MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM IN RURAL AMERICA

POLICY BRIEF AND RECOMMENDATIONS TO THE SECRETARY

SEPTEMBER 2023

NACRHHS

National Advisory Committee on Rural Health and Human Services

EDITORIAL NOTE

In April 2023, The National Advisory Committee on Rural Health and Human Services (hereinafter referred to as "the Committee") convened for its 92nd meeting in Bend, Oregon to discuss the use of the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) in rural America. Throughout the meeting, the Committee engaged with subject matter experts and local community stakeholders on MIECHV. As part of the meeting, Committee members participated in site visits to Crook County Public Health Department in Prineville, Oregon and Jefferson County Public Health in Madras, Oregon. This policy brief presents the benefits and challenges of MIECHV in rural areas that were examined during the meeting, as well as the Committee's policy recommendations to improve MIECHV for families across rural America.

ACKNOWLEDGEMENTS

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The Committee also extends its appreciation to the staff at the Federal Office of Rural Health Policy (FORHP) for coordinating the meeting and to Dhwani Kharel, Jenna Mu, Jocelyn Richgels, and Jason Steele for drafting this policy brief. Furthermore, the Committee thanks Moushumi Beltangady, Tom Morris, Kyle Peplinski, Cynthia Phillips, Sahira Rafiullah, and Karis Tyner for providing their expertise in preparation of this brief.

POLICY RECOMMENDATIONS

Recommendation 1: HHS should provide rural-specific technical assistance to support states' efforts to implement promising approaches and model enhancements in rural communities.

Recommendation 2: The Secretary should support an effort to distinguish between rural and urban outcomes on the MIECHV outcomes dashboard and ensure that tribal data is collected and reported to the extent practicable**.**

Recommendation 3: The Secretary should engage with rural and tribal communities to understand the most burdensome data and administrative requirements they encounter, examine other federal formula grant programs for best practices in data reporting and oversight, and determine where administrative procedures can be streamlined to reduce burdens for local implementing agencies and service providers.

Recommendation 4: HHS should require states to consult with State Offices of Rural Health, State & Territory Minority Health, Indian Health Service Offices, and other local stakeholders in the preparation of their updated needs assessment.

Recommendation 5: HHS should develop a rural Continuous Quality Improvement (CQI) collaborative including state and local program staff among the states implementing MIECHV in rural areas.

Recommendation 6: HHS should provide rural-specific workforce training support to home visiting programs by adding a rural track within the Institute for Home Visiting Workforce Development and the Jackie Walorski Center for Evidence-Based Case Management.

Recommendation 7: To assure continuity of services, HHS should provide technical assistance to states to support the efforts of rural communities who have lost MIECHV funding to transition service delivery to alternative funding sources.

Recommendation 8: HHS should assess the impact of matching grants on rural states with limited financial or in-kind resources.

INTRODUCTION

In April 2023, the National Advisory Committee on Rural Health & Human Services (Committee) convened in Bend, Oregon to discuss the MIECHV program in rural America. While MIECHV programs are only a subset within the broader field of home visiting, the Committee has chosen to focus on MIECHV to narrow the focus to programs administered by the U.S. Department of Health and Human Services (HHS). Throughout the meeting, the Committee engaged with subject matter experts and local community stakeholders on MIECHV. As part of the meeting, Committee members participated in site visits to Crook County Public Health Department in Prineville, Oregon and Jefferson County Public Health in Madras, Oregon. This policy brief presents the benefits and challenges of MIECHV in rural areas that were examined during the meeting, as well as the Committee's policy recommendations to improve MIECHV for families across rural America.

MIECHV BACKGROUND

Home visiting pairs expecting parents and caregivers of young children with a home visitor (usually a nurse, social worker, or early childhood specialist) to empower families with the tools and resources they need to improve their health and well-being. Home visiting may occur in the family's home or in another location agreed upon by the family and home visitor.[1] Recently, in large part due to the COVID-19 pandemic, many visits transitioned to a virtual format.[2] With the lifting of the public health emergency, home visits have generally returned to an in-person format, but the home visiting field continues to discuss the extent to which virtual services can continue to provide support to families.[3]

There are a variety of home visiting models, and services may differ from model to model, but generally involve three common activities: assessing family needs, educating and supporting parents, and referring families to needed services in the community.[4] Assessing family needs may include screening for issues like post-partum depression, substance use, and domestic violence.[5] Education and support can encompass topics such as home safety, child development, and safe sleep.[6] Referral services may include connecting families to prenatal care, mental health treatment, access to healthy food, and domestic violence resources.[7]

These services reach families at a critical juncture of a child's development and have demonstrated positive impacts for children and families.[8,9] The overall body of research on home visiting shows benefits for families in improving school readiness, family economic self-sufficiency, and maternal health.[10,11,12] Studies have also linked home visiting to reductions in child maltreatment, juvenile delinquency, family violence, and crime.[13] There are economic benefits as well: cost-benefit analyses find that for every dollar spent, high-quality home visiting programs can result in returns on investment ranging from $1.75 to $5.70 by saving on social costs associated with child protection, remedial education, and criminal justice.[14,15]

MIECHV Program Aims
(1) **Improve** maternal and child health (2) **Prevent** child abuse and neglect (3) **Reduce** crime and domestic violence (4) **Increase** family education level and earning potential (5) **Promote** children's development and readiness to participate in school (6) **Connect** families to needed community resources and supports Source: https://mchb.hrsa.gov/programs-impact/programs/home-visiting/maternal-infant-early-childhood-home-visiting-miechv-program

History of Home Visiting and the MIECHV Program

Activists during the Progressive Era of the early 20th Century laid the groundwork for home visiting programs today.[16] Home visiting services commonly took place in settlement houses—community-based institutions created to serve the needs of immigrants and the urban poor.[17] As settlement houses grew in popularity, they created jobs for visiting teachers, nurses, and social workers.[18] Home visitors during this time worked to build trust in communities, especially those with many immigrants. For this specific group, home visitors provided information about American culture in addition to general support about how to care for children during early development.[19]

The first randomized control trial of a home visiting program occurred in 1977, marking the start of an evidence-based approach to evaluate home visiting programs.[20] Since then, new models of home visiting programs have emerged based on community experiences and academic research, with home visiting programs like the ones seen today growing rapidly in the 1990's.[21] In 2010, Congress created the federally-funded MIECHV Program and included it as a provision in the Affordable Care Act.

Overview of the Federal Home Visiting Program

MIECHV is administered by the Maternal and Child Health Bureau (MCHB) within the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF).[22] Program objectives are to implement evidence-based home visiting models or promising approaches, ensure the provision of voluntary, high-quality home visiting to eligible families, and target outcomes specified by legislatively mandated benchmarks.[23]

MIECHV was first authorized as a mandatory program in 2010 for $1.5 billion in funding for five years under the Affordable Care Act through an amendment to Title V of the Social Security Act.[24] HRSA awarded primarily competitive funding in the first six years of the program to support state infrastructure development and expansion of services. Beginning in 2016, to increase funding stability from year to year, HRSA transitioned to largely awarding formula awards, with additional competitive funding awarded through innovation grants in 2017 and 2020.[25]

Since its inception, MIECHV has been reauthorized several times, most recently in 2022. The reauthorization received broad bipartisan support and was included in the Fiscal Year 2023 omnibus appropriations legislation, which was signed into law on December 29, 2022.[26] The five-year reauthorization has the potential to double the federal investment in MIECHV, the first increase in funding since 2014, for a total of $3 Billion over five years.[27] Notably, the authorized funding amount increases each year of the five-year program authorization with federal matching funds for the first time.[28] Additionally, the amount set aside for Tribal home visiting programs also doubled, from three percent to six percent of total appropriations. The legislation also includes set-asides for research, evaluation, and federal administration (three percent), technical assistance (two percent), and workforce and case management support (two percent). Furthermore, the authorization extends flexibility for using telehealth or virtual home visits as part of service delivery, when appropriate.[29] It also aims to reduce administrative burden and outlines predictable, transparent funding formulas for the base and matching grants.[30]

Eligibility

A family may be eligible to receive home visiting services if it includes:[31]

(1) A woman who is pregnant and the father-to-be, if available; or
(2) A parent or primary caregiver, including grandparents, other relatives, and foster parents who are serving as a child's primary caregiver in the years between birth and kindergarten entry, including a noncustodial parent who has an ongoing relationship with a child and provides physical care for the child at times.

In FY 2021, MIECHV provided more than 920,000 home visits and served around 140,000 parents and children, reaching an estimated 15 percent of the more than 465,000 families who are likely eligible and in need of MIECHV services.[32]

By law, states must give priority in providing services under the program to eligible families who:[33]

1. Reside in a community that needs home visiting services as determined by the state-wide needs assessment.
2. Are low-income.
3. Include a pregnant woman under the age of 21.
4. Have a history of child abuse or neglect or have had interactions with child welfare services.
5. Have a history of substance abuse or need substance abuse treatment.
6. Have users of tobacco products in the home.
7. Have children with low student achievement.
8. Have children with developmental delays or disabilities.
9. Include individuals who are serving, or formerly served, in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

Of those served by MIECHV in FY 2021, 68 percent of families had household incomes at or below 100 percent of the Federal Poverty guidelines, and 60 percent of adults had a high school education or less. Of all the households served, 20 percent had a history of child abuse and maltreatment, 14 percent reported substance misuse, and ten percent included enrollees who were pregnant teens.[34]

For many of the criteria, rural communities face increased challenges when compared to their urban counterparts. For instance, research shows that relative to urban areas, rural areas face a higher overall rate of poverty,[35] higher rates of teen births,[36] lower levels of educational attainment,[37] and higher rates of tobacco use among adults.[38] In FY 2021, 60 percent of all 1,065 counties served by MIECHV were rural, reaching 28 percent of all rural counties in the U.S.[39]

Program Structure

MIECHV is a partnership between the federal government, 56 states and jurisdictions, tribal entities, and local communities. States and jurisdictions identify a lead agency that applies for MIECHV funds which, in most states, is the department of health or the department of early learning. Other states may operate the program within their state social service or human services agency.[40,41] Some states also have collaborating arrangements between departments. In two states, in which the state has not applied and been approved for MIECHV funds, funding is awarded to a non-profit to conduct a home visiting program in the state. MIECHV statute provides separate grant funding to ACF to make grants to tribal entities planning to implement MIECHV programs, while MCHB makes grants to states and jurisdictions. Grantees then have the flexibility tailor the programs according to their communities' specific needs.

States operating MIECHV programs coordinate activities in eligible areas through Local Implementing Agencies (LIA). LIAs are most often local government agencies (e.g., public health departments), schools or school districts, community-based organizations, or other local nonprofits, including federally qualified health centers. They receive funding to hire and train home visiting staff, implement home visiting models, and report on outcomes. MIECHV programs are often part of larger family and child support programs operated by the organizations.

It is important to note that many states incorporate MIECHV funding into their larger state home visiting efforts, and may not, in practice, differentiate program delivery between MIECHV and non-MIECHV models. These states may also operate MIECHV-eligible models through other funding sources, such as state funds, TANF, and Medicaid. They may also administer locally developed home visiting models that do not meet HHS evidence criteria through these other funding sources.

The recent MIECHV authorization distributes a base level of funding to eligible states, jurisdictions, and nonprofit organizations through a funding formula founded on the number of children under five years of age within the state. State funding matches will begin being distributed in FY 2024, based on a formula that accounts for the number of children under five living below the poverty line, for states that are interested and have the required non-federal matching funds. Funds for tribal entities will continue to be distributed through the statutory set-aside on a competitive basis.

Unlike many federal programs, MIECHV is not means-tested. Rather, the legislation specifically calls for states to target at-risk communities for home visiting services.[42] States conduct a needs assessment, identify and prioritize communities that are most in need, and select the appropriate home visiting service delivery models.[43] States must also coordinate with and consider other state and community administered needs assessments.[44] At least 75 percent of the funding must be used for a home-visiting

program that has been deemed "evidence-based" by HHS, while up to 25 percent of the funding may be used towards "promising approaches, that must undergo rigorous evaluation."[45]

Tribal MIECHV

Tribal MIECHV is administered by ACF and serves Tribes, consortia of Tribes, Tribal organizations, and urban Indian organizations.[46] The program seeks to support the healthy growth and development of American Indian and Alaska Native (AIAN) children and families.[47] Given the limited literature on tribal home visiting, grantees may implement evidence-based home visiting models or a promising approach.[48]

Tribal MIECHV should be consistent with the state MIECHV program "to the extent practicable" and grantees must conduct needs assessments and report on benchmark performance measures, similar to states.[49] ACF interprets this language to provide tribal grantees with flexibility to adjust models with cultural adaptations and enhancements that meet the needs of their communities.[50] The Tribal MIECHV grants are five-year competitive grants rather than formula grants because of the limited amount of available funding. Tribal MIECHV grantees are required to conduct comprehensive community needs and readiness assessments. As do States, tribal grantees must also collect and report on "benchmark" performance measures, but the requirements have been modified to be more appropriate for a tribal community context.

At the start of FY 2023, there were 29 Tribal MIECHV grantees in 16 states. 22 of those grants end in FY 2023, and grantees must compete again for new awards.[51] In FY 2021, Tribal MIECHV programs served over 3,500 parents and children in nearly 1,700 families and provided nearly 19,300 home visits.[52] Most Tribal MIECHV grantees are in rural communities, with about five grantees serving primarily urban areas.[53] With the doubling of the tribal set-aside from three to six percent, the Tribal MIECHV is currently expanding, growing from $12 million in FY 2022 to $30 million in FY 2023 and continuing to increase to $48 million by FY 2027. It is expected that many new awards will be made in the coming years, significantly broadening the reach of the program in rural tribal communities.

MIECHV Eligible Models

HHS uses a rigorous, systematic review process to determine which models are evidence based and eligible for MIECHV funding.[54] The Home Visiting Evidence of Effectiveness (HomVEE) review conducted by HHS includes a broad literature review and an assessment of study quality to determine whether a given model meets the HHS criteria for an "evidence-based early childhood home visiting service delivery model."[55]

The review only includes models that use home visiting as their primary service delivery method. The models must also target outcomes in least one of the following domains:

- Maternal health;
- Child health;
- Positive parenting practices;
- Child development and school readiness;
- Reductions in child maltreatment;
- Family economic self-sufficiency;

- Linkages and referrals to community resources and supports;
- Reductions in juvenile delinquency, family violence, and crime.

It is important to note that the HomVEE team does not directly evaluate models, but rather, reviews research conducted on the models to determine if they meet the evidence-based standard. By 2022, the HomVEE team had reviewed 53 models and determined 25 met HHS evidence criteria.[56] Of these 25 models, 23 are eligible for MIECHV funding (See Appendix A).

Promising Approaches

States may dedicate up to 25 percent of their MIECHV funding to implement and evaluate "promising approaches."[57] Promising approaches are innovative models that can be tailored to meet a community's unique needs, and state evaluations of these programs help build a research base for new programs.[58] States that implement a promising approach must conduct rigorous, well-designed evaluations of these programs. This burden of evaluation, which is often time consuming and costly, may discourage states from implementing a promising approach model.[59] Transitioning a model from a promising approach to one that is deemed evidence-based is also difficult for similar reasons. Most programs do not have sufficient funding to meet the evidence standards of the HomVEE review even if they have been researching and collecting data on their model. Currently, only three state programs—Arkansas, Arizona, and Kansas—implement a promising approach model in their MIECHV-funded home visiting programs.

Despite these challenges, several promising approach models have been successful in establishing sufficient evidence to transition to evidence-based status, including Family Spirit, the only home visiting model specifically designed for and evaluated with Tribal populations.[60] Mothers and Infants Health Outreach Work (MIHOW) is another evidence-based model that began as a MIECHV-funded promising approach designed for economically disadvantaged and geographically isolated communities.[61]

Evaluating Outcomes

HRSA requires MIECHV awardees to provide annual performance reports on their program's outcomes. The performance measurement system includes a total of nineteen measures across the following benchmarks:[62]

- Improvements in maternal, newborn, and child health;
- Prevention of child injuries, child abuse, neglect, or maltreatment and reductions of emergency room visits;
- Improvements in school readiness and child academic achievement;
- Reductions in crime or domestic violence;
- Improvements in family economic self-sufficiency; and
- Improvements in the coordination and referrals for other community resources and supports.

In addition to the annual reporting requirements, HHS has goal-specific, program-wide evaluation efforts. For example, HRSA supports coordinated state-level evaluations of MIECHV programs. States work with one another to evaluate their local programs in four key topics: family engagement and health equity, maternal health, workforce development, and implementation quality/fidelity. Currently, 16 awardees participate in these state-level evaluations.[63,64]

Tribal grantees also conduct local evaluations of their programs. The Tribal Home Visiting Evaluation Institute (TEI) provides tribal grantees with technical assistance for these evaluations. TEI provides support for performance measurements, data management, continuous quality improvement (CQI), and other evaluation activities.[65]

Mother and Infant Home Visiting Evaluation

The Mother and Infant Home Visiting Program Evaluation (MIHOPE) is an example of an ongoing, legislatively mandated study. Beginning in 2012, the study recruited over 4000 women who were either pregnant or had children younger than six months old. The study has had multiple phases, following the families and children at different stages of life. As of April 2023, the evaluation is currently in Phase Four with MIHOPE3G Elementary School Follow-up, as the initially enrolled children are now in elementary school.

Source: https://www.acf.hhs.gov/opre/project/mother-and-infant-home-visiting-program-evaluation-mihope-2011-2021

Additional Funding Support: Medicaid

States may use their Medicaid program as an additional source of funding to support the delivery of certain components of evidence-based home visiting services. Medicaid does not have a distinct state benefit plan called home visiting, but states may cover many of the individual component services through coverage authority granted through Medicaid.[66] Adjustments to the state Medicaid plan may be necessary to ensure that adding a home visiting program as a service delivery line fits within the Medicaid definition of coverable services.

All states have the authority to use Medicaid to fund individual home visiting component services and at least 28 states use this authority to supplement MIECHV funds.[67] Targeted case management and extended services for pregnant women are the most widely used Medicaid benefit categories,[68] but preventive services, rehabilitative and therapy services, and home health services are individual component services that are also incorporated into state plans for home visiting services.[69,70]

MIECHV in Oregon

Currently, MIECHV provides funding for three evidence-based home visiting models in Oregon: Early Head Start-Home Based Option, Healthy Families America, and Nurse Family Partnership. Programs in 13 of Oregon's 36 counties receive MIECHV funding. In addition to MIECHV, Oregon implements home visiting programs that do not receive MIECHV funding.[71] For example, Family Connects Oregon represents an effort to create an evidence-based home visiting program that connects families to nurses and can be offered universally across the state.[72] No tribal entities in Oregon currently receive Tribal MIECHV funds, but some have in the past.

Oregon conducted its first needs assessment in 2012 and a revised needs assessment in 2020.[73,74] The 2020 needs assessment found that rural and frontier communities are areas in particular need of MIECHV program capacity expansion and are also the areas where the MIECHV and Home Visiting programs struggle to enroll and engage families. The reasons are likely familiar to rural practitioners: long travel times, low participant volume across large geographical areas, and a lack of easily accessible support services for clients in need. General workforce recruitment, retention, and training also remains a challenge. Finally, it is difficult to recruit and maintain staff who can provide culturally and linguistically appropriate home visiting services to Tribal communities and a growing population of rural families who speak languages other than English.[75]

POLICY RECOMMENDATIONS

Flexibility

MIECHV's reliance on evidence-based models can prove challenging in rural areas for several reasons. Often, rural entities interested in the model cannot meet the requirements set by statue and program rules. Many evidence-based models were not developed in rural settings, and therefore may be challenging to implement in rural communities due to fewer resources. For example, some models may require that home visitors are registered nurses, but it is often difficult to recruit and retain registered nurses in rural areas.

The Committee acknowledges the dynamic tension of relying on evidence-based models and the need for flexibility in rural areas. However, despite this tension, the MIECHV Program has effectively reached rural communities and 60 percent of counties served by MIECHV are rural. The needs assessment is an essential component in helping states identify communities with the greatest needs, many of which are rural communities. LIAs, in collaboration with MIECHV awardees, can ensure appropriate alignment between community needs and the model selected. MIECHV awardees and LIAs have the option to make enhancements to models in a way that does not alter the model's core components, giving grantees the options to make variations which better reflect their community's needs.[76]

Using the "up to 25 percent" of the "promising approach" funding allocation to develop and evaluate new programs that are targeted to rural circumstances may provide needed flexibility in rural communities. However, the time-consuming and costly nature of evaluation, which is often exacerbated in the rural setting, may discourage states from implementing a promising approach model targeted to rural communities. Additionally, states may find it challenging to identify enough eligible families to ensure the rigor of the evaluation for a promising approach model.

The Committee recognizes the need to maintain a rigorous evaluation standard for promising approaches, as these models act as pilot program to create new evidence-based models for potential inclusion as an MIECHV-eligible program. The Committee urges HHS to consider new ways to support promising approaches that have the potential to address gaps in rural contexts.

> **Recommendation One: HHS should provide rural-specific technical assistance to support states' efforts to implement promising approaches and model enhancements in rural communities.**

Data and Administrative Burden

Data collection is an integral part of MIECHV. Entities receiving MIECHV funding are required to submit performance data on the following benchmarks:[77]

- Improved maternal and newborn health;
- Prevention of child injuries, child abuse, and neglect or maltreatment, and reduction of emergency department visits;
- Improvement in school readiness and achievement;
- Reduction in crime or domestic violence;
- Improvement in family economic self-sufficiency; or
- Improvements in the coordination and referrals for other community resources and supports.

The recent reauthorization bill requires HHS to establish and operate an annually updated, publicly available, outcomes dashboard, that shares state and jurisdiction MIECHV program outcomes. The reauthorization requires reporting of the following information:[78]

- A profile for each entity showing outcome indicators and how they compare to the benchmarks established for those outcomes;
- Information on the outcome indicators and requisite outcome levels for each entity;
- Information on the evidence-based home visiting model(s) used by the entity and specific participant outcomes the model is intended to affect;
- The most recently available information reported in the report on performance improvement;
- An electronic link to the state needs assessment, which identifies high-need communities for MIECHV services; and
- Information regarding any penalty or other corrective action taken by the Secretary against an entity and, if the entity is operating under a corrective action plan, detailed info about the plan and progress toward improvement.

To augment this information, the Committee recommends that the Secretary support an effort to distinguish between rural and urban outcomes on the dashboard and ensure that tribal data is collected and reported to the extent possible. Presenting both rural and urban data when possible may help establish a more accurate representation of needs in rural areas and help support a more equitable distribution of resources and funds based on the needs in communities.[79]

> **Recommendation Two: The Secretary should support an effort to distinguish between rural and urban outcomes on the MIECHV outcomes dashboard and ensure that tribal data is collected and reported to the extent practicable.**

While MIECHV's evidence and data standards serve an important programmatic role, they also introduce administrative burdens. Many state grantees report that extensive administrative procedures and data collection requirements make it difficult to stay within the 10 percent administrative cap in statute.[80] Grantees have stated that they are required to fill out multiple forms, sometimes with duplicate data, on a quarterly basis.[81] Sometimes additional information is required within tight deadlines. Grantees have reported a mismatch between HHS estimates for time required for reporting and the actual time grantees

must spend to meet administrative demands.[82] The recent reauthorization includes a provision to address some of these challenges.[83]

As the Committee heard during its site visits, LIA program staff report facing conflicting priorities between providing services to families and completing administrative paperwork. This burden may be exacerbated in low-resource rural communities without sufficient staff to provide services to all eligible families, and at the same time meet administrative and data requirements. In the Committee's discussions in Crook and Jefferson Counties, home visiting providers spoke of these challenges, which have exacerbated existing challenges relating to funding and workforce capacity in rural communities. The reauthorization also includes instructions to conduct a review of paperwork and data collection for tribal grantees in a manner that respects sovereignty and acknowledges the different focus points for tribal grantees.[84] The Committee urges the Secretary to work with rural communities to streamline data and administrative reporting requirements.

> **Recommendation Three: The Secretary should engage with rural and tribal communities to understand the most burdensome data and administrative requirements they encounter, examine other federal formula grant programs for best practices in data reporting and oversight, and determine where administrative procedures can be streamlined to reduce burdens for local implementing agencies and service providers.**

States have discretion over how they allocate their MIECHV funding across communities and models, based on certain criteria, including the state's needs assessment. However, the true scope of rural needs may not be accurately captured in the data that states use to conduct their needs assessment. For example, the American Community Survey (ACS), administered by the U.S. Census Bureau, is often used as the standard for demographic information to help local officials understand the changes and challenges occurring in their communities. This is problematic because the Census Bureau only releases ACS estimates for non-urban areas every five years, rather than on an annual basis as it does for larger urban areas.[85] Given the limitations on rural data in national surveys, efforts should be made at the state level to incorporate additional rural-specific data in their needs assessments. State Offices of Rural Health may have more complete data on rural-specific issues to supplement gaps in available state data. Other stakeholders, such as State & Territory Minority Health and Indian Health Service Offices, should also be consulted to ensure that the needs of all underserved populations are accurately captured and represented in the needs assessment.

> **Recommendation Four: HHS should require states to consult with State Offices of Rural Health, State & Territory Minority Health, Indian Health Service Offices, and other local stakeholders in the preparation of their updated needs assessment.**

Collaboration

Collaboration of rural-serving MIECHV grantees within a state offers the opportunity discuss their unique challenges, as well as learn from effective strategies implemented by other programs. MCHB currently offers grantees an opportunity to engage in discussions focused on specific topic areas, but the Committee believes that a more structured program through the MIECHV Continuous Quality Improvement (CQI) process focusing on rural communities would provide a more useful forum for rural grantees to collaborate on issues of shared importance.

Recommendation Five: HHS should develop a rural Continuous Quality Improvement (CQI) collaborative including state and local program staff among the states implementing MIECHV in rural areas.

Workforce Challenges in Recruitment and Retention

Maintaining a high-quality workforce is essential to the success of a home visiting program.[86] Home visitors can have a lasting positive impact on a community, particularly if the home visitor is local and understands the community they serve. However, MIECHV awardees and LIAs consistently point to the recruitment and retention of home visitors as a major issue facing their field.[87,88,89] The Indian Health Services faces similar staff shortages to support the tribal MIECHV programs. A national survey of the home visiting workforce finds that home visitors are generally dissatisfied with their compensation and opportunities for promotion, in turn prompting qualified and experienced staff to leave for better-paying jobs.[90,91,92]

Th many challenges facing workforce recruitment and retention are exacerbated in rural areas because rural areas tend to have smaller pools of qualified applicants to fill the home visiting workforce.[93] Some states have begun to address these workforce-related challenges. For example, in Oregon, universities are encouraging students to stay and work in rural communities through unique curricula features such as lived-experience credits. Community colleges in Oregon are also designing early childhood classes that are dual language to train a workforce that more accurately reflects the cultural and linguistic diversity of the population. One example of these workforce improvement efforts is the Partners in Practice (PIP) scholarship program, a collaboration between Central Oregon Community College, Early Learning Hub of Central Oregon, and NeighborImpact Childcare Resources to provide early childcare education professional development.[94]

At the federal level, there are various resources available to support home visitors across the country. The newly awarded Institute for Home Visiting Workforce Development and the Jackie Walorski Center for Evidence-Based Case Management, aim to improve the recruitment and retention of a diverse and qualified home visiting workforce.[95]

Recommendation Six: HHS should provide rural-specific workforce training support to home visiting programs by adding a rural track to the Institute for Home Visiting Workforce Development and the Jackie Walorski Center for Evidence-Based Case Management.

Funding Concerns

During the April 2023 meeting, the Committee heard about various funding concerns held by MIECHV programs. In one particularly difficult situation occurs when a community receives funding one year but not the next, thereby disrupting the continuity of care for families. During the site visit to Jefferson County Public Health in Madras, Oregon, some Committee members learned about the implications of this disruption. Representatives from the public health department shared that in 2016, Jefferson County received MIECHV funding after an assessment deemed it one of the 13 highest risk counties in Oregon. However, after a reassessment in 2020, Jefferson County was no longer considered one of the highest risk counties and did not receive MIECHV funding as a result.[96] This loss of funding threatened the continuity of services and overall quality of care that families in Jefferson County received. As such, the Committee

believes that efforts should be made to better support the transition for communities who have lost funding.

> **Recommendation Seven: To assure continuity of services, HHS should provide technical assistance to states to support the efforts of rural communities who have lost MIECHV funding to transition service delivery to alternative funding sources.**

Another major funding-related concern is the gap between a community's need and the available funding for MIECHV programs. In FY 2022, MIECHV served approximately 15 percent of the more than 465,000 families who are were eligible and in need of services. These percentages are likely even lower in rural areas with larger service areas and insufficient staff capacity to serve all eligible families. In Oregon, the remote rural county of Umatilla has the capacity to serve only about 7 percent of the children under age six living in poverty with home visiting programs.[97] These numbers underscore the reality that the demand for MIECHV services exceeds the amount of available funding.[98]

The Jackie Walorski Maternal and Child Home Visiting Reauthorization Act of 2022 aims to alleviate funding constraints by increasing federal investment over five years. Specifically, the bill includes:[99]

- $100 million increase in base funding starting in FY 2023.
- Phased-in additional federal matching funding starting in FY 2024. The federal program will provide a 75 percent federal match to a state's total investment of non-Federal funds in home visiting program delivery up to a ceiling amount, provided that the state maintains previous total non-federal statewide expenditures for MIECHV.

The Committee is encouraged by the opportunities available to enhance service delivery with the federal match. However, states that are unable to provide a significant investment and have difficulty providing services to rural areas may fall further behind in program outcomes as compared to better resourced states.

> **Recommendation Eight: HHS should assess the impact of matching grants on rural states with limited financial or in-kind resources.**

CONSIDERATIONS

With the most recent reauthorization, MIECHV funding formulas have now been codified in statute; however, prior to this reauthorization, competitive awards were used to allow program expansion and spur innovation. The Committee notes that the Secretary could work with Congress to revise statute to include the flexibility to allow competitive grants for innovation in the MIECHV program. These innovations may include model enhancements specifically designed to meet the needs of eligible families within rural communities.

CONCLUSION

MIECHV represents a unique opportunity to reach families in their homes and provide support that is tailored to their specific needs.[100,101] The program offers benefits ranging from improved child development to family economic self-sufficiency.[102] However, many rural families continue to encounter obstacles to accessing MIECHV services.[103] At the 92nd meeting, Committee members explored these issues by attending presentations from subject matter experts and engaging in discussions with community stakeholders. In turn, the Committee drafted the recommendations mentioned in this brief, with the overarching goal to improve MIECHV for families across rural America.

APPENDIX A – HOME VISITING MODELS ELIGIBLE FOR MIECHV FUNDING

1. Attachment and Biobehavioral Catch-Up (ABC) – Infant
2. Child First
3. Early Head Start - Home-Based Option (EHS-HBO)
4. Early Intervention Program for Adolescent Mothers
5. Early Start (New Zealand)
6. Family Check-Up® for Children
7. Family Connects
8. Family Spirit®
9. Health Access Nurturing Development Services (HANDS) Program
10. Healthy Beginnings
11. Healthy Families America (HFA)®
12. Home Instruction for Parents of Preschool Youngsters (HIPPY)®
13. Intervention Nurses Start Infants Growing on Healthy Trajectories (INSIGHT)
14. Maternal Early Childhood Sustained Home-Visiting Program (MECSH)
15. Maternal Infant Health Outreach Worker (MIHOW)®
16. Maternal Infant Health Program (MIHP)
17. Nurse-Family Partnership (NFP)®
18. Parents as Teachers (PAT)®
19. Play and Learning Strategies (PALS) Infant
20. Promoting First Relationships®—Home Visiting Intervention Model
21. Safe Care Augmented
22. Video-Feedback Intervention to promote Positive Parenting (VIPP)
23. Video-Feedback Intervention to promote Positive Parenting-Sensitive Discipline (VIPP-SD)

APPENDIX B – SITE VISIT PROFILE: CROOK COUNTY PUBLIC HEALTH DEPARTMENT

Crook County is positioned in central Oregon and has a total population of approximately 25,000. It includes one incorporated city, Prineville, with a population of 10,500. Crook County is the second fastest growing in Oregon. The economy in Crook County is driven by forest products, agriculture, livestock, tourism, and the technological sector.

Committee members toured the Crook County Public Health Department and heard from Katie Plumb, Public Health Director at the department. Ms. Plumb provided information about the public health landscape in Crook County and Oregon. In 2010, Oregon began an initiative to modernize public health departments within the state. The goal of the program was to offer the same level of services throughout the state in each county. The initiative outlined four foundational programs for public health departments: Communicable Disease Control; Environmental Public Health; Prevention and Health Promotion; and Access to Clinical Preventative Services. Additionally, the initiative also defined goals for foundational capabilities, which include: assessment and epidemiology; emergency preparedness and response; communications; policy and planning; leadership and organizational competencies; health equity and cultural responsiveness; and community partnership development.

In Crook County, there are five service areas established to align with the Oregon public health modernization effort. These include Health Protection and Response; Prevention and Health Promotion; Administrative Services; Family Health Services; and Access to Clinical Services.

There are many remaining challenges in providing these services because the modernization effort was funded at a low level. In Crook County, workforce recruitment is particularly difficult because providers can earn more in nearby counties like Deschutes, where the cities of Redmond and Bend are located. High staff turnover is a pressing issue as well. In 2022, there was a sharp decline in the public health workforce due to factors like low wages and the toll of the COVID-19 pandemic. Furthermore, teleworking is not permitted in Crook County, which also contributed to the rates of turnover, especially among those who live in nearby counties but work in Crook County. To address the workforce gap created by staff turnover in 2022, Crook County relied heavily on part-time staff and volunteers.

The Crook County Public Health Department is undertaking several new strategies to address these problems, including collaborating with high schools in the area. Crook County has built a robust program that offers volunteer opportunities, internships, and career and technical education credits for students who are interested in rural public health. The county is also working to engage college and post-secondary school students to show the value of a public health career.

APPENDIX C – SITE VISIT PROFILE: JEFFERSON COUNTY PUBLIC HEALTH

Jefferson County Public Health serves Jefferson County, which is one of the most diverse regions in the state and is home to the largest percentage of members of the Confederated Tribes in the Warm Springs Reservation. In 2022, the population of Jefferson County was 25,330. The five primary communities are Madras, Metolius, Culver, Warm Springs, and Crooked River Ranch. Jefferson County ranks as the unhealthiest county in Oregon, facing issues such as high trauma rates, an enormous need for behavioral health services, the highest Sexually Transmitted Disease (STD) rates in the state, and a lower life expectancy rate than any other area in Oregon. Jefferson County Public Health works to tackle issues facing the county and improve the health and well-being of every resident.

During the Committee's site visit, Committee members heard from a variety of speakers. These individuals included:

- Michael Baker, PhD, MS, Health Services Director, Jefferson County Public Health Department
- Barbara Ibrahim, RN, IBCLC, Public Health Nurse – Jefferson County Public Health, Nurse Visiting Program, Warm Springs, Oregon
- Angie Lopez, Family Support Specialist – Healthy Families Oregon (HFO), Jefferson County Public Health, Madras, Oregon
- Janessa Wells, Central Oregon Workforce Navigator – Oregon Coalition of Local Health Officials (CLHO), Portland, Oregon
- Karen Correa, Health Equity and Education Specialist – Jefferson County Public Health, Madras, Oregon
- Tami Kepa'a, Women, Infant, and Children (WIC) Coordinator – Jefferson County Public Health, Madras, Oregon

Dr. Baker worked with county commissioners to create a health impact statement that prioritizes public health. In Jefferson County, home visiting programs all operate under the Jefferson County Healthy Families Program (HFO). HFO collaborates with Babies First, Cocoon, the Oregon Association of Relief Nurses and the Family Connects Oregon (FCO) Model. FCO is a universally offered state-wide home visiting program. Any new parent can meet with a public health nurse after discharge from the hospital with a new baby to answer questions about child development, receive assistance with breastfeeding, or answer any concerns as a new parent.

In 2016, there was an assessment of all the counties in Oregon and 13 of the highest risk counties received MIECHV funding. Jefferson County was one of the 13 counties to receive funding and chose the Healthy Families evidence-based model for their MIECHV program. After the 2020 state wide needs assessment, Jefferson County did not receive MIECHV funding because it was not considered one of the highest risk counties.

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