18. THERE'S NO PLACE LIKE HOME

Improving Outcomes One Home Visit at a Time

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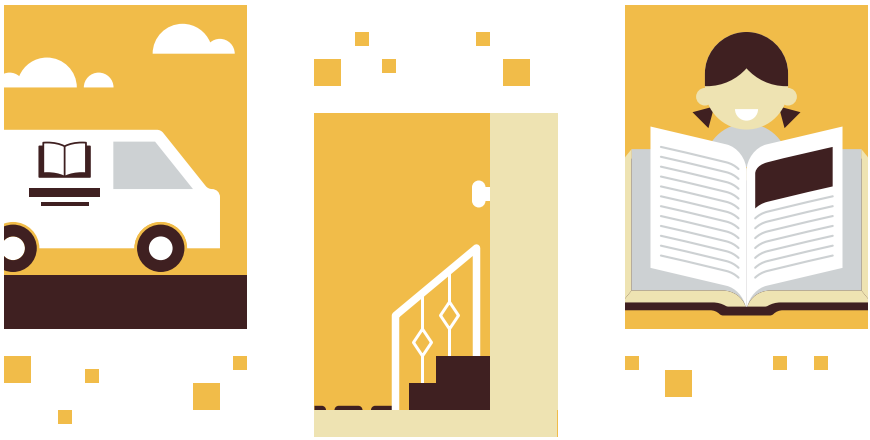

Home visiting is a service delivery strategy that aims to improve a range of outcomes for families with children, including school readiness, maternal and child health, child maltreatment prevention, family economic self-sufficiency, and others.[1] Typically, the model involves sending a trained professional or paraprofessional to visit a household to provide education, support, and referrals to needed community services in order to improve outcomes for children and families. There are numerous models for deploying home visiting approaches that guide structure, procedures, and substantive content of the services for local programs.[2]

The home visiting system in the United States is largely decentralized and supported with funding from multiple levels of government. In 2009, a range of federal, state, and philanthropic sources spent an estimated $500 to $750 million in the United States on early childhood home visiting.[3]

Congress and the White House established a new approach for home visiting in 2009, as part of the Patient Protection and Affordable Care Act. The law provided $1.5 billion in federal funding for a new strategy for conducting home visiting: a tiered evidence approach through the new Maternal Infant and Early Childhood Home Visiting Program (MIECHV). This case study focuses on how evidence was built into the design of the program and then used to justify the program's reauthorization in 2018, extending the program for another five years.

ISSUE BACKGROUND

Congress and the White House designed MIECHV to encourage both the production of evidence and the allocation of program funds predominantly toward strategies that were validated and supported by existing research. The approach, called tiered evidence, was also applied to other grant programs during the Obama administration.

The basic concept of tiered evidence in MIECHV is that the law set up the executive branch as a user of the existing evidence to determine which home visiting models qualified for which proportion of funding. The federal government required 75 percent of the grants it distributed to providers to use models that demonstrated evidence of effectiveness. Providers could use another quarter of program funding for promising models that had not yet been subjected to an impact evaluation, but the grantee had to simultaneously conduct an evaluation to determine if the promising approach could be funded as evidence-based going forward.

Beyond the funding allocation, other strategies encouraged the executive branch staff to integrate multiple forms of evidence into MIECHV. In 2017, the White House's Office of Management and Budget encouraged executive branch agencies to use this type of design as a strategy to support continuous learning and improvement.[4] Even in advance of the reauthorization debates for MIECHV, the program was ready to provide a range of evidence to inform program administration and legislative reauthorization discussion.

EVIDENCE AVAILABILITY

For the reauthorization debates in 2018, policymakers had access to performance information, impact evaluations, and numerous implementation studies. All of the evidence is available through publicly accessible websites, newsletters, social media, presentations at research conferences, and congressional or executive branch staff briefings. MIECHV had such a strong emphasis on data, research, and evaluation that producing relevant evidence was not just part of the program design; it was embedded in the culture of the program for managers, grantees, and participants throughout the country.

Program performance statistics

MIECHV required grantees to report on a series of performance measures on a wide range of outcomes: maternal and child health, child maltreatment, school readiness, crime and domestic violence, family economic self-sufficiency, and improved referrals. MIECHV expected grantees to make improvements in four out of six of these domains in the first three years. If grantees did not accomplish this, they would receive technical assistance to correct identified deficiencies. The information collected was instrumental in providing basic program characteristics and knowledge about grantee trends and conditions. In general, the performance measures suggested the program was meeting the statutory goal of expanding the reach of home visiting to the nation's most vulnerable children and families living in at-risk communities. The data also indicated the majority of grantees demonstrated improvement across the domains over time.[5] The performance measures informed how technical assistance was targeted to areas grantees found challenging, such as dealing with intimate partner violence or family enrollment and retention. These areas also became the focus of continuous quality improvement efforts.

National impact evaluation

Congress required MIECHV to conduct a national impact evaluation using an experimental design. The national evaluation—called the Mother and Infant Home Visiting Program Evaluation—was an ambitious endeavor to measure impacts for programs using consistent measures at the same points in time and, for some, was the first independent evaluation of their model. The impact evaluation, which launched in 2011, only had interim results available by the time Congress considered the 2018 reauthorization.[6] Impact results when the children were 15 months old were made available in 2019, documenting significant positive impacts in parenting, parent mental health, and child behavior.[7] The evaluation is ongoing and will have additional impact results available when the children enter kindergarten.

MIECHV grantee evaluations

As part of the tiered evidence model, MIECHV required grantees to conduct evaluations that addressed policy-relevant questions. HHS provided technical assistance to ensure those evaluations were rigorous. These evaluations were important as they signaled to state and tribal grant administrators that the ongoing investment in evaluation activities was central to this program. It created ownership of evaluation findings because grantees designed evaluations to answer critical implementation and policy questions facing their state or tribe versus priorities of the federal government. For example, these evaluations answered states' questions about building systems to better connect families to needed programs, workforce development, and evaluating the effectiveness of promising approaches.[8]

Implementation science

The law also drew indirectly from research on effective implementation of evidence-based programs mandating features such as a well-trained workforce, reflective supervision, data systems, and continuous quality-improvement methods. HHS directly leveraged the language related to continuous quality improvement. More specifically, all grantees must establish continuous quality-improvement plans, which establishes the use of data for improvement as a core feature of the program. In 2013, the Home Visiting Collaborative Innovation and Improvement Network (HV CoIIN) launched; it uses methods of quality improvement from the health care sector. Grantees analyzed data to identify areas for program improvement, set goals for improvement, and rapidly and iteratively tested innovations to identify service improvements. State administrators reported that the experience of participating in the HV CoIIN embedded the use of data into daily practice and highlighted areas for program and policy improvement.[9]

Systematic review

In order to assess the availability and quality of the research on the home visiting models in a fair and impartial manner, HHS conducted an independent systematic review of the existing evidence. During the first year of the Home Visiting Evidence of Effectiveness research review, HHS identified over 10,000 research articles and over 250 potential home visiting models.[10]

The studies included a mix of evaluation designs. The review could not assess all of the available literature at the same time. Because of the breadth of information, HHS developed a prioritization scheme to ensure the models with the most evidence would be reviewed first.

In the first year, seven models met the review criteria for quality-of-study design and execution on relevant outcomes. In 2018, 20 models of the 250 identified met the criteria for evidence of effectiveness. The Home Visiting Evidence of Effectiveness is still ongoing with many more models to review.

Partnerships for building evidence

One of the primary, likely unintentional, consequences of the statutory requirements for evidence in MIECHV was the forced close partnership between the research office and the programmatic office. Before MIECHV, it was more typical than not that research and program executive branch staff operated in silos that sometimes came together, but it was often intermittent and often focused on a specific study. The depth and breadth of the evidence requirements in MIECHV meant research and practice worked together throughout.

The Administration for Children and Families and the Health Resources Services Administration worked jointly on many aspects of MIECHV implementation that involve research and data. For example, staff from both offices designed (and re-designed) the performance measures over time, and representatives from both offices attended calls with the contractors for projects such as the systematic review and the national MIECHV impact evaluation to ensure the research and practice voices were included.

In another example, staff from both offices developed a learning agenda for building evidence over time for the program as a whole The learning agenda includes a diverse portfolio of evidence-building activities that answer questions for the program both in the near term and the long term, ranging from descriptive data and research, to capacity building in research, to impact research, to answering the program's pressing questions.

EVIDENCE USE

With an impressive array of existing research, evaluation, and performance information, it would have been a mistake to continue to authorize a program based only on the evidence available. The actions of Congress to encourage a robust portfolio of evidence into MIECHV allowed the program to be designed with learning from evaluation at its core, which will continue to improve the program and its outcomes into the future.

Importantly, and without a doubt, the broad portfolio of evidence available to decision-makers about MIECHV was instrumental in securing the program reauthorization, based on allocation of funding toward interventions that work as well as positive performance information and an ever-growing body of research to validate and improve the models used in the field.

During congressional consideration of the MIECHV program, there was strong bipartisan support from members of Congress for the program. In fact, as other reauthorizations were under consideration (such as the *Families First Prevention Services Act*), congressional staff used MIECHV as an example of how to construct an evidence-based program. As a result of this strong support, when negotiating the addition of the MIECHV program to the Bipartisan Budget Act of 2018, the "four corners" of leadership—that is, then-Speaker Paul Ryan, Senator Majority Leader Mitch McConnell, then-Minority Leader Nancy Pelosi, and Senate Minority Leader Chuck Schumer —all agreed to include the MIECHV program without asking for anything in return.

The key controversy surrounding the reauthorization of MIECHV in Congress was how to pay for the program's extension. A five-year extension would cost $400 million per year, and offsetting that cost became the largest source of controversy. Republicans generally wanted to see offsets come from the welfare space; Democrats wanted to see offsets come from outside of the welfare space.

Support for MIECHV was so strong, however, that the offset mix eventually included "pay fors" from two different areas: health and welfare programs. Even within the welfare offsets, evidence played a key role. Congressional negotiators settled on expanding the Reemployment Services and Eligibility Assessments program. The Congressional Budget Office viewed the evidence as strong enough that it even noted the budgetary savings that occurred in other, related programs. This means that the evidence available provided a strong basis for the various congressional actors to perceive it both as worthwhile and able to produce meaningful cost reductions to government expenses in other areas of the budget.

Congressional staff found the additional funding for the program through an offset from the health industry. The health industry has one of the most effective lobbying operations in D.C., and so the support for using offsets within this sector to pay for MIECHV shows the broad, deep, bipartisan support for the MIECHV program.

LESSONS

After implementing MIECHV, the executive branch researchers and program staff learned many lessons about how evidence use and how it impacts program changes. Below is a small handful of lessons learned.

- ***Legislative requirements should balance specificity with flexibility.*** To support a portfolio of evidence and learning, legislative language needs to both provide parameters for quality and flexibility to adapt to the evidence needs over time. Legislative language can both set a bar for study quality and also, unintentionally, limit how evidence is built over time, which may limit the utility of the evidence

for policymakers. The statutory language related to the evidence criteria needs to balance specificity of research designs while allowing evidence standards to evolve and grow to follow the state of the field and best practices. Examples include:

1. Legislative language that pre-specifies methods or thresholds for statistical significance does not align with professional best practices.[11]

2. The requirement to use "peer-reviewed" research, which implies that peer review is a proxy for high-quality research. Unfortunately, much of the peer-reviewed literature may still not meet the quality of the study design and execution required by HomeVEE. In addition, a peer-review requirement can inadvertently prohibit the inclusion of government reports, which can be just as rigorous, or more, than peer-reviewed papers.

3. The MIECHV language uses the word "models," which constrains the systematic review from including the evidence on other elements of the program that have emerged over time, such as program enhancements, targeted content regarding intimate partner violence, or services using telehealth models. These enhancements also contribute to the overall effectiveness of the program, and the field should know about this evidence base.

- ***Interpreting a body of evidence.*** Executing a portfolio of evidence and learning agenda means building the capacity of legislative and executive branch employees to understand how to interpret a body of evidence that may not be straightforward. Evaluations often provide mixed findings about outcomes, making definitive declarations a challenge for users. Evaluations often conclude that outcomes and impacts are mixed, including within the same study or across studies. Evidence from a single evaluation—positive, negative, or null—is not sufficient to universally deem a policy or intervention evidence-based. Often multiple studies of models are testing an approach with different populations, outcomes, or locations. A model may have impacts in one study but not in another. The reason for the discrepancy may be due to the model, but it also may be due to other factors. The complexity of the evidence reinforces the importance of a strong partnership between the research and practice staff to make decisions about the use of evidence.

- ***Evolving evidence.*** The current set of models for home visiting are complex and expensive, which adds to the challenge for decision-makers in deploying the models. This may change over time with further development and innovation. Once deemed evidence-based, models continue to evolve and improve and are not stagnant or set in stone. Federal programs need the flexibility to fund and use a portfolio of evidence to support a learning agenda, including performance measures, descriptive studies, evidence reviews, impact studies, and innovative research. For example, the Health Resources and Services Administration funds the Home Visiting Applied Collaborative to examine whether the methods behind

precision medicine can be applied to home visiting to make models more efficient and effective. While overall home visiting can achieve impacts, researchers need to identify ways to make impacts stronger for the complex set of families served by the programs. This research needs to leverage research designs that get answers to these questions more quickly.

- ***Well-executed evidence-based policy can improve outcomes.*** Evidence-based policy is a lot more complicated than it seems. Implementing evidence-based policy is not straightforward or easy, and there are many areas of nuance and continued learning. It is like Winston Churchill's famous quote about democracy being the worst form of government except for all the other forms of government. Evidence-based policy is not perfect, but the more we can start from what's known, build close partnerships between research and practice, and adopt a culture of curiosity and learning in social services, the better chance we will achieve the outcomes we truly want for children and families. ■

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