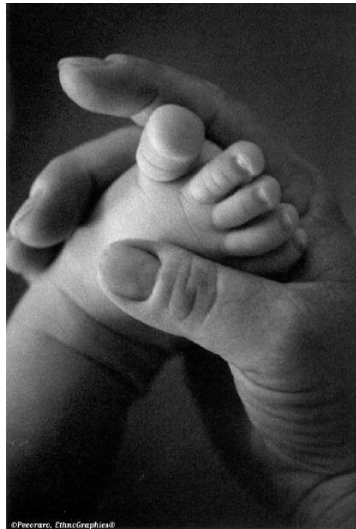

Changing the Conversation About Home Visiting: Scaling up with Quality

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Home Visiting: Scaling Up with Quality

The purpose of this paper is to determine what the evidence and conventional wisdom say about scaling-up home visiting as one of the best ways to support parents and promote early childhood development. To answer this question, we examined the available research evidence, interviewed leaders from six of the national home visiting models, and interviewed researchers who have studied home visiting. The area of interest for guiding future research, practice, and policy is whether home visiting can be delivered at broad scale and with the quality necessary to attain demonstrable, positive outcomes for young children and their parents.

Home visiting programs target children of different ages and have different goals. These differences are important to note because home visiting programs vary depending on who they serve and what they aim to accomplish.

| | Population Served | Program Goals |
|---|--|---|
| Early Head Start | Low-income pregnant women with infants and toddlers | Promote healthy prenatal outcomes, enhance development of young children, promote healthy family functioning |
| Healthy Families America | Parents of all income levels identified as at-risk for abuse and neglect | Promote positive parenting, prevent child abuse and neglect |
| The Home Instruction Program for Preschool Youngsters (HIPPY) | Families, many low-income but no restricted income guidelines | Empower parents as their children's educators, enhance children's early school success |
| The Nurse-Family Partnership | Low-income, first-time mothers | Improve pregnancy outcomes, child health and development, family economic self-sufficiency |
| The Parent-Child Home Program | Low-income families | Develop children's language and literacy skills and prepare them for academic success, empower parents and enhance parenting skills |
| Parents as Teachers | Parents of all income levels | Empower parents and increase their knowledge of child development, prepare children for school success |

Both the scientific evidence and expert opinion support the view that home visiting in general is a promising strategy for helping parents and promoting the growth and development of young children. The Nurse Family Partnership has demonstrated strong positive results including healthy pregnancies, increased time between births, decreased substance abuse, and decreased number of arrests in first time mothers and their children. Early Head Start and Parents as Teachers in combination with center-based care or preschool have shown positive outcomes in young children's literacy, math, and behavioral readiness for school. In addition, there are trials and new evaluations underway in three other programs: the Parent-Child Home Program, Healthy Families America, and HIPPPY. Is it a good bet to invest in taking quality home visiting programs to scale as part of a comprehensive early childhood system? The answer is "Yes, if certain conditions are met."

There is reason to invest in taking high quality home visiting to scale so long as four conditions are met as expansion occurs. First, given the substantial and growing body of evidence about home visiting, both new and continuing funding should ensure that providers have the commitment and capacity to incorporate lessons from their own and others' research and evaluations for program improvement as they go to scale. A number of national as well as local programs are building this capacity with continuous quality improvement and performance monitoring systems. Recent meta-analyses suggest that looking across as well as within programs provides information about specific activities and characteristics that contribute to more positive outcomes for children and parents. Therefore, the second condition is that home visiting programs must regularly collect and report information to ascertain if their hypothesized outcomes are being achieved. If they are not, they should determine why, modify their work accordingly, and continue to report on their progress. The third condition is that programs share research and evaluation on home visiting to continue to build the knowledge base for home visitation. Finally, because recent evaluations have shown that home visiting can be more effective when paired with center-based early childhood care and education, the fourth condition is that home visiting programs support trials in conjunction with center-based early childhood services to verify this finding and to better understand if and how home visiting contributes to a comprehensive system of supports for young children and families. Meeting all of these conditions will help establish realistic expectations for what home visiting can accomplish and help home visiting programs achieve desired outcomes.

In order for high quality home visiting to go to full scale, six specific recommendations are being made.

1. Develop mechanisms to test and report on the extent to which quality home visiting at scale improves outcomes for young children and parents
2. To increase the likelihood of achieving results at scale, programs should use a management information system for tracking and monitoring activities.
3. Identify what capacity is needed to maintain quality at scale in areas such as training, supervision, technical assistance, research, communication, and advocacy
4. Invest in research to better monitor what happens in visits that leads to improved outcomes
5. Invest in research to better match program goals, activities, and intensity with family circumstances, home visitors, and supports to get the best outcomes for young children and parents
6. Identify realistic expectations for what home visiting can accomplish and hold programs accountable for achieving those outcomes

Home Visiting: Scaling Up with Quality

Section 1: Introduction

There are three key sections in this paper:

- Section One provides an overview on why home visiting is important
- Section Two presents evidence and the debates about the scientific literature on home visiting
- Section Three outlines recommendations and conclusions

Overview

Research confirms that young children are most likely to reach their full potential when they have nurturing and supportive relationships, particularly during the first five years of life.¹ Prevention and intervention are most effective when they begin at the earliest possible time, notably before children are born.² That makes parents a critically important factor in determining how successful children are later in life. Careful study of what it takes for young children to develop the language and literacy skills for school success points to positive interactions and experiences between young children, their parents, or their caregivers.³

A common and growing approach to help parents support the development of their young children is home visiting. According to a recent report, home visiting reaches as many as 400,000 children and families across the country each year at an annual cost between \$750 million to \$1 billion.⁴ And home visiting programs are expanding as states and communities add them to their range of early childhood services. In

¹ Shonkoff, J. and Phillips, D. (2002). *From Neurons to Neighborhoods: The Science of Early Childhood Development*. National Academy Press. Washington, D.C.

² Campbell, F.A., Ramey, C.T., Pungello, E.P., Sparling, J., & Miller-Johnson, S. (2002). Early Childhood Education: Young Adult Outcomes from the Abecedarian Project. *Journal of Applied Developmental Science*, 6, 42-57.

³ Hart, B. & Risley, T.R. (2002). *Meaningful Differences in the Everyday Experience of Young American Children*. Brookes Publishing. Washington, D.C.

⁴ Gomby, D.S. (July, 2005). *Home visitation in 2005: Outcomes for children and parents*. Report commissioned by Wellspring Advisors. Washington, D.C.
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2001, at least 37 states had state-based home visiting systems.⁵ However, most states reach only a fraction of eligible families.

Though there are many different types, home visiting programs all share a common delivery method of providing services in family homes and the general goal of helping parents nurture and support the development of their young children.⁶ There are several reasons for the proliferation and relatively fast expansion of all kinds of home visiting programs. First, home visiting is an attractive idea to people who believe it is important to support parents raising young children by serving them at home rather than outside the home. Second, home visiting is a preferred approach for many families who would not choose other forms of early childhood services such as center-based care. And third, there is evidence that home visits can, although they may not always, produce an array of positive benefits for children and their families. Much of this evidence is from evaluations of programs at a few sites. In the instances where there have been evaluations of larger scale efforts, the evidence is mixed with some models showing an array of positive outcomes and others showing few, suggesting the need for effective systems to ensure quality when moving to scale.

Betting on Home Visiting

Many people are betting on the scale-up of home visiting as one of the best ways to support parenting and early childhood development. Is this a good bet? To answer this question, we examined the available evidence, including evaluations of individual programs as well as recent evaluation syntheses and a meta-analysis of 60 programs. On the basis of this evidence, we conclude that home visiting is a promising strategy to promote early childhood growth and development. Given this conclusion, we believe that the key policy and practice question that must then be addressed is whether home visiting can be delivered at broader scale with the quality necessary to attain demonstrable, positive outcomes for young children and their parents.

This is a particularly important question because so much of the existing evidence about home visitation is from evaluations of programs at one or a few sites. So decisions about continued investments in visitation arguably require assessment of whether there is the national organizational capacity to develop, implement, monitor and evaluate early home visiting services so they can be delivered with the quality necessary to achieve their promised child and family outcomes. In order to

⁵ Johnson, K.A. (May 2001). *No place like home: State home visiting policies and programs*. Johnson Group Consulting, Inc. Report commissioned by The Commonwealth Fund. Available at www.cmwf.org.

⁶ Sweet, M.A. & Appelbaum, M.I. (2004). Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children. *Child Development*, 75 (5),1435-1456. Harvard Family Research Project · Harvard Graduate School of Education · 3 Garden Street · Cambridge, MA · 02138 Website: www.hfrp.org · Email: hfrp@gse.harvard.edu · Tel: 617-495-9108 · Fax: 617-495-8594

determine if this is true, and assess what conditions are necessary to produce quality at scale, we talked with evaluators and with representatives of six of the leading national home visit models to examine their views of the readiness for and capacity to carry out significant scale-up. These six national models are attempting not only to go to scale, but to do so with the quality necessary to achieve results and show that the bet on further investment in home visitation is paying off in important child and family outcomes: Early Head Start (EHS), Healthy Families America (HFA), the Home Instruction for Parents of Preschool Youngsters (HIPPY), the Nurse Family Partnership (NFP), Parents as Teachers (PAT), and the Parent-Child Home Program (PCHP). The table in Appendix 4 provides an overview of these models. All are designed to contribute to healthy child development and ultimately to school readiness. It should be noted here that they each target families with children somewhere between the prenatal period and age five, that they may target different kinds of families ranging from first time teen mothers to all parents with children in the requisite age group, and that they each focus on different and sometimes overlapping child and family outcomes.

We chose to focus on these models to address the capacity question because they are reasonably well-established national programs with sites in many communities and states around the country. Each is actively looking for expansion opportunities and is building its national-level organizational infrastructure to support future growth. Each has carried out one or more rigorous evaluations which demonstrated a pattern of positive outcomes on some desired outcomes, and no results on others. As a result, each of these models is considering how to increase and maintain quality with expansion. Finally, all acknowledge that home visiting is necessary but not sufficient to support early child development and are developing ways to position their home visitation models in a broader system of birth-to-five early childhood services.

Our review of both the evaluations of home visitation, and of the existing capacity for bringing home visiting to scale with sufficient quality to achieve outcomes, convinced us that home visiting continues to be a promising approach worthy of further investment as long as some key conditions are, or continue to be met. These four conditions form the basis for six recommendations, informed by those who lead and those who evaluate home visiting, about what will be necessary to increase the odds that home visitation can achieve meaningful, positive results for young children and their parents. Is home visitation a good bet? The answer is a “conditional yes.” It is dependent both on the conditions being met and on further rigorous evaluation to test the most effective ways to scale up home visiting as part of a system of early childhood services and get the promised benefits for children and families.

Our Inquiry Process

In the next section of this paper we examine the evaluation evidence on home visiting. Our particular focus is on scaling-up home visiting with quality and as part of a comprehensive system of early childhood supports.

We began by reviewing the evidence on home visiting that has been summarized by Gomby, Daro, and Sweet and Appelbaum. We also reviewed any new research published since these earlier reports were completed. But the research base does not address all the issues related to quality and scale. Therefore, we supplemented the research with telephone interviews. We talked with representatives from the six national home visit models and selected researchers experienced in home visiting to learn what they believe is necessary to deliver quality home visiting at scale. A list of key informant interview participants is in Appendix 2 and the interview protocol is in Appendix 3.

From the research and the key informant interviews, we offer recommendations about what can be done to risk taking the bet and insure that quality home visiting, as a key component in a comprehensive system of supports for parents and young children, can achieve outcomes at scale.

Section 2: The Evidence Base on Home Visiting

Since the early 1990's and a special edition of *The Future of Children*, there has been ongoing debate about whether the evidence is sufficient to warrant investing in home visiting at scale and as a key part of a system of early childhood supports.⁷ At the time, there were several large scale investments in home visiting and a science base that found overall home visiting was a promising but not proven strategy. Home visiting was deemed “necessary but not sufficient” and the call was made to embed home visiting in a comprehensive early childhood system.⁸

Positioning Home Visiting As A Key Component of A Comprehensive Early Childhood System

Since then, other studies have drawn the same conclusion. Jeanne Brooks-Gunn's research focuses on designing and evaluating interventions aimed at enhancing the well-being of mostly low-income children. As a result of her experience with the Comprehensive Child Development Program, she suggests that “intensive home

⁷ Gomby, D.S. & Larson, C.S. eds. (1993). Home Visiting. *The Future of Children*, 3 (3), 1-216.

⁸ Weiss, H.B. (Winter, 1993). Home visits: Necessary but not sufficient. *The Future of Children*, 3,3, 113–28.

visiting coupled with center-based programs may be a good strategy for enhancing school readiness.”⁹

Since EHS programs provide services either through center-based programs, home-based programs, or a mixed approach that combines the two, they are in a perfect position to test the effectiveness of home visiting in combination with different services.¹⁰ Each delivery approach had different expectations for what would occur as a result of the program. Home-based programs expected changes in the home environment and in parent knowledge and behavior. Center-based programs expected more changes directly related to child growth and development. Mixed approaches expected changes in both children and parents. The impact of the program also varied based on the type of program approach. Center-based programs did not show significantly different results, but slight differences were seen in some effects on children such as better vocabulary and language and engagement with parents and teachers. Home-based programs had slight but significant impacts on parenting, including stronger parental support for the child and more engagement with children during play. Mixed-approach programs had the broadest range of significant impacts including children’s language, social-emotional development, less physical punishment, parents reading more to their children, and parents being more supportive of their children during play. These findings support the case that the best results come when children and parents receive a combination of home visiting and center-based early childhood education.

As a model with large numbers of programs embedded in other early learning programs such as Head Start, public preschools, and child care, PAT is interested in how stand- alone PAT programs do compared to programs that are blended with other services. In 1999 the Missouri School Entry Assessment Project was created to identify early life experiences that either promote or prevent school success. Teachers rated 3500 kindergartners, representative of the state public school population, on physical development, symbol development, communication, math knowledge, conventional knowledge, and working with others. Parents reported on their early learning experiences before entering kindergarten. Based on those reports and classroom observations, a series of comparisons was identified including: no

⁹ Brooks-Gunn, J. (Winter 2004-2005.) A conversation with Jeanne Brooks-Gunn. *The Evaluation Exchange*, 10 (4),12-13.

¹⁰ Love, J.M., Constantine, J., Chazan-Cohen, R., Brady-Smith, C., Raikes, H., Brooks-Gunn, J., Tarullo, L.B., & Schochet, P.Z. (2005). The effectiveness of Early Head Start for 3-year-old children and their parents: Lessons for policy and programs. *Developmental Psychology*, 42, No.6, 885-901.
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PAT, PAT alone, PAT plus center care, PAT plus preschool, and PAT plus both center-care and preschool.¹¹

Similar to the EHS findings, the best outcomes were found when PAT home visiting services are combined with either center-based care or preschool. Among children who participated in PAT and attended preschool, both minority and non-minority children scored above average on kindergarten assessment. Children in both high-poverty and low poverty schools who participated in PAT and attended preschool scored above average on kindergarten entry assessment. Among children whose care and education are solely home-based, those whose families participate in PAT scored significantly higher. Head Start children who also participated in PAT and another preschool scored at average or above when they entered kindergarten. The study used a non-experimental design, so further study is needed to see if the patterns hold under more controlled, experimental conditions.

What Evaluation Research Says About Home Visiting

A comprehensive research review in 2005 conducted by Gomby for the First Five Commission in California provides a thorough overview of the short-term and long-term impacts of home visiting for children and parents.¹² Her review focused on studies in peer-reviewed journals and found that results of home visiting vary in large measure depending on program goals and how program models are designed and implemented. Home visiting programs can produce benefits for children and parents, though they are often modest, and the best impacts are achieved when program goals are clear and focused, programs link with other early childhood and family support services, and services are of high quality.

Just this year, Daro completed a review of home visiting as part of written testimony to Congress.¹³ She cites similar gains from experimental studies that show improved parent-child attachment, improved access to preventive medical care, improved parental capacity and functioning, reduced child abuse and maltreatment, and improved early identification of developmental delays. Daro points out that much of the research is done on state-specific home visitation models, and though most of the findings are not published in peer-reviewed journals, there are a number of evaluations that use rigorous experimental or quasi-experimental research designs

¹¹ Pfannenstiel, J., Seitz, V., and Zigler, E. (2001). Promoting school readiness: The role of the Parents as Teachers Program. *NHSA Dialog*, 6, No. 1, 71-80. ISSN 10892583

¹² Gomby, D.S. (January 2003). *Building school readiness through home visitation*. Paper commissioned for First Five California Children and Families Commission. Available at: <http://www.cfcf.ca.gov/SchoolReady.htm>

¹³ Daro, D. (September 2006). *Home Visitation: Assessing Progress, Managing Expectations*. Written Testimony for House Subcommittee on Education Reform, Committee on Education and the Workforce. Available at: www.chapinhall.org

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and well-developed measures. Some of the findings from these studies show that home visiting is associated with fewer acts of child abuse and neglect, more positive health outcomes, more satisfying interactions between mothers and infants, and more choices to pursue stable and nurturing environments in which to raise children.

After looking at a wide range of the literature, Daro identifies some of the key factors that contribute to positive effects to support program improvement efforts including: solid links between program elements and desired outcomes, establishing lasting relationships between home visitors and families, well trained and competent staff, high quality supervision, strong organizational capacity, and links between home visiting and other community resources and supports.

Research on Individual Program Models

The six national home visitation models discussed here continue to carry out evaluations to ascertain whether they are achieving the outcomes their theories of change specify, to build their performance monitoring systems and to get information to support their efforts to achieve positive outcomes as they expand to greater scale. The studies reported below review the results of more recent evaluations employing rigorous designs to determine impacts on children and parents. The number of rigorous experimental evaluations per model varies and they show a mixed pattern of results, suggesting the need for continued performance monitoring and evaluation as they go to scale. The Nurse Family Partnership, serving first time teen mothers from the prenatal period through age two, has demonstrated strong positive results in its three trials while several others have more mixed results varying by site. Notably, none of the models has reported much about outcomes as they go to scale outside of an experimental condition.

EARLY HEADSTART

A randomized trial of over 13,000 families from 17 EHS program sites studied the effectiveness of the program with respect to both child and parent outcomes. Researchers conducted interviews with primary caregivers, conducted child assessments, and observed parent-child interactions at the end of the program when children were age three. Children in home-based programs (home visiting) made gains in social-emotional development and parents were more supportive during play with their children. Home based programs alone did not produce improvements in children's cognitive and language development. Overall, children and parents made the biggest gains when programs were well implemented according to EHS

performance standards and when children participated in a mix of home visiting and center-based early care and education.¹⁴

THE NURSE FAMILY PARTNERSHIP

The NFP program focuses mostly on maternal life course, children's social development and behavior, and child maltreatment. The NFP is based on randomized control trials that inform program development and has a history of 27 years of research findings on multiple outcomes for both mothers and children. A recent review reported on findings from all three program trials: Elmira, Denver, and Memphis.¹⁵ In Elmira, nurse visited women smoked 25% less and had 75% fewer preterm deliveries. Teen mothers had 80% fewer cases of child abuse and neglect and 32% fewer visits to the emergency room. When children turned four, nurse visited women had fewer subsequent pregnancies and longer intervals between births. At the 15 year follow-up, only the poorest women and children showed lasting benefits including all of the previous outcomes in addition to less time receiving welfare and food stamps, and fewer arrests. The children used less drugs and alcohol and had fewer arrests, convictions, and probation violations. In Memphis the program was tested with low-income African American women. Though there were fewer differences between treatment and control groups, the nurse-visited women still had fewer pregnancies, fewer subsequent births, and longer duration between births. In Denver the results were more similar to Memphis than to Elmira, where positive results are maintained though not at the levels in the original trial. One outcome unique to Denver is worth noting. In Denver, NFP tried a new curriculum component that apparently reduced the incidence of domestic violence by 49 percent. This effort to reduce domestic violence is now being tested in randomly assigned NFP sites around the country.

PARENTS AS TEACHERS

Researchers at Case Western Reserve University School of Medicine recently conducted a randomized, controlled evaluation of the PAT Born to Learn program implemented at the Mayfield Jewish Community Center in Cleveland.¹⁶ A total of 227 families were randomly assigned the intervention group and 232 to the comparison group. Trained research assistants assessed the children at 12, 18, 24 and 36 months of age and looked at differences between low and middle-high socio-

¹⁴ Love, J.M., Constantine, J., Chazan-Cohen, R., Brady-Smith, C., Raikes, H., Brooks-Gunn, J., Tarullo, L.B., & Schochet, P.Z. (2005). The effectiveness of Early Head Start for 3-year-old children and their parents: Lessons for policy and programs. *Developmental Psychology*, 42, No.6, 885-901.

¹⁵ Olds, D. (2006). The Nurse-Family Partnership: An evidence-based preventive intervention. *Infant Mental Health Journal*, 27 (1), 5-25.

¹⁶ Drotar, D., Hurwitz, H.M., and Kirchner, H.L., (In Press). Case Western Reserve University. Cleveland, OH.

economic status (SES) of families in addition to differences between the intervention and comparison groups. Children whose parents received Born to Learn demonstrated better problem solving, persistence, and social skills at 36 months. Intervention children from low SES families demonstrated significantly higher levels of cognitive development and more adaptive behavior at 24 months than did low SES children who did not receive the program, a group that PAT has been questioned about serving in the past. There was no difference for children from middle/high socioeconomic status families, nor between intervention and comparison parent groups in level of knowledge about child development. The researchers suggest that the lack of effects on children's overall cognitive gains and parent outcomes may be in large measure due to "less than optimal program intensity, especially for the 3rd year." In fact, during the final year of the program, intervention families received on average one-third of the recommended number of visits, severely limited their exposure to the curriculum and to the home visitors. PATNC has recently engaged Sweet and Appelbaum to conduct a review of the research that has been conducted on the program to date, with the result being a plan for an experimental study to address both program improvement and results-based accountability.

HIPPY

The HIPPY AmeriCorps evaluation is in year 2 of a three year study. Results to date show after participating in HIPPY AmeriCorps programs for a year, more children were performing at or above their age level on standardized vocabulary tests and parents reported they spend more time reading to their children, more time talking with them about books, more time teaching them the alphabet, and that they have more knowledge about the way young children grow and learn.¹⁷ HIPPY USA has expressed interest in conducting more rigorous research, but has had difficulty obtaining funding for a randomized controlled trial.

HEALTHY FAMILIES AMERICA

A recent randomized control trial of a program in New York modeled after HFA looked at 1173 families at risk for child abuse and neglect, with a major difference from other HFA studies. In this case, 15% of the women were enrolled in the program before giving birth, compared to other HFA programs that enroll mothers who may already have abused or neglected their children. The study also looked at subgroups of mothers with limited intellectual and mental health functioning and younger, first time mothers. Like previous studies of HFA, there were no significant differences in treatment and control groups on the indicator of CPS substantiated

¹⁷ Black, M.M. and Powell, D. October 2005. Year One HIPPY AmeriCorps Evaluation: Parent Involvement in Literacy Activities and Children's Receptive Vocabulary Development. University of South Florida. Department of Child and Family Studies.
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reports of abuse and neglect. However, on other indicators there were significant differences. Overall, mothers in the program reported committing fewer acts of abuse or neglect in the first year and in the second year they reported one-third fewer acts of more serious forms of physical abuse than mothers in the comparison group. Younger, first time mothers were less likely to engage in abusive behavior (41% versus 62%). And similar to the NFP, mothers who have the fewest resources to draw on reported the fewest acts of serious abuse and neglect (20% fewer than other mothers) and benefited the most from the program.¹⁸ More favorable results in this HFA program compared to HFA programs in Hawaii and San Diego are, then, most likely the result of enrolling a different population and one more similar to the NFP: younger, pregnant, first time mothers who are most likely to benefit from a program to prevent abuse and neglect. Future research on HFA should investigate the most promising approaches for different groups of mothers.

THE PARENT CHILD HOME PROGRAM

A longitudinal study of the PCHP in Massachusetts compared at-risk children who completed the program with a control group. Program participants had significantly higher rates of high school graduation: 84% of program participants compared to 53% for the control group.¹⁹ A study in rural South Carolina showed significant increases in school readiness for at-risk children with 93% of program participants determined to be ready based on a state assessment compared to 74% of children who did not participate in the program.²⁰ The PCHP has been fundraising for an updated rigorous study and has recently been awarded over \$400,000 over two years by a private foundation for a randomized controlled trial with 200 families in Philadelphia.

Research Across Multiple Program Models

The previous studies reported findings from individual studies. Meta-analytic assessment of many evaluations of home visitation provides a different and in some ways an even stronger statistical test of programs, as it looks at results across programs. By 2004 there were enough peer-reviewed studies of these six program

¹⁸ DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., & Rodriguez, M. (June 2006). *Healthy Families New York Randomized Trial: Impacts on Parenting After the First Two Years*. New York State Office of Children and Family Services. Working Paper Series: Evaluating Healthy Families New York. Available at: www.ocfs.state.ny.us/main/prevention/assets/HFNYRandomizedtrialworkingpaper.pdf

¹⁹ Levenstein, P., Levenstein, S., Shiminsky, J.A., & Stolzberg, J.E. (1998). Long-term impact of a verbal interaction program for at-risk toddlers: An exploratory study of high school outcomes in a replication of the mother-child home program. *Journal of Applied Developmental Psychology*, 19 (2), 267-285.

²⁰ Levenstein, P., Levenstein, S., Oliver, D. (2002). First grade school readiness of former child participants in a South Carolina replication of the Parent Child Home Program. *Journal of Applied Developmental Psychology*, 23 (3),

models as well as other early home visitation efforts to warrant meta-analysis. This meta-analysis looked at data from 60 programs that used home visiting as their primary strategy and specifically examined 5 outcomes for children and 5 for parents.²¹ In general across the studies reviewed, home visiting was associated with the following outcomes: parenting attitudes and behaviors improved; more mothers returned to school; children had better social, emotional, and cognitive abilities; and the potential for child abuse was lower for home-visited children based on emergency room visits, injuries and accidents. In general, across all studies reviewed, reported or suspected child maltreatment was reduced but the difference was not statistically significant.

The overall conclusion, however, is consistent with the conclusions drawn in most previous summaries of home visiting evaluation research: “home visiting programs as a whole did provide a benefit to both parents and children . . . all effect sizes fall in the small category . . . statistical significance, however, does not necessarily indicate practical significance and whether or not the magnitude of observed effects is meaningful and important remains to be determined.”

When findings from Gomby, Daro, and Sweet and Appelbaum are viewed side by side, it is evident why people can come to different conclusions about potential benefits of taking home visiting to scale. Different results on just one indicator, child abuse and neglect, point out some of the challenges. Some of the difficulty lies in the low incidence of this behavior and may or may not indicate a program problem achieving this outcome. Further, the positive effects of particular programs may be masked when results from multiple studies are pooled (meta-analysis). The ways results are interpreted can also vary based on the size of the sample. For example, there may be differences for a sub-group of parents in a large sample but when the data is averaged together, the improvements they make will no longer be noticed. And when the numbers in the sample are small enough, it isn't even possible to conduct certain types of statistical analyses so they won't be reported. Finally, significant and practical differences may or may not be found, depending on which studies are included in any given research sample. This was seen in the differences in the way child abuse was interpreted in the Sweet and Appelbaum versus the Daro analyses.

²¹ Sweet, M.A. & Appelbaum, M.I. (2004). Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children. *Child Development*, 75 (5),1435-1456.
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Cost-Benefit Research

Two major reports have examined cost-benefit analyses of home visiting. The following table was created by Gomby to show how the costs and benefits are broken out for different types of home visiting programs.²² Home visiting programs show clear benefits that can outweigh costs associated with programs and services. In some cases, the benefits measured up to now may be too low to produce net benefits over costs. For example, none of the current calculations include benefits to siblings that might impact cost benefit calculations in the future.

**Costs and Benefits for Selected Home Visiting Programs:
Results from Aos et al (2004) and Karoly et al (2005), in 2003 dollars**

| Program | Benefits | Costs | Benefits Per Dollar of Cost | Benefits Minus Costs |
|---|----------|---------|-----------------------------|----------------------|
| Home Visiting Programs | | | | |
| Home Instruction for Parents of Preschool Youngsters (HIPPIY) [†] | \$3,313 | \$1,837 | \$1.80 | \$1,476 |
| HIPPIY [‡] | 3,032 | 1,681 | 1.80 | 1,351 |
| Parents as Teachers [†] | 4,300 | 3,500 | 1.23 | 800 |
| Parent Child Home Program ^{†*} | 0 | 3,890 | 0 | -3,890 |
| NFP –overall sample ^{†,‡} | 26,298 | 9,118 | 2.88 | 17,180 |
| NFP –Higher risk sample [‡] | 41,419 | 7,271 | 5.70 | 34,148 |
| NFP—Lower risk sample [‡] | 9,151 | 7,271 | 1.26 | 1,880 |
| Healthy Families America [‡] | 2,052 | 3,314 | .62 | -1,263 |
| Home visiting programs for at-risk mothers and children (meta-analysis) ^{†‡} | 10,969 | 4,892 | 2.24 | 6,077 |
| Home Visiting Plus Other Services | | | | |
| Even Start [†] | 0 | 4,863 | .23 | -16,203 |
| Comprehensive Child Development Program [†] | -9 | 37,388 | 0 | -37,397 |
| Infant Health and Development Program [†] | 0 | 49,021 | 0 | -49,021 |
| High/Scope Perry Preschool Project [‡] | 253,154 | 14,830 | 17.07 | 238,324 |

Sources:

[†] Aos, S., Lieb, R., Mayfield, J., Miller, M., Pennucci, A. (September 2004). *Benefits and costs of prevention and early intervention programs for youth*. Olympia: Washington State Institute for Public Policy. www.wsipp.wa.gov

[‡] Karoly, L.A., Kilburn, M.R., & Cannon, J.S. (2005). *Early childhood interventions: proven results, future promise*. MG-341. Santa Monica, CA.

* Only one study included due per experimental design qualification

²² Gomby, D.S. (January 2003). *Building school readiness through home visitation*. Paper commissioned for First Five California Children and Families Commission. Available at: <http://www.cfcf.ca.gov/SchoolReady.htm>

These early cost benefit studies should be taken as just that, early studies. There have been some useful discussions about whether there is sufficient information to compare cost and benefits across different program models. One report raises two key issues: early cost-benefit studies examined only long-term outcomes (saved medical costs and potential earnings) as opposed to short-term outcomes targeted by many home visiting programs (attitudes about health and parent-child interaction) and only studies with random trials were included, which leaves out the majority of the evaluation research in many of the home visiting programs.²³ It should also be noted that the cost and benefits vary across sites. For example, the cost benefit analysis from NFP suggests that more than one cost-benefit calculation is needed to capture the differences in programs from the same model implemented in different places and under different conditions. Another opportunity for future study comes out of the fact that many of the current figures are based on expected average program costs as opposed to actual costs based on the way programs are implemented. And as previously noted, many home visiting programs are part of a larger system of early childhood supports. The bottom half of the chart addresses the fact that most programs typically connect families to community resources such as health or social services and none of these cost estimates include the costs of services that families and children access based on referrals from home visitors. This is all the more reason further research in this area is needed.

Is It Wise to Bet on Home Visiting: Is it Worth the Investment?

Findings from the research confirm our original hypothesis that the answer is a conditional “Yes, if certain conditions are met.”

Yes, it is worth betting on taking to scale high quality home visiting programs and those that are part of a comprehensive early childhood system, but there are conditions that should be met as new funding is expanded and current funding is being re-evaluated. What are the conditions? First, given the substantial and growing body of evidence about home visiting, both new and continuation funders should ensure that providers have the commitment and capacity to incorporate lessons from their own and others’ research and evaluations for program improvement as they go to scale. A number of national as well as local programs are building this capacity with continuous quality improvement and performance monitoring systems. Recent meta-analyses suggest that looking across as well as within programs provides information about specific activities and characteristics that contribute to more positive outcomes for children and parents. Therefore, the second

²³ Organizational Research Services. (October 2004). *Commentary on the Washington State Institute for Public Policy Report: Benefits and Costs of Prevention and Early Intervention Programs for Youth*. Seattle, WA. Available from: ors@organizationalresearch.com

condition is that home visiting programs must regularly collect and report information to ascertain if their hypothesized outcomes are being achieved. If they are not, they should determine why, modify their work accordingly, and continue to report on their progress. The third condition is that programs share research and evaluation on home visiting to continue to build the knowledge base for home visitation. Finally, because recent evaluations have shown that home visiting can be more effective when paired with center-based early childhood care and education, the fourth condition is that home visiting programs support trials in conjunction with center-based early childhood services to verify this finding and to better understand if and how home visiting contributes to a comprehensive system of supports for young children and families. Meeting all of these conditions will help establish realistic expectations for what home visiting can accomplish and help home visiting programs achieve desired outcomes.

This also changes the policy discussion. The focus would shift away from proving individual program effectiveness, to a focus on how high quality home visiting as a strategy can achieve impacts on both parents and children as it is brought to full scale.

Section 3: Focusing on Quality: Recommendations for What Programs Do and Should Do to Scale Up with Quality

A brief program description for each of the six models is in Appendix 4. Like all home visiting programs, they vary on several dimensions: specific program goals, frequency and intensity of services, population served, background of home visitors, training and supervision, program infrastructure, and sources and amounts of funding. On the other hand these six models share some commonalities: they are primary prevention programs serving young children and families through either the first three or five years of a child's life; they are widely recognized, and they have national centers that coordinate local programs in multiple communities and states across the country. These six models also participated in the National Home Visit Forum, which provides opportunities to learn from one another in an effort to benefit each individual model, and more importantly, to benefit home visiting overall. A brief description of the Home Visit Forum is in Appendix 1.

The following recommendations explain the conditions that leaders from the six national home visiting models and leaders in home visiting research say are necessary to deliver quality services at scale.

Recommendations At A Glance

1. Develop mechanisms to test and report on the extent to which quality home visiting at scale improves outcomes for young children and parents
2. To increase the likelihood of achieving results at scale, programs should use a management information system for tracking and monitoring activities
3. Identify what capacity is needed to maintain quality at scale in areas including training, supervision, technical assistance, research, communication, and advocacy
4. Invest in research to better monitor what happens in visits that leads to improved outcomes
5. Invest in research to better match program goals, activities, and intensity with family circumstances, home visitors, and supports to get the best outcomes for young children and parents
6. Identify realistic expectations for what home visiting can accomplish and hold programs accountable for achieving those outcomes

Recommendation 1:

Develop mechanisms to test and report on the extent to which quality home visiting at scale improves outcomes for young children and parents

Each of the six national home visiting models is committed to operating programs with quality, evidenced by efforts to establish some kind of quality assurance or monitoring system. There is, however, variation among programs when it comes to monitoring the effects of their quality assurance efforts.

HIPPY USA collects data from state leaders on a self assessment tool (SAVI) that is then cross-validated by the National Center. When the SAVI data indicates a deviation from the program model and objectives, HIPPY USA makes a call to either state leaders or local programs to talk about why this is occurring. Operating the program according to the program guidelines is valued, but there is also recognition that “acceptable adaptations” can be good, and therefore acceptable.

“We try to focus on the results of the program modifications that are made and note the conditions and circumstances when they lead to positive changes. These acceptable adaptations are then incorporated into the program model and made available so all programs can benefit.”

-Elisabet Eklind,
HIPPY USA

The PCHP attempts to maintain quality through an annual review by the National Center. From these reports, the PCHP National Center can see where implementation of the key program elements varies. Similar to HIPPI, only if the National Center approves the changes can programs continue to operate under the banner of the PCHP.

“We are committed to evaluating how the standards are affecting quality of our programs, but we’re just getting starting and we want programs to feel comfortable with the process before we evaluate their progress.”

-Karen Guskin, PAT

After four years of development and nearly \$2 million, PAT is rolling out a new quality assurance plan based on eight standards representing four core service delivery components and four areas of program management. The process is intended to help monitor program quality through a combination of program self-assessment and a National Center validation visit that ends with a special program commendation. Success likely rests with state leaders, and in this first year only three of 31 have started the process.

Every Child Succeeds is a large-scale community-based home visiting program that uses both HFA and the NFP in Ohio and Kentucky. The program has adopted Continuous Quality Improvement (CQI) and program accountability that emerged from business and manufacturing as a way to improve processes and outcomes by systematically using data for ongoing monitoring.²⁴ In this case, home visitors and agencies were given regular reports summarizing their performance on multiple quality indicators. For example, the Red/Green Chart displays performance on quality indicators that either meet or exceed pre-established targets (Green) or that fall short of targets (Red). This allows programs to have immediate feedback about strengths, weaknesses, and patterns of performance. Reports are available to agencies on an ongoing basis documenting home visitor performance, activities of home visitors, and outcomes achieved. Prenatal enrollment is one of the indicators that showed immediate and dramatic increases.²⁵

The NFP takes a strong position on what it takes to achieve quality at scale. The hallmark of this program is an absolute belief that a process and structure for

“We are unforgiving when it comes to the standards we believe lead to good results. The key to our success is fidelity to the model that was originally tested.”

-David Olds, NFP

²⁴ Deming, W.E. (1982) *Out of the crisis*. Cambridge, MA: Massachusetts Institute of Technology, Center for Advanced Engineering Study.

²⁵ Ammerman, R.T., Putnam, F.W., Kopke, J.E., Ginkel, J.B., Clark, M.J., and Carrozza, M.A. (in press). Development and implementation of a quality assurance infrastructure in a multisite home visitation program in Ohio and Kentucky. *Journal of Prevention and Intervention in the Community*, 34,(1-2). Harvard Family Research Project · Harvard Graduate School of Education · 3 Garden Street · Cambridge, MA · 02138
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standards to achieve fidelity to the model are crucial to achieving positive results. That translates to implementing the program as close to the way the original pilot was implemented as possible. They evaluate organizations and communities who want to do the program against a commitment to conducting the program as it was outlined in the original Elmira trial. They collect large amounts of data to determine whether programs are being implemented as designed and use it to determine what outcomes are being achieved for a given program and in comparison to other programs in a state and across the country.

EHS has an elaborate process for monitoring and testing quality. Though all programs are supposed to be implemented in accordance with set quality performance standards, there is “considerable variability both within and between programs.”²⁶ Part of the National EHS Research and Evaluation Project is studying how those differences affect the outcomes that can be achieved. One study examined differences associated with whether or not the program was delivered according to standards. Perhaps not surprisingly, home-based programs have stronger impacts on child development and family functioning when they are fully implemented.²⁷ At age 2, children had better vocabularies than control children; at age 3, children had higher scores on language and cognitive measures and demonstrated better social-emotional development during play situations; and parents reported less stress.

But what are the specific quality factors that are most likely to result in positive outcomes? Another study from the Early Head Start Research and Evaluation Project tested how quality of engagement between home visitors and parents impacts outcomes. Data was collected from 11 of the 17 participating research sites that had over 80% of families receiving home visits when children were 14 months and 36 months. Parents who were more actively engaged in the home visits had better outcomes.²⁸ Higher parent engagement was associated with lower levels of maternal depression and more supportive parenting.

This raises the question: What does it mean to be actively engaged? A qualitative study in two sites identified factors related to increased parent engagement during

²⁶ Peterson, C., Roggman, L., Staerkel, F., Cook, G., Jeon, H.J., & Thornburg, K. (2003). Understanding the Dimensions of Family Involvement in Home Visiting Programs. In press.

www.adf.hhs.gov/programs/core/ongoing_research/ehs/ehs_intro.html

²⁷ Administration for Children and Families. (2002). Making a difference in the lives of infants and toddlers and their families: The impacts of Early Head Start.

www.adf.hhs.gov/programs/core/ongoing_research/ehs/ehs_intro.html

²⁸ Raikes, H., Green, B., Atwater, J., Kisker, E., Constantine, J., & Chazan-Cohen, R. (2006). Involvement in Early Head Start Home Visiting Services: Demographic Predictors and Relations to Child and Parent Outcomes. *Early Childhood Research Quarterly*, 21, 2-24.

visits.²⁹ Parents are most engaged in home visits when the purpose of the program is clearly conveyed, visits emphasize child needs, visits are made consistently and follow-through on issues occurs, home visitors help parents connect to the whole program versus only the home visitor, and data systems keep track of families despite high rates of mobility.

Most of the research on quality has been done on individual program models. Home visiting could benefit from some lessons learned in other early childhood interventions. For example, there are studies in process looking at what goes on between preschool age children and their teachers to impact cognitive, social, and behavioral development.³⁰ Rather than looking at one specific program, this research is looking across programs to identify the quality features that result in better outcomes for young children.

In summary, there is some strong evidence about what constitutes quality home visiting, but the safest bet requires more evidence showing how quality home visiting at scale results in improved outcomes for children and parents.

Recommendation 2:

To increase the likelihood of achieving results at scale, programs should use a management information system for tracking and monitoring activities

The national home visiting models vary in terms of the amount and type of data collected, as well as in the degree of compliance that they get from local sites, though all are using some type of management information system. Using data for improving operations is the first step in maintaining quality. Program expansion should be tied to a transparent and effective system for collecting indicators of performance and using it to improve programs and outcomes.

For over four years, the PCHP has been using a web-based MIS. Local sites enter basic demographic information and the National Center uses it to track things like recruitment and retention of families. All site coordinators are trained on how to use it, though some of the older sites are used to documenting things on paper and resist using the electronic system. Similarly, PAT has developed PATSim, an online data system. Sites enter data and are able to get immediate reports on basic demographics. However, the system is reported to be outdated and needs revision to be more user-

²⁹ Brooks, S., Ispa, J.M., Summers, J.A., Thornburg, K.R., & Lane, V. (2003). Building successful home visitor-mother relationships and reaching program goals: A qualitative look at contributing factors. Paper submitted for publication.

³⁰ Pianta, R.C., Howes, C., Burchinal, M., Bryant, D., Clifford, D., Early, D., & Barbarin, O. 2005. Features of pre-Kindergarten programs, classrooms, and teachers: Do they predict observed classroom quality and child-teacher interactions? *Applied Developmental Science*, 9, 3, 144-159.

friendly. Consequently, it is not being used as much as hoped, which limits some of the information available to the National Center.

HFA National Center staff developed a common data system to monitor site implementation and ensure compliance with program standards. They, too, have experienced some resistance: programs used to filling out paper and pencil forms are slow to adapt to the computer system. Attempts are being made to provide all home visitors with lap tops so they can enter data about the visits into the system immediately. In Indiana the system is working well: home visitors completed the HOME inventory to assess quality and are entering the data into the MIS. The National Center is using that information to determine which families are engaging well and which are not. Based on the family characteristics, TA is initiated to improve levels of engagement, one of the areas specified for maintaining the HFA program credential.

The NFP makes it mandatory for local sites to use the MIS as part of the program contract. The system monitors both program implementation and maternal and child health outcomes. Each outcome is tracked and results for the local site are then benchmarked against the program quality standards set in the original Elmira trial. Programs receive real time reports, charts, graphs, and policy tip sheets that they can use to improve program operations, track program outcomes, fundraise by showing progress compared to state and national benchmarks, and advocate for policy change. For the NFP, an effective data system builds in a process for monitoring continuous quality improvement, identifies program vulnerabilities that need to be addressed, and guides program improvement and identifies how to structure future programs.

Having access to data and using it for continuous improvement is an essential component of a quality home visiting strategy. As programs go to scale it will no longer be possible to rely predominantly on relationships with state leaders; home visiting must build capacity for better information systems. According to Sweet, “The technology is there and as programs expand it is even more important to use an information-based system of checks and balances to guide program quality to achieve better results.”

**Recommendation 3:
Identify what capacity is needed to maintain quality at scale in areas including training, supervision, technical assistance, research, communications, and advocacy**

Each of the home visiting national models operates with varying levels of effectiveness in a three-tiered system of sorts: a national office, state-based programs and leaders, and local program sites. One of the questions that must be addressed is how effective this can be as programs go to scale.

HIPPY USA, with private foundation support for program expansion and corresponding organizational capacity building, has been exploring how to build a more effective three-tiered system of quality and accountability. The idea is that effective and ongoing communication to and from each level of the HIPPY network will improve program quality and effectiveness.

Similarly, PAT also functions within a national, state, and local infrastructure. There are currently 37 state leaders, none of whom is employed by PAT. This makes it difficult to have full control over how they operate. PAT has programs in all 50 states and still relies on the National Center to administer all functions except some training (there are regional training coordinators). It is reasonable to question the degree to which a single national office can continue to perform all the functions necessary once programs approach full scale.

“If resources were unlimited we could select, employ, and pay state leaders and then hold them accountable for the quality mechanisms and program operations we put in place.”

-Sue Stepleton, PAT

“We’re beginning to wrestle with how to manage staffing, site visits, and quality assurance on more of a regional basis.”

-Sarah Walzer, PCHP

The PCHP is talking about how to rely on a more regional approach to effectively and efficiently manage program expansion. They recognize that it will be impossible to run everything out of one centralized National Center as programs continue to expand. Because they have instituted a train-the-trainer approach rather than leaving everything up to the national center, they may be primed to rely more on state or regional structures.

The NFP has created a new business plan outlining expansion plans to go from 20 to 38 states serving 14,000 more children by 2010. To manage this expansion, they made a significant structural change. The National Center for Children, Families, and Communities, was established outside the University of Colorado, with \$13 million from private sources. An independent board of directors was created and is in the process of recruiting for a new CEO for programs of the Nurse Family Partnership National Service Office. Olds himself has remained at the University to continue to lead the research functions, separate from the program functions. His goal is to effectively manage scale through a parallel structure model. The national office will identify potential new program sites; develop contracts and facilitate start-up; develop new capacity and competencies; manage the reporting and communications functions through an expanded MIS; provide coordination and seed

capacity for the education, support, and clinical competencies of nurse educators; and work at the policy level for sustained funding. The state offices will conduct training and technical assistance. The University will conduct, analyze, and report most of the research. This structure is being tested in Pennsylvania with the National Institute of Mental Health to test how operational and team factors work to help multiple new sites learn how to deliver the model.

Home visiting programs operate in local sites, but administrative functions that make it possible to run programs occur at state or national levels. More are moving to build in a regionally-based structure. As programs go to scale, it will be important to determine what infrastructure is most effective for operating quality programs and for monitoring their effectiveness.

**Recommendation 4:
Invest in research to better monitor what happens in visits that leads to improved outcomes**

Studies looking specifically at what goes on during home visits are few and far between.

Of the six national home visiting models, EHS has completed the most thorough studies of how time spent in home visits.³¹ On average, 57.2% of the time in a home visit was spent on child-focused activity, 28.4% of the time was spent on parent-focused activity, and 14.4% of the time is spent building rapport between home visitor and parents. When families have more risks, more of the time is focused on the parents. When parents have higher verbal skills, more of the time is focused on the child.

“Training for home visitors should be more prescriptive and focus on the skills home visitors need based on actual interactions during visits. If supervisors could see what is happening during visits, they could provide more directed skill building to help home visitors know how to move a family from one stage to another.”

-Anne Duggan, researcher

Studies linking what occurs in home visits to impacts on children and parents are even more rare. One EHS study examined how the topics of discussion during a visit impact child and parents outcomes. Home visits that focus on child development are associated with greater cognitive and language development in children and greater ability of parents to provide language

³¹ Raikes, H., Green, B., Atwater, J., Kisker, E., Constantine, J., & Chazan-Cohen, R. (2006). Involvement in Early Head Start home visiting services: Demographic predictors and relations to child and parent outcomes. *Early Childhood Research Quarterly*, 21, 2-24.
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and literacy stimulation to their children. Home visits that focus on coaching the parent-child relationships are associated with greater impacts on parents.³²

In the study by Raikes et al., home visitors recorded the percentage of time they spent on child development and family-focused issues.³³ Observers rated videotapes of home visitor-parents interaction and completed the HOME, a standardized measure of the quality of the environment. What happens during visits has a substantial affect on both children and parents. When programs focused on child development, children score higher on standardized measures of cognitive and language development at 36 months, parents provide more stimulating activities that support for their children's language and learning, and the overall quality of the home environment was better for promoting child development.

In the Hebbeler and Gerlach-Downie study, home visitors held the belief that children will improve if parents improve. Consequently, they did not focus on changing parenting behaviors or on guiding more effective parent child-interactions. Instead they spent most of their time supporting and empowering parents to feel good about themselves as parents and the choices they made in raising their children. Operating in a supportive role was valued by both parents and home visitors, but was not sufficient for bringing about the kind of educational and behavioral change that the program was hoping to accomplish.³⁴

One of the reasons for the lack of research during actual home visits is that the data are difficult to obtain. Observations and videotaping are labor intensive, expensive, and can be intrusive for participating families. But as preliminary findings show, the results can be powerful. This makes a compelling case for identifying creative methods for collecting information about actual home visits and using that to improve training and supervision of home visitors.

³² Peterson, C., Roggman, L., Staerkel, F., Cook, G., Jeon, H.J., & Thornburg, K. (2003). *Understanding the Dimensions of Family Involvement in Home Visiting Programs*. Paper in Preparation. www.acf.hhs.gov/programs/core/ongoing_research/ehs/ehs_intro.html

³³ Raikes, H., Green, B., Atwater, J., Kisker, E., Constantine, J., & Chazan-Cohen, R. (2006). Involvement in Early Head Start home visiting services: Demographic predictors and relations to child and parent outcomes. *Early Childhood Research Quarterly*, 21, 2-24.

³⁴ Hebbeler, K.M., & Gerlach-Downie, S.G. (2002). Inside the black box of home visiting: A qualitative analysis of why intended outcomes were not achieved. *Early Childhood Research Quarterly*, 17 (1), 28-51. Harvard Family Research Project · Harvard Graduate School of Education · 3 Garden Street · Cambridge, MA · 02138 Website: www.hfrp.org · Email: hfrp@gse.harvard.edu · Tel: 617-495-9108 · Fax: 617-495-8594

**Recommendation 5:
Invest in research to better match program goals, activities, goals and intensity
with family circumstances, home visitors, and supports to get the best
outcomes for young children and parents**

Much energy has been spent trying to figure out whether professional or paraprofessional home visitors are more effective. And much investment has been put into training home visitors, regardless of their background or education. According to Appelbaum, “training is crucial to the success of home visiting, but one of the issues to consider should be to what degree training can or should lead to professionalism . . . it is much more practical to start with what the program is trying to achieve and then determine the level of training or professionalism needed and ultimately who should be delivering services.”

For example, families with multiple health challenges may need home visitors who are specially educated and trained as nurses or health providers. Families whose first language is not English may do better with a home visitor who can speak their language and understand their cultural practices. Families interested in promoting their child’s success in school may be best served by paraprofessional with special training in child growth and development.

Families and programs have different goals they are trying to achieve. Some are very basic—a roof over the head, nutritious meals for kids, a safe environment. Others want to protect parents and their children from violence in the home. Others are geared towards wanting to prepare their children to be successful in school.

The NFP has looked at professional versus paraprofessional staff in light of program impact. The Denver trial confirmed that nurse-visited mothers had fewer pregnancies before the first child turned two and were more likely to enter the workforce, and that children of nurse-visited mothers had better language development at ages two and four when compared to a control group that got no visits. However, when comparing paraprofessionals and the non-visited control group, paraprofessional-visited mothers interacted better with their children and reported less psychological stress. When comparing nurses and paraprofessionals, the results for paraprofessionals were half the size of the effects found for nurses.³⁵ In a follow-up study two years after the program when the children were age 4, nurse-visited mothers had longer intervals between pregnancies and reported less domestic violence, and children of nurse-visited mothers did better on tests of behavior and language. Paraprofessional-visited mothers had fewer low-birth weight babies, fewer miscarriages, better mental health,

³⁵ Olds, D.L., Robinson, J. O’Brien, R. (2002). Home visiting by paraprofessionals and by nurses: a randomized, controlled trial. *Pediatrics*. 110, 486-496.

and greater responsiveness to their children, but there were no significant effects on the children. In the end, Olds concluded that paraprofessionals are able to produce some good effects, but that they are not as strong as effects produced by nurses and therefore “do not warrant public investment in the paraprofessional version of this program.”³⁶

The Sweet and Appelbaum meta-analysis showed mixed results on effects of professional versus paraprofessional home visitors. When looking across multiple program models, professional home visitors had significantly better impacts on children’s cognitive development, but para-professionals had significantly better impacts on the potential to reduce child abuse.³⁷

In the same vein, there has been much emphasis and debate about whether home visiting should target particular families or be universal in scope. It is important to determine what is meant by universal: does it refer to access, coverage, availability, or uniformity of services? Fewer than 7% of home visiting programs universally enroll families. About 75% of them target services to families at some level of risk, but that risk is defined differently for each program. Accordingly, differential impacts are found when comparing targeted versus universal enrollment. Cognitive outcomes for children were stronger in families that had been targeted for services, but parenting behavior was improved for universally enrolled families. Meta-analysis as well as studies from EHS show that targeting low-income families results in the greatest overall benefits.³⁸

Finally, there has also been much emphasis and question about the intensity of home visiting services needed to have positive impacts. Often referred to as “dosage,” Brooks-Gunn underscores what almost all studies find: “many home visiting programs are not very intensive: that is, families do not receive many visits.”³⁹ Though this has serious implications for the quality and effectiveness of home visiting, there is a lack of systematic research that has studied how many visits it takes to have positive impacts. According to a study by the Rand Corporation, “there is some evidence that more intensive programs are associated with better outcomes,

³⁶ Olds, D.L., Robinson, J., Pettitt, L., Luckey, D.W., Holmberg, J., Ng, R.K., Isacks, K. Sheff, K., and Henderson, C.R. (2004). Effects of home visits by paraprofessionals and by nurses: age 4 follow-up results of a randomized trial. *Pediatrics*. 114. 1560-1568.

³⁷ Sweet, M.A. & Appelbaum, M.I. (2004). Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children. *Child Development*, 75 (5), 1435-1456.

³⁸ Ibid.

Administration for Children and Families. (2002). Making a difference in the lives of infants and toddlers and their families: The impacts of Early Head Start.

www.adf.hhs.gov/programs/core/ongoing_research/ehs/ehs_intro.html

³⁹ Brooks-Gunn, J. (Winter 2004-2005.) A conversation with Jeanne Brooks-Gunn. *The Evaluation Exchange*, 10 (4),12-13.

but not enough to indicate the optimal number of program hours or how they might vary with child risk characteristics.”⁴⁰

In summary, the research is inconclusive about which type and characteristics of programs work best for attaining which outcomes. There is even less known about how these factors related to attaining outcomes across home visiting as an overarching strategy. The best bet for taking quality home visiting to scale is to test how to establish and maintain a good match between home visitors, family circumstances, and program goals, activities, and intensity.

**Recommendation 6:
Identify realistic expectations for what home visiting can accomplish
and hold programs accountable for achieving those outcomes**

In the early 1990’s the U.S. Advisory Board on Child Abuse and Neglect declared that “no other single intervention has the promise that home visitation has” when it comes to reducing child abuse and neglect and spurred the expansion of home visitation.⁴¹ As programs flourished, it became clear that home visiting is not a single service intervention, but “a strategy for service delivery . . . used to serve many different populations and to achieve many different goals.”⁴² Research findings showing mixed results for different programs make it clear that the strategy of home visiting is often most effective when couched in a broader system of early childhood supports.

Young children and families, particularly those most at-risk for poor outcomes, need a set of supports that go beyond any single program, intervention, or strategy in order to make real improvements in their lives. Daro’s review of the literature suggests that improving outcomes for a child and family who live in extreme poverty and are struggling with abuse, neglect, and mental health problems takes home visiting in addition to other early childhood interventions.⁴³ In terms of preventing child abuse and neglect, she recommends that high quality home visiting programs should be expanded and be used in conjunction with other services for children pre-birth to age

⁴⁰ Karoly, L. A., Kilburn, M.R., and Cannon, J.S. (2005). *Early Childhood Interventions: Proven Results, Future Promise*. Rand Corporation. Santa Monica, CA. www.rand.org

⁴¹ U.S. Department of Health and Human Services, U.S. Advisory Board on Child Abuse and Neglect. (1991). *Creating Caring Communities: Blueprint for an Effective Federal Policy for Child Abuse and Neglect*. Washington, D.C.: U.S. Government Printing Office.

⁴² Gomby, D.S., Larson, C.S., Lewit, E.M., and Behrman, R.E. (Winter, 1993). Home visiting: analysis and recommendations. *The Future of Children*, 3, No.3,

⁴³ Daro, D. (September 2006). *Home Visitation: Assessing Progress, Managing Expectations*. Written Testimony for House Subcommittee on Education Reform, Committee on Education and the Workforce. Available at: www.chapinhall.org

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five, such as high quality early learning for children and access to affordable health insurance and providers for both children and their parents.⁴⁴

In 1998 the Florida legislature appropriated \$10 million to create Healthy Families Florida, modeled after HFA to prevent child abuse and neglect.⁴⁵ A statewide office was created to manage the project, which eventually settled on HFA for the home visiting component. They started in 26 counties and in one year expanded to serve 53 of the 67 counties statewide, taking the program almost to full scale. The program director believes a large part of their ability to maintain quality during a period of rapid expansion was keeping a realistic expectation of what any one service can accomplish. In this model, home visiting is linked to a full circle of parent and family supports available across the state.

“Home visiting is one piece of the puzzle. We also rely on making referrals to our community partners, organizations providing child welfare, domestic violence, substance abuse, health, and mental health services.”
-Carol McNally, Florida Ounce of Prevention Program Director

There is some evidence from both the NFP and HFA that the most vulnerable families at risk for child abuse and neglect benefit most from high quality home visiting programs. However, research on home visiting programs including PAT and EHS that focus on more on enhancing parent knowledge of child development and increasing the achievement of young children suggests that families in the very highest-risk categories get the least benefit from home visiting. Research on EHS identified the circumstances under which the challenges are so great that benefits are difficult to attain: teen parents, parents who are depressed and experiencing severe mental health symptoms, and parents who are extremely mobile or transient.⁴⁶

⁴⁴ Ibid.

⁴⁵ Chung, H. (January 2003). Healthy Families Florida Succeeds. *County News Online*, 35 (1). National Association of Counties. Washington, D.C. Available at: www.naco.org/cnews/2003/03-1-13/articles/10Healthy.html.

⁴⁶ Administration for Children and Families. (2002). Making a difference in the lives of infants and toddlers and their families: The impacts of Early Head Start. Washington, D.C.: U.S. Department of Health and Human Services. http://www.acf.hhs.gov/programs/core/ongoing_research/ehs/ehs_intro.html

Conclusion

We began this review by asking if it was wise to bet on scaling-up of home visiting as one of the best ways to support parents and promote early childhood development. To answer this question, we examined the available research evidence, interviewed leaders from six of the national home visiting models, and interviewed researchers who have studied home visiting. The area of interest for guiding future research, practice, and policy is whether home visiting can be delivered at broad scale and with the quality necessary to attain demonstrable, positive outcomes for young children and their parents.

Both the scientific evidence and expert opinion support the view that high quality home visiting is a promising strategy for helping parents and promoting the growth and development of young children. Is it a good bet to invest in taking quality home visiting programs that are part of a comprehensive early childhood system to scale? Yes, but there are conditions that must be met. New funding and the continuation of existing funding to support expansion of quality programs should reflect the substantial and growing body of evidence on home visiting. As expansion occurs, home visiting programs must use systems of continuous quality improvement to ensure that outcomes are achieved and share information to build the knowledge base. Home visiting as an overall strategy that extends beyond individual models or programs must be tested and further research and evaluation should determine how home visiting makes a positive contribution as part of a comprehensive system of supports for young children and families. Meeting all of these conditions will help establish realistic expectations for what home visiting can accomplish and help high quality programs achieve desired outcomes as they go to scale.

We hope that the recommendations outlined in this paper will be followed and that in the next five years, there will be more robust evidence showing the impacts that quality home visiting has on a large scale. Then the bet will have paid off and more young children and parents will be the ultimate beneficiaries.

Appendix 1

The Home Visit Forum

In 1999 two private foundations collaborated on a project to bring all six of the national home visiting programs together to collectively work on continuous improvement in home visiting. The chief executive, director of research, director of training, a local program leader, and often a university-based research partner from each of the programs met over the course of 3 years under the facilitation of Dr. Heather Weiss, Dr. Deborah Daro, and Dr. Barbara Wasik, leaders in the field of home visiting research. The purpose of the Forum was to create opportunities for programs with similar goals and challenges to learn from one another in a way that would benefit each individually, and more importantly, contribute to enhancing the strategy of home visiting overall.

Participants all agreed that participant recruitment, engagement, and retention are challenges that they all share and worked on ways to improve these processes for the benefit of all home visiting programs. Through mini-grants, they studied how their own training and supervision processes could be improved and shared these lessons with one another. In addition, they addressed data quality, the use of data to inform training and supervision practices, and new ways to use data for program expansion. In the final stages of the Forum, participants worked together to develop materials to share beyond just the six program models. They self-selected into three working groups: public policy and advocacy materials to inform policymakers about the benefits of home visiting; training and supervision to develop tools to improve supervision; and research and evaluation to examine and compare how individual theories of change are used, clarified, and tested in each of the six models.

Participants from each of the six program models developed relationships that allowed them to move from operating strictly as competitors to working more cooperatively. This process is captured in the notion of “coopetition”⁴⁷ and allows for continuous learning and improvement. It is striking to note that while the funds supporting the Forum have ended, these models continue to work informally out of a shared commitment to improve the quality of their own services, as well as to improve quality of home visiting in general.

⁴⁷ Defined by Brandenburger and Nalebuff (1996) as “selective cooperation.”
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Appendix 2 Key Informants

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Sarah Walzer
Parent-Child Home Program

Karen Guskin
Parents as Teachers

Sue Stepelton
Parents As Teachers

Appendix 3

Key Informant Interview Protocol

1. What are models/programs doing to insure quality as they take them to scale?
2. What are the key lessons models/programs have learned about quality and scale in relation to implementation, program design, home visitors, etc?
3. How are models/programs using the information to improve programs and get better outcomes?
4. What don't we know yet and should we know about quality, scale, and how home visiting fits in a larger system of early childhood supports?
5. What else should home visiting programs do to sustain quality and get better outcomes as they go to scale?

Appendix 4
National Home Visiting Model Descriptions

TABLE 2. DESCRIPTIONS OF KEY NATIONAL HOME VISITING PROGRAM MODELS

| Program Model | Program Goals | Onset, Duration, and Frequency of Home Visits | Population Served | Background of Home Visitors | Training Requirements for Home Visitors |
|---|---|--|--|---|---|
| <p>Early Head Start</p> <p>708 sites nationally</p> | <ul style="list-style-type: none"> Promote healthy prenatal outcomes for pregnant women Enhance the development of very young children Promote healthy family functioning | <p>For home-based Early Head Start model only:</p> <p>Birth through age 3</p> <p>Weekly home visits</p> | <p>Low-income pregnant women and families with infants and toddlers; 10% of children may be from families with higher incomes; 10% of program spaces reserved for children with disabilities</p> | <p>No specific requirements, although experience with infants and toddlers is preferred</p> | <p>Vary by program. Staff development plans and ongoing professional development required.</p> |
| <p>Healthy Families America</p> <p>430 sites nationally</p> | <ul style="list-style-type: none"> Promote positive parenting Prevent child abuse and neglect. | <p>Birth through 5th birthday</p> <p>Weekly, fading to quarterly</p> | <p>Parents in the mainland U.S. and Canada, all income levels and ethnicities, who are identified at the time of birth as at-risk for abuse and neglect</p> | <p>Paraprofessionals and Bachelor degrees</p> | <p>One week of pre-service training; 1 day of continuing training quarterly; 80 hours of additional training in the first 6 months of service are recommended by Prevent Child Abuse America.</p> |
| <p>The Home Instruction Program for Preschool Youngsters (HIPPY)</p> <p>167 sites nationally</p> | <ul style="list-style-type: none"> Empower parents as primary educators of their children Foster parent involvement in school and community life Maximize children's chances for successful early school experiences | <p>Academic year, or two years before, and through the end of kindergarten</p> <p>Bi-weekly, i.e., at least 15 times, over 30 weeks during the school year</p> | <p>Families in the United States, Guam, and at least 6 other nations; all ethnicities; many low-income and with limited formal education.</p> | <p>Paraprofessionals, typically members of the community and former HIPPY parents. Most work part-time (20-25 hours/week)</p> | <p>Two-day pre-service training in the HIPPY program model, plus weekly ongoing training and staff development.</p> |

| Program Model | Program goals | Onset and duration | Population served | Background of home visitors | Training requirements for home visitors |
|---|--|--|---|--|--|
| The Nurse-Family Partnership 166 sites (250 communities) nationally | <ul style="list-style-type: none"> • Improve pregnancy outcomes • Improve child health and development • Improve families' economic self-sufficiency | Prenatal through 2 nd birthday Weekly, fading to monthly | Low-income, first time mothers, all ethnicities | Public health nurses | Two weeks of training in the program model over the first year of service. Forty-six hours of continuing education in assessing parent-infant interaction, plus additional continuing education as needed. |
| The Parent-Child Home Program 137 sites nationally | <ul style="list-style-type: none"> • Develop children's language and literacy skills • Empower parents to be their children's first and most important teachers • Prepare children to enter school ready to learn • Enhance parenting skills • Prepare children for long-term academic success and parents to be their children's lifelong academic advocates | Typically 2 nd through 4 th birthdays, but as young as 16 months (two years total) Two visits/week | Families in the United States, Canada, Bermuda, and the Netherlands; low-income, low-education families; all ethnicities; families with English as a Second Language; teen parents; homeless families | Paid paraprofessionals from the community, many previously parents in the program. Small number of volunteers, who may be professional. | 16 hours of training prior to becoming a home visitor. Weekly minimum two-hour ongoing training and supervision session. |
| Parents As Teachers 3,000 sites nationally | <ul style="list-style-type: none"> • Empower parents to give their child the best possible start in life • Give children a solid foundation for school success • Prevent and reduce child abuse • Increase parents' feelings of competence and confidence; • Develop home-school-community partnerships on behalf of children | Prenatal through 3 rd birthday; may extend through 5 th birthday Monthly, biweekly, or weekly, depending upon family needs and funding levels | Families in the United States and six other countries, all income levels and ethnicities. | Paraprofessionals, and AA, Bachelor, and advanced degrees | One week of pre-service training, 10-20 hours of in-service training, annual credentialing by the Parents As Teachers National Center |

SOURCES: National program offices and the websites for each home visiting model. Numbers of programs drawn from websites March 2005. Program descriptions accurate as of 2/02. Some programs operate in conjunction with one another (e.g., 45% of PAT programs are blended with programs such as Even Start, Early Head Start, Head Start, or Healthy Families America).

Gomby, D.S. (July, 2005). *Home visitation in 2005: Outcomes for children and parents*. Report commissioned by Wellspring Advisors. Washington, D.C.