

Home Visiting for First-Time Parents: Community Innovation

M. Rebecca Kilburn and Jill S. Cannon

Summary

In this article, M. Rebecca Kilburn and Jill S. Cannon report on First Born, a targeted universal home visiting program operating in over half of New Mexico counties. Created in a small town in response to a lack of support for pregnant women and new parents, First Born adapts features of other home visiting programs, responding to conditions common to high-need, low-resource communities.

As its name suggests, First Born enrolls first-time families. A team of home visitors, including a registered nurse or other licensed health care professional and a paraprofessional parent educator, offers 40 weekly home visits during the child's first year; the frequency of visits diminishes during the child's second and third year. The nurse visits the home both before and after the child's birth, and also when medical issues are the focus of visit. Because nurses are in short supply in many communities, however, most of the home visits are made by parent educators, who coordinate with the nurse visitor.

To promote early childhood health and development, First Born educates parents and helps them access community resources, using a three-pronged approach: helping the family to develop life and social skills, such as decision-making, crisis intervention, and knowledge of child development; using screening tools to identify problems (for example, substance dependency or developmental delays) and referring families to the appropriate sources of help; and promoting effective coordination among community resources.

Based on First Born's scale-up experience, Kilburn and Cannon outline several lessons for other universal programs, including the pros and cons of universal services, the expectation that universal programs will have population-level impact, and barriers to innovation.

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Child services programs begin in different ways and follow different paths.¹ The story of the First Born Program, which we tell here, describes how in the 1990s members of a community in New Mexico, seeking to ameliorate bad outcomes for young children and their families, developed a home visiting program that serves all first-time parents in a community. We discuss why the community made a number of choices, including making First Born universal rather than targeting it to at-risk families and building home visiting teams that comprised both nurses and parent educators rather than one or the other.

First Born's program innovation and development was driven by the community rather than by a top-down process. The community developed a program that was both universal and targeted—universal in that it didn't offer services based on risk status and targeted in that it serves first-time parents only. First Born's features are likely to appeal to other rural communities that have similar workforce and budgetary constraints. Given that child and family disadvantage in the United States is increasingly concentrated in rural areas, adapting models to serve such areas is increasingly important. Finally, the article highlights lessons that can be transferred to home visiting as it matures in the United States as well as to evidence-based policymaking more generally—about the pros and cons of universal services, the expectation that universal programs will have population-level impact, and barriers to innovation.

Background

For decades, New Mexico has seen some of the worst child outcomes in the nation.² Since 2005, it has been among the lowest

five states in the country in the annual Kids Count rankings of child wellbeing.³ Since 2012, it has ranked 49th every year except for 2013, when it ranked 50th.⁴ Within New Mexico, counties have considerable variation in child outcomes, and Grant County, where First Born began, routinely ranks among the lowest half of counties in the state in terms of various measures of child wellbeing.⁵

Grant County sits in the southwest corner of the state, with its westernmost border touching Arizona and its southernmost border coming within 10 miles of Mexico. The Continental Divide runs through it, traversing mountainous regions that include Gila National Forest and the Gila Cliff Dwellings National Monument. Slightly less than half of the county's residents are Hispanic. The largest municipality is Silver City, where about 10,000 of Grant County's 30,000 residents live. Silver City was founded as a mining camp in 1868, and although many types of ore deposits were largely depleted over the next century, copper mining is still one of the most important contributors to the local economy. Tourism, government employment, and cattle ranching are the county's other major industries.

One of the largest employers in Grant County is Gila Regional Medical Center (GRMC). This medical facility is the largest in a 100-mile radius and provides emergency and inpatient hospital services as well as associated family medicine facilities and preventive services. In the mid-1990s, Donald Johnson was chief of pediatrics at GRMC. At the same time, his wife, Victoria Johnson, directed a program—funded by the State of New Mexico's Behavioral Health Services Division—that aimed to improve outcomes of teen mothers and their babies.

The Johnsons reacted similarly to experiences in their respective positions: frustration at observing infants and parents exhibiting poor outcomes that they believed might have been avoided through preventive services delivered during pregnancy or soon after birth. Meanwhile, a set of rigorous research studies conducted for early childhood prevention programs that had a home visiting component, such as the Nurse Family Partnership (NFP) home visiting program, Project CARE, and Houston Parent-Child Development Center, demonstrated that these types of services could indeed improve child and maternal outcomes.⁶

The Johnsons and others providing child and maternal services in the community were excited about the positive findings from NFP and other early interventions, but they were pessimistic about replicating these national evidence-based programs in Grant County. Most of the programs had been developed and tested in large urban areas. Grant County was designated a Health Professional Shortage Area by the US Health Resources and Services Administration (HRSA), meaning that finding registered nurses or other clinicians to staff preventive programs would be challenging or impossible. (See the HRSA website at bhpr.hrsa.gov/shortage for information about Health Professional Shortage Areas.) Furthermore, many Grant County mothers spoke Spanish, and finding bilingual registered nurses would be especially difficult. Grant County service providers felt that some of the national models seemed expensive to implement and also that the county would not meet some of the models' minimum scale requirements, such as being able to support a caseload of 100 mother-child pairs. Last, based on their own practices the Johnsons and

their colleagues perceived that most new parents—and not just those who met the restrictive definitions of risk used by many of the existing programs—could benefit from preventive services.

They had other reasons to object to targeting services only to the highest-risk mothers. For one, almost all births in the county were paid for by Medicaid, implying that most families would likely qualify for a targeted program. The process of determining risk-based eligibility takes time, which can be a barrier to promptly beginning services and may discourage some potential clients from enrolling. The Johnsons and their colleagues also felt that the public would be more likely to support—and clients would be more likely to accept—the program if services were offered not just to families identified as needy but to all families becoming parents for the first time, without regard for the family's socioeconomic status.

At this point, the Johnsons and others could have determined that no models were a good fit for their community, and they could have continued to do business as usual. They decided instead to innovate. Using emerging findings from neuroscience, program evaluation, economics, and other fields, they developed a program incorporating features that had evidence of effectiveness while tailoring the structural requirements to meet the realities of their community. By 1998 it began to go by the name First Born Program, and by 2002 it was acknowledged as one of the nation's 10 most innovative and exemplary prevention programs by the Substance Abuse and Mental Health Services Administration, the Center for Substance Abuse Prevention, and other collaborative national agencies.

The First Born Program

First Born promotes early childhood health and development by creating teams of specially trained parent educators and health care professionals to give parents information, training, and access to community resources. This section describes the theory of change that underlies the program model and provides details about the program's structure.

Theory of Change

First Born uses a three-pronged approach to promote child and family wellbeing and to help with a range of potential family needs:

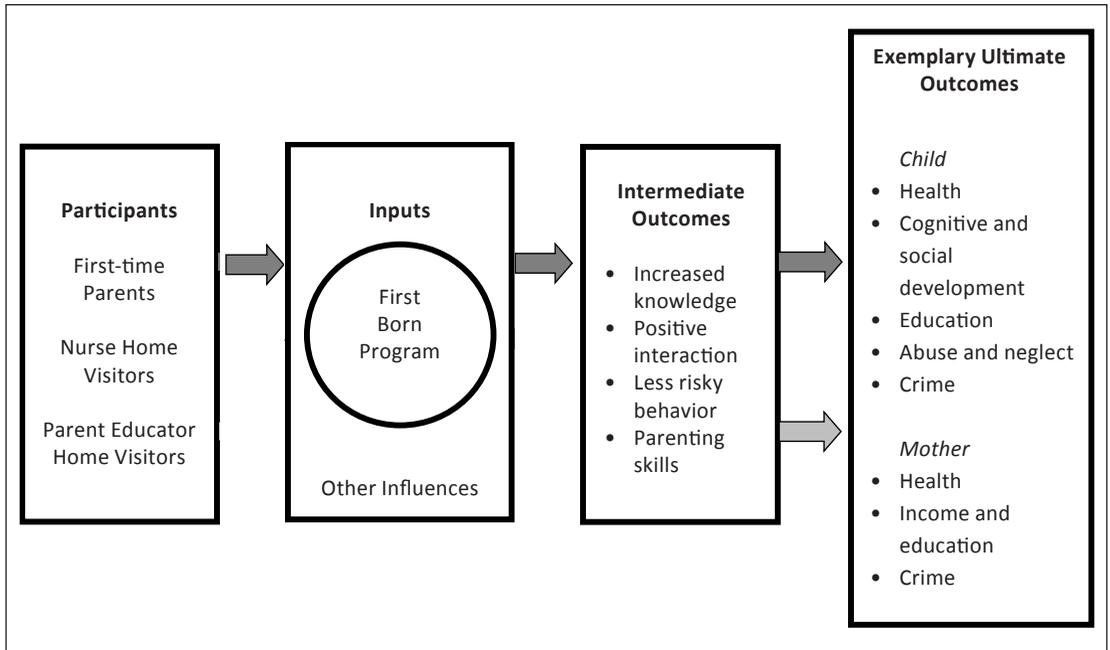
- *Family education.* Home visitors work with the family to develop life and social skills, such as decision-making, crisis intervention, and child developmental assessment and knowledge.
- *Problem identification and referral.* Home visitors use screening tools to identify family members who need referrals to other resources for issues including substance dependency, family violence, and developmental delays.
- *Coordination of community resources.* Program staff participates in community-based councils, task forces, and other teams to promote effective coordination of data and services.

Families who participate in the program are expected to enhance their family functioning and to develop protective factors that will facilitate their positive development in the short and long term (see figure 1 for a simple representation of the First Born logic model). First Born is guided by three theories—self-efficacy and empowerment, family ecology, and attachment and bonding—

which characterize behavioral change as dependent on an individual's beliefs, motivations, and emotions as well as the family's community context. Specifically, the program works to enhance family resiliency by building trusting relationships and by identifying family goals through weekly home visits to promote:

- positive interaction and relationship between parent and child;
- positive parenting behaviors;
- safe, nurturing, and stimulating environments;
- increased factual knowledge about pregnancy, delivery, and child health and development;
- increased knowledge about the effects of alcohol, tobacco, and other drugs;
- decreased risky behaviors on the part of the parents;
- increased knowledge of community resources for the family; and
- opportunities for formal education continuation.

Ultimately, theory suggests that families should experience better outcomes in the areas of physical and mental health, social and family interactions, cognitive development, and family goal and challenge management. The program is designed to help families improve intermediate outcomes in the form of family behaviors, knowledge, and interactions, which in turn promote the mother and child's physical and mental health, and positively affects other outcomes, such as education and abuse and neglect.⁷

Figure 1. First Born Program Basic Logic Model

Program Details

First Born is a universal program; its services are free and are offered to all first-time parents within the service area (typically a county). Program participants (generally mothers) can enroll during pregnancy and up through the child's second month. The program ends when the child reaches age three. To help recruit parents and refer them to services, First Born builds relationships with community providers that work with families and children. The home visitors work closely with local health care providers, hospitals, and social service agencies to identify and recruit first-time parents and to help them get preventive and developmental information and services.⁸ First Born sites aim to enroll parents in the program during pregnancy. Pregnant families learn about the program from a range of sources, including friends, health care providers, civic organizations, and social services. First Born sites also work very

closely with the local hospital maternity ward to identify and recruit additional first-time families at childbirth for families who were not enrolled in First Born prenatally.

The First Born model calls for at least 40 weekly home visits in the child's first year of life, although a study in one site indicates the average number of visits may be lower in practice.⁹ Visits may be less frequent in the child's second and third year. Trained home visitors deliver the program, typically in the child's home, using the trademarked First Born Program, a curriculum-based model that adapts previous home visiting models to high-need, low-resource communities, including rural areas. By going to families' homes rather than requiring them to come into program offices in town, the program can reach families that otherwise might not readily access services.

Rather than choosing to use either nurses or parent educators as home visitors, First

Born decided to create teams that combine the two. New Mexico's nurse shortage is only expected to grow worse, and First Born's two-person home visiting team lets communities use their available workforce to their best advantage.¹⁰ The First Born home visiting team includes a registered nurse or other licensed health care professional, such as a licensed practical nurse, who visits participating families both before and after the child's birth, and when families encounter medical challenges later on. Parent educators, however, are the most frequent visitors; thus First Born's staff has about eight parent educators paired with each nurse. Visits are conducted in English or Spanish, depending on the family's preference.

Parent educator home visitors generally have at least some college education and some human services experience. Once they're hired, they get extensive training in the First Born curriculum, as well as in child development, culturally competent practice, and other topics. Their preparation includes 120 or more hours of lectures and textbook training, 40 or more hours of shadowing a trained First Born home visitor, and about 40 hours of training learning about community resources—for example, food resources or the local child protective services' investigation procedures. Home visitors must demonstrate competency in many areas of the curriculum before they can conduct home visits, including: mission statement and core values; communication and relationship-building skills; managing home visits; program documentation; safety; prenatal and postpartum curricula; breastfeeding; immunizations; medical issues; infant growth and development; mental health issues, such as maternal depression; substance use; family planning; domestic violence; child abuse and neglect; community resources;

hospital orientation; and cardiopulmonary resuscitation. After starting home visits, they also receive regular supervision, including reflection on home visiting experiences, and continuing education on topics like new health insurance eligibility standards or new aspects of the First Born curriculum.

A hallmark of the First Born model is integration into the community, which takes many forms. For example, First Born staff serve on community committees or workgroups like early learning councils, establish informal and formal referral arrangements with other child and family-serving organizations and individuals like WIC offices, doulas, high schools, churches, etc., conduct public outreach campaigns, and encourage clients to refer friends. Integration into the community promotes referrals to and from First Born; it also helps establish First Born's universality, as the program becomes the new normal among all community members who are preparing for childbirth and parenting.

Evaluation Over the Program Life Cycle

Since its inception, First Born has used several types of evaluation to assess implementation and outcomes. These evaluations align to some degree with the stages of implementation, broadly described as program development, initial implementation, and full implementation. First Born's evaluation experience follows recommendations from researchers that programs conduct evaluations sequentially as they go through the following stages: an articulation of a theory of change and logic model that can be tested (program development and initial implementation stages); monitoring of inputs and adherence to the program model during initial

implementation; evaluation during full implementation to assess the program's effectiveness at achieving intended outcomes for participants; and last, assuming that the initial evaluations are promising, a rigorous impact evaluation with a comparison group to determine whether the program is the cause of the observed outcomes.¹¹

Theory of Change, Monitoring, and Implementation Evaluation

First Born sites regularly collect data during implementation for continuous quality improvement and self-evaluation. During initial development, First Born's developers outlined a theory of change, identified the program's key goals, and then created a set of data indicators that reflected those goals.¹² Since then, collecting this data has become a routine part of program implementation in all sites to assess program inputs and outputs for internal evaluation purposes.

The next evaluation step was to conduct an implementation evaluation examining short-term participant outcomes. A researcher-practitioner collaboration between New Mexico State University and First Born articulated a research-based theory of change and designed the evaluation to assess outcomes in relation to that theory. Two published articles from the evaluation showed that the program was achieving its intermediate family-functioning goals for participants.¹³ This evaluation looked at a group of 109 participants receiving services in the Silver City site from 2001 to 2003, after the program had reached the full implementation stage. In what is known as a *pretest-posttest design*, the evaluators examined whether enrolled families' outcomes improved over time, from before program services were received to after. The researchers found that families scored higher

after receiving program services on measures of family resiliency, such as social support and family interaction. They also found that when families had more home visiting contact hours, their scores on these measures improved significantly. This evaluation provided preliminary evidence to build the case for replicating First Born at other New Mexico sites.

Two further evaluations assessed First Born's implementation at other sites as the program was replicated in New Mexico. One was a qualitative study by RAND Corporation researchers that looked at the experiences of six First Born sites in four key areas during the early implementation stages (up to one year after initiating client services), from 2007 to 2010.¹⁴ The sites included four primarily rural locations, one small city, and one larger city. The study found that half of the sites met their intended staffing objectives in early implementation, two-thirds met referral and enrollment objectives, and two-thirds met objectives for adherence to the program model. All the sites were generally able to operate the program within their budgets.

More recently, a University of New Mexico process evaluation examined implementation outcomes for an enhanced version of First Born that employs special staff to support family enrollment and program referrals to community resources.¹⁵ This study included program implementation data from 2010 through 2014, starting while the program was in the initial implementation stage and covering more than 1,500 families. The authors also observed 39 home visits. The study aimed to examine such aspects of the program's operation as number of cases, child and family assessments, services provided, staff knowledge, and coverage of core topics,

and to put these things in the context of how the program was expected to operate and how well it adhered to the model. The researchers found that program staff had a clear understanding of the First Born model and the expectations for implementation, and that home visits generally followed the First Born core curriculum while covering additional topics to meet individual families' needs.

Impact Evaluation

After logic model validation and implementation evaluations showed promising evidence, First Born supporters and potential funders became interested in the next stage of evaluation: an impact study to look at the program's effects on participants compared to those who didn't participate in the program. The study's primary aim was to see whether the program was helping improve family outcomes as intended. A secondary aim was to build stronger evidence to guide future decision-making about the merits of continuing or expanding the program. But the study faced a dilemma: How do you evaluate a universal program for causal impacts when there isn't a control group that's not receiving services?

RAND researchers and First Born supporters were discussing options for an impact evaluation when a situation in Santa Fe County suggested an answer. Santa Fe was starting the program but lacked the funding to serve all families expecting their first child. The community also had prior experience using a lottery system for enrollment in underfunded social services and planned to use a lottery for First Born as well. When the researchers approached the Santa Fe site about using the planned lottery system to randomize eligible families

to receive First Born services or not, it was amenable and the impact study was born. Ideally, the impact evaluation would have been conducted in the original Silver City site after full implementation was reached and before replication to other sites, but circumstances in the real world meant that the impact study occurred at a relatively new site during the program's expansion.

The impact evaluation was a randomized controlled trial, that is, eligible families were randomly offered either enrollment in First Born (the treatment group) or not (the control group). Randomization began after the program had been serving families for over a year (to ensure that it was operating as intended in the initial implementation stage); a pilot randomization was also conducted first. The study ultimately randomized 244 families (138 in the treatment group and 106 in the control group) from June 2011 through October 2013.

A study of the program's effects on infant health care found that families assigned to First Born used less health care in their first year than families not assigned to the program. Specifically, the evaluation found that children in the treatment group were one-third less likely to visit an emergency department than control group children and 41 percent less likely to have visited a primary care provider nine or more times (see table 1).¹⁶ (The median and mean number of visits to a primary care provider in the data was eight, so the study examined the incidence of children visiting primary care more than the average number of times.) No significant differences were found for hospitalizations or for injuries requiring

Table 1. Treatment and Control Group Effects for Child Health Care Use in First Year

Outcome	Treatment Group Mean	Control Group Mean
One or more emergency department visits	0.28	0.42*
Child saw health care provider 9 or more times in first year	0.29	0.49*
One or more hospitalizations	0.12	0.16
One or more injuries requiring medical attention	0.06	0.09
Sample size	138	108

Source: Kilburn and Cannon, 2017.

Note: * denotes treatment and control group means are significantly different ($p < .05$).

medical attention, although the First Born group showed outcomes in a more positive direction than the control group.

This evaluation also compared effects for children in lower-risk and higher-risk families. Most home visiting programs target high-risk families because it's believed that these families will benefit the most from services. Few studies have examined whether a universal program can also be effective for lower-risk families. The Santa Fe evaluation found similar significant results for outcomes among lower-risk families, indicating that they also benefited from the program.

The study's results were disseminated to local and state policymakers, philanthropists, and service providers in New Mexico to help guide decision-making based on the first-year health effects the program achieved. But the study had limitations. For example, it relied on self-reported data through surveys with mothers. It also focused on a single site that had been enrolling families for less than two years when the study began, with a community context that may differ from other First Born sites in New Mexico. Furthermore, the fairly small sample size of the evaluation meant that it could detect

only relatively large effects. (Researchers also collected data on parenting practices, such as laying the baby on the back to sleep or avoiding the use of walkers; these results were being examined in an analysis that had not yet been published when this issue of *Future of Children* went to press.)

What's Next for First Born Program Evaluation

As the program evolves, replication studies at additional First Born sites will help determine whether infant health care use is similar across sites; effects should also be tested at sites with more years of full implementation. Furthermore, longer-term followup and testing of effects for additional outcomes will better guide decision-making, as will cost analyses of returns on initial investments in the program. For instance, cost analyses could assess whether reductions in costs associated with health care use outweigh program costs.

Ongoing monitoring and data collection will remain important to ensure that First Born sites continue to adhere to the program model and meet internal goals and objectives. Last, if the model is adapted to meet community needs or

otherwise changes over time, the program should be reevaluated to assess whether it is achieving intended outcomes.

Scaling Up the Program

The developers of some home visiting programs make plans early on to scale up their program model. But after 10 years of operation, First Born wasn't aiming to expand to additional sites. Then other communities with contextual challenges similar to Grant County's came to First Born's leadership and asked for help to improve their own child and maternal outcomes.

Demand from Other Communities

In 2006, about a dozen home visiting programs were operating in New Mexico, using a range of program models, funding sources, and targeting strategies. They included services for children diagnosed with disabilities under the federal IDEA Part C early intervention program; a state-run case-management program for at-risk families; privately supported programs operated by local United Way agencies; and others that had patched together funding from a variety of government and private sources. At the time, New Mexico had not committed recurring funding to a designated home visiting system.

Meanwhile, home visiting programs were surging across the United States. By 2009, 40 of 46 states responding to a survey were offering state-based home visiting services.¹⁷ The Pew Charitable Trusts, an independent nonprofit NGO that seeks to improve both policy and practice, had launched the Pew Home Visiting Campaign, which aimed to increase federal and state support for voluntary home visiting. And the NFP

home visiting model had grown from two replication sites in 1996 to sites in 31 states in 2010, as well as a National Service Office that supported over \$10 million worth of activity in the fiscal year ending in September 2010.¹⁸

Some of the growing interest in home visiting programs has been attributed to the strong findings from a set of rigorous research studies conducted for the NFP and other early childhood programs, as described above.¹⁹ Indeed, by 2007, NFP had conducted its third randomized clinical trial demonstrating improvements in outcomes for mothers and children well into the teen years.²⁰ The growing evidence related to the NFP coincided with another trend in social programs: the evidence-based policy movement. Organizations like the Coalition for Evidence-Based Policy advocated that the government favor social interventions that demonstrated effectiveness through randomized trial evaluations (see www.evidencebasedprograms.org for more information), and the NFP was the only early childhood program to earn the coalition's Top Tier designation. Late in 2010, the US Department of Health and Human Services released a list of seven home visiting models that it classified as "evidence-based," and the department has since listed other programs that meet its standards.²¹

At the same time, the Los Alamos National Laboratory (LANL) Foundation began to systematically review ways that it could help improve outcomes in northern New Mexico. The LANL Foundation, a private organization committed to improving northern New Mexico communities by investing in education, learning, and community development, is supported largely by LANL and its employees. The foundation's strategic review led it to focus

on early childhood. It decided that home visiting had shown the most promise for improving child and maternal outcomes in the context of the particular challenges facing the area's largely rural, poor counties. The foundation found convincing evidence that NFP was effective and strong support for replication from the National Service Office; for other leading models, such as Healthy Families America and Parents as Teachers, the research evidence was mixed.

After gathering more information about the NFP, the foundation decided that it wasn't able to implement the model. The NFP home visitors are registered nurses, and the foundation determined that it would not be able to hire enough nurses in its largely rural service area. Like Grant County, this region and most of the state of New Mexico were designated as HRSA Health Professional Shortage Areas. Furthermore, NFP's projected total cost per family was sizeable—at that time, the NFP website reported typical costs of \$4,500 per family, per year, with families participating in the program from the first trimester of pregnancy until the child's second birthday.²²

Unexpectedly, the foundation's national search for an appropriate home-visiting program for northern New Mexico took it to the southwestern part of its own state. LANL chose to implement First Born for several reasons, including that the program used both nurses and non-nurse professionals and that costs were about two-thirds of NFP's. Furthermore, as we note above, an evaluation of the original First Born site, published in a peer-reviewed journal, found that the program was meeting its stated objectives to promote family resiliency across several domains.²³ From the foundation's perspective, the only thing missing from First

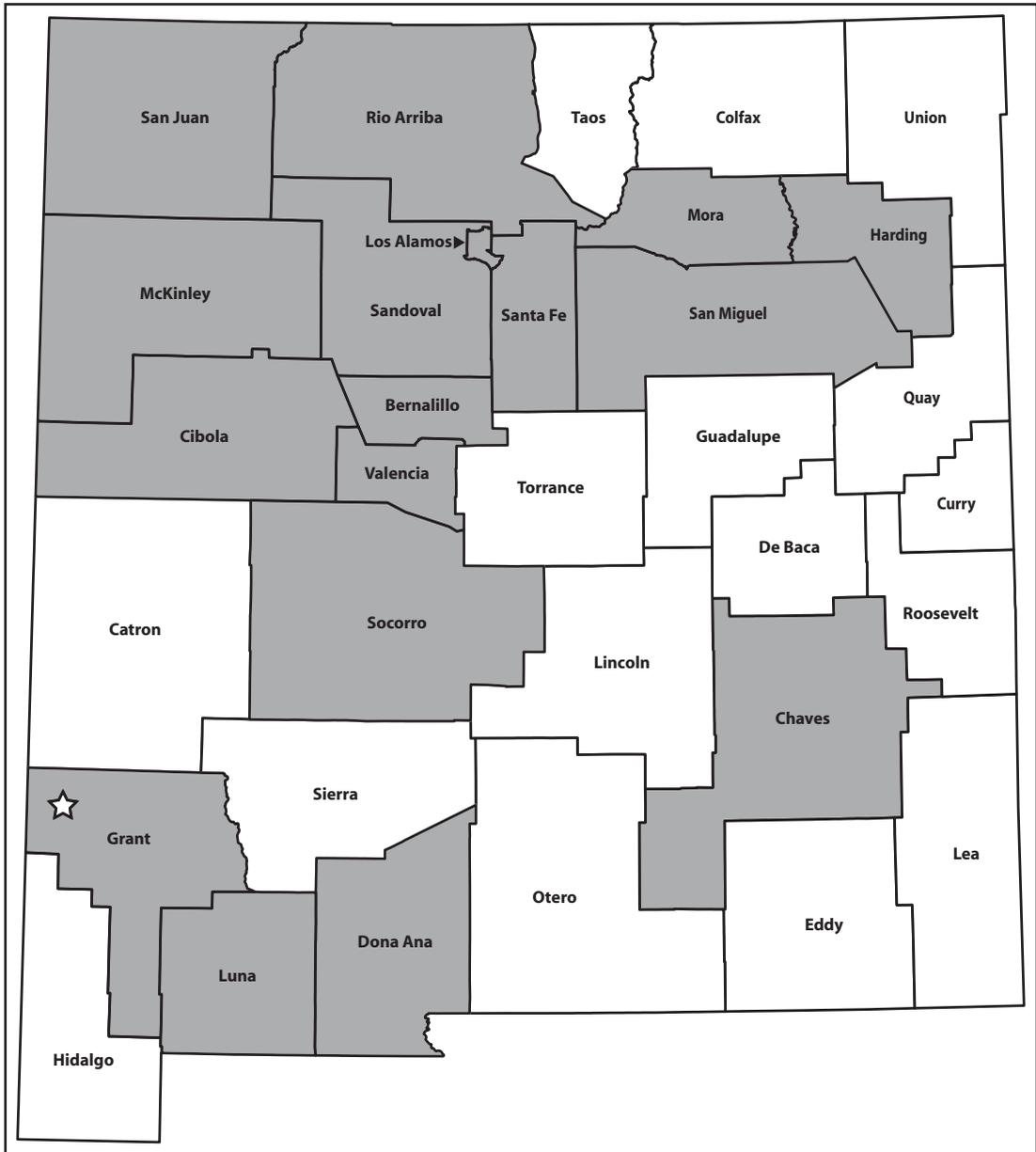
Born was a technical assistance and training infrastructure that could facilitate replication. The foundation persuaded the Grant County First Born team to help with replication, and it provided financial support. The first step was to implement First Born programs in Rio Arriba County and Taos County in northern New Mexico, and both programs began serving children in 2007.

In 2008, the New Mexico state budget included the first recurring funding stream to establish and support a state system of home visiting. By 2009, the state was supporting 14 organizations that offered home visiting services in 19 of the state's 33 counties. By 2010, five state-supported First Born sites were operating, in Grant (Silver City), Los Alamos, Rio Arriba, Santa Fe, and Socorro counties. Additionally, a private nonprofit health-promotion organization, St. Joseph Community Health, began funding and delivering First Born in the metropolitan Albuquerque area in 2010. As figure 2 shows, by 2018 First Born served more families than any other home visiting program in the state, with publicly and privately funded sites in 17 of New Mexico's 33 counties (figure 2), 10 Native American Pueblo communities, and the Navajo Nation.

These sites said that they chose First Born for reasons similar to those cited by the LANL Foundation:

- The organization's goal was to improve the types of child and maternal health outcomes for which home visiting has shown promise compared to other service strategies.
- The organizations recognized the evidence for the NFP program, but thought NFP was impractical for these communities due to nursing

Figure 2. New Mexico Counties Implementing First Born in 2018



Source: <http://www.firstbornprogram.org/programsites.html>

Notes: Dark gray counties implement First Born. Star denotes location of original site.

shortages, perceived high cost, and the fact that they lacked enough births to meet the NFP's requirement of 100 high-risk parents to establish a site. (See www.nursefamilypartnership.org/communities/local-implementing-agencies for site requirements.)

- Two published articles showed that First Born was achieving its intermediate family-functioning goals for participants.²⁴

Rural communities may find it challenging to find nurses or licensed clinicians to serve as

home visitors (as some models require), and they may not meet the scale requirements of some models. For this reason, rural communities have been particularly interested in First Born.

Infrastructure for Replication

Although the team that started the original First Born site in Grant County was able to help initial replication sites in the northern part of the state, supporting the large number of sites that were implementing First Born across the state by 2017 was beyond the capacity of the Grant County program developers. Upon reaching a larger scale, many home visiting programs, including NFP, Parents as Teachers, Healthy Families America, Child First, Family Spirit, and Family Connects, created national program offices to help new sites get started, monitor existing sites' adherence to the program model, and help sites with training and other implementation support. To maintain the quality of existing sites and meet the demand for new ones, First Born realized that it would also need to establish an organization dedicated to supporting quality and replication. Unlike the developers of most other programs that had reached this scale, First Born's program developers hadn't planned to lead this new organization.

Thus there was demand for the services of a First Born national program office, but no such office was in the works. Existing sites were concerned about the future of the program, and philanthropies that had supported First Born's growth from one site to many faced the prospect of no long-term return on their investment. Another challenge to establishing a First Born program office was financial: such an office would require additional resources,

meaning that the new organization would need to raise funds before getting started.

After several years of uncertainty regarding First Born's fate, a partnership of interested parties developed a plan to open a First Born program office at Santa Fe Community College's Early Childhood Center of Excellence. The office will provide statewide training, technical assistance, and licensing of First Born sites throughout New Mexico. As with other programs' service offices, the initial financial model depends on philanthropic support along with licensing fees from sites. Expansion of First Born beyond New Mexico is under consideration.

Lessons for Other Universal Programs

Because the program was a community-led effort, First Born's story is different from that of many programs that have reached full implementation. Yet many of the lessons from First Born are broadly relevant for other programs, no matter where their leadership comes from.

Pros and Cons of Universal Services

Like other universal programs, First Born is sometimes criticized because it may be serving some clients who are not at risk for poor outcomes and, hence, isn't efficiently using scarce funds. First Born has countered these arguments in two ways. The first is by pointing out that First Born isn't fully universal—it doesn't serve all parents of newborns, but only first-time parents, who represent slightly over 40 percent of parents of newborns in the state. And a program that serves all first-time parents will eventually serve most parents with more than one child.

The second response to these criticisms is that in a state as poor as New Mexico that has such poor outcomes for young children, it isn't efficient to target services only to the highest-risk families. New Mexico has the highest percentage of Medicaid births in the nation—72 percent of births in 2016, the latest year for which data are available.²⁵ Given that younger women are more likely to have their births covered by Medicaid, it's likely that the rate for first births is even higher. Other means-tested programs have decided that when rates of qualification are so high, the costs of screening for eligibility are likely to outweigh the benefits, and so they serve everyone; school lunches in some communities are an example of this phenomenon. Furthermore, universal services reduce the stigma associated with participation, thus raising the likelihood that high-risk families will in fact participate. In sum, in a poor state like New Mexico, targeting by socioeconomic status may have low value. This justification for universal services may be less persuasive in states that are more affluent or have better child outcomes.

Interestingly, First Born has also been criticized for targeting too much. Specifically, some policymakers and community members have expressed concerns that by serving only families of first-born children and limiting enrollment to families with infants less than two months old, First Born is denying services to families that clearly need help, such as families that have had a substantiated child-protective services case in the past or families with multiple children and a parent going to prison. In fiscal year 2017, New Mexico initiated Level II targeted home visiting services, which are offered to

families identified as having a high degree of stress (Level I home visiting programs are prevention and promotion programs like First Born). Level II services are currently in a pilot phase; having these services available in First Born locations would alleviate concerns about overtargeting.

Universal Services Suggest Population-Level Impact

Another lesson from First Born is that universal programs may be expected to have population-level impact. Especially when program evaluation results suggest that a program is effective, its relevant indicators for the geographic area being served should show improvements if the program is available to everyone.

In the case of Grant County, First Born has been implemented for nearly 20 years, and yet average outcomes for newborns in Grant County have exhibited only modest improvement.²⁶ Home visiting programs are typically voluntary, and take-up rates among families who are offered services are generally less than 75 percent.²⁷ Furthermore, of the families who enroll in home visiting, large numbers don't complete the entire program.²⁸ As a result, a program would need to produce extremely large changes in participating families' outcomes to generate improvements in indicators for all families in the program's catchment area. Even though it's a question of simple ratios, this type of explanation may be unsatisfactory to funders, particularly in an environment where take-up and completion rates of less than 100 percent for a universal program are themselves the targets of criticism. Furthermore, additional factors may contribute to population-level outcomes

that mask a program's improvements. For example, since First Born began operating in Grant County, the area has experienced the Great Recession, mine closures, the opioid epidemic, and other confounding factors. Though it's easy to explain why a universal program might not generate improvements in population-level indicators, the inference that universal services should lead to upticks in these indicators is nevertheless common.

Barriers to Innovation

A final lesson from First Born is that in addition to incentives and assistance, innovation requires overcoming numerous formidable barriers. One such barrier is the chicken-or-egg aspect of getting funding for a new program that's under development: funders have a strong preference for supporting evidence-based programs, but programs can't achieve evidence-based status until they're tried. The sort of evaluation needed to achieve evidence-based status can often cost more than \$1 million, a sizable "barrier to entry," to use an economics term. Another challenge is that once demand for a program

is generated, creating a service office to support replication entails large fixed costs. State and federal funders focus on reimbursing providers for services delivered, but they rarely provide funding to develop infrastructure for specific programs, leaving philanthropic support or other fundraising to fill that gap. Last, many program developers and communities are not in a position to spend a decade or more developing or modifying programs to improve existing services or adapt programs to meet local needs.

These barriers to innovation are daunting for any sector of human services, but they may be particularly burdensome for communities that don't have the infrastructure that stands behind universities, government agencies, and foundations. The challenges that First Born and other programs had to overcome to reach full implementation raise questions about whether the current approach to supporting programs may be stifling innovation.²⁹ Balancing the funds devoted to established programs with more attention to innovation and adaptation may expedite improvements in human services.

Endnotes

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