OPRE Report #2014-59

Home Visiting Evidence of Effectiveness Review: Executive Summary

November 2014

Contract Number:
HHSP23320095642WC/HHSP23337025T

Mathematica Reference Number:
06969-236

Submitted to:
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EXECUTIVE SUMMARY

Home Visiting Evidence of Effectiveness (HomVEE) was launched in fall 2009 to conduct a thorough and transparent review of the home visiting research literature and provide an assessment of the evidence of effectiveness for home visiting program models that serve families with pregnant women and children from birth to age 5. The HomVEE review was conducted by Mathematica Policy Research under the guidance of a Department of Health and Human Services (DHHS) interagency working group composed of representatives from:

- The Office of Planning, Research, and Evaluation (OPRE), Administration for Children and Families (ACF)
- The Children's Bureau, ACF
- The Centers for Disease Control and Prevention (CDC)
- The Health Resources and Services Administration (HRSA)
- The Office of the Assistant Secretary for Planning and Evaluation (ASPE)

The Patient Protection and Affordable Care Act established a Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) that provides $1.5 billion over five years to states to establish home visiting program models for at-risk pregnant women and children from birth to age 5. The Act stipulates that 75 percent of the funds must be used for home visiting programs with evidence of effectiveness based on rigorous evaluation research. The HomVEE review provides information about which home visiting program models have evidence of effectiveness as required by the legislation and defined by DHHS, as well as detailed information about the samples of families who participated in the research, the outcomes measured in each study, and the implementation guidelines for each model.

This executive summary provides an overview of the HomVEE review process, a summary of the review results, and a link to the HomVEE website for more detailed information.

Review process

To conduct a thorough and transparent review of the home visiting research literature, HomVEE performs seven main activities:

1. Conducted a broad literature search.
2. Screened studies for relevance.
3. Prioritized program models for the review.
4. Rated the quality of impact studies with eligible designs.
5. Assessed the evidence of effectiveness for each model.
6. Reviewed implementation information for each model.
7. Addressed potential conflicts of interest.

To have a complete understanding of possible program effects, the review must include all relevant research to date on program models. Thus reviews of new models and updates of existing models systematically include all of the aforementioned steps.

Literature search

Each year, the HomVEE team conducts a broad search for literature on home visiting program models serving pregnant women or families with children from birth to age 5.[1] The team limits the search to research on models that used home visiting as the primary service delivery strategy and offered home visits to most or all participants. Program models that provide services primarily in centers with supplemental home visits are excluded. The search is also limited to research on home visiting models that aimed to improve outcomes in at least one of the following eight domains specified in the legislation:

1. Child health
2. Child development and school readiness
3. Family economic self-sufficiency
4. Linkages and referrals
5. Maternal health
6. Positive parenting practices
7. Reductions in child maltreatment
8. Reductions in juvenile delinquency, family violence, and crime

HomVEE's literature search included two main activities:

1. **Database Searches**. The HomVEE team searched on relevant key words in a range of research databases. Key words included terms related to the service delivery approach, target population, and outcome domains of interest. The initial search was limited to studies published since 1989; a more focused search on prioritized program models included studies published since 1979 (see Prioritizing Home Visiting Program Models for the Review below). This search is updated annually to identify new literature released the previous year.
2. **Call for Studies**. Since 2009, HomVEE issued annual calls for studies, sent to approximately 40 relevant listservs for dissemination.

In addition to these two activities, in the first year of the review, HomVEE also included the following:

[1] For the purposes of the MIECHV, home visiting program models have been defined as programs or initiatives in which home visiting is a primary service delivery strategy and in which services are offered on a voluntary basis to pregnant women, expectant fathers, and parents and caregivers of children from birth to kindergarten entry, targeting participant outcomes that may include improved maternal and child health; prevention of child injuries, child abuse, 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; improvements in the coordination and referrals for other community resources and supports; or improvements in parenting skills related to child development.

3. **Review of Existing Literature Reviews and Meta-Analyses.** In the first year, the HomVEE team checked initial search results against the bibliographies of recent literature reviews and meta-analyses of home visiting models and added relevant missing citations to the search results. This check was conducted to ensure our search terms identified relevant studies; once the validity of the search terms was confirmed we did not repeat the process in subsequent years.
4. **Website Searches.** The HomVEE team used a custom Google search engine to search more than 50 relevant government, university, research, and nonprofit websites for unpublished reports and papers. Results of this search, however, largely overlapped with the results of the first two activities and this activity was dropped in subsequent years.

By the time of the 2014 review, the literature search yielded approximately 19,363 unduplicated citations, including 301 articles submitted through the HomVEE call for studies.

Screening studies

Each year, the HomVEE review team screens all new citations identified through the literature search for relevance. The team screens out studies for the following reasons:

- Home visiting was not the primary service delivery strategy.
- The study did not use an eligible design (that is, not a randomized controlled trial, quasi-experimental design, or implementation study).
- The program did not include an eligible target population (pregnant women and families with children from birth to age 5 served in a developed world context).
- The study did not examine any outcomes in the eight eligible outcome domains (child development and school readiness; child health; family economic self-sufficiency; linkages and referrals; maternal health; positive parenting practices; reductions in child maltreatment; and reductions in juvenile delinquency, family violence, and crime).
- The study did not examine a named home visiting program model.
- The study was not published in English.
- The study was published before 1989 for the initial search or 1979 for the focused search on prioritized program models.[2]

Prioritizing home visiting program models for the review

Each year, HomVEE releases new review results for program models. This includes reviews of studies on additional models and/or updates to previously reviewed models. Decisions on the number of models to review depend on available resources.

To prioritize home visiting models for inclusion in the review, the HomVEE team created a point system for ranking models. This point system was developed as a means of ranking models by the extent of rigorous research evidence available on their effectiveness. Points are assigned to models based on:

[2] Research that was published or released through December of the preceding year was eligible for inclusion, as was unpublished material provided through the HomVEE call for studies that ended in early January.

- The number and design of impact studies (three points for each randomized controlled trial, single-case design, or regression discontinuity design; and two points for each matched comparison group design)
- Sample sizes of impact studies (one point for each study with a sample size of 250 or more; before 2013, a sample size of 50 earned one point)
- Studies that examined an outcome of interest (starting in 2013, one point for each impact study that had an outcome in selected domains: child maltreatment; juvenile delinquency, family violence, or crime; linkages and referrals; and family economic factors. These domains are of particular interest because, to date, fewer studies reviewed for HomVEE have focused on them.)

During the prioritization process the HomVEE team also tries to determine whether the program appears to be currently operational and identify the availability of implementation information on the model. This information, which may be gleaned from websites, DHHS partners or other sources, helps inform the decision of which models to review in each cycle, especially when deciding among several models with a similar point value.

To be useful to the home visiting field, the review should include information about the most prevalent home visiting program models currently funded and implemented. Some frequently used program models, however, may not have a sufficient number of causal studies to receive priority for review. To ensure that the initial review conducted in 2009 included the most prevalent models, we compared the prioritized list of models to an objective data source on the prevalence of implementation.[3]

As HomVEE proceeds, this prioritization effort may yield more models in the highest point category than can be reviewed within an annual review cycle. Beginning in 2014, if this occurs, the HomVEE team will further prioritize models by randomly ordering the models within the highest category and will work in that order to identify whether each model has been in existence for at least three years, following the legislation. This effort may include contacting study authors or model developers to confirm publicly available information. The team will review information on as many eligible models (that have been in existence for at least three years) as can be completed within the annual cycle. Models lower on the randomly ordered list may not be considered in time for the close of that cycle. Those models will be returned to the pool for consideration in subsequent years, which will be re-randomized each year.

As of 2013, results for previously reviewed models will not be updated every year. Models may only be considered for updates every two years at the earliest. For example, if the review results for a model were updated in 2013, that model may not be considered for additional updating until 2015. However, either a grantee receiving MIECHV funds or HRSA can request that a model be updated ahead of schedule.

Through this process, as of October 2014, the team has prioritized 40 program models for the review (see Appendix for complete list). The first phase of the review included models that were among those with the highest rankings based on HomVEE's point system—these models

[3] Johnson, Kay. State-Based Programs: Strengthening Programs Through State Leadership. National Center for Children and Poverty, New York, 2009

were the most rigorously and extensively evaluated—and were among the most widely used models. As the review continued, we included program models with fewer points, but at least one rigorous study, as determined in the initial screening. In addition, HomVEE accepted submissions from states that wanted a particular model reviewed to determine whether it met the legislation requirements for an evidence-based model.

HomVEE completed impact reviews of 295 studies and implementation reviews of 230 studies about the 40 models. In conducting the review on newly prioritized or updated models, the team focused only on research that was published or released through December of the preceding year or unpublished material provided through the HomVEE call for studies that ended in early January. The review of research on prioritized models may be updated, but not all models are updated annually.

Rating the quality of impact studies

For each prioritized model, HomVEE reviews impact studies with two types of designs: randomized controlled trials (RCTs) and quasi-experimental designs (QEDs)[4] (including matched comparison group designs, single case designs, and regression discontinuity designs). Trained reviewers assess the research design and methodology of each study using a standard review protocol. Each study is assigned a rating of high, moderate, or low to provide an indication of the study design's capacity to provide unbiased estimates of program impacts.

In brief, the high rating is reserved for random assignment studies with low attrition of sample members and no reassignment of sample members after the original random assignment, and single case and regression discontinuity designs that meet What Works Clearinghouse (WWC) design standards (Table 1).[5] The moderate rating applies to random assignment studies that, due to flaws in the study design, execution, or analysis (for example, high sample attrition), do not meet all the criteria for the high rating; matched comparison group designs that establish baseline equivalence on selected measures; and single case and regression discontinuity designs that meet WWC design standards with reservations. Impact studies that do not meet all of the criteria for either the high or moderate ratings are assigned the low rating.

Assessing evidence of effectiveness

After completing all impact study reviews for a model, the HomVEE team evaluates the evidence across all studies of the program models that received a high or moderate rating and measured outcomes in at least one of the eligible outcome domains. To meet DHHS' criteria for an "evidence-based early childhood home visiting service delivery model," program models must meet at least one of the following criteria:

[4] HomVEE defines a quasi-experimental design as a study design in which sample members (children, parents, or families) are selected for the program and comparison conditions in a nonrandom way.

[5] The What Works Clearinghouse (WWC), established by the Institute for Education Sciences in the U.S. Department of Education, reviews education research.

Table 1. Summary of study rating criteria for the HomVEE review

HomVEE research design and criteria				
		Quasi-experimental designs		
HomVEE study rating	**Randomized controlled trials**	**Matched comparison group**	**Single-case design[b]**	**Regression discontinuity design[b]**
High	- Random assignment - Meets WWC standards for acceptable rates of overall and differential attrition[a] - No reassignment; analysis must be based on original assignment to study arms - No confounding factors; must have at least two participants in each study arm and no systematic differences in data collection methods - Controls for selected measures if groups are different at baseline	Not applicable	- Timing of intervention is systematically manipulated - Outcomes meet WWC standards for interassessor agreement - At least three attempts to demonstrate an effect - At least five data points in relevant phases	- Integrity of forcing variable is maintained - Meets WWC standards for low overall and differential attrition - The relationship between the outcome and the forcing variable is continuous - Meets WWC standards for functional form and bandwidth
Moderate	- Reassignment **OR** unacceptable rates of overall or differential attrition[a] - Baseline equivalence established on selected measures - No confounding factors; must have at least two participants in each study arm and no systematic differences in data collection methods	- Baseline equivalence established on selected measures and controls for baseline measures of outcomes, if applicable - No confounding factors; must have at least two participants in each study arm and no systematic differences in data collection methods	- Timing of intervention is systematically manipulated - Outcomes meet WWC standards for interassessor agreement - At least three attempts to demonstrate an effect - At least three data points in relevant phases	- Integrity of forcing variable is maintained - Meets WWC standards for low attrition - Meets WWC standards for functional form and bandwidth
Low	Studies that do not meet the requirements for a high or moderate rating			

Note: "Or" implies that one of the criteria must be present to result in the specified rating.

[a]The What Works Clearinghouse (WWC), established by the Institute for Education Sciences in the U.S. Department of Education, reviews education research (http://ies.ed.gov/ncee/wwc/). The WWC standard for attrition is transparent and statistically based, taking into account both overall attrition (the percentage of study participants lost in the total study sample) and differential attrition (the differences in attrition rates between treatment and control groups).

[b]For ease of presentation, some of the criteria are described very broadly. Additional details about standards are available for single-case designs (http://ies.ed.gov/ncee/wwc/pdf/wwc_scd.pdf) and regression discontinuity designs (http://ies.ed.gov/ncee/wwc/pdf/wwc_rd.pdf).

- At least one high- or moderate-quality impact study of the model finds favorable, statistically significant impacts in two or more of the eight outcome domains; or
- At least two high- or moderate-quality impact studies of the model using non-overlapping analytic study samples find one or more favorable, statistically significant impacts in the same domain.

In both cases, the impacts considered must either (1) be found for the full sample or (2) if found for subgroups but not for the full sample, be replicated in the same domain in two or more studies using non-overlapping analytic study samples. Additionally, following the legislation, if the model meets the above criteria based on findings from randomized controlled trial(s) only, then one or more favorable, statistically significant impacts must be sustained for at least one year after program enrollment, and one or more favorable, statistically significant impacts must be reported in a peer-reviewed journal.[6]

For results from single-case designs to be considered toward the DHHS criteria, three additional requirements must be met:

- At least five studies examining the intervention meet the WWC's pilot single-case design standards without reservations or standards with reservations (equivalent to a "high" or "moderate" rating in HomVEE, respectively).
- The single-case designs are conducted by at least three research teams with no overlapping authorship at three institutions.
- The combined number of cases is at least 20.

In addition to assessing whether each model met the DHHS criteria for an evidence-based early childhood home visiting service delivery model, the HomVEE team examined and reported other aspects of the evidence for each model based on all high- and moderate-quality studies available, including the following:

- **Quality of Outcome Measures.** HomVEE classified outcome measures as primary if data were collected through direct observation, direct assessment, or administrative records; or if study authors indicated that self-reported data were collected using a standardized (normed) instrument. Other self-reported measures are classified as secondary.
- **Replication of Impacts.** HomVEE classified impacts as replicated if favorable, statistically significant impacts were shown in the same outcome domain in at least two non-overlapping analytic study samples.
- **Subgroup Findings.** HomVEE reported subgroup findings if the findings were replicated in the same outcome domain in at least two studies using different analytic samples.
- **Unfavorable or Ambiguous Impacts.** In addition to favorable impacts, HomVEE reported unfavorable or ambiguous, statistically significant impacts on full sample and subgroup findings. While some outcomes are clearly unfavorable (such as an increase in children's behavior problems), others are ambiguous. For example, an increase in the number of days

[6] Section 511 (d)(3)(A)(i)(I)

mothers are hospitalized could indicate an increase in health problems or increased access to needed health care due to participation in a home visiting program.

- **Evaluator Independence.** HomVEE reported the funding source for each study and whether any of the study authors were program model developers.
- **Magnitude of Impacts.** HomVEE reported effect sizes when possible, either those calculated by the study authors or HomVEE computed findings.

Implementation reviews

The HomVEE team collected information about implementation of the prioritized models from all impact studies with a high or moderate rating and from stand-alone implementation studies. In addition, staff conducted Internet searches to find implementation materials and guidance available from home visiting program developers and national program offices. The HomVEE team used this information to develop detailed implementation profiles for each prioritized model that included an overview of the program model and information about prerequisites for implementation, materials and forms, estimated costs, and program contact information. National program offices were invited to review and comment on the profiles before their release. The team also extracted information about implementation experiences from the studies reviewed, including the characteristics of program participants, location and setting, staffing and supervision, program model components, program model adaptations or enhancements, dosage, fidelity measurement, costs, and lessons learned.

Addressing conflicts of interest

All members of the HomVEE team signed a conflict of interest statement in which they declared any financial or personal connections to developers, studies, or products being reviewed and confirmed their understanding of the process by which they must inform the project director if such conflicts arise. The HomVEE review team's project director assembled signed conflict of interest forms for all project staff and subcontractors and monitors for possible conflicts over time. If a team member is found to have a potential conflict of interest concerning a particular home visiting model being reviewed, that team member is excluded from the review process for the studies of that model. In addition, reviews for program models previously evaluated by Mathematica Policy Research were conducted by contracted reviewers who were not Mathematica employees.

Summary of review results

The HomVEE review produced assessments of the evidence of effectiveness for each home visiting model and outcome domain, as well as a description of each model's implementation guidelines. This section provides a summary of evidence of effectiveness by model and outcome domain, a summary of implementation guidelines for program models with evidence of effectiveness, and a discussion of gaps in the home visiting research literature.

Evidence of effectiveness by program model

Overall, HomVEE identified 17 home visiting models that meet the DHHS criteria for an evidence-based early childhood home visiting service delivery model: (1) Child FIRST, (2) Durham Connects/Family Connects (3) Early Head Start-Home Visiting, (4) Early Intervention

Program for Adolescent Mothers (EIP), (5) Early Start (New Zealand), (6) Family Check-Up,® (7) Family Spirit,® (8) Healthy Families America (HFA),® (9) Healthy Steps, (10) Home Instruction for Parents of Preschool Youngsters (HIPPY),® (11) Maternal Early Childhood Sustained Home Visiting Program, (12) Minding the Baby,® (13) Nurse Family Partnership (NFP),® (14) Oklahoma's Community-Based Family Resource and Support (CBFRS) Program, (15) Parents as Teachers (PAT),® (16) Play and Learning Strategies (PALS) Infant,[7] and (17) SafeCare® Augmented.[8] All of them have at least one high- or moderate-quality study with at least two favorable, statistically significant impacts in two different domains or two or more high- or moderate-quality studies using non-overlapping analytic study samples with one or more statistically significant, favorable impacts in the same domain.

Based on the available high- or moderate-quality studies, the review showed the following (Table 2):

- **Models have multiple favorable effects**. Most program models have numerous favorable impacts on primary and secondary measures. The number of outcomes showing favorable effects ranged considerably across models, as did the number of total outcomes measured (not shown).
- **Program models have sustained impacts**. All of the models that met the DHHS criteria have favorable impacts at least one year after program enrollment. For longer programs, families may still have been receiving services at the time the outcomes were measured.
- **Replication is uncommon**. Only 6 of the 17 models that met the DHHS criteria had favorable effects in the same domain in two or more samples. In other words, for most models that met DHHS criteria, favorable impacts were shown in only one sample or in two or more samples that each had favorable effects in different domains.
- **Results are not limited to subgroups**. All of the 17 models that met the DHHS criteria did so by showing results for a total study sample, rather than a subgroup based on particular characteristics. For most models, the study samples were racially, ethnically, and socioeconomically diverse.
- **Few unfavorable effects were reported**. Seven of the 17 models reported at least one unfavorable or ambiguous impact. It is not always clear whether an impact is unfavorable; for example, increased use of health care may reflect poorer health (an unfavorable effect), a better connection to the health care system (a favorable effect), or both, so the HomVEE review classifies these outcomes as unfavorable or ambiguous.

[7] PALS Toddler and PALS Infant + Toddler did not meet the DHHS criteria for an evidence-based program model.

[8] Project 12-Ways/SafeCare did not meet the DHHS criteria for an evidence-based program. Only the adaptation, SafeCare Augmented, met the DHHS criteria.

Table 2. Home visiting evidence dimensions for programs that meet DHHS criteria

	Results from studies with a high or moderate rating					
	Favorable impacts on primary outcome measures[a]	Favorable impacts on secondary outcome measures[a]	Sustained?[b]	Replicated?[c]	Favorable impacts limited to subgroups?	Unfavorable or ambiguous impacts[d]
Child FIRST	16*	12*	Yes*	No	No*	0
Durham Connects/Family Connects	6*	6*	Yes*	No	No*	0
Early Head Start–Home Visiting	5*	33*	Yes*	No	No*	2**
EIP	8*	2*	Yes*	No	No*	1**
Early Start (New Zealand)	9*	2*	Yes*	No	No*	0
Family Check-Up	5*	1*	Yes*	Yes*	No*	0
Family Spirit	12*	10*	Yes*	Yes*	No*	0
Healthy Families America	13*	31*	Yes*	Yes*	No*	4**
Healthy Steps	2*	3*	Yes*	No	No*	0
HIPPY	4*	4*	Yes*	Yes*	No*	0
Maternal Early Childhood Sustained Home Visiting Program	1*	3*	Yes*	No	No*	0
Minding the Baby	2*	0	Yes*	No	No*	0
Nurse Family Partnership	27*	52*	Yes*	Yes*	No*	9**
Oklahoma CBFRS	2*	3*	Yes*	No	No*	0
Parents as Teachers	12*	0	Yes*	Yes*	No*	7**
PALS Infant	12*	0	Yes*	No	No*	1**
SafeCare Augmented	2*	1*	Yes*	No	No*	1**

[a]In the full sample only. Primary measures were defined as outcomes measured through direct observation, direct assessment, administrative data, or self-reported data collected using a standardized (normed) instrument. Secondary measures included other self-reported measures.

[b]Yes, if favorable impacts were sustained for at least one year after the program began.

[c]Yes, if favorable impacts (whether sustained or not) were observed in the same outcome domain for at least two non-overlapping samples across high- or moderate-quality studies.

[d]This number includes unfavorable or ambiguous impacts on both primary and secondary measures in the full sample. Unfavorable findings should be interpreted with caution because there is subjectivity involved in interpreting some outcomes; for some outcomes, it is not always clear in which direction it is desirable to move the outcome. Readers are encouraged to use the HomVEE website, specifically the reports by program model and by outcome domain, to obtain more detail about unfavorable findings.

*Green-shaded table cell = favorable dimension of the study.

**Red-shaded table cell = unfavorable or ambiguous impact.

In addition to the 17 home visiting models described above, HomVEE reviewed 23 other home visiting program models (see Appendix for full list). Six models had a high or moderate quality study, but not two favorable, statistically significant impacts in two or more of the eight outcome domains.[9] Therefore, these program models did not meet the DHHS criteria for an evidence-based model. Two models had a high or moderate quality study with impacts in two or more of the eight outcome domains, but no favorable impact from a randomized controlled trial was sustained for at least one year after program enrollment.[10] For the remaining 15 models, no high- or moderate-quality studies were identified and consequently HomVEE was unable to assess their effectiveness.[11]

Evidence of effectiveness by outcome domain

In seven of the eight outcome domains, at least one of the home visiting models had favorable impacts on a primary measure (Table 3). None of the models, however, show impacts on reductions in juvenile delinquency, family violence, and crime, using a primary outcome measure. Most models had favorable impacts on primary measures of child development and school readiness and positive parenting practices. Healthy Families America has the greatest breadth of total findings, with favorable impacts on primary and/or secondary measures in all eight domains. Nurse Family Partnership had the greatest breadth of favorable primary findings, with favorable impacts on primary measures in six outcome domains.

Summary of implementation guidelines for models with evidence of effectiveness

The MIECHV legislation specifies a number of program implementation requirements.[12] The review of information about implementation identified a number of requirements for implementing home visiting models included in the review (Table 4). All of the 17 programs that met the DHHS criteria had been in existence for at least three years prior to the start of the review, 16 of them are associated with a national program office or institute of higher education that provides training and support to local program sites, 16 have minimum requirements for the frequency of home visits, and 13 have minimum requirements for home visitor supervision. In addition, 12 of the programs with evidence of effectiveness have pre-service training requirements, a system for monitoring fidelity, and specified content and activities for the home visits. Eleven programs have fidelity standards to which local implementing agencies must adhere.

[9] Those models were: Childhood Asthma Prevention Study; Computer Assisted Motivational Intervention; Home-Start; MOM Program; Parent-Child Home Program; and Resources, Education and Care in the Home.

[10] Those models were Child Parent Enrichment Project and REST Routine.

[11] We identified high or moderate rated studies on components and adaptations of Triple P-Positive Parenting Program, but not on the main model.

[12] See section 511(d)(3)(A)(i)(I), which includes variables such as "the model has been in existence for at least 3 years…" and section 511 (d)(3)(B), which specifies variables such as "well-trained and competent staff, as demonstrated by education and training…"

Table 3. Number of favorable impacts on primary measures for home visiting models with evidence of effectiveness, by outcome domain

	Child health	Maternal health	Child development and school readiness	Reductions in child maltreatment	Reductions in juvenile delinquency, family violence, and crime	Positive parenting practices	Family economic self-sufficiency	Linkages and referrals
Child FIRST	Not measured	10	5	1	Not measured	Not measured	Not measured	Not measured
Durham Connects/Family Connects	6	Not measured	Not measured	Not measured	Not measured	Not measured	Not measured	Not measured
Early Head Start–Home Visiting	Not measured	0	2	Not measured	Not measured	3	Not measured	Not measured
EIP	8	0	Not measured	Not measured	Not measured	0	Not measured	Not measured
Early Start (New Zealand)	2	0	2	2	Not measured	3	Not measured	Not measured
Family Check-Up	Not measured	Not measured	3	Not measured	Not measured	2	Not measured	Not measured
Family Spirit	Not measured	2	10	Not measured	Not measured	0	Not measured	Not measured
Healthy Families America	0	0	9	1	0	2	Not measured	1
Healthy Steps	2	Not measured	0	Not measured	Not measured	0	Not measured	Not measured
HIPPY	Not measured	Not measured	3	Not measured	Not measured	1	Not measured	Not measured
Maternal Early Childhood Sustained Home Visiting Program	0	0	Not measured	Not measured	Not measured	1	Not measured	Not measured
Minding the Baby	1	1	Not measured	0	Not measured	0	Not measured	Not measured
Nurse Family Partnership	4	3	5	7	0	4	4	Not measured
Oklahoma CBFRS	Not measured	Not measured	Not measured	Not measured	Not measured	2	Not measured	Not measured
Parents as Teachers	0	Not measured	7	1	Not measured	3	1	Not measured
PALS Infant	Not measured	Not measured	1	Not measured	Not measured	11	Not measured	Not measured
SafeCare Augmented	Not measured	0	Not measured	1	0	Not measured	Not measured	1

Table 4. Overview of the implementation guidelines for the home visiting models with evidence of effectiveness

	In existence for at least 3 years?[a]	Associated with national organization or institution of higher education?[a]	Minimum requirements for frequency of visits?	Minimum education requirements for home visiting staff?[a]	Supervision requirements for home visitors?[a]	Pre-service training for home visitors?[a]	Fidelity standards for local implementing agencies [a]	System for monitoring fidelity?[a]	Specified content and activities for home visits?
Child FIRST	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*
Durham Connects/Family Connects	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*
Early Head Start–Home Visiting	Yes*	Yes*	Yes*	No	Yes*	Yes*	Yes*	Yes*	No
EIP	Yes*	Yes*	Yes*	Yes*	No	Yes*	No	No	Yes*
Early Start (New Zealand)	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*
Family Check-Up	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	No	No	Yes*
Family Spirit	Yes*	Yes*	No	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*
Healthy Families America	Yes*	Yes*	Yes*	No	Yes*	Yes*	Yes*	Yes*	No
Healthy Steps	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	No	Yes*
HIPPY	Yes*	Yes*	Yes*	No	Yes*	Yes*	Yes*	Yes*	Yes*
Maternal Early Childhood Sustained Home Visiting Program	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*
Minding the Baby	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	No	Yes*	Yes*
Nurse Family Partnership	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*
Oklahoma CBFRS	Yes*	No	Yes*	Yes*	Yes*	Yes*	No	Yes*	Yes*
Parents as Teachers	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*
PALS Infant	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	No	Yes*	Yes*
SafeCare[b]	Yes*	Yes*	Yes*	No	Yes*	Yes*	No	Yes*	Yes*

Source: HomVEE implementation profiles.

Notes: If the documents reviewed by HomVEE (see the implementation report reference lists) did not include information about the topic and the developer provided no additional guidance then the answer is No.

*Shaded table cell = in compliance with implementation guidelines.

[a]Included in legislation.

[b]This information pertains to SafeCare; separate information is not available for SafeCare Augmented.

Gaps in the research

The HomVEE review identified several gaps in the existing research literature on home visiting models that limit its usefulness for matching program models to community needs. First, research evidence of program effectiveness is limited. As noted earlier, many models do not have high- or moderate-quality studies of their effectiveness; thus, policymakers and program administrators cannot determine whether those models are effective. Other models have only a few high- or moderate-quality studies, indicating that additional research on those models may be needed.

Second, more evidence is needed about the effectiveness of home visiting models for different types of families with a range of characteristics. Overall, the studies included in the HomVEE review had fairly diverse study samples in terms of race/ethnicity and socioeconomic status. However, sample sizes in these studies are not typically large enough to allow for analysis of findings separately by subgroup. Moreover, HomVEE found little or no research on the effectiveness of home visiting program models for immigrant families that have diverse cultural backgrounds or may not speak English as a first language, or military families.

For more Information

The HomVEE website (http://homvee.acf.hhs.gov/) provides detailed information about the review process and the review results, including the following:

- Reports on the evidence of effectiveness for each program model
- Reports on the evidence of effectiveness across models for each outcome domain
- Implementation profiles and information on implementation experiences for each program model
- A searchable reference list that provides the disposition of each study considered for all reviewed models
- Details about the review process and a glossary of terms

APPENDIX

PROGRAM MODELS REVIEWED BY HOMVEE

1	Attachment and Biobehavioral Catch-Up (ABC) Intervention	21	Maternal Early Childhood Sustained Home Visiting Program
2	Child FIRST	22	Maternal Infant Heath Outreach Workers (MIHOW)
3	Child Parent Enrichment Project (CPEP)	23	Minding the Baby
4	Childhood Asthma Prevention Study (CAPS)	24	MOM Program
5	Computer-Assisted Motivational Intervention (CAMI)	25	Mothers' Advocates in the Community (MOSAIC)
6	Durham Connects/Family Connects	26	North Carolina Baby Love Maternal Outreach Workers Program
7	Early Head Start–Home Visiting	27	Nurse Family Partnership (NFP)
8	Early Intervention Program for Adolescent Mothers (EIP)	28	Nurturing Parenting Program (Birth to Age 5)
9	Early Start (New Zealand)	29	Oklahoma's Community-Based Family Resource and Support (CBFRS) Program
10	Even Start-Home Visiting (Birth to Age 5)	30	Parent-Child Home Program
11	Family Check-Up	31	Parents as Teachers (PAT)
12	Family Connections (Birth to Age 5)	32	Philani Outreach Programme
13	Family Spirit	33	Play and Learning Strategies (PALS)
14	Health Access Nurturing Development Services (HANDS) Program	34	Pride in Parenting (PIP)
15	Healthy Families America (HFA)	35	Project 12-Ways/SafeCare
16	Healthy Start–Home Visiting	36	Resource Mothers Program
17	Healthy Steps	37	Resources, Education, and Care in the Home (REACH)
18	Home Instruction for Parents of Preschool Youngsters (HIPPY)	38	REST Routine
19	HOMEBUILDERS (Birth to Age 5)	39	Seattle-King County Healthy Homes Project
20	Home-Start	40	Triple P—Positive Parenting Program