



Home Visitation for Families with Young Children

Emilie Stoltzfus

Specialist in Social Policy

Karen E. Lynch

Analyst in Social Policy

October 23, 2009

Congressional Research Service

7-5700

www.crs.gov

R40705

Summary

Home visiting is a strategy for delivering support and services to families or individuals in their homes. This report deals exclusively with home visiting as a service strategy for families with young children or those expecting children. There are a variety of early childhood home visitation models. These models typically seek to positively impact one or more outcomes across three main domains: maternal and child health; early childhood social, emotional, and cognitive development; and family/parent functioning. Depending on the particular model of early home visitation being used, the visitors may be specially trained nurses, other professionals, or paraprofessionals. Visits, which often occur weekly, may begin during a woman's pregnancy or some time after the birth of a child and may continue until the child reaches his/her second birthday (in some cases) or enters kindergarten. Participation of families is voluntary.

Early childhood home visitation programs are in operation in all 50 states and the District of Columbia. The current combined public and private annual investment in these services has been estimated at between \$750 million and \$1 billion. This funding supports services for an estimated 400,000-500,000 families, or about 3% of all families (17.4 million) with children under six years of age. In addition to private and state and local public funds provided for early childhood home visitation, a number of federal programs have been tapped to support home visitation programs. Among others, these include Medicaid, the Temporary Assistance for Needy Families block grant, the Social Services Block Grant, the Promoting Safe and Stable Families program, Community-Based Grants to Prevent Child Abuse and Neglect, Even Start, Part C early intervention services for infants under the Individuals with Disabilities Education Act, the Maternal and Child Health Block Grant, Healthy Start, and Early Head Start.

The current popularity of early childhood home visitation draws, in some measure, from newer research on how the human brain develops and, specifically, the significance of prenatal and early childhood environments to later life outcomes. Further, since at least the 1960s, a variety of home visiting programs have undergone evaluations to test their effectiveness. While the results have been mixed, some research has shown results that promise both immediate and longer term benefits to children and their families, including improvements in birth outcomes, enhanced child cognitive development and academic success, and strengthened child-parent interactions. Overall, researchers caution that home visiting is not a panacea, but many have encouraged its use as part of a range of strategies intended to enhance and improve early childhood.

Federal and congressional interest in early childhood home visitation is reflected in a number of recent or current proposals. These include a proposal in the Administration's FY2010 budget that proposes mandatory funding for grants to states to support the establishment and expansion of home visitation programs with strong evidence of effectiveness, as well as for programs showing promise of efficacy. The FY2010 Budget Resolution (S.Con.Res. 13) anticipates possible consideration of home visitation legislation (provided it is "deficit neutral"). Although the details differ somewhat, health care reform bills pending in both the House (H.R. 3200) and Senate (S. 1796) would appropriate funds to provide grants to states for early childhood home visitation programs. The House health care reform legislation would additionally clarify states' ability to claim federal Medicaid reimbursement for nurse home visiting services. Finally, several other bills have been introduced in this Congress that would authorize or provide funds to states for early childhood home visitation programs (including S. 244, H.R. 2205, H.R. 2667, and S. 1267). This report will be updated as warranted.

Contents

Introduction	1
Current Practices and Initiatives in Home Visiting	2
Review of Selected Home Visiting Models	2
Target Population	2
Age of Child When Service Begins and Ends	3
Length of Home Visits	3
Staff Qualifications and Training	3
Goals	4
Implementation of Home Visiting by States	12
Current ACF Home Visitation Initiative	13
Existing Federal, State, and Local Funding Streams for Home Visiting	15
Federal Funding Sources	15
State and Local Funding Sources	18
Funding Sources by Home Visiting Model	19
Current Investment In and Estimated Costs of Home Visiting	21
Research and Evaluation of Existing Home Visiting Programs	22
Methods for Evaluating Program Models	23
Research Findings by Desired Program Outcomes	24
Findings in the Maternal and Child Health Domain	25
Findings in the Child Social, Emotional, and Cognitive Development Domain	30
Findings in the Family/Parent Functioning Domain	33
Recent Administration and Congressional Proposals to Support Home Visiting	36
Obama Administration’s FY2010 Budget Proposal	36
FY2010 Budget Resolution	38
Proposed Grants to States for Home Visitation in Health Care Legislation	38
Proposed Nurse Home Visitation Services Under Medicaid	44
Hearing on Proposals to Support Early Childhood Home Visitation	44

Tables

Table 1. Overview of Six Home Visiting Models	5
Table 2. Number of Home Visiting Sites, by Selected Program Model and State	10
Table 3. Selection of Federal Funding Streams by Administering Agency and How Program Funds May Be Used to Support Early Childhood Home Visiting	17

Appendixes

Appendix A. Selected Federal Programs That Provide or Support Home Visitation	46
Appendix B. Federal Initiatives Related to Coordination of Early Childhood Programs and Services	52

Contacts

Author Contact Information 55
Acknowledgments 55

Introduction

Home visiting is a strategy for delivering support and services to families or individuals in their homes. While home visiting may also be used to address needs of the chronically ill or elderly, this report deals exclusively with home visiting as a service strategy for families with young children or those who are expecting children. Further, as used in this report, the terms “home visitation” or “home visiting programs” refer to structured models of interaction with families and children; these programs have specific child and family goals, involve regular home visits over a sustained period of time, and have established components or curricula to be covered during those visits. Further, this kind of home visitation is typically implemented as a primary prevention strategy—home visiting is offered before any specific “problem” (e.g., abuse or neglect of children, early childhood developmental delays) has been identified. At the same time, many home visitation models discussed in this report target services to families with certain risk factors (e.g., low income, low social support) for poor child outcomes. In addition, some home visiting programs implement intervention strategies meant to prevent recurrence of a poor outcome or to limit any ongoing negative consequences.

There are a variety of early home visiting models. These models typically seek to positively impact one or more child or family outcomes across three main domains: maternal and child health; early childhood social, emotional, and cognitive development; and family/parent functioning. Some estimates suggest that, at any point in time, as many as 400,000 to 500,000 families may be receiving early childhood home visitation services.¹ This equals about 3% of all families with children under the age of six (17.4 million families), or a little more than 7% of those same families with income below 200% of the poverty line (7.0 million families).² Depending on the particular model of early childhood home visitation being used, the visitors may be specially trained nurses, other professionals, or paraprofessionals; visits may begin during a woman’s pregnancy or later; and the visits may continue, regularly, until the child reaches his/her second birthday or enters school. Participation of families is voluntary.

Early childhood home visitation is currently undergoing a phase of broad popularity. This appears to be driven in some part by newer research on how the human brain develops and, specifically, the significance of the prenatal and early childhood environments to later life.³ To a large extent, parents shape their children’s earliest experiences, and because most home visiting programs seek to help parents understand their own child’s development, advocates see these programs as an opportunity to enhance child development, thereby achieving long-term positive benefits for the children, their parents, and society. Further, at least since the 1960s, a variety of early childhood home visiting models have undergone many assessments and evaluations intended to test how effectively they achieve their goals. While the results of these evaluations have been mixed, some models, or aspects of models, have been shown to be particularly effective. Overall, while

¹ Deanna Gomby, *Home Visitation in 2005: Outcomes for Children and Parents*, Committee for Economic Development, Invest in Kids Working Paper No. 7, 2005, p. 1 (hereinafter Gomby, *Home Visitation in 2005*). Deborah Daro, Chapin Hall Center for Children and Families, Testimony before House Ways and Means Committee, Subcommittee on Income Security, June 9, 2009.

² U.S. Census Bureau, Population Division, Current Population Survey, 2008, Annual Social and Economic Supplement, POV08 “Families with Related Children Under 6 by Number of Working Family Members and Family Structure: 2007.” See http://www.census.gov/hhes/www/macro/032008/pov/new08_000.htm.

³ *From Neurons to Neighborhoods: The Science of Early Childhood Development*, ed. Jack P. Shonkoff, Deborah A. Phillips (Washington, DC: National Academy Press, 2000).

researchers have cautioned that home visiting is not a panacea, they have generally encouraged its use as part of a range of strategies intended to enhance and improve early childhood.

Current Practices and Initiatives in Home Visiting

There are many “models” used to provide voluntary prenatal and early childhood home visitation. At the state and community level, implementation of early childhood home visitation models can vary greatly. Some states and communities rely on established models, others blend components from more than one model, and some develop their own models. In addition, many states support more than one model of home visiting. These models may target different groups of families, have different primary goals, and/or operate in different parts of the state.

The Administration for Children and Families (ACF), an agency of the U.S. Department of Health and Human Services (HHS), is currently carrying out a competitive grant initiative intended to assist grantees in implementing home visitation models that have been proven effective. Apart from this research initiative (described below), the federal government currently supports some ongoing programs in which home visitation is a primary strategy for achieving program goals (e.g., Early Head Start), others in which support for home visiting is explicitly permitted or strongly suggested by the program’s statutory authority (e.g., Maternal and Child Health Block Grant and Promoting Safe and Stable Families), and still others where the broad purposes of the program allow use of funds for some or all of the activities supported by home visitation programs (e.g., Temporary Assistance for Needy Families (TANF), Medicaid).

Review of Selected Home Visiting Models

Home visiting models can be differentiated by, among other things, who they intend to serve, the intensity and duration of services, staff qualifications and training, specific program goals, and the exact services or curricula they use in working with families. Some program characteristics of six early childhood home visitation models—Healthy Families America, Parents as Teachers, Nurse-Family Partnership, Home Instruction for Parents of Preschool Youngsters, the Parent-Child Home Program, and SafeCare—are discussed below as examples of early childhood home visitation programs. Each of these home visitation models was privately originated, has established core program components and specific training standards, and has been evaluated with results published in peer-reviewed journals. Further, each of these models has available materials and other resources that may be used to replicate the model. Readers should be aware, however, that there are other models in existence that meet some or all of the criteria discussed above (e.g., Maternal and Infant Health Outreach Worker⁴). Therefore, the discussion of these models is meant to be illustrative rather than exhaustive.

Target Population

Early childhood home visitation is typically understood as a primary prevention strategy rather than an intervention strategy. Accordingly, in most of the home visiting models reviewed here services are made available to families *before* any “problem” has been identified. For example,

⁴ The MIHOW program is associated with the Vanderbilt University Medical Center and has been implemented at 20 sites in five states. For more information see <http://www.mihow.org/overview.html>.

services are typically available before a family is reported as having abused or neglected a child, or before any particular developmental delay is found in a child. At the same time, some models target families with specific demographic features that suggest additional family support may be needed or useful. The Nurse Family Partnership model focuses exclusively on low-income, first time mothers who are identified during their pregnancy. The Healthy Families model typically targets a broader set of families, including pregnant women or families with pre-school age children who are identified as “at-risk” using a standardized assessment tool. However, individual sites where the Healthy Families model is being implemented may choose to serve only particular subgroups within that broader target population. By contrast, the Parents as Teachers model espouses a principle of universal access for families with young children (including pregnant women). Finally, the SafeCare model is more narrowly focused, and is primarily directed at families where a report of child abuse or neglect has been made. Thus while it intends to prevent additional maltreatment, it is specifically designed to intervene in families where a problem (report of child abuse or neglect) has already been identified.

Age of Child When Service Begins and Ends

As noted above, several models are being used to provide home visitation programs to pregnant women or to families with young children. These programs may continue for the length of time it takes to cover a specific model’s curriculum or they may continue until the child reaches a certain age. For example, both the Healthy Families America and the Parents as Teachers models may begin visitation during pregnancy or after birth of a child and generally continue until the child is enrolled in kindergarten. By contrast, the Home Instruction for Parents of Preschool Youngsters (HIPPY) and Parent-Child Home Program models do not begin until a child is approximately 2 or three years of age, but also typically end around the time of the child’s enrollment in preschool or kindergarten. Separately, the Nurse Family Partnership model requires that services begin during the first-time mother’s pregnancy and end with the child’s second birthday. The SafeCare model is implemented after the birth of a child and continues only for the length of time it takes to cover the program curriculum (typically four or five months).

Length of Home Visits

Visits may occur weekly, biweekly, or on a monthly basis. In some models, visits may occur less often as the family progresses through the program. Both the HIPPY and Parents as Teachers models include group meetings (outside the home and with other families) as part of their program model. Home visits typically last one hour, although some models include 30-minute visits and others suggest that a single visit may continue for up to 90 minutes.

Staff Qualifications and Training

The Nurse Family Partnership program is the only model discussed here that requires a specific education degree; home visitors in this model must be registered nurses. In all of the other program models, individuals of any education level may become visitors provided they successfully complete training under the program model. Home visitors in these models may have bachelor’s or higher level education degrees, though this is not always required. The Healthy Families model stresses the home visitor’s ability to establish rapport with families as critical. Some program models (e.g., Parents as Teachers, HIPPY, Parent-Child Home Program) prefer that home visitors be from the local community—or even that they be alumni of the home visiting program—as a way to help establish credibility or a connection between home visitors and

families. Finally, the SafeCare model identifies willingness to implement a structured service delivery protocol as a key criterion for its home visitors.

Goals

Primary goals also vary by program model, as do the kinds of activities used by each model to achieve those goals. Some program models focus more heavily on the school-readiness aspect of early childhood development (e.g., HIPPIY, Parent-Child Home Program) while others are more broadly focused on child development issues, as well as maternal and child health, and family functioning. Across all program models, a variety of methods (some very structured, others less so) are used to offer parents information about their child's growth and development.

Table 1 outlines goals and other characteristics of the six home visiting program models discussed above.

Table 1. Overview of Six Home Visiting Models

Program Model, Target Population, and Annual Cost	Service Onset and Duration	Staff and Training	Goals	Services / Curricula
<p><i>Healthy Families America (HFA)</i></p> <p>Families with preschool age children or pregnant women identified as “at risk” using a standardized assessment tool (sites may choose particular target populations within this group).</p> <p>\$3,348 per family on average</p>	<p>During pregnancy or within two weeks of child’s birth through child’s enrollment in either preschool (age three or four) or kindergarten (age five).</p> <p>For the first six months, visits are intended to be weekly, after which visits are intended to occur twice each month.</p>	<p>Ability of visitor to connect with family is of primary importance. Visitors may, but are not required to, have bachelor’s degree in social work, education, or nursing.</p> <p>Home visitors receive four days of “primary” training on supporting healthy child development, positive parent-child relationships, improved parental problem-solving skills, and family support systems.</p> <p>Visitors also receive about 80 hours of wraparound training (e.g., local challenges and resources) during their first six months on the job.</p>	<p>Prevent child abuse and neglect;</p> <p>Enhance child health and development; and</p> <p>Promote positive parenting.</p>	<p>Healthy Families America visitors will (1) ensure that families have a medical provider; (2) share information on child development processes and work with parents on caring for children as babies, toddlers, and beyond; (3) help parents to recognize the child’s needs and to obtain appropriate resources; (4) assist families in following through with recommended immunization schedules; (5) help families to feel empowered; and (6) link families with community resources for additional services (e.g., job placement, child care providers, financial services, food and housing assistance programs, family support centers, substance abuse treatment programs, domestic violence shelters, etc.).</p> <p>Services focus on supporting the parent as well as supporting parent-child interaction and child development.</p>
<p><i>Nurse Family Partnership (NFP)</i></p> <p>Low-income, first-time mothers (including pregnant women)</p> <p>\$2,914-\$6,463 per family on average</p>	<p>Home visits during pregnancy through child’s second birthday.</p> <p>Ideally, home visits begin in the 16th week of pregnancy.</p> <p>Over the course of about 2.5 years, visitors plan to conduct around 64 visits of 60-90 minutes each.</p>	<p>Registered nurses.</p> <p>Nurses receive over 60 hours of instruction from the NFP Professional Development Team over a period of 12 to 16 months.</p>	<p>Improve pregnancy outcomes;</p> <p>Improve child health and development; and</p> <p>Improve economic self-sufficiency of the family.</p>	<p>Prior to the birth of the child, NFP home visitors seek to improve pregnancy outcomes by addressing (1) effects of smoking, alcohol, and drugs (including identifying plans to decrease usage, as necessary); (2) best practices in nutrition and exercise for pregnant women (including monitoring for adequate weight gain and other risk factors); (3) preparation for childbirth and basics of newborn care; (4) adequate use of office based prenatal care; (5) referrals to other health and human services as needed.</p> <p>After the child’s birth, nurses work with families to improve the child’s health and development. To this end, nurse home visitors (1) conduct parent education on infant/toddler nutrition, health, growth and development, and environmental safety; (2) conduct role model activities to promote sensitive parent-child interactions to enhance child’s development; (3) use specific assessment tools</p>

Program Model, Target Population, and Annual Cost	Service Onset and Duration	Staff and Training	Goals	Services / Curricula
<p><i>Parents as Teachers (PAT)</i></p> <p>All families with young children (including pregnant women)</p> <p>\$1,400-\$1,500 per family on average</p>	<p>Visits occur weekly during the first month and in the postpartum period. Visits later fade to bimonthly (through 21 months) and then monthly.</p> <p>During pregnancy through enrollment in preschool (age three) or kindergarten (age five).</p> <p>Combination of 60-minute home visits (these may be monthly, biweekly, or weekly) and group meetings.</p>	<p>Home visitors, or “parent educators,” are typically paraprofessionals (about 50% had a bachelor’s degree in 2006-2007). These home visitors may be parents who previously received PAT services themselves.</p> <p>Certification requires that home visitors attend a five-day institute and a follow-up training within the first year.</p> <p>Training covers sequences of early development, screening techniques to identify health or developmental issues, and facilitation of parent-child interaction.</p>	<p>Increase parent knowledge of early childhood development and improve parenting practices;</p> <p>Detect developmental delays and health issues early;</p> <p>Prevent child abuse and neglect; and</p> <p>Increase children’s school readiness and success.</p>	<p>to monitor parent-child interactions and infant/toddler developmental progress at selected intervals, providing follow-up guidance to parents as needed; (4) provide guidance in cultivating social support networks and assessing safety of potential/actual child care arrangements; (5) promote adequate use of preventative/well-child care; and (6) continue to provide referrals to other health and human services as needed.</p> <p>Nurse home visitors also seek to improve the parent’s life-course by working with parents on (1) realistic goal-setting exercises to facilitate decision-making about the future, including strategies to achieve education and work goals; (2) fostering relationships with community services; and (3) issues related to family planning.</p> <p>PAT has four service delivery components: (1) home visits, (2) group meetings, (3) screenings, and (4) resource networks.</p> <p>Home visits are the primary service delivery component. During visits, parent educators share age-appropriate child development information with parents, help parents learn to observe their child’s development, address parenting concerns, and engage the family in activities that provide meaningful parent/child interaction and support the child’s development.</p> <p>Group meetings are opportunities to discuss information about parenting issues and child development. Parents learn from and support each other, observe their children with other children, and practice parenting skills.</p> <p>Parent educators are required to conduct annual developmental, health, vision, and hearing screenings for early identification of developmental delays and other problems. Home visitors conduct screening themselves if they have received adequate required training. As an alternative, a program may have other trained personnel or agencies conduct the screenings. Regular review of each child’s developmental progress identifies strengths as well as areas of concern that may require referral for follow-up services.</p> <p>Parent educators also help families to connect with needed resources and overcome barriers to accessing services. PAT programs establish ongoing collaborative relationships with community agencies and organizations that offer helpful family services.</p>

Program Model, Target Population, and Annual Cost	Service Onset and Duration	Staff and Training	Goals	Services / Curricula
<p><i>Home Instruction for Parents of Preschool Youngsters (HIPPY)</i></p> <p>Typically low-income families with little education</p> <p>\$1,250 per child on average</p>	<p>Children ages three to five years old.</p> <p>Blend of 30 minute biweekly home visits and two hour biweekly group meetings over the course of three years.</p>	<p>Home visitors are paraprofessionals (most have a high school diploma or equivalent). Home visitors are members of the community and are usually current or former recipients of HIPPY services.</p> <p>Home visitors are not encouraged to serve in that capacity for more than three years.</p> <p>Coordinators and visitors receive intensive pre-service training.</p> <p>Coordinators provide weekly and periodic in-service training to increase the knowledge, confidence, and effectiveness of the home visitors.</p>	<p>Promote school readiness and early literacy through parental involvement.</p>	<p>HIPPY has a prescriptive curriculum containing 30 weekly activity packets, nine storybooks and a set of 20 manipulative shapes for each year. During each visit, the home visitor provides the parent with the tools and materials that enable parents to work directly with their children on developmentally appropriate, skill building activities.</p> <p>Role play is the primary method of instruction used by the HIPPY curriculum—coordinators role play with home visitors, home visitors role play with parents, and parents then implement activities directly with their children.</p> <p>The HIPPY curriculum is primarily cognitive-based, focusing on language development, problem solving, logical thinking, and perceptual skills. Learning and play mingle throughout the HIPPY curriculum as parents expose their children to early literacy skills such as (1) phonological and phonemic awareness, (2) letter recognition, (3) book knowledge, and (4) early writing experiences. The HIPPY curriculum emphasizes early reading and writing skills, as well as skill building activities through singing, rhyming, puzzles, etc.</p> <p>Group meetings are two hours long and are intended to bring parents together to share their experiences. During the first hour, parents discuss the previous week’s activity and role play the subsequent week’s activity. In the second hour, parents engage in enrichment activities, which may cover issues related to parenting, employment, school/community/social services, and personal growth. The topics and objectives for the enrichment activities are selected by parents. Child care is provided during the group meeting—many programs also include Parent and Child Time (PACT) as a component of group meetings, allowing parents to observe and practice alternative methods of child rearing.</p>

Program Model, Target Population, and Annual Cost	Service Onset and Duration	Staff and Training	Goals	Services / Curricula
<p><i>Parent-Child Home Program (PCHP)</i></p> <p>Typically low-income families with little education and multiple risk factors</p> <p>\$2,187 per family on average</p>	<p>Most children participate while two to three years old. (Services may go to a child as young as 16 months or as old as four years.)</p> <p>30-minute home visits twice a week over two program years.</p> <p>A “program year” consists of a minimum of 23 weeks of home visits (or 46 home visits).</p>	<p>Home visitors are typically paraprofessionals. Visitors are not required to have bachelor’s degree in social work, education, or nursing, but some do. Some are also former recipients of PCHP services (about one-third per a 2003 study).</p> <p>They receive training in multicultural awareness and the ethics of home visiting. Visitors model, rather than teach, behaviors to parents. Visitors provide families with developmentally appropriate books and toys.</p>	<p>Prepare young children for school readiness by:</p> <ul style="list-style-type: none"> Increasing language and literacy skills; Enhancing social-emotional development; and Strengthening the parent-child relationship. 	<p>The PCHP curriculum espouses <i>modeling</i> behavior (rather than teaching) as the most effective, non-intimidating way to empower parents and strengthen the quality of parent-child interactions.</p> <p>On the first visit of each week, PCHP home visitors bring a carefully selected book or educational toy as a gift to the family. Over the course of two years in the program, families acquire a library of children’s books and a collection of educational and stimulating toys. Among other things, books and toys are used to (1) stimulate verbal interaction, (2) expand vocabulary, (3) reinforce phonemic awareness, and (4) promote problem solving and reasoning.</p> <p>During visits with parents and children, the home visitor models verbal interaction, reading, and play activities, demonstrating how to use the books and toys to cultivate language and literacy skills to promote school readiness. These activities are carefully designed to enhance the child’s cognitive and social-emotional development.</p>
<p><i>SafeCare</i></p> <p>Parents who are at-risk or have been reported for child abuse or neglect.</p> <p>\$2,275 per family on average (program estimate based on statewide implementation in Oklahoma)</p>	<p>Birth to five years</p> <p>One- to two-hour visits per week for 18-20 weeks.</p>	<p>There are no educational requirements. Trainees must be motivated to implement SafeCare, open to new services models, and interested in using a structured protocol for service delivery.</p> <p>Trainings is conducted with low trainee to trainer ratios of 1:3 or 1:4. and is based on the same principles of behavioral skill acquisition used in the SafeCare program for parents.</p> <p>Training begins with a five-day workshop focused on</p>	<p>Teach parents skills that enable them to:</p> <ul style="list-style-type: none"> Recognize symptoms of illnesses and injuries and seek the most appropriate health treatment; Identify and reduce environmental and health hazards in the home; Engage in positive parent-child/parent-infant interactions and prevent child behavior problems. 	<p>The SafeCare parent-training curriculum includes three modules that are taught sequentially. The home visitor uses a seven step format, which is based on social learning theory. The steps are (1) describe desired target behaviors; (2) explain rationale or reason for each behavior; (3) model each behavior; (4) ask parents to practice the behavior; (5) point out positive aspects of parent’s performance; (6) point out aspects of parent’s performance needing improvement; (7) review parents’ performance and have them practice areas needing improvement and set goals for the next week. Each module is typically covered in six visits (one for assessment and five for training) but trainers work with parents until they meet the set of skill based criteria established for each module. Throughout these modules, the home visitor is also expected to do problem solving, with parents, as necessary.</p> <p>Health module: In the first module parents learn to use reference materials to prevent illness, identify symptoms of childhood illnesses or injuries, and provide or seek appropriate treatment. Parents are given a medically validated health manual, health</p>

Program Model, Target Population, and Annual Cost	Service Onset and Duration	Staff and Training	Goals	Services / Curricula
		<p>the three SafeCare modules and on problem solving and communication. In addition to lectures and viewing videos of sample home visits, trainees watch modeling of skills by the trainer, participate in role-play exercises, and receive feedback from the trainer. They are provisionally certified after completing the workshop and then receive field implementation feedback from a SafeCare coach. They receive full SafeCare certification after mastering skills. Additional training is required for SafeCare coaches and trainers.</p>		<p>recording charts, and basic health supplies (e.g., thermometer).</p> <p>Home safety module: In the second module the focus is on helping parents identify and eliminate safety and health hazards by making them inaccessible to children. A standardized checklist is used. Safety latches are supplied to families.</p> <p>Parent-infant (birth to 8-10 months)/parent-child (8-10 months to five years) interaction module: In this module parents are taught how to provide engaging and stimulating activities with their children. The visitor observes parent-child play and/or daily routines and provides feedback to reinforce positive behavior and address problem behavior. Parents are taught to use a Planned Activities Training checklist to help structure everyday activities. Parents also receive activity cards with prompts for engaging in planned activities.</p> <p>Structured problem-solving and counseling: Structured problem solving is used by home visitors to help parents work through issues not addressed in the curriculum. This involves framing the problem, identifying possible solutions, identifying pros and cons of each solution, choosing a solution, and acting.</p>

Source: Prepared by the Congressional Research Service based primarily on information provided at program model websites.

Table 2 shows the presence of five of these program models by state, including the number of locations in which the model operates within the state. Please note that the number of sites for a given model are not necessarily comparable because they may be of very different sizes (both geographically and in terms of the number of families served). Data shown are based on information provided on the websites of the given program. State-by-state information was not available on the program website for SafeCare. (However, the SafeCare website does indicate that the model has been implemented statewide in Oklahoma, is undergoing statewide implementation in Georgia, and has also been implemented in one or more locations in California, Washington, and Maryland.)

Table 2. Number of Home Visiting Sites, by Selected Program Model and State

State	Healthy Families America ^a	Parents as Teachers ^b	HIPPY ^c	Nurse Family Partnership ^d	Parent-Child Home Program ^e
Alabama	2	21	12	1	0
Alaska	5	19	0	0	0
Arizona	14	34	1	1	0
Arkansas	1	14	45	0	0
California	2	120	7	10	7
Colorado	0	37	6	18	0
Connecticut	8	107	0	0	1
Delaware	0	4	0	0	0
District of Columbia	1	1	2	0	1
Florida	39	37	19	1	2
Georgia	14	49	0	0	0
Hawaii	9	2	5	0	0
Idaho	0	33	0	0	0
Illinois	36	197	2	2	2
Indiana	56	61	0	0	1
Iowa	14	73	0	0	0
Kansas	5	223	1	0	0
Kentucky	4	41	1	1	0
Louisiana	2	7	7	16	0
Maine	9	17	0	0	0
Maryland	15	48	5	1	0
Massachusetts	33	5	0	0	34
Michigan	10	99	1	5	2
Minnesota	3	9	1	5	1
Mississippi	0	33	0	0	0
Missouri	1	559	0	3	0
Montana	0	14	0	0	0

State	Healthy Families America ^a	Parents as Teachers ^b	HIPPY ^c	Nurse Family Partnership ^d	Parent-Child Home Program ^e
Nebraska	0	16	0	0	0
Nevada	0	9	2	1	0
New Hampshire	0	22	0	0	0
New Jersey	18	26	1	7	2
New Mexico	1	42	0	0	0
New York	28	49	4	7	32
North Carolina	9	86	0	7	1
North Dakota	1	18	0	1	0
Ohio	9	71	3	4	1 ^f
Oklahoma	7	103	1	1	0
Oregon	15	47	2	1	0
Pennsylvania	4	90	0	23	28
Rhode Island	0	20	1	0	0
South Carolina	5	89	0	6	22
South Dakota	0	22	0	2	0
Tennessee	4	8	1	0	0
Texas	6	87	14	11	0
Utah	0	18	0	1	0
Vermont	0	2	0	0	0
Virginia	33	32	1	0	0
Washington	0	26	0	10	6
West Virginia	2	15	0	0	0
Wisconsin	5	37	1	1	0
Wyoming	0	14	0	14	0
Total program sites	430	2,813	146	161	143

Source: Prepared by the Congressional Research Service (CRS), based on sources outlined below.

Note: The numbers of sites for a given model are not necessarily comparable because they may be of very different sizes (both geographically and in terms of number of families served).

- a. 2003 Annual Profile of Program Sites dated December 2004, available on HFA website (as of April 9, 2009), http://www.healthyfamiliesamerica.org/downloads/hfa_site_survey.pdf.
- b. Document at PAT website, dated August 2007. No “Meld” or “Meld affiliate” sites shown.
- c. Information at HIPPY website (as of April 9, 2009), <http://www.hippyusa.org/site/view/StateOfficesContactswithMap.pml>.
- d. Information at NFP website (as of April 9, 2009), <http://www.nursefamilypartnership.org/content/index.cfm?fuseaction=showMap&navID=17>.
- e. Information at PCHP website (as of April 9, 2009), <http://www.parent-child.org/localsites/index.html>.
- f. Ohio is listed as a PCHP state, but no information was provided about the number of participating sites. For the purposes of this table, CRS assumes a minimum of one site operating within the state.

Implementation of Home Visiting by States

Currently many states and localities have implemented home visiting programs as part of a range of family support and/or early childhood interventions or services. Among 46 states that responded to a 2007 survey conducted by Columbia University's National Center on Children in Poverty (NCCP), 40 indicated the presence of one or more "state-based" home visiting programs.⁵ The survey defined "state-based" to include any distinct program model that was administered by the state (in most instances) or otherwise coordinated by state agencies (excluding Early Head Start, Healthy Start, and the Infants and Toddlers Program funded under Part C of the Individuals with Disabilities Education Act).⁶ The survey separately noted that in 24 states, at least 32 distinct programs operated under a state legislative mandate or with some state-legislated program content.

The NCCP survey indicated that most publicly funded home visiting programs targeted low income families with certain risk factors.⁷ Further, the survey showed that the most commonly identified program goals for state-based home visiting programs were related to parenting and children's early health and development. Around 70% of the state-based programs included in the 2007 survey identified program goals in those categories. Just above half of all programs identified outcomes related to pregnancy (e.g., increased time interval between pregnancies). Reduction of government services related to child abuse was cited as a program goal in a little more than 40% of the programs.⁸

As used in the NCCP survey, a single state-based "program" refers to a particular home visiting model that might be in operation at one or many sites in the state. Many of the states responding to the survey had more than one distinct "state-based" home visiting program in place. Further, the survey showed that while some of those programs were based on well-known home visiting models, most were not.⁹ Of the 70 state-supported, administered, or coordinated programs identified in 40 states, only 17 (identified by 14 states) were implementing one of the well-known home visiting models, such as Healthy Families, Nurse Family Partnership, Home Instruction Program for Preschool Youngsters (HIPPY), and Parents as Teachers. Separately, 14 of the state-supported, administered, or coordinated programs (in 14 states) used more than one of those well-known home visiting models or some combination of different elements from those models (e.g., a "blended design").¹⁰ However, the majority (the remaining 39) of these state-funded, administered, or coordinated programs reported using "homegrown" models.¹¹ The use of

⁵ Kay Johnson, *State-based Home Visiting: Strengthening Programs through State Leadership*, National Center for Children in Poverty, Mailman School of Public Health, Columbia University, February 2009 (hereinafter Johnson, *State-based Home Visiting Programs*, 2009). The District of Columbia along with four states (Indiana, Kansas, Vermont, and Washington) did not respond to this survey.

⁶ Six states are listed as reporting no state based programs: Alaska, California, Idaho, Mississippi, North Dakota, and Nebraska. While the survey does not include California among those reporting "state based" programs, it is worth noting that, according to the website of the Parent-Child Home Program, seven PCHP sites operating in California are funded under California's First 5 initiative.

⁷ Johnson, *State-based Home Visiting*, 2009, p. 5.

⁸ Kay Johnson, *Results from a Survey of State-based Home Visiting Programs*, National Center for Children in Poverty, "Focus on Home Visiting" webinar, December 2, 2008, http://www.nccp.org/projects/events/event_43.html (hereinafter, NCCP "Focus on Home Visiting" webinar, 2008).

⁹ *Ibid.*

¹⁰ Johnson, *State-based Home Visiting*, p. 11.

¹¹ Kay Johnson remarks, NCCP "Focus on Home Visiting" webinar, 2008.

blended or homegrown models may reflect efforts by states to address particular needs of a specific target population, to vary intensity of service by identified family need, to offer the amount of services they can financially support, and/or to provide a level of service that will be locally accepted.¹²

In a 2006 report reflecting on implementation of home visiting programs in several states, researcher Miriam Wasserman observed that in most locations there was not a deliberate effort to identify a program with the most evidence of success. Typically, she writes, statewide programs—of whatever model—were launched in one or more sites based on response to specific, locally identified needs. This attracted the notice and interest of other sites in the state (along with some entrenched local interests), which in turn led to more secure federal or state funding, and ultimately to greater proliferation of that program model. Noting that grassroots efforts have been critical, she also cites the importance of influential champions of a particular model. These might be legislators or other state leaders. As examples, she cites the importance of a 1991 early childhood initiative by then Indiana Governor Evan Bayh in the development of a statewide Healthy Families network in that state; the efforts of Michele Ridge, wife of former Pennsylvania Governor Tom Ridge, in the spread of Nurse Family Partnership in Pennsylvania; support of then Arkansas first lady Hillary Clinton in spreading the HIPPIY model in Arkansas; and the arrival of the Parents as Teachers model in Idaho, which she credits to the relationship between Senator “Kit” Bond of Missouri—where the Parents as Teachers model was first demonstrated and then broadly replicated—and former Idaho Senator Dirk Kempthorne,¹³ who subsequently became governor of that state.

Current ACF Home Visitation Initiative

Noting that states did not always follow “proven-effective” models of home visitation, the Bush Administration requested additional funding in FY2008 to provide competitive grants to “expand, upgrade, or build nurse home visitation programs.” The Bush Administration sought \$10 million (as a set aside within the discretionary activities account of the Child Abuse Prevention and Treatment Act, CAPTA) for these grants to “support investments in quality assurance systems, training, technical assistance, workforce recruitment and retention, evaluation, and other administrative mechanisms needed to successfully implement and sustain high quality, evidence-based home visitation programs that have strong fidelity to a proven effective model” and to support a national cross-site evaluation to examine factors associated with successful replication or expansion of “proven-effective models.”¹⁴ Congress supported the funding request, providing \$10 million in FY2008 appropriations (P.L. 110-161) to support “competitive grants to States to encourage investment of existing funding streams into evidence-based home visitation models.” Further, Congress stipulated that HHS must “ensure that States use the funds to support models that have been shown, in well-designed randomized controlled trials, to produce sizeable, sustained effects on important child outcomes such as abuse and neglect. Funds shall support

¹² Miriam Wasserman, *Implementation of Home Visitation Programs: Stories from the States*, Chapin Hall Center for Children, University of Chicago, Issue Brief No. 109, September 2006, p. 16 (hereinafter Wasserman, *Implementation of Home Visiting*, 2006); and Johnson, *State-based Home Visiting*, 2009, p. 16.

¹³ Wasserman, *Implementation of Home Visitation Programs*, 2006.

¹⁴ U.S. Department of Health and Human Services, Administration for Children and Families, *FY2008 Justification of Estimates for Appropriations Committees*, February 2007, pp. 115-116. The initial request also made several references to the effectiveness of nurse home visitation and specifically to expanding “proven effective models of nurse home visitation.”

activities to assist a range of home visitation programs to replicate the techniques that have met these high evidentiary standards.”¹⁵ For FY2009, Congress directed that \$13.5 million be set aside to continue the home visitation initiative¹⁶ and the Obama Administration has requested continued funding at that same level for FY2010.¹⁷

On September 30, 2008, the Administration for Children and Families (ACF) at HHS awarded cooperative agreements to 17 grantees in 15 states to support “state and local infrastructure needed for the high quality implementation of existing evidence-based home visiting programs to prevent child maltreatment.” The grants are valued at \$500,000 per year and, if appropriations are continued, should be extended across a total of five years. These 17 grantees seek to implement or enhance and study a variety of home visiting models (alone or in combination). These models include the Nurse Family Partnership, Healthy Families America, Parents as Teachers, and SafeCare models, as well as the Positive Parenting Program (Triple P) and a separate model known as Family Connections. In addition to these cooperative agreements, HHS/ACF awarded funds to Mathematica Policy Research, Inc., and the Chapin Hall Center for Children to conduct a cross-site evaluation of the funded programs, to include study of model implementation, fidelity, outcomes, and costs. Mathematica and Chapin Hall are also charged with providing technical assistance to grantees and their local evaluators, and they must establish and coordinate a peer learning network to allow grantees, federal staff, and other stakeholders to share information.¹⁸

Recipients of the cooperative agreement award were to spend the majority of the first year under the agreement (i.e., most of FY2009) engaged in collaborative planning efforts and the remaining expected four years (i.e., FY2010-FY2013) implementing that plan. Among other things, the collaborative planning effort is meant to ensure that “all relevant programs and funding streams are identified and included” in the coordination efforts. Ultimately, the plan is expected to lay out the necessary infrastructure for widespread adoption, implementation, and continuation of evidence-based home visiting programs and it will serve as a roadmap for the implementation phase of the cooperative agreement.¹⁹

Because it is “very interested in interagency collaborative efforts across various disciplines,” HHS/ACF (through its Children’s Bureau) has required that the planning and implementation process for these home visitation projects must include the state or local child welfare agency and the state’s designated lead agency for the Community-Based Child Abuse Prevention Program (CBCAP, authorized under Title II of the Child Abuse Prevention and Treatment Act (CAPTA), which is administered by the Administration for Children and Families of HHS).²⁰ (For more

¹⁵ U.S. Congress, House Appropriations Committee Print, Division G, Explanatory Statement to accompany the Consolidated Appropriations Act, 2008 (H.R. 2764), pp. 1540-1541.

¹⁶ See *Congressional Record*, February 23, 2009, H.R. 2228. The additional funding will be used to increase support for the original grantees.

¹⁷ U.S. Department of Health and Human Services, Administration for Children and Families, *FY2010 Justifications of Estimates for Appropriations Committees*, May 2008, p. 122 (hereinafter cited as HHS/ACF, *FY2010 Justifications of Estimates*).

¹⁸ See ACF, Children’s Bureau, “Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment,” no date, http://www.acf.hhs.gov/programs/cb/programs_fund/discretionary/visitation/ebhv_project_description.pdf. For FY2009, the maximum grant amount for the 17 grantees was increased above \$500,000 and additional funding was provided for the cross-site evaluation because of increased appropriations in that year.

¹⁹ ACF Grant Opportunities, Funding Opportunity HHS-2008-ACF-ACYF-CA-0130, Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment (expired July 21, 2008).

²⁰ CBCAP funding was \$42 million for FY2009. The grants are distributed by formula to a lead entity in every state. That entity, which may be public or a private non-profit, must use the fund to support community based activities to (continued...)

information on CBCAP, see “Selected Federal Programs That Provide or Support Home Visitation,” **Appendix A.**) The Children’s Bureau also “strongly recommended” collaboration with grantees under two other federally supported efforts related to improving outcomes for young children. These are the State Maternal and Child Health Early Childhood Comprehensive Systems (ECCS) grantees (competitive grants administered by the Health Resources and Services Administration of HHS and currently funded in as many as 47 states)²¹ and Linking Actions for Unmet Needs in Children’s Health (or “Project LAUNCH” competitive cooperative agreements, now in place in seven locations and administered by the Substance Abuse and Mental Health Services Administration of HHS). (For more information on these and other “Federal Initiatives Related to Coordination of Early Childhood Programs and Services,” see **Appendix B.**)²²

Existing Federal, State, and Local Funding Streams for Home Visiting²³

Most home visiting programs now in operation use a blend of federal and state funding streams, with some additional support coming from local public funds or private sources.²⁴ For example, support for Healthy Families America (HFA) programs in 2004 came from an average of 2.4 federal funding sources, 2.0 state funding sources, and 2.7 local funding sources by state.²⁵

Federal Funding Sources

Current and/or past sources of federal funding for home visiting have come from programs administered by several different federal agencies, most commonly the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Education (ED). Support from existing federal programs comes in several different ways. Some programs, such as Early Head Start, operate what amounts to their own home visiting model. For other programs, such as the Maternal and Child Health Block Grant, home visiting services are explicitly permitted by statute, but as one of a range of activities eligible to receive a share of program funding. Finally, there is a larger pool of federal programs, including Medicaid and Temporary Assistance for Needy Families (TANF), which may support early childhood home visitation under broadly stated program authorities. In the latter case, the statute does not explicitly focus on home visiting;

(...continued)

prevent child abuse and neglect. Voluntary home visiting is described in the program statute as a “core service” and is supported in many if not all states with a portion of these funds.

²¹ The FY2009 funding for Early Childhood Comprehensive Systems (ECCS) was \$7 million. The ECCS seeks to foster integrated efforts for the delivery of services to young children across health, human service, and education agencies. For more information see <http://www.state-eccs.org/componentareas/index.htm>.

²² The FY2009 funding for Project LAUNCH was \$20 million, up from \$7.5 million in FY2008. For more information see <http://projectlaunch.promoteprevent.org/>.

²³ CRS sought to be thorough in compiling these data. However, information included on funding sources (particularly at the state and local levels) may not be comprehensive.

²⁴ For more information, see Johnson, *State-based Home Visiting*, 2009; Wasserman, *Implementation of Home Visitation*, 2006; and Healthy Families America, “Chapter 8: Funding,” in *State Systems Development Guide*, 2003, <http://www.healthyfamiliesamerica.org/downloads/ssdg8.pdf>.

²⁵ Healthy Families America, *State of State Systems in 2004: Funding Results from the 2004 State Systems Survey*, May 17, 2004, PowerPoint at http://www.healthyfamiliesamerica.org/network_resources/hfa_state_of_state_systems.pdf

rather, some or all of the activities provided under home visiting programs can be considered to be appropriate, allowable strategies for accomplishing the program's overall goals.

HHS programs that have or may be used to support home visiting programs include a number authorized under the Social Security Act as well as other acts. Social Security Act programs that have been used to support home visiting include Temporary Assistance for Needy Families (TANF, Title IV-A), Stephanie Tubbs Jones Child Welfare Services (Title IV-B, Subpart 1), Promoting Safe and Stable Families (Title IV-B, Subpart 2), Maternal and Child Health Block Grant (Title V), Social Services Block Grant (SSBG, Title XX), Medicaid (Title XIX), and the Children's Health Insurance Program (CHIP, Title XXI). Programs authorized in other acts include the Community-Based Child Abuse Prevention Program (CBCAP, Title II of CAPTA), Early Head Start (Head Start Act), the Child Care and Development Fund (Child Care and Development Block Grant Act and Title IV-A of the Social Security Act), the Community Services Block Grant (Community Services Block Grant Act), Healthy Start (Section 330H of the Public Health Service Act), and the Adolescent and Family Life Care Demonstration Grants (Title XX of the Public Health Service Act).²⁶

Among the ED programs that support home visiting are the Infants and Toddlers Program authorized by Part C of the Individuals with Disabilities Education Act, as well as several programs that are authorized under the Elementary and Secondary Education Act (ESEA). ESEA programs that may support home visiting include Even Start (Title I, Part B), Education for the Disadvantaged (Title I, Part A), and the Parental Information and Resource Centers (PIRC, Title V, Part D).

In addition to HHS and ED, several other federal agencies administer programs that have provided financial support for home visiting programs. Among these are the Office of Juvenile Justice and Delinquency Prevention (OJJDP) at the U.S. Department of Justice, which has supported home visiting through initiatives such as Safe Start;²⁷ the Corporation for National and Community Service, an independent agency which supports home visiting through AmeriCorps programs;²⁸ and the Department of Defense, which funds home visiting efforts as part of its New Parent Support Program for families with children ages 0-3.²⁹

Table 3 parses these federal programs into one of two categories based on how home visiting activities relate to the program goals or statute. The first category lists programs for which home visitation is either a mandatory program component (e.g., Even Start³⁰) or an explicitly permitted

²⁶ CRS consulted a variety of sources, including Healthy Families America, *How are Healthy Families America Programs Funded?*, 2002; Kay Johnson, *No Place Like Home: State Home Visiting Policies and Programs*, Johnson Consulting Group, Inc. with support from The Commonwealth Fund, May 2001 (hereinafter Johnson, *No Place Like Home*, 2001); and Steffanie Clothier and Julie Poppe, *Early Care and Education State Budget Actions FY2007 and FY2008*, National Conference of State Legislatures, April 2008 (hereinafter Clothier and Poppe, *Early Care and Education*, 2008).

²⁷ For a program summary of the Safe Start initiative see <http://ojjdp.ncjrs.org/programs/ProgSummary.asp?pi=15&ti=&si=&kw=&PreviousPage=ProgResults>. For information on a local site's use of these funds for home visitation, see information about the Dayton, OH, Safe Start community's use of the Nurse Family Partnership model (as well as other intervention strategies) at <http://www.safestartcenter.org/pdf/safestartbooklet.pdf>.

²⁸ See information on the HIPPY website at <http://www.hippyusa.org/site/view/PublicPolicy.pml#americorps>, as well as the HIPPY 2008 Annual Report at http://www.hippyusa.org/site/view/157074_AnnualReport.pml.

²⁹ See on overview of this DOD program at http://www.militaryhomefront.dod.mil/portal/page/mhf/MHF/MHF_HOME_1?section_id=20.40.500.420.0.0.0.0.0.

³⁰ See Title I, Part B, Subpart 3, Section 1235 of the Elementary and Secondary Education Act, which requires that (continued...)

(or recommended) activity for achieving the program’s goals. The latter refers to programs like Early Head Start, for which home-based programs are a primary strategy³¹ for achieving program goals and are explicitly detailed in statute and regulation. This first category also includes programs such as Community-Based Child Abuse Prevention grants, for which “voluntary home visiting” services are considered one of several possible core resource and support services for families. The second category includes a selection of programs that have broadly stated goals and authorities; while home visiting is not explicitly required or permitted for these programs, their expansive and flexible nature may allow them to fund some or all home visiting services. For instance, home visiting services could be funded through Temporary Assistance for Needy Families (TANF) programs as a strategy to meet the program’s goal of providing “assistance to needy families so that children may be cared for in their own homes or in the homes of relatives.” While programs in this category *may* support home visiting activities, it is not necessary for them to do so. Moreover, even if funds from these programs are used to support home visiting activities, they may account for only a very small portion of total spending.

The list of federal programs in **Table 3** is illustrative only. It is not meant to be exhaustive, nor is it meant to be an exact typology. Rather, it is intended to suggest how strongly home visiting may be linked to current programs, either through common practice or program rules. Descriptions of the programs listed in the first category of the table are included in **Appendix A** of this report.

Table 3. Selection of Federal Funding Streams by Administering Agency and How Program Funds May Be Used to Support Early Childhood Home Visiting

Department– Agency	Home Visiting Is Explicitly Permitted or Required for Achieving Program Goals	Home Visiting May Be Supported Under Broadly Stated Program Goals
Department of Health and Human Services– <i>Administration for Children and Families (ACF)</i>	- Early Head Start - ACF Home visitation Initiative - Community-Based Child Abuse Prevention (CAPTA, Title II) - Promoting Safe and Stable Families	- Temporary Assistance for Needy Families - Child Welfare Services - Social Services Block Grant - State Grants (CAPTA, Sec. 106) - Community Services Block Grant - Child Care and Development Fund
Department of Health and Human Services– <i>Centers for Medicare and Medicaid (CMS)</i>		- Medicaid - Children’s Health Insurance Program
Department of Health and Human Services– <i>Health Resources and Services Administration (HRSA)</i>	- Healthy Start - Maternal and Child Health Block Grant	

(...continued)

programs “provide and monitor integrated instructional services to participating parents and children through home-based programs.”

³¹ In 2006, home-based programs accounted for about 41% of Early Head Start programs. Center-based programs accounted for 51%. Combined, these two program options accounted for approximately 92% of Early Head Start programs. The remaining programs were combination programs (4%), family child care settings (3%), and locally designed programs (2%). For more information, see http://www.clasp.org/publications/ehs_pir_2006.pdf.

Department– Agency	Home Visiting Is Explicitly Permitted or Required for Achieving Program Goals	Home Visiting May Be Supported Under Broadly Stated Program Goals
Department of Health and Human Services– <i>Office of Population Affairs</i>		- Adolescent Family Life Care Demonstration Grants
Department of Education– <i>Office of Elementary and Secondary Education (OESE)</i>	- Even Start	- Education for the Disadvantaged (Title I, ESEA)
Department of Education– <i>Office of Innovation and Improvement (OII)</i>	- Parent Information Resource Centers	
Department of Education– <i>Office of Special Education and Rehabilitative Services (OSERS)</i>	- Infants and Toddlers Program (Part C, IDEA)	
Department of Justice– <i>Office of Juvenile Justice and Delinquency Prevention</i>		- Safe Start
Department of Defense Corporation for National and Community Service	- New Parent Support Program	- AmeriCorps

Source: Prepared by the Congressional Research Service (CRS).

Note: This categorization is meant to be suggestive of levels of attention to, and program fit with, home visitation rather than an exact typology.

State and Local Funding Sources

State funding sources for early childhood home visiting programs include state general revenues, TANF maintenance of effort (MOE) funds, and state funds allocated to match federal grant programs.³² One study published in 2001 found that 44% of the reported home visiting program budget dollars came from state revenues.³³ In addition, programs often tap into state tobacco settlement dollars to support home visiting programs. This may be due to fortuitous timing, as the tobacco settlement of 1998 awarded funding to 46 states at a time when home visiting programs were rapidly emerging across the country. The tobacco settlement required five tobacco manufacturers to make annual payments to states (allocated by formula) in perpetuity. Approximately 13 bills were then enacted by state legislatures targeting children’s services with tobacco settlement funds, and home visiting organizations have encouraged programs to tap into these resources when seeking state funds.³⁴

³² See Johnson, *State-based Home Visiting*, 2009, pp. 10-11; Johnson, *No Place Like Home*, 2001, pp. 12-13; Laura Galbraith, *Proactive Funding Strategies for Home Visitation: A Resource for Counties*, National Association of Counties and Healthy Families America, 2007, pp. 9-10 (hereinafter Galbraith, *Proactive Funding*, 2007).

³³ Johnson, *No Place Like Home*, 2001.

³⁴ Galbraith, *Proactive Funding*, 2007.

While federal and state sources typically provide the largest contributions to program budgets, local public funds (such as county taxes or school funds) and private funds (such as those from charitable foundations) also support home visiting efforts.³⁵

Funding Sources by Home Visiting Model

Most home visiting programs are funded by multiple sources. In addition, funding sources appear to vary by program model and, in some cases, within program models over time.

For instance, a 2004 Healthy Families America (HFA) survey found that 54% of program funding came from the federal government, 38% came from the state, and 8% came from local sources.³⁶ This is a change from 2002 and 2003, when HFA survey data suggested that a greater share of the total funding came from state, rather than federal, funding streams. In 2004, the bulk of federal funding for Healthy Families America programs came from TANF (86%), with smaller contributions from Title IV-B programs (e.g., Child Welfare Services, Promoting Safe and Stable Families), CAPTA, and other federal sources. This reported composition of federal funding sources also represents a change from prior years. HFA data indicate that in FY2003 the sources of federal funding were more balanced, with Title IV-B programs representing about 35% and TANF accounting for about 28% of total federal funding.³⁷ Results from these annual Healthy Families America surveys also suggest that funding for HFA programs has decreased over time, from nearly \$296 million in FY2002 to almost \$185 million in FY2004. Notably, results from these surveys represent only a subset of all HFA programs (due to a response rate of about 73%).

While these survey data may provide useful insight into Healthy Families America budgets, they should not be interpreted as reflecting a comprehensive picture of HFA funding. Moreover, the results of these HFA surveys should not be generalized to other home visiting program models, as the sources of federal funding may differ across programs, depending on the program model's origin and primary focus. Healthy Families America, for example, was launched in 1992 by Prevent Child Abuse America³⁸ with an explicit emphasis on preventing child abuse and neglect. Thus, it is not surprising that many Healthy Families America sites appear to receive more support from HHS human services programs (e.g., Title IV-B programs, TANF, CAPTA), while programs like the Nurse Family Partnership, by contrast, report significant support from public health programs at HHS (e.g., Medicaid, Maternal and Child Health Block Grant).

In fact, the original Nurse Family Partnership (NFP) trial study, launched in Elmira, NY, in 1978, was funded by the Maternal and Child Health Bureau within the Health Resources and Services Administration (HRSA) at HHS.³⁹ In subsequent years, the Maternal and Child Health Bureau

³⁵ Johnson, *State-based Home Visiting*, 2009.

³⁶ Includes responses from 33 of 45 states, with a site sample of 398. See http://www.healthyfamiliesamerica.org/network_resources/hfa_state_of_state_systems.pdf.

³⁷ See http://www.healthyfamiliesamerica.org/network_resources/hfa_state_of_state_systems.pdf. Note that FY2003 results are reported differently in another HFA report at <http://www.healthyfamiliesamerica.org/downloads/ssdg8.pdf>. The other report also shows funding from CAPTA outstripping TANF, but the percentages vary, with CAPTA representing 39% and TANF representing 31% of federal funds in that fiscal year.

³⁸ Prevent Child Abuse America (formerly known as the National Committee to Prevent Child Abuse) launched HFA in partnership with Ronald McDonald House Charities. HFA also credits the Freddie Mac Foundation with being instrumental in supporting ongoing development of the program.

³⁹ Andy Goodman, *The Story of David Olds and the Nurse Home Visiting Program*, Robert Wood Johnson Foundation, July 2006.

remained a common source of funding for Nurse Family Partnership programs, though federal support grew to include grants offered by the National Institutes of Health, as well as programs such as TANF and Medicaid. Recently, David Olds, founder of the Nurse Family Partnership, reported during congressional testimony that Medicaid was a growing source of funding for NFP programs, while the use of TANF funds was decreasing.⁴⁰ He indicated that states had used TANF funds more during the program's start-up phase, but that they now rely more on Medicaid funding. In his testimony, Olds also pointed to the Maternal and Child Health Block Grant as a common source of federal support for NFP programs.

In contrast to both Healthy Families America and the Nurse Family Partnership, Parents as Teachers (PAT) and Home Instruction for Parents of Preschool Youngsters (HIPPY) have both reported significant financial support from ED programs, such as Education for the Disadvantaged, Even Start, and Parent Information Resource Centers (all three programs are funded under the Elementary and Secondary Education Act).⁴¹ For instance, the 2005-2006 HIPPY USA End-of-Year Report notes that 120 HIPPY sites received federal funding from ED programs, compared to only eight sites that reported federal support from HHS (this split is roughly consistent with data in prior year reports).⁴² The Parents as Teachers model, meanwhile, originated largely due to support from the education community. PAT started in 1981 with a pilot project in Missouri, funded by the state Department of Elementary and Secondary Education and the Danforth Foundation. Four years later, the Missouri Department of Elementary and Secondary Education had expanded the PAT program to all school districts across the state. Today, more than 160 Local Education Agencies (LEA) are using Title I funds from ED to support PAT programs.⁴³

In fact, both Parents as Teachers and HIPPY programs are referenced by name in the authorizing statute for three programs in the Elementary and Secondary Education Act (ESEA). Education for the Disadvantaged (Title I, Part A) requires that local education agencies coordinate and integrate their parental involvement strategies under Title I with those provided under other programs, such as Parents as Teachers and HIPPY.⁴⁴ Organizations receiving grants through Parent Information Resource Centers (Title V, Part D) are required to use at least 30% of the funds they receive in each fiscal year to “establish, expand, or operate Parents as Teachers programs, Home Instruction for Preschool Youngsters programs, or other early childhood parent education programs.”⁴⁵ The Even Start (Title I, Part B) statute allows for the provision of funds to “eligible organizations” for program improvement and replication activities.⁴⁶ The statute defines eligible organizations as “any public or private nonprofit organization with a record of providing effective services to family literacy providers” and goes on to list Parents as Teachers and HIPPY as examples of such organizations.

⁴⁰ See the testimony of David Olds, in U.S. Congress, House Committee on Ways and Means, Subcommittee on Income Security and Family Support, Health Care for Children in Foster Care, hearings, 110th Cong., 1st sess., July 19, 2007, H-Hrg. 110-(Washington: GPO, 2007), <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=7167>.

⁴¹ Wasserman, *Implementation of Home Visitation*, 2006. On page 3, Wasserman notes that PIRC grantees are required to use a minimum of 30% of their awards to establish, expand, or operate early childhood parent education programs such as PAT and HIPPY. See also Section 5563 of the Elementary and Secondary Education Act (ESEA).

⁴² See the 2005-2006 HIPPY USA End-of-Year Report online at http://www.hippyusa.org/site/view/136428_HIPPYEndofYearMISReport.pml.

⁴³ See PAT Fact Sheet at <http://www.parentsasteachers.org/atf/cf/%7B00812ECA-A71B-4C2C-8FF3-8F16A5742EEA%7D/PAT%20and%20Title%20I%20ARRA.pdf>.

⁴⁴ See Title I, Part A, Subpart 1, Section 1118 of the Elementary and Secondary Education Act.

⁴⁵ See Title I, Part D, Subpart 16, Section 5563 of the Elementary and Secondary Education Act.

⁴⁶ See Title I, Part B, Subpart 3, Section 1232 of the Elementary and Secondary Education Act.

Current Investment In and Estimated Costs of Home Visiting

Largely because there is such variety in home visiting program models and the sources that fund them, it is difficult to estimate the current level of national investment in home visiting programs. Partial information provided by some states support the assertion that *no less than* \$250 million⁴⁷ is currently being spent each year on home visitation and one researcher has estimated total annual spending for this purpose (from all sources) at “perhaps \$750 million to \$1 billion.”⁴⁸

Based on reporting from 31 states in the study conducted by the National Center for Children in Poverty (NCCP), the aggregate annual level of support for home visiting programs in responding states in 2007 was more than \$250 million (covering about 55 programs).⁴⁹ This figure represents only a partial accounting of spending for early childhood home visitation, however, because it does not include funding for programs operating in states that did not respond to this survey question and it does not capture spending on programs that did not meet the definition of “state-based” used in the NCCP report.

A survey of state appropriations for “parent education and home visiting” programs (including some Healthy Families America, Nurse Family Partnership, HIPPPY, and Parents as Teachers programs) conducted by the National Conference of State Legislatures (NCSL) found that among the 26 responding states a total of about \$250 million was appropriated for FY2007 and \$281 million for FY2008.⁵⁰ Of this total, it appears that federal funding sources account for roughly 15% of total appropriations, with most federal contributions attributed to TANF or Medicaid. The NCSL report is likely to under-represent federal contributions, as not all federal programs require state legislative action in order to be directed toward services at the state or local level.

Taking a broader view of home visiting programs across the United States, home visitation researcher Deanna Gomby estimated in a 2005 report that annual costs for these programs are “perhaps \$750 million to \$1 billion.” Gomby’s estimate assumes a range of \$1,000 to \$3,000 per family per year and is based on the number of children enrolled in seven selected home visiting programs operating nationally.⁵¹

Estimating costs for home visiting is also difficult because costs may vary significantly by program model and site, as demonstrated in **Table 1**. For example, Healthy Families America estimates that their programs spent from \$1,950 to \$5,768 per family in FY2004, with costs averaging about \$3,348 per family in that year.⁵² This was up from an average cost of \$2,764 in FY2003, when spending ranged from \$1,550 to \$4,500 per family. The Nurse Family Partnership offers more current numbers in a 2009 fact sheet, indicating that their typical costs range from

⁴⁷ Consistent with Johnson, *State-based Home Visiting Programs*, 2009, p. 4, and with Clothier and Poppe, *Early Care and Education*, 2008, Appendix C.

⁴⁸ Gomby, *Home Visitation*, 2005, p. 1.

⁴⁹ Johnson, *State-based Home Visiting Programs*, 2009, p. 4.

⁵⁰ Clothier and Poppe, *Early Care and Education*, 2008, Appendix C.

⁵¹ Gomby, *Home Visitation*, 2005, p. 1. Gomby’s calculations are based on numbers of children enrolled in “the seven largest home visiting programs nationally” (as determined by Gomby). These include Even Start, Early Head Start, Parents As Teachers, HIPPPY, Healthy Families America, Nurse-Family Partnership, and the Parent-Child Home Program. Gomby assumes some duplication in counts across the programs (at least 45% for PAT) and then assumes a range of \$1,000 to \$3,000 per family per year.

⁵² See HFA website at http://www.healthyfamiliesamerica.org/network_resources/hfa_state_of_state_systems.pdf.

\$2,914 to \$6,463 per family per year.⁵³ Variation in costs across program models and sites can be attributed to a number of factors, including the intensity of services provided (e.g., number of visits), the qualifications and salary requirements of staff, the differences in cost of living for communities across the country, and the variety and scope of services offered. Typically, the more comprehensive the program, the higher the cost.⁵⁴ The average cost for a slot in Early Head Start, for instance, is estimated to exceed \$11,000 annually (though this average is based on all Early Head Start programs, which include center-based, home-based, and combination programs).⁵⁵

Research and Evaluation of Existing Home Visiting Programs

Looking at findings across multiple home visiting studies, researchers conclude that home visiting can provide benefits to children and their parents, including preventing *potential* child abuse and neglect, enhancing cognitive development, improving parenting attitudes and parenting behaviors (e.g., discipline strategies), and increasing maternal education. They caution, however, that while all of those positive effects for home visiting programs were statistically significant, the size of the effect is small. (That is to say, the difference between observed outcomes for home visited as opposed to not-visited parents and children is small.) Further, while one or more individual studies may have shown positive effects with regard to many other desired outcomes, those effects have not necessarily been studied and/or achieved across more than one study or program site.⁵⁶ Efforts to better understand the components of successful home visitation and to find additional effective methods for meeting a range of family and child needs continue with newer research providing additional information on positive outcomes.⁵⁷

In sum, most researchers seem confident that early childhood home visitation can be effective in improving outcomes for families and children, although they differ on how strong they think this evidence is across the range of program models and across the variety of outcomes. Other researchers caution that to be effective (regardless of program model or goal) a home visitation program's goals must be aligned with the program's content (e.g., if you want to prevent child abuse and neglect you have to focus on the aspect(s) of the home visit that will accomplish this), and that home visitors must appropriately and adequately deliver the services. They also make clear that home visiting is not a silver bullet strategy that can solve all prevention needs. Instead they suggest it will be most successful if it is integrated into a broader set of services that are focused on supporting families and ensuring positive outcomes for young children. These include quality center-based education for preschoolers, preventive health care as part of medical homes⁵⁸

⁵³ See NFP website at http://www.nursefamilypartnership.org/resources/files/PDF/Fact_Sheets/NFP_Benefits&Cost.pdf.

⁵⁴ Galbraith, *Proactive Funding*, 2007, p. 4.

⁵⁵ See FY2008 Head Start Program Fact Sheet online at <http://eclkc.ohs.acf.hhs.gov/hslc/About%20Head%20Start/dHeadStartProgr.htm>.

⁵⁶ Monica A. Sweet and Mark I. Appelbaum, "Is Home Visiting an Effective Strategy? A Meta-Analytic Review of Home Visiting Programs for Families with Young Children," *Child Development*, vol. 75, no. 5 (September/October 2004), pp. 1435-1456 (hereinafter Sweet and Appelbaum, "A Meta-Analytic Review," 2004); and Gomby, *Home Visitation*, 2005.

⁵⁷ Testimony of Deborah Daro before House Ways and Means Committee, Subcommittee on Income Security and Family Support, June 9, 2009, available at <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=7842>.

⁵⁸ As currently used, a "medical home" means provision of primary care in a manner that is "accessible, continuous, (continued...)"

for all children, parenting support groups, and clinical mental health and other treatment services for parents who need them. Finally, they seek continued study of programs to understand what is most effective and they urge that programs be implemented in a manner that permits continuous quality improvement.⁵⁹

Methods for Evaluating Program Models

There is a fairly large and growing body of research looking at a variety of home visiting programs. Some of these studies have been designed as randomized control trials. Findings generated from these experiments, provided they are well designed and implemented, can demonstrate the level of effectiveness. In this kind of program evaluation, study participants are randomly assigned to a “treatment” or “experimental” group, while others are randomly assigned to a “control” group. Families assigned to the “treatment” group subsequently receive home visiting services; families assigned to the control group do not. The outcomes for both groups are tracked and tested for statistically significant differences. To ensure that the findings accurately reflect what is achieved, however, these studies must have a participant pool that is large enough to allow researchers to draw conclusions that are statistically significant. Finally, the experiment should be carried out in more than one site and the findings of the study should be consistent (or replicated) across those multiple sites. Follow-up studies (longitudinal analysis) of the original may be used to determine if any initial positive effects are maintained over time and/or to measure later effects (e.g., academic success in grade school of home visited versus not-visited infants and toddlers).

Other studies that have been used to evaluate home visitation programs are referred to as “quasi-experimental.” Although they do not randomly assign participants, quasi-experimental studies are designed so that outcomes for the group of families and children receiving the treatment (e.g., home visiting) may be compared to a group of families who did not receive these services. Ideally, the characteristics of this comparison group closely match those of the group receiving the treatment (home visiting services) so that any differences are fairly attributed to the treatment received rather than to differences in the groups studied. As with randomized control tests, findings from quasi-experimental studies that use larger participant pools and test outcomes in more than one location are considered of greater merit than those not meeting these standards.

(...continued)

comprehensive, family centered, coordinated, compassionate, and culturally effective.” As part of this concept, primary care providers are expected to coordinate with other health, education, and family support professionals to ensure a child and his/her family access to, and coordination of, specialty health care, educational services, family support in and out of home care, and other public and private community services important to the overall health of the child and his/her family. See Children’s Health Topics, “Medical Home,” American Academy of Pediatrics at <http://www.aap.org/healthtopics/medicalhome.cfm>.

⁵⁹ Council on Community Pediatrics, “The Role of Preschool Home Visiting Programs in Improving Children’s Developmental and Health Outcomes,” Policy Statement, *Pediatrics*, vol. 123, no. 2 (February 2009), pp. 598-603 (hereinafter Council on Community Pediatrics, “The Role of Preschool Home Visiting Programs,” 2009). Johnson, *State-based Home Visiting Programs*, 2009. Deanna S. Gomby, “The Promise and Limitations of Home Visiting: Implementing Effective Programs,” *Child Abuse & Neglect*, vol. 31 (2007), pp. 793-799. Deborah Daro, *Home Visitation: Assessing Progress, Managing Expectations*, Ounce of Prevention and Chapin Hall Center for Children, University of Chicago, 2006. Lisa Thompson et al., *Home Visiting: A Service Strategy to Deliver Proposition 10 Results*, UCLA Center for Healthier Children, Families and Communities, December 2001 (hereinafter Thompson et al., *Home Visiting: A Service Strategy*, 2001).

Finally, some evaluations of home visitation programs look at changes across time (e.g., pre-test, post-test) but only among the group of families who were served. This kind of program feedback can be important in implementing a program—particularly if consistent data are regularly collected and reviewed as part of a structured and continuous program improvement process. However, this type of study is considered “non-experimental” because it lacks a contemporaneous comparison group, and some of the changes observed could have occurred even without implementing home visiting.

Randomized control studies may provide the clearest evidence of a home visiting program’s effects, and some researchers call for continued implementation of these studies to ensure effectiveness of home visiting models.⁶⁰ Others note that randomized control studies are expensive and time consuming, and that they require social service providers to withhold what may be valuable family support from “control group” members.⁶¹ Reflecting on their own efforts to implement a randomized control trial of a particular service strategy for children and families, two researchers at the Michigan State University Child Health Care Clinic note that these trials are based on three assumptions—standardized interventions, equal groups, and equal environments—and that “most if not all, of these assumptions are difficult to meet in the complex environment of practice.”⁶² Some researchers and home visitation advocates cite the wide range of family needs and circumstances as dictating that more than one model of home visiting is necessary and they further argue that each of those iterations can not be tested, practically, in a random trial.⁶³ Instead, these researchers assert that the overall efficacy of home visiting has been proven and therefore efforts should be placed on fine tuning existing program models to ensure their quality and monitor outcomes.⁶⁴

Research Findings by Desired Program Outcomes

As discussed above, home visiting programs have goals that cross several major domains, including maternal and child health; early childhood social, emotional, and cognitive development; and family/parent functioning. Programs may identify one or more desired outcomes across one or more of these main domains. In the maternal and child health domain, desired program outcomes may include decreased infant mortality and improved infant health and physical development; improved perinatal maternal health and health behaviors; a reduced number of subsequent pregnancies and/or a longer time interval between pregnancies; and prevention of child injuries, intentional or unintentional. In the early childhood development domain, desired program outcomes may include improved parent-child interaction to enhance and ensure children’s social/emotional and cognitive development; enhanced school readiness for children and longer-term academic success. Finally, in the domain of family/parent functioning, home visitation programs may seek to improve parenting skills, knowledge, and behaviors; reduce the incidence of child abuse or neglect; and increase maternal education attainment and family self sufficiency.

⁶⁰ Harriet L. MacMillan et al., “Interventions to Prevent Child Maltreatment and Associated Impairment,” *The Lancet*, vol. 373 (January 17, 2009), p. 261 (hereinafter, MacMillan, et al, “Interventions,” 2009).

⁶¹ Wasserman, *Implementation of Home Visitation*, 2006.

⁶² Rebecca Anne Malouin and Jane Turner, Letter to the Editor, “A Review of the Evidence for the Medical Home of Children with Special Health Care Needs,” *Pediatrics*, vol. 123, no. 2 (February 2009), p. e369.

⁶³ Question and Answer Period, NCCP “Focus on Home Visiting,” webinar, 2008.

⁶⁴ Ibid. Johnson, *State-based Home Visiting*, 2009.

A variety of factors have been cited as important to the effectiveness of home visiting generally without regard to the model being employed or outcome sought. These include, but are not limited to, clear program goals that are tied to program content; educational status and training of the home visitors; intensity and duration of service provision, including the ability to attract and retain families; and integration of the program with other kinds of parenting support programs and early childhood programs related to children's health, education, and socio-emotional development.⁶⁵

There is a large and still growing body of research on home visitation programs. Some of the findings to date are discussed below.

Findings in the Maternal and Child Health Domain

A number of home visiting studies have considered the effectiveness of these programs in improving maternal and child health outcomes, including maternal mental health and substance abuse (during or after pregnancy), the number and spacing of subsequent pregnancies, the incidence of preterm and low birth weight babies, use of preventive/well-child care, and frequency of emergency room treatment or injuries among children.

A 2004 meta-analysis found that home visiting programs could be effective in reducing, for children, the number of emergency room visits, injuries or ingestions treated, and accidents requiring medical attention.⁶⁶ In her 2005 review of the research on home visitation, however, Deanna Gomby concluded that home visitation programs had not been shown to increase the use of preventive health care.⁶⁷ With regard to outcomes for mothers, some home visitation programs, discussed below, have been shown to reduce the number of subsequent pregnancies or to increase the time interval between pregnancies. Researchers have identified maternal depression, substance abuse, and intimate partner violence as critical issues that home visitors have not necessarily known how to identify or address, and that may, in turn, reduce the effectiveness of home visitation on other outcomes.⁶⁸

Maternal Mental Health and Substance Abuse

Maternal mental health and substance abuse can have significant implications for both mother and child. For instance, research shows that clinical depression can be a barrier to employment and that it can affect interactions between mother and child. In fact, poor maternal mental health

⁶⁵ Gomby, "The Promise and Limitations of Home Visiting," 2007. Testimony of Jeanne Brooks-Gunn and Testimony of Deborah Daro before U.S. House Ways and Means Committee, Subcommittee on Income Security and Family Support, "Hearing on Proposals to Provide Federal Funding for Early Childhood Home Visitation Programs," June 9, 2009. See <http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=682>.

⁶⁶ Sweet and Appelbaum, "A Meta-Analytic Review," 2004.

⁶⁷ Gomby, *Home Visitation*, 2005, pp. 18-19.

⁶⁸ S. Darios Tandon et al., "Formative Evaluation of Home Visitors' Role in Addressing Poor Mental Health, Domestic Violence, and Substance Abuse Among Low-Income Pregnant and Parenting Women," *Maternal and Child Health Journal*, vol. 9, no. 3 (September 2005), pp. 273-283. Robert T. Ammerman et al., "Changes in Depressive Symptoms in First Time Mothers in Home Visitation," *Child Abuse & Neglect*, vol. 33 (2009), pp. 127-138. John Eckenrode et al., "Preventing Child Abuse and Neglect with a Program of Nurse Home Visitation: The Limiting Effects of Domestic Violence," *Journal of the American Medical Association*, vol. 284, no. 11 (September 2000), pp. 1385-1390.

has been linked to higher rates of behavioral, academic, and health problems among children.⁶⁹ Meanwhile, studies have shown that prenatal exposure to alcohol or drugs can increase the risk of preterm birth, miscarriage, and birth defects, including physical, cognitive, and behavioral disorders.⁷⁰ Despite this, data from the combined 2006-2007 National Survey on Drug Use and Health show that substance usage among pregnant women ages 15 to 44 is prevalent, with an average of 5.2% reporting use of illicit drugs in the past month, 16.4% indicating cigarette use in the past month, and 11.6% reporting current alcohol use.⁷¹

A randomized trial study of the Hawaii Healthy Start Program (generally acknowledged as the prototype for Healthy Families America) concluded that there were positive maternal mental health outcomes for participating mothers compared to the control group in one of the three Hawaii Healthy Start programs operating in Hawaii.⁷² The same Hawaii Healthy Start Program study found that home visitation had no statistically significant effect on maternal substance abuse.⁷³ However, when isolating families receiving a higher dose of services, this study concludes that, compared to control group mothers, those who received a higher dose of home visiting services did demonstrate reduced maternal “problem alcohol use.”⁷⁴ This suggests that intensity and duration of services may be critical factors in determining program success.

Results from a randomized control trial of the Nurse Family Partnership model in Denver, CO, concluded that two years after the program of home visits was completed, mothers who had been visited by paraprofessionals exhibited better mental health (on a standardized scale) than did control group mothers in the study. However, there was no statistically significant difference for nurse-visited mothers (compared to control group mothers) on mental health outcomes. Neither nurse-visited nor paraprofessional-visited mothers in Denver showed statistically significant outcomes that were different from control group mothers with regard to substance abuse.⁷⁵ The nine-year follow-up to the NFP’s program in Memphis, TN, found that nurse-visited mothers used fewer substances.⁷⁶ However, this evaluation found no statistically significant effect on maternal depression.

⁶⁹ Surjeet K. Ahluwalia, Sharon M. McGroder, and Martha J. Zaslow et al., *Symptoms of depression among welfare recipients: A concern for two generations*, Child Trends Research Brief, December 2001. Gomby, *Home Visitation*, 2005.

⁷⁰ Katrine Albertsen et al., “Alcohol consumption during pregnancy and the risk of preterm delivery,” *American Journal of Epidemiology*, vol. 159, no. 2 (2004), pp. 155-161. Also see the 2005 press release from the U.S. Surgeon General’s Office, online at <http://www.surgeongeneral.gov/pressreleases/sg02222005.html>, and the fact sheet by the March of Dimes Foundation online at http://www.marchofdimes.com/professionals/14332_1170.asp.

⁷¹ U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), *Results from the 2007 National Survey on Drug Use and Health: National Findings*, NSDUH Series H-34, HHS Publication No. SMA 08-4343, September 2008, pp. 4, 24, 33.

⁷² Anne Duggan, Loretta Fuddy, and Lori Burrell et al., “Randomized trial of a statewide home visiting program to prevent child abuse: Impact in reducing parental risk factors,” *Child Abuse & Neglect*, vol. 28, no. 6 (June 2004) pp. 630-632 (hereinafter Duggan et al., “Impact in reducing parental risk factors,” 2004).

⁷³ Duggan et al., “Impact in reducing parental risk factors,” 2004, pp. 630-631. Anne K. Duggan, Elizabeth C. McFarlane, and Amy M. Windham et al., “Evaluation of Hawaii’s Healthy Start Program,” *The Future of Children*, vol. 9, no. 1 (Spring/Summer 1999), p. 84 (hereinafter Duggan et al., “Hawaii’s Healthy Start Program,” 1999).

⁷⁴ Duggan et al., “Impact in reducing parental risk factors,” 2004, p. 631.

⁷⁵ David L. Olds et al., “Effects of Home Visits by Paraprofessionals and by Nurses: Age 4 Follow-Up Results of a Randomized Trial,” *Pediatrics*, vol. 114, no. 6 (December 2004), pp. 1560-1568.

⁷⁶ David L. Olds et al., “Effects of Nurse Home Visiting on Maternal and Child Functioning: Age-9 Follow-Up of a Randomized Trial,” *Pediatrics*, vol. 120, no. 4 (October 2007), pp. e841.

Number and Frequency of Subsequent Pregnancies

Some researchers argue that “rapid successive pregnancies” can negatively affect mothers’ educational and workforce achievements.⁷⁷ Several studies have looked at the effectiveness of home visiting programs on maternal health outcomes.

Research on the Nurse Family Partnership site in Elmira, NY, found that by the child’s fourth birthday (two years after program ended) nurse-visited mothers had fewer subsequent pregnancies.⁷⁸ Results from studies at the NFP site in Memphis found that four years after the program ended nurse-visited mothers had experienced fewer subsequent pregnancies. This study also found evidence of longer intervals between births of the first and second child.⁷⁹ The follow-up to this study found that nine years after the intervention, these results held; on average, nurse-visited women had longer intervals between the births of first and second children and fewer cumulative subsequent births per year.⁸⁰ Notably, while both sites showed effects on reducing subsequent pregnancies, the effect size was much larger in Elmira (67% reduction) than in Memphis (23% reduction).⁸¹ A study from the Denver NFP site found that, among the nurse-visited mothers who had at least one additional child (within four years of their first pregnancy), there was a greater interval between that pregnancy and the first one, compared to the control group. However, this same study found no statistically significant difference for paraprofessional-visited mothers (compared to control group mothers) in birth intervals and that neither nurse-visited nor paraprofessional-visited mothers showed statistically significant outcomes that were different from control group mothers with regard to the number of subsequent pregnancies.⁸²

A randomized control trial among teen mothers in California of the Parents as Teachers home visiting model found that significantly fewer home visited mothers had multiple pregnancies during the study period than did control group mothers (1.4% versus 4.8%).⁸³ By contrast, the randomized trial evaluation of the Hawaii Healthy Start program showed no effects on repeat births.⁸⁴

⁷⁷ David L. Olds, Charles R. Henderson, Jr., and Harriet J. Kitzman et al., “Prenatal and Infancy Home Visitation by Nurses: Recent Findings,” *The Future of Children*, vol. 9, no. 1 (Spring/Summer 1999), p. 44.

⁷⁸ Research cited in RAND Corp., Promising Practices Network, Programs that Work, Nurse Family Partnership, <http://www.promisingpractices.net/program.asp?programid=16#findings>.

⁷⁹ David L. Olds et al., “Effects of Nurse Home Visiting on Maternal Life Course and Child Development: Age 6 Follow-Up Results of A Randomized Trial,” *Pediatrics*, vol. 114, no. 6 (December 2004), pp. 1550-1559.

⁸⁰ David L. Olds et al., “Effects of Nurse Home Visiting on Maternal and Child Functioning: Age-9 Follow-Up of a Randomized Trial,” *Pediatrics*, vol. 120, no. 4 (October 2007), pp. e838-e840.

⁸¹ David L. Olds, Charles R. Henderson, Jr., and Harriet J. Kitzman et al., “Prenatal and Infancy Home Visitation by Nurses: Recent Findings,” *The Future of Children*, vol. 9, no. 1 (Spring/Summer 1999), p. 61.

⁸² David L. Olds et al., “Effects of Home Visits by Paraprofessionals and by Nurses: Age 4 Follow-Up Results of a Randomized Trial,” *Pediatrics*, vol. 114, no. 6 (December 2004), pp. 1560-1568.

⁸³ Mary Wagner et al., *Intervention in Support of Adolescent Parents and Their Children: A Final Report on the Teen Parents as Teachers Demonstration*, SRI International, 1996. (As reported by the RAND Corp., Promising Practices Network, Program that Work at <http://www.promisingpractices.net/program.asp?programid=88#findings>.)

⁸⁴ Samer S. El-Kamary, Susan M. Higman, and Elizabeth McFarlane et al., “Hawaii’s Healthy Start home visiting program: Determinants and impact of rapid repeat birth,” *Pediatrics*, vol. 114, no. 3 (September 2004), pp. e317-e326.

Healthy Birth Weight

Birth weight can be another important indicator of maternal and child health. Low birth weight is a leading cause of infant deaths and childhood illnesses and disabilities.⁸⁵ Several home visiting studies have looked at outcomes in this area. For instance, nurse-visited young adolescents (ages 14 to 16) in the Nurse Family Partnership's Elmira study had babies who were an average of 395 grams heavier than the babies of adolescents in the comparison group.⁸⁶ In the nine-year follow-up of the Memphis site, researchers found a significantly lower number of subsequent low birth weight infants (0.18 versus 0.27).⁸⁷

The randomized control trial of teen mothers in California found that among those who entered the study while pregnant, mothers in the PAT-only group had marginally lower rates of low birth weight babies than did mothers in the control group (4% versus 8%).⁸⁸ In addition, a study of the Healthy Families America program in New York found that, of those who began participating in the Healthy Families America program at least two months prior to the birth of their children, control group mothers were significantly more likely to deliver low birth weight babies than were participating mothers. The rate of low birth weight was two-and-a-half times higher for the control group (8.3%) than it was for participating mothers (3.3%).⁸⁹ However, it is worth noting that this study found no significant program effects on the rate of premature births or the percentage of babies requiring neonatal intensive care.

Adequacy of Preventative Health Care

Many home visiting studies have looked at outcomes related to children's health, including access to health insurance, primary care physicians, well-child visits, and immunization rates.

A study of the New York Healthy Families America program found that parents in the control group were significantly less likely than participating parents to have health insurance for their children as of the first-year follow-up interview (90.4% compared to 93.9%).⁹⁰ There was no program effect, however, on the parents' likelihood of having health insurance coverage for themselves. There were also no significant differences between the participating families and

⁸⁵ Susan Mitchell-Herzfeld et al., *Evaluation of Healthy Families New York (HFNY): First Year Program Impacts*, New York State Office of Children and Family Services, Bureau of Evaluation and Research, and the Center for Human Services Research, University at Albany, February 2005, p. vii, http://www.ocfs.state.ny.us/main/prevention/assets/HFNY_FirstYearProgramImpacts.pdf.

⁸⁶ David L. Olds et al., "Improving the Delivery of Prenatal Care and Outcomes of Pregnancy: A Randomized Trial of Nurse Home Visitation," *Pediatrics*, vol. 77, no. 1 (January 1986), pp. 16-28.

⁸⁷ David L. Olds et al., "Effects of Nurse Home Visiting on Maternal and Child Functioning: Age-9 Follow-Up of a Randomized Trial," *Pediatrics*, vol. 120, no. 4 (October 2007), pp. e832-e845.

⁸⁸ Mary Wagner et al., *Intervention in Support of Adolescent Parents and Their Children: A Final Report on the Teen Parents as Teachers Demonstration*, SRI International, 1996. (As reported by the RAND Corp., Promising Practices Network, Program that Work at <http://www.promisingpractices.net/program.asp?programid=88#findings>.)

⁸⁹ Susan Mitchell-Herzfeld et al., *Evaluation of Healthy Families New York (HFNY): First Year Program Impacts*, New York State Office of Children and Family Services, Bureau of Evaluation and Research, and the Center for Human Services Research, University at Albany, February 2005, pp. 47-50, http://www.ocfs.state.ny.us/main/prevention/assets/HFNY_FirstYearProgramImpacts.pdf.

⁹⁰ Susan Mitchell-Herzfeld et al., *Evaluation of Healthy Families New York (HFNY): First Year Program Impacts*, New York State Office of Children and Family Services, Bureau of Evaluation and Research, and the Center for Human Services Research, University at Albany, February 2005, pp. 50-51, http://www.ocfs.state.ny.us/main/prevention/assets/HFNY_FirstYearProgramImpacts.pdf.

control group families in outcomes related to the child having a regular health care provider, the child ever having been without needed medical care, the number of well-child visits, and completion of all immunizations.

Meanwhile, results from the second-year follow-up on the random trial study of the Hawaii Healthy Start Program indicate that participating parents were statistically more likely to describe themselves as having a primary care provider who handles most of their child's health care needs and understands their concerns about their child's health.⁹¹ However, this same study found no differences in the rates of immunization or well-child visits for participating children compared to control group children.⁹² By contrast, in a third-year follow-up of a randomized control study of the Parents as Teachers program (one site only), participating children were significantly more likely to be fully immunized than control group children.⁹³

To gain the most health benefits for young children, researchers have also looked at the importance of linking home visiting with quality pediatric care, including establishment of a medical home⁹⁴ for all children.⁹⁵

Need for Urgent Care or Hospitalization

Child health and safety can also be linked to need for urgent care, hospitalization, or frequency of ingestions or injuries. Research on the Nurse Family Partnership site in Elmira, NY, found that at the program's end (when children were two years old), children in nurse-visited homes had fewer emergency room visits for injuries and ingestions than did children in homes of control group mothers, as well as fewer emergency room visits overall when compared to those children.⁹⁶ Results from the Memphis NFP site suggest that at the end of the program (when the child was two years old) nurse-visited children had fewer health care encounters for injuries and ingestions compared with control group children.⁹⁷

By contrast, the Hawaii Healthy Start study reported that children participating in the program experienced no beneficial effect with respect to emergency room use, hospitalization, and need for urgent medical care when compared to children in the control group.⁹⁸

⁹¹ Duggan et al., "Hawaii's Healthy Start Program," 1999, pp. 77, 80.

⁹² Deanna S. Gomby, Patti L. Culross, and Richard E. Behrman, "Home Visiting: Recent Program Evaluations—Analysis and Recommendations," *The Future of Children*, vol. 9, no. 1 (Spring/Summer 1999), p. 12.

⁹³ Mary Wagner et al., *The Multisite Evaluation of the Parents as Teachers Home Visiting Program: Three-Year Findings From One Community*, SRI International, August 2001.

⁹⁴ See footnote 58 for an explanation of the "medical home" concept.

⁹⁵ Council on Community Pediatrics, "The Role of Preschool Home Visiting," p. 601. Thompson et al., *Home Visiting: A Service Strategy*, 2001, p. 27.

⁹⁶ David L. Olds, et. al., "Does Prenatal and Infancy Nurse Home Visitation Have Enduring Effects on Qualities of Parental Caregiving and Child Health at 24 to 50 months of Life?" *Pediatrics*, vol. 93, no. 1 (January 1994), pp. 89-98.

⁹⁷ Harriet Kitzman, et.al., "Effects of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries, and Repeated Childbearing: A Randomized Controlled Trial," *Journal of the American Medical Association*, vol. 278, no. 8 (1997), pp. 644-652. (As cited in RAND Corp, Promising Practices Network, Programs that Work, Nurse Family Partnership, <http://www.promisingpractices.net/program.asp?programid=16#findings>.)

⁹⁸ Duggan et al., "Hawaii's Healthy Start Program," 1999, p. 82.

Findings in the Child Social, Emotional, and Cognitive Development Domain

A number of studies of home visiting programs have evaluated program effectiveness in enhancing children's social, emotional, and cognitive development. Among other things, these outcomes may be manifested in early language skills and behaviors, as well as school-aged academic achievement, and matriculation rates. Overall, most analyses conclude that cognitive and socio-emotional outcomes were stronger for home visited children than for control group children.⁹⁹ However, researchers caution that the effect sizes for child development outcomes were usually small to medium at best, noting that home visited children might see improved scores on a standardized intelligence test of only a few points.

School Readiness and Achievement

As reported in Deanna Gomby's 2005 paper, some studies of home visiting programs such as Parents as Teachers,¹⁰⁰ HIPPY,¹⁰¹ or the Parent-Child Home Program¹⁰² have demonstrated that home visited children outperform other children in the community through the 4th, 6th, or 12th grades, respectively, in measures such as school grades and achievement test scores on reading and math, suspensions, or high school graduation rates.¹⁰³ However, large cognitive benefits such as these are not always demonstrated reliably in high-quality randomized control trials of home visiting programs.

Many evaluations of Nurse Family Partnership programs do not assess child cognitive development outcomes. However, some studies of the randomized control trials in Elmira, NY, and Memphis, TN, suggest very limited to no significant program effects on children's cognitive development and intellectual functioning.¹⁰⁴ By contrast, the nine-year follow-up study of participants in the Nurse Family Partnership's program in Memphis found that nurse-visited children born to low-resource mothers had grade point averages (GPAs) that were equivalent to those of control group children who were born to high-resource mothers.¹⁰⁵ In contrast, control

⁹⁹ Lynn A. Karoly, M. Rebecca Kilburn, and Jill S. Cannon, *Early Childhood Interventions: Proven Results, Future Promise*, RAND Corporation, 2005. Sweet and Appelbaum, "A Meta-Analytic Review," 2004.

¹⁰⁰ D. Coates, *Early childhood evaluation: A report to the Parkway Board of Education*, Parkway School District, St. Louis, MO, 1994. D. Coates, *Memo on one-year update on Stanford scores of students*. Early Childhood Evaluation Study Group, December 26, 1996. D. Coates, *Memo on one-year update on Stanford scores of students*, Early Childhood Evaluation Study Group, December 26, 1996. (As cited in Gomby, *Home Visitation*, 2005. Also cited in Winter, M.M., 1999). "Parents as Teachers," *The Future of Children*, vol. 9, no. 1 (Spring/Summer 1999), pp. 179-189.)

¹⁰¹ Robert H. Bradley and Barbara Gilkey, "The impact of the Home Instructional Program for Preschool Youngsters (HIPPY) on school performance in 3rd and 6th grades," *Early Education and Development*, vol. 13, no. 3 (July 2002), pp. 302-311. (As cited in Gomby, *Home Visitation*, 2005.)

¹⁰² Phyllis Levenstein et al., "Long-term impact of a verbal interaction program for at-risk toddlers: An exploratory study of high school outcomes in a replication of the Mother-Child Home Program," *Journal of Applied Developmental Psychology*, vol. 19, no. 2 (1998), pp. 267-285. (As cited in Gomby, *Home Visitation*, 2005.)

¹⁰³ Gomby, *Home Visitation*, 2005, p. 23.

¹⁰⁴ David L. Olds, Charles R. Henderson, Jr., and Harriet Kitzman, "Does Prenatal and Infancy Nurse Home Visitation Have Enduring Effects on Quality of Parental Caregiving and Child Health at 25 to 50 Months of Life?," *Pediatrics*, vol. 93, no. 1 (January 1994), p. 97. David L. Olds, Charles R. Henderson, Jr., and Harriet J. Kitzman et al., "Prenatal and Infancy Home Visitation by Nurses: Recent Findings," *The Future of Children*, vol. 9, no. 1 (Spring/Summer 1999), pp. 44, 52-55.

¹⁰⁵ David L. Olds et al., "Effects of Nurse Home Visiting on Maternal and Child Functioning: Age-9 Follow-Up of a Randomized Trial," *Pediatrics*, vol. 120, no. 4 (October 2007), pp. e841-e842.

group children with low-resource mothers had the lowest GPAs in the study.¹⁰⁶ This same study found that nurse-visited children had fewer failures in conduct during the first three years of elementary school than control group peers.

Sixteen to twenty years after their participation in the randomized control study, high school drop out rates for children who were assigned to participate in the Parent-Child Home Program were found to be lower than those for children assigned to the control group. (This result was just below statistical significance. Some outside researchers have described it as “marginally significant,” while others have argued that the effect may have been due to chance rather than to the program.¹⁰⁷) At the time of their enrollment in the study, both PCHP participants and control group children were considered “at-risk” based on the presence of certain child or family factors, including parental unemployment, welfare receipt, low child IQ, single parenting, and/or poverty status. The study’s researchers noted that the high school graduation rates for PCHP participants were 30% higher than those of the control group that remained in the community and over 20% higher than low-income students nationally.¹⁰⁸

Examining Child Development Outcomes by Program Strategies

Controlled trials of Nurse Family Partnership programs have found mixed results with respect to child development, sometimes concluding that these programs produced “few effects on children’s development,”¹⁰⁹ while at other times finding that home visited children of mothers with “low psychologic resources” (i.e., low-functioning mothers, based on levels of intelligence, mental health, and coping abilities) experienced home environments that were more “conducive to early learning”¹¹⁰ than control group counterparts.

In an attempt to better parse effects, some studies have raised the issue of linking program quality to program outcomes. For instance, the Nurse Family Partnership controlled trial in Denver looked at differential outcomes for children based on whether or not the home visitor was a registered nurse or a paraprofessional.¹¹¹ In Denver studies, the paraprofessional program for low-resource mothers was statistically linked to home environments that were more supportive of early learning than the control group. However, the paraprofessional program had no statistically significant effects on children’s language, executive functioning, or behavioral adaptation. By contrast, the nurse program for low-resource mothers was linked to statistically significant, positive effects on the home learning environment, as well as language development, executive functioning, and behavioral adaptation during testing, compared to the control group.

¹⁰⁶ Ibid.

¹⁰⁷ Coalition for Evidence-Based Policy, *Early Childhood Home Visitation Models: An Objective Summary of the Evidence About Which Are Effective*, April 2009, pp. 4-5, <http://www.evidencebasedpolicy.org/docs/OverviewOfEvidenceOnHomeVisitationModels409.pdf>.

¹⁰⁸ Phyllis Levenstein et al., “Long-term impact of a verbal interaction program for at-risk toddlers: An exploratory study of high school outcomes in a replication of the Mother-Child Home Program,” *Journal of Applied Developmental Psychology*, vol.19, no. 2 (1998), pp. 267-286.

¹⁰⁹ David L. Olds, Charles R. Henderson, Jr., and Harriet J. Kitzman et al., “Prenatal and Infancy Home Visitation by Nurses: Recent Findings,” *The Future of Children*, vol. 9, no. 1 (Spring/Summer 1999), pp. 44, 54-55.

¹¹⁰ David L. Olds et al., “Effects of Home Visits by Paraprofessionals and by Nurses: Age 4 Follow-Up Results of a Randomized Trial,” *Pediatrics*, vol. 114, no. 6 (December 2004), pp. 1560-1568.

¹¹¹ Ibid. See also Olds, David et al., “Home Visiting by Paraprofessionals and by Nurses: A Randomized, Controlled Trial,” *Pediatrics*, vol. 110, no. 3 (September 2002), pp. 486-496.

Some of the literature has suggested that child-focused strategies may be more successful than parent-focused strategies in generating large benefits in a child's cognitive development.¹¹² A meta-analysis conducted by Abt Associates in 2001 compares the effect of home visiting and center-based early childhood education on cognitive development, and concludes that home visiting services generate an effect size for cognitive development of 0.26, but programs with early childhood education components generate effects almost twice as large (0.48).¹¹³ Others have suggested that the center-based preschool education component accounted for 63% of the variance in cognitive outcomes during the preschool years.¹¹⁴ In fact, there is a body of research which suggests that to generate lasting cognitive and other developmental benefits for children, home visiting should be linked with high-quality center-based child care and/or enrollment in a high-quality preschool.¹¹⁵

Results from Early Head Start (which has center-based programs, home-based programs, and programs that combine center-based and home-based services) research have found that, compared to control groups, participation in center-based programs has consistently enhanced cognitive development and, by age three, reduced negative aspects of children's social-emotional development.¹¹⁶ On the other hand, not all home-based Early Head Start programs have demonstrated positive effects on cognitive development.¹¹⁷ In fact, one study reports that "home-based programs had few significant impacts" compared to center-based programs and programs combining center-based and home-based services.¹¹⁸ However, recent studies have found that full implementation of HHS performance standards can affect program effectiveness.¹¹⁹ For instance, HHS reports that when home-based Early Head Start programs fully implemented performance standards, they demonstrated positive impacts on child cognitive development at the three-year mark (suggesting that previous studies may have shown no effect because the performance standards were not being rigorously implemented).¹²⁰ Studies have found that some of the largest gains from Early Head Start programs occur in the programs that combine center-based and

¹¹² Jean Layzer, Barbara D. Goodson, and Lawrence Bernstein et al., *National Evaluation of Family Support Programs: Final Report Volume A: The Meta-Analysis*, Abt Associates (prepared for the U.S. Department of Health and Human Services), April 2001 (hereinafter Layzer, *National Evaluation*, 2001). Gombo, *Home Visitation*, 2005. Lynn A. Karoly, M. Rebecca Kilburn, and Jill S. Cannon, *Early Childhood Interventions: Proven Results, Future Promise*, RAND Corporation, 2005. Sweet and Appelbaum, "A Meta-Analytic Review," 2004.

¹¹³ Layzer, *National Evaluation*, 2001.

¹¹⁴ Geoffrey Nelson et al., "A meta-analysis of longitudinal research on preschool prevention programs for children," *Prevention & Treatment*, vol. 6, no. 1 (December 2003).

¹¹⁵ Layzer, *National Evaluation*, 2001. Gombo, *Home Visitation*, 2005, pp. 24-25. Rand Corporation, Promising Practices Network, "Early Head Start," <http://promisingpractices.net/program.asp?programid=135>.

¹¹⁶ John M. Love, Ellen Eliason Kisker, and Christine M. Ross et al., *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start*, Mathematica Policy Research (prepared for the U.S. Department of Health and Human Services), 2002 (revisions made January 2004), p. xxix (hereinafter Love et al., *Making a Difference*, 2004).

¹¹⁷ U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), *Program Models in Early Head Start*, Early Head Start Research and Evaluation Project, April 2006, http://www.acf.hhs.gov/programs/opre/ehs/ehs_resrch/reports/program_models/program_models.pdf.

¹¹⁸ Love et al., *Making a Difference*, 2004, p. 315.

¹¹⁹ Love et al., *Making a Difference*, 2004, pp. 303, 317.

¹²⁰ U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), *Early Head Start Benefits for Children and Families*, Early Head Start Research and Evaluation Project, April 2006, http://www.acf.hhs.gov/programs/opre/ehs/ehs_resrch/reports/dissemination/research_briefs/research_brief_overall.pdf.

home-based services, with some effects in the 20-30% range.¹²¹ Moreover, combination programs consistently demonstrated enhanced language development and aspects of social-emotional development among children, as well as improved parenting behaviors and participation in self-sufficiency oriented activities among parents.¹²² This held true, even at the three year mark, for participating children and families.¹²³

Findings in the Family/Parent Functioning Domain

Home visitation programs often seek to affect parenting behaviors to, among other things, reduce child abuse and neglect. They may also seek to encourage family self-sufficiency through higher educational attainment and increased work attachment.

Preventing Abuse and Neglect

Among other activities, providing parents with information about their children's developmental needs and abilities as well as communicating positive parenting skills are typical home visitation activities intended to reduce the incidence of child maltreatment. The assumption that improved parenting practices and attitudes may prevent child abuse and neglect is supported by research suggesting that a lack of parenting knowledge may serve as one predictor of child maltreatment.¹²⁴

In randomized control trials of home visiting, researchers have been more likely to find indications of changed parenting behaviors or attitudes—which suggest less harsh or abusive parenting—than to find a significant difference in rates of reported or substantiated child abuse or neglect. In a randomized control trial, the Nurse Family Partnership (NFP) showed reduced substantiated child abuse and neglect reports in one site (Elmira), although this difference was not shown as statistically significant until a number of years after the program ended. Any difference in substantiated child abuse and neglect reports between treatment and control group families was not tested at other NFP evaluation sites (Memphis and Denver).¹²⁵ A randomized trial involving parents who had already been reported for abuse and neglect found that home visited parents who completed all three SafeCare training modules were less likely to recommit child maltreatment than those in the control group.¹²⁶ Other studies have shown no statistically significant results. Implementers of Healthy Families America home visitation programs were encouraged early on

¹²¹ Love et al., *Making a Difference*, 2004, p. 286. U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), *Early Head Start Benefits for Children and Families*, Early Head Start Research and Evaluation Project, April 2006, http://www.acf.hhs.gov/programs/opre/ehs/ehs_resrch/reports/dissemination/research_briefs/research_brief_overall.pdf.

¹²² Love et al., *Making a Difference*, 2004, p. 286. U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), *Early Head Start Benefits for Children and Families*, Early Head Start Research and Evaluation Project, April 2006, http://www.acf.hhs.gov/programs/opre/ehs/ehs_resrch/reports/dissemination/research_briefs/research_brief_overall.pdf.

¹²³ Love et al., *Making a Difference*, 2004, p. 286.

¹²⁴ Lawrence M. Berger and Jeanne Brooks-Gunn, "Socioeconomic Status, Parenting Knowledge and Behaviors, and Perceived Maltreatment of Young Low-Birth-Weight Children," *Social Service Review* (June 2005), pp. 237-267.

¹²⁵ Harriet L. MacMillian et al., "Interventions to Prevent Child Maltreatment and Associated Impairment," *The Lancet*, vol. 373 (January 17, 2009), pp. 250-266.

¹²⁶ Michelle A. Johnson et al., *Assessing Parent Education Programs for Families Involved with Child Welfare Services: Evidence and Implications*, Full Report (Supported by the Bay Area Social Services Consortium and the Zellerbach Family Foundation), March 2006, p. 21.

by some quasi-experimental studies in Hawaii that showed much higher rates of abuse and neglect in families where home visiting had *not* occurred (18%) compared to those where it had occurred (1%).¹²⁷ However, a subsequent randomized control study of the program did not find any significant program effect with regard to rates of child maltreatment.¹²⁸ Similarly, some evaluations of the Parents as Teachers model where the number of child maltreatment reports were compared between control and treatment groups found no significant differences. In one study of teenage mothers, however, those who received PAT services *combined with* case management were less likely to be investigated for child maltreatment than were mothers in the control group who received no services. This study found no statistically significant difference, however, in this measure between teen mothers who received PAT-only services and those in the control group.¹²⁹

For a variety of reasons, it may be that the number of substantiated (or all reported) cases of child maltreatment (studied at the individual level) is not a strong measure of program effectiveness related to children's experiences of abuse or neglect. The overall incidence of substantiated abuse or neglect is relatively low across the population. Generally, this means that to show a "statistically significant" effect, a fairly large number of participants must be included in a study. If the number of participants is relatively small, even what appears to be a large difference in the proportion of children abused among the control group and the treatment group may not be statistically significant. Differing definitions of child abuse and neglect by state as well as varied state policies for how investigators are to determine whether child abuse or neglect has occurred also complicate any national or multisite effort that uses substantiated child abuse and neglect reports to measure program effectiveness. Finally, families who are regularly visited by a nurse or other family worker are subject to a high degree of surveillance and may thus be more likely to be reported to the Child Protective Services (CPS) agency.¹³⁰ Testing this common sense proposition, a recent study in New York state found that mothers who participated in the Healthy Families program and who admitted to having committed acts of serious abuse and neglect were nearly twice as likely to have a CPS report than were control group parents who admitted to having committed serious abuse or neglect.¹³¹

Improved Parenting Behaviors

Other measures have sometimes been used as proxies for the effect of a home visiting program on child abuse or neglect. These include the number of health care or emergency department visits that are tied to injuries or ingestions (see "Findings in the Maternal and Child Health Domain"), and parental self reports of abusive actions, discipline strategies, or other relevant parenting

¹²⁷ See discussion in Gomby, *Home Visitation*, 2005, p. 20. Gomby notes that some quasi-experimental studies continue to produce findings like those early findings in Hawaii. Specifically she cites Oregon's Healthy Family program where rates of child maltreatment were 12 per 1000 for families served by Healthy Families program compared to 22 per 1000 among non-served 0-two years olds in the same counties.

¹²⁸ Anne Duggan, Elizabeth McFarland, and Loretta Fuddy et al., "Randomized Trial of Statewide Home Visiting Program to Prevent Child Abuse: Impact in Preventing Child Abuse and Neglect," *Child Abuse & Neglect*, vol. 28, no. 6 (June 2004), pp. 597-622.

¹²⁹ Mary Wagner and Serena Clayton, "The Parents as Teachers Program: Results from Two Demonstrations," *The Future of Children*, vol. 9, no.1 (Spring/Summer 1999), pp. 91-115.

¹³⁰ Kimberly S. Howard and Jeanne Brooks-Gunn, "The Role of Home Visiting Programs in Preventing Child Abuse and Neglect," *Future of Children*, vol. 19, no. 2 (in press).

¹³¹ RAND Corporation, Promising Practices Network, Programs that Work, "Healthy Families New York," <http://www.promisingpractices.net/program.asp?programid=147#findings>.

practices. A randomized control study of the Healthy Families New York model found that home visited mothers reported engaging in fewer abusive practices (i.e., fewer instances of neglect, severe physical abuse, minor physical aggression, and psychological aggression against their children) than did control group mothers. The researchers also noted that the positive effects were stronger among only the subgroup of participants who were first-time mothers under age 19 and enrolled in the prenatal period.¹³² An evaluation of SafeCare implementation found that parents receiving the training were more likely to engage in positive parent behaviors.¹³³

Effectiveness of home visitation in changing parenting behaviors and/or reducing child abuse or neglect may be related to home visitors' recognition of and response to additional family stress factors and/or to provision of opportunities for peer support and interaction. In a randomized control study of a statewide home visiting program in Hawaii (Hawaii Healthy Start, considered the predecessor of the Healthy Families America program), researchers found a trend toward less *neglectful* behavior from home visited mothers compared to those in the control group. Overall, however, they concluded that the program did not prevent child *abuse* or promote use of nonviolent parenting. Among the critical issues cited by the researchers as hindering program effectiveness was the frequent failure of home visitors to identify and address family risk factors (e.g., domestic violence, mental health needs).¹³⁴ In a large meta-analysis of family support programs, including many that used home visiting as the primary means of providing services and others that did not, researchers found that efforts to improve parenting behaviors, attitudes, and practices were most successful when they specifically focused on developing parents' skills as effective adults—their self-confidence, self-empowerment, family management, and parenting—and included opportunities for peer support (e.g., parent mutual support groups meeting outside the home).¹³⁵ The Parents as Teachers home visiting model includes, as a core part of its program, parent group meetings and other opportunities for parents to share information with and learn from each other, and the HIPPIY model also includes regular group meetings.¹³⁶

Family Self-Sufficiency

Many home visitation programs seek to improve family self-sufficiency over the longer term by ensuring increased educational attainment and labor force participation among visited families. A study comparing at-risk PAT families (40) to a comparison group in Binghamton, NY, found that welfare dependence doubled for both groups in the year following the child's birth, but that between the first and second birthday "marginally significant differences" emerged, with welfare dependence declining in the visited group and increasing among the control group.¹³⁷ In the initial

¹³² Kimberly DuMont, Susan Mitchell-Herzfeld, and Rose Greene et al., "Healthy Families New York (HFNY) Randomized Trial: Effects on Early Child Abuse and Neglect," *Child Abuse and Neglect*, vol. 32 (2008), p. 295-315.

¹³³ Ronit M. Gershater-Molko, John R. Lutzker, and David Weeks, "Project SafeCare: Improving Health, Safety and Parenting Skills in Families Reported for, and At-Risk for Child Maltreatment," *Journal of Family Violence*, vol. 18, no. 6 (December 2003), p. 377-386.

¹³⁴ Duggan et al., "Impact in reducing parental risk factors," 2004, pp. 625-645.

¹³⁵ Layzer, *National Evaluation*, 2001. With regard to overall family functioning, the evaluators noted that family support programs with a specific focus on prevention of child abuse and neglect tended to be the same programs that provided parents with peer support activities, and that because of the inter-relationship among these factors they were not able to determine which of these program characteristics had the greatest positive effect on family functioning outcomes.

¹³⁶ Fostering parent leadership through mutual support groups and other avenues is a key object of Community-Based grants to Prevent Child Abuse and Neglect (Title II of CAPTA).

¹³⁷ RAND Corporation, Promising Practices Network, Programs That Work, "Parents as Teachers," (continued...)

NFP test in Elmira, NY, nurse-visited first-time mothers had greater labor force participation than did control group mothers two years after the evaluation ended (i.e., at child's fourth birthday). Thirteen years after the Elmira evaluation ended (by the child's 15th birthday), nurse-visited mothers who were unmarried and from low socioeconomic backgrounds at the time of program enrollment had spent less time receiving public aid (including cash aid and Food Stamps) than comparable mothers in the control group who did not receive nurse visits.¹³⁸ Similar findings related to public assistance use were found among first-time at-risk mothers both four years and seven years after an NFP trial in Memphis ended: nurse-visited mothers spent less time receiving public assistance than did control group mothers who were not visited.¹³⁹ In a third NFP trial, this one in Denver, comparisons were made between low-income mothers who received home visits by nurses, those who receive home visits by paraprofessionals, and those who received no visits. Two years after the trial ended, paraprofessional-visited mothers worked more than mothers in the control group. There was no significant difference between nurse-visited mothers and control group mothers with regard to workforce participation. Finally, neither nurse-visited nor paraprofessional-visited mothers showed statistically significant outcomes that were different from control group mothers with regard to their own educational achievement or use of welfare two years after the trial ended.¹⁴⁰

Recent Administration and Congressional Proposals to Support Home Visiting

The President's FY2010 budget request includes a proposal to provide mandatory funding to states for home visitation programs, and the FY2010 budget resolution (S.Con.Res. 13) supports increased federal funding for these programs provided this can be done in a "deficit neutral" manner. A number of legislative proposals to provide more support for home visitation programs have been offered, and both the pending health care reform proposal (H.R. 3200) in the House and the health care legislation reported by the Senate Finance Committee (S. 1796) include funding for grants to states to support the expansion of home visiting to families with young children and those expecting children.

Obama Administration's FY2010 Budget Proposal

As part of its FY2010 budget request the Obama Administration proposes a new capped entitlement program to support formula grants to states, territories, and tribes for the establishment and expansion of "evidence-based" home visitation programs for low-income

(...continued)

<http://www.promisingpractices.net/program.asp?programid=88>.

¹³⁸ David L. Olds 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," *Journal of American Medical Association*, vol. 278, no. 8 (2007), pp. 637-643.

¹³⁹ David L. Olds et al., "Effects of Nurse Home Visiting on Maternal and Child Functioning: Age-9 Follow-up of a Randomized Trial," *Pediatrics*, vol. 120, no. 4 (October 2007), pp. e832-e843. David L. Olds, et. al., "Effects of Nurse Home Visiting on Maternal Life Course and Child Development: Age-6 Follow-up Results of a Randomized Trial," *Pediatrics*, vol. 114, no. 6 (December 2004), pp. 1550-1559.

¹⁴⁰ David L. Olds et al., "Effects of Home Visits by Paraprofessionals and by Nurses: Age 4: Follow-Up Results of a Randomized Trial," *Pediatrics*, vol. 114, no. 6 (December 2004), pp. 1560-1568.

mothers and pregnant women. The program is expected to “create long-term positive impacts for children and their families, as well as generate long-term positive impacts for society as a whole.”¹⁴¹ Outcomes the Administration cites that may be achieved by home visitation include reductions in child abuse and neglect, improvements in children’s health and development and their readiness for school, and improvements in the ability of parents to support children’s optimal cognitive, language, social-emotional, and physical development. It notes that one model of home visitation, which used nurses to visit low-income first-time mothers, was found to reduce Medicaid costs in several randomized control trials. Accordingly the Administration assumed that expanding proven effective home visitation programs would result in savings to the Medicaid program (via reductions in preterm births, emergency room use, and subsequent births) totaling \$77 million in the first five years and \$664 million over the entire 10 years.¹⁴²

Mandatory funding for the newly proposed home visitation program is proposed at \$124 million in budget authority (\$87 million in “outlays”¹⁴³) in FY2010, rising each year to \$790 million in budget authority (\$710 million in outlays) by year five of the program (FY2014) and to \$1.837 billion in budget authority (\$1.753 billion in outlays) in year ten (FY2019).¹⁴⁴ This funding is expected to allow home visiting services to 50,000 families in the initial year of the program, rising to 450,000 new families by FY2019.¹⁴⁵

Under the Administration’s proposal, states would be expected to provide some matching funds to receive federal home visitation grants. Further, the Administration would give priority to funding for models “that have been rigorously evaluated and shown to have positive effects on critical outcomes for families and children.” Accordingly, states, territories, and tribes seeking grants under the proposed home visitation program would be required to submit a plan describing, among other things, the program model they will follow, evidence for the effectiveness of the program model, and how the state will ensure that the proven program model is adhered to (model fidelity). Funding related to programs with strong research evidence demonstrating their effectiveness would include technical assistance, monitoring, and evaluation to ensure fidelity of the model and for “evaluating effectiveness of these models as conditions change over time.” The Administration also anticipates that additional funds will support “promising programs” such as those based on some research evidence and those that are adaptations of previously evaluated programs. Funding for these programs would also include technical assistance, monitoring, and evaluation that focuses on developing these promising models and on “rigorous (random assignment) evaluations of effectiveness.” Finally, the Administration proposes that no less than 5% of the program’s overall funding be reserved for research, evaluation, training, technical assistance, monitoring, and administration.¹⁴⁶

¹⁴¹ U.S. Department of Health and Human Services, Administration for Children and Families (ACF), *FY2010 Justification of Estimates for the Appropriations Committees* (hereinafter FY2010 ACF budget justification), p. 267.

¹⁴² *Ibid.* U.S. Department of Health and Human Services (HHS), *Fiscal Year 2010 Budget in Brief*, p. 84.

¹⁴³ Budget authority is the amount of money Congress allows a federal agency to commit to spend (i.e., the legal authority for an agency to incur financial obligations that will result in immediate or future outlays involving federal funds). Outlays are the amount of money that actually flows out of the federal treasury in a given year (i.e., a payment by the government in fulfillment of an obligation). Outlays during a fiscal year may be for payment of obligations incurred in the same year or in prior years. In the example above, Congress is authorizing \$124 million to be made available for obligation in FY2010, but is estimating that only \$87 million of the \$124 million will actually be outlaid (or expended) in that fiscal year.

¹⁴⁴ Office of Management and Budget, Updated Summary Tables, May 2009, p. 24 and communications with ACF.

¹⁴⁵ FY2010 ACF budget justification, p. 268.

¹⁴⁶ *Ibid.*, pp. 267-268.

Based on its inclusion in the Administration for Children and Families (ACF) budget justifications, this HHS agency is expected to administer the program. At the same time, the FY2010 budget request notes an effort to coordinate planning for the proposal across HHS agencies to ensure the most effective program structure. It further notes that “a coordinated strategy” involving the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), the Health Resources and Services Administration (HRSA), and ACF will “enable HHS to respond to varying approaches that States may wish to use to implement this initiative.”¹⁴⁷

FY2010 Budget Resolution

In late April 2009, the House and Senate approved a conference agreement on the FY2010 budget resolution (S.Con.Res. 13), which reconciles separate FY2010 budget resolution proposals passed earlier that month by the House (H.Con.Res. 85) and Senate (S.Con.Res. 13). The FY2010 budget resolution is designed to set federal funding priorities across all purposes for the upcoming fiscal year. According to the conference report on the budget resolution (H.Rept. 111-89), the agreement includes a “deficit neutral reserve fund” for establishing or expanding home visitation programs.

Proposed Grants to States for Home Visitation in Health Care Legislation

Health care reform bills under consideration in the House and in the Senate would provide funds for grants to states to support expanded delivery of evidence-based home visitation services to families with young children and those expecting children. In the House, America’s Affordable Health Choices Act of 2009 (H.R. 3200), as ordered reported in mid-July,¹⁴⁸ would appropriate \$750 million over five years (FY2010-FY2014) for this purpose. On the Senate side, America’s Healthy Futures Act (S. 1796), as reported by the Senate Finance Committee in mid-October (S.Rept. 111-89), would appropriate \$1.5 billion over five years (FY2010-FY2014).¹⁴⁹ Separately, H.R. 3200, as ordered reported, would amend Medicaid to clearly permit states to claim federal reimbursement for “nurse home visitation services” provided to certain Medicaid eligible individuals. S. 1796, as reported by the Senate Finance Committee, does not include a comparable amendment to Medicaid.

Congressional interest in greater support for early childhood home visitation programs predates the pending health care reform legislation. Both the Early Support for Families Act (H.R. 2667) and the Evidence-Based Home Visitation Act (S. 1267) were introduced in June 2009. The home

¹⁴⁷ U.S. Department of Health and Human Services (HHS), *Fiscal Year 2010 Budget in Brief*, p. 84.

¹⁴⁸ Discussion of provisions in H.R. 3200 throughout this report refer to Sections 1713 and 1904 of that bill as included in “Amendment in the Nature of a Substitute,” posted on the House Energy and Commerce Committee website at http://energycommerce.house.gov/Press_111/20090715/health_amendment.pdf. The text of the bill spans multiple committee jurisdictions. Provisions in Section 1904 (related to grants to states for home visiting) were ordered reported by the House Ways and Means Committee. Provisions in Section 1713 (related to nurse home visitation services under Medicaid) were ordered reported by the House Energy and Commerce Committee.

¹⁴⁹ Discussion of provisions in S. 1796 throughout this report refers to Section 1801 of the bill as included in “Legislative Language of American’s Healthy Futures Act” posted on the Senate Finance Committee website at <http://finance.senate.gov/sitepages/leg/LEG%202009/101909%20America's%20Healthy%20Furture%20Act%202009%20Leg.pdf>.

visitation provisions included in Section 1904 of H.R. 3200, as ordered reported in July, are most similar to those included in H.R. 2667. In turn, H.R. 2667 and S. 1796, as reported by the Senate Finance Committee, appear to have drawn some inspiration from the Education Begins at Home Act (S. 244 and H.R. 2205), which has been under congressional consideration for a number of years. An initial version of the Education Begins at Home Act was introduced in the Senate during the 107th Congress and in the House in the 108th Congress. Further, during the 110th Congress, the House Education and Labor Committee marked up and reported an amended version of the bill (H.Rept. 110-818), although the full House did not subsequently act on it before that Congress ended.¹⁵⁰ Finally, although the Healthy Families and Children Act (S. 1052/H.R. 3024 in the 110th Congress) has not been reintroduced in this Congress, a central concept of that bill—defining “medical assistance” under the Medicaid program to include certain nurse home visitation services—is included in the House health care reform proposal (Section 1713 of H.R. 3200, as ordered reported).

The following section discusses the home visitation provisions included in H.R. 3200, as ordered reported, and S. 1796, as reported by the Senate Finance Committee.

Purposes and Funding Proposed for Home Visitation

Both H.R. 3200 and S. 1796 would provide funds to support home visitation programs for families with young children or infants and for those expecting children.

H.R. 3200 would amend Title IV-B of the Social Security Act, which currently authorizes the Stephanie Tubbs Jones Child Welfare Services and the Promoting Safe and Stable Families program, to establish Home Visitation Programs for Families with Young Children and Families Expecting Children. The purpose of this support would be to improve the well-being, health, and development of children. Funds would be made available to eligible states, territories, and tribes that applied. H.R. 3200 would appropriate five years of funding as follows: \$50 million for FY2010, \$100 million for FY2011, \$150 million for FY2012, \$200 million for FY2012, and \$250 million for FY2014.

S. 1796 would amend Title V of the Social Security Act, which currently authorizes the Maternal and Child Health Services block grant, to establish Maternal, Infant and Early Childhood Visitation programs. The overall purposes of the amendment include improving outcomes for families in “at-risk” communities through provision of comprehensive services. Grants for home visitation programs would be provided specifically to promote improvements in maternal and prenatal health, infant and child health, child development, parenting related to child development outcomes, and school readiness, as well as the socioeconomic status of pregnant women, men expecting to be fathers, and parents or other primary caregivers of young children. States, territories, and tribal entities that successfully applied for these funds would be awarded funds to support early childhood home visitation programs. (In addition, HHS would be permitted to provide funds to other eligible nonprofit organizations in any given state if, as of FY2012, that state had not applied for and been awarded a home visitation grant.) S. 1796 would appropriate funds for these grants for five years as follows: \$100 million for FY2010; \$250 million for FY2011; \$350 million for FY2012; \$400 million for FY2012; and \$400 million for FY2014.

¹⁵⁰ The current House version of the Education Begins at Home Act (H.R. 2205) largely reflects that reported version of the bill while the Senate version (S. 244) remains closer to its 107th Congress origins.

Home Visitation Program Criteria

Both the House and Senate proposals would require that these new federal funds be used to primarily support home visitation services that follow a clearly designed program model that has demonstrated positive effects for families with young children and those expecting children. However, they would also permit states to use at least some of the funds for promising program models with less established records of success.

H.R. 3200 stipulates that federal funds are to be used to support programs that “adhere to clear evidence-based models of home visitation and that have demonstrated positive effects on important program-determined child and parenting outcomes.” At the same time, states would be permitted to use a declining share of their federal home visiting funds to support programs that “do not adhere to a model of home visitation with the strongest evidence.” For FY2010, states would be permitted to spend as much as 60% of their funds on programs that did not have the “strongest evidence,” but this amount would decrease by 5 percentage points each year, until it reached 40% for FY2014.

S. 1796 would permit states to spend up to 25% of their funds on home visitation program models that follow a new approach to achieving a range of improved child and family outcomes, provided the model was developed or identified by a national organization or institution of higher education and will be rigorously evaluated. The remaining 75% of the funding received, however, would need to be used in support of home visitation services that 1) follow a clear and consistent model that has been in existence for at least three years; 2) are research-based, grounded in relevant empirically based knowledge, and linked to program-determined outcomes; 3) are associated with a national organization or institution of higher education that has comprehensive home visitation program standards to ensure high-quality service delivery and continuous program quality improvement; and 4) demonstrated significant positive outcomes on a range of specific child and family outcomes when evaluated in well-designed research studies (see “Outcomes of Interest,” below). Finally, the rigorous evaluation of these programs must have been conducted using a quasi-experimental research design or a randomized control research design. (Further, if the evaluation used a random control research design, the results must indicate “sustained” positive outcomes and must have been published in a peer-reviewed journal.)

H.R. 3200 and S. 1796 would both additionally require that the home visitation programs supported with federal funds employ well-trained staff and provide ongoing training, maintain high-quality supervision, monitor fidelity of program implementation to the program model being used, and establish appropriate linkages and referrals to other community resources.

H.R. 3200 would further require that any home visitation program model used provide parents with 1) knowledge of age-appropriate child development in cognitive, language, social, emotional and motor domains, along with expectations of age-appropriate child behavior; 2) skills for interacting with children to enhance age-appropriate development and for being able to recognize and seek help related to developmental delays or any health, social, or behavioral issues; 3) knowledge of health and wellness issues for children and parents; 4) coaching on modeling of parenting practices; and 5) activities designed to help parents become full partners in the education of their children. Alternatively, S. 1796 would require that any program model used be designed to result in improvements in relevant outcome areas (as identified by the state in an individualized family assessment for participants). Improvements in any of the following areas may be determined to be relevant: prenatal, maternal, newborn, and child health; child development (including prevention of injuries and maltreatment and improved cognitive,

language, social-emotional, and physical development), parenting skills, school readiness, and child academic achievement; reductions in crime or domestic violence; family economic self-sufficiency; and coordination of resources and supports for families.

Outcomes of Interest

S. 1796 would require each state to establish benchmarks that would be used to measure changes in outcomes related to maternal and newborn health; child injuries and use of emergency rooms; school readiness and achievement; crime or domestic violence; family economic self-sufficiency; and coordination of community resources and supports. States must demonstrate improvements in at least four of these areas by the end of their third year of grant funding (and submit this information in a report to HHS) and they must submit a final report on any improvements in these outcome areas no later than December 31, 2014. Any state that does not show improvement in at least four of the outcome areas by the end of the third year must develop and implement, subject to the approval of HHS, a corrective action plan to improve outcomes in each of the specified areas. The plan must include provisions for HHS to monitor its implementation, and HHS would be required to provide or otherwise support technical assistance to any state needing to implement such a plan. Finally, if after a period of time (determined by HHS) the state does not show improvement in any of its benchmarks, or it has not submitted a report describing changes in outcomes as measured against those benchmarks, HHS must terminate funding to the state for home visitation.

H.R. 3200 would require states to use federal funds under the new home visitation program in support of programs that have demonstrated positive effects on “important-program-determined child and parenting outcomes, such as reducing abuse and neglect and improving child health and development.” It does not include provisions comparable to those in S. 1796 related to establishing benchmarks to measure improvements in specified outcome areas.

Additional Requirements for Receipt of Funds

Statewide Needs Assessment: Before states received federal support for home visitation programs, both the House and Senate proposals would require a statewide needs assessment. The assessment would look at the quality and capacity of home visitation programs currently operating in the state, the number and types of families receiving services, and any gaps in provision of the services. States would also need to identify high-risk or high-need communities.

H.R. 3200 would require states to report the results of this assessment in their application for home visitation funds. S. 1796 would require states, no later than six months after enactment of the bill, to make this assessment as a condition of receiving funds under the Maternal and Child Health (MCH) block grant for FY2011. Further, S. 1796 would require states to coordinate this needs assessment with several other relevant statewide assessments that are now required under the MCH block grant, the Head Start Act, and the Community-Based Grants to Prevent Child Abuse and Neglect program (Title II of the Child Abuse Prevention and Treatment Act). States would be required to submit the results of this unique statewide needs assessment to HHS, including a description of how they intended to address the needs identified—especially in high-risk communities—and which might include applying to receive a federal grant to support early childhood home visitation services. Finally, S. 1796 would require states to explain in any application for early childhood home visitation services how the populations to be served and the program model(s) to be used are consistent with the needs assessment.

Grant Application: In order to receive grant funds, both H.R. 3200 and S. 1796 would require states to submit an application to HHS. The specific application requirements vary somewhat, but under both proposals a state would need to include a description of the home visitation program(s) to be funded, identify the populations to be served, and include an assurance that the state will give priority to serving families in high-need or high-risk communities, including communities with high concentrations of low-income families and those with high incidence of child maltreatment and/or family involvement with child welfare. In addition, both bills would require states to give assurance that they would cooperate with any research or evaluation conducted (or supported by HHS) under this program and provide annual reports to HHS and any other information required by HHS. H.R. 3200 would additionally require states to give assurance in their grant application that they will set aside no less than 5% of the federal funds they receive for training and technical assistance to the home visitation programs receiving federal funding. No comparable requirement of states is included in S. 1796.

Maintenance of Effort

S. 1796 would not require states to maintain a specified level of funding for home visitation but would stipulate that any funds provided under the new grant program be used to “supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives.” H.R. 3200 would require states to maintain funding for home visitation programs as follows: Beginning with FY2011, a state would not be eligible for the new home visitation funding unless HHS determined that the state’s total non-federal (state and local) spending for home visitation programs serving families with young children and those expecting children was no less in the immediately preceding fiscal year than in the second preceding fiscal year. (For example, to receive FY2011 funds, HHS would need to find that the state’s total non-federal spending for home visiting services in FY2010 was no less than it had been in FY2009; for a state to receive FY2012 funds, HHS must find that the state’s home visitation spending in FY2011 was no less than it had been in FY2010, and so on.)

State Match and Distribution

Matching Funds: S. 1796 would not require a state to provide matching funds under the early childhood home visitation program. By contrast, to receive their full allotment of home visitation funding, H.R. 3200 would require states (in FY2010) to provide no less than 15% of the total federal and state dollars spent for home visitation programs serving families with young children and families expecting children. The required share of state spending under H.R. 3200 would rise to 20% in FY2011 and 25% in FY2012, where it would remain for every succeeding year in which the program is funded. (Under H.R. 3200, these state matching dollars might also be counted toward the state’s required maintenance of effort.)

Set Asides: Both bills would appropriate funds for home visitation and would require that before their distribution to eligible states and territories, funds be set aside for certain purposes. H.R. 3200 would require HHS to annually set aside 5% of the home visitation funds appropriated for program-related training, technical assistance, and evaluation, and, after making this reservation, 3% of the appropriated funds for grants to tribes. S. 1796 would require HHS to set aside 3% of the annual appropriated amount for research, technical assistance, and evaluation, and 3% for grants to tribal entities.

Distribution: H.R. 3200 would allocate funds to each eligible state (including territories) based on the number of children in each state who live in families with incomes that do not exceed 200% of the poverty line compared to the number of all children in those states and territories who live in families with incomes that do not exceed 200% of the poverty line. A state that fully meets the match requirements would be eligible to receive its full allotment. (Funds set aside for tribes each year would be distributed in a similar manner, with an eligible tribe's share of the total tribal funding based on its relative share of the children living in families with incomes that do not exceed 200% of the poverty line among all eligible tribes.)

S. 1796 would require HHS to make early childhood home visitation grants to eligible applicants (including states, territories, tribal entities, and, in certain situations, other nonprofit organizations) and would permit HHS to determine the duration of the grants. However, it does not describe how the funds are to be distributed.

Evaluation and Research, Other Reports to Congress, and Technical Assistance

Evaluation and Research: Both H.R. 3200 and S. 1796 would require HHS to provide for, and report to Congress on, an evaluation of the effectiveness of the federally supported home visitation programs. S. 1796 would separately require HHS to conduct (via grants, cooperative agreements, or contracts) a continuous program of research and evaluation activities to increase knowledge about the implementation and effectiveness of home visiting programs.

Other Reports to Congress: H.R. 3200 would also require HHS to submit annual reports to Congress on activities carried out with the grant funds. S. 1796 would not require HHS to report to Congress annually on activities under the program, however, it would require that a report on the program, including recommendation for any legislative or administrative actions determined appropriate, be made to Congress no later than December 31, 2015.

Technical Assistance: S. 1796 would require HHS to provide (directly or otherwise) technical assistance to states that fail to demonstrate improved outcomes in at least four of the areas measured and that are consequently required to develop corrective action plans (see "Outcomes of Interest"). The bill would further require HHS to establish an advisory panel to make recommendations regarding provisions of this technical assistance. H.R. 3200 would require HHS to provide technical assistance and training to states, including dissemination of best practices in early childhood home visitation.

Program Administration

Neither H.R. 3200 nor S. 1796 specify any particular agency that is expected to administer the funds at the *state* level. H.R. 3200 also does not specify any specific federal agency within HHS that would be expected to administer the program. However, as noted above, it would add this new program to the Child and Family Services section of the Social Security Act (Title IV-B), and the programs in that part of the law are currently administered by the Administration for Children and Families (ACF) within HHS. Also as noted earlier, S. 1796, as reported by the Senate Finance Committee, amends Maternal and Child Health Services authorized in the Social Security Act (Title V), and programs and activities in this part of the law are now administered by the Health Resources and Services Administration (HRSA), also within HHS. S. 1796 would require HRSA and ACF to collaborate in all aspects of the federal administration of the program and would also stipulate that in doing this they consult with additional relevant federal agencies.

Proposed Nurse Home Visitation Services Under Medicaid

Section 1713 of H.R. 3200, as ordered reported by the House Energy and Commerce Committee, would create a new optional Medicaid benefit called “nurse home visitation services,” and would permit states to seek federal reimbursement at their Federal Medical Assistance Percentage (or FMAP) rate (which may range from 50%-83%)¹⁵¹ for providing these services. The bill would define “nurse home visitation services” as home visits by trained nurses to families with a first-time pregnant woman or a child (under two years of age) and who are otherwise eligible for Medicaid, but only if HHS determines that there is evidence that these services are effective in one or more of the following areas: 1) improving maternal or child health and pregnancy outcomes or increasing birth intervals between pregnancies; 2) reducing the incidence of child abuse, neglect, and injury, improving family stability (including reductions in domestic violence), or reducing maternal and child involvement in the criminal justice system; and 3) increased economic self-sufficiency, employment advancement, school readiness and other educational achievement, or reducing dependence on public assistance.

Federal reimbursement for this new optional Medicaid service would be effective January 1, 2010. H.R. 3200 would stipulate that creation of this new optional Medicaid benefit must not be construed to prevent states from continuing to claim federal reimbursement for home visitation services under currently authorized Medicaid care coordination and case management activities (as an administrative activity or a benefit).

Hearing on Proposals to Support Early Childhood Home Visitation

On June 9, 2009, the Subcommittee on Income Security and Family Support of the House Ways and Means Committee held a hearing on proposals to provide funds to states for early childhood home visitation programs. Witnesses included researchers, an administrator of state funding for home visitation programs, a former participant and current home visitor, and a nurse consultant.¹⁵²

The witnesses generally supported broader implementation of early childhood home visitation programs that are informed by evidence on efficacy. Most witnesses appeared to support availability of home visitation services to any family, without regard to any specific demographic or family risk factors, although one witness clearly favored providing services to low-income mothers. At the same time, in responding to a question regarding which families they would target if limited funds were available, at least one witness cautioned against using demographic markers to select families, but suggested the importance of engaging families early, perhaps during pregnancy (via prenatal clinics or obstetric offices) or at birth (via hospital). Another witness stressed first-time young mothers as an important group, and one where research to date has shown the greatest level of successful outcomes.

¹⁵¹ The reimbursement rate would be linked to a state’s Federal Medical Assistance Percentage (or FMAP), which varies based on the state’s per capita income. By statute, it may range from a low of 50% (in states with high per capita income) to a high of 83% (in states with low per capita income). The American Recovery and Reinvestment Act temporarily (from October 1, 2009, through December 31, 2010) raises each state’s FMAP. For more information, see CRS Report R40223, *American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5): Title V, Medicaid Provisions*, coordinated by Cliff Binder.

¹⁵² To view hearing testimony, go to <http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=682>.

In their written testimony, at least two of the witnesses, both researchers, cautioned that supported programs—regardless of any prior demonstrated level of evidence—must have certain attributes to succeed. Both mentioned the need for (1) clearly linking program activities to expected program goals, (2) providing services (engaging family) with sufficient frequency and for a sufficient length of time to have an impact, and (3) employing well-trained home visitors whose work is evaluated/supervised on an ongoing basis.¹⁵³ Other factors given as important to program success included solid organizational capacity and linkages to other community resources and supports.¹⁵⁴

¹⁵³ Written testimony of Deborah Daro, June 9, 2009, p. 5. Written testimony of Jeanne Brooks-Gunn, June 9, 2009, p. 3. In addition to well-trained staff, Brooks-Gunn suggested the importance of well-educated staff (whether nurses, social workers, or some other professional).

¹⁵⁴ Written testimony of Deborah Daro, June 9, 2009, p. 5.

Appendix A. Selected Federal Programs That Provide or Support Home Visitation

As discussed in the section on “Existing Federal, State, and Local Funding Streams for Home Visiting,” a number of federal programs are already being used to support early childhood home visitation efforts. Federal statute for these programs may require some amount of home-based services (e.g., Even Start), explicitly permit home visiting as a possible activity (e.g., Maternal and Child Health Block Grant), or allow home visiting under broad authorities or program goals (e.g., Medicaid). Selected programs, arranged alphabetically, are briefly described below.

Community-Based Grants for the Prevention of Child Abuse and Neglect (CBCAP)

Title II of the Child Abuse Prevention and Treatment Act (CAPTA) authorizes grants to support community-based services for the prevention of child abuse and neglect. CBCAP grants are distributed by formula to a lead entity in all states (which may be a public agency, a quasi-public entity, or a nonprofit private organization). The lead entity is charged with developing a continuum of community-based services for children and families that are designed to strengthen and support families to prevent child abuse and neglect. Core family resource and support services to be provided by community-based programs include voluntary home visiting services, parent education, community and social services referrals, and respite care services, among others. In their FY2007 program summaries, the majority of state CBCAP contacts indicated explicit support of home visiting services. In FY2009, the CBCAP program received funding of approximately \$42 million (P.L. 111-8). CBCAP is administered by the Office of Child Abuse and Neglect within the Children’s Bureau of the Administration for Children and Families at HHS.¹⁵⁵

Early Head Start

Early Head Start is a federally funded community-based program for low-income expectant parents and families with infants and toddlers that seeks to (1) promote healthy prenatal outcomes; (2) enhance the development of infants and toddlers; and (3) promote healthy family functioning. Nationwide, there are more than 650 Early Head Start programs providing child development and family support services, serving approximately 62,000 children under the age of three annually.¹⁵⁶ Grantees select an Early Head Start service delivery option (typically center-based, home-based, or a combination) to meet the needs of the children and families in their communities. In 2006, about half (51%) of Early Head Start slots were center-based, while 41% were in home-based programs.¹⁵⁷ Children and families enrolled in center-based programs

¹⁵⁵ Child Abuse Prevention and Treatment Act, Title II. FY2007 CBCAP program summaries at <http://www.friendsnrc.org/resources/07sum.htm>. See also certain CBCAP requirements in Table 3 of CRS Report RL31242, *Child Welfare: Federal Program Requirements for States*, by Emilie Stoltzfus.

¹⁵⁶ See Head Start Program Fact Sheets at http://eclkc.ohs.acf.hhs.gov/hslc/About%20Head%20Start/headstart_factsheet.html.

¹⁵⁷ Elizabeth Hoffman and Danielle Ewen, *Supporting Families, Nurturing Young Children: Early Head Start Programs in 2006*, CLASP Policy Brief No. 9, December 2007, pp. 2-5, http://www.clasp.org/publications/ehs_pir_2006.pdf.

receive comprehensive child development services in a center-based setting, supplemented with limited home visits by the child's teacher and other Early Head Start staff (a minimum of two home visits a year to each family). In home-based programs, children and their families are supported through weekly home visits of at least 90 minutes and bimonthly group socialization experiences. Combination programs provide a blend of center class sessions and 90-minute home visits (regulations specify acceptable combinations of minimum numbers of class sessions and corresponding home visits).¹⁵⁸

Home visits are conducted by professionals who receive training in child development, family development, and community building. In FY2008, the majority of Early Head Start teachers (54%) and home visitors (66%) held a degree in early childhood education (or a related field).¹⁵⁹ Legislation that reauthorized the program in 2007 (P.L. 110-134) required HHS to develop standards for Early Head Start home visitors related to staff training and qualifications, as well as to conduct of home visits.¹⁶⁰

In FY2009, HHS estimated that Early Head Start programs received over \$675 million out of the total appropriation provided for Head Start, and additional funds (approximately \$619 for FY2009) were provided via the American Recovery and Reinvestment Act (P.L. 111-5).¹⁶¹ The program is administered by the Office of Head Start within the Administration for Children and Families (ACF) at HHS.

Even Start

Even Start programs are authorized by ESEA Title I, Part B, Subpart 3, and are intended to integrate early childhood education, adult basic education, and parenting skills education into a unified family literacy program.¹⁶² Funds are distributed to all states and must be subgranted to local education agencies working in collaboration with community based organizations. Even Start programs generally serve children aged zero to seven and their parents. Services must include home-based instruction, adult literacy instruction, early childhood education, instruction to help parents support their child's education, participant recruitment, screening of parents, and staff training. An assumption underlying Even Start is that children whose parents have low

¹⁵⁸ See relevant regulations at 45 CFR 1306.

¹⁵⁹ Statistics are based on 2007-2008 Program Information Reports (PIR) data. Note that "degree" encompasses associate, baccalaureate, and advanced degrees.

¹⁶⁰ The reauthorized Head Start Act specifies that the standards for training, qualifications, and the conduct of home visits shall include content related to (1) structured, child-focused home visiting that promotes parents' ability to support the child's cognitive, social, emotional, and physical development; (2) effective strengths-based parent education, including methods to encourage parents as their child's first teachers; (3) early childhood development with respect to children from birth through age three; (4) methods to help parents promote emergent literacy in their children from birth through age three, including use of research-based strategies to support the development of literacy and language skills for children who are limited English proficient; (5) ascertaining what health and developmental services the family receives and working with providers of these services to eliminate gaps in service by offering annual health, vision, hearing, and developmental screening for children from birth to entry into kindergarten, when needed; (6) strategies for helping families coping with crisis; and (7) the relationship of health and well-being of pregnant women to prenatal and early child development.

¹⁶¹ In total, P.L. 111-5 appropriated \$1.1 billion specifically for the expansion of Early Head Start and HHS expected to award approximately \$619 million of these expansion funds in FY2009. For more information, see CRS Report R40211, *Human Services Provisions of the American Recovery and Reinvestment Act*, by Gene Falk et al.

¹⁶² For more information, see CRS Report RL30448, *Even Start Family Literacy Programs: An Overview*, by Gail McCallion, and CRS Report RL33071, *Even Start: Funding Controversy*, by Gail McCallion.

literacy or basic education levels are more likely to be educationally successful if, in addition to receiving early childhood instruction themselves, their parents receive educational services plus instruction in how to help their children learn. The program is administered by the Office of Elementary and Secondary Education, within the Department of Education. It was funded in FY2009 at \$66 million. President Obama's FY2010 Budget requests no funding for the program, arguing that this program has not demonstrated effectiveness in improving child and adult learning outcomes.

Healthy Start

The Healthy Start program provides funding through competitive grants or cooperative agreements to provide health and related services to high-risk pregnant women, infants, and mothers in communities with exceptionally high rates of infant mortality. Among other purposes, the program seeks to reduce racial and ethnic disparities in the proportion of pregnancy-related maternal deaths, preterm births, and infant mortality. Healthy Start projects also work to ensure that the basic needs of mothers and infants (including "housing, psychosocial, nutritional and education support, and job skill building") are met. The program operates in 40 states (including the District of Columbia and Puerto Rico) and reaches roughly 100 communities.¹⁶³

Home visits are frequently a part of services offered under this program. A 2003 survey of Healthy Start grantees (n=95) found that 99% provided home visits to at least some of their clients, with most offering home visits to a majority of their pregnant or parenting clients: 76% of grantees provided home visits to at least three-fourths of their pregnant clients and 64% of grantees provided home visits to their inter-conceptional clients. A little more than one-third of the grantees (35%) used a specific schedule to provide these home visits, but most (64%) reported scheduling visits in accordance with client need. Home visiting services provided to Healthy Start clients frequently included depression screening and treatment (84%), well baby care (75%), and smoking cessation and reduction services (73%). The large majority of grantees (87%) also conducted home visits to assess the home environment for infants and toddlers.¹⁶⁴ The program is authorized under the Public Health Service Act (Section 330H, as amended by P.L. 106-310) and is administered by the Maternal and Child Health Bureau within the Health Resources and Services Administration (HRSA) of HHS. For FY2009, it received funding of approximately \$100 million.

Infants and Toddlers Program, Part C, IDEA

The Infants and Toddlers Program ("Part C") component of the Individuals with Disabilities Education Act (IDEA) provides grants to states to assist them in implementing statewide systems of "coordinated, comprehensive, multidisciplinary, interagency programs" that identify children (ages birth through three) that have or are at risk of physical, mental, or social skills developmental delays.¹⁶⁵ The Part C program may be targeted toward children experiencing a

¹⁶³ U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), *FY2010 Justification of Appropriations Estimates for Congress*, pp. 166-171.

¹⁶⁴ U.S. Department of Health and Human Services, Health Resources Services Administration (HRSA), Maternal and Child Health Bureau, *A Profile of Healthy Start: Findings from Phase I of the Evaluation*, 2006, pp.11-12.

¹⁶⁵ The Act (Section 602(3)(B)(i)) leaves the definition of developmental delay to the states, except to enumerate that delays may occur in one or more areas (physical, cognitive, communication, social/emotional, or adaptive (continued...))

developmental delay in one or more physical, mental, or social skill areas; The IDEA requires that these Part C services be delivered to the “maximum extent possible” in a child’s “natural environment,” and the very large majority of Part C services are delivered in the home.¹⁶⁶ In fact, one report indicates that more than 80% of Part C Services are delivered in the home.¹⁶⁷ However, specific services are not based on any statutorily developed curriculum. Instead, they are provided pursuant to an Individual Family Services Plan (IFSP) that must be created to address the identified developmental delays. The Part C program is administered by the Office of Special Education within the Department of Education. The program received an annual appropriation of \$436 million in FY2009. (The American Recovery and Reinvestment Act, P.L. 111-5, appropriated \$500,000 in additional funding for this program in FY2009.)¹⁶⁸

Maternal and Child Health Block Grant

The Maternal and Child Health Block grant (Title V of the Social Security Act) is a public health program that seeks to 1) ensure access to and improve the quality of health care for mothers and children, especially those with low income or limited availability of care; 2) reduce infant mortality; 3) provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at-risk pregnant women); 4) increase the number of children receiving health assessments and follow-up diagnostic and treatment services; 5) provide and ensure access to preventive and child care services as well as rehabilitative services for certain children; 6) implement family-centered, community-based systems of coordinated care for children with special health care needs; and 7) provide toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Medicaid. States use Title V block grant funds for a variety of purposes, including direct services; efforts to build community capacity to deliver “enabling services” (e.g., home visiting, care coordination, transportation, and nutrition counseling); personal and preventive health services; and infrastructure-building services. Separately, Title V funds Community Integrated Service Systems (CISS). These projects use six specified strategies to increase capacity and integration of local service systems, including through provision of maternal and infant home health visiting, health education, and related support services for pregnant women and infants up to one year old.¹⁶⁹

The Title V program received FY2009 funding of \$662 million, of which \$554 million was distributed to all states under the block grant, \$10 million was provided for CISS grants and \$93 million was devoted to research via the Special Projects of Regional and National Significance (SPRANS) grants. The Title V block grant is administered by the Maternal and Child Health Bureau within the Health Resources and Services Administration (HRSA) at HHS.¹⁷⁰

(...continued)

development) and to require that appropriate diagnostic assessments are to be used to determine such delays.

¹⁶⁶ Ibid, pp. I-41 and I-48.

¹⁶⁷ NCCP “Focus on Home Visiting” webinar, 2008.

¹⁶⁸ U.S. Department of Education, “Special Education,” in *Justifications of Appropriations Estimates to Congress, FY2010*, pp. I-41 and I-48.

¹⁶⁹ Ibid. Christie Provost Peters, *The Title V Maternal and Child Health Block Grant*, National Health Policy Forum, George Washington University, September 24, 2007.

¹⁷⁰ U.S. Department of Health and Human Services, Health Resources and Services Administration, *FY2010 Justification of Estimates for Appropriations Committees*, May 2009, p. 139-149.

New Parent Support Program

The military's New Parent Support Program (NPSP) was developed in recognition of the unique parenting challenges faced by military families (e.g., frequent deployments, long duty hours, moves to unfamiliar locations, and separation from extended families and friends). NPSP services are available to military families who are expecting a child, or who have a child or children up to three years of age (or five years of age for the Marine Corps). Services offered may vary across military branches and installations, but all NPSP programs include a home visiting component. In addition, programs may include supervised playgroups, prenatal and parenting classes, hospital visits, and referrals to other resources. Home visitors provide parents with guidance on child growth and development and address topics such as breastfeeding, sleeping, nutrition, and behavior management. The Department of Defense notes that home visits per family may be limited unless the family has been identified as being at high risk for child abuse. Every professional NPSP program staff member is required to be licensed as a Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist, or Registered Nurse (RN). In addition, all staff must complete a criminal background check. The NPSP program is a part of the military's Family Advocacy Program (FAP).¹⁷¹

Parent Information Resource Centers

Parent Information and Resource Centers (PIRCs) help implement parental involvement policies, programs, and activities designed to improve student academic achievement and strengthen partnerships among parents, teachers, principals, administrators, and other school personnel in meeting the education needs of children. The Elementary and Secondary Education Act (ESEA) (Section 5563) requires the recipients of PIRC grants to serve both rural and urban areas; use at least half their funds to serve areas with high concentrations of low-income children; and use at least 30% of the funds they receive to establish, expand, or operate Parents as Teachers (PAT) programs, HIPPIY programs, or other early childhood parent education programs. Projects generally include a focus on serving parents of low-income, minority, and limited English proficient (LEP) children enrolled in elementary and secondary schools. According to the most recent data available, nearly 60% of parents served in the 2006-2007 school year were from low-income families, and nearly 25% had limited English proficiency. PIRC funding is distributed through competitive grants to nonprofit organizations or a consortium of a nonprofit organization and a local education agency (LEA). The FY2009 Omnibus (P.L. 110-8) included \$39 million for PIRC grants, of which about 30% (roughly \$11.7 million) may go toward PAT, HIPPIY, or other early childhood parent education programs selected by the grantee. PIRC grants are administered by the Office of Innovation and Improvement (OII) at the Department of Education.

Promoting Safe and Stable Families

The Promoting Safe and Stable Families program (PSSF, Title IV-B, Subpart 2 of the Social Security Act) primarily authorizes funds to state child welfare agencies for provision of four categories of services. The statute requires that states spend a "significant" amount of program

¹⁷¹ See an overview of the NPSP on the Department of Defense's Military Homefront website at http://www.militaryhomefront.dod.mil/portal/page/mhf/MHF/MHF_HOME_1?section_id=20.40.500.420.0.0.0.0.0 and military one source website at <http://www.militaryonesource.com/MOS/FindInformation/Category/Topic/Issue/Material.aspx?MaterialID=14058>.

funding on each of the categories: family support, family preservation, time-limited reunification (for families whose children have been removed to foster care within the past 15 months), and adoption promotion and support. For FY2009, the PSSF program received funding of \$408 million, of which an estimated \$64 million, at a minimum, should be made available for family support services. Home visitation is typically considered a family support service and the statutory definition of “family support services” for purposes of the PSSF program is “community-based services to promote the safety and well-being of children and families designed to increase the strength and stability of families (including adoptive, foster, and extended families), to increase parents’ confidence and competence in their parenting abilities, to afford children a safe, stable and supportive family environment, to strengthen parental relationships and promote healthy marriages and otherwise to enhance child development.”¹⁷² Current data on the number of states using PSSF dollars to support home visitation are not available. The PSSF program is administered by the Children’s Bureau within the Administration for Children and Families at HHS.

¹⁷² Section 431(2) of the Social Security Act. The PSSF statute also defines “family preservation services” in terms that could be used to encompass home visitation. However, family support services—like most home visitation programs—are considered to be primary prevention services, whereas family preservation services are generally secondary prevention/interventions.

Appendix B. Federal Initiatives Related to Coordination of Early Childhood Programs and Services

Researchers have noted the importance of providing home visitation services in the context of other community supports intended to support and improve the well-being of young children and their families.¹⁷³ In recent years, a number of federal initiatives have been established that seek to improve coordination among early childhood health, education, and social services programs and which might be relevant to home visitation programs. Several are discussed below.

State Advisory Councils on Early Childhood Education and Care

The 2007 reauthorization of Head Start (P.L. 110-134) 2007 included a new requirement for governors to establish State Advisory Councils on Early Childhood Education and Care (“State Advisory Councils”) for children from birth to school entry. These councils are intended to improve coordination across critical early childhood programs within each state and are expected to have representation from a broad spectrum of stakeholders, ranging from the state child care and education agencies to agencies responsible for health and mental health care.¹⁷⁴ State Advisory Councils must:

- conduct a statewide needs assessment;
- identify opportunities for collaboration and coordination among entities carrying out federally funded and state-funded child development, child care, and early childhood education programs;
- develop recommendations for increasing the participation of children in existing federal, state, and local early childhood education and child care programs;
- develop recommendations for establishing a unified data collection system for publicly funded programs offering early childhood education, development, and services;
- develop recommendations for a statewide professional development and career plan for early childhood education and care;

¹⁷³ Heather Weiss, et. al., *Changing the Conversation About Home Visiting: Scaling up with Quality*, Harvard Family Research Project, Harvard Graduate School of Education, December 2006. American Academy of Pediatrics, Council on Child and Adolescent Health, “The Role of Preschool Home-Visiting Programs in Improving Children’s Health and Developmental Outcomes,” *Pediatrics*, v. 123 (2009), pp. 598-603. Testimony of Deborah Daro before the Committee on Ways and Means, Subcommittee on Income Security and Family Support, June 9, 2009.

¹⁷⁴ Section 642B(b)(1)(C) of the Head Start Act specifies that State Advisory Councils are expected (to the extent possible) to include representatives from (1) the state child care agency, (2) the state education agency, (3) local education agencies, (4) higher education institutions within the state, (5) local providers of early childhood education and development services, (6) Head Start agencies within the state (including migrant and seasonal Head Start and Indian Head Start, as appropriate), (7) the state director of Head Start collaboration, (8) the state agency responsible for programs under section 619 or part C of the Individuals with Disabilities Education Act, (9) the state agency responsible for health or mental health care, and (10) other representatives deemed relevant by the governor.

- assess the capacity and effectiveness of two- and four-year public and private institutions of higher education toward supporting the development of early childhood educators; and
- make recommendations for improvements in state early learning standards, as appropriate.

The Head Start Act requires that governors officially “designate” a council to serve as the State Advisory Council and an individual to coordinate the activities of the council (which might be a pre-existing advisory council). The Head Start Act allows HHS to award one-time start-up grants of \$500,000 or more to states for the development or enhancement of high-quality systems of early childhood education and care designed to improve school preparedness. Funding (\$100 million) was made available for these grants for the first time in FY2009.¹⁷⁵ Grantees are required to provide a 70% match. All Head Start activities, including State Advisory Councils, are administered by the Office of Head Start within the Administration for Children and Families at HHS.

Early Childhood Comprehensive Systems

State Early Childhood Comprehensive Systems (ECCS) are funded via competitive grants to states, and are to ensure school readiness through creation of a seamless system of early childhood services for all children. There are five core areas in which these systems, by fostering integrated efforts across health, human service, and education agencies, are meant to ensure delivery of services for young children. The five areas are 1) access to health care and medical homes; 2) assessment of and services to address socio-emotional development and mental health needs; 3) early care and learning programs; 4) parenting education; and 5) family support services. The initiative, which is supported with a part of the Title V (of the Social Security Act) Maternal and Child Health Block Grant funding reserved for Special Projects of Regional or National Significance (SPRANS), was first funded in FY2003 and received FY2009 funding of just over \$7 million. As of FY2007, nearly all states received these grants and were developing or implementing these systems. States have tended to focus ECCS activities on state early care and learning policies and programs, and one analysis concluded that “most states need to give more importance to strategies that promote health, mental health, and family support.” Home visiting is one family support strategy that is generally consistent with the overall school readiness aim of the initiative and which has received specific attention by some ECCS grantees. In its announcement of FY2009 funding, the Maternal and Child Health Bureau (HRSA, HHS), stated that this phase of the initiative was expected to support continued implementation of the state early childhood strategic plans and “the integration of the ECCS program with the Substance Abuse and Mental Health Services Administration’s Project LAUNCH [described below in this Appendix], the Administration for Children and Families Home Visiting Program [see “Current ACF Home Visitation Initiative”], and the State Early Learning Councils mandated by the Head Start reauthorization legislation [described above in this Appendix].”¹⁷⁶

¹⁷⁵ For more information about FY2009 funding for State Advisory Councils, visit http://eclkc.ohs.acf.hhs.gov/hslc/Program%20Design%20and%20Management/sac/ARRA_HS_funds.html.

¹⁷⁶ U.S. Department of Health and Human Services, Health Resources and Services Administration, *State MCH Early Childhood Comprehensive System Implementation Grants*, HRSA-090176, 2009. U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, *State Early Childhood Comprehensive Systems Program*, Announcement Type: Competing Continuation, Program Guidance Fiscal (continued...)

Project LAUNCH

The Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health) initiative provides competitive grants for states and tribes to promote the wellness (defined as positive physical, emotional, social, and behavioral health) of children from birth to age eight.¹⁷⁷ Grantees are charged with supporting evidence-based initiatives to achieve the overall goal of wellness. In their November 2008 applications, each grantee identified multiple programs to support, and all but one state (Rhode Island) identified one or more specific home visitation models. These included Parents as Teachers, Healthy Steps Home Visitation Component, Baby University Nurse Home Visiting Program, First Born Home Visiting Program, Safe Care, and “Visitation to at-risk infants and parents by Touchpoints trained visitors.” In addition, grantees identified numerous additional parent training and family strengthening programs, along with programs focused on developmental assessments, mental health, and physical health. Among other requirements, grantees are required to create a State (or Territorial or Tribal) Council on Young Child Wellness and to include public agencies that administer health, education, and human services for young children (including child welfare agencies). In addition, grantees are specifically required to link their efforts to those of any HRSA-funded ECCS grantee in the state as well as any ACF Home Visitation grantee.¹⁷⁸ Initial funding of just under \$7.5 million was provided for FY2008 (P.L. 110-161) under authority of Section 520A of the Public Health Service Act; for FY2009 Congress provided \$20 million for the initiative (P.L. 111-8).¹⁷⁹ Consequently, the number of grantees is expected to grow beyond the seven cooperative agreements that were funded in the initial year of the initiative. The program is administered by the Center for Mental Health Services within the HHS, Substance Abuse and Mental Health Services Administration (SAMHSA).

Interagency Coordinating Councils

The Individuals with Disabilities Education Act (IDEA)¹⁸⁰ requires that each state establish a state Interagency Coordinating Council, appointed by the governor of the state, for the purpose of advising and assisting the state’s lead agency in the implementation of the Part C program. States receiving funds under Part C are expected to establish such a council. The statute gives governors authority to appoint members to the council and goes on to specify a broad spectrum of early

(...continued)

Year 2009, February 5, 2009. National Center for Children in Poverty, Columbia University Mailman School of Public Health, *State of States’ ECCS Initiatives*, Project Thrive, Short Takes No. 5, July 2007 at http://nccp.org/publications/pub_748.html. NCCP, “About Early Childhood Comprehensive Initiatives,” at <http://www.state-eccs.org/componentareas/index.htm>.

¹⁷⁷ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), Grant Announcement: Project LAUNCH, April 16, 2008, at http://www.samhsa.gov/grants/2008/sm_08_011.aspx.

¹⁷⁸ National Center for Mental Health Promotion and Youth Violence Prevention, “LAUNCH Links,” vol. 1, Issue 2, March 2009. “Evidence-based Practices Proposed by Project LAUNCH Grantees,” as of November 2008 at http://projectlaunch.promoteprevent.org/EBP_Proposed_by_PL_Grantees_Chart_As_of_11_2008.doc.

¹⁷⁹ Funding for Project LAUNCH appears to have followed from a Congressional request that the HHS, SAMHSA, Center for Mental Health Services support a “wellness initiative” to “assist local communities in the coordination and improvement of the integration of behavioral/mental and physical health services.” See Joint Explanatory Statement Accompanying Division G of H.R. 2764, P.L. 110-161, p. 1528, and Explanatory Statement for Division F, H.R. 1105, P.L. 111-8, p. 1411.

¹⁸⁰ See section 641 of the IDEA.

childhood stakeholders that should be included.¹⁸¹ At least 20% of council members must be parents of children with disabilities, a requirement that emphasizes the role of family involvement in policy and program development. The IDEA state councils are required to meet on a quarterly basis and council meetings may be open to the public. State councils are responsible for advising and assisting the lead state agency in the identification of fiscal and other resources for early intervention programs. Moreover, the councils may advise and assist the lead agency and the state educational agency on the provision of appropriate services for children from birth through age five, including the transition to preschool. The councils may also advise appropriate agencies in the state with respect to the integration of services for infants and toddlers with disabilities and at-risk infants and toddlers and their families, regardless of whether at-risk infants and toddlers are eligible for early intervention services. The councils are also required to prepare an annual report on the status of the state's early intervention programs for infants and toddlers with disabilities and their families.

Author Contact Information

Emilie Stoltzfus
Specialist in Social Policy
estoltzfus@crs.loc.gov, 7-2324

Karen E. Lynch
Analyst in Social Policy
klynch@crs.loc.gov, 7-6899

Acknowledgments

We are grateful to Jennifer Reed, whose work as a visiting research associate at the Congressional Research Service during the summer of 2007 laid significant groundwork for this report.

¹⁸¹ IDEA statute makes the governor responsible for ensuring that the membership of the council “reasonably represents” the population of the state. Composition of the council is expected to include parents of infants, toddlers, or children with disabilities (at least 20%) as well as public or private providers of early intervention services (at least 20%). In addition, the council should include at least one member representing the following agencies and/or qualifications: (1) the state legislature; (2) each of the state agencies involved in early intervention; (3) the state educational agency responsible for preschool services for children with disabilities; (4) the state Medicaid agency; (5) a Head Start agency or program; (6) the state agency responsible for child care; (7) the state agency responsible for state regulation of health insurance; (8) the Office of Coordinator for Education of Homeless Children and Youths; (9) the state child welfare agency overseeing foster care; and (10) the state agency responsible for children’s mental health. The council must also include at least one member who is involved in personnel preparation and may include other members of the governor’s choosing, including a representative from the Bureau of Indian Affairs, the Indian Health Service, or the tribal council.