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Maternal and Infant Early Childhood Home Visiting (MIECHV) Program: Background and Funding

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Summary

The federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program supports home visiting services for families with young children who reside in communities that have concentrations of poor child health and other risk indicators. Home visits are conducted by nurses, mental health clinicians, social workers, or paraprofessionals with specialized training. Generally, they visit the homes of eligible families on a regular basis (e.g., weekly or monthly) over an extended period (e.g., six months or longer) to provide support to caregivers and children, such as guidance on creating a positive home environment and referrals to community resources. Families participate on a voluntary basis. Research on the efficacy of home visiting has shown that some models can help improve selected child and family outcomes, such as reducing child abuse. In FY2014, the MIECHV program supported 115,545 individual participants (parents and children) and conducted approximately 746,000 home visits.

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148) established the MIECHV program under Section 511 of the Social Security Act in March 2010. The program is jointly administered by the U.S. Department of Health and Human Services' (HHS's) Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF). Congress directly appropriated five years of mandatory funding for the program in the MIECHV statute: \$100 million for FY2010; \$250 million for FY2011; \$350 million for FY2012; and \$400 million for each of FY2013 and FY2014. (The funds in FY2013 and FY2014 were subject to sequestration.) The statute has twice been amended to appropriate funding for FY2015, FY2016, and FY2017. MIECHV funding is provided primarily to states and territories to administer home visiting programs, and funds are awarded on both a formula and a competitive basis. The law requires that HHS reserve 3% of the annual appropriation for Indian tribal entities, and funding is provided to tribes on a competitive basis to carry out home visiting services.

States, territories, and tribes must carry out their home visiting programs as specified in the law. Among other requirements, jurisdictions had to conduct needs assessments to identify communities with concentrations of poor infant health and other negative outcomes for children and families; the availability and use of home visiting services; and the capacity for providing substance abuse treatment and counseling in the jurisdiction. Under the program, these jurisdictions are required to achieve gains in four of six "benchmark" (or outcome) areas pertaining to family well-being and coordination of community resources. Further, the majority of annual funding (a minimum of 75%) for jurisdictions that administer home visiting programs must be used to support a program model that has shown sufficient evidence of effectiveness, as designated by HHS. The remaining 25% of funds may be used to implement models that have promise of effectiveness.

The MIECHV program provides technical assistance, research, and evaluation. Technical assistance is available to MIECHV grantees via several resource centers. HHS has established criteria for determining whether home visiting models are effective and reviews home visiting models on an ongoing basis via the Home Visiting Evidence of Effectiveness (HomVEE) project. As of September 30, 2015, the project determined that 19 models are evidence-based. Generally, these models seek to positively impact one or more outcomes in maternal and child health; early childhood social, emotional, and cognitive development; family/parent functioning; and links to other resources. As of February 2015, states, tribes, and territories had implemented 10 of the models using MIECHV funding: Healthy Families America, Nurse Family Partnership, Parents as Teachers, Early Head Start-Home Visiting, Home Instruction for Parents of Preschool Youngsters, Healthy Steps, SafeCare Augmented, Family Spirit, Child First, and Family Check-Up.

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Introduction

Home visiting is a strategy for delivering services to improve health, well-being, and education outcomes for vulnerable families with young children. Nurses, social workers, and other professionals provide support in the homes of families who participate on a voluntary basis. The federal government has long supported programs in which home visiting is a major component or is otherwise permitted. The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program is the primary federal program that focuses exclusively on home visiting.¹ The program was implemented in March 2010, following the Obama Administration’s FY2010 budget request for a national home visiting program and a home visitation pilot program carried out in 15 states that had been initiated in FY2008 by the Bush Administration.

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148) established MIECHV under Section 511 of the Social Security Act.² The program—jointly administered by the U.S. Department of Health and Human Services’ (HHS’s) Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF)—seeks to strengthen and improve home visiting services and support to families residing in at-risk communities, while also improving coordination of supportive services in these communities. States, territories, and Indian tribes (“jurisdictions”)³ determine which communities are at risk by conducting needs assessments. The MIECHV statute requires that jurisdictions must administer programs that are evidence-based.⁴ Specifically, jurisdictions must use no less than 75% of their program funds to implement home visiting models that HHS has determined are effective; ensure that services are carried out with fidelity to these program models; and demonstrate improvements in outcomes for participating families. Congress appropriated \$400 million in FY2015 to support the MIECHV program, and jurisdictions have until September 30, 2017, to expend these funds. HHS expects that FY2016 funds will be available to jurisdictions in spring 2016.⁵

This report begins with an overview of home visiting generally and discusses federal efforts to increase and support home visiting services. It goes on to describe the MIECHV program, including administration, coordination, and funding. Following this is an outline of MIECHV requirements for states and other jurisdictions, including information on the types of home visiting models that have been implemented across jurisdictions. The report concludes with information about efforts to research, evaluate, and provide technical assistance on the MIECHV program. **Appendix A** includes legislative history on home visiting; **Appendix B** includes funding levels by state for the MIECHV program in selected years; **Appendix C** includes a timeline of relevant dates for the program; and **Appendix D** provides information about home visiting models adopted by states and territories, and features of selected home visiting models that meet HHS criteria for being effective.

¹ The New Parent Support Program, operated by the Department of Defense, also has a primary focus on home visiting; however, it is available only to military families.

² All references to law are to the Social Security Act unless otherwise noted.

³ The law describes these as “grantees” or “eligible entities.” This report primarily uses the term “jurisdictions.”

⁴ The Obama Administration has focused on implementing evidence-based social policy initiatives, including the MIECHV program. For further information, see Ron Haskins and Greg Margolis, “The Maternal, Infant, and Early Childhood Home Visiting Initiative,” in *Show Me the Evidence: Obama’s Fight for Rigor and Results in Social Policy* (Washington, DC: Brookings Institution Press, 2014).

⁵ Congressional Research Service (CRS) correspondence with HHS, HRSA, October 2015.

Overview of Home Visiting

Home visiting is a comprehensive strategy that involves social, health, and/or educational services for parents and their young children. For many years, greater attention has focused on early childhood home visitation as a way to improve child and family outcomes. In the past decade, this trend appears to be driven in some part by newer research on how the human brain develops and, specifically, the significance of prenatal and early childhood environments to later life.⁶ To a large extent, parents shape their children's earliest experiences. Home visiting programs seek to help parents understand their own child's development, and proponents see these programs as an opportunity to enhance parents' role in ensuring their children's physical well-being and positive social-emotional growth, and supporting their early education. In turn, the programs can help achieve positive benefits for children, parents, and possibly their communities.

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. 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 visiting programs can lead to improvements, the difference is small between observed outcomes for families that received home visits versus those who did not. 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. Nonetheless, some models or aspects of models have been shown to be particularly effective. Overall, while 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.⁷

Overview of MIECHV

The MIECHV law does not define “early childhood home visiting.” In practice, this generally entails visits to the homes of families with young children (e.g., under age five or six) on a regular basis (e.g., weekly or monthly) over an extended period (e.g., six months or longer). Depending on the program model, visits may be conducted by nurses, mental health clinicians, social workers, or paraprofessionals who have received specialized training. These visitors provide services such as parenting education, and they refer families to other services in the community. HHS provides MIECHV funding to states, territories, and tribal entities for home visiting services in at-risk communities, as identified by these jurisdictions. MIECHV prioritizes certain eligible families who are low-income, including young mothers, or have history of substance abuse, among other risk factors. Families participate on a voluntary basis. In 2014, the

⁶ National Research Council and Institute of Medicine, *From Neurons in to Neighborhoods: The Science of Early Childhood Development*, ed. Jack P. Shonkoff and Deborah A. Phillips (National Academy Press, 2000).

⁷ For further information, see Office of the President, *The Economics of Early Childhood Investments*, Invest in US: The White House Summit on Early Childhood Education, December 2014; CRS Report R40705, *Home Visitation for Families with Young Children*, by (name redacted) and (name redacted); and U.S. Department of Health and Human Services (HHS), Administration for Children, Youth and Families, Administration for Children and Families (ACF), Office of Planning, Research, and Evaluation (OPRE), *Home Visiting Evidence of Effectiveness Review: Executive Summary*, OPRE Report #2013-42, September 2013 (revised June 2014), http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2013.pdf.

MIECHV program served 115,545 individual participants (parents and children) and provided 746,303 home visits.⁸ As of November 2014, the program was available in 721 counties across the country—or 22% of all counties—with 30% of urban counties, 17% of rural counties, and 11% of frontier (i.e., isolated and remote) counties having MIECHV-funded home visiting services.⁹

Jurisdictions that carry out home visiting programs under MIECHV must adhere to specific requirements in the law and guidance. For example, they must use most of their program funding to implement one or more home visiting models that have been identified by HHS to be effective. As of September 2015, HHS has identified 19 such models. Separately, HHS provides training and technical assistance to jurisdictions and is carrying out research activities to evaluate the impacts of the program. **Figure 1** summarizes the major components of the program.¹⁰

⁸ HHS, HRSA, *Justification of Estimates for Appropriations Committees, FY2016*, pp. 270-271. This is up from 34,180 participants in 2012 and 75,970 participants in 2013; and 174,257 home visits in 2012 and 489,363 home visits in 2013. This is the most recent information available, as of October 2015.

⁹ *Ibid.*, November 2014.

¹⁰ For information about each state's and territory's home visiting program, see HHS, HRSA, *Maternal Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed.*; and an interactive map that includes information about their programs. Both the brief and map are available at HHS, HRSA, "Home Visiting Helps At-Risk Families Across the U.S.," <http://mchb.hrsa.gov/programs/homevisiting/states/>.

Figure I. Overview of the MIECHV Program



Source: Congressional Research Service (CRS), based on Section 511 of the Social Security Act.

Eligible Families

Under the program, jurisdictions provide home visiting services to eligible families who volunteer to participate. An eligible family includes (1) a woman who is pregnant, and the father of the child if he is available; (2) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the parent's primary caregiver from birth to entry into kindergarten; and (3) a noncustodial parent who has an ongoing relationship with, and at times provides physical care for, the child from birth to entry into

kindergarten.¹¹ Jurisdictions must give priority to serving eligible families who meet any of the following criteria:

- reside in communities that are in need of home visiting services, as identified in the statewide needs assessment;
- are low-income;
- include a pregnant woman under the age of 21;
- have a history of child abuse or neglect or have had interactions with child welfare services;
- have a history of substance abuse or need substance abuse treatment;
- have users of tobacco products in the home;
- have children with low student achievement;
- have children with developmental delays or disabilities; or
- individuals who are serving, or formerly served, in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.¹²

Funding

The ACA directly appropriated five years of funding for the MIECHV program: \$100 million for FY2010, \$250 million for FY2011, \$350 million for FY2012, and \$400 million for each of FY2013 and FY2014. The Protecting Access to Medicare Act of 2014 (P.L. 113-93) provided \$400 million for the program for the first half of FY2015 (October 1, 2014, through March 31, 2015).¹³

The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10), which was signed into law on April 16, 2015, extended the \$400 million made available under P.L. 113-93 through all of FY2015 (October 1, 2014, through September 30, 2015). In other words, the law allows HHS to obligate FY2015 funds through the end of FY2015 but otherwise did not change the level of funding for FY2015.¹⁴ P.L. 114-10 also provided \$400 million for each of FY2016 and FY2017 under the program.

The law requires that 3% of the appropriation is to be reserved for Indian tribal entities, and another 3% is to be reserved for technical assistance (related to corrective action on benchmark areas, discussed subsequently), research, and evaluation. MIECHV funding may be expended by the recipient through the end of the second succeeding fiscal year after the award.

The law does not specify how the funds are to be awarded. In practice, HHS distributes MIECHV funds by both formula and competitive grants to states and other jurisdictions. Formula funding is available annually for home visiting in the 50 states, the District of Columbia, Puerto Rico,

¹¹ Section 511(k)(2).

¹² Section 11(d)(4).

¹³ Section 511(j). MIECHV funds were subject to sequestration in each of FY2013 and FY2014, resulting in an operating level of \$379.6 million and \$371.2 million, respectively. See, HHS, HRSA, *Justification of Estimates for Appropriations Committees, FY2016* p. 272.

¹⁴ Under P.L. 113-93, HHS had until March 31, 2015, to obligate all FY2015 funding. HHS reported that all funds had been obligated by this date. States and territories have more than two years to expend these funds, which will be available through September 30, 2017 (the end of FY2017).

Guam, the U.S. Virgin Islands, the Northern Mariana Islands, and American Samoa. Funding is distributed according to the relative share of children under age five in families at or below 100% of the federal poverty line in each state.¹⁵ The poverty data are derived from the Census Bureau's Small Area Income Poverty Estimates (SAIPE). SAIPE data are not available for the territories (except Puerto Rico), and the territories have generally received a minimum level of funding (i.e., \$500,000 each in FY2010 and \$1 million per year from FY2011 through FY2015).¹⁶ Four states (Florida, North Dakota, Oklahoma, and Wyoming)¹⁷ have declined funding for the program, and, as permitted under law, nonprofit programs have successfully applied and have operated the program in these states in selected years.¹⁸ To be eligible to operate home visiting programs under MIECHV, nonprofits must have an established record of providing early childhood home visiting programs or initiatives in one or more states and receive funding that would have otherwise been awarded to the states in which they operate.

HHS also awards competitive funding to states based on the strength of their program or their effort to develop a strong program. This funding is provided for development grants focused on building the capacity of the workforce, data infrastructure, and care coordination and referral systems and to build upon their efforts already underway and expand services to more families and communities under grants known as expansion grants. (Since FY2014, HHS has not distinguished between development and expansion grants, since each jurisdiction has developed a program.) HHS separately awards competitive grants to tribal entities to operate home visiting programs under the Tribal MIECHV program (tribal grantees are not eligible for formula funding). Tribal entities must generally follow the same requirements that apply to states and nonprofit organizations.¹⁹ In addition, four tribal entities receive competitive funds under the MIECHV Tribal Early Learning Initiative (TELI). These entities participate in the Tribal MIECHV program and two other early learning programs administered by ACF (American Indian/Alaska Native Head Start/Early Health Start, Tribal Child Care, and Tribal MIECHV). The purpose of TELI is to improve collaboration across these programs to improve efficiency and raise the quality of services provided to children and families.²⁰

Table 1 summarizes obligated funding for the program from FY2010 through FY2015.²¹ While formula grants to jurisdictions initially made up the majority of MIECHV funding, they

¹⁵ However, in each of FY2010 through FY2012, MIECHV funding was provided to support 17 grantees under a previous home visiting program, Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment (EBHV). See **Appendix A** for more detail about the program. Additionally, in FY2011, HHS proportionally modified this formula to ensure that each jurisdiction received at least 120% of its FY2010 allocation. In FY2013, HHS proportionally modified funding to ensure that each jurisdiction received no less than the amount they received in FY2012.

¹⁶ HHS, HRSA, "Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visiting Formula Grant Program Limited Competition," HRSA-14-1081, April 11, 2014.

¹⁷ North Dakota received regular formula funding for FY2010; declined this funding for FY2011; and received nonprofit formula funding for each of FY2012 through FY2015. Florida and Wyoming received regular formula funding for FY2010 and FY2011; declined this funding in FY2012; and received nonprofit formula funding for each of FY2013 through FY2015. Oklahoma received regular formula funding for FY2010, FY2011, FY2012, and FY2015; declined this funding in FY2013; and received nonprofit formula funding for FY2014. CRS correspondence with HHS, HRSA, February 2015.

¹⁸ Section 511(h)(2)(B).

¹⁹ For further information, see HHS, HRSA, "Early Childhood Development Newsletter: Home Visiting" vol. 3, special ed., March 2015. (Hereinafter, HHS, HRSA, "Early Childhood Development Newsletter: Home Visiting.") March 2015.

²⁰ HHS, ACF, "Tribal Early Learning Initiative," <http://www.acf.hhs.gov/programs/ecd/tribal-early-learning-initiative>.

²¹ For a list of most grantees in each of these years, see HHS, HRSA, *MIECHV Grants and Grantees*, (continued...)

represented only about 29% of the funding by FY2015. That same year, competitive grant funding for states made up nearly 60% of the funding. **Table B-1** in **Appendix B** includes formula and competitive grant funding by state for FY2014 and FY2015.

(...continued)

<http://mchb.hrsa.gov/programs/homevisiting/grants.html>.

Table I. Obligated Funding for the MIECHV Program, by Type of Award, FY2010-FY2015

Dollars in Millions, Percentages Based on Total Obligated Funding for a Given Year

Year	Formula Grants to States and Territories (a)	Formula Grants to Nonprofit Organizations (b)	Total Formula Grants (c=a+b)	Competitive Grants			Total Competitive Grants (g=d+e+f)	Technical Assistance, Evaluation, and Research and Other Evaluation Activities (h)	Federal Administration and Grant Review (i)	Total Obligated Funding (j=c+g+h+i)
				Development (d)	Expansion (e)	Tribal Entities (f)				
FY2010	\$91.8 (92.0%)	\$0 (0.0%)	\$91.8	\$0 (0.0%)	\$0 (0.0%)	\$3.0 (3.0%)	\$3.0	\$2.8 (2.8%)	\$2.4 (2.4%)	\$100.0
FY2011	\$124.0 (49.6%)	\$0 (0.0%)	\$124.0	\$33.7 (13.5%)	\$66.3 (26.5%)	\$7.5 (3.0%)	\$107.5	\$12.7 (5.1%)	\$5.7 (2.3%)	\$249.9
FY2012	\$118.0 (33.7%)	\$1.0 (0.3%)	\$119.0	\$46.7 (13.3%)	\$143.3 (40.9%)	\$10.5 (3.0%)	\$200.5	\$17.4 (5.0%)	\$6.8 (1.9%)	\$343.7
FY2013	\$109.5 (28.8%)	\$7.5 (2.0%)	\$117.0	\$7.4 (1.9%)	\$203.9 (53.7%)	\$11.5 (3.0%)	\$222.8	\$18.2 (4.8%)	\$5.9 (1.6%)	\$363.9
FY2014	\$106.7 (28.7%)	\$9.3 (2.5%)	\$116.0	\$217.7 ^a (58.6%)		\$12.0 (3.0%)	\$229.7	\$18.0 (4.8%)	\$6.8 (1.8%)	\$370.5
FY2015 (estimates)	\$116.6 (29.2%)	\$8.4 (2.1%)	\$125.0	\$235.9 ^a (59.0%)		\$12.0 (3.0%)	\$247.9	\$18.2 (4.6%)	\$8.9 (2.2%)	\$400.0

Source: CRS based on correspondence with HHS, HRSA and HHS, ACF, February 2015; and HHS, HRSA, "Home Visiting Grants & Grantees," <http://mchb.hrsa.gov/programs/homevisiting/grants.html>.

Note: Congress appropriated \$400 million for this program in both FY2013 and FY2014; however, this funding was subject to sequestration, which reduced the actual funding available to the amounts shown. In addition, figures do not add to obligated totals for FY2011 through FY2014 because of funds that were unobligated in each of those years: FY2011 (\$0.1 million was unobligated, or 0.1%; total funding would otherwise be \$250 million); FY2012 (\$6.3 million was unobligated, or 1.8%; total funding would otherwise be \$343.7 million); FY2013 (\$15.7 million was unobligated, or 4.1%; total funding would otherwise be \$379.6 million); and FY2014 (\$0.7 million was unobligated, or 0.2%; total funding would otherwise be \$371.2 million). All unobligated funding is carried over to the next fiscal year to be available for obligation.

The law requires that 3% is to be reserved for corrective action technical assistance (Section 511(d)(1)(B)(iii)), evaluation (Section 511(g)), and research and other evaluation activities (Section 511(h)(3)). Funding for general technical assistance to grantees (Section 511(c)(4)) is included in the column for technical assistance. This funding is not subject to the 3% set-aside provision.

a. HHS no longer distinguishes between the two types of competitive grants because each state has developed a home visiting program.

Administration

HHS formula and competitive grant funding for states and territories is allocated to a lead agency in each state that successfully applies for the MIECHV program. Jurisdictions are required to effectively implement home visiting models (or a single home visiting model) in the state's at-risk community or communities, as identified by the jurisdiction via its needs assessment.

States and territories can determine which state agency or agencies will administer the MIECHV program. The public health department is the lead agency that administers home visiting funds in most states, the District of Columbia, and the five territories. In eight of these jurisdictions (Delaware, Guam, Idaho, Maine, Montana, Nebraska, New Hampshire, and West Virginia) the department of health also includes the state social service agency. Eight states administer the program through other departments with a social service focus (Alabama, Colorado, Georgia, Illinois, Mississippi, Nevada, Pennsylvania, and Texas). Specifically, Alabama, Georgia, and Washington administer the programs through agencies or governmental entities that focus on children and families or early childhood. Kentucky, New Jersey, and Oregon each have two lead health and social service agencies. South Carolina operates its program through a nonprofit organization, the Children's Trust Fund of South Carolina, which is authorized under state law and overseen by the state Office of Executive Policy and Programs.

In states that declined to participate, funds that would have otherwise been awarded to the state agency go instead to an eligible nonprofit organization that must carry out the MIECHV program in a community or communities identified in the statewide needs assessment. The nonprofit organizations that operate MIECHV programs in three states are the Northeast Florida Health Start Coalition; Prevent Child Abuse, North Dakota; and Parents as Teachers National Center (Wyoming).²²

Coordination

The MIECHV program includes several provisions that seek to ensure holistic services to families and promote coordination between agencies. For example, the law states that grants for home visiting programs are intended to improve specific family outcomes across a number of domains related to health, emotional and physical well-being, and education. Related to this, jurisdictions carrying out MIECHV programs were required to conduct a needs assessment coordinated with needs assessments and planning processes under other federal programs, including those pertaining to child abuse, early childhood education, and domestic violence. Jurisdictions must also establish and demonstrate improvements in coordinating with other community resources and supports, among other areas.

In addition, the law requires coordination at the federal level between HRSA (specifically, the Maternal and Child Health Bureau) and ACF in awarding MIECHV funds and overseeing the grants. The two HHS agencies must also coordinate and collaborate on research with other federal agencies that have responsibility for administering or evaluating programs for eligible MIECHV families. Such agencies include the HHS Office for Planning and Evaluation (OPRE), the Centers for Disease Control and Prevention (CDC), the Eunice Kennedy Shriver National

²² HHS, HRSA, *Division of Home Visiting and Early Childhood Systems, Contact Information of MIECHV State Leads*, updated March 2014, <http://mchb.hrsa.gov/programs/homevisiting/statecontacts.pdf>; and CRS correspondence with HHS, HRSA and ACF, November 2014. Oklahoma began using regular formula funds as of FY2015, and therefore Parents as Teachers National Center no longer operates the program.

Institute of Child Health and Human Development of the National Institute of Health (NIH), the Department of Justice’s Office of Juvenile Justice and Delinquency Prevention (OJJDP), and the Department of Education’s Institute of Education Sciences.²³

Requirements for Grantees

Overview

The law specifies a variety of requirements for jurisdictions receiving MIECHV funds. These jurisdictions were required to conduct an initial needs assessment to identify communities with concentrations of poor infant health and mortality, poverty, and other negative outcomes. They had to submit the results of the assessments and how the jurisdiction intended to address the needs of the assessment. Jurisdictions must also submit an application for funding to HHS that includes several items, such as a description of the populations to be served under the program and how they will serve high-risk populations as identified by the jurisdiction. Further, the law requires jurisdictions to establish, subject to HHS approval, quantifiable and measurable benchmarks for demonstrating improvements in six child, parent, and family indicators for eligible families in the program. Jurisdictions must also meet other requirements, such as using MIECHV funding to supplement, and not supplant, other federal funding for home visiting services.

Needs Assessment

As a condition of receiving funds under the Maternal and Child Health (MCH) Services Block Grant for FY2011,²⁴ “states” were required to conduct a statewide needs assessment for the MIECHV program.²⁵ (The MIECHV authorizing law does not specify that territories conduct such assessments, but in practice, they were required to do so.) The MIECHV law separately requires that tribes and nonprofit organizations carry out needs assessments similarly to the assessment required for all states.²⁶ The statewide needs assessments had three purposes:

1. Identify communities with concentrations of

²³ Section 511(h)(1).

²⁴ Section 511(b)(1) references Section 502 of the Social Security Act, which addresses allotments to states and federal set-asides for the MCH Services Block Grant program. For further information about the program, see CRS Report R42428, *The Maternal and Child Health Services Block Grant: Background and Funding*, by (name redacted) . In addition, the law specifies that certain requirements under the Maternal and Child Health Services Block Grant apply to the MIECHV program. This includes provisions relating to prohibitions on payments to excluded individuals and entities (Section 504(b)(6)); use of funds for the purchase of technical assistance (Section 504(c)); limitations on administrative expenditures (Section 504(d)); reports and audits, but as determined appropriate for the MIECHV program (Section 504(d)); criminal penalty for false statements (Section 507); nondiscrimination (Section 508); and administration of title and state programs (Section 509(a)). All references are to the Social Security Act.

²⁵ Section 511(b).

²⁶ Section 511(h)(2). See also, HHS, ACF, Office of Child Care, “Tribal Maternal, Infant, and Early Childhood Home Visiting Program, Guidance for Submitting a Needs Assessment and Plan for Responding to Identified Needs (Phase 2 Implementation Plan),” September 17, 2012. (Hereinafter HHS, ACF, Office of Child Care, “Tribal Maternal, Infant, and Early Childhood Home Visiting Program, Guidance for Submitting a Needs Assessment and Plan for Responding to Identified Needs (Phase 2 Implementation Plan).”)

- premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect or other indicators of at-risk prenatal, maternal, newborn, or child health;
 - poverty;
 - crime;
 - domestic violence;
 - high school dropouts;
 - substance abuse;
 - unemployment; or
 - child maltreatment.
2. Determine the quality and capacity of existing programs or initiatives for early childhood home visitation in the jurisdiction, including
 - the number and types of individuals and families who are receiving services under such programs or initiatives;
 - gaps in early childhood home visitation in the jurisdiction; and
 - the extent to which such programs and initiatives are meeting the needs of eligible families.
 3. Determine the state's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.²⁷

In carrying out the needs assessment, jurisdictions were required to coordinate with, and take into account, other appropriate needs assessments conducted by the state, as determined by the HHS Secretary, including similar assessments already required under law: (1) the needs assessment for the Maternal and Child Health Services Block Grant (both the most recent completed assessment and any assessments in progress); (2) the community strategic planning and needs assessment under the Head Start program; and (3) the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect and other family resource services under the Child Abuse Prevention and Treatment Act (CAPTA).²⁸ HHS guidance issued in August 2010 also specified that the assessment should be coordinated with the state advisory council established under the Head Start Act (for children from birth to school entry); the state's child care agency; the state's education agency; the state's

²⁷ Section 511(b)(1).

²⁸ Section 511(b)(2). In order to receive MCH block grant funds, states must submit to the Secretary of the Department of Health and Human Services (HHS) an application that includes a statewide needs assessment (to be conducted once every five years) and a plan for meeting the needs identified in the needs assessment. The needs assessment must identify statewide health status goals (consistent with national health objectives); the need for preventive and primary care services for pregnant women, mothers, infants, and children; and services for children with special health care needs. The plan to address the needs assessment must include a description of how and where block grant funds will be used within the state to address those needs. See Section 505(a) of the Social Security Act. In applying to expand Head Start programs, the HHS Secretary is to take into account the extent to which an applicant has undertaken a community-wide strategic planning and needs assessment involving other entities, including community organizations and federal, state, and local public agencies that provide services to children and families. See Section 640(g)(1)(C) of the Head Start Act. As a condition of receiving CAPTA funds, states must submit an application to the HHS Secretary that includes a description of the inventory of current unmet needs and available programs and activities to prevent child abuse and neglect, and other family services operating in the state. See Section 204(3) of CAPTA (Section 511(b)(2) of the Social Security Act incorrectly references Section 205(3) of CAPTA).

agencies administering federal funds to prevent and respond to domestic violence (under the Family Violence Prevention and Services Act [FVPSA] and STOP grants authorized under the Violence Against Women Act [VAWA]); and the state child welfare agency (if this agency is not also administering programs under CAPTA). In addition, the guidance encouraged coordination with the state Individuals with Disabilities Act (IDEA) agency.²⁹

Each jurisdiction was required to submit the needs assessment by September 20, 2010, as a condition of receiving MCH Block Grant funds for FY2011, regardless of whether it intended to apply for a grant to provide home visiting services. The 50 states, the District of Columbia, and the territories submitted the assessment and subsequently received a portion of their FY2010 MIECHV funds if they applied for them. (The four states that did not ultimately apply for MIECHV funds, and whose MIECHV programs are now operated by nonprofit organizations, also submitted an assessment.)³⁰ Jurisdictions that applied for a MIECHV grant (which included the remainder of the FY2010 funds) had to subsequently submit an updated state plan in 2011 that included a final designation of the at-risk communities, provided a more detailed needs assessment for the targeted communities, and provided a specific plan for home visiting services tailored to address those needs.³¹

As part of the needs assessment, HHS directed states and territories to describe their understanding of the term “community” based on the unique structure and makeup of the state or territory. For example, “community” could be composed of zip codes, neighborhoods, or census tracts (in urban areas) or counties (for rural areas). HHS defined “at risk community” as a community for which indicators, in comparison to statewide indicators, demonstrate that the community is at greater risk than the state as a whole. States and territories had the option of targeting all at-risk communities or sub-communities or neighborhoods deemed to be at greatest risk, if data on these smaller units were available. Jurisdictions were required to provide a justification for each such community identified, using the most recent and/or relevant data available on each of the risk factors (defined further in the guidance), for both the entire jurisdiction and each community defined as at risk.³²

Tribal grantees are required to conduct a needs assessment of the tribal community and to develop a plan to address those needs. The assessment is to be conducted within the first year of receiving funding under the program.³³

Application for Funding

Further, jurisdictions applying for a grant must submit an application with multiple requirements, including the following:³⁴

²⁹ HHS, HRSA, “Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program Supplemental Information Request for the Submission of the Statewide Needs Assessment,” August 19, 2010. (Hereinafter, HHS, HRSA, “Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program Supplemental Information Request for the Submission of the Statewide Needs Assessment.”)

³⁰ One of the four states, Oklahoma, began using regular formula funds as of FY2015, and its home visiting program is no longer operated by a nonprofit organization.

³¹ HHS, HRSA, “Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program,” February 8, 2011.

³² HHS, HRSA, “Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program Supplemental Information Request for the Submission of the Statewide Needs Assessment.”

³³ HHS, ACF, “Tribal Maternal, Infant, and Early Childhood Home Visiting Program Guidance for Submitting a Needs Assessment and Plan for Responding to Identified Needs,” no date.

- A description of the populations to be served by the jurisdiction, including specific information regarding how the jurisdiction will serve high-risk populations (e.g., eligible families who reside in communities in need of home visiting services, as identified in the statewide needs assessment; are low income; include pregnant women under age 21; and have a history of child abuse or neglect or have had interactions with child welfare services, among others).
- An assurance that the jurisdiction will give priority to serving low-income eligible families and eligible families who reside in at-risk communities identified in the statewide needs assessment.
- The home visiting model or model(s) that the jurisdiction will use under the program and the basis for the selection of the model or models (based on the requirements in the law for selecting such model(s)).
- A statement identifying how the service delivery model(s) used and the populations to be served is consistent with the results of the statewide needs assessment.
- The quantifiable, measurable benchmarks established by the jurisdiction to demonstrate that the program contributes to improvements in family and other indicators (discussed in following section).
- An assurance that the jurisdiction will obtain and submit documentation from the organization or entity that developed the home visiting model(s) used under the program to verify that the program is implemented and services are delivered according to the model specifications.
- Assurances that the jurisdiction will establish procedures that ensure (1) the participation of each eligible family in the program is voluntary and (2) services are provided to an eligible family in accordance with the individual assessment for that family.
- Assurances that the jurisdiction will (1) submit annual reports to the HHS Secretary regarding the program and activities carried out under the program that include information and data required by the Secretary; (2) participate in, and cooperate with, data and information collection necessary for the required evaluation and other research and evaluation activities specified under the law.
- A description of other programs in the jurisdiction that include home visitation services, including, where applicable—other programs carried out under Title V of the Social Security Act with funding from the Maternal and Child Health Services Block Grant; programs funded under the Child Abuse Prevention and Treatment Act (CAPTA) community-based grants for the prevention of child abuse and neglect; and Early Head Start programs.
- Other information as required by the HHS Secretary.

Benchmark Areas

The MIECHV statute requires states and other jurisdictions that receive grant funds for home visiting programs to demonstrate improvements among eligible families in what the law refers to

(...continued)

³⁴ Section 511(e).

as six “benchmark areas” (HHS sometimes calls benchmark areas “outcomes”).³⁵ These six benchmark areas are desired outcomes for participants; for each of those outcomes, a state or jurisdiction operating a MIECHV program must establish a baseline to allow for performance measurement (see **Table 2**). HHS has identified 37 items (described as “constructs”) that jurisdictions use to measure performance. Each benchmark area has two to nine constructs. Jurisdictions were given flexibility in developing how they would measure performance for each construct. For example, all grantees must assess prenatal care under the benchmark area for improved maternal and newborn health; however, grantees may focus on different aspects of performance, such as the onset of prenatal care, the adequacy of prenatal care, or a comparison of participants’ prenatal care to an identified recommended prenatal care schedule. The law requires jurisdictions to show that they are making improvements in at least four out of six of the benchmark areas both three and five years after the law is implemented.³⁶

Table 2. MIECHV Benchmark Areas (Outcomes) and Constructs

There are 37 constructs spanning 6 benchmark areas

Benchmark Areas (outcomes)	Constructs (Items that must have a benchmark)
<i>Improved maternal and newborn health</i>	(1) Prenatal care; (2) alcohol, tobacco, and illicit drugs; (3) preconception care; (4) inter-birth interval; (5) maternal depressive symptoms; (6) breastfeeding; (7) well-child visits; and (8) maternal and child health insurance status.
<i>Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits</i>	(1) Visits for children to emergency department; (2) visits for mother to emergency department; (3) information/training on prevention of child injuries; (4) child injuries; (5) reported suspected maltreatment; (6) reported substantiated maltreatment; and (7) first-time victims of maltreatment.
<i>Improvements in school readiness and child academic achievement</i>	(1) Parent support for child learning and development; (2) parent knowledge of child development; (3) parenting behaviors/parent-child relationship; (4) parent emotional well-being/parenting stress; (5) child communication, language, and emerging literacy; (6) child cognitive skills; (7) child positive approaches to learning; (8) child social behavior/emotional well-being; and (9) child physical health and development.
<i>Reduction in crime or domestic violence^a</i>	(1) Screening for domestic violence; (2) referrals for domestic violence services; (3) domestic violence-safety plans; (4) arrests; and (5) convictions.
<i>Improvements in family economic self-sufficiency</i>	(1) Income and benefits; (2) employment or education; and (3) health insurance status.
<i>Improvements in the coordination and referrals for other community resources and supports</i>	(1) Identification for necessary services; (2) referrals for necessary services; (3) receipt for necessary services; (4) number of memorandums of understanding (MOU) with community agencies; and (5) information sharing.

Source: CRS based on Section 511(d)(1) of the Social Security Act and HHS, ACF, and HRSA, *The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Summary of Benchmark Measures Selected by Grantees, Design Options for Home Visiting Evaluation (DOHVE) – A DOHVE TA Resource Document, July 2014.*

Note: For further information about each state’s and territory’s home visiting program, see HHS, HRSA, *Maternal Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed.*; and an

³⁵ Section 511(d)(1) for states and territories, and Section 511(h)(2) for tribal entities and nonprofit organizations. These grantees are required to measure benchmarks in the same way; however, tribal grantees have an additional construct (regular visits to a primary health care provider or medical home). HHS, ACF, Office of Child Care, “Tribal Maternal, Infant, and Early Childhood Home Visiting Program, Guidance for Submitting a Needs Assessment and Plan for Responding to Identified Needs (Phase 2 Implementation Plan).”

³⁶ Section 511(d)(1).

interactive map that includes information about their programs. Both the brief and map are available at HHS, HRSA, “Home Visiting Helps At-Risk Families Across the U.S.,” <http://mchb.hrsa.gov/programs/homevisiting/states/>.

- a. Grantees have the option of choosing either the crime constructs (arrests and convictions) or the domestic violence constructs (screenings, referrals, and safety plans).

Jurisdictions are using a variety of tools to measure performance. According to HHS and its technical assistance partners, the purpose of this data collection effort is to collect data about grantee performance over time rather than the impacts of the program.³⁷ (As discussed in a subsequent section, HHS is assessing the effects of MIECHV programs with respect to each of the benchmark areas through a separate evaluation effort.)

By October 30, 2014, all states and territories operating a MIECHV program (along with Oklahoma, whose MIECHV program is operated by a nonprofit organization) had submitted reports to demonstrate their performance against the benchmarks for the first three years of the program. The tribal entities awarded funding under the first cohort of the Tribal MIECHV grants were required to submit their reports by December 31, 2014. The three nonprofit organizations that operate programs in Florida, North Dakota, and Wyoming awarded funding after September 2011 will be required to submit reports on the three-year benchmarks by October 30, 2016.³⁸

December 31, 2015, Report to Congress

The HHS Secretary must submit a report to Congress by **December 31, 2015**, regarding the programs carried out using MIECHV funding. It must include information on the extent to which grantees demonstrate improved outcomes in the six benchmark areas and any technical assistance provided by the Secretary to grantees that were required to develop and implement an improvement plan because they did not demonstrate improvements in at least four of the areas.

Sources: Section 511(h)(4) of the Social Security Act; HHS, ACF, and HRSA, *Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Plans for the 2015 Report to Congress*.

If a jurisdiction fails to demonstrate improvements in at least half of the constructs³⁹ in four of the benchmark (outcome) areas, it must develop and implement a plan to make improvements in each of the applicable areas, subject to approval by HHS. HHS must provide technical assistance to the grantee in developing and implementing the plan. As directed by statute, HHS has convened an advisory panel to make recommendations about this technical assistance.⁴⁰ The law requires HHS to terminate a jurisdiction’s MIECHV funding if, after a period of time specified by HHS, the jurisdiction has failed to demonstrate any improvements in outcomes, or if HHS determines that the jurisdiction has failed to submit the required report on performance in benchmark areas.⁴¹

³⁷ HHS, ACF and HRSA, *The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Summary of Benchmark Measures Selected by Grantees*, Design Options for Home Visiting Evaluation (DOHVE) – A DOHVE TA Resource Document, July 2014.

³⁸ CRS correspondence with HHS, HRSA and ACF, November and December 2014.

³⁹ HHS, HRSA and ACF, “Maternal, Infant, and Early Childhood Home Visiting Program Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program,” no date, p. 17. (Hereinafter, HHS, HRSA and ACF, “Maternal, Infant, and Early Childhood Home Visiting Program Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program.”)

⁴⁰ Ibid.

⁴¹ Section 511(d)(1)(B).

According to HHS, nine jurisdictions (including both states and territories) failed to demonstrate improvement in at least four of six benchmark areas by the end of the third year of the program. Each of these grantees has developed an improvement plan that has been approved by HRSA. HRSA is monitoring implementation of the plans, and along with technical assistance providers has provided ongoing technical assistance. HHS has explained that the technical assistance is individualized for each jurisdiction, and includes an intensive site visit. HRSA will use FY2015 data, and FY2016 data if needed, to assess whether jurisdictions have made improvements in the benchmark areas (using FY2014 data as the baseline) under which the grantees previously did not show improvement.⁴²

Related to efforts to improve outcomes for participants, in 2013 HHS convened 35 teams from local home visiting service agencies as part of the Home Visiting Collaborative Improvement and Innovation Network (HVCoIIN). The purpose of the initiative was to encourage grantees to use data for both accountability and to drive improvements in services to families. The initiative was a short-term (6-18 months) learning activity that targets four program outcomes: (1) improve rates of initiation and extent of breast feeding; (2) improve the screening and surveillance of developmental delays and linking clients to appropriate services; (3) improve the screening, referral, and provision of services for maternal depression; and (4) improve family engagement in home visits. Within the first seven months of implementation, the initiative reported promising outcomes in each of these four areas.⁴³

Additional Requirements

The law also specifies other requirements for jurisdictions carrying out MIECHV programs. In addition to making improvements under the benchmark areas for eligible participating families overall, jurisdictions must also design their home visiting programs to assist individual families in the program. Jurisdictions are to conduct individualized assessments of the families and to make improvements in particular outcomes that are relevant to each participating family. Such desired individual family outcomes are nearly identical to the benchmark areas, except that the outcomes also include improvements in parenting skills and in cognitive, language, social-emotional, and physical developmental indicators.⁴⁴

Jurisdictions must also ensure that the program

- adheres to a clear, consistent home visiting model that meets the requirements for being research-based (discussed further in the next section) and is linked to the benchmark areas and outcomes for individual families;
- employs well-trained and competent staff, as demonstrated by education or training (such as nurses, social workers, educators, and child development specialists) and provides ongoing and specific training on the home visiting model;
- maintains high-quality supervision to establish “home visitor competencies”;
- demonstrates strong organizational capacity to implement the activities involved;
- establishes appropriate linkages and referral networks to other community resources and supports for eligible families; and

⁴² CRS correspondence with HHS, HRSA, October 2015.

⁴³ HHS, HRSA, “Early Childhood Development Newsletter: Home Visiting,” March 2015.

⁴⁴ Section 511(d)(2).

- implements the model with fidelity.⁴⁵

Jurisdictions may use MIECHV funding to supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives.⁴⁶ Finally, as discussed in the next section, jurisdictions must spend most of their MIECHV funds on specified home visiting models that meet certain standards of effectiveness.

Home Visiting Models

Jurisdictions must use at least 75% of their funds within a given fiscal year to carry out home visiting models that are “evidence-based.” As outlined in the statute, models are evidence-based if they

- have been in existence for at least three years;
- are associated with a national organization or institution of higher education that has comprehensive standards to ensure that services are high quality and that the program continuously makes improvements;
- are research-based and grounded in relevant empirically based knowledge; and
- have demonstrated significant positive outcomes in the benchmark areas and the desired individual family outcomes when evaluated using well-designed and rigorous quasi-experimental research designs or randomized controlled research design in which the evaluation results have been published in peer-reviewed journals.

In implementing the MIECHV program, HHS established criteria for determining which home visiting models have evidence of effectiveness after seeking public comment on the criteria (as required under the law).⁴⁷ The criteria expand on the requirements in the law about models that are linked to specified outcomes and demonstrate significant positive outcomes. The criteria are as follows:

- at least one high- or moderate-quality impact study of the model finds favorable, statistically significant impacts in two or more of eight outcome domains; or
- at least two high- or moderate-quality impact studies of the model using non-overlapping study samples find one or more favorable, statistically significant impacts in the same domain.⁴⁸

⁴⁵ Section 511(d)(3).

⁴⁶ Section 511(f).

⁴⁷ Section 511(d)(3)(iii). HHS, HRSA and ACF, “Maternal, Infant, and Early Childhood Home Visiting Program,” 75 *Federal Register*, July 23, 2010. HHS received approximately 140 comments and published the final criteria in HHS, HRSA and ACF, “Maternal, Infant, and Early Childhood Home Visiting Program Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program.” The proposed and final criteria are the same.

⁴⁸ HHS has determined that “high-quality” studies are those that use randomized control trials (RCTs, or “randomized controlled research design”) in which sample members are assigned to the program and comparison groups by chance. In addition, high-quality studies have low attrition of sample members and no reassignment of sample members after the original random assignment. Models evaluated with RCTs must demonstrate that one or more impacts in an outcome domain is sustained for at least one year after program enrollment, and one or more impacts in an outcome domain must be reported in a peer-reviewed journal. “Moderate-quality” studies are those that use quasi-experimental design with a comparison group, or random assignment design with high attrition or any reassignment of sample members. Quasi-experimental design refers to sample members who are selected for the program and comparison (continued...)

In this context, impact studies evaluate whether the home visiting model results in favorable outcomes for participants generally. As specified by HHS (and in accordance with the MIECHV law), the outcome domains are based on the combined benchmark areas and individual family outcomes for the program: (1) maternal health; (2) child health; (3) child development and school readiness; (4) positive parenting practices; (5) family economic self-sufficiency; (6) reductions in child maltreatment; (7) reductions in juvenile delinquency, family violence, and crime; and (8) linkages and referrals.

Jurisdiction may use up to 25% of their formula and/or competitively awarded funds for administering home visiting models that conform to a promising and new approach for achieving improved outcomes under the benchmark areas and improved family outcomes. The law specifies that such a “promising” model must have been developed or identified by a national organization or institution of higher education and will be evaluated through a well-designed and rigorous process.⁴⁹ HHS has further explained that a promising approach is one that meets the standards outlined in the statute but for which there is little to no evidence of effectiveness; one with evidence that does not meet the criteria for an evidence-based model; or a modified version of an evidence-based model that includes significant alterations to core components.⁵⁰

Home Visiting Evidence of Effectiveness (HomVEE)

In 2009, prior to implementation of ACA, HHS/ACF created the Home Visiting Evidence of Effectiveness (HomVEE) initiative to determine which home visiting models have shown evidence of effectiveness. The project has been incorporated into the MIECHV program. It annually (on a fiscal year basis) reviews the research literature on studies of models in which home visiting is the primary service strategy for pregnant women or families with children from birth to age 5.⁵¹ HomVEE prioritizes the home visiting models for further study based on a point system. Points are assigned to models based on their number and design of impact studies (with three points for each randomized control trial (RCT) and two points for each quasi-experimental design) and their sample size of impact studies (with one point for each study with a sample size of 250 or more). In addition, HomVEE reviewers determine whether the program is currently in operation and if additional information on the model can be gleaned from websites and others sources.

Of those models that receive sufficient points for further review, HomVEE examines applicable impact studies with RCTs and quasi-experimental designs and assigns each study a rating of high, moderate, or low quality. After reviewing studies for a model, HomVEE evaluates the evidence across all studies that receive a high or moderate rating and measure outcomes in at least one of the eight domains. The reviewers additionally examine and report on other aspects of the evidence for each model, based on all high- and moderate-quality studies available. These other aspects include (1) the quality of the outcome measures, to determine if they were collected through direct observation or were self-reported using a standardized instrument; (2) whether the impacts were measured at least one year after program services ended; (3) whether the impacts

(...continued)

groups in a nonrandom way (e.g., families may self-select into groups).

⁴⁹ Section 511(d)(3)(A)(i)(II). The law does not specify a time frame for when the evaluation is to be evaluated.

⁵⁰ HHS, HRSA and ACF, “Maternal, Infant, and Early Childhood Home Visiting Program Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program.”

⁵¹ This review involves searching research databases of studies published since 1989, and a more focused search on prioritized program models published since 1979. The search is updated annually to identify new literature.

were replicated and showed favorable, statistically significant impacts in the same outcome domain in at least two non-overlapping study samples; (4) whether subgroup findings could be replicated in the same outcome domain in at least two studies using different samples; (5) whether some impacts were unfavorable or ambiguous; (6) the funding source for each study and whether any of the study authors were program model developers; and (7) the magnitude of the impacts.

Nineteen Models Found to be Evidence-Based as of September 2015

As of September 30, 2015, HHS had identified 39 home visiting models as suitable for review and identified 19 of these models as having met the criteria for an evidence-based program.⁵² Of the 19 models, 10 have been implemented by one or more jurisdiction’s MIECHV program. The HomVEE project also reviewed home visiting models to examine specific impacts for American Indian and Alaska Native populations. One model, Family Spirit, had such impacts and is one of the 19 models that meet the HHS criteria.⁵³

Table 3 summarizes information on the number of jurisdictions implementing each evidence-based model in FY2015. In addition, five jurisdictions (Arkansas, Kansas, Tennessee, Virginia, and West Virginia) used a portion of their funds to implement a home visiting model in FY2015 that was promising, but not yet determined to be effective.⁵⁴ Specifically, these states are using 25% or less of their FY2014 formula grant allocation for this purpose.

Table 3. Evidence-Based Models Used by Jurisdictions with Funding Under the MIECHV Program, February 2015

There were 17 possible models as of February 2015, of which 10 were implemented

Evidence-Based Model	Number of Jurisdictions Using Model
Healthy Families America	41
Nurse-Family Partnership	40
Parents as Teachers	33
Early Head Start-Home Visiting	18
Home Instruction for Parents of Preschool Youngsters	8
SafeCare Augmented	4
Healthy Steps	3
Family Spirit	2

⁵² CRS review of HHS, ACF, Home Visiting Evidence of Effectiveness (HomVEE), *Model Reports*, <http://homvee.acf.hhs.gov/programs.aspx>, as of November 2014; and Sarah Avellar et al., “Home Visiting Evidence of Effectiveness Review,” Mathematica, for HHS, ACF, Office of Policy Research and Evaluation (OPRE), September 2013, revised June 2014. An additional model, Durham Connects/Family Connects was identified following this publication. See HHS, Health Resources and Services Administration (HRSA), Maternal and Child Health (MCH), “Home Visiting Models,” <http://mchb.hrsa.gov/programs/homevisiting/models.html>.

⁵³ Andrea Mraz Esposito, “Assessing the Evidence of Effectiveness of Home Visiting Models Implemented in Tribal Communities,” Mathematica, for HHS, ACF, Office of Policy Research and Evaluation (OPRE), September 2014.

⁵⁴ CRS correspondence with HHS, HRSA and ACF, October 2015.

Evidence-Based Model	Number of Jurisdictions Using Model
Child First	1
Family Check-Up	1

Source: CRS correspondence with HHS, HRSA and ACF, October 2015. Additional evidence-based home visiting models are Durham Connects/Family Connects, Early Intervention Program for Adolescent Mothers, Early Start (New Zealand), Maternal Early Childhood Sustained Home-Visiting Program, Minding the Baby, Oklahoma’s Community-Based Family Resource and Support Program, and Play and Learning Strategies.

Note: Table D-3 in Appendix D includes the home visiting model(s) adopted as of February 2015 by each state, territory, and four states (Florida, North Dakota, Oklahoma, and Wyoming) in which a nonprofit administers the MIECHV program.

HHS determined that each of the 19 models is effective in at least two of the eight areas that were included in the HHS criteria for evidence of effectiveness of home visiting models. Just over half of the models (11) target at-risk pregnant women, and all of them target parents and their young children. All but two models serve families with children under age one, and nearly all (15) serve children across multiple age ranges (birth to 23 months, 24 to 48 months, etc.). The models are implemented by a variety of entities that include hospitals, health clinics, or physicians; nonprofit and community-based organizations; a state governmental agency (e.g., child welfare or health care agency); Head Start agencies; and other types of entities (e.g., preschool and criminal justice programs).

All but four of the models require home visitors to meet certain minimum educational requirements. Home visitors are typically registered nurses, mental health professionals, social workers, or paraprofessionals; four of the models use two of these types of workers. Each model requires pre-placement training on the model, and the majority of the models (14 models) require ongoing training, as opposed to having voluntary training (5 models).⁵⁵ The caseload for home visitors varies, with a range of about 10 to 30 cases per worker (for 12 of the models); however, some models assign greater or fewer caseloads based on the needs of families. Many of the models call for weekly visits with the family for an initial period of time, and the visits often become less frequent over time. A few models specify a particular number of visits overall (ranging from 1 to 52 visits), and others provide a certain number of visits based on family needs. Four models provide additional types of interventions that include classes on preparing for motherhood and meetings with other program participants.⁵⁶ See Table D-1 and Table D-2 in Appendix D for further detail on the characteristics of the 19 models designated as effective.

Technical Assistance, Research, and Evaluation

Technical Assistance

The law directs the Secretary to provide technical assistance (TA) to grantees, specifically with regard to administering programs or activities that are funded by the MIECHV program.⁵⁷ In

⁵⁵ Section 511(d)(3)(B)(ii) of the Social Security Act requires that MIECHV-funded programs employ well-trained and competent staff, as demonstrated by education or training. Such staff can include nurses, social workers, educators, child development specialists, or other well-trained and competent professionals. The program should also provide ongoing and specific training on the model delivered.

⁵⁶ This is based on CRS review of the HomVEE website, which provides background about each model. This level of detail varies across models, and in some cases information is not available or is limited.

⁵⁷ Section 511(c)(4).

addition, HHS is to provide technical assistance to any jurisdiction that is required to implement an improvement plan because it failed to improve in the benchmark (or outcome) areas.⁵⁸ As mentioned, HHS/HRSA has convened an advisory panel to determine the technical assistance that is to be provided to any such jurisdiction.⁵⁹

HHS provides technical assistance through various resource centers. The MIECHV Technical Assistance Coordinating Center (TACC) is operated by Zero to Three, a national nonprofit organization that provides support to states and territories in implementing and improving their programs. TACC provides TA in partnership with other entities—the Association of Maternal & Child Health Programs (AMCHP), Chapin Hall Center for Children at the University of Chicago, and Walter R. McDonald and Associates. TACC delivers training and technical assistance to grantees through webinars, an e-newsletter, and an online portal designed for the exchange of information. In addition, TACC hosts regional forums on multiple topics for grantees.⁶⁰ ACF provides similar types of technical assistance to Tribal MIECHV grantees via Programmatic Assistance for Tribal Home Visiting (PATH), operated by Walter R. McDonald and Associates in partnership with other organizations.⁶¹

HHS also provides assistance to grantees through the Design Options for Maternal, Infant, and Early Childhood Home Visiting Evaluation (DOHVE) Technical Assistance Team. This team works in collaboration with TACC to assist grantees in strengthening their evaluation of promising programs, developing data and reporting on the federal benchmarks, and implementing quality improvement systems. MDRC, in partnership with James Bell Associates and other organizations, operate the DOHVE Technical Assistance Team.⁶² Tribal entities receive technical assistance on these same topics via the Tribal Home Visiting Evaluation Institute (TEI), also operated by MDRC in partnership with James Bell Associates, John Hopkins University, and the University of Colorado, Denver.⁶³

Research and Evaluation

The law directs the HHS Secretary to carry out a continuous program of research and evaluation activities to increase knowledge about home visiting programs, using random assignment designs when feasible.⁶⁴

The Secretary must appoint an independent advisory committee of experts in program evaluation and research, education, and early childhood development. The purpose of this panel is to review, and make recommendations, on the design and plan for a national evaluation of the MIECHV

⁵⁸ Section 511(d)(1)(B)(iii).

⁵⁹ Ibid.

⁶⁰ Valerie Lane, *MIECHV Technical Assistance Coordinating Center*, MIECHV Technical Assistance Coordinating Center, Zero to Three, <http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/Archive/2013/NovDec2013/Pages/Feature2.aspx>.

⁶¹ HHS, ACF, “Tribal MIECHV Technical Assistance,” <http://www.acf.hhs.gov/programs/ecd/home-visiting/tribal-home-visiting/technical-assistance>; and HHS, HRSA, “Early Childhood Development Newsletter: Home Visiting,” March 2015.

⁶² MDRC, *Design Options for Home Visiting Evaluation: Project Overview*, http://www.mdrc.org/project/design-options-home-visiting-evaluation#featured_content.

⁶³ HHS, ACF, *Tribal Home Visiting Evaluation Institute, 2011-2015* <http://www.acf.hhs.gov/programs/opre/research/project/tribal-home-visiting-evaluation-institute-2011-2015>; and HHS, HRSA, “Early Childhood Development Newsletter: Home Visiting,” March 2015.

⁶⁴ Section 511(g).

program. Based on these recommendations, the Secretary is to conduct an evaluation. The evaluation must include an (1) analysis of the results of the statewide needs assessments and state actions in response to the assessments; (2) an assessment of the effect of early childhood home visitation programs on child and parent outcomes, including with respect to the benchmark areas and the individual family outcomes (described previously); (3) an assessment of the effectiveness of home visiting programs on different populations, including the extent to which the ability of programs to improve participant outcomes varies across programs and populations; and (4) an assessment of the potential for the activities carried out under home visiting programs, if scaled broadly, to improve health care practices, health care system quality, and efficiencies; eliminate health disparities; and reduce costs.⁶⁵

HHS appointed the panel, and the evaluation is underway.⁶⁶ Known as the Mother and Infant Home Visiting Program Evaluation (MIHOPE), the evaluation is looking at programs that use four evidence-based home visiting models: Early Head Start-Home Visiting, Healthy Families America (HFA), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT). The MIHOPE study will include 5,100 families in 88 sites across 12 states who are (or will be) randomly assigned to receive home visiting services.⁶⁷ The evaluation is designed to address the requirements outlined in the law and will include (1) an analysis of state needs assessments, (2) an implementation study of local program services, (3) an impact analysis of the effects of MIECHV on child and family outcomes, and (4) an economic analysis of program costs and cost effectiveness. MDRC is conducting the evaluation, along with Mathematica, James Bell Associates, Johns Hopkins University, University of Georgia, and Columbia University. The MIECHV law directs the HHS Secretary to submit a report to Congress by March 31, 2015, on the results of the national evaluation. HHS issued a report to Congress in January 2015 that presents the first findings from the study.⁶⁸ This report provides an early look at implementation of MIECHV, including information on the needs identified by states and their plans for using MIECHV funds to meet those needs, a description of where the study is being conducted, information about families in the study, and a discussion of whether plans for local home visiting programs reflect the requirements. Families were being recruited for the study through calendar

⁶⁵ Section 511(h)(3).

⁶⁶ (1) HHS, ACF and HRSA, *Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Plans for the 2015 Report to Congress*, September 12, 2013, http://www.acf.hhs.gov/sites/default/files/opre/mihope_sac_materials_revised_0.pdf. (Hereinafter, HHS, ACF and HRSA, *Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Plans for the 2015 Report to Congress*.) (2) Charles Michalopoulos et al., *The Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Early Findings on the Maternal, Infant, and Early Childhood Home Visiting Program, A Report to Congress*, for HHS, ACF, OPRE, OPRE Report 2015-11, January 2015, http://www.acf.hhs.gov/sites/default/files/opre/mihope_report_to_congress_final.pdf. (Hereinafter, Charles Michalopoulos et al., *The Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Early Findings on the Maternal, Infant, and Early Childhood Home Visiting Program, A Report to Congress*.) (3) MDRC, MIHOPE Newsletter, *MIHOPE Update*, May 2015. For a list of advisory committee members, see HHS, ACF, *Advisory Committee on the Maternal, Infant, and Early Childhood Home Visiting Program: Roster*, http://www.acf.hhs.gov/sites/default/files/opre/miechvpe_roster_september_2013.pdf.

⁶⁷ As of August 2015, more than 4,100 participants had been enrolled in MIHOPE. In-person interviews with program participants were underway. In addition, the second phase of the study was underway, which involves members of the study team visiting the parents or primary caregivers in their homes and conducting a survey interview with parents or caregivers when their children are about 15 months old. For further information, see MDRC, *MIHOPE News*, September 2014 and August 2015, <http://www.mdrc.org/mihope-news-september-2014> and <http://www.mdrc.org/mihope-newsletter-august-2015>.

⁶⁸ Charles Michalopoulos et al., *The Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Early Findings on the Maternal, Infant, and Early Childhood Home Visiting Program, A Report to Congress*.

year 2014, and therefore information on the effectiveness and costs of home visiting programs are not available in the report.

As part of an initial analysis of state needs assessments, the study found that states generally proposed using MIECHV funds in counties with high rates of risk indicators and to implement the four models studied in MIHOPE. The states involved in the study are using MIECHV funds to expand at least two of the four evidence-based models and are each planning to support five or more eligible local programs. Given that the study is continuing to recruit families, the initial report discusses characteristics of about one-third of the families who will eventually be enrolled. Nearly 70% of the mothers in the study were pregnant at the time they enrolled, with an average age of 23 at enrollment. Women in the study exhibited healthy behavior and were in good health; however, more than a third reported using tobacco and almost 60% exhibited symptoms of anxiety or depression. Nearly all families in the study were receiving some government benefits. Consistent with the statute, all four of the MIHOPE models intend to serve families at risk of poor child outcomes and most prioritized the outcomes mentioned in the authorizing legislation. According to the study, MIECHV encouraged some local programs to broaden the outcomes they focused on. Home visitors reported that were generally well trained and supported in working with families to address outcomes.⁶⁹

In addition to the MIHOPE evaluation, the MIHOPE expansion evaluation (MIHOPE-Strong Start) is examining birth and health outcomes for mothers and infants through the Strong Start for Mothers and Newborns (Strong Start) initiative. Strong Start is carried out by the Centers for Medicare and Medicaid (CMS). The initiative is examining whether nonmedical prenatal interventions, when provided in addition to routine medical care, can improve health outcomes for pregnant women and newborns and decrease the cost of medical care during pregnancy, delivery, and over the course of the child's first year of life. One of those interventions is home visiting.⁷⁰

The MIHOPE-Strong Start evaluation is a component of the Strong Start initiative and seeks to determine whether home visiting services can impact health outcomes for disadvantaged pregnant women. The evaluation plans enroll 3,400 pregnant women from HFA and NFP sites in 75 local home visiting programs in 17 states. Families are being randomly assigned to a home visiting group (program group) or to a non-home visiting group (control group). Recipients will include pregnant women who have Medicaid or CHIP (Children's Health Insurance Program) and are interested in and eligible for home visiting services. The evaluation will include an implementation study and an impact analysis of the outcomes in three areas: (1) birth outcomes, (2) maternal prenatal health and health care use, and (3) infant health and health care use. It is also intended to provide information relevant to CMS actuaries on how participation in such programs might affect Medicaid costs. The evaluation was designed by CMS and ACF, is funded by CMS (without MIECHV funds), and is implemented in partnership with HRSA.⁷¹

⁶⁹ Section 511(h)(3).

⁷⁰ HHS, Centers for Medicare and Medicaid, *Strong Start for Mothers and Newborns Initiative; Enhanced Prenatal Care Models*, <http://innovation.cms.gov/initiatives/Strong-Start-Strategy-2/index.html>.

⁷¹ MDRC is conducting the evaluation, along with Mathematica, James Bell Associates, Johns Hopkins University, and New York University. The first Strong Start report on the evaluation was issued in December 2013. The first report provides an overview of the evaluation design, the components of each of the two programs, and the outcomes that will be measured. According to this report, HHS will issue subsequent reports for each year of the study. A final report will provide detailed information about how the program was implemented and impact results for the full sample of enrolled families. Jill H. Filene et al., *The Mother and Infant Home Visiting Program Evaluation-Strong Start: First Annual Report*; for HHS, ACF, Office of Planning, Research and Evaluation (OPRE), OPRE Report 2013-54, (continued...)

Separate from the efforts to evaluate home visiting programs funded under MIECHV, HHS also provides MIECHV funding to the Tribal Early Childhood Research Center (TRC), which also receives funding from the HHS-funded Head Start and Child Care programs. The TRC seeks to partner with American Indian and Alaska Native communities, programs, practitioners, and researchers to advance research into young children's development and early childhood programs and to facilitate the translation of research findings to inform early childhood practice with American Indian and Alaska Native children and families. The TRC is carried out by the University of Colorado, Johns Hopkins University, and Michigan State.⁷²

Recent Congressional and Executive Branch Action

On January 9, 2014, the House Energy and Commerce Committee held a hearing on the extension of health care policies that included discussion of the MIECHV program.⁷³ Two witnesses from HHS testified about how the MIECHV program has been carried out and on the screening and use of evidence-based models selected by jurisdictions in the program. On April 1, 2014, the President signed into law the Protecting Access to Medicare Act of 2014 (P.L. 113-93), which extended funding for the MIECHV program through March 31, 2015 (the law also extended funding for other health care programs and policies). On April 2, 2014, the House Ways and Means Committee held a hearing on the MIECHV program. Witnesses included a home visiting nurse and her client, an administrator of a home visiting program, and two researchers.⁷⁴ They discussed how the program works in practice, both from the perspectives of program staff and the client. In addition, researchers discussed the current research on home visiting, including the efficacy of selected home visiting models.

As mentioned, Congress passed and the President enacted the Protecting Access to Medicare Act of 2014 (P.L. 113-93). The act, signed into law on April 1, 2014, provided funding of \$400 million for the first half of FY2015 (October 1, 2014, through March 31, 2015). The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10), signed into law on April 16, 2015, extended the \$400 million made available under P.L. 113-93 through all of FY2015 (October 1, 2014, through September 30, 2015).⁷⁵ P.L. 114-10 also provided \$400 million for each of FY2016 and FY2017 under the program.

(...continued)

December 2013, http://www.acf.hhs.gov/sites/default/files/opre/mihope_ss_final_12_24_13.pdf. The second report was issued in January 2015. It describes the study's efforts to acquire birth certificate records and Medicaid data from states targeted for MIHOPE-Strong Start to assess the key health outcomes of interest. The report focuses on the challenges with accessing such data. Helen Lee, Anne Warren, and Lakhpreet Gill, *Cheaper, Faster, Better: Are State Administrative Data the Answer? The Mother and Infant Home Visiting Program Evaluation-Strong Start, Second Annual Report*, MDRC, for HHS, ACF, OPRE, OPRE Report 2015-09, January 2015. The third report was issued in June 2015. It provides further information about the design of the evaluation. Charles Michalopoulos et al., *Design for the Mother and Infant Home Visiting Program Evaluation-Strong Start*, MDRC for HHS, ACF, OPRE, OPRE Report 2015-63, June 2015.

⁷² University of Colorado, Centers for American Indian and Alaska Native Health, *Tribal Early Childhood Research Center*, <http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/trc/Pages/TRC.aspx>.

⁷³ U.S. Congress, House Committee on Energy and Commerce, *The Extenders Policies: What Are They and How Should They Continue Under a Permanent SGR Repeal Landscape?*, 113th Cong., 2nd sess., January 9, 2014, H.Hrg. 113-111 (Washington: GPO, 2014).

⁷⁴ U.S. Congress, House Committee on Ways and Means, Subcommittee on Human Resources, *The Maternal and Early Childhood Homevisiting Program*, 113th Cong., 2nd sess., April 2, 2014, H.Hrg. 109-59 (Washington: GPO, 2014).

⁷⁵ In other words, the law allows HHS to obligate FY2015 funds through the end of FY2015 but otherwise does not (continued...)

Appendix A. Legislative History of Home Visiting

Federal Efforts to Establish a Home Visiting Program

Congressional and executive branch interest in early childhood home visiting programs predated the Affordable Care Act and implementation of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Since 2004, Congress has considered home visiting legislation and held related hearings across multiple committees. Some of these efforts have supported selected home visiting models and/or particular aspects of home visiting, such as its role in promoting parent and child education, responding to domestic violence, and reducing child maltreatment.

The Education Begins at Home Act (S. 2412; 108th Congress) was introduced in 2004, sought to authorize a stand-alone home visiting program, and would have directed the Departments of Education and Health and Human Services to collaboratively award grants to support home visiting. It would have also amended the Early Head Start program to establish standards for home visiting staff. The bill was not taken up; however, several similar bills were introduced in subsequent years.⁷⁶ One of these bills (the Education Begins At Home Act, H.R. 3628; 109th Congress) was the focus of a hearing by the House Education and the Workforce Committee.⁷⁷ At the hearing, Representative Osborne said that home visiting can “deliver parent education and family support services directly to parents with young children and aim to offer guidance to parents on how to support their children’s development from birth through their enrollment in kindergarten.”⁷⁸ Other witnesses, including representatives from two home visiting programs (Parents as Teachers and Nurse-Family Partnership), testified about the role of home visiting in improving multiple child and family outcomes in education, health, and other domains.

In 2006, the Violence Against Women and Department of Justice Reauthorization Act of 2005 (P.L. 109-162) was signed into law. It authorized \$7.0 million each fiscal year for FY2007-FY2011 for the Department of Justice to develop and implement policies and procedures to help home visitors address the effect of domestic violence on pregnant women as well as young children and their parents. Congress did not appropriate funds for the program, and the Violence Against Women Reauthorization Act of 2013 (P.L. 113-4) repealed the authorizing language.

Congress subsequently funded a home visiting pilot program that had been proposed by the Bush Administration in the FY2008 budget request and had a child maltreatment focus. As part of the request, the Administration sought \$10 million (as a set-aside within the discretionary activities account of the Child Abuse Prevention and Treatment Act, CAPTA) for competitive grants to

(...continued)

change the level of funding for FY2015. Under P.L. 113-93, HHS had until March 31, 2015, to obligate all FY2015 funding. HHS reported that all funds had been obligated by this date.

⁷⁶ The Education Begins at Home Act appeared to draw inspiration from the Head Start Improvements for School Readiness Act (S. 1940), and was (re)introduced in the House and the Senate in the 109th Congress (S. 503 and H.R. 3628) and 110th Congress (S. 667 and H.R. 2343). Related legislation was also introduced around this same time: the Prevention of Childhood Obesity Act (S. 2894) in 2004; the Prevention of Childhood Obesity Act (S. 799) and the Head Start Improvements for School Readiness Act (S. 1107) in 2005; and the Balancing Act of 2007 (H.R. 2392) and the Healthy Children and Families Act of 2007 (S. 1052 and H.R. 3024) in 2007.

⁷⁷ U.S. Congress, House Committee on Education and the Workforce, *Perspectives on Early Childhood Home Visitation Programs*, 109th Cong., 2nd sess., September 27, 2006, H.Hrg. 109-59 (Washington: GPO, 2006). Two years later, in the 110th Congress, the committee marked up and reported a bill of the same name but with some differences (H.R. 2343; H.Rept. 110-818).

⁷⁸ Ibid, Statement of the Honorable Tom Osborne.

expand, upgrade, or develop home visiting programs that have “proven effective models,” and to support a national cross-site evaluation to examine factors associated with successful replication or expansion of such models.⁷⁹ To support this initiative, Congress provided \$10 million in FY2008 and \$13.5 million in FY2009 as a set-aside from the CAPTA discretionary activities account. Funding in years 3 through 5 of the initiative was provided under MIECHV.

This initiative—Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment (EBHV)—was carried out by ACF, which awarded cooperative agreements to 17 grantees (mostly private, nonprofit organizations; state or local agencies; or hospitals or medical centers) in 15 states. The goals of the initiative were to (1) support implementation with fidelity to home visiting program models; (2) help scale-up home visiting models, by replicating the program in a new area, adapting the model for a new population, or increasing enrollment capacity in an existing service area; and (3) help sustain the home visiting model beyond the end of the grant period. EBHV funding was not used to cover the full cost of direct home visiting services; instead, grantees used other funding sources for such services. Grantees were expected to adopt home visiting models that, as defined by ACF, were evidence-based programs.⁸⁰

Each grantee worked with one or more implementing agencies to deliver home visiting services to families or served as the agency and provided services directly. The implementing agencies used one or more of the following five models in carrying out home visiting services: Healthy Families America, Nurse-Family Partnership, Parents as Teachers, SafeCare, and Triple P. In addition to the cooperative agreements, 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.

The evaluation found that the grantees generally adhered to standards that measured fidelity to a home visiting model; however, they often struggled to maintain caseloads and deliver services as intended. In addition, the grantees participated in activities to build infrastructure and partnerships. Such activities included strengthening fiscal capacity through partnering and fundraising, building community awareness or political support for programs, and evaluating and monitoring programs. The evaluation found that grantees with greater investment in these activities tended to achieve the initiative’s goals.⁸¹

While the EBHV initiative was underway, the Obama Administration proposed a new capped entitlement program as part of its FY2010 budget request for grants to states, territories, and tribes to establish and expand evidence-based home visitation programs for low-income mothers and pregnant women. The program was intended to “create long-term positive impacts for children and their families, as well as generate long-term positive impacts for society as a whole.” Under the proposal, the Administration sought to give priority to funding for home visiting

⁷⁹ HHS, ACF, *Justification of Estimates for Appropriations Committees, Fiscal Year 2008*, pp. 115-116.

⁸⁰ Criteria for such evidence-based programs included the following: (1) there must be no evidence that the home visiting program would constitute a substantial risk of harm to participants; (2) the program must identify outcomes and describe activities that are related to those outcomes; and (3) the evaluation research supporting the efficacy of the program must be based on at least rigorous randomized controlled trials (RCTs) that were reported in published, peer-reviewed journals; and (4) meet other related criteria related to sustaining the effects of the program over time.

⁸¹ Kimberly Boller et al., *Making Replication Work: Building Infrastructure to Implement, Scale-up, and Sustain Evidence-Based Early Childhood Home Visiting Programs with Fidelity*, Mathematica Policy Research, for HHS, ACFY, ACF, Children’s Bureau, January 2014, http://www.mathematica-mpr.com/~media/publications/PDFs/earlychildhood/EBHV_makingreplication.pdf. (Hereinafter Kimberly Boller et al., *Making Replication Work: Building Infrastructure to Implement, Scale-up, and Sustain Evidence-Based Early Childhood Home Visiting Programs with Fidelity*.)

models “that have been rigorously evaluated and shown to have positive effects on critical outcomes for families and children.” The proposal also included provisions to ensure that states and other jurisdictions would adhere to a proven program model and sought to direct some of this funding for technical assistance and program assessment and monitoring. The Administration requested \$124 million for an initial year of the program and envisioned a “gradual growth” in the program so that it would, in 10 years (as of FY2019), reach an estimated 450,000 new families at a cost of \$1.8 billion.⁸²

Home Visiting as Part of Health Reform

At the same time that Congress was considering whether to fund the Obama Administration’s initiative,⁸³ other home visiting proposals were moving forward in the House and the Senate. In June 2009, the House Ways and Means Subcommittee on Income Security and Family Support held a hearing on early childhood home visitation programs, related research, and a bill introduced by members of the subcommittee (H.R. 2667) to establish a home visiting program. Witnesses included researchers, an administrator of state-funded home visitation programs, a former participant and current home visitor, and a nurse consultant. The witnesses generally supported broader implementation of early childhood home visiting models with a proven record of positive outcomes for families based on rigorous research.⁸⁴

In November 2009, the House passed the Affordable Health Care for America Act (H.R. 3962). The bill included two home visiting provisions. Section 1713 specified that the Medicaid program support home visits by trained nurses. This section appeared to draw from the Healthy Children and Families Act of 2007 (H.R. 3024/S. 1052). Section 1904 sought to provide a program for home visiting, to be funded at \$750 million over five years (FY2010-FY2014). This section appears to have been drawn primarily from H.R. 2667, which had been introduced earlier in 2009. Separate health care reform efforts in the Senate culminated in the passage of the Patient Protection and Affordable Care Act (H.R. 3590) on December 24, 2009; the bill included the MIECHV program. H.R. 3590 was taken up by the House on March 21, 2010, and was signed into law on March 23, 2010, as P.L. 111-148.⁸⁵

HHS first allocated funding for the MIECHV program in FY2010. As the MIECHV program was implemented, the EBHV grantees entered into subcontracts with the MIECHV lead agency in their states, and these states received additional funds from FY2010 through FY2012 to pass through to EBHV grantees. Some of the EBHV grantees received MIECHV funds to allow them to sustain services beyond the EBHV funding period or to expand services. However, some of the grantees were using models that did not meet HHS criteria under the MIECHV program for being effective and therefore were ineligible for funding.⁸⁶

⁸² HHS, ACF, *Justification of Estimates for Appropriations Committees, Fiscal Year 2010*, p. 267.

⁸³ The FY2009 budget resolution in both the House (H.Con.Res. 85) and the Senate (S.Con.Res. 13, as amended by S.Amdt. 880) included reserve language for home visiting programs.

⁸⁴ U.S. Congress, House Committee on Ways and Means, Subcommittee on Income Security and Family Support, *Hearing on Proposals to Provide Federal Funding for Early Childhood Home Visitation Programs*, 111th Cong., 1st sess., June 9, 2009, H.Hrg. 111-24 (Washington: GPO, 2010).

⁸⁵ P.L. 111-148 was amended by the Health Care and Education Reconciliation Act (P.L. 111-152), but these amendments did not affect the MIECHV program.

⁸⁶ Kimberly Boller et al., *Making Replication Work: Building Infrastructure to Implement, Scale-up, and Sustain Evidence-Based Early Childhood Home Visiting Programs with Fidelity*.

Appendix B. MIECHV Funding by State and Territory

Table B-1. MIECHV Formula and Competitive Grant Funding by State and Territory, FY2014-FY2015

	FY2014 Formula Grant	FY2014 Competitive Grant	Total FY2014 Funding	FY2015 Formula Grant	FY2015 Competitive Grant	Total FY2015 Funding
Alabama	\$1,929,999	\$6,384,589	\$8,314,588	\$2,103,623	\$0	\$2,103,623
Alaska	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$2,344,479	\$3,344,479
Arizona	\$2,606,162	\$8,751,040	\$11,357,202	\$2,854,557	\$8,809,435	\$11,663,992
Arkansas	\$1,269,015	\$5,794,012	\$7,063,027	\$1,369,547	\$7,801,146	\$9,170,693
California	\$11,923,154	\$8,751,040	\$20,674,194	\$13,201,834	\$9,400,000	\$22,601,834
Colorado	\$1,387,778	\$6,792,534	\$8,180,312	\$1,501,443	\$8,450,000	\$9,951,443
Connecticut	\$1,000,000	\$8,571,850	\$9,571,850	\$1,000,000	\$9,400,000	\$10,400,000
Delaware	\$1,000,000	\$4,235,617	\$5,235,617	\$1,000,000	\$0	\$1,000,000
District of Columbia	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$0	\$1,000,000
Florida	\$5,801,252	\$0	\$5,801,252	\$6,402,965	\$8,361,139	\$14,764,104
Georgia	\$4,049,695	\$0	\$4,049,695	\$4,457,718	\$9,310,630	\$13,768,348
Hawaii	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$8,430,783	\$9,430,783
Idaho	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$3,200,000	\$4,200,000
Illinois	\$3,652,101	\$2,511,741	\$6,163,842	\$4,016,157	\$9,399,351	\$13,415,508
Indiana	\$2,221,339	\$8,486,876	\$10,708,215	\$2,427,180	\$9,400,000	\$11,827,180
Iowa	\$1,000,000	\$6,124,800	\$7,124,800	\$1,000,000	\$0	\$1,000,000
Kansas	\$1,000,000	\$0	\$1,000,000	\$1,056,142	\$9,400,000	\$10,456,142
Kentucky	\$1,712,449	\$8,576,944	\$10,289,393	\$1,862,016	\$0	\$1,862,016
Louisiana	\$1,976,345	\$7,989,378	\$9,965,723	\$2,155,095	\$9,389,965	\$11,545,060
Maine	\$1,000,000	\$8,740,242	\$9,740,242	\$1,000,000	\$0	\$1,000,000
Maryland	\$1,255,134	\$6,117,470	\$7,372,604	\$1,354,131	\$7,412,419	\$8,766,550

	FY2014 Formula Grant	FY2014 Competitive Grant	Total FY2014 Funding	FY2015 Formula Grant	FY2015 Competitive Grant	Total FY2015 Funding
Massachusetts	\$1,331,952	\$8,720,679	\$10,052,631	\$1,439,443	\$0	\$1,439,443
Michigan	\$3,194,711	\$6,681,600	\$9,876,311	\$3,508,188	\$0	\$3,508,188
Minnesota	\$1,250,187	\$7,424,000	\$8,674,187	\$1,348,637	\$9,400,000	\$10,748,637
Mississippi	\$1,573,578	\$0	\$1,573,578	\$1,707,789	\$0	\$1,707,789
Missouri	\$2,001,926	\$0	\$2,001,926	\$2,183,504	\$0	\$2,183,504
Montana	\$1,000,000	\$5,224,070	\$6,224,070	\$1,000,000	\$0	\$1,000,000
Nebraska	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$0	\$1,000,000
Nevada	\$1,050,524	\$961,615	\$2,012,139	\$1,126,895	\$0	\$1,126,895
New Hampshire	\$1,000,000	\$1,356,158	\$2,356,158	\$1,000,000	\$3,775,229	\$4,775,229
New Jersey	\$1,922,005	\$8,751,040	\$10,673,045	\$2,094,745	\$9,400,000	\$11,494,745
New Mexico	\$1,022,912	\$3,574,127	\$4,597,039	\$1,096,229	\$3,000,877	\$4,097,106
New York	\$5,705,155	\$0	\$5,705,155	\$6,296,241	\$9,400,000	\$15,696,241
North Carolina	\$3,562,511	\$0	\$3,562,511	\$3,916,661	\$0	\$3,916,661
North Dakota	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$0	\$1,000,000
Ohio	\$3,772,726	\$0	\$3,772,726	\$4,150,121	\$8,457,000	\$12,607,121
Oklahoma	\$1,494,597	\$7,452,000	\$8,946,597	\$1,620,074	\$9,025,081	\$10,645,155
Oregon	\$1,314,666	\$6,681,600	\$7,996,266	\$1,420,246	\$9,399,810	\$10,820,056
Pennsylvania	\$3,171,406	\$8,609,642	\$11,781,048	\$3,482,306	\$9,400,000	\$12,882,306
Rhode Island	\$1,000,000	\$5,357,069	\$6,357,069	\$1,000,000	\$9,272,115	\$10,272,115
South Carolina	\$1,838,453	\$6,680,778	\$8,519,231	\$2,001,954	\$6,492,893	\$8,494,847
South Dakota	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$0	\$1,000,000
Tennessee	\$2,338,635	\$7,454,368	\$9,793,003	\$2,557,447	\$9,374,047	\$11,931,494
Texas	\$10,442,961	\$6,681,600	\$17,124,561	\$11,557,960	\$9,400,000	\$20,957,960
Utah	\$1,000,000	\$7,000,000	\$8,000,000	\$1,043,901	\$0	\$1,043,901

	FY2014 Formula Grant	FY2014 Competitive Grant	Total FY2014 Funding	FY2015 Formula Grant	FY2015 Competitive Grant	Total FY2015 Funding
Vermont	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$0	\$1,000,000
Virginia	\$1,799,010	\$5,842,230	\$7,641,240	\$1,958,149	\$6,244,950	\$8,203,099
Washington	\$1,891,214	\$8,700,754	\$10,591,968	\$2,060,549	\$9,398,651	\$11,459,200
West Virginia	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$9,400,000	\$10,400,000
Wisconsin	\$1,536,448	\$6,681,600	\$8,218,048	\$1,666,553	\$9,400,000	\$11,066,553
Wyoming	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$0	\$1,000,000
American Samoa	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$0	\$1,000,000
Guam	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$0	\$1,000,000
Northern Mariana Islands	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$0	\$1,000,000
Puerto Rico	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$0	\$1,000,000
U.S. Virgin Islands	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$0	\$1,000,000
<i>Total Funding</i>	<i>\$116,000,000</i>	<i>\$217,663,063</i>	<i>\$333,663,063</i>	<i>\$125,000,000</i>	<i>\$260,750,000.00</i>	<i>\$385,750,000</i>

Source: Congressional Research Service (CRS) based on data provided by HHS, HRSA, February 2015.

Notes: The table displays grant obligations for states and territories only, and does not include obligations for tribal entities, research, evaluation, technical assistance, and federal administration. Obligations are as of the end of each fiscal year.

The formula awards include formula funds that are allocated to states; territories; and three nonprofit organizations that operate home visiting programs in states that have declined formula funding. North Dakota received regular formula funding for FY2010; declined this funding for FY2011; and received nonprofit formula funding for each of FY2012 through FY2015. Florida and Wyoming received regular formula funding for FY2010 and FY2011; declined this funding in FY2012; and received nonprofit formula funding for each of FY2013 through FY2015. Oklahoma received regular formula funding for FY2010, FY2011, FY2012, and FY2015; declined this funding in FY2013; and received nonprofit formula funding for FY2014. CRS correspondence with HHS, HRSA, February 2015.

The competitive awards include those for development grants and expansion grants to states and territories and grants to tribal entities. Development grants focus on building the capacity of the workforce, data infrastructure, and care coordination and referral systems. Expansion grant support efforts already underway and expand services to more families and communities. HHS separately awards competitive grants to tribal entities to operate home visiting programs under the Tribal MIECHV program.

Appendix C. Timeline for the MIECHV Program

Table C-1. Relevant Dates for the MIECHV Program

Date	Activity
March 23, 2010	The Patient Protection and Affordable Care Act (ACA; P.L. 111-148) established the MIECHV program under Section 511 of the Social Security Act.
September 20, 2010	All states, the District of Columbia, and the five territories were required to submit statewide needs assessments as a condition of receiving funding under the Maternal and Child Health Block Grant for FY2011.
May-June 2010	Jurisdictions were required to submit final statewide needs assessments.
March 22, 2011	The HHS Secretary was required to appoint an independent advisory panel to review and make recommendations on the design of an evaluation that examines the statewide needs assessments, and effects of the home visiting programs on child and parent outcomes and the potential effects on broader health outcomes.
October 1, 2012	If a state had not applied or been approved for a MIECHV grant, the HHS Secretary could provide grants for the home visiting program in that state to be conducted by a nonprofit organization with an established record of providing early childhood home visitation programs in one or more states. (Such grants have since been awarded to three nonprofit organizations that operate MIECHV programs in Florida, North Dakota, Oklahoma, and Wyoming.)
October 30, 2014	Most states (including Oklahoma, whose MIECHV program is operated by a nonprofit organization) and all territories were required to submit a report to HHS to demonstrate improved outcomes in four of six benchmark areas for the first three years of the program.
December 31, 2014	The first cohort of Tribal MIECHV grantees were required to submit a report HHS to demonstrate improved outcomes in four of six benchmark areas for the first three years of the program.
March 31, 2015	HHS must submit a report to Congress on the results of the national evaluation. The evaluation must include an (1) analysis of the results of the statewide needs assessments and state actions in response to the assessments; (2) assessment of the effect of early childhood home visitation programs on child and parent outcomes, including with respect to the benchmark areas and the individual family outcomes (described previously); (3) assessment of the effectiveness of home visiting programs on different populations, including the extent to which the ability of programs to improve participant outcomes varies across programs and populations; and (4) assessment of the potential for the activities carried out under home visiting programs, if scaled broadly, to improve health care practices, health care system quality, and efficiencies; eliminate health disparities; and reduce costs. Early results from the evaluation were submitted in January 2015. ^a
December 31, 2015	HHS must submit a report to Congress regarding the programs conducted with MIECHV grants. The report must include information regarding the programs carried out using MIECHV funding. It must include information on the extent to which grantees demonstrate improved outcomes in the six benchmark areas and any technical assistance provided by the Secretary to grantees that were required to develop and implement an improvement plan because they did not demonstrate improvements in at least four of the areas.
October 30, 2016	The three nonprofit organizations that operate MIECHV programs in Florida, North Dakota, and Wyoming must submit a report to HHS to demonstrate improvements (if any) in six “benchmark” areas for the first three years of the program.
September 30, 2017	This is the last day that jurisdictions can expend funds appropriated for FY2015.

Source: Section 511 of the Social Security Act and CRS correspondence with HHS/HRSA, November and December 2014.

- a. Charles Michalopoulos et al., *The Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Early Findings on the Maternal, Infant, and Early Childhood Home Visiting Program*, A Report to Congress.

Appendix D. Home Visiting Models Used Under the MIECHV Program

Table D-1. Selected Characteristics of Home Visiting Models That Meet HHS Criteria for Being Evidence-Based Under the MIECHV Program

19 Models as of September 30, 2015

	Target Population						Intensity				Caseload	Favorable Results in Outcome Domains								
	Pregnant Women	Birth to 11 Months	12 to 23 Months	24 to 35 Months	36 to 47 Months	48+ Months	Program Intervention	Interventions Vary Based on Family Needs	Visits and Services Diminish in Frequency	Intervention May Be Longer	Number of Families (over specified period, if known) Per Home Visitor	Maternal Health	Child Health	Child Development and School Readiness	Positive Parenting Practices	Family Economic Self-Sufficiency	Reductions in Child Maltreatment	Reductions in Juvenile Delinquency, Family Violence, and Crime	Linkages and Referrals	
Child First		X	X	X	X	X	Weekly home visits for 6 to 12 months.		X	X	14-18	X		X			X			X
Durham Connects/Family Connects		X					One home visit.	X		X	5-7 per week	X	X		X	X				X
Early Head Start-Home Visiting	X	X	X	X			Weekly home visits and group socialization.	X			10-12			X	X	X				X
Early Intervention Program for Adolescent Mothers	X	X					17 home visits (2 prenatal, 15 postpartum) at set intervals; and 4 "preparation for motherhood" classes.						X			X				

	Target Population						Intensity				Caseload	Favorable Results in Outcome Domains							
	Pregnant Women	Birth to 11 Months	12 to 23 Months	24 to 35 Months	36 to 47 Months	48+ Months	Program Intervention	Interventions Vary Based on Family Needs	Visits and Services Diminish in Frequency	Intervention May Be Longer	Number of Families (over specified period, if known) Per Home Visitor	Maternal Health	Child Health	Child Development and School Readiness	Positive Parenting Practices	Family Economic Self-Sufficiency	Reductions in Child Maltreatment	Reductions in Juvenile Delinquency, Family Violence, and Crime	Linkages and Referrals
Early Start (New Zealand)	X	X	X	X	X	X	Up to 3 contact hours per week, including direct and indirect contact. ^a	X			30 case load points ^b		X	X	X		X		
Family Check-Up				X	X	X	Not available				Not available	X		X	X				
Family Spirit		X	X	X			63 independent lessons in six domains taught during 52 home visits.	X	X		20-25	X		X	X				
Health Access Nurturing Development Services	X	X	X				A screening, followed by weekly visits.	X	X		20-30	X	X		X		X		
Healthy Beginnings (Australia, program is no longer active) ^c	X	X					8 home visits at set intervals.		X		50	X	X	X	X				
Healthy Families America	X	X	X	X	X	X	At least one home visit per week until child age 6 months.	X	X	X	15-25	X	X	X	X	X	X	X	X

	Target Population						Intensity				Caseload	Favorable Results in Outcome Domains							
	Pregnant Women	Birth to 11 Months	12 to 23 Months	24 to 35 Months	36 to 47 Months	48+ Months	Program Intervention	Interventions Vary Based on Family Needs	Visits and Services Diminish in Frequency	Intervention May Be Longer	Number of Families (over specified period, if known) Per Home Visitor	Maternal Health	Child Health	Child Development and School Readiness	Positive Parenting Practices	Family Economic Self-Sufficiency	Reductions in Child Maltreatment	Reductions in Juvenile Delinquency, Family Violence, and Crime	Linkages and Referrals
Healthy Steps		X	X	X			Up to a 5 home visits at set intervals. ^d	X		X	150-300 ^e		X		X				
Home Instruction for Parents of Preschool Youngsters					X	X	30 week curriculum for parents of 3-, 4-, and 5-year-olds. Curriculum differs by age group. Group meetings offered monthly.	X	X		10-25			X	X				
Maternal Early Childhood Sustained Home-Visiting Program	X	X	X				Minimum 25 home visits that begin during pregnancy.			X	30	X	X		X				

	Target Population						Intensity				Caseload	Favorable Results in Outcome Domains							
	Pregnant Women	Birth to 11 Months	12 to 23 Months	24 to 35 Months	36 to 47 Months	48+ Months	Program Intervention	Interventions Vary Based on Family Needs	Visits and Services Diminish in Frequency	Intervention May Be Longer	Number of Families (over specified period, if known) Per Home Visitor	Maternal Health	Child Health	Child Development and School Readiness	Positive Parenting Practices	Family Economic Self-Sufficiency	Reductions in Child Maltreatment	Reductions in Juvenile Delinquency, Family Violence, and Crime	Linkages and Referrals
Minding the Baby	X	X	X				27-month program beginning in 3 rd trimester of pregnancy, and involving 8-10 weekly visits during pregnancy, weekly visits until age 1, and biweekly visits until age 2.		X		24	X	X						
Nurse Family Partnership	X	X	X				Weekly home visits for the first month; then every other week until the baby is born; weekly for first six weeks after birth; and biweekly until baby is 20 months. Last four visits are monthly until the child is 2 years old.		X		25	X	X	X	X	X	X	X	

	Target Population						Intensity				Caseload	Favorable Results in Outcome Domains							
	Pregnant Women	Birth to 11 Months	12 to 23 Months	24 to 35 Months	36 to 47 Months	48+ Months	Program Intervention	Interventions Vary Based on Family Needs	Visits and Services Diminish in Frequency	Intervention May Be Longer	Number of Families (over specified period, if known) Per Home Visitor	Maternal Health	Child Health	Child Development and School Readiness	Positive Parenting Practices	Family Economic Self-Sufficiency	Reductions in Child Maltreatment	Reductions in Juvenile Delinquency, Family Violence, and Crime	Linkages and Referrals
Oklahoma's Community-Based Family Resource and Support Program	X	X					Eight prenatal visits and 12 postnatal visits until child reaches age 1.		X		Not available	X			X				
Parents as Teachers	X	X	X	X	X	X	12 home visits annually. Group "connections" (meetings) also offered. ^f	X	X		60 visits per month			X	X	X	X		
Play and Learning Strategies		X	X	X			11 to 13 weekly sessions, depending on child's age.	X			12-15			X	X				
SafeCare Augmented		X	X	X	X	X	Weekly or biweekly home visits.	X			10-12	X		X	X		X		X

Source: CRS review of HHS, ACF, Home Visiting Evidence of Effectiveness (HomVEE), *Model Reports*, <http://homvee.acf.hhs.gov/programs.aspx>, as of November 2014.

Note: The HomVEE website includes varying level of detail about the models, and in some cases, information is not available or is limited. The spaces left blank indicate that information is not applicable. HHS established the criteria for evidence of effectiveness, including that models meet at least one of the following: (1) at least one high- or moderate-quality impact study of the model finds favorable, statistically significant impacts in two or more of eight outcome domains; (2) at least two high- or moderate-quality impact studies of the model using non-overlapping study samples find one or more favorable, statistically significant impacts in the outcome domains listed in the table.

- a. Early Start includes four levels of intensity, with level 1 being weekly contact and level 4 being a graduate of the program with up to one hour of contact per three months. Indirect contact can include paperwork that is completed by the family and visitor.

- b. Home visitor caseloads are calculated by allocating case load points (CLP) to each family based on its service level. For example, a family enrolled in level one has an allocation of 2.75 CLP.
- c. Healthy Beginnings was a demonstration project designed by researchers from Sydney and South Western Sydney Local Health Districts Health Promotion Service and the University of Sydney, in Australia. It was implemented from 2007 to 2010.
- d. Health Steps includes three levels of intensity, with high-intensity involving a minimum of five home visits with additional home visits as needed and with low-intensity being two home visits.
- e. The number of families that a Healthy Steps Specialist serves varies depending on the (1) intensity of the Healthy Steps intervention implemented, (2) characteristics and needs of the families being served, and (3) amount of administrative support provided. It is unclear which period of time home visitors have this caseload.
- f. PAT affiliates are required to provide services for at least two years. Affiliates may choose to focus services primarily on pregnant women and families with children from birth to age 3; others may offer services from pregnancy to kindergarten.
- g. The expectation for completing monthly visits is based on parent educators having two hours per visit for planning and travel, having time for other responsibilities such as recruitment activities, and have time for planning and participating in group connections.

Table D-2. Implementing Agencies and Home Visiting Staff Associated with Home Visiting Models That Meet HHS Criteria for Being Evidence-Based Under the MIECHV Program

19 Models as of September 30, 2015

	Type of Implementing Agency				Required Training of Home Visiting Staff				Educational Requirements of Home Visiting Staff				
	Health Clinic, Hospital, or Physician	Nonprofit or Community Based Organization	Government Agency	Other	Pre-service Optional	Pre-service Required	In-Service Optional	In-Service Required	Minimum Education Requirement	Registered Nurses (RN) or Physician	Mental Health or Developmental Clinician	Social Workers	Paraprofessionals (e.g. Training in child development)
Child First		X				X		X	X		X		X
Durham Connects/Family Connects						X		X		X		X	
Early Head Start-Home Visiting		X	X			X	X						X
Early Intervention Program for Adolescent Mothers			X	X				X	X	X			
Early Start (New Zealand)		X				X		X	X	X		X	
Family Check-Up				X		X		X	X		X		
Family Spirit	X			X		X	X		X				X
Health Access Nurturing Developing Services			X			X		X	X	X		X	X
Healthy Beginnings (Australia, program no longer active) ^a				X		X		X	X	X			
Healthy Families America						X	X						
Healthy Steps	X	X				X	X		X				X

	Type of Implementing Agency				Required Training of Home Visiting Staff				Educational Requirements of Home Visiting Staff				
	Health Clinic, Hospital, or Physician	Nonprofit or Community Based Organization	Government Agency	Other	Pre-service Optional	Pre-service Required	In-Service Optional	In-Service Required	Minimum Education Requirement	Registered Nurses (RN) or Physician	Mental Health or Developmental Clinician	Social Workers	Paraprofessionals (e.g. Training in child development)
Home Instruction for Parents of Preschool Youngsters	X	X	X	X		X	X					X	X
Maternal Early Childhood Sustained Home-Visiting Program	X					X		X	X	X			
Minding the Baby	X					X		X	X	X			
Nurse Family Partnership		X				X		X	X	X			
Oklahoma's Community-Based Family Resource and Support Program			X			X		X	X				X
Parents as Teachers		X	X	X		X		X	X				X
Play and Learning Strategies		X		X		X		X	X				X
SafeCare Augmented	X	X	X			X		X					X

Source: CRS review of HHS, ACF, Home Visiting Evidence of Effectiveness (HomVEE), *Model Reports*, <http://homvee.acf.hhs.gov/programs.aspx>, as of November 2014.

- a. Healthy Beginnings was a demonstration project designed by researchers from Sydney and South Western Sydney Local Health Districts Health Promotion Service and the University of Sydney, in Australia. It was implemented from 2007 to 2010.

**Table D-3. Home Visiting Models Adopted by States and Territories
Under the MIECHV Program, as of February 2015**

10 Adopted Out of 17 Models (at the time) That Met HHS Criteria for Being Evidence-Based

<i>State or Territory</i>	Healthy Families America	Nurse-Family Partnership	Parents as Teachers	Early Head Start-Home Visiting	Home Instruction for Parents of Preschool Youngsters	Healthy Steps	SafeCare Augmented	Family Spirit	Child First	Family Check-Up
Alabama		X	X		X					
Alaska		X								
Arkansas	X	X	X		X					
Arizona	X	X						X		
California	X	X								
Colorado		X	X		X	X	X			
Connecticut		X	X	X					X	
District of Columbia	X		X		X					
Delaware	X	X	X							
Florida	X	X	X							
Georgia	X	X	X	X						
Hawaii	X		X	X	X					
Idaho		X	X	X						
Illinois	X	X	X	X	X					
Indiana	X	X								
Iowa	X	X		X						
Kansas	X		X	X						
Kentucky	X									

<i>State or Territory</i>	Healthy Families America	Nurse-Family Partnership	Parents as Teachers	Early Head Start-Home Visiting	Home Instruction for Parents of Preschool Youngsters	Healthy Steps	SafeCare Augmented	Family Spirit	Child First	Family Check-Up
Louisiana		X	X							
Maine			X							
Maryland	X	X		X						
Massachusetts	X		X	X		X				
Michigan	X	X		X						
Minnesota	X	X								
Mississippi	X									
Missouri		X	X	X						
Montana		X	X				X	X		
Nebraska	X									
Nevada		X		X	X					
New Hampshire	X									
New Jersey	X	X	X		X					
New Mexico		X	X				X			
New York	X	X								
North Carolina	X	X								
North Dakota	X		X							
Ohio	X	X								
Oklahoma	X	X	X				X			
Oregon	X	X		X						
Pennsylvania	X	X	X	X						

State or Territory	Healthy Families America	Nurse-Family Partnership	Parents as Teachers	Early Head Start-Home Visiting	Home Instruction for Parents of Preschool Youngsters	Healthy Steps	SafeCare Augmented	Family Spirit	Child First	Family Check-Up
Rhode Island	X	X	X							
South Carolina	X	X	X			X				X
South Dakota		X								
Tennessee	X	X	X							
Texas		X	X	X	X					
Utah	X	X	X	X						
Vermont		X								
Virginia	X	X	X							
Washington		X	X							
West Virginia	X		X	X						
Wisconsin	X	X	X	X						
Wyoming			X							
America Samoa	X									
Guam	X		X							
Northern Mariana Islands	X									
Puerto Rico	X									
U.S. Virgin Islands	X	X								
Total	40	39	33	18	8	3	3	2	1	1

Source: CRS correspondence with HHS, HRSA and ACF, October 2015.

Note: Five jurisdictions (Arkansas, Kansas, Tennessee, Virginia, and West Virginia) used a portion of their funds to implement a home visiting model in FY2015 that was promising, but not yet determined to be effective.

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