Children's Defense Fund

New Investments to Help Children and Families: The Patient Protection and Affordable Care Act and the Maternal, Infant, and Early Childhood Home Visiting Program

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The Patient Protection and Affordable Care Act signed into law by the President in 2010 will help 95 percent of children in America access health coverage. Health coverage helps children grow up healthy, ready to learn and able to become productive members of society. The new act also established a number of important prevention initiatives, including the Maternal, Infant, and Early Childhood Home Visiting Program that will help improve the lives of expectant families and families with young children through voluntary home visitation services.

1. What are early childhood home visiting programs?

Early childhood home visiting programs generally provide voluntary, in-home services to families with children beginning prenatally up to kindergarten entry age. Trained home visitors, who may be nurses, social workers, early childhood education specialists or other trained paraprofessionals, meet with families in their homes to help advise them on their children's health and development and skills to help their children grow and thrive. These programs also help connect families to a broader range of community services and supports. Rigorous research studies have found that quality, evidence-based home visitation services produce measurable outcomes for children and families that are real and lasting: better health, greater school readiness, academic achievement, parental involvement, economic self sufficiency, reduced child maltreatment and injuries and juvenile delinquency.

2. How does the Patient Protection and Affordable Care Act support home visiting?

It establishes the Maternal, Infant, and Early Childhood Home Visiting Program, a $1.5 billion five-year federal grant program for voluntary quality evidence-based home visiting programs to support young children and their families. This is the first time there has been federally mandated funding specifically for home visiting. Funding for states begins at $100 million in FY2010 and increases to $250 million in FY2011, $350 million in FY2012, and $400 million in each of FY2013 and FY2014.

3. How much funding for the Maternal, Infant, and Early Childhood Home Visiting Program will each state receive?

Funds are allocated to states and territories based on the number of children in families at or below 100 percent of the Federal poverty level in the State as compared to the number of such children nationally. There is a $500,000 minimum level of grant funding for each state and territory. In addition, 13 states will receive an amount equal to the grant funding under the Supporting Evidence Based Home Visiting Program they had previously been awarded.

For each fiscal year, three percent is set aside for grants to tribes and another three percent is set aside for research and evaluation. There is no state or local match required. States cannot use the new federal funds to substitute for existing state funds invested in home visiting. See Appendix A for a detailed state by state allocation of funding for FY2010.

4. Who can be served under the Maternal, Infant, and Early Childhood Home Visiting Program?

Young children and their families can be served, including:

- Pregnant women and the fathers of the children;
- Parents, including a non-custodial parent that has an ongoing relationship with the child and at times provides physical care for the child; and
- Primary caregivers of a child, including grandparents, other relatives or foster parents who are serving as the child's primary caregiver from birth to kindergarten entry.

States must give *priority* to serving certain "high-risk" children and families described in the law, including:

- Families living in communities identified in the needs assessment as in need of services;
- Low-income families;
- Pregnant women not yet 21-years-old;
- Families with histories of child abuse or neglect and/or involvement with the child welfare services;
- Families with a history of substance abuse or in need of treatment or who use tobacco products in the home;
- Children with low student achievement and/or developmental delays or disabilities;
- Families who had a member serve in the Armed Forces, or have had multiple deployments outside the country.

5. Who can apply for grants under the Maternal, Infant, and Early Childhood Home Visiting program?

States and Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations or Urban Indian Organizations can apply. If a state does not apply or has not been approved for a grant within the first two years of the program (by the beginning of FY 2012), a nonprofit organization that has an established record of providing early childhood home visiting services may be awarded a grant. The governor will designate a lead state agency or agencies to apply for the grant and administer the funds but it may do so in collaboration with others. The agency or agencies appointed should have strong organizational capacity to implement an evidence-based home visiting program. Regardless of which entity or entities the governor appoints, the application must include signed letters of support from the Director of the State's Title V agency; the Director of the State's agency for Title II of the Child Abuse Prevention and Treatment Act (CAPTA); the Director of the State's Single State Agency for Substance Abuse Services; and the Director of the State's Head Start State Collaboration Office. It is also recommended that the application be coordinated with the State Advisory Council established under the Head Start Act as well as the State's child care agency, education agency, and child welfare agency, if this agency is not already required to be a collaborator as the administrator of Title II of the CAPTA program.

6. What steps must states take to be eligible for a grant under the Maternal, Infant, and Early Childhood Home Visiting program?

There are three steps a state must take to be eligible to receive a grant under the Maternal, Infant, and Early Childhood Home Visiting program for FY2010.

- The first step was the submission of an initial application for funding, including a plan for completing the needs assessment and a plan for developing the program in order to meet the criteria identified in the legislation. The legislation identifies several requirements that must be included in an application to HHS, including that the application must:
  - Describe who will be served, the home visiting model or models that will be used and how these are consistent with the results of the needs assessment and with other existing state programs that include home visiting services;
  - Establish quantifiable, measurable benchmarks that will be used to demonstrate improvements in the following areas: (1) maternal and newborn health; (2) prevention of child injuries, child abuse, neglect or maltreatment, and reduction of emergency department visits; (3) school readiness and achievement; (4) reduction in crime or domestic violence; (5) family economic self-sufficiency; and (6) coordination and referral for other community resources and supports;
  - Make several assurances, including that the program will: (1) give priority to serving low-income families and families in at-risk communities identified in the statewide needs assessment; (2) be implemented and services will be delivered according to the model(s)' specifications; (3) be voluntary; (4) and include services provided to families.

  This initial submission was due by *July 9, 2010*.[1] All states and six jurisdictions submitted plans by that date and had them approved. HRSA awarded formula grants to 50 states and six jurisdictions on July 21, 2010. $500,000 was unrestricted and available to support the home visiting needs assessment and planning process for the Maternal, Infant, and Early Childhood Home visiting Program.

- The second step was submission of the needs assessment itself, due by *September 1, 2010*. All states and jurisdictions submitted needs assessments by that date. The needs assessment had to identify high risk communities and the state or jurisdiction's current capacity for home visitation and special treatment for families as described below.
  - Communities with concentrations of: (1) premature births, low birthweight infants and infant mortality; (2) poverty; (3) crime; (4) domestic violence; (5) high rates of high school drop outs; (6) substance abuse; (7) unemployment; or (8) child maltreatment;
  - The quality and capacity of the state's existing early childhood home visitation programs; and
  - The state's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

  The needs assessment had to be coordinated with those required under the Maternal and Child Health Block Grant, the Head Start Act and the Child Abuse Prevention and Treatment Act.

[1] For more information on the initial application and the expected timeline for subsequent steps, see the Funding Opportunity Announcement, HRSA-10-275, which can be accessed at www.grants.gov and searching by the announcement number.

- The third step is submission of an updated plan for addressing the needs identified in the assessment. HRSA transmitted to states on February 8, 2011, a Supplemental Information Request (SIR) that provides guidance for submission of an Updated State Plan for a State Home Visiting Program. See www.hrsa.gov/grants/manage/homevisiting. The plan is due within 90 to 120 days of the transmittal of the guidance. Plans will be reviewed and updated on a rolling basis. The plan, which is discussed further below, should include:
    1) Identification of at risk communities where home visiting services are to be provided;
    2) Detailed assessment of the particular needs of communities in terms of risk factors, community strengths, and and existing home visiting and other early childhood services;
    3) Identification of quality evidence-based home visiting model(s) proposed to be implemented to meet identified needs in the community;
    4) Specification of any additional infrastructure necessary to achieve program success;
    5) Plan for collecting benchmark data, conducting continuous quality improvement, and performing any required research or evaluation available to support the program. It must also include an updated description and justification for the proposed program design, including how proposed models meet the evidence-based criteria as part of the plan for addressing identified needs and how the state will implement the selected programs effectively and with fidelity to the model(s).

- NOTE: A separate Funding Opportunity Announcement was issued for Tribes, Tribal Organizations and Urban Indian Organizations. For more information specific to this opportunity, see HHS-2010-ACF-OFA-TH-0134 which can be downloaded at http://www.acf.hhs.gov/grants/open/foa/view/HHS-2010-ACF-OFA-TH-0134. The initial application for tribes was due *July 28, 2010 and 13 awards were announced on September 29, 2010*.

7. What home visiting models can be funded by states?

States can use multiple models within the state but they all must meet certain requirements. States must use at least 75 percent of their grant funds to support *evidence-based home visiting models that have been evaluated through well-designed and rigorous randomized control trials or quasi-experimental research designs*. The remaining 25 percent of grant funding can go to *promising and new approaches that 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.*

8. What requirements must all the program models meet?

All of the models, whether evidence-based models or promising approaches, they must:

- Adhere to a clear, consistent model that is grounded in empirically based knowledge related to home visiting and linked to the benchmark areas required above and participant outcomes;
- Employ well-trained and competent staff and provide ongoing and specific training on the model being delivered;
- Maintain high quality supervision;
- Demonstrate strong organizational capacity to implement the activities involved;

- Establish appropriate linkages and referral networks to other community resources and supports for families; and
- Monitor the fidelity of program implementation to ensure that services are delivered according to the specified model.

9. What special requirements must the evidence-based models meet?

The state must ensure that different evidence-based models funded within a state together have collectively demonstrated significant positive outcomes in the benchmark areas listed in Question 6 above in the discussion of the initial application and related participant outcomes. The participant outcomes generally are the same as those noted in the benchmark areas, with only slight variations in language. In addition, the participant outcomes also must include improvements in parenting skills. Grantees must also make improvements in the constructs /elements under each benchmark that were identified by HRSA in the SIR.

The evidence-based models also must have been in existence for at least three years, be associated with a national organization or higher education program and have comprehensive program standards to ensure high quality service and continuous improvements in the program.

10. Have specific evidence-based models been identified by HHS?

Yes. In its February 8, 2011 Guidance HRSA listed seven approved models and described other ways that home visiting programs may apply or re-apply to be considered evidence-based models.

The seven models that as of February 8, 2011 meet the criteria for evidence-based programs are:

- Early Head Start
- Family Check Up
- Healthy Families America
- Healthy Steps
- Home Instruction Program for Preschool Youngsters
- Nurse Family Partnership
- Parents as Teachers

Each of them is described in more detail at the HomVEE website (http://www.acf.hhs.gov/programs/opre/homvee).

11. May additional evidence-based models be considered?

Yes. In addition to the seven models that have been listed, states may use two different methods to attempt to identify additional home visiting models that meet the criteria of effectiveness. They include:

- Submit for review and approval to the HRSA Project Officer within 45 days of the issuance of the SIR other home visiting models that can meet the criteria of effectiveness but have not been reviewed by HomVEE.
- Submit for review and approval to HVEE@mathematica_mpr.com models already reviewed by HomVEE. These re-reviews will be conducted by an independent outside team.

Funds may be used for additional models that have been approved by HomVEE as meeting the criteria of effectiveness.

States may also use up to 25 percent of their program funds for promising approaches for home visiting. These include models for which there is little or no evidence of effectiveness, those with evidence that does not meet the criteria for an evidence-based model, or an adaptation of an approved model that includes significant alteration to the core components of the model. Research must be conducted on each of the promising approaches that are funded.

12. How must states track the effectiveness of the home visiting programs that they use?

State grantees must collect data on all the legislatively mandated benchmark areas and on all the multiple constructs/elements identified under each by HHS. They must use developmentally appropriate measures for each that are appropriate for use with the populations being served and describe their reliability and validity. They must also specify how they will define improvement in each of the constructs/elements. HHS encourages the use of standard measures for constructs/elements across various models used and they must set forth a proposed data collection and analyis plan. In addition to the data on benchmarks and constructs/elements, states must also collect individualized demographic and service utilization data on the participants in the program to understand the progress they are making.

10. How will the effectiveness of the programs be judged?

The grantee must submit a report to the Secretary of HHS demonstrating improvement in at least four of the six benchmark areas (and half of the constructs/elements in each) after the end of the third year of the program. If the report fails to demonstrate improvements the benchmarks and constructs/elements, the state will be required to develop and implement a plan to improve outcomes in all six with technical assistance provided by HHS. States must then submit a final report to HHS by December 31, 2015 describing improvements made in each of the six benchmark areas.

HHS must conduct an overall evaluation of the Maternal, Infant, and Early Childhood Home Visiting grants made and carry out a continuous program of research and evaluation to increase knowledge about the implementation and effectiveness of home visiting programs. HHS must then submit two reports to Congress. The first report on the results of the evaluation must be made publicly available and submitted to Congress no later than March 31, 2015. By December 31, 2015, HHS must submit the second report regarding the program of continuous research and evaluation and include any legislative or administrative recommendations the Secretary determines are appropriate.

For more information on the Maternal, Infant, and Early Childhood Home Visiting Program, contact Beth Davis-Pratt (edavis-pratt@childrensdefense.org or 202-662-3629) or Stefanie Sprow (ssprow@childrensdefense.org or 202-662-3568)

APPENDIX A:
State Allocations for FY2010 for the Early Childhood Home Visiting Program as reported in the Funding Opportunity Announcement from the Maternal and Child Health Bureau (HRSA-10-275)

Appendix B: Approximate Funding Levels per State[1]

Alabama	$1,414,473		Nevada	$881,142
Alaska	$584,256		New Hampshire	$599,503
Arizona	$1,792,003		New Jersey[3]	$2,035,554
Arkansas	$1,145,502		New Mexico	$951,952
California[4]	$7,782,987		New York [3]	$3,897,893
Colorado[3]	$1,842,294		North Carolina	$2,134,807
Connecticut	$829,224		North Dakota	$583,156
Delaware[3]	$1,280,893		Ohio [3]	$3,047,074
District of Columbia	$606,115		Oklahoma[3]	$1,920,105
Florida	$3,193,733		Oregon	$1,061,379
Georgia	$2,419,658		Pennsylvania	$2,070,398
Hawaii [3]	$1,298,018		Rhode Island[3]	$1,304,596
Idaho	$763,792		South Carolina[3]	$2,036,888
Illinois [3]	$3,135,997		South Dakota	$635,074
Indiana	$1,546,658		Tennessee [4]	$3,047,046
Iowa	$889,743		Texas[3]	$6,918,471
Kansas	$904,690		Utah[3]	$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[3]	$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

[1] U. S. Census Bureau, Small Area Income and Poverty Estimates, Estimates for The United States , 2008, Under age 5 in poverty, 2008 http://www.census.gov/cgi-bin/saipe/national.cgi?year=2008&ascii=

[3] States with one EBHV Program grantee site

[4] States with two EBHV Program grantee sites