Home Visiting Programs

Reviewing Evidence of Effectiveness

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The Patient Protection and Affordable Care Act, signed into law in 2010, established a new program designed to improve outcomes for at-risk pregnant women and mothers and children from birth through age 5: the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). MIECHV offers funding to states and territories to provide home visiting services. Three percent of MIECHV funds must be set aside for grants to federally recognized tribes, tribal organizations, or urban American Indian organizations. The act requires that 75 percent of grantees' funds must be used for home visiting program models with evidence of effectiveness based on rigorous evaluation research. As a result of this requirement, the Administration for Children and Families (ACF), Office of Planning, Research, and Evaluation (OPRE), part of the U.S. Department of Health and Human Services (DHHS), in collaboration with the Health Resources and Services Administration, contracted with Mathematica Policy Research to conduct a systematic review of home visiting research. Mathematica conducted the review under the guidance of a DHHS interagency working group. This review, known as the Home Visiting Evidence of Effectiveness (HomVEE) project, determines which home visiting program models have sufficient evidence to meet the DHHS criteria for an "evidence-based early childhood home visiting service delivery model." States, territories, and tribes direct the majority of their funding to support implementation of these program models.

The HomVEE review only includes program models that use home visiting as the primary mode of service delivery and aim to improve outcomes in at least one of the eight domains specified in the legislation. These domains are (1) maternal health; (2) child health; (3) positive parenting practices; (4) child development and school readiness; (5) reductions in child maltreatment; (6) family economic self-sufficiency; (7) linkages and referrals to community resources and supports; and (8) reductions in juvenile delinquency, family violence, and crime.

The HomVEE website:
http://homvee.acf.hhs.gov/

Weighing the Evidence

To ensure a meticulous and transparent review of the research, the HomVEE team uses a systematic process. The team first conducts a literature search; screens studies; and prioritizes program models for review, based on factors such as the number and design of the studies and their sample sizes. The team then assesses each eligible impact study (that is, those using randomized controlled trials or quasi-experimental designs) for every prioritized program model and rates the study quality as high, moderate, or low. The HomVEE team rates the causal studies on their ability to produce unbiased estimates of a program model's effects. This rating system helps the team distinguish between more- and less-rigorous studies; the more rigorous the study, the more confidence we have that its findings were caused by the program model itself, rather than by other factors. All studies with a high or moderate rating are used to determine if the program model meets the level of effectiveness specified in the DHHS criteria. The team also creates implementation profiles for all program models included in the review using information from impact studies with a high or moderate rating, stand-alone implementation studies, and Internet searches. This process is conducted annually.

The DHHS criteria specify that to be considered "evidence based," program models must have at least (1) one high or moderate quality impact study showing favorable,

statistically significant impacts in two or more of the eight outcome domains or (2) two high or moderate quality impact studies, examining separate study samples, that show one or more favorable, statistically significant impacts in the same domain. Additionally, following the statute, if a model meets the above criteria based only on findings from randomized controlled trials, then two additional requirements must be met. First, at least one favorable, statistically significant impact must be sustained for at least one year after program enrollment, and second, at least one favorable, statistically significant impact must be reported in a peer-reviewed journal.

Summarizing the Results

As of September 2013, HomVEE has reviewed the available evidence on 35 home visiting program models, including impact reviews of 270 studies and implementation reviews of 217 studies. Some studies are included in both reviews because they contain information on both impacts and implementation.

Evidence of effectiveness: Among the 35 program models reviewed, 14 met the DHHS criteria for an evidence-based early childhood home visiting program model (see table).

14 Program Models Meet DHHS Criteria

Program	Favorable Impacts on Primary Outcome Measures	Favorable Impacts on Secondary Outcome Measures	Sustained Impacts?	Replicated?
Child FIRST	16	12	Yes	No
Early Head Start-Home Visiting	5	33	Yes	No
Early Intervention Program for Adolescent Mothers	8	2	Yes	No
Early Start (New Zealand)	9	2	Yes	No
Family Check-Up	5	1	Yes	Yes
Healthy Families America	14	31	Yes	Yes
Healthy Steps	2	3	Yes	No
Home Instruction for Parents of Preschool Youngsters	4	4	Yes	Yes
Maternal Early Childhood Sustained Home Visiting Program	1	3	Yes	No
Nurse Family Partnership	27	59	Yes	Yes
Oklahoma's Community-Based Family Resource and Support Program	2	3	Yes	No
Parents as Teachers	12	0	Yes	Yes
Play and Learning Strategies (Infant)	12	0	Yes	No
SafeCare Augmented	2	1	Yes	No

Note: The table only shows the results from studies with a high or moderate rating.

Program impacts: In seven of the eight outcome domains, there was at least one program model with a favorable impact found using a primary measure.[1] None of the program models showed reductions in the domain of juvenile delinquency, family violence, and crime as reported using a primary measure. Most program models showed improvement on primary measures of child development and school readiness and positive parenting practices. Healthy Families America had the widest range of impacts, with favorable impacts on primary or secondary measures in all eight outcome areas. Nurse Family Partnership was next, with favorable impacts in seven areas.

Program implementation requirements: MIECHV has a number of implementation requirements regarding length of operations, the existence of a national program office, and standards for staff and service delivery. HomVEE produces implementation reports regardless of the quality of the studies reviewed. The HomVEE team found that 33 program models in the review have been operating for at least three years before the start of the review. Furthermore, 31 program models were associated with a national program office that provides training and support to local program sites, and 32 had established requirements for the frequency of home visits. Half or more of the program models also had requirements for staff training or fidelity of implementation.

Moving Forward

Many program models do not yet have rigorous impact studies of their effectiveness. Some program models have a few impact studies of high or moderate quality, but could benefit from more research. One question that requires more study is how well these program models work with certain types of families. Although the HomVEE review has identified impact studies with fairly diverse samples in terms of race, ethnicity, and income, the samples for many groups were small. More research with larger samples is needed to understand the effectiveness of home visiting program models for families with specific social and demographic characteristics.

Visit the HomVEE website (http://homvee.acf.hhs.gov) for detailed information about the review process and results. For more information, please contact the HomVEE team at HomVEE@acf.hhs.gov.

Endnote

[1] The HomVEE team classified outcome measures as primary if data were collected through direct observation, direct assessment, or administrative records or if self-reported data were collected using a standardized (normed) instrument. Other self-reported measures were classified as secondary.