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Effective, Evidence-Based Home Visiting Programs in Every State at Risk if Congress Does Not Extend Funding

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The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), a federal and state partnership that supports family- and child-related home visiting programs in every state, will expire at the end of fiscal year 2014 unless Congress takes steps to extend it — threatening a host of programs that have proven effective for strengthening high-risk families and saving money over the long run.

MIECHV targets high-risk families who are most likely to benefit from intensive home visiting services, through which trained professionals (often nurses, social workers, or parent educators) help parents acquire the skills to promote their children’s development. The home visiting programs help families connect to necessary services, such as health care or community resources, and monitor child development and progress on developmental milestones. MIECHV provides the federal funds to support the programs, while states and localities implement them. Congress provided \$400 million for MIECHV this year.

MIECHV puts a high premium on evidence-based family support programs, providing most of its funds to support rigorously evaluated programs for which there’s well-documented evidence of success. These programs have proven an effective strategy for strengthening families and saving money over the long term. Research shows they can lead to reduced health care costs, reduced need for remedial education, and increased family self-sufficiency.²

MIECHV-funded programs are in place in every state and operating in 656 counties. Despite their documented success and broad, bipartisan support, they are now in jeopardy. MIECHV was originally authorized and funded for five years at a total of \$1.5 billion, with \$400 million for fiscal year 2014; the funding and authority expire at the end of 2014. For the program to continue, Congress needs to extend it by September 30, when fiscal year 2014 ends.

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² Sarah Avellar et al., *Home Visiting Evidence of Effectiveness Review: Executive Summary*, Washington, D.C. U.S. Department of Health and Human Services, Office of Policy, Research and Evaluation, September 2013, http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2013.pdf#exec_summary.

If Congress fails to extend MIECHV this year, it will jeopardize many of the program's key features:

- **Targeting high-risk families.** MIECHV targets vulnerable families with very young children residing in at-risk areas. Targeted families include those at risk for negative child outcomes, pregnant adolescents from underserved minority groups, and families at risk for maltreatment, among others. Without federal funding, fewer families in at-risk communities would be served.
- **Evidence-based practices, with state innovation and flexibility.** The MIECHV law requires that 75 percent of grant funds be used to support the implementation of evidence-based practices that have been rigorously evaluated and for which there is well-documented evidence of success. A state can invest up to 25 percent of grant funds to implement and rigorously evaluate promising and new approaches or significant innovations. States' evaluations of these new or innovative approaches will continue to build the research base for effective home visiting and can lead to more kinds of effective programs, especially for previously underserved groups for which no or few evidence-based models exist. Without an extension of MIECHV, states may discontinue some of these new approaches and abandon plans to adopt more evidence-based models.
- **State accountability.** The MIECHV law requires that grantees demonstrate improvement among eligible families participating in the program in six benchmark areas: (1) improved maternal and newborn health; (2) prevention of child injuries, child abuse, neglect or maltreatment, and reduction of emergency department visits; (3) improvement in school readiness; (4) reduction in crime or domestic violence; (5) improvements in family economic security; and (6) improved coordination and referrals for other community resources and support. In addition, a national large-scale evaluation using a random assignment design is under way that will provide detailed information on MIECHV-funded programs' impact on families' outcomes and state approaches to delivering home visiting services. MIECHV's expiration would undercut this opportunity to further build the evidence base for effective home visiting programs.
- **Coordination and collaboration.** Another key MIECHV goal is to increase coordination of services in at-risk communities and promote greater intra-agency collaboration. In their MIECHV plans, states must demonstrate how they will achieve greater coordination and develop benchmarks for measuring their progress. States would likely scale back these efforts, too, without continued federal support.

MIECHV's success as an evidence-based, social policy initiative is important not only for its long-term impact on vulnerable children's lives, but also for what it can tell us about using evidence to make programmatic and funding decisions. "Evidence-based policy offers a demonstrated path to more effective, less expensive government," Jon Baron, President of the Coalition for Evidence-Based Policy, told the House Ways and Means Committee last summer. "...[W]e believe it could provide the basis for a bipartisan effort to reinvent U.S. social spending, so as to greatly increase its effectiveness in improving people's lives."³

³ Testimony of Jon Baron before the House Ways and Means Committee, Subcommittee on Human Resources, July 17, 2013, http://waysandmeans.house.gov/uploadedfiles/jon_baron_testimony_071713.pdf.

In many ways, MIECHV represents a new approach to government funding — it uses evidence to increase the chances that individuals participate in programs that *will* work, and it requires building even more evidence on what works to improve the short- and long-term outcomes of some of our most vulnerable infants and young children. In a recent co-bylined article on the importance of using evidence to make policy and funding decisions, John Bridgeland and Peter Orszag, senior officials in the George W. Bush and Obama administrations, respectively, noted, “Every time a young person participates in a program that doesn’t work but could have participated in one that does, that represents a human cost.”⁴

Background on the Maternal, Infant, and Early Childhood Home Visiting Program

MIECHV was established in 2010 through the Maternal and Child Health Subtitle (Title V) of the Affordable Care Act (ACA). (MIECHV was part of a package of provisions related to improving maternal and child health services and well-being, not directly related to expanded coverage under the ACA.) The 2010 initiative built on earlier efforts. In 2004, former Senators Kit Bond (R-MO) and Jim Talent (R-MO) first introduced the Education Begins At Home Act (EBAH), broadly considered to be the precursor to MIECHV. In 2008, the first federal funding for evidence-based home visiting programs was appropriated under President George W. Bush.

MIECHV was authorized for five years, from 2010 to 2014, with a total of \$1.5 billion in funding. Funding for the first year was \$100 million, gradually increasing by 2013 to its full current annual funding level of \$400 million. All 50 states, the District of Columbia, and five territories were eligible to receive formula grants based on their child poverty rates. The U.S. Department of Health and Human Services (HHS) has awarded two types of competitive grants: development grants for states or jurisdictions with modest home visiting programs that wanted to build on existing efforts, and expansion grants for states and jurisdictions that had already made significant progress toward implementing high-quality home visiting programs and were ready to take programs to scale. Since the start of the program, 19 states have received development grants and 31 have received expansion grants.⁵ The program also includes a 3 percent set aside for grants to tribes, tribal organizations, and urban Indian organizations. MIECHV funds must be used to supplement, not supplant, funds from other sources that are used for early childhood home visiting initiatives.

MIECHV prioritizes use of home visiting models with demonstrated effectiveness while providing states important flexibility to tailor their approach to their local communities’ needs. HHS contracted with Mathematica Policy Research to conduct a rigorous review of the home visiting research and provide an assessment of the evidence of the effectiveness for home visiting program models that serve families with pregnant women and young children. The review has identified (to date) 14 home visiting models that meet the evidence-based criteria.⁶ The models target different

⁴ John Bridgeland and Peter Orszag, “Can Government Play Moneyball?” *The Atlantic*, June 19, 2013, <http://www.theatlantic.com/magazine/archive/2013/07/can-government-play-moneyball/309389/>.

⁵ Further details on funding are available at <http://mchb.hrsa.gov/programs/homevisiting/grants.html>.

⁶ See <http://homvee.acf.hhs.gov/Default.aspx>. The list of the 14 models as well as additional detail about each is available in the Appendix and <http://mchb.hrsa.gov/programs/homevisiting/models.html>. See also, Sarah Avellar et al., “Home Visiting: Evidence of Effectiveness Review,” Mathematica Policy Research, September 2013, http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2013.pdf#exec_summary.

populations and support a variety of interventions. Recognizing the diversity of needs among high-risk families, 41 states have implemented more than one evidence-based model.

All evidence-based models provide voluntary, home-based services to families with young children, but they differ with respect to whom they reach and what services they provide. (See Appendix.) Most models target parents or children with particular risk factors, including low-income parents, first-time mothers, teen parents, and children exhibiting developmental concerns. Some models allow mothers to enroll prenatally, while others provide services post-birth based on the child's age. Models may provide services for one year or may continue based on need or until a child reaches a certain age. The goals of each model vary and include improving child and/or parental health, addressing school readiness, fostering healthy child development, and improving family self-sufficiency. The activities that occur during visits vary by model and are informed by the model goals. Examples of home-visiting activities include: parent education, referrals to community resources, activities to support and encourage parent-child interaction, and screenings for parents and children to identify additional potential risk. The frequency of visits with families varies by models but is often weekly or every other week.

The legislation mandates an evaluation of the MIECHV program. The evaluation uses a randomized controlled design to determine what difference the home visiting program makes in a wide range of outcomes.⁷ This study will include roughly 85 program sites and 5,100 families clustered in about 12 states nationwide. Sites in the evaluation will operate one of four models: Early Head Start-Home Visiting, Healthy Families America, Nurse Family Partnership, and Parents as Teachers. These models were chosen for the evaluation because they: (1) meet HHS' criteria for evidence-based models and (2) are being implemented in at least 10 states as part of their MIECHV programs. The study is intended to answer questions of overall impacts of home visiting as well as impacts for individual models. It will examine features of models and their implementation that lead to stronger impacts and will include information on the costs of implementing home visiting models and the cost effectiveness of MIECHV. The first evaluation results are expected in 2015.

Home Visiting Improves Child and Family Outcomes

Home visiting has a strong evidence base, backed by rigorous research that supports models' effectiveness at promoting children's health and development and strong parenting skills while leading to fewer children in the social welfare, mental health, and juvenile corrections systems, with considerable cost savings for states. Research shows home visiting can be an effective method of delivering family support and child development services. The programs' outcomes vary depending upon the model used, but similar, positive outcomes have been found across many home visiting models.

- **Home visiting programs improve child health and development.** Children need support for their physical, cognitive, and social-emotional development in order to thrive. Research shows that home visiting programs effectively support healthy child development, beginning in the prenatal period. Pregnant women who participate in the programs have better birth outcomes, and the programs have been found to have a positive impact on breast feeding and

⁷ For more information on the Maternal, Infant, and Early Childhood Home Visiting Evaluation, visit <http://www.mdrc.org/mihope-project-description>.

immunization rates as well as to lower depressive symptoms and stress.⁸ A study of the Nurse-Family Partnership found that families participating in the program during pregnancy and the first two years of the child's life had fewer days that children were hospitalized with injuries or ingestions and fewer closely spaced subsequent pregnancies than their counterparts in the control group.⁹

- **Home visiting programs can increase children's school readiness.** Studies of various home visiting programs have shown positive impacts on children's cognitive development and behavior, higher grade point averages and achievement scores at age 9, and higher graduation rates from high school.¹⁰ A study conducted on the Healthy Families New York program found that, in first grade, children who participated in the program were nearly twice as likely as other at-risk children to be able to follow directions, complete work on time, or work cooperatively with others.¹¹
- **Home visiting programs can enhance parents' abilities to support their children's development.** Research shows that home visiting programs help parents increase positive parenting actions and reduce negative ones, have more responsive interactions, create more developmentally stimulating home environments, engage in activities that promote early language and literacy, and know more about child development.¹² In a study of the Parents as Teachers program, participating parents were more likely to read aloud, tell stories, say nursery rhymes, and sing with their children — all activities that are key to child development and promoting early language and literacy.¹³

⁸ Healthy Families America, *Research Spotlight on Success: Healthy Families America Promotes Child Health and Development*; Brian D. Johnston, Colleen E. Huebner, Melissa L. Anderson, et al., "Healthy Steps in an Integrated Delivery System: Child and Parent Outcomes at 30 Months," *Archives of Pediatrics and Adolescent Medicine* 160, no. 8 (2006): 793–800; D. Lowell, A. Carter, L. Godoy, et al., "A Randomized Controlled Trial of Child FIRST: A Comprehensive Home-Based Intervention Translating Research into Early Childhood Practice."

⁹ Harriet Kitzman, David Olds, Charles Henderson, Carole Hanks, Robert Cole, Robert Tatelbaum, et al., "Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing: A randomized controlled trial," *JAMA: The Journal of the American Medical Association*, 278, no.8 (1997): 644–652.

¹⁰ Healthy Families America, *Research Spotlight on Success: Healthy Families America Promotes Child Health and Development*, Healthy Families America, 2008, www.healthyfamiliesamerica.org; David L. Olds, Harriet Kitzman, Carole Hanks, et al., "Effects of Nurse-Home Visiting on Maternal and Child Functioning: Age Nine Follow-Up of a Randomized Trial," *Pediatrics* 120, no. 4 (2007): 832–845; Phyllis Levenstein, Susan Levenstein, James A. Shiminski, 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* 19, no. 2 (1998): 267–285.

¹¹ Kristen Kirkland and Susan Mitchell-Herzfeld, "Evaluating the Effectiveness of Home Visiting Services in Promoting Children's Adjustment in School: Final Report to the Pew Center on the States," New York State Office of Children and Family Services, 2012, http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/School_Readiness_executive_summary.pdf.

¹² Kimberly DuMont, Kristen Kirkland, Susan Mitchell-Herzfeld, et al., "A Randomized Trial of Healthy Families New York (HFNY): Does Home Visiting Prevent Child Maltreatment?"; *Research Spotlight on Success: Healthy Families America Promotes Positive Parenting*, Healthy Families America, 2008, www.healthyfamiliesamerica.org; David L. Olds, JoAnn Robinson, Lisa Pettitt, et al., "Effects of Home Visits by Paraprofessionals and by Nurses: Age Four Follow-Up of a Randomized Trial," *Pediatrics* 114, no.6 (2004): 1560–1568; Mary Wagner, Elizabeth Iida, and Donna Spikes, *The Multisite Evaluation of the Parents as Teachers Home Visiting Program: Three Year Findings from One Community* Menlo Park, CA: SRI International, 2001; Brenda Jones Harden, Rachel Chazan-Cohen, Helen Raikes, et al., "Early Head Start Home Visitation: The Role of Implementation in Bolstering Program Benefits," Unpublished manuscript, 2010.

¹³ Mary Wagner and Donna Spikes, "Multisite Parents as Teachers Evaluation: Experience and Outcomes for Children

- **Home visiting programs can improve family economic self-sufficiency.** One in four young children lives in poverty, which negatively affects their physical, social, and emotional development and impedes their ability to learn. By helping parents enroll in educational and training programs and pursue employment, home visiting programs can help counteract the negative consequences of economic insecurity and encourage success not only at home but also in school and at work. Studies have found that compared with a control group, more parents participating in home visiting programs work, are enrolled in education or training, and have higher monthly incomes.¹⁴ A study of the Early Head Start-Home Visiting program showed that parents of children in the program were more likely to be in education and job training programs.¹⁵ This is important as it is known that mothers with more years of formal education are more likely to have higher family income, be married, and have a spouse who is also employed.¹⁶

The positive outcomes outlined above combine to improve child and family outcomes. In addition to the positive outcomes outlined in the research, the Coalition on Evidenced-based Policy has identified some home visiting models as best practices according to the congressional evidence standards.¹⁷

States Have Used MIECHV Funds to Create Evidence-Based and Coordinated Systems of Services for At-Risk Families

Between 2011 and 2013, HHS awarded about \$330 million in formula grants and \$500 million in competitive grants to grantees in each of the 50 states and the District of Columbia.¹⁸ It also awarded planning grants to states in 2010. The amounts of state grant awards for 2014 are not yet available. The states have used the flexibility afforded them to tailor their programs to fit their communities' needs. Each state conducted a needs assessment to identify its communities most at

and Families,” SRI Project PO7283, 2001.

¹⁴ David Olds, Charles Henderson, Robert Tatelbaum, et al., “Improving the Life-Course Development of Socially Disadvantaged Mothers: A Randomized Trial of Nurse Home Visitation,” *American Journal of Public Health* 78, no. 11 (1988): 1436–1445; H. Kitzman, David L. Olds, Charles R. Henderson, Jr., et al., “Effect 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* 278, no. 8 (1997): 644–652; Craig W. LeCroy and Judy Krysik, “Randomized Trial of the Healthy Families Arizona Home Visiting Program,” *Children and Youth Services Review* 33, no. 10 (2011): 1761–1766; Jones Harden, Chazan-Cohen, Raikes, et al., “Early Head Start Home Visitation: The Role of Implementation in Bolstering Program Benefits.”

¹⁵ John Love, Ellen Kisker, Christine Ross, Peter Schochet, Jeanne Brooks-Gunn, Kimberly Boller, et al., “Building their futures: How Early Head Start programs are enhancing the lives of infants and toddlers in low-income families,” Summary report, Report to Commissioner’s Office of Research and Evaluation, Head Start Bureau, Administration on Children, Youth and Families, and Department of Health and Human Services, Mathematica Policy Research, 2001, <http://www.mathematica-mpr.com/PDFs/buildingvol1.pdf>.

¹⁶ Pedro Carneiro, Costas Meghir, and Mattias Pary, “Maternal Education, Home Environments, and Child Development,” *Journal of the European Economic Association* 11(S1) (2013): 28–29.

¹⁷ See <http://evidencebasedprograms.org/about/early-childhood> for more information.

¹⁸ In Florida, North Dakota, and Wyoming, MIECHV funding did not go through the state agency but instead went to qualified nonprofits pursuant to a provision in the federal law. Neither the timing nor the amount of the grants for these three states are included in the figures presented here as complete information is not available.

risk; it used the needs assessments to decide how to target its resources. For example, Washington State chose to focus on several very rural at-risk counties. In Michigan, communities within targeted at-risk counties chose populations to target; for example, Flint is targeting services to teen parents.

To foster high-quality implementation of evidence-based practices, MIECHV encourages states to engage in collaborative planning processes and to build statewide infrastructure to support local implementation. States have brought together diverse stakeholders and community interests to decide which home visiting models they would implement, how they would measure the outcomes of the program, how they could use this opportunity to create a more coordinated early childhood system, and how they could put systems in place to support high-quality implementation of the evidence-based models. States have engaged local agencies, often community-based organizations or health providers, to implement the evidence-based models.

MIECHV has catalyzed states to take steps to increase use of effective evidence-based programs and increase accountability. In a number of states, this has resulted in the creation of a statewide infrastructure to support adoption of common outcomes across diverse programs and the implementation of initiatives to continuously monitor the quality of program implementation. Modeling the policy components of the MIECHV program, since 2010, 10 states have enacted legislation that requires all of the state's home visiting investments to go to programs with a proven record of effectiveness and requires those programs to measure and report on their outcomes.

State and Tribal Organization Examples of MIECHV-Funded Successes

MIECHV funds have been used to spur important accomplishments and innovations in many states. Here are several examples:

- **Iowa: Expanding home visiting to underserved communities and building a statewide infrastructure to foster high-quality local implementation.** Iowa is using MIECHV funds to expand three evidence-based home visiting models (Early Head Start-Home Visiting, Healthy Families America, and Nurse Family Partnership) to 15 at-risk communities. The state selected these models because they target groups at especially high risk for negative childhood outcomes. Iowa also is using some of its MIECHV funds to build a statewide data-driven early childhood system with a focus on quality and systems coordination. Key components of Iowa's infrastructure include a statewide data collection system, a centralized intake system for home visiting and other family support programs, and a mandatory state certification for all home visiting and family support practitioners. The state is exploring the options for providing online resources to lower-risk families.¹⁹
- **Michigan: Expanding evidence-based practices to underserved communities.** Michigan is using MIECHV funds to expand home visiting services to 10 high-risk communities. The targeted populations include teen parents and African American and Latino populations in distinct geographic areas. The state is expanding four evidence-based models: Early Head Start-Home Visiting, Healthy Families America, Nurse Family Partnership, and Parents as Teachers. Michigan received an initial competitive development grant that it used to assess the

¹⁹ For more information on Iowa's MIECHV efforts, see the state's home visiting website at https://www.idph.state.ia.us/hpcdp/family_health_support.asp.

communities' readiness to expand home visiting. Communities had to demonstrate that they were already implementing the evidence-based programs with fidelity, that is, according to the programs' design. They also had to demonstrate that they had systems in place to coordinate services and to hold programs accountable for agreed-upon outcomes, and that they had program funding in place to support the expansion efforts. The state deemed eight of the 10 communities ready to expand services with MIECHV funds and is providing technical assistance to the remaining two communities to help them improve their systems and processes so they can eventually be eligible for expansion funding.²⁰

- **New Mexico: Expansion of home visiting in tribal communities.** Native American Professional Resources in New Mexico has used MIECHV funding to create the Tribal Home Visiting program, implementing the Parents as Teachers home visiting model in four New Mexico counties. In addition to providing regular home visits, the program sponsors monthly group meetings for parents and their children. The goal of the group sessions is to support the strengthening of tribal communities by bringing together Native parents to focus on their relationship with their children in a healthy and fun way. The program also works with parents and their children to develop a healthy Native identity and to support indigenous language use and cultural life ways. The home visitors work with resources in the community to incorporate traditional Native parenting practices into their home visits, including stressing the use of extended family members as support for parents and teachers. The program provides specialized services for teen parents, grandparents raising children, and fathers.²¹
- **Oregon: Coordinating early intervention services that previously operated in a non-coordinated fashion and expanding home visiting services to first-time mothers.** Oregon is using MIECHV funds to expand two evidence-based practices that were already operating in the state (Early Head Start-Home Visiting and Healthy Families America) and is using its competitive grant funds to implement the Nurse Family Partnership for first-time mothers in five counties. In addition to expanding services, Oregon is using its MIECHV funds to expand its capacity to develop a collaborative, coordinated early-intervention system. Prior to MIECHV, the state lacked a system to ensure that at-risk families received the services that best matched their needs. Now, with added capacity, it is developing a fully coordinated system that brings together programs from multiple agencies. The state intends for the coordinated system to help capitalize on the strengths of each program, decrease overlap and redundancy, decrease administrative barriers, and ensure that families receive appropriate services as their needs change. This effort has brought together multiple partners, including those in the areas of public health, mental health, addiction services, special needs, early childhood, and human services to its network of service providers. Oregon identified in its needs assessment that African Americans, Hispanics, American Indians/Alaska Natives, those in poverty, and those in urban areas were more likely to possess more of the 10 at-risk indicators and thus be at risk for adverse outcomes.²²

²⁰ For more information on Michigan's MIECHV initiatives, see the state home visiting website at <http://www.michigan.gov/homevisiting/>.

²¹ For more information on New Mexico's Tribal Home Visiting Program, see <http://www.nappr.org/images/thv-summer-2013.pdf>.

²² For more information on Oregon's home visiting program, see Oregon's Home Visiting System website at <http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HomeVisiting/Pages/index.aspx>.

- Tennessee: Creating a strong home visiting workforce.** Tennessee has used its MIECHV formula and competitive dollars to fund the Healthier Beginnings program, which serves 30 counties across the state deemed most “at risk,” using three evidence-based models: Healthy Families America, Nurse Family Partnership, and Parents as Teachers. In addition to expanding home visiting to underserved communities, the Tennessee Department of Health, in partnership with other programs and agencies related to early care and education, child welfare, health, mental health, and substance abuse, has embarked on a major effort to develop a high-quality home visiting workforce. Its Home Visiting Professional and Leadership Plan has three goals: 1) to ensure high-quality home visiting services for families in Tennessee; 2) to increase recognition of the professional experience, training, and education that home visitors bring to their work; and 3) to encourage high standards for quality training and support for professionals who work with families. The department developed the program based on the recognition that staff, managers, and leaders, while trained professionals, need access to ongoing training and technical assistance.²³
- Texas: On a path to reaching half of all high-risk young children through evidence-based home visiting programs.** Texas is using MIECHV funds to help achieve its bipartisan goal of reaching half of all high-risk young children through home visiting programs within 10 years. Prior to MIECHV, Texas had already made a commitment to devote state resources to providing home visiting services. In 2007, Texas reinvested \$4.3 million in criminal justice cost savings to provide home visiting services in at-risk communities. The state has increased state funding bi-annually to \$7.9 million and created the Texas Home Visiting Trust Fund, expected to raise an additional \$2 million in private funds for program services. The MIECHV funding has enabled the state to develop the Texas Home Visiting Program (THV) that includes the implementation of four evidence-based home visiting models (Nurse Family Partnership, Parents as Teachers, Home Instruction for Parents of Preschool Youngsters or HIPPPY, and Early Head Start-Home Visiting) in seven at-risk target communities across the state. Within THV, Texas has focused on three key goals: 1) use of a common screening tool in all home visiting programs; 2) implementation of a community referral, matching, and intake system; and 3) an increase in father participation and engagement in home visiting programs.²⁴
- Washington State: Building public-private partnerships and reaching rural communities.** Washington stands out as a model for forging collaboration between the public and private sectors in home visiting efforts. In 2010, the state created a state Home Visiting Services Account (HVSA), administered collaboratively by the Washington State Department of Early Learning and Thrive by Five Washington, the state’s public-private partnership for early learning. The projected 2013-2014 funding is 70 percent federal funds, 20 percent private funds, and 10 percent state funds. Washington State also used MIECHV funds to start the Rural Home Visiting Project, which expands home visiting to three rural communities. The three communities will implement the Parents as Teachers program, which they selected for its fit with

²³ For more information on Tennessee’s home visiting program, see the Tennessee Home Visiting Programs Annual Report (July 1, 2012 – June 30, 2013) at http://health.state.tn.us/LegislativeReports/PDFs/HomeVisiting_AnnualReport_2013.pdf.

²⁴ For more information on Texas’ home visiting program, see “Home Visiting in Texas: Current and Future Directions,” The Texas Association for the Protection of Children, December 2012, at http://www.texprotects.org/site/DocServer/Final_Home_Visiting_Report_03_11_13.pdf?docID=5641.

the communities' needs and structure. Washington identified at-risk populations related to both geographic areas as well as racial/ethnic background.²⁵

Failure to Extend MIECHV Would Weaken and Diminish Use of These Effective Home Visiting Programs

Without an extension by Congress, MIECHV's authorization will expire on September 30, 2014 and new funds will not be available for states for future years. This would likely lead to states retrenching their recent efforts to expand capacity, increase coordination, and strengthen data collection, analysis, and evaluation. This would mean that fewer families in at-risk communities would be served and the potential long-term savings from better child and family outcomes would never be realized. While the MIECHV funds have supplemented other funding that states were previously using for home visiting programs, the significant boost they have provided to help states focus on implementing evidence-based practices, developing statewide infrastructure to support local implementation and data collection, and increasing knowledge of how to replicate evidence-based practices could all be lost if states are unable to replace these lost federal dollars.

The potential costs of not extending MIECHV are high:

- **Fewer families in at-risk communities would be served.** States have added capacity and new home visiting program models to reach at-risk communities that had not been reached previously. Without ongoing federal funding or additional state funding, these programs may close or shrink considerably. Families may lose services before they complete the programs. This would also likely end or compromise efforts to track data and outcomes (or conduct evaluations) of terminated programs, wasting some of the investments that have been made to learn from families' experiences.
- **States may have to end their efforts to build statewide infrastructure and promote better coordination across programs.** Some states have made infrastructure investments for new online tools for data collection or assessment or have made other efforts to improve coordination, develop the programs' workforce, or increase fidelity to models. Most of these efforts require continuing investments — but without ongoing federal dollars, these improvements are at risk of not being maintained.
- **The opportunity to expand the use of evidence-based program models would be lost.** MIECHV embraces the idea that we should focus our efforts to expand programs on strategies that rigorous evaluations have proven to be effective. States' expansions of home visiting programs have primarily focused on the implementation of evidence-based models, although some states have also taken advantage of the opportunity to test whether promising models produce significant positive changes in children and families' outcomes. States have taken seriously the need to implement models with fidelity and to ensure high-quality staff are available to implement them. Without an extension and additional funding, states may discontinue some of these new approaches and abandon plans to shift to more evidence-based models.

²⁵ For more information on Washington's home visiting program, see Home Visiting in Washington at <http://www.del.wa.gov/development/visiting/>.

- **A significant opportunity to further build the evidence base for effective home visiting programs would be lost.** The robust evaluation and the opportunity for increasing our knowledge of effective program models is one of MIECHV's hallmarks. The program's national evaluation is designed to examine the impact of MIECHV, the implementation on the ground, the features of implementation that lead to stronger impacts, and a cost analysis. The evaluation is already underway with families currently being enrolled. The study design calls for data collection to continue through 2017, as it follows the impacts on participants over a period of time. If the federal funding is not extended, there will not be resources to complete the data collection or analyze the results. This would result in a lost learning opportunity and a waste of some of the investments to date. In addition, many states are developing and evaluating new models that do not yet have an evidence base. Here, too, evaluations may be curtailed and the opportunity for increased knowledge lost.

Conclusion

The failure of Congress to extend funding for the MIECHV program would have unfortunate consequences for communities in every state. Research supports the notion that home visiting programs can enhance parenting and support young children's early development with long-term outcomes for children, parents, and public cost savings. MIECHV has brought evidence-based home visiting services to more vulnerable children in the most at-risk communities.

The MIECHV program has also been essential for the development of statewide home visiting systems with states building the infrastructure needed to support lasting, effective programs. But, without a continued federal investment, states — and the nation — will lose the opportunity to reap the benefits of a well-crafted, evidence-based initiative.

Appendix

Target Population and Program Goals of Evidence-Based Models

Model	Target Population	Program Goals
Child FIRST	Pregnant women and families with children from birth to age 6.	The goal of the program is to decrease the incidence of emotional and behavioral disturbance, developmental and learning problems, and abuse and neglect among high-risk young children and their families.
Early Head Start-Home Visiting (EHS-HV)	Low-income pregnant women and families with children birth to age 3. Most families must be at or below the federal poverty level.	The program is a comprehensive, two-generation federal initiative aimed at enhancing the development of infants and toddlers while strengthening families.
Early Intervention Program for Adolescent Mothers	Pregnant adolescents (ages 14-19) from underserved minority groups who are referred to the county health department or another health services agency for nursing care.	The program is designed to help young mothers gain social competence and achieve program objectives by teaching self-management skills, techniques for coping with stress and depression, and skills to communicate effectively with partners, family, peers, and social agencies.
Early Start (New Zealand)	The program targets at-risk families with newborn children up to age 5.	The program is designed to improve child health, reduce child abuse, improve parenting skills, support parental physical and mental health, encourage family economic well-being, and encourage stable, positive partner relationships.
Family Check-Up	Families (with children ages 2 to 17) with risk factors including socioeconomic; family and child risk factors for child conduct problems; academic failure; depression; and risk for early substance use.	The program is designed as a preventative program model to help parents address typical challenges that arise with young children before these challenges become more serious or problematic.
Healthy Families America (HFA)	The program is designed for parents facing challenges (single parenthood; low income; childhood history of abuse and adverse child experiences, for example). HFA requires that families be enrolled prenatally or at birth.	The program goals include reducing child maltreatment, increasing utilization of prenatal care, improving parent-child interactions, and promoting children's school readiness.
Healthy Steps	The program is designed for parents with children from birth to age 3.	The program is designed to support the physical, emotional, and intellectual development of the child by enhancing the relationship between health care professionals and parents.

Appendix

Target Population and Program Goals of Evidence-Based Models

Model	Target Population	Program Goals
Home Instruction for Parents of Preschool Youngsters (HIPPY)	The program is designed for parents, with children ages 3 through 5, who have doubts about or lack confidence in their ability to instruct their children and prepare them for school.	HIPPY aims to promote preschoolers' school readiness and support parents as their children's first teacher by providing instruction in the home.
Maternal Early Childhood Sustained Home-Visiting Program (MECSH)	The program targets disadvantaged, pregnant women at risk of adverse maternal and/or child health and development outcomes.	The MECSH program is designed to enhance maternal and child outcomes by providing antepartum services in addition to the traditional postpartum care.
Nurse Family Partnership (NFP)	NFP is designed for first-time, low-income mothers and their children.	NFP is designed to improve (1) prenatal health and outcomes, (2) child health and development, and (3) families' economic self-sufficiency and/or maternal life course development.
Oklahoma's Community-Based Family Resource and Support (CBFRS) Program	Oklahoma's CBFRS program targeted first-time mothers living in rural counties.	The CBFRS program, which targeted first-time mothers, was developed to improve maternal and child health and child development.
Parents as Teachers (PAT)	Eligibility criteria, selected by affiliates, might include children with special needs, families at risk for child abuse, and income-based criteria, among others. The model is designed to serve families throughout pregnancy through kindergarten entry.	The goal of the program is to provide parents with child development knowledge and parenting support, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness.
Play and Learning Strategies (PALS)	Families with children ages 5 months to 3 years.	The program is designed to strengthen parent-child bonding and stimulate children's early language, cognitive, and social development.
Project 12-Ways/SafeCare	SafeCare is designed for families with a history of child maltreatment or risk factors for child maltreatment.	SafeCare aims to prevent and address factors associated with child abuse and neglect among the clients served.

Source: U.S. Department of Health and Human Services, Administration for Children & Families, "Home Visiting Evidence of Effectiveness," <http://homvee.acf.hhs.gov/>.