POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Early Childhood Home Visiting

James H. Duffee, MD, MPH, FAAP,[a] Alan L. Mendelsohn, MD, FAAP,[b] Alice A. Kuo, MD, PhD, FAAP,[c] Lori A. Legano, MD, FAAP,[b] Marian F. Earls, MD, MTS, FAAP,[d] COUNCIL ON COMMUNITY PEDIATRICS, COUNCIL ON EARLY CHILDHOOD, COMMITTEE ON CHILD ABUSE AND NEGLECT

High-quality home-visiting services for infants and young children can improve family relationships, advance school readiness, reduce child maltreatment, improve maternal-infant health outcomes, and increase family economic self-sufficiency. The American Academy of Pediatrics supports unwavering federal funding of state home-visiting initiatives, the expansion of evidence-based programs, and a robust, coordinated national evaluation designed to confirm best practices and cost-efficiency. Community home visiting is most effective as a component of a comprehensive early childhood system that actively includes and enhances a family-centered medical home.

abstract

FREE

[a]Boonshoft School of Medicine, Wright State University, Dayton Children's Hospital, Dayton, Ohio; [b]Department of Pediatrics, School of Medicine, New York University, New York, New York; [c]Internal Medicine Pediatrics, University of California, Los Angeles, California; and [d]Pediatric Programs, Community Care of North Carolina, Raleigh, North Carolina

Dr Duffee was intimately involved with the concept, organization, and design during the early phases of writing, he reviewed the contributions of the other authors, consolidated the contributions (along with his own) into the final product, took responsibility for responding to comments and direction from staff and the Board of Directors, and reviewed the references in detail to ensure that the evidence supports the recommendations; and Drs Kuo, Legano, Mendelsohn, and Earls assisted with revisions; and all authors approve the final manuscript as submitted.

Policy statements from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, policy statements from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.

The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

DOI: https://doi.org/10.1542/peds.2017-2150

Address correspondence to James H. Duffee, MD, MPH, FAAP. E-mail: DuffeeJ1@childrensdayton.org

To cite: Duffee JH, Mendelsohn AL, Kuo AA, et al. Early Childhood Home Visiting. *Pediatrics.* 2017;140(3):e20172150

Recent advances in program design, evaluation, and funding have stimulated widespread implementation of public health programs that use home visiting as a central service. This policy statement is an update of "The Role of Preschool Home-Visiting Programs in Improving Children's Developmental and Health Outcomes" (2009) and summarizes salient changes, emphasizes practical recommendations for community pediatricians, and outlines important national priorities intended to improve the health and safety of children, families, and communities.[1] By promoting child development, early literacy, school readiness, informed parenting, and family self-sufficiency, home visiting presents a valuable strategy to buffer the effects of poverty and adverse early childhood experiences that influence lifelong health.

The term "home visiting" refers to an evidence-based strategy in which a professional or paraprofessional renders a service in a community or private home setting. Home visiting also refers to the variety of programs that employ home visitors as a central component of a comprehensive service plan.[2] Early childhood home-visiting programs may be focused on young children, children with special health care needs, parents of young children, or the relationship between children and parents, and they can use a 2-generational strategy to simultaneously address parental and family social and economic challenges.[3]

Home-visiting programs vary widely with regard to target populations and goals. Many successful home-visiting models are directed toward mothers

and infants in high-risk groups, such as adolescent mothers and single-parent families. Other models concentrate on specific populations, such as recently incarcerated adolescents, children with special needs, or immigrants. Some programs are designed to identify risk factors, such as environmental hazards and maternal mental health, but others include mentoring, coaching, and other therapeutic interventions. Many employ independently licensed health professionals, but others depend on trained paraprofessionals (including community health workers) drawn from the communities they serve. Community-based care coordination (including housing, transportation, and nutritional support) often are service components. Integration with the family-centered medical home (FCMH) has been a recent focus for program improvement and medical education.[4]

HISTORY AND DEVELOPMENT OF HOME VISITING IN THE UNITED STATES

Social Justice Movements Before 1950

Home visiting began in the United States in the 1880s as an activity of each of 3 social justice movements. Derived from the British models developed a few decades earlier, home visitors were deployed to promote universal kindergarten, improve maternal-infant health through public health nursing, and support impoverished immigrant communities as part of the philanthropic settlement house movement. From the late 19th through the early 20th century, teachers and public health nurses visited communities and families to provide in-home education and health care to urban women and children. These efforts were based on the assumptions still held that education is the most powerful strategy to lift children out of poverty and that the lifelong health of families in immigrant and poor neighborhoods is improved by addressing the social and economic aspects of health and disease.[5]

The War on Poverty and Prevention of Child Maltreatment

From the Great Depression through World War II, funding for social initiatives decreased and philanthropic support for home visitors declined. After the relatively prosperous postwar period, renewed interest developed in antipoverty activities, including home visiting, especially in the context of the Civil Rights Movement. In the 1960s, home visiting became an important component of the government's so-called War on Poverty. Home visiting was and remains integral to programs such as Head Start, although it is applied on a limited basis compared with Early Head Start, for which home visiting is a central service component. A decade later, many home-visiting programs shifted to include case management, intending to help families achieve self-sufficiency and link them to other broad community support services.[6] Improving school readiness, moderating poverty-related social risk determinants, reducing environmental safety hazards, and promoting population-based health remain core goals of contemporary home visiting.

In the last quarter of the 20th century, home visiting gained renewed attention as a strategy for the prevention of child abuse and neglect, promotion of child development, and improvement of parental effectiveness. C. Henry Kempe, MD, called for a home visitor for every pregnant mother and preschool-aged child in his 1978 Abraham Jacobi Memorial Award address.[7] He suggested that integral to every child's right to comprehensive care is the assignment of a home health visitor to work with the family until each child began school. The visionary pediatrician who developed the concept of the medical home, Cal Sia, MD, reiterated Kempe's call to action in his 1992 Jacobi Award address[8] based on his experience with Hawaii's Healthy Start Program, which is an innovative, statewide home-visiting initiative to prevent child abuse and neglect. Another pioneer in modern home visiting, David Olds, PhD, initiated the Nurse-Family Partnership (NFP) with families at risk in Elmira, New York, in 1978.[1]

Expansion of Home Visiting in Recent Decades

Before 2009, at least 22 states recognized the critical role of home visitors within statewide systems for at-risk pregnant mothers, infants, and toddlers from birth to 5 years old. States legislated funding for home-visiting programs while insisting on proof of effectiveness, fiscal accountability, and continuous quality improvement. Even during the Great Recession that followed the US financial crisis of 2007 to 2008, some state governments enacted home-visiting legislation to ensure long-term sustainability through innovative financing mechanisms and the strategic allocation of limited public resources.

In 2009, the American Recovery and Reinvestment Act (Public Law Number 111-5) included $2.1 billion for the expansion of Head Start and Early Head Start (including the home-visiting components of Early Head Start) to benefit young children in low-resource communities. The next year, the Patient Protection and Affordable Care Act of 2010 (ACA) (Public Law Number 111-148) designated $1.5 billion, allocated over 5 years, for the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). The Health Resources and Services Administration currently administers the MIECHV in collaboration with the Administration for Children and Families. The allocations to states, territories, and tribal entities are designed to support the implementation and evaluation of evidence-based home-visiting programs regarding specified

goals and objectives. All 50 states, the District of Columbia, and 5 US territories have home-visiting programs.[9] In addition, ACA funding provides support for home-visiting initiatives to serve American Indian and Alaskan native children through the Tribal MIECHV program.[10]

Nineteen home-visiting models have met the criteria of the US Department of Health and Human Services (HHS) for evidence of effectiveness through the Home Visiting Evidence of Effectiveness (HomVEE) review. Supported by federal grants through the MIECHV, states receive funding to implement 1 or more evidence-based models designated eligible by the MIECHV that best meet the needs of particular at-risk communities. The program objectives must improve outcomes that are statutorily defined and must include increased family economic self-sufficiency, improved health indicators (eg, a reduction in health disparities) in target populations, and improved school readiness. After 2013, potential program outcomes were expanded to include reductions in family violence, juvenile delinquency, and child maltreatment.[11] A review of 4 common programs illustrates the range of measurable outcomes. Healthy Families America identifies family self-sufficiency as a principal objective measured by a reduction of dependence on public assistance.[12] Early Head Start and other home-visiting programs focus on the promotion of child development and positive family relationships. NFP is designed to improve prenatal health, maternal life course development, and positive parenting.[13] Parents as Teachers promotes child development and school readiness.[14]

HOME VISITING OUTSIDE THE UNITED STATES

Home visiting for families with young children is an early intervention strategy in many industrialized nations outside of the United States. In several European countries, home health visiting is provided at no cost to the family, participation is voluntary, and the service is embedded in a comprehensive maternal and child health system.[3] While visiting young mothers at home, public health nurses in other countries provide many child health-promotion services that are provided by pediatricians in the United States. For instance, Denmark established home visiting in 1937 after a pilot program showed lower infant mortality rates linked with the services of home visitors. France provides universal prenatal care and home visits by midwives and nurses, who educate families about smoking, nutrition, drug use, housing, and other health-related issues.

The Early Start program in New Zealand targets families with 2 or more risk factors on an 11-point screening measure that includes parent and family functioning. Randomized controlled trials showed improvement in access to health care, lower hospitalization rates for injuries and poisonings, longer enrollment in early childhood education, and more positive and nonpunitive parenting.[15,16] The Dutch NFP program, VoorZorg, was found to reduce victimization and perpetration of self-reported intimate partner violence during pregnancy and 2 years after birth among low-educated, pregnant young women,[17] and there were fewer reports of child abuse. At 24 months, measurable improvements were evident in the home environments of participating families, and the children exhibited a significant reduction in internalizing symptoms.[18]

Paraprofessionals (ie, trained but unlicensed lay people) are often employed as home visitors in low-resource areas of the world. In Haiti, for example, community health workers trained by Partners in Health improve the care of those with HIV, multidrug-resistant tuberculosis, and such waterborne illnesses as cholera. In southern Mexico and other areas in Central America, "promotoras de salud," or community health workers, coordinate with lay midwives to care for expectant mothers in rural, isolated, and other low-resource regions. Promotoras are deployed in many regions in the United States and have been recognized by HHS for their ability to reduce barriers and improve access to culturally informed and linguistically appropriate health care.[19]

POVERTY, CHILD HEALTH, AND HOME VISITING

More than 1 in 5 young children in the United States live in families with incomes below the federal poverty level, and more than 2 in 5 live at less than twice that level.[20] Living at or below 200% of the federal poverty level places children,[21] especially infants and toddlers, at high risk for adverse early childhood experiences that lead to lifelong detrimental effects on health, education, and vocational success.[22] Home visitors can help families attain economic self-sufficiency by linking them to community support services (such as quality preschool) while encouraging parents to enroll in training opportunities that lead to employment. Although they differ in structure, targeted populations, and intended outcomes, high-quality home-visiting programs deliver family support and child development services that provide a foundation for physical health, academic success, and economic stability in vulnerable families that are at risk for the adverse effects of poverty and other negative social determinants of health.

By applying multigenerational interventions, home visiting may improve child health and family wellbeing in many domains. Individual neuroendocrine-immune function, behavioral allostasis, and relational health are all established in the first

3 years of life,[23] when home visiting is most often applied.[24] The emerging science of toxic stress indicates that poverty and its accompanying problems, such as food insecurity, may disrupt the architecture and function of the developing brain.[25,26] Home visitors have the opportunity to assess risk and protective factors in families, identify potential adversity, and intervene at the earliest opportunity. By promoting supportive relationships, reducing parental stress, and increasing the likelihood of positive experiences, home visiting may help avoid the deleterious behavioral and medical health outcomes associated with child poverty.[27–31]

Young mothers in poverty disproportionately suffer moderate to severe symptoms of maternal depression, elevating the risk of poor developmental and educational outcomes for their children.[32] Almost 1 in 4 mothers who are near or below the federal poverty level experience significant depression, but few obtain appropriate treatment. In-home cognitive behavioral therapy is a novel treatment modality for maternal depression that has proved to be effective in early trials.[33] Combining in-home cognitive behavioral therapy with other home-visiting programs, such as Early Head Start, that promote positive parenting and infant development provides a model of 2-generational care that has the potential to mitigate the effects of poverty and improve both family financial stability and school readiness.[34]

Home-visiting programs are most effective when they are components of a community-level, comprehensive early childhood system that reaches families as early as possible with needed services, accommodates children with special needs, respects the cultures of the families in the communities, and ensures continuity of care in a continuum from prenatal life to school entry.[35,36]

An early childhood system may include safety-net resources (such as supplemental food and subsidies for housing, heating, and child care), adult education, job training, cash assistance, quality child care, early childhood education, and preventive health services.[37] Communicating the strengths and risk factors of individual families to the FCMH may further increase the coordination of care and efficient use of services.[38]

NATIONAL EVALUATION AND EVIDENCE OF EFFECTIVENESS

When the MIECHV program was established by the ACA, HHS established the HomVEE review of the research literature on home visiting.[11] Results of that review are used to identify home-visiting service delivery models that meet HHS criteria for evidence of effectiveness because, by statute, at least 75% of the funds available from the ACA are to be used for programs that use service delivery models that are evidence based. The HomVEE conducts a yearly literature search to identify promising studies of home-visiting models. It includes only studies that are considered to meet quality standards on the basis of overall design (only randomized controlled trials or quasiexperimental studies are included) and design-specific criteria. Studies that meet criteria for entry are then assessed for outcomes in the following 8 domains, as defined by HHS:

- Child health;
- Maternal 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; and
- Linkages and referrals.

To meet HHS criteria for evidence of effectiveness, home-visiting models must demonstrate favorable outcomes in either 1 study with results in 2 or more domains or 2 studies with significant benefits in the same domain. To be included, study designs must meet evaluation quality standards, and outcomes need to show statistically significant benefits using nonoverlapping analytic samples. As of April 2017, the 18 models that meet these standards (along with 2 programs that do not meet criteria for implementation) with target populations, ages of participants, and outcomes for which there is evidence are listed in Table 1.[11]

A rapidly expanding evidence base documents the benefits of high-quality home-visiting programs, especially when they are integrated in a comprehensive early childhood system of care.[39] Home visiting has been shown to increase children's readiness for school, promote child health (such as vaccine rates), and enhance parents' abilities to promote their children's overall development. There is evidence that home visiting reduces the risk of both child abuse and unintended injury.[16,40] Maternal health is improved by more frequent prenatal care, better birth outcomes, and early detection and treatment of depression.[41] Outcome studies have established the effectiveness of home visiting by nurses or community health workers in reducing child maltreatment,[42] improving birth outcomes,[43] and increasing school readiness.[44]

A close examination of the evidence of effectiveness published in 2015 by the HomVEE review provides additional insights about the potential benefits and limitations of current models of home visiting.[11] Of the 44 models assessed in 2015, 19 showed improvements in at least 1 primary outcome measure, and 15 had favorable effects on secondary measures. These results are consistent with both the broad scope of many of the models as well as the likelihood that improvements in 1

TABLE 1 Home-Visiting Programs Meeting HHS Criteria for Evidence of Effectiveness (as of April 2017)

Home-Visiting Program	Ages Served (With Evidence of Effectiveness)	Target Population	Evidence for Effect on Outcomes[a]
Attachment and Behavioral Catch-Up Intervention	0–2 y	Caregivers of infants and young children aged 6–24 mo, including high-risk birth parents and caregivers of young children in foster care, kinship care (such as a grandparent raising a grandchild), and adoptive care	1, 3, 6
Child First	0–3 y	Pregnant women and families with children aged 0–6 y; children with emotional, behavioral, or developmental concerns; or families facing multiple risks for child outcomes	2, 3, 4, 8
Durham Connects (also known as Family Connects)	0–1 y	All families residing within a defined service area that have newborns aged 2–12 wk; supports families' efforts to enhance their children's health and wellbeing and reduces rates of child abuse and neglect	1, 2, 6, 8
Early Head Start Home Visiting	Pregnant women, 0–3 y	Children with emotional, behavioral, or developmental concerns, or families facing multiple risks	3, 4, 6, 7, 8
Early Intervention Programs for Adolescent Mothers	Pregnant women, 0–1 y	Pregnant adolescents from underserved minority groups referred to the county health department or health services agency for nursing care; eligible if aged 14–19 y, at ≤26 wk gestation, pregnant with first child, or planning to keep the infant	1, 7
Early Start (New Zealand)	0–5 y	At-risk families with children from age 0–5 y; also, a focus on the Maori population	1, 3, 4, 6
Family Check-Up	2–5 y	Families with children aged 2–17 y who have the following risk factors: socioeconomic, child conduct problems, academic failure, depression, or risk for early substance use	2, 3, 6
Family Spirit	0–3 y, begins in pregnancy	American Indian mothers and their children (incorporates traditional tribal teachings)	2, 3, 6

domain sometimes lead to benefits in another (eg, positive parenting improving child development). All 19 models that showed positive results had evidence of sustained benefits for at least 1 year after enrollment.

In addition to the 19 models approved in 2015, 8 of the 25 that were not approved had evidence of benefit, perhaps because of stringent criteria for study quality and number. Even among programs showing positive outcomes, there was not a high level of consistency across domains. For example, only 7 of 19 models demonstrated benefits in the same domain across 2 or more studies. Many effect sizes were fairly small (approximately 0.2 SDs) but comparable to those seen in many studies of programs located in other settings (eg, early child education).[45] However, modest effect sizes in studies concerning developmental delay can result in important population-level effects given the high proportion of children in low-income families (nearly 20%) meeting criteria for early intervention services.[46,47]

Longitudinal studies within the HomVEE review of the NFP have shown improvements in adolescent mental health, middle school achievement, substance use and/or criminality immediately after high school, and overall maternal and child mortality.[48–50] Other studies document the persistence of beneficial outcomes after population-level scaling. A study of Durham Connects (also known as Family Connects) showed more than 80% participation and 84% adherence among all mothers delivering in Durham, North Carolina, during an 18-month period.[51] Researchers in this study, using rigorous methodology, documented important and beneficial effects on child health, including a 59% reduction in emergency medical care, an increase in positive parenting, successful linkages to community services, and

TABLE 1 Continued

Home-Visiting Program	Ages Served (With Evidence of Effectiveness)	Target Population	Evidence for Effect on Outcomes[a]
Health Access Nurturing Development Services	Pregnant women, birth–3 mo	First-time pregnant mothers, mothers with multiple risks	1, 2, 4, 7
Healthy Beginnings	Pregnant women, birth–23 mo	First-time mothers of infants from socially and economically disadvantaged communities	1, 2, 3, 6
Healthy Families America	Pregnant women, 0–5 y (enroll prenatally or at birth)	Parents facing challenges such as single parenthood, low income, childhood history of abuse and adverse child experiences, current or previous issues related to substance abuse, mental health issues, and/or domestic violence	1–8
Healthy Steps (national evaluation 1996 protocol) Note: These results focus on Healthy Steps as implemented in the 1996 evaluation. HHS has determined that home visiting is not the primary service delivery strategy, and the model does not meet current requirements for MIECHV program implementation.	0–3 y	Implemented in primary care for parents with children aged 0–3 y	1, 6
Home Instruction for Parents of Preschool Youngsters	3–5 y	Parents who have doubts about or lack confidence in their ability to instruct their children and prepare them for school	3, 6
Maternal Early Childhood Sustained Home-Visiting Program	Pregnant women, 0–2 y	Disadvantaged, pregnant women at risk for adverse maternal and/or child health and development outcomes with the following risk factors: lack of support, history of mental illness or childhood abuse, depression, life stressors, history of domestic violence, or alcohol or drug use in the home	1, 2, 6
Minding the Baby	Pregnant women, 0–2 y	First-time mothers living in low-income settings, in their second or third trimester of pregnancy, who are aged 14–25 y, and who are receiving prenatal services from 1 of 2 collaborating community health clinics	1, 2

improved maternal mental health. In addition, a large-scale study of SafeCare home-based services showed reductions in reports to child protective services after a scale-up of the program in Oklahoma.[52] These beneficial outcomes of rigorous program evaluation counterbalance other studies that found little or no benefit after a scale-up, such as the finding of reduced implementation fidelity and limited benefit after scaling up Hawaii's Healthy Start Program.[53]

Other studies document the capacity of home visiting to successfully target specific high-risk populations and implement interventions of varying intensity specific to the intended outcome. For example, Computer-Assisted Motivational Intervention, when applied in combination with home visiting, successfully reduced subsequent pregnancies among pregnant teenagers.[54] Other 2-generational interventions, including Family Spirit (which targets American Indian teen-aged mothers) and Family Check-Up (which targets young mothers with depression), improved behavioral problems in infants and young children as well as the mental health of the young mothers.[55–57]

Finally, the outcomes documented by the HomVEE need to be considered in the context of a number of meta-analyses and systematic reviews that have been conducted outside of the HomVEE. One of the most cited is a meta-analysis that documented significant benefits across 4 broad domains, including child development, child abuse prevention, childrearing, and maternal life course.[58] Benefits were maximized when specific rather than general populations were targeted, when interventions used professionals versus paraprofessionals, and when interventions were more specifically focused on parental rather than child wellbeing.[59–61]

TABLE 1 Continued

Home-Visiting Program	Ages Served (With Evidence of Effectiveness)	Target Population	Evidence for Effect on Outcomes[a]
NFP	Pregnant women, 0–2 y (enroll early in pregnancy)	First-time, low-income mothers and their children	1–7
Oklahoma Community-Based Family Resource and Support Program Note: Implementation support is not currently available for the model.	Pregnant women, 0–1 y	First-time mothers (begins before 28 wk gestation)	1, 6
Parents as Teachers	Pregnant women, 0–5 y	Children with special needs, families at risk for child abuse, income-based criteria, teen-aged parents, first-time parents, immigrant families, low-literate families, or parents with mental health or substance abuse issues	3, 4, 6, 7
Play and Learning Strategies	0–3 y	Children, to strengthen parent-child bonding and stimulate children's early language, cognitive, and social development	3, 6
SafeCare Augmented (an adaptation of SafeCare)	0–5 y	Families with a history of child maltreatment or families at risk for child maltreatment	4, 8

Reference: https://www.mathematica-mpr.com/our-publications-and-findings/publications/home-visiting-evidence-of-effectiveness-review-executive-summary-april-2017. Descriptions of specific home-visiting programs by state can be accessed at: https://homvee.acf.hhs.gov/models.aspx.

[a] Outcomes: (1) child health; (2) maternal health; (3) child development and school readiness; (4) reductions in child maltreatment; (5) reductions in juvenile delinquency, family violence, and crime; (6) positive parenting practices; (7) family economic self-sufficiency; and (8) linkages and referrals.

HOME VISITING AND THE MEDICAL HOME

Integration of home visiting with the medical home expands the multidisciplinary team into the community, enhancing the goals of communication, coordination of care, and comprehensive care. With effective leadership, the pediatric or FCMH may become a community hub that connects early education and child development activities with health promotion to support maximum outcomes for children and families. The Institute for Healthcare Improvement has described the triple aim as improvement of the health of populations, improvement of the quality of care and experience of each patient, and the reduction of per capita cost. The history of home visiting also reveals another triple aim of improving health, preparing children for education, and reducing poverty. An advanced medical home that reaches out to the community by collaborating with or integrating a high-quality home-visiting program has the potential of meeting both sets of triple aims.[62,63]

Some important factors that are common among home-visiting programs that are also characteristic of an FCMH include an emphasis on relationships, the provision of culturally informed care, coordination with other community support agencies, an emphasis on strength-based assessments, and collaboration with families to support self-identified goals. Of particular importance is the relationship that develops between the visitor and the family engaging in a natural environment and the consequent improvement in the relationships among family members.[64] As more has been learned about toxic stress and its negative effect on the life trajectory, close and nurturing relationships have emerged as a most important protective factor. The home visitor can extend the support of the medical home into the community and provide an important link for the family to the relationship with a compassionate pediatric practitioner while improving family relational health.[65]

The integration or colocation of home visiting with the medical home presents many opportunities for synergy and collaboration. The joint statement from the Academic Pediatric Association and the American Academy of Pediatrics (AAP) regarding integration of the FCMH with home visiting emphasizes the potential for coordinated anticipatory guidance, improved early detection, and enhanced community involvement.[66] Recommendations in the joint statement include integrated, computerized record systems; the creation of a joint registry; coverage of home visiting by payers, including Medicaid and the Children's Health Insurance Program; and supporting the evaluation of coordination between an FCMH and home visiting. In a collaborative model, referrals between a pediatric practitioner and the home visitor may constitute a warm handoff (face-to-face introduction), increasing the likelihood that family concerns are communicated and addressed. For example, a home visitor has the opportunity to complete developmental screening with the parent in a child's natural environment. The results of screening may be communicated to the pediatric practitioner for use and comparison with the developmental assessment during health-promotion visits. A shared chronic condition care plan facilitates common therapeutic goals, linkages to community resources, and

follow-up on referrals. Particularly helpful have been home-visiting strategies for children with diabetes or asthma. Researchers have associated home visiting with improvements in symptoms, urgent care use, and family quality of life.[67]

Home visiting may be used effectively as an adjunctive strategy in comprehensive community-based programs serving children. Although not approved for MIECHV funding, Healthy Steps for Young Children is a comprehensive primary-care model that may include on the treatment team a home visitor who supports positive parenting, provides in-home developmental assessment, and links the family more strongly to the medical home.[68] The example of Healthy Steps illustrates the significant potential benefits from improved collaboration between the medical home and community home-visiting programs. These include common documentation, centralized intake services, strength-based assessments, colocation of home visitors in the pediatric practice, and multidisciplinary team meetings convened by the practice. Through these coordinated activities, home visitors are in partnership with the medical home to build parental resilience, promote child development, and support healthy family relationships.[66,69] Other models that similarly employ home visiting as an adjunctive strategy, such as the Health Resources and Services Administration's Bridging the Word Gap Research Network[70,71] and the New York City Council's City's First Readers program, exemplify systematic linkages among the medical home, home-visiting programs, and other community-based services with early childhood education.[63,72]

RECOMMENDATIONS AND POSITION STATEMENT

Because home-visiting models and programs cross many health systems and involve many funding sources, this policy divides recommendations into the following 3 levels: community pediatricians, large health systems, and researchers. The section concludes with AAP-supported federal and state advocacy strategies.

Community Pediatricians

- Provide community-based leadership to promote home-visiting services to at-risk young mothers, children, and families;
- Be familiar with state and local home-visiting programs and develop the capacity to identify and refer eligible children and pregnant mothers;
- Consider opportunities to integrate or colocate home visitors in the FCMH;
- Recognize home-visiting programs as an evidence-based method to enhance school readiness and reduce child maltreatment;
- Recognize home visiting as a promising strategy to buffer the effects of stress related to the social determinants of health, including poverty; and
- Serve as a referral source to home-visiting programs as a strategy to engage families in services and strengthen the connection between home visiting and the medical home.

Large Health Systems, Managed Care Organizations, and Accountable Care Organizations

- Develop a continuum of early childhood programs that intersects or integrates with the FCMH;
- Ensure that home-visiting programs are culturally responsive, linguistically appropriate, and family centered, emphasizing collaboration and shared decision-making;
- Ensure that all home-visiting programs incorporate evidence-based strategies and achieve program fidelity to ensure effectiveness;
- Support the use of trained community health workers, especially in lower-resourced, tribal, and immigrant communities; and
- Develop training and certification programs for community health workers to ensure quality and fidelity to program expectations.

Researchers

- Improve understanding of how to engage difficult-to-reach and high-risk communities and populations, including immigrant families, families with low literacy and/or health literacy and limited English proficiency, families that are socially isolated, and families living in poverty in evidence-based home-visiting programs;
- Improve understanding of how to take successful programs to scale while maintaining fidelity;
- Improve understanding of how to optimize links between evidence-based home-visiting programs and the medical home;
- Determine the degree to which the medical home and strategies using multidisciplinary and integrated interventions can provide added value to and synergy with evidence-based home-visiting programs;
- Determine the degree to which home-visiting programs can augment the medical home in the prevention or mitigation of chronic disease, such as asthma and obesity, and associated morbidities;
- Improve understanding of how to tailor the implementation of evidence-based home-visiting programs to diverse populations with heterogeneous strengths and challenges; and
- Investigate and establish the cost-effectiveness and return on investment of home-visiting programs as well as program components.

The AAP Endorses and Promotes the Following General Policy Positions and Advocacy Strategies:

- The continuation and expansion of federal funding for evidence-based home-visiting programs;
- Public support for the dissemination of home-visiting programs that meet the HomVEE criteria for evidence of effectiveness as well as other programs with early and promising evidence of potential effectiveness;
- The establishment of state systems that integrate home-visiting infrastructure (such as data collection and evaluation) into a comprehensive early childhood service system;
- Coordination across state agencies and health systems that serve young children to build an efficient and effective infrastructure for home-visiting programs;
- The simplification and standardization of referral processes in and among states to improve the coordination of care and integration of home-visiting services with the medical home; and
- The inclusion of home-visiting experience in community pediatrics education and exposure by residents and medical students to the evidence of effectiveness of home-visiting models.

CONCLUSIONS

The objectives of contemporary home-visiting programs have strong roots in public health, early childhood education, and antipoverty efforts. Home visiting has expanded rapidly in the recent past, with the current generation of programs providing strong evidence of effectiveness in many domains of family life. Rigorous national outcome evaluations substantiate that home-visiting programs are effective in the promotion of healthy family relationships, improvement of overall child development, prevention of child maltreatment, advancement of school readiness, and improvement of maternal physical and mental health. By linking families to opportunities such as employment and continuing education, home visiting increases family economic stability and thereby is a successful antipoverty strategy. Home-visiting programs have shown the most effectiveness when they are components of community-wide, early childhood service systems. With pediatrician leadership, the FCMH can serve as the hub for coordinating community-based, family support programs at the intersection of early education with public health promotion designed to help children avoid the lifelong effects of early childhood adversity.

LEAD AUTHORS

James H. Duffee, MD, MPH, FAAP
Alan L. Mendelsohn, MD, FAAP
Alice A. Kuo, MD, PhD, FAAP
Lori Legano, MD, FAAP
Marian F. Earls, MD, MTS, FAAP

COUNCIL ON COMMUNITY PEDIATRICS EXECUTIVE COMMITTEE, 2016–2017

Lance A. Chilton, MD, FAAP, Chairperson
Patricia J. Flanagan MD, FAAP, Vice Chairperson
Kimberley J. Dilley, MD, MPH, FAAP
James H. Duffee, MD, MPH, FAAP
Andrea E. Green, MD, FAAP
J. Raul Gutierrez, MD, MPH, FAAP
Virginia A. Keane, MD, FAAP
Scott D. Krugman, MD, MS, FAAP
Julie M. Linton, MD, FAAP
Carla D. McKelvey, MD, MPH, FAAP
Jacqueline L. Nelson, MD, FAAP

LIAISONS

Jacqueline R. Dougé, MD, MPH, FAAP – *Chairperson, Public Health Special Interest Group*
Kathleen Rooney-Otero, MD, MPH – *Section on Pediatric Trainees*

STAFF

Camille Watson, MS

COUNCIL ON EARLY CHILDHOOD EXECUTIVE COMMITTEE, 2016–2017

Jill M. Sells, MD, FAAP, Chairperson
Elaine Donoghue, MD, FAAP
Marian Earls, MD, FAAP
Andrew Hashikawa, MD, FAAP
Terri McFadden, MD, FAAP
Alan Mendelsohn, MD, FAAP
Georgina Peacock, MD, FAAP
Seth Scholer, MD, FAAP
Jennifer Takagishi, MD, FAAP
Douglas Vanderbilt, MD, FAAP
Patricia Gail Williams, MD, FAAP

LIAISONS

Laurel Murphy Hoffmann, MD – *Section on Pediatric Trainees*
Barbara Sargent, PNP – *National Association of Pediatric Nurse Practitioners*
Alecia Stephenson – *National Association for the Education of Young Children*
Dina Lieser, MD, FAAP – *Maternal and Child Health Bureau*
David Willis, MD, FAAP – *Maternal and Child Health Bureau*
Rebecca Parlakian, MA – *Zero to Three*
Lynette Fraga, PhD – *Child Care Aware*

STAFF

Charlotte Zia, MPH, CHES

COMMITTEE ON CHILD ABUSE AND NEGLECT, 2016–2017

Emalee G. Flaherty, MD, FAAP
Amy R Gavril, MD, FAAP
Sheila M. Idzerda, MD, FAAP
Antoinette "Toni" Laskey, MD, MPH, MBA, FAAP
Lori A. Legano, MD, FAAP
John M. Leventhal, MD, FAAP

LIAISONS

Harriet MacMillan, MD – *American Academy of Child and Adolescent Psychiatry*
Elaine Stedt, MSW – *Department of Health and Human Services Office on Child Abuse and Neglect*
Beverly Fortson, PhD – *Centers for Disease Control and Prevention*

STAFF

Tammy Hurley

ABBREVIATIONS

AAP: American Academy of Pediatrcs
ACA: Patient Protection and Affordable Care Act
FCMH: family-centered medical home
HHS: US Department of Health and Human Services
HomVEE: Home Visiting Evidence of Effectiveness
MIECHV: Maternal, Infant, and Early Childhood Home Visiting Program
NFP: Nurse-Family Partnership

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

REFERENCES

1. Council on Community Pediatrics. The role of preschool home-visiting programs in improving children's developmental and health outcomes. *Pediatrics*. 2009;123(2):598–603
2. Boller K, Strong DA, Daro D. Home visiting: looking back and moving forward. *Zero Three*. 2010;30(6):4–9
3. Finello KM, Terteryan A, Riewerts RJ. Home visiting programs: what the primary care clinician should know. *Curr Probl Pediatr Adolesc Health Care*. 2016;46(4):101–125
4. Tschudy MM, Platt RE, Serwint JR. Extending the medical home into the community: a newborn home visitation program for pediatric residents. *Acad Pediatr*. 2013;13(5):443–450
5. Buhler-Wilkerson K. What is a public health nurse? Historical visions of public. University of Pennsylvania School of Nursing. Available at: http://www.nursing.upenn.edu/nhhc/home-care/what-is-a-public-health-nurse/index.php. Accessed June 10, 2016
6. Finello KM; California Center for Infant-Family and Early Childhood Mental Health. A brief history of home visiting in the United States. Available at: http://cacenter-ecmh.org/wp/a-brief-history-of-home-visiting-in-the-united-states/. Accessed June 10, 2016
7. Kempe CH. Child abuse--the pediatrician's role in child advocacy and preventive pediatrics. *Am J Dis Child*. 1978;132(3):255–260
8. Sia CC. Abraham Jacobi Award address, April 14, 1992 the medical home: pediatric practice and child advocacy in the 1990s. *Pediatrics*. 1992;90(3):419–423
9. US Department of Health and Human Services, Health Resources and Services Administration; Maternal and Child Health Bureau. Maternal, infant, and early childhood home visiting. Available at: http://mchb.hrsa.gov/programs/homevisiting/. Accessed June 10, 2016
10. Adirim T, Supplee L. Overview of the federal home visiting program. *Pediatrics*. 2013;132(suppl 2):S59–S64
11. Avellar S, Paulsell D, Sama-Miller E, Del Grosso P, Akers L, Kleinman R; Office of Planning, Research and Evaluation, Administration for Children and Families, US Department of Health and Human Services. Home Visiting Evidence of Effectiveness Review: Executive Summary. 2015. Available at: http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2015.pdf. Accessed June 10, 2016
12. Healthy Families America. Available at: www.healthyfamiliesamerica.org/. Accessed June 10, 2016
13. Office of Planning, Research and Evaluation, Administration for Children and Families, US Department of Health and Human Services. Home visiting evidence of effectiveness: nurse family partnership. Available at: http://homvee.acf.hhs.gov/Model/1/Nurse-Family-Partnership–NFP–In-Brief/14. Accessed June 10, 2016
14. US Department of Health and Human Services; Administration for Children and Families. Parents as teachers. Available at: https://homvee.acf.hhs.gov/Model/1/Parents-as-Teachers--PAT-/16/#ModelsProgramModelDescription. Accessed July 13, 2017
15. Fergusson DM, Grant H, Horwood LJ, Ridder EM. Randomized trial of the Early Start program of home visitation. *Pediatrics*. 2005;116(6). Available at: www.pediatrics.org/cgi/content/full/116/6/e803
16. Fergusson DM, Boden JM, Horwood LJ. Nine-year follow-up of a home-visitation program: a randomized trial. *Pediatrics*. 2013;131(2):297–303
17. Mejdoubi J, van den Heijkant SC, van Leerdam FJ, Heymans MW, Hirasing RA, Crijnen AA. Effect of nurse home visits vs. usual care on reducing intimate partner violence in young high-risk pregnant women: a randomized controlled trial. *PLoS One*. 2013;8(10):e78185
18. Mejdoubi J, van den Heijkant SC, van Leerdam FJ, Heymans MW, Crijnen A, Hirasing RA. The effect of VoorZorg, the Dutch nurse-family partnership, on child maltreatment and development: a randomized controlled trial. *PLoS One*. 2015;10(4):e0120182
19. US Department of Health and Human Services. HHS Promotores de Salud Initiative. Available at: http://minorityhealth.hhs.gov/omh/content.aspx?ID=8929. Accessed June 10, 2016
20. Child Trends Data Bank. Children in poverty, Indicators of Child and Youth Well-being. 2016. Available at: https://www.childtrends.org/wp-content/uploads/2016/12/04_Poverty.pdf. Accessed July 13, 2017
21. Council on Community Pediatrics. Policy statement: poverty and child health in the United States. *Pediatrics*. 2016;137(4):e20160339
22. Garner AS, Shonkoff JP; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health. *Pediatrics*. 2012;129(1). Available at: www.pediatrics.org/cgi/content/full/129/1/e224
23. Shonkoff JP, Garner AS; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012;129(1).

Available at: www.pediatrics.org/cgi/content/full/129/1/e232

24. Pascoe JM, Wood DL, Duffee JH, Kuo A; Committee on Psychosocial Aspects of Child and Family Health; Council on Community Pediatrics. Mediators and effects of childhood poverty in the United States. *Pediatrics*. 2016;137(4):e20160340
25. National Scientific Council on the Developing Child; Harvard University, Center on the Developing Child. Excessive stress disrupts the architecture of the developing brain: working paper 3. 2014. Available at: http://developingchild.harvard.edu/wp-content/uploads/2005/05/Stress_Disrupts_Architecture_Developing_Brain-1.pdf. Accessed June 10, 2016
26. Noble KG, Houston SM, Brito NH, et al. Family income, parental education and brain structure in children and adolescents. *Nat Neurosci*. 2015;18(5):773–778
27. Harvard University, Center on the Developing Child. Supportive relationships and active skill-building strengthen the foundations of resilience: working paper 13. 2015. Available at: http://developingchild.harvard.edu/wp-content/uploads/2015/05/The-Science-of-Resilience.pdf. Accessed June 10, 2016
28. National Center for Injury Prevention and Control at the US Centers for Disease Control and Prevention. Essentials for childhood: steps to create safe, stable, nurturing relationships and environments. 2014. Available at: www.cdc.gov/violenceprevention/pdf/essentials_for_childhood_framework.pdf. Accessed June 10, 2016
29. Sege R, Linkenbach J. Essentials for childhood: promoting healthy outcomes from positive experiences. *Pediatrics*. 2014;133(6). Available at: www.pediatrics.org/cgi/content/full/133/6/e1489
30. Dreyer BP. To create a better world for children and families: the case for ending childhood poverty. *Acad Pediatr*. 2013;13(2):83–90
31. Heckman JJ. Skill formation and the economics of investing in disadvantaged children. *Science*. 2006;312(5782):1900–1902
32. Harvard University Center on the Developing Child. Maternal depression can undermine the development of young children: working paper 8. 2009. Available at: http://developingchild.harvard.edu/resources/maternal-depression-can-undermine-the-development-of-young-children/. Accessed July 5, 2016
33. Ammerman RT, Putnam FW, Teeters AR, Van Ginkel JB. Moving beyond depression: a collaborative approach to treating depressed mothers in home visiting programs. *Zero Three*. 2014;34(5):20–27
34. Schmit S, Golden O, Beardslee W; Center for Law and Social Policy. Maternal depression: why it matters to an anti-poverty agenda for parents and children. 2014. Available at: http://www.clasp.org/resources-and-publications/publication-1/Maternal-Depression-and-Poverty-Brief-1.pdf . Accessed July 5, 2016
35. Szekely A; National Governors' Association Center for Best Practices. Maximizing the impact of state early childhood home visitation programs. 2011. Available at: https://www.nga.org/files/live/sites/NGA/files/pdf/1103HOMEVISIT.PDF. Accessed June 10, 2016
36. High PC; American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care, Council on School Health. School readiness. *Pediatrics*. 2008;121(4). Available at: www.pediatrics.org/cgi/content/full/121/4/e1008
37. Daro D. Chapin Hall at the University of Chicago. Embedding home visitation programs within a system of early childhood services. Chapin hall issue brief. 2009. Available at: www.chapinhall.org/sites/default/files/publications/Issue_Brief_R3_09_09_09_0.pdf. Accessed June 10, 2016
38. Minkovitz CS, O'Neill KMG, Duggan AK. Home visiting: a service strategy to reduce poverty and mitigate its consequences. *Acad Pediatr*. 2016;16(suppl 3):S105–S111
39. Zero to Three Policy Center. The MIECHV program: smart investments build strong systems for young children. 2014. Available at: https://www.zerotothree.org/resources/171-the-miechv-program-smart-investments-build-strong-systems-for-young-children. Accessed June 10, 2016
40. Macmillan HL, Wathen CN, Barlow J, Fergusson DM, Leventhal JM, Taussig HN. Interventions to prevent child maltreatment and associated impairment. *Lancet*. 2009;373(9659):250–266
41. Ammerman RT, Putnam FW, Altaye M, Teeters AR, Stevens J, Van Ginkel JB. Treatment of depressed mothers in home visiting: impact on psychological distress and social functioning. *Child Abuse Negl*. 2013;37(8):544–554
42. Olds DL, Eckenrode J, Henderson CR Jr, et al. Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-year follow-up of a randomized trial. *JAMA*. 1997;278(8):637–643
43. Redding S, Conrey E, Porter K, Paulson J, Hughes K, Redding M. Pathways community care coordination in low birth weight prevention. *Matern Child Health J*. 2015;19(3):643–650
44. Olds DL, Henderson CR Jr, Tatelbaum R, Chamberlin R. Improving the delivery of prenatal care and outcomes of pregnancy: a randomized trial of nurse home visitation [published correction appears in *Pediatrics*. 1986;78(1):138]. *Pediatrics*. 1986;77(1):16–28
45. Knudsen EI, Heckman JJ, Cameron JL, Shonkoff JP. Economic, neurobiological, and behavioral perspectives on building America's future workforce. *Proc Natl Acad Sci USA*. 2006;103(27):10155–10162
46. Love JM, Kisker EE, Ross C, et al. The effectiveness of early head start for 3-year-old children and their parents: lessons for policy and programs. *Dev Psychol*. 2005;41(6):885–901
47. Rosenberg SA, Zhang D, Robinson CC. Prevalence of developmental delays and participation in early intervention services for young children. *Pediatrics*. 2008;121(6). Available at: www.pediatrics.org/cgi/content/full/121/6/e1503
48. Kitzman HJ, Olds DL, Cole RE, et al. Enduring effects of prenatal and infancy home visiting by nurses on children: follow-up of a randomized trial among children at age 12 years. *Arch Pediatr Adolesc Med*. 2010;164(5):412–418

49. Eckenrode J, Campa M, Luckey DW, et al. Long-term effects of prenatal and infancy nurse home visitation on the life course of youths: 19-year follow-up of a randomized trial. *Arch Pediatr Adolesc Med*. 2010;164(1):9–15

50. Olds DL, Kitzman H, Knudtson MD, Anson E, Smith JA, Cole R. Effect of home visiting by nurses on maternal and child mortality: results of a 2-decade follow-up of a randomized clinical trial. *JAMA Pediatr*. 2014;168(9):800–806

51. Dodge KA, Goodman WB, Murphy RA, O'Donnell K, Sato J, Guptill S. Implementation and randomized controlled trial evaluation of universal postnatal nurse home visiting. *Am J Public Health*. 2014;104(suppl 1):S136–S143

52. Chaffin M, Hecht D, Bard D, Silovsky JF, Beasley WH. A statewide trial of the SafeCare home-based services model with parents in Child Protective Services. *Pediatrics*. 2012;129(3):509–515

53. Duggan AK, McFarlane EC, Windham AM, et al. Evaluation of Hawaii's healthy start program. *Future Child*. 1999;9(1):66–90; discussion 177–178

54. Barnet B, Liu J, DeVoe M, Duggan AK, Gold MA, Pecukonis E. Motivational intervention to reduce rapid subsequent births to adolescent mothers: a community-based randomized trial. *Ann Fam Med*. 2009;7(5):436–445

55. Berkule SB, Cates CB, Dreyer BP, et al. Reducing maternal depressive symptoms through promotion of parenting in pediatric primary care. *Clin Pediatr (Phila)*. 2014;53(5):460–469

56. Shaw DS, Connell A, Dishion TJ, Wilson MN, Gardner F. Improvements in maternal depression as a mediator of intervention effects on early childhood problem behavior. *Dev Psychopathol*. 2009;21(2):417–439

57. Barlow A, Mullany B, Neault N, et al. Effect of a paraprofessional home-visiting intervention on American Indian teen mothers' and infants' behavioral risks: a randomized controlled trial. *Am J Psychiatry*. 2013;170(1):83–93

58. Sweet MA, Appelbaum MI. Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children. *Child Dev*. 2004;75(5):1435–1456

59. Olds DL. The nurse-family partnership: an evidence-based preventive intervention. *Infant Ment Health J*. 2006;27(1):5–25

60. Peacock S, Konrad S, Watson E, Nickel D, Muhajarine N. Effectiveness of home visiting programs on child outcomes: a systematic review. *BMC Public Health*. 2013;13:17

61. Raikes H, Green BL, Atwater J, Kisker E, Constantine J, Chazan-Cohen R. Involvement in Early Head Start home visiting services: demographic predictors and relations to child and parent outcomes. *Early Child Res Q*. 2006;21:2–24

62. Wills D. Maternal, infant and early childhood home visiting program. Building health and early development with the pediatric family-centered medical home. *Zero Three*. 2013;34(1):51–58

63. Gebhard B. Early childhood systems and home visiting. Presentation to zero to three policy center national summit on home visiting. Available at: https://www.zerotothree.org/resources/645-early-childhood-systems-and-home-visiting. Accessed June 27, 2016

64. DiLauro E; Zero to Three. Reaching families where they live. Available at: https://www.zerotothree.org/resources/997-reaching-families-where-they-live-supporting-parents-and-child-development-through-home-visiting. Accessed June 10, 2016

65. Garner AS. Home visiting and the biology of toxic stress: opportunities to address early childhood adversity. *Pediatrics*. 2013;132(suppl 2):S65–S73

66. Toomey SL, Cheng TL; APA-AAP Workgroup on the Family-Centered Medical Home. Home visiting and the family-centered medical home: synergistic services to promote child health. *Acad Pediatr*. 2013;13(1):3–5

67. Raphael JL, Rueda A, Lion KC, Giordano TP. The role of lay health workers in pediatric chronic disease: a systematic review. *Acad Pediatr*. 2013;13(5):408–420

68. Piotrowski CC, Talavera GA, Mayer JA. Healthy steps: a systematic review of a preventive practice-based model of pediatric care. *J Dev Behav Pediatr*. 2009;30(1):91–103

69. Tschudy MM, Toomey SL, Cheng TL. Merging systems: integrating home visitation and the family-centered medical home. *Pediatrics*. 2013;132(suppl 2):S74–S81

70. Bridging the Word Gap: National Research Network. Available at: www.bwgresnet.res.ku.edu/. Accessed June 8, 2016

71. US Department of Health and Human Services, Maternal and Child Health Bureau; Bridging the Word Gap National Research Network. Final report. Available at: http://mchb.hrsa.gov/research/project_info.asp?ID=267. Accessed June 8, 2016

72. City's First Readers. Available at: www.citysfirstreaders.com. Accessed June 10, 2016

Early Childhood Home Visiting

James H. Duffee, Alan L. Mendelsohn, Alice A. Kuo, Lori A. Legano, Marian F. Earls, COUNCIL ON COMMUNITY PEDIATRICS, COUNCIL ON EARLY CHILDHOOD and COMMITTEE ON CHILD ABUSE AND NEGLECT

Pediatrics 2017;140;
DOI: 10.1542/peds.2017-2150 originally published online August 28, 2017;

PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Early Childhood Home Visiting

James H. Duffee, Alan L. Mendelsohn, Alice A. Kuo, Lori A. Legano, Marian F. Earls, COUNCIL ON COMMUNITY PEDIATRICS, COUNCIL ON EARLY CHILDHOOD and COMMITTEE ON CHILD ABUSE AND NEGLECT

Pediatrics 2017;140;
DOI: 10.1542/peds.2017-2150 originally published online August 28, 2017;