An interview with David Willis

'Be guided by the evidence'

The implementation of the Home Visiting Program in USA has been an exciting, rapid and heavy lift for many states and local communities. Photo • mlive.com/Landov

As the Director of the Division of Home Visiting and Early Childhood Systems at the US Department of Health and Human Services, David Willis administers the Maternal, Infant and Early Childhood Home Visiting Program. The Program was created by the Patient Protection and Affordable Care Act of 2010, better known as Obamacare.

David, please first give us some background on what the Home Visiting Program sets out to achieve, and how it works.
The Home Visiting Program supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to age 5. These services have been proven to improve maternal and child health outcomes in the early years of a child's life. Although home visiting models have been around for decades, the Home Visiting Program is the first nationwide expansion of these services. The home visiting models have a long history of compelling scientific evidence to positively impact birth outcomes, improve children's health and reduce child maltreatment, and promote long-term benefits for at-risk families and their children. Thus, evidence-based home visiting is not only a violence reduction strategy, as you're exploring with the articles this edition of *Early Childhood Matters*, but also a public health strategy, an early education strategy, a workforce development strategy, and a community-building strategy.

The Home Visiting Program promotes collaboration and partnerships among states and local communities, home visiting model developers, families and early childhood stakeholders. In March 2014, funding for the Home Visiting Program was extended through March 2015,

building upon the $1.5 billion investment in the Home Visiting Program for fiscal years 2010 through 2014. Priority populations for the Program include pregnant women under age 21 and families who:

- live in at-risk communities
- are low-income
- have a history of child abuse, neglect, or substance abuse
- have users of tobacco in the home
- have children with low student achievement or developmental delays or disabilities
- are military families.

When the Home Visiting Program began, each state, territory and Tribal grantee developed a mandatory needs assessment to identify communities with concentrations of premature birth, low-birthweight infants and infant mortality. Then, as defined by statute, grantees chose from a list of Health and Human Services-approved, evidence-based home visiting models to promote:

- improvements in maternal and prenatal health, infant health, and child health and development
- increased school readiness
- reductions in the incidence of child maltreatment
- improved parenting related to child development outcomes
- improved family socio-economic status
- greater coordination of referrals to community resources and supports
- reductions in crime and domestic violence.

The Home Visiting Program is completely voluntary: families choose to participate and can leave the Program at any time. It is also administered with state and local flexibility and built on decades of scientific evidence demonstrating both the effectiveness and the cost benefit of home visiting. According to a recent Pew Charitable Trusts study, every dollar invested in home visiting yields a return of up to $9.50 to society. Home visit services are conducted in the home, over time, with multiple visits and careful attention to relationship building and trust building.

Which are the approved home visiting programmes that states can choose to implement?

By legislation, the Home Visiting Evidence of Effectiveness review (HomVee) was designed to provide comprehensive, systematic and transparent review of the evidence[1]. (Seven evidence-based home visiting models were initially approved and served as a foundation for the Program. And with ongoing review of the evidence, HomVee now includes a total of 14 Health and Human Services (HHS)-approved evidence-based models. The majority of current Home Visiting Program investments are supporting the following models:

- Nurse–Family Partnership (NFP)
- Healthy Families America (HFA)
- Parents as Teachers (PAT)
- Early Head Start – Home Visiting Option (EHS).

The legislation for the Home Visiting Program also encourages innovation by allowing up to 25% of funds to support promising approaches. In addition, the legislation provides for a 3% investment in evaluation, research, and corrective action technical assistance and 3% of the funding goes specifically for grants to Indian Tribes (or consortia of Indian Tribes), Tribal organisations, and Urban Indian Organisations.

What have been the biggest challenges with scaling up?

The implementation of the Home Visiting Program has been an exciting, rapid and heavy lift for many states and local communities. The programmes had to conduct needs assessments, contract with local providers and home visiting models, develop data and reporting systems, create quality improvement and evaluation plans and engage many stakeholders to assure the success of the Program. For many states, the Home Visiting investment builds on decades of successful early childhood system infrastructures, allowing those states to use this nationwide expansion of home visiting to new levels of innovation and scale.

One of the common problems with scaling up is achieving consistency across different geographical areas; how have you approached that?

The Home Visiting Program has a keen focus on fidelity, accountability, and quality of programmes, built from

the knowledge and experience of the evidence-based home visiting models. In addition, to further address differences in grantees' capacities, Home Visiting has a comprehensive and robust technical assistance programme to assure its success.

What has been the biggest surprise since you started the Home Visiting Program?
The prevalence and extent of toxic stress within families and communities has been sobering and challenging. The 'big three' issues that have been most identified as challenges for the home visitors have been parental mental health (especially maternal depression), substance abuse and domestic violence. Of course, home visitors are trained to address these challenges, but the depth and severity of these risks in some communities have been challenging, especially when local resources are limited. Yet, these challenges have driven the development of new partnerships, innovations and local solutions.

How else has the Program moved forward the evidence base on home visiting?
The home visiting legislation mandated a national evaluation of the Program in a random assignment study of approximately 5100 families in 85 local sites across 12 states. This study, called MIHOPE (Mother and Infant Home Visiting Program Evaluation), will examine child and family outcomes, implementation and cost effectiveness. MIHOPE includes the four major evidence-based home visiting models I mentioned earlier: HFA, NFP, PAT and EHS. In addition, there is a second national evaluation called the MIHOPE-SS, which will be specifically examining the effectiveness of Healthy Families America and Nurse Family Partnership home visiting on reducing preterm birth, increasing birthweight and improving infant and maternal health outcomes.

We have also developed the Home Visiting Collaborative Improvement & Innovation Network (CoIIN), which includes Home Visiting Program state grantees and local implementing agencies to focus on developing quality improvement and rapid cycle methods to accelerate improvements in Program outcomes.

What advice would you give to other countries that are thinking of scaling-up home visiting?
Be guided by the evidence. Make use of multiple evidence-based home visiting models, not just one, so that flexibility and choice will address the local circumstances, local resources and the local needs of families. In addition, it is imperative to view home visiting as a key component of a continuum of services for vulnerable families within the child health and public health systems. Intentional linkage of resources, public health services and home visiting can become breakthrough strategies to address the toxic stress and generational transmission of trauma that so disrupts life course health and developmental trajectories.

In addition, it is important to be sensitive to public messaging and framing – to stress that home visiting is embedded in a public health and human capital development agenda, not just a social welfare agenda. The home visiting message must be grounded in a broad community context of building healthy communities and assuring healthy development for all children. Home visiting is intended to lift up families who seek support and need more intensive parent coaching. Home visiting must develop within the context of a continuum of services and supports for all young families.

Note
1 Information about the Home Visiting Evidence of Effectiveness review is available online from the US Department of Health and Human Services Administration for Children and Families, at: http://homvee.acf.hhs.gov/