*:* South Carolina is considered a leader in outcomes-based financing, using private investment to scale programs like Nurse-Family Partnership with repayment triggered by proven health improvements. Connecticut has a program rewarding providers for specific qualitative metrics (i.e., reaching underserved communities).

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Other Innovative Approaches: Iowa, North Carolina and South Carolina leverage CHIP HSI funds to support specific models that don't fit perfectly into traditional clinical billing.

State	Federal Core Funding	State General Fund & Local Support	Medicaid Financing Approach	Dedicated or Innovative Revenue Approach
Colorado	MIECHV	Nurse Home Visitor Program Fund	Targeted Case Management (TCM)	Child Abuse Prevention Trust Fund transfers
Connecticut	MIECHV	OEC Strategic Investments	State Plan Amendment for coordinated care	Outcome-based rate add-ons
Illinois	MIECHV & Early Head Start	General Fund line items	State Plan Amendment for preventative services	ISBE Prevention Initiative (Education funds). A set aside attached to early childhood block grant requires a % of new dollars go to birth-to-three programming, including home visiting
Iowa	MIECHV & TANF	Early Childhood Iowa (ECI) Local Boards	Targeted Case Management and CHIP HSI	Community-based block grant allocations
Kentucky	MIECHV	General fund used to provide services for families ineligible for Medicaid	State Plan Amendment	Tobacco Master Settlement Agreement funds used at match for Medicaid
Michigan	MIECHV	General Fund appropriation	Home Visiting established as a core State Plan Benefit	School Aid Act (Education-funded) County Millages: Several Michigan counties have passed local property tax millages specifically for early childhood services including home visiting.
Minnesota	MIECHV & TANF	Strong Foundations grants	State statute mandates a flat reimbursement	Early Childhood Family Education (ECFE) levy

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			rate for evidence-based home visits provided by public health nurses	
New Mexico	MIECHV	ECECD Cabinet-level funding	1115 Waiver	Tobacco Settlement Permanent Fund
New York	MIECHV & TANF	Multi-agency line items (DOH/OCFS)	First 1,000 Days on Medicaid initiative and 1115 Waiver	Combined social service block grants
North Carolina	MIECHV	Smart Start Appropriation	1115 Waiver, Targeted Case Management and CHIP HSI	Required 10% private/philanthropic local match
Pennsylvania	MIECHV	Community-Based Family Support funds	Home Visiting established as a core State Plan Benefit	Marriage certificate and divorce complaints fees
South Carolina	MIECHV	State First Steps allocations	1915b Waiver Targeted Case Management and CHIP HSI	Pay for Success (Social Impact Bonds)
Washington	MIECHV	Home Visiting Services Account (HVSA)	Maternity Support Services and Infant Case Management	Dedicated Marijuana Tax Account
Wisconsin	MIECHV & TANF	State general fund line item	Prenatal Care Coordination and Child Care Coordination (restricted to high-risk pilots)	Highly structured braided funding stream - the Family Foundations Home Visiting program.

3. State Braided Funding and Contracting Method Comparisons

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The following chart details the braided funding sources and contracting methods for the 14 highlighted states. These strategies demonstrate how states coordinate federal and state revenue to support home visiting while managing various local implementation structures.

Fiscal Consolidation: States like Minnesota and New York are increasingly using unified or braided grant applications to reduce the administrative burden on local providers who utilize multiple funding streams.

Regional Intermediaries: Colorado, Iowa, and North Carolina utilize regional or local boards (e.g., ECI or Smart Start) to act as fiscal and governance leads for their respective geographic areas.

Medicaid Integration: Kentucky and New Mexico have established robust Medicaid reimbursement pathways, often requiring state-level policy alignment to ensure home visiting is recognized as a billable health service.

The Single Grant Approach: Minnesota's Strong Foundations model is a leading example of administrative simplification, where three separate funding streams are managed as a single award to local agencies to reduce their reporting burden.

Medicaid Integration: New Mexico and Washington require local providers to become Medicaid-credentialed, effectively braiding clinical health dollars with social support funding to increase the total pool of home visiting resources.

State	Primary Braided Funding Sources	Contract & Procurement Approach	Local Implementing Entities
Colorado	MIECHV, State General Funds, and CCDBG	State contracts with regional hubs and local agencies to drive community-specific delivery. Model intermediaries help local providers navigate multiple funding streams, including MIECHV (federal), state general funds, and private philanthropic dollars.	Early Childhood Councils (31 regions) and Local Implementing Agencies (LIAs).

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Connecticut	MIECHV, TANF, and State General Funds	Centralized state-level procurement through the OEC Division of Family Support Services.	Community-based organizations and health care systems.
Illinois	MIECHV, State General Funds	State contracts directly with Local Implementing Agencies (LIAs) but allows local model selection.	Community-based organizations, school districts, health departments, and some hospitals, often utilizing doula enhancements.
Iowa	MIECHV, TANF and State General Funds	Distributed funding via local citizen-led boards that cover all 99 counties.	Early Childhood Iowa (ECI) Local Boards and designated area providers.
Kentucky	Medicaid (HANDS) and State General Funds	State-level authorization for a universal outreach model reimbursed via Medicaid.	Local Health Departments and contracted HANDS provider agencies.
Michigan	MIECHV and State General Funds	Procurement managed through MDHHS Business Service Centers (BSCs) to coordinate regional services.	Local health departments and non-profit counseling contractors.
Minnesota	MIECHV, TANF and State Funds	Unified "Strong Foundations" grant program that consolidates multiple streams into single awards.	County governments, Tribal nations, and Community Health Boards (CHBs).
New Mexico	MIECHV, State General Funds, and Medicaid	Direct state contracts managed by ECECD, utilizing a centralized referral portal for intake.	33 home visiting provider organizations statewide. Highly centralized at the state level

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New York	MIECHV, TANF, State Funds, and Medicaid (First 1000 Days)	Interagency contracts targeting specific high-need counties for evidence-based models.	County health departments and non-profits (HFNY/NFP projects).
North Carolina	MIECHV and state-funded Smart Start initiative	Contracts managed through a public-private backbone organization (NCPC) and local partnerships.	Local Smart Start Partnerships and community providers.
Pennsylvania	MIECHV and State Funds	Joint administration by Education and Human Services (OCDEL) to align cross-sector funding.	School districts and community-based social service agencies.
South Carolina	MIECHV and State Funds	A hybrid approach split between a state agency (First Steps) and a non-profit fiscal intermediary.	SC First Steps Local Partnerships and MIECHV-funded LIAs.
Washington	MIECHV and State General Funds	Performance-based contracts managed centrally by the Department of Children, Youth, and Families.	Local community-based providers and specialized health agencies.
Wisconsin	MIECHV, TANF, and State General Funds	Strategic alignment between the Dept. of Children and Families and the Dept. of Health Services.	Local health departments and family resource centers.

4. State Home Visiting Governance Models

This chart describes how the 14 highlighted states organize governance for home visiting systems. It identifies each state's lead agency, coordinating entity, and key governance features. Across states, common approaches include leadership by health, human services, or early childhood agencies, with coordination handled through state boards, quasi-governmental organizations, or cross-agency partnerships.

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Centralized Models: (e.g., CT, NM) Governance is housed within a single cabinet-level agency with direct authority over all funding.
Decentralized/Local Models: (e.g., IA, NC, CO) Governance is shared between state agencies and local boards that identify community needs and contract directly with providers.
Intermediary Models: (e.g., WA, CO) The state agency holds the funds but delegates system management—like systems coordination, professional development, and data dialogues—to a neutral nonprofit intermediary

State	Lead State Agency	Coordinating Entity	Governance Detail
Colorado	CDEC (Dept. of Early Childhood)	Implementation coordination is distributed across several non-profit model intermediaries. These organizations act as the specialized coordinating hubs for their respective evidence-based models.	The Colorado Home Visiting Investment Task Force,advises the state's early learning council.
Connecticut	OEC (Office of Early Childhood)	OEC Strategic Planning Div.	Cabinet-level agency reporting directly to the Governor.
Illinois	IDHS (Dept. of Human Services)	Department of Early Childhood (beginning July 1, 2026)	The Health and Home Visiting Committee advises the state's early learning council.
Iowa	Iowa HHS (Dept. of Health and Human Services)	Early Childhood Iowa (ECI) State Board	Decentralized through 38 Local ECI Area Boards
Kentucky	Dept. for Public Health	Regional Quality Assurance Teams	A statewide network of Local Health Departments
Michigan	Dept. of Health and Human Services	MDHHS Home Visiting Section collaborates with Department of Education	Home Visiting Advisory Committee includes parents and providers.

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Minnesota	Dept. of Health & Department of Education	Target Home Visiting Coalition	Shared governance across health and education departments.
New Mexico	Early Childhood Education and Care Dept. (ECECD)	ECECD Home Visiting Unit	Governance centralized at state-cabinet-level status.
New York	NYSDOH (Dept. of Health)	Division of Family Health	Statewide Home Visiting Workgroup includes broad cross-agency stakeholders.
North Carolina	NCDHHS (Dept. of Health and Human Services)	Smart Start (NCPC) & HVPE Collaborative	Smart Start - local partnerships as backbones in each county, MIECHV - managed at state level
Pennsylvania	PA OCDEL (Office of Child Development & Early Learning)	BEISFS (Bureau of Early Intervention Services)	OCDEL is a joint office between the Dept. of Education and Dept. of Human Services.
South Carolina	South Carolina First Steps	SC First Steps Board of Trustees	A public-private partnership authorized by the state
Washington	DCYF (Dept. of Children, Youth, and Families)	Start Early Washington	Public-private partnership between the Department of Children, Youth, and Families (DCYF), Dept. of Health, Start Early Washington and Home Visiting Advisory Committee (HVAC)

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Wisconsin	DCF (Dept. of Children and Families)	Family Foundations Program Team	Lead agency DCF works in partnership with the Dept. of Health Services (DHS).

5. State-to-Local Governance for Home Visiting Systems

The following chart describes the state-to-local governance relationships of 14 states. These structures generally transition from state-level policy and funding oversight to local implementation through regional hubs, county boards, or specialized partnerships.

***Regional Consolidation*:** States like Colorado and Pennsylvania are moving toward regional "hubs" (Councils and ELRCs) to reduce administrative fragmentation.

Citizen-Led Oversight: Iowa and North Carolina utilize citizen-led local boards (ECI and Smart Start) to ensure that funding decisions reflect specific community needs.

Accountability Mandates: New Mexico utilizes statutory frameworks (Accountability Act) to ensure state funding only supports programs meeting rigorous quality standards at the local level.

State	State Lead Agency (Governance)	Local Governance & Implementation Mechanism
Colorado	Department of Early Childhood (CDEC)	Early Childhood Councils are transitioning in 2026 to be the primary local infrastructure, consolidating former coordinating roles to manage regional service delivery.
Connecticut	Office of Early Childhood (OEC)	Local Governance Partners (LGPs) act as community hubs focused on building partnerships and shaping local approaches to family support.
Illinois	Department of Human Services (IDHS)	MIECHV Local Hubs: Regional entities that manage coordinated intake facilitating streamlined access to home visiting within certain regions across different models and funding streams.

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Iowa	Dept. of Health and Human Services (HHS)	Early Childhood Iowa (ECI) Local Boards: 38 citizen-led local boards representing all 99 counties develop community plans and allocate local funding.
Kentucky	Cabinet for Health & Family Services (CHFS)	Division of Service Regions operates through regional offices to manage local family support programs.
Michigan	Dept. of Health and Human Services (MDHHS)	MDHHS coordinates with local agencies and community resource centers through the Michigan Home Visiting Initiative
Minnesota	Minnesota Department of Health (MDH)	Local entities, along with Tribal governments and non-profits, receive state/federal formula grants to implement HV services.
New Mexico	Early Childhood Education & Care Dept. (ECECD)	Guided by the Home Visiting Accountability Act, state-funded local providers manage regional caseloads and reporting.
New York	Office of Children & Family Services (OCFS)	Children & Family Trust Fund: Local non-profits and county-based organizations serve as primary implementing partners.
North Carolina	NCDHHS & NC Partnership for Children	Smart Start Local Partnerships: A statewide network of county-based partnerships that coordinate local early childhood health and learning services.
Pennsylvania	Office of Child Development & Early Learning (OCDEL)	Early Learning Resource Centers (ELRCs): 19 regional hubs serve as a single point of contact for families and coordinate local providers.
South Carolina	South Carolina First Steps	County level local nonprofit affiliates manage state-allocated funds and partner with local agencies to deliver home visiting.
Washington	Dept. of Children, Youth, and Families (DCYF)	DCYF contracts directly with local community agencies.
Wisconsin	Department of Children and Families (DCF)	DCF administers funding to a mix of county human service departments, tribal nations, and local non-profits.

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6. State Home Visiting Intake and Referral

This chart describes how the 14 highlighted states structure entry, intake, and referral pathways for home visiting and related family support services. It shows each state's primary entry point or system name alongside how intake and referral are organized. Across states, common approaches include centralized hotlines, online portals, coordinated intake hubs, regional entry teams, and directory-based resource systems.

***Centralized Intake**:* Many states (CT, IA, NM, WA) use a single statewide hotline or portal to serve as the front door for all families.

***Coordinated Intake** (CI):* This model (prevalent in IL and NC) focuses on a "hub" system where dedicated workers manage referrals across different agencies to ensure a "no-wrong-door" experience.

***Resource Hubs**:* States like MN and MI use broader 211 or resource-finder systems that integrate home visiting into a wider array of social and health supports.

State	Primary Entry Point / System Name	Intake & Referral Structure
Colorado	Family Support Programs Referral List	A directory-based model where families and providers use a statewide list to find and contact specific program partners.
Connecticut	Help Me Grow (HMG) CT	A centralized point of entry utilizing a toll-free information line with care coordinators who screen for developmental concerns and refer to community services.
Illinois	Illinois Coordinated Intake (CI)	A single point of entry only in specific communities where intake workers assess needs, match families to programs, and track referral outcomes.
Iowa	Iowa Family Support Network (IFSN)	A statewide coordinated intake and referral system with a central portal and hotline for both family support and early intervention services.

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Kentucky	Regional Point of Entry (POE)	Referrals are directed to teams at regional offices that determine eligibility and coordinate service plans for families.
Michigan	Michigan 211 / Home Visiting	A centralized system where families answer a few questions online or via 211 to see eligible programs and request contact from home visitors.
Minnesota	Help Me Connect	A statewide resource hub that links families and providers to local public health referral forms and community services.
New Mexico	NM Home Visiting Referral System	A centralized system managed through a web portal and a state-run home visiting
New York	Coordinated Intake & Referral System	A web-based tool for providers and a central hotline used to screen and direct new parents to appropriate services
North Carolina	Wake Connections / HVPE System	Regional coordinated intake portals (e.g., Wake Connections) to capture family needs and link them with a variety of in-home services.
Pennsylvania	Philly Families CAN / Family Centers	County-based coordinated intake and regional Family Center hubs that referrals.
South Carolina	Central Referral Team (CRT) for early intervention Regional Hubs for Children's Trust home visiting services	A hybrid system of centralized intake for early intervention and regional hubs for MIECHV services.
Washington	Help Me Grow Washington and local programs	Provides a centralized resource finder and hotline to help families navigate and access local programs
Wisconsin	MIECHV Coordinated Intake	regional coordinated intake workers assess families and manage the referral pipeline.

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7. State Baseline Reporting & Outcome Measures Comparison

This chart describes the baseline reporting and outcome measures the 14 highlighted states apply across all home visiting models. While most states use the federal MIECHV benchmarks as a foundation, several have scaled these requirements to create a universal floor for all state-funded programs.

In states with a universal or statutory baseline like New Mexico, Iowa, and Michigan,, the following measures are typically required regardless of the specific evidence-based model:

***Standardized* Screenings:** Mandated use of specific tools for Maternal Depression (e.g., PHQ-9), Intimate Partner Violence, and Child Development (e.g., ASQ-3).

Health Benchmarks: Reporting on prenatal care, breastfeeding initiation, and up-to-date well-child visits.

Safety Metrics: Tracking of emergency department visits for injuries and substantiated maltreatment.

Educational Alignment: Data on parent-child interaction and reading/literacy activities in the home.

State	Universal Baseline?	Primary Framework & Outcome Focus
Colorado	Yes	Department of Early Childhood (CDEC) maintains a unified reporting system focused on child health, safety, and school readiness for all state-funded HV.
Connecticut	Yes	Office of Early Childhood (OEC) uses standardized performance indicators across all state-funded models, focusing on maternal health and developmental screenings.
Illinois	Partial	Highly standardized for all MIECHV-funded programs. State-only funded programs are being moved toward the same performance measures.
Iowa	Yes	Early Childhood Iowa (ECI) mandates a set of statewide indicators that all local areas and models must report.
Kentucky	Yes	The HANDS program and other models align reporting with state health outcomes and MIECHV standards.

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Michigan	Yes	The Michigan Home Visiting Initiative uses a set of Common Indicators required for all state-funded programs.
Minnesota	Yes	Dept. of Health requires standardized screening and outcome reporting across all models.
New Mexico	Yes (Statutory)	The Home Visiting Accountability Act legally requires a common data framework for all programs to track birth outcomes and school readiness.
New York	Yes	Office of Child and Family Services uses a common evaluation framework across most models, measuring positive parenting and economic self-sufficiency.
North Carolina	Yes	Smart Start and the state's MIECHV system share a common set of benchmarks for early childhood health and learning. MIECHV funded programs also report the federally required benchmarks.
Pennsylvania	Yes	Office of Child Development and Early Learning maintains a standard system that collects data on 19 MIECHV-aligned performance indicators from all contracted providers.
South Carolina	Yes	South Carolina First Steps applies a standardized evaluation framework to all models, focusing on child maltreatment and kindergarten entry.
Washington	Yes	Dept. of Children, Youth, and Families uses standardized metrics for well-child visits, safe sleep, and maternal health as a baseline for all programs in its provider network.
Wisconsin	Yes	Dept. of Children and Families applies a comprehensive baseline of 19 performance and system outcomes to all state-supported models.

8. Early Childhood Home Visiting Professional Development Frameworks

This chart describes the early childhood workforce registries and professional development (PD) frameworks across these 14 states. It highlights the specific platforms and features used to support and track the qualifications of professionals in home visiting roles.

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National Alignment: Many states (SC, MN, CT) utilize the National Family Support Competency Framework and the "My Career Compass" tool developed by the Institute for the Advancement of Family Support Professionals to standardize home visitor training.

Credentialing: The Home Visitor Child Development Associate (CDA) serves as a common cross-state baseline for professionalizing the workforce.

Specialized Training: Beyond basic orientation, states are increasingly funding enhancement training, such as Infant and Early Childhood Mental Health (IECMH) and specialized screenings like the Ages & Stages Questionnaire (ASQ).

State	Workforce Registry	Professional Development Platform & Notable Features
Colorado	Colorado Shines PD	Employs the Home Visitor Child Development Associate (CDA) credential as a primary benchmark, requiring 120 hours of formal education and 480 hours of professional experience.
Connecticut	Early Childhood Professional Registry	Utilizes a voluntary Core Competency Framework specifically for home visitors, consisting of 150 competencies across 10 domains such as cultural responsiveness and family relationships.
Illinois	Gateways to Opportunity	Features a career lattice that explicitly includes Home Visitor roles. Start Early Professional Learning Network provides specialized state-supported training including Doula Enhancement for Home Visiting.
Iowa	I-PoWeR	Centralizes PD through the AEA Learning Online portal, which offers self-paced training and graduate credit for early childhood professionals in partnership with state agencies.
Kentucky	TRIS (Training Records & Info System)	Requires all early childhood staff to complete a mandatory 6-hour health and safety training within 90 days; TRIS tracks annual training and state certifications.
Michigan	MiRegistry	The Michigan Home Visiting Initiative maintains a specialized PD infrastructure, including a web-based training catalog mapped to established core knowledge areas.

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Minnesota	Develop	Offers a Career Compass tool for personalized learning maps. Provides specific state-led training in evidence-based tools like PICCOLO and CUES.
New Mexico	ECLN Portal	Managed by the Early Childhood Education and Care Department (ECECD), which maintains a dedicated home visiting training calendar and online training modules.
New York	The Aspire Registry	Part of the New York Works for Children system, Aspire provides a free professional portfolio to track credentials and register for statewide PD opportunities.
North Carolina	WORKS	PD is heavily integrated with specific models with workforce data linked to statewide MIECHV outcomes dashboards.
Pennsylvania	PA PD Registry	The PA Early Learning Keys to Quality Career Lattice defines professional pathways for home visitors, requiring a CDA or equivalent for Level III advancement.
South Carolina	SC Endeavors	Partners with the Institute for the Advancement of Family Support Professionals to offer digital tools for online skill assessment and training.
Washington	MERIT	Tracks all required health, safety, and foundational training for early learning professionals through its managed education and registry information tool.
Wisconsin	The Registry	Features a Professional Development Approval System (PDASystem) that aligns all training curricula with Wisconsin's Core Competencies and adult learning principles.

9. Workforce Supports: Reflective Supervision and Well-Being

The following chart outlines the reflective supervision, supports available to home visitors in the 14 highlighted states. All states require some form of reflective supervision, many referring to the model specific standards in this category.

***Funding Intersections**:* Many states leverage the Social Services Block Grant (SSBG) and MIECHV to fund professional development and related supports that other funding streams might not cover.

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The Parallel Process: There is consensus that a supervisor's ability to hold a home visitor's emotions directly impact the visitor's ability to support a parent.

Standardization: States like Washington and Connecticut are moving toward official endorsements to codify the quality of reflective supervision.

State	Reflective Supervision (RS) Support	Secondary Trauma & Well-being Supports
Colorado	Provides a national registry for endorsed RS/C providers to support infant mental health practitioners.	Conducts safety and risk assessment audits that address burnout and secondary trauma.
Connecticut	Utilizes the CT-AIMH Endorsement® system as the primary driver of a statewide RS structure. Program contracts explicitly state RS time is non-negotiable and cannot be replaced with field visits.	RS is provided by a formally endorsed practitioner. Home visitors use a rating tool to provide feedback on their experience and whether the RS provided is meeting their needs.
Illinois	Programs are required to adhere to model expectations for reflective supervision. There is a minimum number of hours required (72/year; 6 – 8/month). There are specific RS skill/knowledge requirements for home visiting supervisors	Programs are funded to access Infant and Early Childhood Mental Health Consultants (required for IDHS and MIECHV programs, allowed for ISBE programs).
Iowa	State mandates specific staffing structures to ensure supervisors have the capacity for deep reflective work. If the complexity of the families served or the inexperience of the staff warrants more intensive oversight the ratios may be reduced	Offers webinars on managing traumatic stress and practicing cultural humility in family interactions.
Kentucky	Encourages RS through professional development tracks in partnership with child welfare agencies.	Structured supervision models, statewide trauma-informed initiatives, and wellness initiatives managed through partnership with universityy

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Michigan	Integrates RS principles into statewide stakeholder groups like the Child Welfare Partnership Council.	Employs Motivational Interviewing training and multidisciplinary approaches to reduce workforce stress.
Minnesota	Uses a research-based tool to define and measure the active ingredients of a reflective session. A high value is placed on culturally responsive RS.	Provides intensive permanency services focused on trauma, grief, and loss for children and staff.
New Mexico	Utilizes Social Services Block Grant (SSBG) funds to facilitate family support and practitioner training.	Focuses on trauma-informed post-adoption services for families and the providers serving them.
New York	Integrates RS into intensive family service models like ParentCorps.	Established the 2025 Task Force on Adverse Experiences and Trauma Prevention to guide policy.
North Carolina	Leverages centralized care coordination models to screen for provider and family mental health needs.	Participates in the "Listening to Women" (LTW) toolkit focusing on maternal mental health and IPV.
Pennsylvania	Focuses on building "relational leadership" and data-informed support for staff well-being.	Offers tuition support for students to address secondary trauma in child and family services.
South Carolina	Supports family-led organizations through HRSA-funded Family-to-Family (F2F) Health Information Centers.	Provides training in family support services that address historical and secondary trauma.
Washington	Developed the Region X Reflective Supervision Guide to standardize practice across the state.	Implements Learner Centered Coaching (LCC) to help supervisors address staff secondary trauma.
Wisconsin	Promotes RS through treatment foster care and intensive permanency services.	Focuses on building resilience for children and providers via trauma-informed care models.

10. State System Standardization

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This chart provides a description of how the 14 highlighted states have approached a baseline or common floor, largely built upon the MIECHV framework. However, states vary significantly in their use of neutral backbone organizations - non-profit or quasi-governmental entities that coordinate the system - versus state-led governance models.

Funding: All states utilize braided funding models, combining federal MIECHV with state general funds, TANF, and often Medicaid.

Outcome Measures: Baseline reporting for all 14 states includes the six federal MIECHV benchmarks: (1) Maternal and Newborn Health, (2) Child Injury/Maltreatment, (3) School Readiness, (4) Domestic Violence, (5) Economic Self-Sufficiency, and (6) Coordination/Referrals.

Workforce Supports: States increasingly utilize a Career Lattice approach, where professional development is tracked through a statewide registry (e.g., Develop in MN, MERIT in WA) to ensure wage parity and advancement.

CQI: Continuous Quality Improvement is typically managed through state-level Learning Collaboratives that use data-driven small tests of change (Breakthrough Series model) to improve family retention and engagement.

State	Governance & Backbone Entity	Intake & Referral Structure	Workforce & CQI Highlights
Colorado	CDEC (Dept. of Early Childhood) acts as lead. The Colorado Home Visiting Coalition provides advocacy and coordination support.	Coordinated through local Early Childhood Councils and regional partnerships.	Uses Colorado Shines PD Information System; CQI focuses on school readiness and health.
Connecticut	Office of Early Childhood (OEC); single cabinet-level lead agency with no external backbone.	Centralized via Help Me Grow CT, acting as the "no-wrong-door" entry point.	Mandates standardized screenings (maternal depression/IPV) as baseline outcomes.
Illinois	Start Early provides professional development, acts as a funding intermediary	Utilizes regional Coordinated Intake (CI) hubs and the CI Assessment Tool	All state-grantees get their core HV and doula training from a single entity - Start Early Professional Learning

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	and developer of innovative pilots, and provides policy support in partnership with state agencies.	(CIAT in some regions. Remaining regions manage intake and referral by program.	Network, using a Breakthrough Series CQI model.
Iowa	Early Childhood Iowa (ECI); a public-private partnership backbone.	Centralized via the Iowa Family Support Network and local ECI boards.	Mandatory state certification for all practitioners; unified data tracking across models.
Kentucky	The Governor's Office of Early Childhood serves as the central coordinating entity.	Primary entry through Regional Points of Entry (POE) for family support services.	Tracks all training via the TRIS (Training Records & Info System) registry.
Michigan	Michigan Home Visiting Initiative (MHVI); state-led multi-agency hub.	Coordinated intake pilots in high-risk communities; integration with Michigan 2-1-1.	Workforce supports include the MiRegistry and model-specific fidelity monitoring.
Minnesota	Dept. of Health (MDH); direct state lead for family home visiting.	Referrals managed through local Community Health Boards and Tribal nations.	Monthly CQI Connect and Learn sessions
New Mexico	ECECD (Early Childhood Education & Care Dept.); cabinet-level lead agency.	Centralized AIE (Apply, Interest, Enroll) Portal and a dedicated HV hotline.	Home Visiting Accountability Act mandates common outcomes across all state funds.
New York	NYS Council on Children & Families; state coordinating entity.	Decentralized local intake with moves toward a more coordinated regional system.	Workforce tracked via The Aspire Registry; focuses on maternal mental health outcomes.
North Carolina	Smart Start (NC Partnership for Children); statewide non-profit backbone.	Smart Start Local Partnerships manage community-specific intake and referrals.	Uses the NC WORKS registry; CQI is aligned with Smart Start's accountability system.

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Pennsylvania	OCDEL (Office of Child Development & Early Learning); joint state agency.	Entry points through 19 regional Early Learning Resource Centers (ELRCs).	Features a tiered Career Lattice within the PA Professional Development Registry.
South Carolina	SC First Steps; quasi-state backbone created by legislation.	Managed by County First Steps Partnerships that coordinate with local providers.	Partners with the Institute for the Advancement of Family Support Professionals for PD.
Washington	Start Early (backbone) partners with DCYF to manage the HVSA.	Integrates with Help Me Grow WA for local community-based resource matching.	Professional development resources centralized via the MERIT data system.
Wisconsin	Dept. of Children and Families (DCF); direct state agency lead.	Managed through local health departments and tribal nations; move toward CI.	Employs a Statewide CQI Team that conducts monthly Plan-Do-Study-Act cycles.

Conclusion

Taken together, these examples show that effective coordination in early childhood home visiting depends on a clear set of system functions carried out consistently across agencies and communities. States with stronger systems tend to align funding, establish shared outcomes, support a skilled and sustainable workforce, and create intake and referral pathways that are easier for families to navigate. They also balance statewide consistency with local flexibility by defining core components while allowing adaptation to community context, ensuring family directed, culturally and linguistically respectful programming. For Oregon, the key lesson is that building a more coordinated home visiting system will require both structural alignment and shared stewardship—supported by neutral

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convening, transparent data use, and governance that centers equity, accountability, and family access.

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Appendices

A Brief History of Oregon's Home Visiting System

Historical Evolution & Infrastructure

Legacy of Care: Oregon's home visiting transitioned from early 20th-century public health nursing into a structured, evidence-based system for maternal and child health in the 1990s, with MIECHV marking the beginning of federal funding for expansion of evidence-based home visiting services in 2010. Oregon has historically been a national leader, with several home visiting models such as Nurse Family Partnerships, Healthy Families Oregon, and Early Head Start for several years prior to the federal investments.

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Universal Access: With the 2019 expansion of Family Connects, Oregon became the first state to offer universal newborn home visits. As of May 2026, 13 of Oregon's 36 counties are successfully offering Family Connects. The program continues to expand as part of the state's goal to build a universal, equitable home visiting system. The current service areas include: *Central Oregon*: Crook, Deschutes, and Jefferson; *Willamette Valley:* Benton, Lane, Linn, Polk, and Yamhill; *Portland Metro:* Multnomah and Washington; *Coastal & Southern Oregon:* Lincoln and Douglas; *Eastern Oregon:* Malheur.

Centralized Coordination: Launched in 2024, CCOHVS serves as a neutral backbone to link program models, support alignment of funding and policies, and support equitable practices throughout the systems and within programming—representing decades of both formal and informal cross-agency partnership. A wide network of state and local agencies, home visiting programs and staff, and families and community members work with CCOHVS to ensure equitable access to early childhood home visiting services that meet family needs, characteristics, and strengths. The Early Childhood Home Visiting Theory of Action, developed collaboratively with home visiting partners across the state and informed by the 2024 statewide Home Visiting Landscape Report, drives this work.

Cost Modeling & Sustainability

Comprehensive Analysis: Completed in early 2026 by Prenatal to Five Fiscal Strategies, new cost modeling estimates true costs of home visiting services and systems coordination at the state and local levels.

Key Cost Factors: The model incorporates staff salaries, benefits, caseload sizes, supervision ratios, travel, and professional development.

Inclusive Programming: Funding estimates specifically include costs for program-specific infrastructure and linguistically/culturally representative services.

Future Application: This data can be used to structure local program contracts and project the funding required to sustain and expand the system.

Strategic Vision (Raise Up Oregon 2024-2028)

Overarching Goals: The system aims to improve health outcomes for mothers and babies, improve family economic stability, increase family leaders' understanding of child development, and provide early learning experiences for children.

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Priority Areas: The statewide strategic plan identifies system coordination, local implementation, and governance as the categories with the highest number of goals. Workforce support and professional learning opportunities are also emphasized.

Collaborative Governance: There is a recognized need for a structure that ensures both family and provider voices are represented at multiple levels of the system.

Home Visiting Specific: Prenatal and early childhood home visiting services are central to this plan, with 18 specific strategies in the plan naming home visiting and the need for improved cross system coordination.

State Profiles: Iowa, North Carolina, Washington and Wisconsin.

Start Early Conducted interviews with home visiting systems leaders in four states, and then created profiles of these states for a deeper dive beyond the information provided in Part II of the memo.

State: Iowa

Date: Monday, April 13, 2026	**Interviewee Name(s):** Amanda McKee (State funded EC funding CB CAP funding), PJ West, Family Services

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	Program Chief (MCVEE Lead); Alexius Aguiar, Early Childhood TA Manager (State funding/MOE)
Interviewer Name: Megan Turner	**Support Staff Name:** Judy Reidt-Parker

Overview:

A mix of federal and state funding managed through Early Childhood Iowa. Early Childhood Iowa (ECI) is a state-led partnership between the Department of Health and Human Services and local community boards." (ECI) was established in 1998, originally known as "Community Empowerment". The state initiative has existed for over 25 years, aimed at improving the well-being of children ages 0-5 through local and state partnerships.

Models supported with this funding are:

- Healthy Families America
- Nurse Family Partnership
- Early Head Start
- Parents as Teachers
- Family Development and Self-Sufficiency (FaDSS)

Design, Governance, and Decision Making

The state system governance bodies are the ECI State Board and the Stakeholders Alliance. The State Board provides oversight of state and local efforts while serving as an advisory group to the Iowa legislature and the Governor's Office. The Stakeholders Alliance provides advice regarding the coordination of early childhood activities in the state and is made up of public and private stakeholders; the Alliance branches into several component groups and subgroups focused on a range of expertise.

The local system consists of 38 area Early Childhood Iowa Boards representing all 99 counties. Each area has a citizen-led board to support activities to promote collaboration and develop systems in the community for young children and their families. In their role, ECI area boards develop a comprehensive community plan that includes data gathered through various assessment processes. This information assists the community in planning, funding, professional development and overall support of early childhood programming in the community.

Over the last three years multiple child and family serving agencies have merged, with most programs sitting under one department- HHS - and one division - Family Well Being and Protection. HHS works closely with the Iowa Department of Education (IDE), which is

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where Part C/IDEA is housed. IDE puts funding into the shared fund that HHS manages for home visiting. This funds state wide coordinated intake. HHS and IDE have letters of Agreement for how the funding is managed.

Many decisions are brought for discussion to the state advisory bodies (see description above). The current structure allows for a lot of flexibility at the local level. The state is working toward a minimum required investment per slot for evidence-based home visiting ($5,000) and promising practices ($4,000). There is some push back from local implementers that prevents them from getting the most out of the funding. The State's perspective is that lower amounts per slot result in overloading staff with too many cases, and lower compensation. There has been some cost modeling done using the free version developed by Prenatal to Five Fiscal Strategies. The State is very interested in conducting a more comprehensive cost modeling.

Funding Structure

Key funding streams include the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant, Medicaid, the Title V Maternal and Child Health Block Grant, TANF, state general revenue, and Tobacco Settlement funds. Some of the state funding is part of the ECI funding that can be used for other early childhood programs other than home visiting. Iowa pools these funds and then distributes them either through direct contracts with providers or through the local ECI boards.

Expected Legislative Changes: Current legislative efforts (HF 2712) are aimed at centralizing some of the funding managed at the local systems level under state control to maximize federal funding, specifically the Family First Prevention Services Act. While this bill was advanced through the House committee, it has been slowed down with an amendment requiring a study commission to determine the most efficient way to move the funding to the State's oversight.

Funding Interface

The MIECHV funds are prioritized for the 17 counties identified in the needs. Contracts with local boards and individual providers may include MIECHV and state funds. It's important to pay attention to tracking the allocations. Many contractors are contracted with multiple funding streams, so making sure there's clear guidance around cost allocations and fiscal reporting is important.

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There are currently 70 contracts with 44 agencies. Of those 44 agencies, a few are already funded with MIECHV and other sources. There's significant billing and reporting duplication, and HHS is working to standardize reporting, training requirements and overall reducing the administrative burden.

These are annual contracts with the availability to receive same funding for up to three years and can expand to five years. State staff anticipate when local funds are moved to the state (see expected legislative changes described above) there will be a new round of competitive bidding, but currently funds are put out for bid every 5 years.

Data and Accountability - ROI and Outcomes

The outcomes and reporting are aligned to MIECHV standards. State staff perspective is that it's important to collect evidence that tells the story of children and families thriving when they participate in home visiting. The State uses the DAISEY software system which was designed and is managed by University of Kansas. DAISEY provides reports for monitoring home visits, task timelines and it can track data/outcomes for all the families in the system.

Implementation

State and local funder relationships can be challenging, but everyone tries to stay focused on wanting the best outcomes for children and families. The State did make it non-negotiable that MIECHV standards would be required for all home visiting programs funded with public dollars. Some county foundations support local programs. The state has worked with those funders to simplify the reporting requirements, highlighting that most of what they were looking for could be found in the MIECHV standards. Many programs are isolated because of the rural nature of much of the state – this shared approach reduces the isolation by creating a peer community with shared indicators.
Recent conversations with providers have been around wage parity and equity in service delivery. They have hosted panels of bilingual staff talking about workplace conditions that make them stay – compensation, reflective supervision and supportive supervisors, autonomy and a sense of competence. Another panel of parents – both Spanish speaking and English speaking – talking about what makes participating in the program desirable. The hope is that programs will learn from these events and use the information to make improvements in workplace conditions and service delivery. The State plans to provide guidance on how to ensure linguistically and culturally respectful programming. Additionally, how to support bilingual staff – there is extra time and energy spent by that staff person so the caseload should be lower.

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State: North Carolina

Date: Thursday, March 26, 2026	**Interviewee Name(s):** Greer Cook
Interviewer Name: Megan Turner	**Support Staff Name:** Judy Reidt-Parker

Overview:

North Carolina operates a diverse and evolving system that is currently shifting from a fragmented collection of programs toward a more unified, statewide coordinated system. The system is characterized by its decentralized governance, a variety of evidence-based models, and recent efforts to pioneer Medicaid-funded home visiting.
Models funded include:

- Family Connects
- Nurse-Family Partnership (NFP)
- Healthy Families America (HFA)
- Parents as Teachers (PAT)
- Early Head Start (EHS)
- Attachment & Biobehavioral Catch Up (ABC)

A key policy priority is the expansion of Family Connects as a universal entry point that feeds into more intensive models like NFP or HFA. However, funding remains a challenge. For the 2024–2025 fiscal year, the state did not renew $2.5 million in one-time funding previously allocated for the Nurse-Family Partnership, highlighting the ongoing reliance on a mix of non-recurring state funds, federal MIECHV grants, and local Smart Start investments.

Recently there has been a reorganization within the North Carolina Department of Health and Human Services (NCDHHS), creating a Division of Child Well-Being. While it is a division rather than a standalone cabinet-level Department, the reorganization was a massive structural shift designed to end the siloed nature of child services. Launched officially in 2022, it reached a major implementation phase in 2025–2026 with a focus on whole-child health and a total overhaul of the child welfare system.

The DCFW was created by pulling programs out of the Divisions of Public Health, Social Services, and Mental Health. It centralizes four primary pillars:

- Whole Child Health: Houses home visiting, school health, and child behavioral health.
- Early Intervention: Manages the Infant-Toddler Program (Part C of IDEA).
- Food and Nutrition Services: Administers SNAP (FNS).
- Community Nutrition Services: Manages WIC and the Child and Adult Care Food Program.

<u>Design, Governance, and Decision Making</u>
The governance of home visiting in North Carolina is decentralized with three primary entities that manage funding, policy, and implementation.

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- NC Department of Health and Human Services (NCDHHS): The Division of Public Health (DPH) serves as the lead agency for the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program (Work, 2014). NCDHHS provides statewide oversight for data collection, federal reporting, and quality assurance for MIECHV-funded sites.
- Smart Start (The North Carolina Partnership for Children): This is a unique statewide public-private initiative that operates through 75 local partnerships covering all 100 counties (Watts, 2023). Local partnerships receive state appropriations and have the autonomy to select and fund home visiting models that meet their specific community needs (Porter, 2010).
- Established as a backbone organization, the HVPE Collaborative acts as a neutral system-building entity. It aims to unify the fragmented landscape of home visiting by aligning standards, professional development, and assessment across all funded models. Its board is a multi-stakeholder body that provides strategic guidance, aiming to create a seamless continuum of support from the prenatal period through age eight, with a family advisory board.

Funding Structure

The two primary funding sources for home visiting in North Carolina, MIECHV and Smart Start, differ significantly in their administration, eligibility requirements, and geographic scope.

MIECHV Funds

The North Carolina Department of Health and Human Services (NC DHHS), specifically the Division of Child and Family Well-Being (DCFW) administers the MIECHV funds.7 sites that serve 28 counties are currently funded. As of the 2024 Needs Assessment, 64 counties are identified as "high-risk" and eligible for MIECHV-supported services. North Carolina has primarily met federal match requirements using existing state general fund allocations specifically designated for the Nurse-Family Partnership program.

Smart Start Funds

Smart Start is a state-funded initiative - a network of 75 local non-profit partnerships serving all 100 North Carolina counties. The North Carolina Partnership for Children (NCPC) oversees the network, but funding decisions for specific programs are made by Local Partnership Boards. These funds provide flexible funding for early childhood initiatives (0–5 years) based on specific community needs, including child care, health, and family support. Statewide. Smart Start ensures home visiting or parenting education options are available in all 100 counties, filling gaps where federal funding like MIECHV is not present. Smart Start funds can be used for a wider range of models, including promising practices. Under state legislation, local partnerships must spend 70% of their direct service dollars on child care-related activities. Home visiting is funded out of the remaining portion. A local agency might use MIECHV to fund the slots for a Nurse-Family Partnership program while using Smart Start funds to provide supplemental parenting education or to support families that do not meet the strict MIECHV risk criteria.

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Funding Interface

In North Carolina, the braiding of home visiting funding occurs at both the state and program levels, but the responsibility for the complex, day-to-day management of these funds falls most heavily on local program providers and Smart Start partnerships. North Carolina's model is highly decentralized, requiring local organizations to piece together multiple funding streams to achieve full sustainability. If a program receives multiple funding streams at state and county levels, they must make sure that cost allocations are clear and attributed to the correct funding source. They must send supporting documentation to the state monitoring staff who approve the expenditures. The burden and risk is fully on the local program.

State-Level: Strategic Braiding & Match Management

- Federal Match: The state identifies specific state general fund allocations (notably those directed to the Nurse-Family Partnership) to serve as the required 25% match for federal MIECHV funds.
- Inter-Agency Blending: The state also uses Title V (Maternal and Child Health Block Grant) and TANF funds to support the broader system infrastructure, such as state-level training, technical assistance, and data systems.

Program/Local Level: Operational Braiding

The actual heavy lifting of braiding occurs at the community level, primarily through the Smart Start network and local program sites.

Each of the 75 local Smart Start partnerships acts as a fiscal hub. They receive a base allocation of state funds and braid these with:

- Local County Funds: Many programs receive supplemental funding from county commissioners.
- Philanthropic Dollars: Private grants from local foundations often fill gaps in reach that federal funds cannot cover.
- Medicaid Reimbursements: Programs like Family Connects and Nurse-Family Partnership are increasingly navigating the braiding of Medicaid billing for clinical services alongside grant funding for non-clinical home visiting components.

North Carolina's HVPE System Action Plan emphasizes moving more of this burden away from the local program level. The goal is to create a more coordinated funding plan where the state's neutral backbone staff does the work of aligning eligibility and reporting requirements, making it easier for local programs to access a braided pot of money without having to navigate five different reporting systems.

Data and Accountability - ROI and Outcomes

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As of 2025–2026, North Carolina has been rolling out a unified HVPE Outcomes Dashboard. This tool is designed to braid data from multiple sources. The ultimate benchmarks for the home visiting system are tied to the state's Healthy North Carolina 2030 objectives, such as reducing the racial disparity in infant mortality and increasing third grade reading proficiency.

Historically, reporting was fragmented by funding stream (e.g., MIECHV vs. Smart Start), but the state is now transitioning to a unified framework led by the Home Visiting and Parenting Education (HVPE) System Collaborative. Under the HVPE System Action Plan, North Carolina is establishing a core set of common outcomes that apply across all program models and funding sources. A combination of programmatic and systems outcomes have been established.

- Targeted Outcomes: Reducing child maltreatment, improving maternal and infant health (specifically infant mortality), enhancing school readiness, and increasing family economic self-sufficiency.
- System Indicators: Tracking reach (percentage of families served), equity (disparities in access), and coordination (success of referrals between agencies).

For programs receiving federal MIECHV funding, North the six federal benchmark areas still apply and are required measures these programs report on.

Because the Smart Start network funds a large portion of non-MIECHV home visiting, there is a Smart Start Community Indicators Dashboard. This dashboard tracks outcomes at the county level, allowing local partnerships to report on specific performance measures (e.g., the percentage of children reaching age-appropriate developmental milestones) that align with state-level health goals.

Implementation

Caseloads vary from 8 to 40 families, with eligibility based on risk factors, income, or universal access. Programs target maternal and child health, developmental concerns, trauma, and family support, emphasizing early intervention and community-wide outcomes.

One of the functions of the state MIECHV staff is to facilitate the NC Home **Visiting Consortium**. Since 2015 – prior to that it was HVPE. They are trying to revitalize the consortium, which fell apart during the pandemic – currently meeting every two months instead of quarterly. The Consortium's primary functions include encouraging coordination between different home visiting models and stakeholders across the state, providing training and educational materials to home visiting professionals and programs, identifying and implementing research-based standards for home visiting services, supporting the development of enhanced referral systems to better connect families with appropriate programs, and conducting research and collecting data to monitor program performance and community impact. This is focused primarily on MIECHV funded programs.

The interface between the NC Home Visiting Consortium and the HVPE is best understood as an integration of on-the-ground expertise into a "neutral backbone" administrative framework. The

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HVPE System serves as the overarching governance framework, while the Consortium functions as the primary vehicle for stakeholder engagement and practitioner-led collaboration.

- The HVPE System is the statewide infrastructure designed to coordinate funding, data, and policy across multiple agencies (DHHS, NCPC, etc.). It acts as the backbone that ensures the system is equity-centered and sustainable.
- The Consortium provides the technical and model-specific expertise. It ensures that the policies developed at the HVPE level are practically applicable for the various evidence-based models operating in the field.

The North Carolina Partnership for Children is the parent organization for the HVPE. It facilitates the interface with the Consortium by:

- Coordinating Workgroups: The Consortium members often lead or populate the HVPE workgroups focused on specific system pillars, such as Data & Evaluation, Professional Development, and Public Awareness.
- Neutral Facilitation: Much like the neutral backbone model used for coordinating systems in other states, the HVPE System uses the Consortium to ensure that no single program model dominates the policy agenda.
-

The two entities interface primarily through three functional channels:

- Strategic Planning: The Consortium's historical data and needs assessments directly inform the HVPE System's Strategic Plan, ensuring that the statewide plan reflects the actual capacity and gaps identified by local programs.
- Braided Funding Oversight: While the HVPE System manages the high-level braiding of MIECHV and Smart Start funds, the Consortium provides the feedback loop necessary to understand how these funding streams interact at the point of service delivery.
- Data Integration: The Consortium supports the HVPE goal of creating a unified data dashboard. By aligning the various data requirements of different models into a more cohesive system, the Consortium helps the HVPE System move toward real-time system performance tracking

<u>Lessons Learned</u>

The interface between the state agency administering the MIECHV funding and the NCPC has been fraught with challenges. The HVPE was launched in 2021, but there were some staffing issues, significant turnover. And then the pandemic stalled everything. The recent reorganization also drew the attention of the state staff away from deeper coordination. Things are picking up again, and hopefully there will be enough time to formalize the structure and not rely on specific individuals to keep the work moving.

A centralized intake system has been a point of conversation for a long time. The state's current implementation of HIPPA policy has caused this to stall. One centralized referral source is the NC Care 360 – it's a great system for practitioners and families but is underfunded.

There needs to be strong fiscal oversight for all sides of the program, not just MIECHV side of things. Programs need to understand the reporting requirements, and the state needs to fully understand

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how programs deliver services, what changes they might need to make to be relevant to their community, and how that influences running the program overall.
The site visit from HRSA in 2021 was difficult – COVID created a lot of challenges, including trying to get data from state partners. Due to staff turnover, there was a lack of institutional knowledge that impacted that review. 2024 was the most recent review – 100% rating across the board. That represents a significant effort to improve program management and implementation. Internally the state staff responsible for the MIECHV funds have established a much stronger relationship with the financial department.

State: Washington

Date: 5//2026	**Interviewee Name(s):** Cassie Morley
Interviewer Name: Megan Turner	**Support Staff Name:** Judy Reidt-Parker

Overview:

Washington State operates a coordinated, public-private home visiting system designed to support expectant parents and families with young children. This system is centered on the Home Visiting Services Account (HVSA), which serves as the primary funding and coordination vehicle. Established by the state legislature in 2010, the HVSA is a partnership between the public and private sectors and allows the state to braid various funding streams, including federal MIECHV (Maternal, Infant, and Early Childhood Home Visiting) funds, TANF, dedicated cannabis funds, state general funds, and private philanthropic investments.

It is j administered by the Department of Children, Youth, and Families (DCYF), the state agency providing governmental oversight, policy direction, and federal grant management. The Department of Health provides the structure for reporting on outcome measures and the related data, and Start Early Washington, a nonprofit partner that acts as the systems convenor, provides technical assistance, coaching, and professional development to local programs.

Service Delivery Models

- Nurse-Family Partnership
- Parents as Teachers (PAT):
- Parent Child +
- Early Head Start
- Family Spirit
- Outreach Doula Program
- Early Steps to School Success

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- STEEP

Design, Governance, and Decision Making

Washington's home visiting system is overseen by a triad of organizations, each handling a specific pillar of the system: policy, implementation, and data. The system is managed through a collaborative framework involving three main entities:

- Department of Children, Youth, and Families (DCYF): Acts as the lead fiscal and contracting agency. DCYF is responsible for procuring services through competitive bids, negotiating contracts with local providers, and managing federal (MIECHV) and state funding streams.
- Start Early Washington: Functions as the Implementation Hub. This nonprofit partner provides ground-level support, including technical assistance, coaching program supervisors, and professional development for the workforce. Start Early also engages in policy and advocacy work for home visiting overall as well as the HVSA.
- Department of Health (DOH): Manages data and evaluation. DOH oversees the data collection systems that track family outcomes and ensures the state meets the rigorous performance benchmarks required by federal and state law.

The *Home Visiting Advisory Committee* (HVAC) is mandated by state law to advise the partnership on:

- The equitable distribution of funds to local communities is important.
- Research and system-wide improvements.
- Strategies for workforce development and expanding service capacity.

The HVAC includes a diverse range of stakeholders, including program providers, advocates, and state agency representatives, ensuring that administrative decisions are informed by those directly doing the work. Successful implementation of this committee and its processes have been inconsistent. Primarily, this committee provides advice on the distribution of new home visiting resources.

Funding Structure

Home Visiting Services Account (HVSA) was formed by legislation, DCYF distributes the funding. HVSA acts as a braided account, meaning the administrators can combine diverse types of money into one contract to simplify things for local providers. As of 2026, this includes:

- Federal Funds: Primarily MIECHV grants, TANF,
- State Funds: General Fund appropriations and dedicated accounts (such as the Dedicated Marijuana Account).
- Private Philanthropy: Contributions from private donors and foundations that are leveraged alongside public tax dollars. These funds support the systems coordination work.

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Funding Interface

Home Visiting Services Account (HVSA) formed by legislature distributed by DCYF – the state funds give durable flexibility to the system that could lead to changes based on changing demographics, community need, and state priority. In practice, this has not been fully realized in the past decade, plus since the HVSA was created.

Funding streams are braided at the contract level, although enrollment remains specific to each individual source. Because reporting requirements differ across streams, implementation can be complex; to ensure consistency and compliance, many programs apply the most restrictive approach (MIECHV) across the entire program. Some programs manage this complexity by assigning staff to specific funding streams. These operational choices significantly affect caseload and workload expectations, since the most intensive data collection and reporting protocols naturally require more time to complete.

Collaboration with local funding streams (such as county investments) is limited. To address this, Start Early has begun convening a funders' table to bring partners together and surface how disconnected decision-making across funders can create additional administrative burden for providers. Differences in priorities and approaches between state and county offices also shape how home visiting is funded and implemented. Tribal entities are also included in this group. Tribal MIECHV programs may blend federal funds with state and county support.

So far contracts have not been rebid since HVSA was created. Stability great for programs – downsides are that accountability is not well implemented.

Data and Accountability - ROI and Outcomes

The management of data and outcome measures is a collaborative effort between the Department of Children, Youth, and Families (DCYF), the Department of Health (DOH), and Start Early Washington

Washington uses a "hub and spoke" model for data entry:

- Local Systems: Local Implementing Agencies (LIAs) enter day-to-day data into model-specific or state-approved systems, including Flo, DAISY, and Visit Tracker.
- The Data Warehouse: The DOH maintains a centralized SQL Server database that integrates raw data from these various platforms. This allows the state to standardize information across different home visiting models (like Nurse-Family Partnership or Parents as Teachers) without requiring agencies to perform duplicate data entry.
- The 5-Day Rule: To ensure accuracy, home visitors are expected to enter data into their respective systems within five business days of each visit.

The state tracks data across five primary categories to measure the health and impact of the system:

- Demographics: Collected at enrollment to ensure services are reaching priority populations.
- Enrollment & Service Utilization: Tracking visit frequency, duration, and "dosage" of the intervention.

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- HVSA Aligned Performance Measures: A set of eight standardized indicators reported every State Fiscal Year (July–June) that measure outcomes like child development screenings and maternal health.
- MIECHV Measures: Programs receiving federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funds must track additional benchmarks, such as tobacco cessation referrals and safe sleep practices.
- Performance-Based Contracting Milestones: Data is tied directly to funding, where agencies must meet specific milestones to comply with their HVSA contracts.

Data management is strictly governed by data sharing agreements. Families must provide explicit consent for their identifiable information (like names or Medicaid IDs) to be shared with DOH and DCYF. If a family opts out, their data is typically de-identified or "masked" before it is used for state-level reporting and research.

Implementation

Families have the flexibility to enroll in home visiting services through either a centralized entry point or by contacting local providers directly. The most common centralized route is through Help Me Grow (HMG) Washington. This system is designed to streamline the referral process, so families do not have to navigate multiple eligibility requirements on their own.

- Hotline and Online Forms: Families or providers can call the HMG hotline or use an online referral form.
- Family Resource Navigators: Once a referral is made, a navigator identifies the programs that best fit the family's needs and location, then facilitates the connection to a local home visitor.

Unfortunately, HMG was defunded in the most recent budget passed by the state legislature and will likely stop providing service at the end of the state fiscal year, June 30, 2026. It is unclear what, if anything will replace HMG at the time this profile is written (May 2026).

Families are not required to use the hotline and can reach out directly to LIAs.

- Direct Contact: Many families enroll by contacting local organizations—such as community health clinics, non-profits, or Tribal organizations—that host specific models like Nurse-Family Partnership or Parents as Teachers.
- Provider Referrals: Local doctors or social service providers often refer families directly to a known local home visiting program rather than going through the statewide hotline.

Lessons Learned

Early on, it is important to establish clear definitions of what the state means by home visiting, why it is investing in it, and the values or beliefs that should guide the work. Those definitions can then inform explicit criteria for which models are included in the system—and how the state will handle approaches that do not neatly fit within the funded portfolio. Washington's system also includes some overlap with Early Head Start (EHS): HVSA currently funds two EHS programs, but the broader system is not structured to fully support Early Head Start's home-based model. Relatedly, some

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models may be appropriate for professional development, even if they are not included in funding decisions and outcome measurement.
HVSA due to an overhaul and introspection after 10 plus years. We just navigated a ginormous shortfall in the state budget. It seems like an opportunity to clean the house, so speak.
The changes that are needed are not too extreme. A couple of small shifts could really make a difference. Just a few things for examples:

- There are multiple ways for programs to share feedback anonymously or with their name attached for the work Start Early implements, but no feedback loop to state agencies/or the services account.
- When HVSA was created, outcome measures were based on MIECHV subset of data and titled the aligned measures. We learned over time that those requirements do not align well to the models we have chosen to fund. For example, Parent-Child + enrolls at the beginning of two years of age, so their program does not line up with the outcome measures for breastfeeding. It is a clever idea to have the aligned measures – but we need to make sure the outcome measures are a good match for all the models.
- We should also loosen the requirements for which assessment tools are used – it was designed for white people 30 years ago and not culturally respectful for the very families programs are being encouraged to serve.

State: Wisconsin

Date: Tuesday, March 24, 2026	**Interviewee Name(s):** Terri Enters, State Home Visiting Coordinator
Interviewer Name: Megan Turner	**Support Staff Name:** Judy Reidt-Parker

Overview:

Wisconsin Department of Children & Families is the lead agency for child welfare, child care assistance, TANF, child support, emergency assistance/general assistance, and recipient of MIECHV funds. The name of the state home visiting program is Family Foundations.
Models supported with this funding are:

- Healthy Families America
- Nurse Family Partnership
- Early Head Start
- Parents as Teachers
- Family Spirit

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Design, Governance & Decision Making:
All funds follow MIECHV requirements for data, outcomes reporting and programming requirements. At 10,000 feet - a pot of money that state agency fiscal staff then determines which of those funds will be used to implement home visiting in each grantee contract. Different timelines are navigated at the state table.

The state does procurement in a 10-year cycle with 9-year renewals. It was determined that this approach to funding stabilizes programs and allows them to do this work to fidelity of their chosen program model more successfully. Grantees are given time to get established, rise to the required standards and engage in continuous quality improvement without the threat of funding removal. The funding is going out for procurement this year. It will be another 10-year contract. All contracted providers will be submitting proposals and being evaluated at the same time, and new providers will be invited to apply as well, with the increase in MIECHV funds.

Transparency is connected to the mechanism for awarding funds. The Department contracts with some regional and local public health departments, very small non-profits, a large hospital system, and with HS/EHS organizations. The local entity that receives the home visiting contract is determined by local community, in response to criteria established by the Department in the RFP. An evidence-based program is required, but it is the community that determines which of the potential five models is most appropriate.

The state has recently been approached by a philanthropic organization wanting to support home visiting. Current conversations are about how these funds can be braided as well. How will a formula for distribution of the funding be developed? Should there be a separate cost center or should the funds be pooled with an existing funding stream (i.e., state funds)?

Funding:

Braided funds are MIECHV, state general funds and TANF. All three of these funding sources are managed by the same agency. The state currently does not use child welfare, CSBG or SSBG funding for home visiting.

There is a conversation currently as to whether Family First dollars could be used for home visiting for a specific type of family served only with those funds. Discussions include how we can slide that funding into the braided funds contracts with providers and manage the reporting requirements of that funding stream. With the way the state manages the braided funds currently, for example, there could be a contract expectation for those funds to serve a specific type of family with a designated reporting code in the data system.

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There are some grantees that also have local funding – either from the county or the local United Way. There can be an imbalance of what the program looks like if it is funded only with these local sources because the state funding formula covers materials and operating costs that are not included in the local formulas. Another consideration is the cost allocation methods of grantees. For example, Family Resource Centers may also support home visiting programs. Sometimes there might be questions about how the funding is allocated in these settings. The state provides cost allocation guidance through the contracting methodology. And the fiscal staff is available to help grantees understand what is appropriate to charge to the home visiting system and what needs to be allocated to their other funding sources.

Some providers can be hesitant to jump into federal funding. There's work to be done helping these providers understand because of the braided approach there's flexibility in funding – if one source goes away, the agency can hold grantees together for a much longer time. A most recent example is when a few of WI HS programs got stuck in government funding snafu –it was negotiated that they could spend their MIECHV funds until the Head Start funding came through, so they didn't have to close.

Equitable Distribution:

State funds are also used to fund 6 of 11 federally recognized Tribes. The intentionality to support culturally and linguistically unique communities is represented in efforts to make sure procurement doesn't swing only to agencies experienced in home visiting. Applicants are invited without the expectation that there's years of experience doing this work. It's one of the reasons for the 10-year procurement – give greater opportunity to stabilize and be established in the community over time. With the recent procurement announcement, the state agency has been promoting what home visiting is with enough lead time to help people feel confident in applying. It's important also to not put so many requirements in the contracts that people are afraid they can't live up to the expectations.

Technical assistance is incredibly important as well for an equitable system. It's important to stay in touch with the people doing the work. Technical assistance is a requirement of MIECHV – as well as part of the procurement process. The state agency has a Continuous Quality Improvement lead that supports contracted providers with improvement plans; a Data Quality Coordinator, and fiscal technical assistance available to contracted providers. There are professional learning programs delivered by the state that providers must participate in as well as training for foundational and highly skilled professionals provided by UW-Milwaukee.

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Outcomes and Reporting

The outcomes and reporting are aligned to MIECHV standards, as that is the funding stream with the most rigorous requirements. Providers must also demonstrate they are meeting their program affiliate standards. They send a letter demonstrating the status of meeting affiliate standards. WI uses the DAISEY software system which was designed and is managed by University of Kansas. Utilizing DAISEY does mean that grantees are doing double entry data, but DAISEY provides reports for monitoring home visits, task timelines and it can track data/outcomes for all the families in their system. Every grantee has a data quality plan which is an important part of the work, so data support is included in the cost model – either as part of paid time for home visitors or as a separate position. How this is structured is determined by the grantee.

Cost Savings and Minimizing Complexity

Because of the structure of contracts, and shared language, efficiency moves with ease. For example, relief funds were easy to move through the braided funding structure with a separate cost center and basic contract amendments. It was very efficient and didn't need months to develop new systems for the temporary funding. Grantees aren't on different timelines doing different things which is an efficiency. One benefit to managing the money this way is that they're able to take advantage of all the federal funding available. Because funding is braided, if there are funding increases, those funds can be added quickly to contracts or add new contracts, depending on the amount and funding stream. The state did explore unbraiding funds, and the decision was that it would be burdensome for not just local providers but also for state administrators.

Lessons Learned:

Everything depends on the funds being braided together and their funding sources. MIECHV is the funding source with the greatest number of requirements - building outcomes and reporting around that is important. State staff do some cross checking to ensure they are meeting state and TANF requirements, but overall MIECHV is the lead.

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