National Advisory Committee
On Rural Health and Human Services

Rural Policy Implications for Maternal, Infant and Early Childhood Home Visitation Program

White Paper September 2011

Editorial Note: *In 2011, the National Advisory Committee on Rural Health and Human Services will focus on the rural implications of key provisions from the Patient Protection and Affordable Care Act through a series of white papers with policy recommendations for the Secretary of the U.S. Department of Health and Human Services.*

INTRODUCTION

Section 2951 of the Affordable Care Act created the Maternal, Infant, and Early Childhood Home Visiting Program with the goal of improving health outcomes for families who reside in at-risk communities. This program, which is funded for 5 years at $1.5 billion, promotes maternal, infant, and early childhood health, safety, and development, as well as strong parent-child relationships by improving the programs and activities carried out under Title V and coordinating services for at-risk communities.

Recommendations

1. The Committee recommends that the Secretary provide technical assistance for evaluation of promising approaches to States who are implementing them in high-need rural communities.

2. The Committee recommends that the Secretary require States to collect rural-urban community data so as to allow for meaningful rural-urban evaluation of program impact.

This is a unique program that involves a Federal-State partnership, with much of the discretion over allocation of funding left to the States based on the use of national benchmarks[1] for indicators of need while restricting much of the funding to seven evidence-based models.[2]

DISCUSSION & RECOMMENDATIONS

On face value, the Committee believes this program holds great potential for addressing pressing needs in rural communities. A number of indicators show rural women and children are at higher risk than their urban counterparts. In the area of maternal and newborn health, rural communities' face increased risk for low birth weight, infant mortality, and inadequate care. Rural counties experience higher risk of poor birth outcomes and inadequate prenatal care than urban counties.[3] Pregnant rural women, when compared to their urban counterparts, are younger, have a higher

[1] The benchmarks include: improved maternal and newborn health; prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency

[2] The seven approved models are: Early Head Start – Home-Based Option, Family Check Up, Healthy Families America (HFA), Healthy Steps, Home Instruction Program for Preschool Youngsters (HIPPY), Nurse-Family Partnership (NFP), and Parents as Teachers

[3] Larson E.H., Murowchick E. and Hart L.G. *Poor birth outcome in the rural United States: 1985-1987 to 1995-1997.* Final Report #119. Seattle, WA: WWAMI Rural Health Research Center, University of Washington; Feb 2008. Available at: http://depts.washington.edu/uwrhrc/uploads/RHRC_FR119_Larson.pdf

maternal mortality rate, have a larger number of children, experience higher fetal death rates, and are more likely to be on public health insurance or no insurance.[4] Furthermore, rural women encounter higher rates of crime and domestic violence than their urban counterparts. Rural women have been found to be more entrenched in the relationship and to experience more severe violence and fear.[5]

Given the factors identified above, it is reasonable to expect that the Early Childhood and Home Visiting Program would have a significant focus on rural communities. However, the Committee has historically expressed concerns with the effectiveness of large State programs to appropriately target high-need rural areas. Absent specific language in the statute targeting rural areas, there is always a concern that the funding may not reach areas of low population density despite indicators of need.

As a result of this concern, the Committee asked for a review of eight States' response to the second Supplemental Information Request (SIR) for an Updated State Plan (due June 8, 2011). The Committee is encouraged that all eight States included at least one rural community[6]. This assessment examined each State's prioritized counties and whether any of those counties were defined as rural by HHS' Office of Rural Health Policy. At this point in the development of the program, the States appear willing to include rural counties and communities in their Home Visiting Program despite the unique challenges in serving this population.

All of the States reviewed mentioned similar barriers that they anticipate facing in rural communities. The unique barriers to rural home visitation include serving geographically isolated populations, which can lead to higher per-unit service costs due to travel, and the difficulty of staffing some of the approved evidence-based practices, which may require a workforce infrastructure that is not available in some rural communities.

According to the benchmarks identified above, it is apparent that home visitation is needed in rural America. The Committee continues to be concerned about the statutory reliance on evidence-based models given that many of the approved seven models are predicated on urban-based environments and resources. This reliance on urban-centric models continues to be a barrier for the inclusion of rural communities in these State-wide programs. HHS, however, does have the authority to use 25 percent of the funds to support promising practices which could be used to target programs in rural communities. The challenge will be meeting the requirement that the States conduct a rigorous evaluation of these approaches in order to demonstrate their effectiveness. This requirement may be challenging in a rural setting because of the small sample size and the added cost of evaluation. Therefore, the Committee recommends that HHS target specific technical assistance to States to assist high-need rural communities with help on meeting the evaluation requirements.

The ACA required HHS to create an independent advisory panel to design the evaluation for the program. The Committee recommends the Secretary require States to collect data on the geographic range of communities served to determine how much of the program investment went to rural communities relative to urban communities. This data should then be compared to national indicators of need to determine if the program addressed those communities in greatest need of

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[4] Acosta DC. "Obstetric Care." In Geyman and colleagues (eds), *Textbook of Rural Medicine* (2001): 103-121.

[5] Logan, T.K. and Walker , R. 2011. *Civil Protective Orders Effective in Stopping or Reducing Partner Violence: Challenges Remain in Rural Areas with Access and Enforcement.* Durham, NH: Carsey Institute, Policy Brief No. 18. Available at http://www.carseyinstitute.unh.edu/publications/IB-Logan-Civil-Protective-Order.pdf

[6] The SIRs that were reviewed were from California, Florida, Georgia, Missouri, New York, North Dakota, Oregon and Pennsylvania.

these services. The failure to collect rural-urban data and to assess the impact on rural residents could have the effect of making this an urban-only program.

CONCLUSION

Home visiting programs can dramatically improve the lives of mothers and their children who live in at-risk communities. As noted in the benchmarks cited above, there is great need for these types of services in rural areas.

Increased coordination of services is critical to the success of these programs, especially in rural areas where fewer services are available. However, guidance and technical assistance is needed to ensure that all States are able to provide comprehensive home visiting services to their at-risk communities, including rural populations where the needs are great. This will be particularly important as HHS implements the promising practices portion of the program.