Evidence-Based Home Visitation: South Carolina's Opportunity

On March 23rd, President Barack Obama signed into law the *Patient Protection and Affordable Care Act* (P.L. 111-148)*.* The measure creates the nation's most broad sweeping health reform in history, and when fully implemented, will provide coverage for 32 million individuals.

The legislation provides broad enhancements for children, including strengthening the Children's Health Insurance Program, allowing coverage for preexisting conditions such as juvenile diabetes, and allowing young adults up to age 26 to stay on their parents health insurance if needed, among many other provisions.

The legislation also provides the single largest investment in child abuse prevention strategies in history. The funding made available is the fulfillment of candidate Obama's promise to support the development of evidence-based home visitation programs.

Maternal, Infant and Early Childhood Home Visiting Programs:

- **$1.5 billion of mandatory funding is provided for a new state grant program through FY2014**
  - FY2010--$100 million
  - FY2011--$250 million
  - FY2012—$350 million
  - FY2013--$400 million
  - FY2014--$400 million
- **State Match**
  - Funds provided to states "shall supplement, and not supplant funds from other sources for early childhood home visitation programs."
- **Eligible Use of Funds**
  - 3 percent for research and evaluation to be conducted by the U.S. Department of Health and Human Services;
  - 3 percent to provide home visitation services to Indian families;
  - 25 percent can be used by states to support promising new models that are to be rigorously evaluated
  - The Secretary of Health and Human Services may allocate unused grant funds to nonprofit organizations, or if the state is found out of compliance.

- **Needs Assessment**

    - Not later than six months following enactment, a state shall, conditional upon receiving Title V Maternal and Child Health Block Grant funds, complete a needs assessment identifying:

        - Communities with concentrations of: (1) premature birth, low-birth weight infants, and infant mortality (including infant death due to neglect, or other at-risk prenatal, maternal, newborn or child health); (2) poverty; (3) crime; (4) domestic violence; (5) high rates of high-school drop-outs; (6) substance abuse; (7) unemployment; and (8) child maltreatment.

        - Quality and capacity of existing programs or initiatives for early childhood home visitation in the state that includes: (1) number and types of individuals—and families—receiving services; (2) gaps in services; and (3) how the programs are meeting needs of eligible families.

        - A state's capacity for providing substance abuse treatment and counseling services.

        - The needs assessment shall coordinate with existing Title V assessment along with those required through Head Start and Child Abuse Prevention and Treatment Act.

        - As a prerequisite for funding, states must also identify how they plan to address the needs identified in the assessment.

- **Eligibility and Application**

    - Grants shall be provided to states for services for eligible families promoting improvements in maternal and prenatal health, infant health, child health and development, parenting related to child development, school readiness, the socioeconomic status of families, and reductions in child abuse, neglect and injuries.

    - Application must include description of: (1) populations served, with an assurance of priority to low-income families and others identified in the needs assessment; (2) the service delivery model(s) to be used; (3) how the model (s) will benefit those identified in the needs assessment; (4) quantifiable, measurable benchmarks; (5) assurances that programs will be delivered according to model specifications; (6) services are voluntary in nature; and (7) services provided are aligned with individual family assessments.

- **Benchmarks**

    - A eligible entity must detail "quantifiable, measurable three and five year benchmarks" demonstrating program results for eligible families for: (1) improved maternal and newborn health; (2) prevention of child injuries, child abuse, neglect or maltreatment, and reduction of emergency department visits; (3) reduction in crime or domestic violence; (4) improvements in family economic self-sufficiency; (5) improvements in coordination for other community resources.

    - If improvements are not demonstrated in at least four of the above areas, the state shall develop an improvement plan subject to approval by the Secretary.

    - Failure to demonstrate improvements shall allow the Secretary to terminate the grant and remaining allocations.

- **Core Components of Programs**
    - Model must be at least three years old and is "research based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program improvement" and has shown positive outcomes aligned with above benchmarks.
    - Models must have been evaluated using "well-designed and rigorous: randomized controlled research designs, and the evaluation results have been published in a peer reviewed journal; or quasi-experimental research designs."
- **Priority Service Populations**
    - Those identified in the needs assessment including families who: (1) are low-income; (2) pregnant women up to age 21; (3) have involvement in child welfare system; (3) have a history of substance abuse; (4) are users of tobacco products; (5) have children with low student-achievement; (6) have children with developmental delays; and (7) those serving or have served in the Armed Forces.
- **Evidence-Based Models**
    - The Secretary shall establish criteria for effectiveness of delivery models available to public comment, but will include: (1) programs adhering to consistent models of empirically based knowledge and linked to above mentioned benchmarks; (2) the program employs well-trained and competent staff that may include nurses, social workers, educators, child development specialists, or other well-trained staff, and includes ongoing training on model delivery; (3) program maintains high supervision; (4) strong organizational capacity; (5) appropriate linkages to referral networks; and (6) maintains program fidelity.