Evidence-based home visiting programs support a family’s ability to enhance their child’s growth and development. Trained and competent home visitors evaluate homes for risk factors that may lead to adverse child health outcomes and provide support and intervention that will ultimately enhance a child’s ability to learn, grow, and flourish. The federal government augmented its commitment to home visiting programs by including funding for evidence based home visiting programs within the Patient Protection and Affordable Care Act in 2010. This funding created the Maternal Infant and Early Childhood Home Visiting grant program (MIECHV). The MIECHV program awards grant funding to all states and territories to establish comprehensive home visiting programs that will show improvement in six benchmark areas ranging from maternal and newborn health to the economic sufficiency of families. The program currently serves 15,000 families.

The purposes of home visiting programs are to:
- support pregnant mothers and new families,
- promote healthy parent-child interactions,
- promote appropriate child development,
- identify risks early, and
- support parents to create loving and positive home environments.

Home visitors are trained providers who support families experiencing a variety of factors that place their children at high risk for developmental, academic, social, or behavioral challenges (Table 1).

**TABLE 1** What Makes a Family “At-risk” for Adverse Child Health Outcomes?

- Parents under 21 years old
- Low socioeconomic status
- Life in at-risk communities
- Have history of child abuse or neglect
- Parental substance abuse or mental illness
- Mothers who are in recovery
- Children who are delayed or disabled
- Other factors that could put healthy child development in jeopardy such as unstable home environments or inappropriate parenting

A major goal of home visiting programs is to increase the likelihood that children will enter school ready and eager to learn. Home visiting programs typically consist of one-to-one home meetings between the parent and the home visitor. Some programs also offer group socialization sessions, assessment and evaluation of child development, and follow-up with the family.

Home visiting programs have historically been funded through a combination of philanthropic and government funds. Evidence-based evaluations of home visiting programs have consistently demonstrated positive outcomes for children and their families.

Although home visiting programs have been available for many years, the federal government increased its commitment to the program in 2010 with the passage of the Patient Protection and Affordable Care Act (PPACA). The PPACA provided $1.5 billion to fund the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant program. The MIECV program provides states with federal funds to implement evidence-based home visiting programs.

History of Home Visiting

Home visiting programs in the United States trace their origins to several key social developments in the 19th century that brought public attention to the challenges faced by many families and children due to poverty, lack of education, and social exclusion or marginalization. The early childhood education, or “kindergarten,” movement began in the mid-1800s and was modeled on the early childhood “play-based” education programs started in Germany in 1837. Centered primarily on the poor immigrant populations in large cities, teachers would hold kindergarten class sessions in the morning and conduct home visits in the afternoon. These home sessions primarily focused on the parent, instructing them in child rearing practices and how to use play to stimulate the child’s learning. The teacher also served as an advocate for the family and helped the family form connections within the community.

The emergence of public health nursing in the United States also precipitated the rise of home visiting programs. Community nursing programs were developed to address social conditions in poor communities and to bring health education and preventive care to families within communities with poor sanitation and limited resources. The Settlement House movement, which began in America in the 1880s, consisted of reform minded women attempting to improve the living conditions of poor immigrants in large cities through a combination of social and educational programs. With a heavy emphasis on early education, women regularly visited children’s homes providing support to the parents, and teaching homemaking and child rearing skills. A shift from philanthropic to government funded programs emerged around the time of the Great Depression. These home visiting programs shifted focus from a primarily educational to a medical focus, centering around maternal and child health. The more holistic home visiting model picked up speed again during the 1960s’ “War on Poverty” with the birth of programs like Head Start and Home Start. Today, home visiting programs focus largely on at-risk families emphasizing the importance of promoting infant development and preparing young children for school success.

Home Visiting in Action

Ms. V., a young single mother, supports her four-year-old son with little family assistance. She was struggling to make ends meet and improve life for herself and her son by working long hours at two jobs. Ms. V. found it hard to engage with her son, and she worried that he would not be ready to enter school in when he turned 5.

On the advice of her pastor, Ms. V. decided to enroll in a free home visiting program offered in her community, and soon a trained home visitor began coming to the house on a weekly basis.

The home visitor brought toys and activities and taught Ms. V. how to positively interact with her son through play. Ms. V. had never read to her son before, but after reading him a story during a weekly session, it became part of their nightly routine. Ms. V. felt closer to her son and watched him blossom from a quiet and withdrawn little boy to a confident child whom she had no doubt would be able to succeed in school.
According to the Urban Institute (Golden, 2011) home visiting programs reach approximately 500,000 children through an estimated 400 publicly and privately funded home visitation programs. Home visiting programs use a variety of models and curricula. Programs use both trained paraprofessionals and professionals such as nurses or social workers to conduct the visits. Programs may be based on validated curricula and others are more informal.

The Maternal, Infant and Early Childhood Home Visiting Programs (MIECHV)

Congress established the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) in 2010, providing states federal funds with which to offer voluntary and evidence-based home-visiting services to at-risk families. MIECHV is an addition to the existing Maternal and Child Health Bureau’s (MCHB) services and supports funded under Title V of the Social Security Act. MIECHV provides funding to states to implement evidence-based home visiting programs. In order to receive MIECHV funds, states must implement home visiting programs that demonstrate a solid evidence base of positive outcomes, as defined by the federal Home Visiting Evidence of Effectiveness (HomVEE).

Since its enactment in 2010, MIECHV-funded programs have been implemented in 544 communities across all 50 states, the District of Columbia, and five territories and serve approximately 15,000 families.

The MIECHV programs must demonstrate improvement among participating families in six benchmark areas (Table 2). Sixteen (16) home visiting programs are considered evidence-based programs by HomVEE and states who implement these are eligible to receive MIECHV funding (Table 3).

<table>
<thead>
<tr>
<th>TABLE 2</th>
<th>MIECHV Benchmarks</th>
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</thead>
<tbody>
<tr>
<td><strong>BENCHMARK</strong></td>
<td><strong>CONSTRUCTS</strong></td>
</tr>
</tbody>
</table>
| Maternal and newborn health | • Adequacy and completion of prenatal care, referrals, provision of information regarding prenatal care  
• Reduction in alcohol, tobacco, and illicit drug use by mother  
• Provision of information and assistance regarding preconception care and inter-birth spacing  
• Rates of screening for maternal depressive symptoms and referrals for positive screenings  
• Rates of breastfeeding  
• Well-child visits  
• Maternal and child health insurance status |
| Child injuries, child maltreatment, and reduction of emergency department visits | • Reduction in visits of child and mother to emergency department  
• Provision of information and training on prevention of child injuries  
• Rates of reported suspected and substantiated maltreatment |
| School readiness and achievement | • Parent support for child learning and development  
• Parent knowledge of child development  
• Parenting behaviors and parent-child relationship  
• Parental emotional well-being and parenting stress  
• Child communication, language, and emergent literacy  
• Screening for child cognitive skills, social behavior, and physical health/development |
| Crime or domestic violence | • Screening for domestic violence  
• Referrals for domestic violence services  
• Implementation of domestic violence safety plans |

Continued
### Table 2: MIECHV Benchmarks Continued

<table>
<thead>
<tr>
<th>BENCHMARK</th>
<th>CONSTRUCTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Economic Self-Sufficiency</td>
<td>• Income and benefits</td>
</tr>
<tr>
<td></td>
<td>• Employment or education</td>
</tr>
<tr>
<td></td>
<td>• Health insurance status</td>
</tr>
<tr>
<td>Coordination and referrals for other</td>
<td>• Screening of participants and identification</td>
</tr>
<tr>
<td>community resources and supports</td>
<td>of necessary services</td>
</tr>
<tr>
<td></td>
<td>• Rates of referrals for necessary services</td>
</tr>
<tr>
<td></td>
<td>• Receipt of necessary services</td>
</tr>
</tbody>
</table>


### TABLE 3 Evidence-Based Home Visiting Program Models

<table>
<thead>
<tr>
<th>PROGRAM NAME</th>
<th>TARGET POPULATION</th>
<th>TARGET OUTCOME</th>
<th>PROGRAM DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child First</td>
<td>Pregnant women and their families</td>
<td>To improve maternal mental health, promote child development, and access to community services for family</td>
<td></td>
</tr>
<tr>
<td>Early Head Start – Home Visiting</td>
<td>Low-income pregnant women and families with children up to 3 years old (children with disabilities comprise 10% of enrollment)</td>
<td>To ensure healthy prenatal outcomes for pregnant women, enhance the development of young children and to promote healthy functioning of the family</td>
<td>Early Head Start – Home Visiting consists of weekly 90-minute home visits and two group socialization activities per month. The program follows a nine principle theoretical model to enhance infant and toddler development while simultaneously strengthening families.</td>
</tr>
<tr>
<td>Early Intervention Program for Adolescent Mothers (EIP)</td>
<td>14-19 year olds from underserved minorities who are pregnant with their first child</td>
<td>To improve prenatal health and birth outcomes for both mother and child, build maternal caregiving, improve mother-child interactions, and build maternal social competence</td>
<td>EIP delivers its services through a case management approach utilizing nurse home visitors. Home visits start mid-pregnancy and continue until the child’s 2nd birthday. These 2 prenatal and 15 postpartum visits focus on health, sexuality and family planning, the maternal role, life skills, and social support.</td>
</tr>
<tr>
<td>Early Start (New Zealand)</td>
<td>At-risk families with children from birth to 5 years</td>
<td>To improve maternal health, reduce child abuse, improve parenting skills, support parental physical and mental health, and encourage the economic well-being of the family</td>
<td>The Early Start program creates a partnership between the home visitor and the family to maximize positive outcomes for both the family and child. Families are assessed and placed in one of four need groups, with the highest need group receiving up to 3 hours of direct contact each week with the home visiting professional. The lowest need group receives one hour of contact quarterly.</td>
</tr>
<tr>
<td>Family Check-Up (FCU)</td>
<td>At-risk families with children age 2-17</td>
<td>To reduce conduct and academic issues in children and improve positive parental involvement</td>
<td>FCU serves as the cornerstone model for the Ecological Approach to Family Intervention and Treatment (EcoFIT). EcoFIT assesses all aspects of a child’s environment to determine need and risk factors. FCU consists of three home sessions with the child and yearly checkups, as well as an intervention recommendation tailored to the needs of the family.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>PROGRAM NAME</th>
<th>TARGET POPULATION</th>
<th>TARGET OUTCOME</th>
<th>PROGRAM DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Spirit</strong></td>
<td>Native American mothers and their children from birth to 3 years</td>
<td>To increase parenting knowledge and skills, address maternal risk factors that could negatively impact the child, promote child development and ensure school readiness, and link family with community services for specific needs</td>
<td>Family Spirit consists of home visits with 63 lessons covering 6 domains: prenatal care, infant care, child development, toddler care, life skills, and healthy living. The 45-90 minute sessions begin prenatally at 28 weeks gestation and continue to the child’s 3rd birthday.</td>
</tr>
<tr>
<td><strong>Healthy Families America (HFA)</strong></td>
<td>Parents facing challenges (single parenthood, low income, substance abuse, mental health issues, domestic violence)</td>
<td>To reduce child maltreatment, increase utilization of prenatal care, improve parent-child interactions and school readiness, ensure healthy development, and promote family self-sufficiency</td>
<td>HFA is aimed primarily at preventing child maltreatment by providing at least 1 home visit per week for the first 6 months after the child’s birth.</td>
</tr>
<tr>
<td><strong>Healthy Steps</strong></td>
<td>Parents with children from birth to 3 years</td>
<td>To enhance the information and support services available to parents of young children</td>
<td>The focus of Healthy Steps is fostering a close relationship between healthcare professionals and parents of young children and emphasizing the importance of this relationship to the child’s early development. MIECHV-funded Healthy Steps programs implement 5 home visits in the child’s first 30 months. Each home visiting team consists of a pediatrician or family medicine clinician as well as a Healthy Steps specialist, who conduct the visits on an alternating schedule.</td>
</tr>
<tr>
<td><strong>Home Instruction for Parents of Preschool Youngsters (HIPPY)</strong></td>
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<tr>
<td></td>
<td>Parents who lack confidence in their ability to prepare their children for school (due to limited formal education, English proficiency, and/or financial resources, etc.)</td>
<td>To help vulnerable children achieve long-term academic success and increase parents’ involvement in their children’s schools and communities</td>
<td>HIPPY focuses on the role of the parent in a child’s early learning and offers services directly to parents who then work with their own children. The program consists of weekly home visits during the academic school year as well as monthly or bimonthly group meetings. HIPPY is used for parents of 3, 4, and 5 year olds, to prepare them to enter school at their optimal potential.</td>
</tr>
<tr>
<td><strong>Maternal Early Childhood Sustained Home Visiting Program (MESCH)</strong></td>
<td>Disadvantaged pregnant women at risk of adverse maternal and child health and development outcomes</td>
<td>To support women’s transition to parenthood and help mothers foster relationships within their families and communities to improve their health and the health of their child</td>
<td>MESCH addresses maternal and child issues at the individual, family, and community levels to optimize positive health outcomes. The program model consists of a minimum of 25 home visits beginning during pregnancy and continuing to the child’s 2nd birthday.</td>
</tr>
<tr>
<td>PROGRAM NAME</td>
<td>TARGET POPULATION</td>
<td>TARGET OUTCOME</td>
<td>PROGRAM DESCRIPTION</td>
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</tr>
<tr>
<td><strong>Minding the Baby (MTB)</strong></td>
<td>14-25 year old 1st time mothers in low-income settings who are receiving prenatal care from a community health clinic</td>
<td>To promote secure attachment between mother and child, improve maternal health and mental health, and to increase maternal self-efficacy</td>
<td>The MTB program focuses on helping mothers “mind their baby” both physically and emotionally. A nurse practitioner and social worker alternate in conducting home visits, which occur from 8-10 weeks during the pregnancy until the 2nd birthday. MTB emphasizes a close relationship between the home visitor and mother, and the home visitors maintain contact with the mother’s prenatal and pediatric clinicians throughout the program’s duration.</td>
</tr>
<tr>
<td><strong>Nurse Family Partnership (NFP)</strong></td>
<td>1st-time low-income mothers and their children</td>
<td>To improve prenatal health outcomes, improve the child’s health and development, and increase the family’s economic self-sufficiency</td>
<td>Participation in NFP begins early in pregnancy and continues until the child is 2 years old. A registered nurse conducts weekly home visits for the child’s first 6 weeks, followed by visits every other week until the 1st birthday, and monthly visits until the 2nd birthday.</td>
</tr>
<tr>
<td><strong>Oklahoma Community-Based Family Resource and Support Program (CBFRS)</strong></td>
<td>1st-time mothers in rural areas</td>
<td>To reduce the incidence of child abuse and neglect</td>
<td>The CBFRS Program offers weekly or biweekly home visits from 28 weeks gestation to the child’s 1st birthday. Sessions cover topics such as maternal and child health, child growth and development, and parenting skills.</td>
</tr>
<tr>
<td><strong>Parents as Teachers (PAT)</strong></td>
<td>Children with special needs, at-risk families or parents</td>
<td>To increase parental knowledge of early childhood development and improve parenting practices, provide early detection of developmental delays, prevent child abuse, and improve the child’s school readiness</td>
<td>The PAT program consists of one-on-one home visits, as well as group meetings, child health and development screenings, and a resource network for families.</td>
</tr>
<tr>
<td><strong>Play and Learning Strategies (PALS) for Infants</strong></td>
<td>Children 5 months to 1 year and their parents</td>
<td>To strengthen bonding between parent and child and to stimulate the child’s early language, cognitive, and social development</td>
<td>The PALS program consists of 10 one-on-one home visits aimed at helping parents master the skills necessary to interact with their infants and strengthen the parent-child bond. Home visitors also work directly with the child to stimulate early language, cognitive, and social development.</td>
</tr>
<tr>
<td><strong>SafeCare Augmented</strong></td>
<td>Families with a history of child maltreatment, depression, substance abuse, or intellectual disabilities</td>
<td>To provide training to parents of children from birth to age 5 in order to address and prevent factors associated with child abuse and neglect</td>
<td>The SafeCare Augmented program consists of one-on-one home visits with 3 main focus areas: infant and child health, home safety, and positive parent-child interactions. Home visitors conduct weekly or biweekly visits, consisting of observation, assessment, and training with the parents that emphasize the program’s 3 main focuses.</td>
</tr>
</tbody>
</table>
Home Visiting Programs in Washington, DC

Home visiting programs in Washington DC currently have the capacity to serve around 500 families, yet an estimated 3500 children in the area could benefit from services. DC has a high proportion of at-risk children, especially in wards 5, 7, and 8 (Table 4). The DC Home Visiting Council collaborates with a variety of programs to integrate all aspects of the home visiting delivery system and strengthen DC’s implementation of the programs.

DC implements a variety of evidence based home visiting programs. MIECHV funds Parents as Teachers (PAT), Healthy Families America (HFA), and Home Instruction for Parents of Preschool Youngsters (HIPPY). Further programs are offered through the Office of the State Superintendent of Education (OSSE) and the Georgetown University Center for Child and Human Development (GUCCHD). In addition to MIECHV, the DC Department of Health implements the DC Healthy Start Project (DCHS) providing case management and home visitation to pregnant and postpartum women and men and their children. Child and Family Services Administration (CFSA) funds 5 home visiting programs.

<table>
<thead>
<tr>
<th>TABLE 4</th>
<th>At-risk Children in DC</th>
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</thead>
<tbody>
<tr>
<td>BIRTH OUTCOME</td>
<td>WARD 5</td>
</tr>
<tr>
<td>Low birth weight (&lt;2,500 grams)</td>
<td>10.8%</td>
</tr>
<tr>
<td>Infant mortality (rate per 1,000 live births)</td>
<td>16.3</td>
</tr>
<tr>
<td>Births to mothers 15-19 years old</td>
<td>16.6%</td>
</tr>
<tr>
<td>Births to unmarried women</td>
<td>71.1%</td>
</tr>
</tbody>
</table>

The DC Department of Health has created a comprehensive framework (Figure 1) depicting the interconnections among programs within DC that support children and families. The figure is used with permission from District of Columbia, Department of Health
MIECHV-Funded Programs Implemented in DC

The DC Department of Health is responsible for overseeing the implementation of DC’s MIECHV funds, which are authorized by the Affordable Care Act. Funding includes a grant to implement Parents as Teachers (PAT) and Home Instruction for Parents of Preschool Youngsters (HIPPY) in wards 5, 7, and 8. Also included is funding to implement Healthy Families America (HFA) in all wards.

Parents as Teachers (PAT)

Started in Missouri in 1981, Parents as Teachers (PAT) is now implemented in all 50 states. PAT home visitors work with parents from pregnancy until the child enters kindergarten. The program focuses on increasing the parent’s role in preparing the child for academic success. The home visitors use the Born to Learn curriculum to provide parents with knowledge of child development.

In addition to home visits the PAT model incorporates, group meetings, developmental screenings, and a resource network for families. Research indicates that the PAT program positively affects children’s school readiness, with PAT children scoring higher on kindergarten readiness tests than children raised in similar environments who did not go through the PAT program. Parents also benefit from participation, learning how to interact with their children more effectively and improving their understanding of child development. The DC Department of Health, Healthy Start Program, has also implemented PAT independently of MIECHV, with 267 families served in Wards 5, 6, 7, and 8.

Healthy Families America (HFA)

Healthy Families America (HFA) is an evidence-based home visiting program that focuses on parents facing such challenges as single parenthood, low income, substance abuse, mental health issues, and histories of child abuse or neglect, as well as domestic violence. Services are provided from before the child's birth up until the child's 5th birthday. Following the Growing Great Kids curriculum HFA offers weekly (if necessary) home visits, teaching parents to identify and respond to their child’s needs and how to care for the child in a way that will optimize successful development. HFA staff also work to link families with a medical provider and other community resources, such as job placement opportunities and day care providers. The MIECHV funding is used to implement HFA through Mary’s Center. Mary’s Center serves families in Wards 1, 2, 4, 5, 6, 7, and 8 through the MIECHV program.

Home Instruction for Parents of Preschool Youngsters (HIPPY)

Operated through DC’s Family Place, Home Instruction for Parents of Preschool Youngsters (HIPPY) serves at-risk families in Wards 5, 7, and 8. The main focus of HIPPY is to ensure that preschoolers are ready to enter and succeed in school and that parents have the skills and confidence necessary to help their children achieve this success. The HIPPY Curriculum consists of weekly home visits over a 30-week period and focuses on language development, problem solving, and perceptual skills in children ages 3 through 5. The program consists of one-on-one home visits and group meetings with educational material and activities. In May 2011, DC’s Family Place began offering the first HIPPY program provided completely in Spanish. HIPPY sites offer three-year programs for 3 to 5 year olds as well as two-year programs for 4 to 5 year olds.
Play and Learning Strategies (PALS)
Offered through the Office of the State Superintendent of Education (OSSE), the focus of the Play and Learning Strategies (PALS) program is to help parents develop the skills to interact with their toddlers and infants in ways that will lead to better developmental outcomes for the child. PALS offer a 10-session infant curriculum for parents of infants age five months to one year and a 12-session toddler curriculum for parents of toddlers age 18 months to 3 years. Sessions in both curricula focus on responding to babies’ communicative signals, supporting infants’ and toddlers’ learning by maintaining their interest and attention rather than redirecting their focus, simulating language development, encouraging cooperation, and responding to misbehavior. Through PALS, parents are also taught what to expect from children at different ages and how to respond to the child’s needs as they develop.

Home Instruction for Parents of Preschool Youngsters (HIPPY)
OSSE also funds HIPPY at The Family Place and the Perry School.

Healthy Family America (HFA)
Healthy Family America is offered through Mary’s Center with funding from OSSE.

DC Developmental Disabilities Agency-Funded Programs
Parents as Teachers (PAT)
The Georgetown University Center for Child and Human Development (GUCCHD), the University Center for Excellence in Developmental Disabilities (UCEDD) for the District of Columbia, offers home visiting services following the Parents as Teacher (PAT) model, in collaboration with the DC Department on Disability Services. Similar to the PAT program implemented by Mary’s Center with MIECHV funds, GUCCHD’s PAT program focuses on the parent’s role in their child’s development and school readiness. GUCCHD’s program, however, concentrates on families in which the parents have developmental disabilities and may need assistance to provide a developmentally enriched environment for their child. PAT’s goal is ultimately to improve parent’s knowledge of their child’s development and increase their parenting skills.

Child and Family Services Agency (CFSA) -Funded Programs
Healthy Families America
Mary’s Center provides the Healthy Family America program to low income families, specifically expectant mothers or mothers with babies under 10 months of age.

Chicago Parenting/Ordinary Miracles Curriculum
Mary’s Center provides a hybrid program that combines Chicago Parenting Model with the Ordinary Miracles Curriculum to low income fathers with children under the age of 5.

Nurturing Parents
Nurturing Parents is offered through the Mary’s Center to low income families’ prenatally until the child is 3 months post-natal age.
Summary

Home visiting programs have a rich history of providing support to high risk families. The benefits of providing support to families of young children cannot be overestimated. Research over the last 30 years indicates that providing support to families of young children:

• reduces the achievement gap
• improves health outcomes through the life span
• is economical and
• boosts earning potential.

References


This paper was prepared in part by Madeline Uelk, Georgetown University, School of Nursing and Health Sciences ’16.