Future Directions for Home Visiting in Texas

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Introduction

Positive influences during early childhood—especially attentive, supportive, and stimulating relationships with parents or caretakers—can strengthen brain development and promote positive long-term outcomes in learning, behavior, and health.[1] Home visiting (HV) is a well-established, evidence-based approach to promoting these positive relationships.[2] As the Texas Department of Protection and Early Intervention's (PEI) most prominent strategy for preventing child maltreatment, HV programs will be an integral part of a community-focused twenty-first century child welfare system.[a] HV programs provide expectant parents and parents of young children with in-home parenting support, information, and connections to additional services. Texas currently offers multiple evidence-based HV programs (e.g., Home Instruction for Parents of Preschool Youngsters, Nurse-Family Partnership, Parents as Teachers, Healthy Families America) that serve approximately 16,000 families annually.[3]

Many stakeholders across Texas are seeking to expand HV to serve more families throughout the state. Texas has approximately 1.8 million families with children under age 6. Among these families, there are about 413,000 that research suggests may particularly benefit from HV.[4,b] This means that less than 4 percent of families who could benefit from HV currently receive it.

PEI, which houses most Texas HV programs, released a Five-Year Strategic Plan in 2016 that details the agency's approach to expand and improve HV.[5] However, expanding and improving HV in Texas will require overcoming several hurdles, including the need to reach families in rural communities, grow and support a stable HV workforce, improve connections to community resources, and access additional funding. This brief describes the research base around innovative, efficient, and cost-effective approaches that Texas could implement to expand HV and help more families thrive. The innovations described below align with PEI's goals to increase funding for prevention services, enhance program implementation, integrate community-level resources, rely on research, and incorporate a public health framework.[5]

Innovative strategies to expand and improve home visiting

Strategy 1: Partnering with other agencies to access new funding sources

In 2018, Texas served 15,613 of the approximately 413,000 families who could most benefit from HV services.[3,4] Expanding HV to reach significantly more of these families, and incorporating the innovative strategies described in this brief, will require more funding. Currently, HV funding in Texas comes through a combination of federal funds, including the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program and Temporary Assistance to Needy Families (TANF), as well as state general revenue funds.[6] A combination of local and state governments, private organizations, and the Federal government can all help support additional funding for HV. Two of the more innovative approaches for funding HV at the Federal level include Medicaid and the Family First Prevention Services Act:

- As of 2019, 20 states use Medicaid funding to finance HV, but Texas is not yet one of them.[7] Medicaid is the primary source of health insurance for pregnant women and young children with incomes under 200 percent of the Federal Poverty

[a] A "twenty-first century" child welfare system is an idea of capitalizing on changes like the Family First Prevention Services Act to transform the child welfare system. One vision for the twenty-first century, articulated by the National Foster Care Youth and Alumni Policy Council, includes robust resources for substance misuse and mental health; a focus on systemic factors that lead to child removal; support for families beyond reunification; thoughtful consideration of families' strengths and protective factors; an end to punitive removals and a centering of child safety; an understanding and integration of attachment science; and an emphasis on the child's input on safety, services, and any out-of-home placements.

[b] For more information on how this figure was calculated and the research supporting it, please email Dr. April Wilson (awilson@childtrends.org).

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Level (FPL).[8,9,10,c] Although HV is not a covered benefit under Medicaid, many components of HV models (e.g. developmental screenings, case management, and home health services) can be covered through Medicaid.[8] States can access Medicaid funding for covered HV components in multiple ways, including through targeted case management (TCM), the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, traditional medical assistance services, administrative case management, and waiver programs, such as 1115 waivers and 1915(b) waivers.[11] The variety of Medicaid funding pathways target different types of services and populations; therefore, the type of Medicaid funding a state selects will determine the populations and services that can be billed to Medicaid. For example:

  - In Wisconsin, Healthy Families America (HFA) and Nurse-Family Partnership (NFP) bill Medicaid for prenatal care coordination activities with pregnant and post-natal women, including outreach, assessment, care coordination and monitoring, and health and nutrition education. Once the child is two months old, HFA and NFP use Medicaid's TCM provision instead and can bill for case management activities up to age 5.[8]

- The Family First Act broadens a major federal funding stream (Title IV-E of the Social Security Act) to states with an approved plan for qualifying programs that prevent children's removal from the home and placement in foster care. Texas has not yet submitted a state prevention plan but will likely do so in 2021.[12,13] Through a state prevention plan, HV programs may be eligible for a federal match because "in-home parent skill-based prevention programs" for children at imminent risk of removal by Child Protective Services is one of the categories of programs eligible for Family First Act reimbursement.[14] The Family First Act includes stipulations about the proportion of state expenditures that must go to programs that the Prevention Services Clearinghouse has determined to have a well-supported evidence base.[14] Three HV programs available in Texas are currently classified as well-supported: Nurse-Family Partnership, Healthy Families America, and Parents as Teachers.[15]

Texas Highlight: County funding for Healthy Families America

The majority of HV in Texas is funded with federal and state dollars; however, several counties in Texas have used public health dollars to provide services. Travis and Harris County are both offering Healthy Families America (HFA) programming using county general fund dollars.

HFA is working to address areas of need and gaps in the local community. For example, because of the high infant mortality rates and low birth weights of African American babies within Travis County, one unit in the program specifically serves African American families.

An additional innovative approach for financing HV is to partner with private organizations in a pay for outcomes (PFO) approach through social impact bonds:

- Under a PFO contract, a private investor funds evidence-based services that meet an assessed need in a community. If the services result in certain contractually agreed-upon outcomes, the grantee or government would then pay back the investor. If the services do not meet the established outcome requirements, the private investor assumes the loss.[16] The Bipartisan Budget Act of 2018 allows for MIECHV grantees to engage in PFO approaches and establishes requirements for PFO-funded initiatives, including feasibility assessments and rigorous, independent evaluations.[17,16] However, there are significant challenges to using PFO for HV: the outcomes associated with evidence-based HV programs often occur on a longer timeframe than investors may be willing to wait for results, and MIECHV requires that a PFO cannot lead to a reduction in families served.[17]

  - In 2013, South Carolina conducted a feasibility assessment around using PFO to scale up HV in the state and determined that NFP had the appropriate evidence base and record of outcomes to move forward. South Carolina has raised $17 million in philanthropic funds and another $13 million through a Medicaid waiver for their PFO project. If the rigorous evaluation finds positive results, the state government will provide up to $7.5 million in funding to sustain the expanded services.[8,7]

[c] To be eligible for Texas Medicaid a family of two must have a pre-tax income of less than $34,136 and the adult "must also be either pregnant, a parent or relative caretaker of a dependent child(ren) under age 19, blind, have a disability or a family member in your household with a disability, or be 65 years of age or older," according to benefits.gov.

Strategy 2: Leveraging technology to engage more families

Technology can be used in a variety of ways to engage families in HV. In virtual home visits, for example, families meet with their home visitor over a video call, instead of in person. Programs that conduct virtual home visits may use an exclusively virtual approach or a blended approach that combines some virtual home visits with in-person visits. Other forms of technology that can be used to help engage families in traditional or virtual HV include interactive mobile applications, online content, and text messaging or emailing between meetings.

Virtual home visits may be particularly helpful for engaging families who face barriers to participation with in-person home visiting or who programs struggle to reach. A significant challenge for HV in Texas has been reaching the 15.3 percent of Texans who live in rural areas.[18] Using technology to offer virtual home visits provides an opportunity to reach rural Texans and provide them with parenting support and educational resources, as well as increase their access to health care and other services. These virtual visits reduce the burden on home visitors to travel long distances for visits, thereby reducing the resources required for each visit and increasing service delivery efficiency. Virtual HV also allows participants increased scheduling flexibility for their home visits, which may help programs serve more families with irregular work schedules.[19] Virtual home visits also have the potential to ensure continuity of HV services for families who move frequently, such as military families.[20] Research on the use of virtual visits to-date finds that parents, on average, receive the target number of visits, have high rates of rapport with their home visitor, and are highly satisfied with virtual home visits.[19] The use of text messaging in between home visits is associated with greater parent engagement and satisfaction.[27,28]

Prior research and practice also suggest that the use of technology in HV holds considerable promise for engaging families and reaching new parents who are familiar with using technology.[21] Virtual health care services, often referred to as telehealth, share many similar elements with HV services, such as assessment of and meeting clients' needs, collaborative problem solving between providers and clients, and mutual information sharing. Therefore, research on the challenges and opportunities associated with telehealth may provide insight into virtual HV.[22] Research has previously established that telehealth is beneficial for the management of service provision for children with special needs, remote monitoring of patients, and access to consultations with specialists not otherwise available to residents of rural areas.[23,24,25]

Texas Highlight: A note about COVID-19

As of March 2020, most HV services in Texas shifted to a virtual service delivery model in response to COVID-19. Less than 20% of Texas sites had been providing any virtual services prior to the pandemic but at least 78% have received guidance from their model regarding how to adapt the model for virtual modalities.[26] This rapid shift in service delivery across a diverse field of providers spurred the development of new tools, policies, and practices, and has provided an unprecedented opportunity to evaluate strengths and challenges of virtual delivery of HV programs. The innovations by models, sites, and parent educators during this challenging time will likely pave the way for continued and improved telehealth approaches that will improve access and outcomes for families.

The COVID-19 pandemic has further highlighted how virtual visits can be viable methods of supporting parents and nurturing children's development, and it will likely increase funders' and programs' readiness to use virtual HV models. In response to the pandemic, many programs across the country and in the state transitioned from in-person HV to virtual HV, which has yielded important information on the strengths, opportunities, and challenges of virtual HV. Providers can use the following types of strategies to increase the efficacy of virtual home visits:

- Develop strong coaching skills to guide parents in a virtual setting;[21]
- Place the screen properly to promote effective eye contact with both parents and children;[21] and
- Text parents between visits. This has been shown to improve parent engagement, decrease maternal depression and stress, increase parents' use of the strategies that they learned in the program, and promote adaptive behaviors among children.[27,28]

The pandemic has also highlighted challenges associated with virtual home visiting. Families may lack a stable internet connection, hardware (i.e. tablets, computers, webcams), printing capabilities, and software for interactive virtual visiting.[29,30,31] When possible, providers can help bridge technology access gaps by accommodating a variety of virtual visiting

platforms (including free or low-cost platforms), supplementing or replacing web-based software with smartphones, or mailing and/or dropping off printed materials to families' homes.[29] Families may have concerns about confidentiality, so providers can prepare informed consent protocols, demonstrate their commitment to preserving client privacy, and minimize potential privacy breaches by using video conferencing software that meets the privacy guidelines established by the Health Insurance Portability and Accountability Act (HIPAA).[30,31,32]

Texas Highlight: Connect Texas telehealth pilot

Six Parents as Teachers (PAT) programs in Central and East Texas have recently started enrolling families in a PAT pilot, Connect Texas, a hybrid in-person and virtual HV program. An evaluation will examine changes in parenting outcomes and in the relationship between the family and the parent educator over the year-long program. About 20 parent educators and supervisors are also participating in a monthly Community of Practice. This pilot will provide valuable information about the effectiveness of virtual HV using interactive video conferencing.

Lessons learned from virtual HV during the pandemic lay the groundwork for incorporating technology-based approaches in HV programs in the future. Policymakers and practitioners looking to expand the use of virtual HV to reach more families and keep existing families connected to providers can also capitalize on promising research from several HV programs that have integrated technology into their programs. For example:

- Parents as Teachers (PAT) has tested different formats for providing their home-based curriculum virtually. For instance, PAT recently delivered their entire program virtually and found that parents were highly satisfied, and the virtual format succeeded in replicating the key features of the evidence-based, in-person model.[19] Furthermore, over 90 percent of parents who participated in the entirely virtual version of the program reported an increase in their knowledge of child development and reported being motivated to try new parenting strategies.[19]
- Triple P Online is a self-directed, web-based version of part of the evidence-based program, Triple P (Positive Parenting Program). Triple P Online teaches positive parenting skills through a series of modules that use psychoeducational videos, skill-modeling videos, and other activities.[33,34] Two randomized control trials found that parent and child behavioral outcomes were significantly better for participants in the Triple P Online intervention group compared to the control group.[35,36]
- The Incredible Years has tested a hybrid approach that combines online content with some in-person visits, as well as phone calls and electronic messages. A previous study found that families in the hybrid program reported achieving their goals for the program, and they were highly satisfied.[37]

In addition to reaching families who may otherwise face barriers to engaging in HV, integrating technology into HV has other potential benefits for strengthening programs. Technology could allow programs to provide light-touch services to families who have fewer needs and to increase professional development opportunities for providers in rural areas through recorded visits. The flexibility afforded by virtual settings can help providers more easily meet federal and state regulations that mandate them to establish eligibility and initiate services within specific timeframes.[30] Further, virtual HV can reduce providers' costs on travel expenses, travel time, and personnel costs associated with travel.[30] Reduced travel can create greater efficiency in providers' daily schedules, increase time to interact with families, and reduce vehicle mileage and gas consumption.[30] Online programs such as Triple P Online can also be used as part of a stepped care approach in which parents who are unsure about participating in an in-person program can begin by participating in an online program and then assess whether they would like to participate in an in-person program.

Strategy 3: Addressing workforce challenges to ensure a strong and stable workforce

Expanding HV in Texas will require a larger workforce, yet turnover among home visitors poses challenges for programs and families. In the national Mother and Infant Home Visiting Program Evaluation (MIHOPE), 17 percent of home visitors intended to leave their position within the next year, and 50 percent of home visitors had less than three years of experience in their position.[38] Similarly, the Region X Home Visiting Workforce Study found one-year turnover rates of 23 percent for home visitors and 20 percent for supervisors.[47] High turnover rates disrupt families' experience of HV and create an obstacle to program effectiveness. Families are more likely to stay in a program when they have consistent and trustworthy relationships with their

home visitors, and programs may be more effective when families remain in them for longer periods of time.[39,40,41] Home visitor turnover is also expensive for programs that frequently have to recruit, onboard, and train new home visitors. For example, a study assessing home visitor compensation and turnover among HV programs in California found that the cost of training a new home visitor was, on average, $8,000.[42] Despite these challenges, research finds promising strategies to strengthen and stabilize the HV workforce.

Home visitors frequently cite high caseloads (number of clients), administrative work (maintaining paperwork, attending staff meetings, searching for resources/referrals), and secondary trauma (trauma experienced by listening to or witnessing trauma in the families they serve) as the leading stressors in their work.[38,43,44,45,46,47] While these stressors contribute to turnover, increasing workplace supports can help reduce many of the stressors reported by home visitors. For example:

- **Weighted caseloads.** To reduce caseload burdens, programs can weigh caseloads based on the intensity of client needs.[46] Using a weighted approach allows for cases with more complicating factors that require more time and resources from the home visitor to be counted as more cases than those that are more straightforward and less stressful.
- **Reflective supervision.** To increase home visitors' sense of support in relation to their cases, and potentially reduce one driver of turnover, programs can support the use of reflective supervision.[47] Reflective supervision is a trauma-informed "relationship-based practice where a home visitor and supervisor reflect" [46] on the home visitor's experiences and feelings in the context of the families they serve. This practice acknowledges the influence of the home visitors' own experiences in how they interact with families. For example, a home visitor may be triggered when supporting families experiencing trauma. Reflective supervision provides an outlet for home visitors to discuss and work through these emotions, ultimately leading to better quality services. Home visitors and supervisors can also work together to identify appropriate ways to respond when families experience difficult situations.[48] Studies indicate that reflective supervision increases home visitors' feelings of support, may lead to better engagement with families, and is associated with greater program effectiveness than administrative supervision.[43,45,46,49]
- **Staff connections.** To build more solidarity and stronger bonds among staff, programs can reserve time and space for staff to discuss difficult cases, celebrate achievements, and offer support to build on positive relationships in an organization.[43,38,44,45,46]

Attracting a pool of applicants with the skills and experiences needed for long-term success in HV positions presents another challenge related to turnover. Researchers and practitioners have identified strategies to improve the quality of recruitment practices:

- **Optimize recruitment advertising.** HV programs have shared the importance of creating highly accurate, comprehensive home visitor job descriptions, advertising through word of mouth, and sharing openings through professional networks to help attract individuals who are likely to succeed in HV.[46]
- **Leverage the insights of experienced home visitors.** Including seasoned home visitors on hiring panels can help mitigate some of the challenges in selecting a candidate. Experienced home visitors can provide insight about whether candidates possess the skills and characteristics that are needed to succeed as a home visitor.[46]
- **Incorporate job shadowing.** For top candidates that lack HV training or experience, but otherwise show promise, programs can incorporate job shadowing to give individuals a better sense of the work.[46]
- **Offer internships**. Programs can also partner with educational institutions to offer internships for students, thereby building a potential pipeline of individuals with experience in the field.[46]

Texas Highlight: Flexible education requirements for nurse home visitors in remote areas

Nurse-Family Partnership's (NFP) model requires a minimum of a Bachelor of Science in Nursing (BSN). However, in remote areas with limited applicant pools, Nurse Supervisors, with support from the National Service Office (NSO), are empowered to recruit experienced nurses who do not currently have a BSN.

Non-BSN nurses who work for NFP receive targeted assessments and support. They are required to pursue a BSN degree within 2-3 years of hire, and organizations can offer support by affording them a flexible work schedule to attend online or in-person courses while continuing to work in HV. Texas has had several non-BSN nurses pursue their BSN and then complete a Master of Science in Nursing (MSN), which is preferred for Supervisors.

Home visitors frequently rate their work with families as very rewarding; however, these benefits are eclipsed by low compensation, limited benefits, and few opportunities for promotion or growth.[38,46] In the Home Visiting Career Trajectories study, 51 percent of program managers cited low compensation as a major reason for staff turnover.[46] Programs could make HV a more attractive position to potential and existing home visitors by:

- **Compensation packages**. Making salaries more competitive by considering a home visitor's level of education and qualifications and providing a comprehensive benefit package that includes affordable health insurance and paid time off, including mental health days, can show employees that they are valued and supported.[46]
- **Career growth.** Implementing career ladders or lattices (e.g. senior home visitor, trainer, mentor) can provide opportunities for home visitors to grow and develop new skills as they become more seasoned in the field. Similarly, instituting a salary structure with minimum, midpoint, and maximum rates comparable to market rates for similar professions could incentivize employees to gain additional education, certifications, and language skills to receive higher pay.[42] Importantly, career ladders can help make HV a long-term career for some individuals, rather than just a job.[46]

Funding is a significant obstacle to improving compensation and benefits for home visitors, which is often determined at a systems level, not by individual programs. Earlier in this brief, we discussed potential avenues to expand funding for HV.

Strategy 4: Expanding connections with other systems to reach new families and better meet the needs of families receiving HV services

Home visitors can best meet families' needs when they have knowledge about the range of social services offered in their communities and the capacity of those services to support families at a given time. For example, families may need home visitors to connect them with a combination of services, including early care and education (ECE), employment, mental health, domestic violence prevention, substance use, and/or pediatric care. Home visitors can only refer families to these services if they know they exist, and families can only receive the support they need if those organizations have the capacity to provide services. Further, while it is likely that community programs serve many of the same families, each organization possesses different information about the same families.[50,51] To more thoroughly and efficiently meet the unique needs of families, HV programs and adjacent family-serving organizations stand to benefit from service coordination and information sharing at the state, local, and/or program level.

Texas Highlight: Help Me Grow

Texas is working towards a statewide early childhood system that is integrated, comprehensive, and effective. Toward this end, the Department of State Health Services (DSHS) is launching the Help Me Grow Texas initiative, starting with a cohort of six communities in summer 2020. Help Me Grow is a system framework that builds on existing resources to develop and enhance a comprehensive approach to early childhood system-building. Help Me Grow strengthens the network of community resources, linking families to an organized flow of resources allowing them to easily access the services and supports they need. One of the Help Me Grow components is a centralized access point, which connects families and providers to the grid of community resources.

Help Me Grow North Texas is the first Help Me Grow affiliate in Texas and will serve families in 14 counties.

Thorough and consistent data collection, as well as data sharing or integration among family-serving organizations, could help home visitors and other service providers to more efficiently guide families to the services they need.[52,53,54] One successful strategy used in Florida for data systems integration is the implementation of a coordinated intake and referral system (CI&R) for HV and adjacent social services, such as mental health providers.[55] CI&R systems employ a single-entry approach to intake so that several community services and resources use a shared system for referrals and service assessments. This approach allows families to be easily directed to the most appropriate service in their community based on eligibility and availability, and it limits duplication of screenings for additional services.[56] CI&R systems might be managed by a state's Department of Health and Human Services or a similar agency.[57]

In addition to better serving families who currently benefit from HV, researchers and practitioners have explored ways that HV programs can reach and recruit new families through increasing connections with other family-serving organizations. One strategy is to directly inform public health providers who serve pregnant women, families, or young children about HV programs, so they can identify and refer patients who may benefit from HV.[58] Educating these service providers (e.g.

pediatricians) about HV programs and offering scripted referral materials can help them accurately describe HV services and engage new families.[59]

Texas Highlight: Family Connects

Family Connects is an evidence-based model that provides between 1-3 nurse home visits to every family with a newborn, regardless of income or other characteristics. The services are free to families and begin when a child is about three weeks of age. Registered nurses conduct the home visits, refer parents to community programs, resources, and services based on the family's specific needs, and follow up with the families to ensure the referrals result in community connections. Families with higher needs may be referred to more intensive HV models. This partnership accelerates referrals and helps ensure the right fit between families and programs.

In Texas, Family Connects is currently serving families in Austin/Travis County, Bastrop County, Bexar County, Johnson County, Tarrant County, and Victoria County.

Research also suggests that referral or outreach materials about HV programs must be culturally and linguistically appropriate; if outreach materials are not translated across relevant languages or reflective of the cultural values and preferences of a community, they may fail to effectively engage new participants.[59]

Strategy 5: Using precision research to support efficient, effective practice

The innovative strategies described above provide opportunities to engage more families across the state in HV programs. However, expansion should also be efficent and effective at supporting families. For instance, technology holds promise to reach and engage more families, but it is important to understand which families have the best outcomes when all visits are virtual, which families benefit most from a blended approach, and which families need all in-person visits to get the same positive effects. Precision research, which stems from the fields of precision medicine and precision public health, can be used to answer this type of question (see side bar for other examples of precision research questions). Precision research focuses on understanding what specifically works best for whom and in what circumstances. This focus differs from traditional HV research, which often compares the outcomes of families who receive HV services against those who do not to determine whether a program works on average.[60] Precision research can help ensure that HV programs maintain the compelling outcomes shown in small-scale studies when implemented using innovative strategies at a broader community and population level.[61] This type of research recognizes that families have unique strengths and needs, and it incorporates information from different stakeholders—including the families who receive services—to identify what a family specifically needs to achieve the best possible outcomes.[60] Precision research can also be used to ensure that investments in HV are used efficiently. For instance, precision research can identify which families only need light touch services versus which families need more intensive and costly services.

Precision research can answer questions like:

- What are the characteristics of home visitor supervision that are most effective at reducing staff turnover?
- What are the most cost-efficient ways to use technology to expand HV services to families in rural communities while maintaining positive results?
- Which families only need a condensed version of a program to achieve the same positive results?
- What specific supports do parents with a history of child maltreatment need to promote positive discipline practices?

Precision research can improve practice for programs at the community level:

- **Programs will have a better understanding of what works for whom in what context and can tailor their program accordingly.**
    - For instance, a program that serves families in the child welfare system may aim to improve child safety as one of its key outcomes. However, the program recognizes that some parents already have a safe home and understand when to take their children to the doctor for illness or injury. Through a precision study, the program may learn that these families only need one session on this topic to achieve the desired outcomes, whereas others whose homes are currently

unsafe may need four sessions. Currently, most HV programs aim to implement the same number of sessions for all families to maintain fidelity, but a precision study could allow for efficient and effective tailoring.[62,61]

- **Findings from precision research can be applied to support families throughout a community.**
    - For instance, a centralized intake system can apply precision research findings to match specific families to the best possible service or program based on their individual needs and desired outcomes.
- **Findings from precision research can ensure that some families with fewer needs receive less costly or light-touch services, whereas only those most in need receive intensive services or programs.**
    - For instance, precision research may establish that all pregnant women in a community benefit from basic information about when wellness visits should occur. However, some women who already had a child with poor birth outcomes may need specific, more intensive services to help ensure their next child is born healthy.

Ultimately, applying a precision approach to a community requires collecting and integrating data across systems. Integrated data can help show where the investments are, where the needs are, and how those needs may change over time at a state, county, and/or community level. At a local level, integrated data can help programs coordinate referrals and reduce duplication of services and data collection.

Conclusion

As stakeholders in Texas seek to reach more families who could benefit from HV services, innovative, research-informed approaches will be necessary to address new and existing challenges. This brief has identified strategies that can be used to finance expansion and innovation; to assess how to reach and engage families in remote areas; to reduce turnover and stabilize the HV workforce; to better connect and coordinate with other family-serving organizations; and to provide HV in the most effective and efficient manner. Implementing some or all these approaches holds promise for benefitting thousands of Texas families.

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