



Home, but Not Alone: Evidence-Based Maternal, Infant, and Early Childhood Home Visitation

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OVERVIEW — Home visitation services for young and expectant families have the potential to improve child and parent outcomes in a broad variety of ways, but the effectiveness of home visits may depend on the nature, frequency, and duration of these services. The Patient Protection and Affordable Care Act of 2010 (PPACA) created a new federal funding stream to promote the development and implementation of evidence-based home visiting programs. This issue brief provides an overview of the newly established Maternal, Infant, and Early Childhood Home Visiting program, describes existing approaches to home visitation, and discusses the implications of federal funding for state and local practices.

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Prenatal and early childhood development represents a critically sensitive window of opportunity (and vulnerability) in a child's life. An ever-expanding evidence base documents the intersecting and reinforcing nature of physical, emotional, cognitive, and social development in early childhood and demonstrates that early experiences and exposures irrevocably set the stage for future outcomes.¹ Early intervention to mitigate risks and maximize protective influences has the potential to significantly improve children's overall well being, as well as reduce the societal costs associated with poor health and academic failure.

Over the past two decades, home visitation has become an increasingly popular tool for early intervention. States and communities have developed many different approaches to home visitation—some focused on improving maternal health and birth outcomes, others on reducing child abuse and neglect, others on promoting school readiness, and still others on achieving multiple program goals. A recent survey conducted by the Pew Center on States found a total of 117 home visiting programs across 46 states. At least 33 states have implemented more than one program, and 20 states administer three or more different types of home visiting models.²

While grounded in the common principle that early intervention can profoundly influence a child's life course, the nature and structure of these home visiting programs can vary substantially depending on purpose and population served. Although most home visiting programs focus on the needs of low-income families, eligibility for services varies widely. Some programs are designed to serve families with pre-school children, while others engage women during pregnancy. Referral sources for home visitation services differ across programs and include local public health and social service agencies, schools, primary care providers, hospital discharge planners, and self-referrals. Even among programs with comparable target populations and objectives, significant differences can be found in design, duration, intensity, staffing, and evidence of effectiveness.

Multiple funding sources have been used to develop and maintain these diverse home visitation programs. State and local governments

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have made significant investments of their own resources but have also leveraged flexibility in existing federal funding streams, such as the Title V Maternal and Child Health Block Grant, Temporary Assistance for Needy Families (TANF), Medicaid, Healthy Start, Early Head Start, and the Individuals with Disabilities Education Act (IDEA) Part C early intervention program.³ The first dedicated federal support for home visitation began in 2008 when the Administration for Children and Families (ACF) launched a competitive demonstration project to implement home visiting services and evaluate their effectiveness for preventing child abuse and neglect (see text box, page 6).

The Patient Protection and Affordable Care Act of 2010 (PPACA) created a new federal funding stream⁴ that promises to provide \$1.5 billion over five years to states, tribes, and territories for the development and implementation of maternal, infant, and early childhood home visitation programs. The Department of Health and Human Services (HHS) has been charged with implementing the new Maternal, Infant and Early Childhood Home Visiting (MIECHV) program through the collaborative efforts of the Health Resources and Services Administration (HRSA) and ACF. The home visiting grants represent a significant expansion of maternal and child health programs authorized under Title V, as well as a somewhat novel approach to federal funding for state public health activities. In addition to creating an unprecedented federal investment in maternal, infant, and early childhood home visitation, the new program also takes the unusual step of channeling funding to evidence-based programs.

Evidence-based practices have an obvious appeal, but moving home visiting services toward evidence-based models is likely to be a complex and challenging undertaking. Only some of the programs currently operating are likely to meet the evidentiary standard set for the new federal grants. Therefore, states will face some difficult decisions regarding the expansion of programs determined to be evidence-based, as well as the continuation and evaluation of existing home visiting services not proven to be effective.

PROMOTING EVIDENCE-BASED PRACTICE

Newly available federal funds create strong incentives for states to adopt or expand evidence-based home visiting programs. PPACA

both authorizes and appropriates significant funding for evidence-based maternal, infant, and early childhood home visitation: \$100 million for fiscal year (FY) 2010, \$250 million for FY 2011; \$350 million for FY 2012, \$400 million for FY 2013, and \$400 million for FY 2014. State allotments in FY 2010 were determined by formula⁵ on the basis of the number of children living in families with incomes at or below 100 percent of the federal poverty level. (FY 2010 funding levels by state are summarized in Appendix A).

Unrestricted awards of \$500,000 per state were made in July 2010 to support initial planning efforts, and the remainder of funds will be released following the submission of updated state implementation plans. In future years HHS plans to award all increased grant funding above the 2010 baseline on a competitive basis in order to encourage exemplary programs. No matching funds are required, but states must agree to maintain state general fund support for all activities that will benefit from federal grants.

States must dedicate the majority of federal grant funds to evidence-based home visiting programs, but some funding is available to test innovative new approaches. Statutory language stipulates that at least 75 percent of funding is restricted to supporting service delivery models that

- 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 high-quality service delivery and continuous program quality improvement, and
- have demonstrated significant, positive outcomes when evaluated using a rigorous, well-designed study (either a randomized controlled research design or a quasi-experimental design).

States may use up to 25 percent of funds to implement promising new models that have not yet demonstrated effectiveness but will be evaluated through a well-designed process. States must also demonstrate that grant-funded programs (whether evidence-based or promising new models) result in measureable improvements for participating families and are required to establish three- and five-year benchmarks in the areas of (i) maternal and newborn health; (ii) child injuries, child abuse, neglect, or maltreatment, and emergency department visits; (iii) school readiness and achievement; (iv) crime or domestic violence; (v) family economic self-sufficiency; and (vi) the coordination and referrals for other community resources and supports.

Evidence-Based Models Identified

Using formal review criteria (summarized in the text box below), HHS has identified seven widely implemented home visiting models as eligible for evidence-based federal home visiting funds:

- Early Head Start: Home-based option
- Family Check Up
- Healthy Families America
- Healthy Steps
- Home Instruction Program for Preschool Youngsters (HIPPY)
- Nurse-Family Partnership (NFP)
- Parents as Teachers (PAT)

Appendix B summarizes key characteristics of these national models, and more detailed information on the content of and evidence supporting these programs is available through the Home Visiting

Criteria for Evidence-Based Home Visiting Programs

HHS considers program impacts in the eight benchmark domains identified by Congress:

- Maternal health
- Child health
- Child development and school readiness (including improvements in cognitive, language, social-emotional or physical development)
- Prevention of child injuries and maltreatment
- Parenting skills
- Reductions in crime or domestic violence
- Improvements in family economic self-sufficiency
- Improvements in the coordination and referrals for other community resources and supports

A service delivery model will be considered eligible for evidence-based funding if at least one high- or moderate- quality impact study finds favorable, statistically significant impacts in two or more of the eight outcome domains OR at least two high- or moderate- quality impact studies using different, nonoverlapping analytic samples find one or more favorable, statistically significant impacts in the same domain. HHS criteria for rating the quality of study designs are based on a variety of factors. In general, randomized controlled trials and certain quasi-experimental designs qualify as high-quality studies. See HomVEE* for additional details on study rating criteria.

* HomVEE, "Review Process: Producing Study Ratings," available at <http://homvee.acf.hhs.gov/document.aspx?rid=4&sid=19&mid=5>.

Evidence of Effectiveness (HomVEE) website.⁶ These models differ from one another in a number of ways, with average annual cost per family ranging from approximately \$1,500 to \$6,500. Despite these variations, all of these approved programs have been determined

ACF Demonstration Grants

In 2008 the Administration for Children and Families (ACF) launched a demonstration grant program entitled "Supporting Evidence-based Home Visitation Programs to Prevent Child Maltreatment." The five-year grant program funded 17 cooperative agreements in 15 states to support the implementation and evaluation of six different home visiting models.

Three of the models funded by the ACF demonstration project (Nurse-Family Partnership, Healthy Families, and Parents and Teachers) were later approved as evidence-based programs by HHS. Among the other three models funded by ACF (Safecare, Positive Parenting Program, and Family Connections), only Safecare was reviewed by HHS,* and the evidence was found insufficient to determine program effectiveness. However, evidence currently being developed through the ACF demonstration project may be available to support applications for federal funding in future years.

* HHS prioritized models for review based on the number of available impact studies and the prevalence of model implementation nationally.

to meet HHS's requirements for evidence of effectiveness, have been implemented in multiple sites across the country, use clearly defined program standards, and are routinely monitored to ensure compliance with these standards.

The number of existing programs that conform to these models and are certain to be eligible for evidence-based funding is somewhat unclear. Implementation of approved evidence-based models appears widespread across the country. The Pew Center on the States found that at least 35 states have implemented programs that conform to one or more of these approved models.⁷ Investments in Healthy Families America, NFP, and PAT appear the most substantial. Respectively, these models accounted for 9 percent, 6 percent,

and 3 percent of the \$1.36 billion⁸ states made available for home visiting services in FY 2009–2010.⁹

Evidence-based funding through the MIECHV program will not necessarily be limited only to the seven evidence-based national models that have been reviewed and approved by HHS. States have the opportunity to provide evidence of effectiveness for any model or models they choose to propose in their grant applications. Such evidence will be reviewed using the same criteria applied to the national models. States can also apply to use the 25 percent of their allotment that is available for promising programs in order to build an evidence base that can be reviewed in the future.

Programs with Insufficient Evidence of Effectiveness

Programs not yet identified as evidence-based by HHS can be divided into three broad categories: national models with insufficient evidence of effectiveness, models developed by individual states, and community-level programs.

- **National models with insufficient evidence of effectiveness** — Four prevalent models reviewed by HHS—Healthy Start-Home Visiting, Parent-Child Home, Resource Mothers Program, and Safecare—did not meet the established evidence criteria. At least six states¹⁰ have implemented one or more of these unapproved national models.¹¹ In all cases, HHS did not conclude that the models were ineffective, only that the available evidence is insufficient to determine program effectiveness.
- **State models** — At least 30 states¹² have developed “home grown” state models that have been implemented widely within each state, use a consistent program design, and define program standards. These state models sometimes represent adaptations of evidence-based national models (commonly referred to as evidence-informed models). Other states have blended the designs of different national home visiting models or complemented these models with supplemental services related to substance abuse and mental health counseling.¹³ States have made these adaptations for a variety of reasons including cost considerations, staff recruitment challenges, and quality improvement efforts. The eligibility of these programs for evidence-based funding is unclear. Anecdotal accounts suggest that states have rarely invested in formal evaluations of homegrown programs and existing evidence is unlikely to meet established criteria. However, HRSA has indicated that adaptations to evidence-based models will be permitted if model developers determine that these adaptations have not altered core design components related to program impact.
- **Community-level programs** — Home visiting services are also provided at the community level in conjunction with a variety of programs that serve mothers, infants, and young children, such as Early Head Start, Healthy Start, IDEA, and child protective services. Unlike the national and state models described above, these community-based home visiting services may not adhere to well-defined program standards. Therefore the nature and content of these services can vary significantly across implementation sites and sometimes across individual home visitors within program sites.

IMPLEMENTATION STRATEGIES AND CHALLENGES

Although some states may ultimately elect to forgo federal funding for home visiting services, all states were required to complete a home visiting needs assessment as a condition of receiving their Title V Maternal and Child Block Grant. Needs assessments were due to HHS in September 2010 and were required to (i) identify communities that have a concentration of risk factors for premature birth, low-birth weight infants, infant mortality, poor maternal and child health, poverty, crime, domestic violence, high drop-out rates, substance abuse, unemployment, and child maltreatment; (ii) describe the quality and capacity of existing programs or initiatives for prenatal, infant, and early childhood home visitation; and (iii) characterize capacity for substance abuse treatment and counseling services.¹⁴

The needs assessments were designed to help states determine both where new or additional evidence-based home visiting services are needed and how to use federal funds to initiate or expand the implementation of these services. These decisions rest in large part on the nature and reach of existing home visiting programs and the degree to which these programs are likely to meet the evidentiary standard established by HHS.

States seeking federal grant support through the newly established MIECHV program must submit an updated state plan to HHS by June 2011. This plan must both identify the at-risk population(s) for whom home visiting services will be funded under the MIECHV and provide a rationale for why the targeted population was selected from among the at-risk communities identified in the state's needs assessment. States are encouraged to ensure that proposed services will be complementary to, rather than duplicative of, existing services.

The clearest path to securing federal funds under the new program is to adopt (or expand) implementation of one of the seven approved national models. For the states that do not have a prior history implementing these programs, adopting these models may represent a significant management challenge. States must determine if they will discontinue existing programs, pilot new models alongside established programs, or modify existing programs to meet the standards associated with approved models.

States that have implemented adaptations of approved models may consider making the programmatic changes necessary to conform to model program standards. Such changes may be relatively minor (such as increasing the frequency of visits) or significant (such as altering qualification requirements for home visitor personnel). Not-for-profit organizations that monitor model fidelity and support implementation typically require affiliated programs to pay licensing, training, and other fees, so even administrative changes could have substantial cost implications.¹⁵

Expansion of approved evidence-based programs to unserved populations is arguably less challenging in states that already have experience implementing these models. However, such states must still determine where to target additional federal resources. States are required to give priority to serving families who are determined to be at-risk using the measures specified in the needs assessment, as well as other indicators, including low-income, young maternal age, and involvement with child protective services.

Although the risk profile of target populations is a major factor in the development of implementation plans, the fit between model and population must also be considered. Identifying appropriate expansion populations is more complex than may first appear and raises difficult questions about who is best served by each program model. For example, NFP is specifically limited to first-time mothers, who account for approximately 40 percent of births each year.¹⁶ Evidence also suggests that none of the approved models may be effective for the highest risk families (such as those with substance abuse or mental health problems, or those experiencing domestic violence).¹⁷ Particularly in states where approved models have already been widely implemented, these limitations may force some difficult decisions about which populations should be targeted for program expansions.

Beyond determining where and to whom additional home visiting services will be offered, states face a variety of challenges in bringing evidence-based programs to scale. Replicating the results of controlled trials and demonstration projects in new settings or for new populations is often difficult. Even among programs with rigorous mechanisms in place to ensure fidelity to evidence-based models, results may vary across populations and stage of program maturation at a particular site. A recent study examining the success of NFP following statewide implementation in Pennsylvania found that program effects were muted in the first three years of program

implementation, presumably due to diminished effectiveness as the service infrastructure was being developed at new sites.¹⁸ Also, the study found that program effects were stronger among both younger participants and participants living in rural locations, although the reasons for these differences are unclear.

Confusion regarding maintenance of effort (MOE) requirements has further complicated the development of state implementation plans. Authorizing legislation requires MOE, and HRSA guidance indicates that non-federal funding must be maintained at levels observed on the date of PPACA enactment (March 23, 2010). Many states have experienced recent across-the-board cuts in their health and human services budgets, and it is uncertain whether these cuts will disqualify programs from MIECHV funding. Also, states remain unsure of which expenditures must be included in MOE calculations. HRSA has indicated that MOE requirements apply only to evidence-based home visiting activities. It is unclear whether states will be required to maintain expenditures for existing home visiting programs that do not currently meet evidence of effectiveness criteria but may be adapted to conform to evidence-based models using federal funds.

AUGMENTING THE EVIDENCE BASE

Some states are likely to seek funding for home visiting programs not currently approved by HHS. Experts believe that relatively few states have already conducted the level of evaluation needed to satisfy HHS evidence review criteria on their state-developed programs. Therefore, most applications to implement unapproved models are likely to seek funding through the 25 percent of grant funds available for promising programs.

Establishing evidence of effectiveness through well-designed, rigorous studies is resource-intensive and time consuming. The number of states willing to make these investments in order to assess the effectiveness of unapproved national models or home-grown programs is unclear. Conducting effectiveness research on community-based programs that lack consistent practices will be particularly challenging. However, the desire to eliminate wasteful spending on programs that may be ineffective could motivate necessary investments in effectiveness research.

Research needs extend far beyond effectiveness assessments of discrete home visitation models. Myriad opportunities exist for improving the quality and delivery of home visiting services, even among evidence-based programs. Experts have raised a variety of questions meriting further research including:

- To what extent is the effectiveness of home visiting services dependent on the breadth and quality of other maternal and child health services (for example, prenatal care, developmental services)?
- Which aspects of model design appear most critical to program effectiveness? To what extent should oversight of model fidelity focus on these high-impact design features?
- Which models work best for achieving which goals for which populations? Are the needs of the highest risk populations, such as families experiencing problems with mental health, substance abuse, and domestic violence, adequately met by existing evidence-based programs? What adaptations improve effectiveness for these populations?
- What are the most successful approaches to coordinating different types of home visiting models with different programmatic goals?

The new federal program has been heralded as an important catalyst for building the evidence base surrounding home visitation. Federal funding specifically encourages the evaluation of untested or unproven models, but experts hope that increased study and scrutiny will more broadly advance the entire field of home visiting programs and facilitate sharing of best practices across models.

CONCLUSION

Newly established federal funding opportunities promise to significantly increase the number of families with access to evidence-based home visitation services and have the potential to accelerate state efforts to learn from (and add to) this evidence base. Yet, the capacity of states to leverage these funds varies depending on the nature of existing home visiting services, the ability to invest in the adoption or expansion of evidence-based models, and the willingness to assess the effectiveness of unproven approaches. The initial emphasis of the MIECHV program may be the expansion of specific home visiting programs that have been shown to “work.” But as

the program evolves and the evidence base expands, increased attention may be given to the development of a more nuanced understanding of how home visitation can best support improvements in child and parent outcomes within a broader continuum of maternal and child health services.

ENDNOTES

1. Neal Halfon, Helen DuPlessis, and Moira Inkelas, "Transforming the U.S. Child Health System," *Health Affairs*, 26, no. 2 (March/April 2007): pp. 315–330, available with subscription at <http://content.healthaffairs.org/content/26/2/315.abstract>.
2. Pew Center on the States, "Pew Home Visiting Inventory - National Overview," available at www.pewcenteronthestates.org/initiatives_detail.aspx?initiativeID=61054.
3. Kay Johnson, "State-based Home Visiting: Strengthening Programs through State Leadership," National Center for Children in Poverty, February 2009, available at www.nccp.org/publications/pdf/text_862.pdf.
4. Section 511 under Title V of the Social Security Act.
5. FY 2010 funds were distributed to states using a formula determined by (i) an equal base allocation of \$500,000 for each state; (ii) an amount equal to the funds, if any, currently provided under the Supporting Evidence Based Home Visiting (EBHV) Program administered by the Administration for Children and Families; and (iii) an amount based on the number of children in families at or below 100% of the federal poverty level in the state as compared with the number of such children nationally.
6. <http://homvee.acf.hhs.gov>.
7. Pew Center on the States, "State Home Visiting Programs and Investments, FY 2010," updated November 23, 2010, available at www.pewcenteronthestates.org/uploadedFiles/wwwpewcenteronthestatesorg/Initiatives/Home_Visiting/Home_Visiting_Index/home_visiting_inventory_state_list.pdf?n=5669.
8. Federal funds newly available in FY 2010 represent a 7 percent increase in home visiting funding relative to existing state support.
9. Pew Center on the States, "Pew Home Visiting Inventory."
10. California, Georgia, Massachusetts, Pennsylvania, Oklahoma, and Virginia.
11. Pew Center on the States, "State Home Visiting Programs and Investments, FY 2010," and Administration for Children and Families, "Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment: Project Summary," available at www.acf.hhs.gov/programs/cb/programs_fund/discretionary/visitation/ebhv_project_description.pdf.
12. Pew Center on the States, "State Home Visiting Programs and Investments, FY 2010."

13. Johnson, "State-based Home Visiting."
14. "Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program: Supplemental Information Request for the Submission of the Statewide Needs Assessment," available at www.hrsa.gov/grants/apply/assistance/homevisiting/homevisitingsupplemental.pdf.
15. Refer to the implementation reports available at <http://homvee.acf.hhs.gov/implementations.aspx> for more detailed information on the fees associated with each model.
16. Joyce A. Martin *et al.*, *Births: Final Data for 2007*, National Center for Health Statistics, National Vital Statistics Reports, 58, no. 24 (August 9, 2010), available at www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_24.pdf.
17. Johnson, "State-based Home Visiting," p. 15.
18. David M. Rubin *et al.*, "Variation In Pregnancy Outcomes Following Statewide Implementation of a Prenatal Home Visitation Program," *Archives of Pediatric and Adolescent Medicine*, 165, no. 3 (March 2011): pp. 198–204.

Appendix A: Approximate Fiscal Year 2010 Funding Levels by State or Territory for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

State/Territory	Funding (\$)	State/Territory	Funding (\$)
Alabama	\$1,414,473	Nevada	\$881,142
Alaska	584,256	New Hampshire	599,503
Arizona	1,792,003	New Jersey*	2,035,554
Arkansas	1,145,502	New Mexico	951,952
California**	7,782,987	New York*	3,897,893
Colorado*	1,842,294	North Carolina	2,134,807
Connecticut	829,224	North Dakota	583,156
Delaware*	1,280,893	Ohio*	3,047,074
District of Columbia	606,115	Oklahoma*	1,920,105
Florida	3,193,733	Oregon	1,061,379
Georgia	2,419,658	Pennsylvania	2,070,398
Hawaii*	1,298,018	Rhode Island*	1,304,596
Idaho	763,792	South Carolina*	2,036,888
Illinois*	3,135,997	South Dakota	635,074
Indiana	1,546,658	Tennessee**	3,047,046
Iowa	889,743	Texas*	6,918,471
Kansas	904,690	Utah*	1,535,817
Kentucky	1,374,345	Vermont	557,408
Louisiana	1,502,540	Virginia	1,411,739
Maine	667,546	Washington	1,311,814
Maryland	997,636	West Virginia	855,628
Massachusetts	1,096,728	Wisconsin	1,160,815
Michigan	2,014,745	Wyoming	562,864
Minnesota*	1,701,396	American Samoa	500,000
Mississippi	1,301,012	Guam	500,000
Missouri	1,500,096	No. Mariana Islands	500,000
Montana	651,999	Puerto Rico	500,000
Nebraska	740,789	Virgin Islands	500,000
Total Awards:		\$87,999,989	

*States with one evidence-based home visiting (EBHV) program grantee site. ** States with two EBHV program grantee sites.

Source: Health Resources and Services Administration, "Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program, Funding Opportunity Announcement," issued June 10, 2010, revised July 1, 2010, p. 46.

FY 2010 funds were distributed to states using a formula determined by: (i) an equal base allocation of \$500,000 for each state; (ii) an amount equal to the funds, if any, currently provided under the Supporting Evidence Based Home Visiting (EBHV) Program administered by the Administration for Children and Families; and (iii) an amount based on the number of children in families at or below 100 percent of the federal poverty level in the state as compared with the number of such children nationally.

Appendix B: Summary of Evidence-Based Models Identified By HHS

Model & Target Population	Goals	Service Onset, Duration, and Frequency	Staffing Qualifications and Training
<p>Early Head Start: Home-based option</p> <p>Low-income pregnant women and families with children birth to age 3 years.</p>	<ul style="list-style-type: none"> Promote healthy prenatal outcomes for pregnant women Enhance development of very young children Promote healthy family functioning 	<p>Services begin prenatally and last through age 3 years.</p> <p>One home visit per week per family (with a minimum of 32 home visits per year) lasting for a minimum of 1.5 hours each.</p> <p>A minimum of 2 group socialization activities per month for each family (with a minimum of 16 group socialization activities each year).</p>	<p>Approximately 62 percent of home visitors have at least an associate's degree in early childhood education or related discipline; 43 percent have a bachelor's degree or higher.</p> <p>Programs are required to provide pre-service orientation to new staff, as well as ongoing opportunities for training and professional development through a structured system, with the potential for academic credit where possible.</p>
<p>Family Check Up</p> <p>Families with children age 2 to 17 years old with risk factors including socioeconomic challenges, family and child risk factors for child conduct problems, academic failure, depression, and risk for early substance use.</p>	<p>Prevent problem behavior for youth and families, including the prevention of substance use, delinquency, and high-risk behaviors that occur during developmental transitions.</p>	<p>Age of service initiation varies.</p> <p>Services consist of at least three sessions, which are usually conducted in the home.</p> <p>After the first three sessions, the home visitor makes recommendations for a variety of family-based interventions, which vary in intensity and duration depending on family need. These options include (i) monthly to weekly follow-up support, either in person or by phone, (ii) assistance with specific child behavior problems or parent issues, (iii) parent management training, (iv) preschool/day care/school consultations, and (v) community referrals.</p>	<p>Doctoral or master's degree in psychology or a related field and previous experience carrying out family-based interventions is recommended. If given additional support, staff with bachelor's or associate's degree may provide home visits.</p> <p>Staff training is designed and provided by the Child and Family Center at the University of Oregon.</p>

Model & Target Population	Goals	Service Onset, Duration, and Frequency	Staffing Qualifications and Training
<p>Healthy Families America (HFA) Families with preschool-age children or pregnant women identified as "at risk" using a standardized assessment tool (sites may choose particular target populations within this group).</p>	<ul style="list-style-type: none"> Prevent child abuse and neglect Enhance child health and development Promote positive parenting 	<p>During pregnancy or within two weeks of child's birth with visits continuing through child's enrollment in either preschool (age 3 or 4) or kindergarten (age 5).</p> <p>For the first six months, visits are intended to be weekly, after which visits are intended to occur twice each month.</p>	<p>Home visitors may, but are not required to, have a bachelor's degree in social work, education, or nursing.</p> <p>Home visitors receive four days of "primary" training on supporting healthy child development, positive parent-child relationships, improved parental problem-solving skills, and family support systems. Visitors also receive about 80 hours of wraparound training (e.g., local challenges and resources) during their first six months on the job.</p>
<p>Healthy Steps for Young Children Parents with children from birth to age 3.</p>	<p>Improve the physical, emotional, and intellectual growth and development of children from birth to age 3.</p>	<p>Home visits offered soon after a newborn is discharged from the hospital and at key developmental stages.</p> <p>Services can be delivered at different levels of intensity, chosen at the site. High-intensity sites offer five home visits: at birth–1 month, 9–12 months, 18 months, 24 months, and 30 months. Medium-intensity sites offer three home visits: at birth–1 month, 9–12 months, and 18 months. Low-intensity sites offer two home visits: at birth–1 month and 9–12 months.</p> <p>Delivered in conjunction with other services, such as well-child visits, formal developmental screens, a child development telephone information line, referrals for additional services (such as speech or hearing specialists, maternal depression counseling), age-appropriate books for children, and written materials for parents on topics such as toilet training, discipline, and nutrition. Participating practices might offer parent support groups.</p>	<p>Uses a team approach to primary health care for young children. Programs must (i) be based in, or linked to, a primary health care practice that includes at least one physician or pediatric nurse practitioner who has participated in Healthy Steps training and (ii) use a qualified Healthy Steps Specialist.</p> <p>Bachelor's degree with advanced training or education in child development, family studies, nursing, psychology, or a related field preferred for Healthy Steps Specialists.</p> <p>The Healthy Steps national office (Boston University School of Medicine) requires that Healthy Steps Specialists complete a three-day training institute.</p>

Model & Target Population	Goals	Service Onset, Duration, and Frequency	Staffing Qualifications and Training
<p>Home Instruction Program for Preschool Youngsters (HIPPY)</p> <p>Low-income families with limited education.</p>	<p>Promote school readiness and early literacy through parental involvement.</p>	<p>Services delivered to children ages 3 to 5 years old.</p> <p>Blend of 30-minute biweekly home visits and two-hour biweekly group meetings over the course of three years.</p>	<p>Home visitors are paraprofessionals (most have a high school diploma or equivalent), members of the community, and usually current or former recipients of HIPPY services.</p> <p>Coordinators and visitors receive intensive pre-service training. Coordinators provide weekly and periodic in-service training to increase the knowledge, confidence, and effectiveness of the home visitors.</p>
<p>Nurse-Family Partnership (NFP)</p> <p>Low-income women pregnant with first child.</p>	<ul style="list-style-type: none"> • Improve pregnancy outcomes • Improve child health and development • Improve economic self-sufficiency of the family 	<p>Ideally, home visits begin in the 16th week of pregnancy thru second birthday.</p> <p>Over the course of about 2.5 years, visitors conduct ~ 64 visits of 60–90 minutes each. Visits occur weekly during the first month and in the postpartum period, later diminishing to bimonthly (through 21 months) and then monthly.</p>	<p>Home visitors must be registered nurses.</p> <p>Nurses receive over 60 hours of instruction from the NFP Professional Development Team over a period of 12 to 16 months.</p>
<p>Parents as Teachers (PAT)</p> <p>All families with young children (including pregnant women).</p>	<ul style="list-style-type: none"> • Increase parent knowledge of early childhood development and improve parenting practices • Detect developmental delays and health issues early • Prevent child abuse and neglect • Increase children's school readiness and success 	<p>During pregnancy through enrollment in preschool (age 3) or kindergarten (age 5).</p> <p>Combination of 60-minute home visits (conducted monthly, biweekly, or weekly) and group meetings.</p>	<p>Home visitors are typically paraprofessionals (about 50 percent had a bachelor's degree in 2006–2007). May be parents who previously received PAT services themselves.</p> <p>Home visitors must attend a five-day institute and a follow-up training within the first year. Training covers sequences of early development, screening techniques to identify health or developmental issues, and facilitation of parent-child interaction.</p>

Source: Emilie Stoltzfus and Karen E. Lynch, "Home Visitation for Families with Young Children," *Congressional Research Service*, report R40705, October 23, 2009 and *HomeVEE website*, <http://homevee.acf.hhs.gov>.