Overview of the Federal Home Visiting Program

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ABBREVIATIONS
ACF—Administration for Children and Families
DHHS—Department of Health and Human Services
FY—fiscal year
HomVEE—Home Visiting Evidence of Effectiveness
HRSA—Health Resources and Services Administration
MIECHV—Maternal, Infant, and Early Childhood Home Visiting
MIHOPE—Mother and Infant Home Visiting Program Evaluation

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abstract

On March 23, 2010, the President signed into law the Affordable Care Act (Public Law 111-148), which included an amendment of Title V of the Social Security Act authorizing the creation of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Authorized and funded at $1.5 billion for 5 years, the MIECHV represents a large investment in health and development outcomes for at-risk children through evidence-based home visiting programs. The MIECHV presents unprecedented opportunities to integrate early childhood services systems, not only on the federal level but also within states and local communities. The MIECHV is funded in escalating amounts over 5-year period authorized, as follows: $100 million in fiscal year (FY) 2010, $250 million in FY 2011, $350 million in FY 2012, $400 million in FY 2013, and $400 million in FY 2014. Most of the funding is being provided to states and territories to provide home visiting services in their at-risk communities. In addition, the legislation included a 3% set-aside for tribes, tribal organizations, and urban Indian organizations and a 3% set-aside for research and evaluation. This investment has spurred the creation of more comprehensive and coordinated early childhood service systems across the United States. This article provides an overview of the MIECHV program, including descriptions of the various requirements under the Affordable Care Act. These include partnering with states to provide evidence-based home visiting services to at-risk families, working with tribal communities to implement culturally competent home visiting programs, and developing a mechanism to systematically review the evidence of effectiveness for home visiting program models and to conduct a national evaluation of the MIECHV program. *Pediatrics* 2013;132:S59–S64

On March 23, 2010, the President signed into law the Affordable Care Act,[1] which included an amendment of Title V of the Social Security Act authorizing the creation of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Authorized and funded at $1.5 billion for 5 years, the MIECHV represents a large investment to support improvements in health and development outcomes for at-risk children through evidence-based home visiting programs. Before 2010, it is estimated that states spent between $500 and $750 million annually on home visiting programs.[2] The MIECHV also represents an opportunity to improve coordination of early childhood service systems at the federal, state, and community level.

The MIECHV is a partnership between the federal government and states and local communities. At the federal level, the program is administered collaboratively between the Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF) within the Department of Health and Human Services (DHHS) to provide grant funding to states and 6 jurisdictions and to Indian tribes, tribal organizations, and/or urban Indian organizations. MIECHV grantees are encouraged to coordinate home visiting and related services at the state and local levels, moving toward an integrated early childhood system.

Multiple studies have revealed that early life experiences have profound effects on the brain and body that can last a lifetime. These effects not only determine physical health but also emotional and cognitive development.[3–5] Maternal separation and nonbonding have a significant impact on early brain development, which places children at risk of emotional and cognitive deficit. The evidence reveals that intrapartum stressors and poor parenting can have lifelong impacts on infants with regard to their health, their development, and their ability to learn.[6] The biological basis for the home visiting intervention is discussed in more detail in this issue in Andrew Garner's article, "Home Visiting and the Biology of Toxic Stress: Opportunities to Address Childhood Adversity."

Home visiting is one of several service strategies embedded in a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development; strong parent-child relationships; and responsible parenting among mothers and fathers. For more than a century, home visiting has been a service and support delivery strategy for families. Home visiting gained prominence in the 1960s.[7] Today, it is regarded as an effective mechanism to reach the highest risk families.

The MIECHV authorizing legislation requires that grantees demonstrate improvement in 6 domains, including the following:

1. improved maternal and newborn health;
2. prevention of child injuries, child abuse, neglect, or maltreatment and reduction in emergency department visits;
3. improvement in school readiness and achievement;
4. reduction in crime or domestic violence;
5. improvements in family economic self-sufficiency; and
6. improvements in the coordination and referrals for other community resources and supports.

Pairing a strong early childhood system, including partnerships with the pediatric community and the large-scale implementation of evidence-based home visiting models, the MIECHV has the potential to have significant impacts on public health and the well-being of children and families.

PROGRAM STRUCTURE

A number of elements distinguish the MIECHV program from other federal programs. First, rather than being an individual-means tested program, the MIECHV legislation specifies that states must target at-risk communities for home visiting services. The legislation defines at-risk communities as those with high concentrations of the following: premature birth, low-birthweight infants, and infant mortality, including infant deaths due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high school dropouts; substance abuse; unemployment; or child maltreatment. In addition, the legislation specifies priority for serving specific high-risk populations including those who are living in an at-risk community; low-income, pregnant women younger than 21 years; families with a history of child abuse or neglect; families with a history of substance abuse; families with tobacco users; families with children with low student achievement or developmental delays; and military families. Home visiting operates through both direct interactions with families but also through community resources and referrals. Therefore, in at-risk communities, evidence-based home visiting must be paired with a strong early childhood system.

Second, the MIECHV program funding structure is noteworthy. The grants to states and territories represent a significant federal investment in home visitation. To be eligible for the funding, states had to provide assurances that they would continue their current investment in home visiting and use the federal funds to build a stronger program. Unlike other federal programs, states have the ability to determine their target populations and service needs and to select among a set of

models that meet DHHS criteria for effectiveness. In addition, the grants are given to states and territories through 2 mechanisms: formula grants and competitive grants. Formula grants are awarded to every participating state and jurisdiction on the basis of the number of children living in poverty under the age of 5 years in that state or jurisdiction. Therefore, every eligible state and jurisdiction has the opportunity to implement home visiting programs for their at-risk communities. The competitive grants are structured such that states have opportunities to develop the infrastructure to support early childhood home visiting services, test new innovations in supporting home visiting services, or expand services or innovations more broadly. There is a specific set-aside of funds reserved for tribal programs. The grants to tribes allow some tribes to begin investment in home visiting where none existed before the MIECHV. It is important to note that the intent of the MIECHV is not just service replication but rather is designed to use home visiting as leverage to create a more comprehensive and coordinated early childhood service system.

The MIECHV is funded in escalating amounts over the 5-year period authorized, as follows: $100 million in fiscal year (FY) 2010, $250 million in FY 2011, $350 million in FY 2012, $400 million in FY 2013, and $400 million in FY 2014. Most of the funding is being provided to states and territories to not only provide home visiting services to their at-risk communities but also to build the infrastructure capacity for early childhood systems. The program does not just invest in home visiting replication and dissemination across communities, it uses home visiting as the focal point in the creation of more comprehensive and coordinated early childhood services systems. In addition, the legislation includes a 3% set-aside for tribes, tribal organizations, and urban Indian organizations and a 3% set-aside for research and evaluation.

Third, the MIECHV program is one of the first federal evidence-based policy initiatives. The program reserves the majority of funding (at least 75%) for the implementation of ≥1 evidence-based home visiting models. In addition, the legislation supports continued innovation by allowing for up to 25% of the awards to states to support promising approaches and rigorous evaluation of those approaches. The DHHS established criteria for evidence of effectiveness that home visiting models must meet to be eligible for the evidence-based funding. To inform the execution of the MIECHV program, the Home Visiting Evidence of Effectiveness (HomVEE) project was launched to conduct a thorough and transparent systematic review of the home visiting research literature.

HOMVEE SYSTEMATIC REVIEW

HomVEE is the DHHS systematic review of the evidence of effectiveness for home visiting program models that serve families with pregnant women and children from birth to age 5 years. The systematic review includes a broad literature search, an assessment of the quality of the study (ie, its ability to produce unbiased impact estimates), and a determination of whether the model meets the DHHS criteria for evidence of effectiveness on the basis of the quality of the study and its findings. The HomVEE Web site summarizes which models were found to have evidence of effectiveness, detailed information on the samples of families who participated in the research, the outcomes measured in each study, and the implementation guidelines for each model.[8]

To date, 32 models have been reviewed and 14 meet the DHHS criteria for evidence of effectiveness. They are as follows: Child First, Early Head Start–Home Visiting, Early Intervention Program for Adolescent Mothers, Early Start, Family Check-Up, Healthy Families America, Healthy Steps, Home Instruction for Parents of Preschool Youngsters (HIPPY), Nurse Family Partnership, Oklahoma Community-Based Family Resources and Support, Parents as Teachers, Play and Learning Strategies–Infant, SafeCare Augmented, and Maternal Early Childhood Sustained Home Visiting Program. All of the 14 models had at least 1 favorable impact in a high- or moderate-quality study in 1 of the 8 domains specified in the legislation. Focusing on measures that were either direct observation, direct assessment, administrative records, or self-report on a normed, standardized measure only, HomVEE determined that most of the 14 evidence-based models had favorable impacts on child development or school readiness and positive parenting. In addition, 3 of the 14 models had impacts on maternal health, 6 of the 14 models had impacts on child health, and 5 of the 14 had impacts on child maltreatment. In fact, this issue provides a review of the impacts on child health and child maltreatment in Avellar and Supplee's "Effectiveness in Improving Child Health and Reducing Child Maltreatment." Table 1 provides a list of all models currently meeting DHHS criteria for evidence of effectiveness and includes the target populations served and service objectives. The HomVEE review also highlights areas in which more research is needed. For example, few of the reviewed models had impacts, using primary measures, on crime or family violence, family economic self-sufficiency, or coordination of resources and referrals. For more information on the review results, see the executive summary (http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2012.pdf), and for more information on lessons learned, gaps in the research literature, and suggestions for strengthening future research in this

TABLE 1 Home Visiting Models Meeting DHHS Criteria for Evidence of Effectiveness

Home Visiting Models Meeting DHHS Criteria	Target Population	Service Objectives
Child First	Birth to 11 months, 12–23 months, 24–35 months, 36–47 months, ≥48 months	Maternal health, child development and school readiness, reductions in child maltreatment, linkages and referrals
Early Head Start–Home Visiting	Pregnant women, birth to 11 months, 12–23 months, 24–35 months	Child development and school readiness, positive parenting practices, family economic self-sufficiency
Early Intervention Program for Adolescent Mothers	Pregnant women, birth to 11 months	Child health, family economic self-sufficiency
Early Start (New Zealand)	Birth to 11 months, 12–23 months, 24–35 months, 36–47 months, ≥48 months	Child health, child development and school readiness, reductions in child maltreatment
Family Check-Up	12–23 months, 24–35 months, 36–47 months, ≥48 months	Maternal health, child development and school readiness, positive parenting practices
Healthy Families America	Pregnant women, birth to 11 months, 12–23 months, 24–35 months, 36–47 months, ≥48 months	Child health, child development and school readiness, reductions in child maltreatment, positive parenting practices, family economic self-sufficiency, linkages and referrals
Healthy Steps	Birth to11 months, 12–23 months, 24–35 months	Child health, positive parenting practices
Home Instruction for Parents of Preschool Youngsters (HIPPY)	36–47 months, ≥48 months	Child development and school readiness, positive parenting practices
Maternal Early Childhood Sustained Home Visiting Program	Pregnant women, birth to 11 months, 12–23 months	Child health, positive parenting practices
Nurse Family Partnership	Pregnant women, birth to 11 months, 12–23 months	Maternal health, child health, child development and school readiness, reductions in child maltreatment, reductions in juvenile delinquency, family violence, and crime, positive parenting practices, family economic self-sufficiency
Oklahoma's Community-Based Family Resource and Support Program	Pregnant women, birth to 11 months	Maternal health, positive parenting practices
Parents as Teachers	Birth to 11 months, 12–23 months, 24–35 months, 36–47 months, ≥48 months	Child development and school readiness, positive parenting practices
Play and Learning Strategies (infant version only)	Birth to 11 mo, 12–23 months, 24–35 months	Child development and school readiness
Project 12 Ways/Safe Care (only Safe Care Augmented)	Birth to 11 months, 12–23 months, 24–35 months, 36–47 months, ≥48 months	Reductions in child maltreatment, positive parenting practices

Source: Home Visiting Evidence of Effectiveness (http://homvee.acf.hhs.gov/programs.aspx).

area, see http://homvee.acf.hhs.gov/Lessons_Learned.pdf.

RESEARCH AND EVALUATION

The MIECHV program has an exceptional focus on research and evaluation. First, the legislation requires a national evaluation of this new program. The Mother and Infant Home Visiting Program Evaluation (MIHOPE) is a randomized clinical trial that includes ~12 states, 85 local implementing agencies, and 5100 pregnant women or families with infants <6 months of age. The evaluation will study the 4 home visiting models selected by at least 10 states, including the following: Early Head Start–Home Visiting, Healthy Families America, Nurse Family Partnership, and Parents as Teachers. The evaluation will examine the efficacy of MIECHV, the efficacy of MIECHV by variations in programs and populations, and the potential for MIECHV to reduce health care costs and create health care efficiencies. This evaluation includes examining impacts across all of the domains in the legislation as well as a detailed cost and implementation study. The intent of the design will be to link features of programs to impacts; for example, we will link the training of staff in talking to parents about child development to impacts on child development. In addition to surveys and direct assessments of families, the study will assess administrative data including vital records, child welfare records, and Medicaid and Medicaid managed care records. The rich set of data from MIHOPE will not only be used to report to Congress on MIECHV but the data will be archived for restricted use for furthering the research on home visiting. A report to Congress is due in 2015, and a second report is anticipated in 2018. More detailed information about this study can be found at http://www.acf.hhs.gov/programs/opre/other_resrch/miece/index.html.

In addition, the HRSA and ACF partnered with the Center for Medicare and Medicaid Services to support the Strong Start for Mothers and Newborns Initiative. This partnership will expand the core MIHOPE study to recruit an additional 15 000 pregnant women in ~20 states to examine the efficacy of evidence-based home visiting to reduce preterm births, increase birth weight, and improve infant health. Reports on the MIHOPE–Strong Start program are due annually beginning in late 2013.

The legislation also calls for a continuous program of research to increase

knowledge about implementation and effectiveness of home visiting programs. A Home Visiting Research Network has been funded to create an interdisciplinary research forum on home visiting research. In addition, several investigator-initiated research projects were funded to support applied research relating to home visiting services that show promise of advancing knowledge about the implementation and effectiveness to improve life outcomes among mothers, infants, and young children.[9] This issue includes more details on this home visiting research network in the article by Anne Duggin and colleagues, "Creating a National Home Visiting Research Network."

Another way the MIECHV is contributing to our understanding of how home visiting helps children is a requirement for rigorous evaluation of promising approaches funded through the 25% allocation described above. In addition, beginning in FY 2011, a condition of the competitive grants awarded was that grantees conduct rigorous evaluation of the activities under those grants to expand services or enhance existing services. Many states are partnering with academic researchers to study activities, such as scale-up of evidence-based home visiting, the efficacy of enhancements on home visiting models, or the efficacy of infrastructure supports such as state- or county-level centralized intake and screening systems.

Finally, the legislation requires grantees to collect regular benchmark data on a range of domains and demonstrate improvement in those domains within 3 years. The domains include maternal and child health, child development and school readiness, child maltreatment, family economic self-sufficiency, crime or domestic violence, and increases in coordination of resources and referrals. Building from the legislatively mandated benchmark data collection, grantees have been required to establish continuous quality improvement plans to specify the processes and outcomes of the grantee's MIECHV program through regular data collection, the use of data to inform administration, and monitoring the application of changes to improve performance. It is anticipated that the use of continuous quality improvement methods in the MIECHV program will result in more effective program implementation and improved participant outcomes.

PURPOSE OF THIS SUPPLEMENT

This journal supplement is an exciting opportunity to share with the pediatric community information on the MIECHV and the early childhood home visiting field more broadly. To provide a strong basis for home visiting and home visiting research, we invited several authors to provide background and context for home visiting as an important early childhood intervention. Garner provides the biological impacts of in utero and early childhood adversity and toxic stress, which we now understand to be the underpinnings of poor child outcomes. His article provides clear justification for prenatal and early childhood interventions, of which home visiting is one of the few with an evidence base that demonstrates improvements in child health and development. The article by Tschudy and colleagues provides a conceptual framework for integrating home visiting into the medical home, and Duggan and colleagues provide a peek into the development of a national research agenda for home visiting.

In the fall of 2012, we held a call for abstracts and received 57. Through an objective competition, we chose 12 that demonstrated the best and most interesting results in home visiting practice, impacts, and home visiting innovation and invited those 12 to submit full articles. We believe the articles selected provide a variety of lenses on the field of home visiting and hope that the readers of the supplement will find this supplement to be a resource on the current state of home visiting practice and research. Furthermore, we hope that the supplement promotes exploration of opportunities for new collaborations and partnerships. The success of home visiting is dependent on the partnerships among the clinical and academic communities and among community educational institutions, social services, and researchers and evaluators to strengthen the early childhood systems that support children and families.

CONCLUSIONS

The MIECHV program provides an unprecedented opportunity to reach families and at-risk communities to improve child outcomes and reduce health disparities. Evidence-based home visiting models address physiologic, social, psychological, economic, family status, and other factors that influence children's health and development. The grounding of this program in evidenced-based policy recognizes the importance of using rigorous evidence of effectiveness to inform policy decision-making. Coordination of these services, including partnerships with clinicians and researchers working toward improving services and outcomes for children and families, is critical to the MIECHV's success. The HRSA and ACF look forward to promoting collaborative activities that are essential for effective, comprehensive home visiting and early childhood systems.

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