



ADMINISTRATION FOR
CHILDREN & FAMILIES

The Maternal, Infant, and Early Childhood Home Visiting Program *Partnering with Parents to Help Children Succeed*

Background

Congress created the Maternal, Infant, and Early Childhood Home Visiting Program (Home Visiting Program) to support voluntary, evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry. The Home Visiting Program builds upon decades of scientific research showing that home visits by a nurse, social worker, early childhood educator, or other trained professional during pregnancy and in the first years of life improve the lives of children and families by preventing child abuse and neglect, supporting positive parenting, improving maternal and child health, and promoting child development and school readiness.ⁱ Research also shows that evidence-based home visiting can provide a positive return on investment to society through savings in public expenditures on emergency room visits, child protective services, special education, as well as increased tax revenues from parents' earnings.^{ii,iii}

The Home Visiting Program is administered by the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF). States, territories, and tribal entities receive funding through the Home Visiting Program, and have the flexibility to tailor the program to serve the specific needs of their communities. By law, grantees must spend the majority of their Home Visiting Program grants to implement evidence-based home visiting models, with up to 25 percent of funding available to implement other promising approaches that will undergo rigorous evaluation. As of February 2015, 17 models have met the rigorous criteria for evidence of effectiveness and are considered evidence-based, and six grantees are implementing and evaluating nine different promising practices.

While there is some variation across evidence-based home visiting models (e.g., some programs serve expecting mothers while others serve families after the birth of a child), all programs share some common characteristics. In these voluntary programs, trained professionals meet regularly with expectant parents or families with young children in their homes, building strong, positive relationships with families who want and need support. Home visitors evaluate the families' needs and provide services tailored to those needs, such as:

- Teaching parenting skills and modeling effective techniques.
- Promoting early learning in the home with an emphasis on positive interactions between parents and children and the creation of a language-rich environment that stimulates early language development.
- Providing information and guidance on a wide range of topics including breastfeeding, safe sleep position, injury prevention, and nutrition.
- Conducting screenings and providing referrals to address postpartum depression, substance abuse, and family violence.
- Screening children for developmental delays and facilitating early diagnosis and intervention for autism and other developmental disabilities.
- Connecting families to other services and resources as appropriate.

Evidence-based home visiting programs help children and families get off to a better, healthier start.

Expanding to Serve More Families and Communities

In fiscal year 2014, states reported serving approximately 115,500 parents and children in 787 counties in all 50 states, the District of Columbia, and five territories through the Home Visiting Program (Figure 1). Nearly 60,000 (52 percent) of those participating were new enrollees. The number of children and parents served by the Home Visiting Program has tripled since 2012, and the number of home visits provided has quadrupled, with more than 1.4 million home visits provided over the past three years (Figure 2).

Recent Growth in the Home Visiting Program

Figure 1: Number of Children and Parents Served (2012-2014)

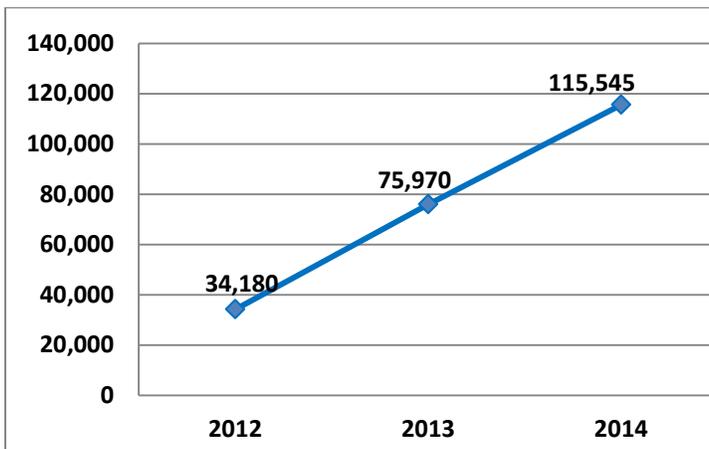
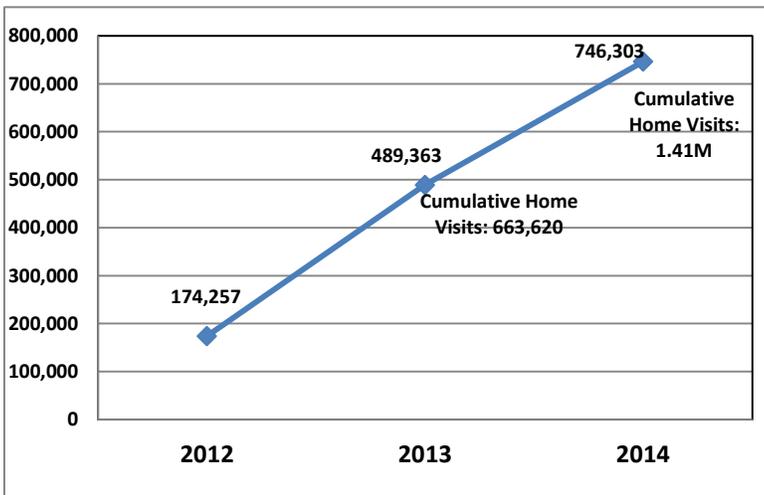


Figure 2: Number of Home Visits (2012-2014)



States have also extended the reach of the Home Visiting Program into more communities:

- The total number of counties being served by the Home Visiting Program has more than doubled since the start of the program, reaching families in 787 counties as of February 2015, which represents 22 percent of all U.S. counties.
- The Home Visiting Program is reaching more communities with the highest need, serving families in approximately one-third of counties with high rates of infant mortality, children living in poverty, low-weight births, and teen births in 2014, compared to 18 percent of these counties in 2010.
- In 2014, the Home Visiting Program funded services in 30 percent of all urban counties, and 17 percent of all rural counties.
- In 2014, tribal grantees reported serving approximately 2,800 children and families as a result of the Tribal Home Visiting Program, and tribal grantees have provided nearly 18,000 home visits since the start of the program.

In order to effectively expand high-quality, evidence-based home visiting programs, many grantees spent the first two years of the program focusing much of their efforts on building infrastructure (e.g., establishing referral and data systems, conducting outreach to families, and recruiting and training a highly skilled home visiting workforce).

Program Participants

The Home Visiting Program serves many of our most vulnerable families. In 2014:

- 79 percent of participating families had household incomes at or below 100 percent of the federal poverty guidelines (\$23,850 for a family four), and 48 percent were at or below 50 percent of those guidelines.
- 34 percent of adult program participants had less than a high school education, and 35 percent had a high school degree.
- 67 percent of program participants belonged to a racial or ethnic minority.
- Families served by the Home Visiting Program were at risk for poor family and child outcomes:
 - 27 percent of newly enrolled households included pregnant teens.
 - 20 percent of newly enrolled households reported a history of child abuse and maltreatment.
 - 12 percent of newly enrolled households reported substance abuse.

Notable Achievements

Home visiting services are already making a meaningful difference in the lives of vulnerable children and families.¹ Some examples of this progress include:

Developmental Delay: Less than 50 percent of young children with developmental or behavioral disabilities—such as autism, attention-deficit/hyperactivity disorder, or delays in language—are identified before they start school.^{iv} Early identification has been shown to improve the developmental trajectories of children with such delays or a developmental disability. In 2014, 14 grantees (AL, AZ, CA, CO, CT, ID, IL, KS, LA, MS, ND, NE, NM, TN) reported screening rates of at least 75 percent, more than twice the national average of 31 percent in 2011-2012.^{v,vi}

¹ The 56 Home Visiting Program grantees measure some aspect of screening for developmental delays, intimate partner violence, maternal depression and whether children receive well-child care. Since grantees have the flexibility to develop performance measures that are meaningful to their specific programs and local community needs, the benchmarks are measured in a number of ways.

- **New Mexico:** At six months after enrollment or birth, 90 percent of children in the Home Visiting Program were screened for developmental delay. In comparison, the state-wide screening rate among children aged 10 months to five years in 2011-2012 was 38 percent.^v
- **Illinois:** 87 percent of enrolled children aged 12 months were screened for developmental delay. In 2011-2012, the state-wide screening rate among children aged 10 months to five years was 34 percent.^v
- **Alabama:** 83 percent of enrolled children were screened for developmental delay within six months of enrollment. The state-wide screening rate was 25 percent in 2011-2012.^v

Intimate Partner Violence (IPV): More than one-third of women report having experienced rape, physical violence, and/or stalking by an intimate partner at some point in their lifetime while nearly six percent report experiencing IPV in the past 12 months.^{vi} In addition to injuries, IPV is associated with adverse physical and mental health outcomes, and exposure of children to IPV can lead to health and behavioral problems, such as anxiety and depression.^{vii,viii,ix} Despite these consequences, screening for IPV in many health care settings remains low, with only three percent to 41 percent of physicians reporting regularly screening for IPV.^{x, xi} In 2014, 12 grantees (AK, AS, DE, IL, KY, LA, MI, NE, NV, SD, TN, VT) reported screening rates of at least 95 percent.

- **Tennessee:** More than 98 percent of enrolled mothers were screened for IPV at enrollment.
- **South Dakota:** More than 97 percent of enrolled pregnant women were screened for IPV within 36 weeks of pregnancy.
- **Indiana:** Nearly 95 percent of enrolled women were screened for IPV at enrollment.

Well-Child Visits: Well-child visits provide important opportunities for health care providers to evaluate a child's physical, emotional, and social development, as well as provide preventive care.

- **Colorado:** More than 99 percent of enrolled children had at least one well-child visit by six months of age.
- **Minnesota:** More than 99 percent of enrolled children had at least half of the recommended well-child visits.²
- **Pennsylvania:** 99 percent of enrolled children received the recommended number of well-child visits.³

Maternal Depression: When left untreated, maternal depression has been associated with adverse birth outcomes, poor mother-child bonding, and negative parenting behaviors,^{xii,xiii,xiv} which can impair the development, health, and safety of young children.^{xv,xvi,xvii} Yet, it has been estimated that less than half of primary care physicians regularly screen for maternal depression.^{xviii,xix} In 2014, seven grantees (AZ, DE, IL, IN, ND, NY, SD) reported screening rates of at least 95 percent.

- **Arizona:** More than 99 percent of new mothers were screened for maternal depression within the first six months postpartum.
- **New York:** More than 95 percent of enrolled pregnant women were screened for maternal depression.
- **Wisconsin:** Nearly 95 percent of new mothers were screened for maternal depression within 60 days postpartum.

In addition to these services, home visitors support families by providing needed referrals and connections to services. For example, when a home visitor identifies that a child has a developmental delay, he or she will facilitate additional diagnostic testing and help the family access appropriate early intervention services.

² Adherence rate according to the Minnesota Child and Teen Check-up schedule.

³ Adherence rate according to Pennsylvania Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

Tribal Home Visiting Program

The Tribal Home Visiting Program, administered by ACF, has awarded 25 grants to tribes, consortia of tribes, tribal organizations, and urban Indian organizations to develop, implement, and evaluate home visiting programs. The program is designed to develop and strengthen tribal capacity to support and promote the health and well-being of American Indian and Alaska Native families, expand the evidence base around home visiting in tribal communities, and support and strengthen cooperation and linkages between programs that serve Native children and their families.

Due to the limited evidence base on effective home visiting in tribal communities, Tribal Home Visiting grantees may adopt home visiting models that are either evidence-based or considered a promising approach. Model selection is designed to be a collaborative and community-driven process based on community needs. Because most home visiting models selected by grantees are designed for non-Native populations, many grantees have enhanced or adapted models to fit culture and context. Adaptations and enhancements include hiring culturally competent staff from the community, incorporating traditional parenting practices, and involving cultural leaders and elders as well as model developers throughout the program development and implementation process. In 2014, tribal grantees reported serving about 2,800 children and families as a result of the Tribal Home Visiting Program, and tribal grantees have provided nearly 18,000 home visits since the start of the program. For more information on the Tribal Home Visiting Program visit <http://www.acf.hhs.gov/programs/ecd/home-visiting>.

Research and Evaluation

ACF, in collaboration with HRSA, is overseeing the Mother and Infant Home Visiting Program Evaluation ([MIHOPE](#)), a large-scale, random assignment evaluation of the effectiveness of the Home Visiting Program. Using scientifically rigorous research methods, MIHOPE will estimate the effects of home visiting on a wide range of outcomes, study the variation in how programs are implemented, and conduct a cost analysis. The national evaluation will examine what components of home visiting programs work, for whom, and why, to provide all programs and models with information they can use to promote even greater positive outcomes for families. Study enrollment and data collection began in October 2012 and will continue through September 2015. As of December 2014, 12 states and 88 local programs are participating in the evaluation, and more than 3,700 families are enrolled (with up to 4,300 expected to participate overall).

In February 2015, HHS delivered the report to Congress on MIHOPE. This report presents the first findings from the study, and includes an analysis of the states' needs assessments, as well as baseline characteristics of families, staff, local programs, and models participating in the study.

The report shows that women enrolled in the evaluation face risks of adverse outcomes for themselves and their children, with:

- 34 percent having symptoms of depression, and approximately 20 percent having health problems that limited their activities.
- 33 percent reporting binge drinking or using illegal drugs before pregnancy.
- 35 percent having smoked in the past two years.
- 10 percent having been a victim of physical intimate partner violence in the past year.

The report found that local programs' infrastructure is aligned with Home Visiting Program expectations and designed to support quality service delivery for these families:

- Home visitors are well trained, especially in child development and parenting support, with most home visitors reporting that they are trained to help families across the full range of outcome areas specified in legislation.
- 66 percent of local programs have formal referral agreements.
- 73 percent have expert consultants available.
- 84 percent had some continuous quality improvement activities in the past year.

In addition, the report found that, prior to creation of the Home Visiting Program, home visiting programs were an important resource throughout the country, but many communities did not use evidence-based models or had unmet home visiting needs. In response, states planned to spend Home Visiting Program funds in communities that, compared with states' overall averages, had higher rates of poverty, poor birth outcomes, and child maltreatment. States' plans also pointed to an increase in use of evidence-based models, with funds used to support a combination of national models with evidence of effectiveness. Final reports on impacts, implementation, and cost effectiveness will be available in 2018.

For more information on the Home Visiting Program, visit <http://www.mchb.hrsa.gov/programs/homevisiting>.

ⁱ U.S. Department of Health and Human Services, Administration for Children and Families, Home Visiting Evidence of Effectiveness (HomVEE). Available at : <http://homvee.acf.hhs.gov/>.

ⁱⁱ Karoly, L, et al. (2005). Early Childhood Interventions: Proven Results, Future Promise. RAND Corporation. Santa Monica, California. Available at: <http://www.rand.org/pubs/monographs/MG341.html>

ⁱⁱⁱ Washington State Institute of Public Policy. Benefit-Cost Results. Available at: <http://www.wsipp.wa.gov/BenefitCost>

^{iv} U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS), Part C Child Count, 1997–2006, from <http://www.ideadata.org/PartCChildCount.asp> (Accessed December 7, 2007).

^v Child and Adolescent Health Measurement Initiative. Data Resource Center. Available at: <http://www.childhealthdata.org/>. (Accessed December 31, 2014).

^{vi} American Academy of Pediatrics, Council on Children With Disabilities, Section on Developmental and Behavioral Pediatrics, Bright Futures Steering Committee, and Medical Home Initiatives for Children With Special Needs. (2006). Identifying Infants and Young Children with Developmental Disorder in the Medical Home: An Algorithm for Developmental Surveillance and Screening. [Published correction appears in *Pediatrics*. 2006;118(4):1808–1809]. *Pediatrics*. 118(1): 405–420.

^{vii} U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2010). National Intimate Partner and Sexual Violence Survey: 2010 Summary Report. Available at: http://www.cdc.gov/violenceprevention/nisvs/summary_reports.html. (Accessed December 16, 2014).

^{viii} Lamers-Winkelmann, F, et al. (2012). Children's Physical Health Complaints After Exposure to Intimate Partner Violence. *British Journal of Health Psychology*. 17(4): 771-84.

^{ix} Yates, T, et al. (2003). Exposure to Partner Violence and Child Behavior Problems: A Prospective Study Controlling for Child Physical Abuse and Neglect, Child Cognitive Ability, Socioeconomic Status and Life Stress. *Development and Psychopathology*. 15(1): 199-218.

^x Russell, D, et al. (2010). Witnessing Domestic Violence in Childhood as An Independent Risk Factor for Depressive Symptoms in Young Adulthood. *Child Abuse and Neglect*. 34(6): 448-453.

^{xi} De Boynville, M. (2013) ASPE Policy Brief: Screening for Domestic Violence in Health Care Settings. Available: http://aspe.hhs.gov/hsp/13/dv/pb_screeningdomestic.cfm (Accessed January 8, 2015).

^{xii} Stayton, C, and Duncan, M. (2005). Mutable Influences on Intimate Partner Abuse in Health Care Settings: A Synthesis of the Literature. *Trauma, Violence, and Abuse*. 6(4). Available: <http://tva.sagepub.com.ezproxyhhs.nihlibrary.nih.gov/content/6/4/271.full.pdf+html> (Accessed October 30, 2012).

^{xiii} Field, T. (2010). Postpartum Depression Effects on Early Interactions, Parenting, and Safety Practices: A Review. *Journal of Infant Behavioral Development*. 33: 1–6.

^{xiv} Paulson, J, et al. (2006). Individual and Combined Effects of Postpartum Depression in Mothers and Fathers on Parenting Behavior. *Pediatrics*. 118(2): 659-668.

^{xv} Henderson, J, et al. (2003). Impact of Postnatal Depression on Breastfeeding Duration. *Birth*. 30(3): 175-180.

^{xvi} Whitaker, R, et al. (2006). Maternal Mental Health, Substance Use, and Domestic Violence in the Year after Delivery and Subsequent Behavior Problems in Children at Age Three Years. *Archives of General Psychiatry*. 63(5): 551-560.

^{xvii} Kavanaugh, M, et al. (2006). Maternal Depressive Symptoms Are Adversely Associated with Prevention Practices and Parenting Behaviors for Preschool Children. *Ambulatory Pediatrics*. 6(1): 32-37.

^{xviii} Sills, M, et al. (2007). Association between Parental Depression and Children's Health Care Use. *Pediatrics*. 119(4): 829-836.

^{xix} LaRocco-Cockburn A, et al. (2003). Depression Screening Attitudes and Practices Among Obstetrician-Gynecologists. *Obstetrics & Gynecology*. 101: 892-8.

^{xx} Seehusen, L, et al. (2005). Are Family Physicians Appropriately Screening for Postpartum Depression? *Journal of the American Board of Family Practice*. 18: 104–112.