May 13, 2011

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MEMORANDUM

TO: Naomi Goldstein and Peter van Dyck (HHS)
Robert Gordon, Martha Coven, and Kathy Stack (OMB)

RE: Evaluation Plan for HHS's Maternal, Infant, and Early Childhood Home Visiting Program

I'm writing to you regarding the proposed plan for the national evaluation of HHS's Home Visiting Program, as recently presented to the Secretary's Advisory Committee for the evaluation. We support the plan's call for a random-assignment design, but urge certain modifications as critical to the success of the evaluation and of the Program. In offering this input, we note that the Coalition is a nonprofit, nonpartisan organization that has no affiliation with any program or program model.

Overview: *We believe certain aspects of the plan are inconsistent with the Administration's tiered-evidence approach in home visitation, K-12 education, and other areas – a central goal of which is to grow the number of program models that are backed by strong evidence of effectiveness. In contrast to the model-based impact evaluations in the Administration's other major evidence-based initiatives (such as DoED's Investing in Innovation program, and CNCS's Social Innovation Fund), this plan's approach is not to evaluate the impact of specific models, but rather to estimate the impact of the HHS Home Visiting Program as a whole through a large randomized controlled trial. Like the 10 other randomized "whole-program" evaluations that the federal government has funded since 1990 (Head Start, Upward Bound, Even Start, Job Corps, etc.), we believe this approach will (i) likely show that the Program's overall impact on key outcomes is small or none; and (ii) miss the opportunity to identify the few models within the Program that produce sizable impacts, and which if more widely disseminated could evolve the whole Program toward greater effectiveness over time. We suggest possible modifications to the evaluation design to remedy this problem.*

1. We strongly support the Administration's "tiered-evidence" approach to federal social programs, as a way to break the demonstrated pattern of weak or no effects for many such programs.

As you know, federal programs using the tiered-evidence approach provide (i) sizable funding to program models that are backed by strong evidence of effectiveness (the top tier); and (ii) modest funding to models backed by supportive – but not yet strong – evidence, with a requirement for a rigorous evaluation to see whether they work.

a. The focus of this approach is on program models: increasing the number that are proven-effective (i.e., top tier), and scaling up such top-tier models. As summarized on the White House/OMB website: *"This two-tiered structure will provide objective criteria to inform our decisions on which home visitation and teen pregnancy models to invest in. It will also create the right incentives for the future. Organizations will know that to be considered for funding, they must provide credible evaluation results that show promise, and be ready to subject their models to analysis. As more models move into the top tier, it will create pressure on all the top-tier models to improve their effectiveness, so they continue to receive support."*

b. Our understanding is that the HHS Home Visiting Program incorporates this tiered-evidence approach, including the focus on models. As you're aware, last year HHS commissioned a systematic evidence review, carried out by Mathematica, which identified

seven program models that meet the minimum evidence threshold set out in the Program's authorizing statute. Our understanding is that this was only the initial step in the tiered-evidence process because Mathematica's evidence review, as well as our own review and a 2009 review published in one of the top medical journals (Lancet 2009), found that most of these models – although perhaps meeting the minimum statutory threshold – produced weak or no lasting effects on key outcomes. A few models were found – in studies of at least moderate quality – to produce stronger, more durable effects.

Consistent with the tiered-evidence approach, HHS outlined its plans in a July 2010 Federal Register notice to (i) allocate a baseline amount of Program funds by formula to the states, which may adopt any of the seven models meeting the minimum statutory threshold; and (ii) in future years, to allocate Program funding above this baseline amount through competition, in which: "*HHS proposes to give significant weight to the strength of the available evidence of effectiveness of the model or models employed by the State. In this context, the use of program models satisfying the criteria outlined [for the program's formula grants] would be a minimal requirement, but HHS would consider additional criteria that further distinguish models with greater and lesser support in evidence*."

c. We strongly support this Program structure, as it enables the Program to evolve toward greater effectiveness over time based on evidence about impact of the various models.

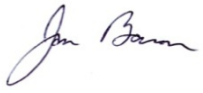
2. However, the proposed national evaluation design would not estimate the impact of specific models, and thus would not build the key evidence needed for this evolution.

a. The plan instead calls for a large randomized evaluation to estimate the impact of the Program as a whole – which we believe will find few or no lasting impacts on key outcomes. This is because, as noted above, most of the seven models that will be funded were found in previous studies to produce few lasting impacts on these outcomes. Thus, we believe it is likely that this evaluation – like almost all of the other large, randomized "whole-program" evaluations that the federal government has sponsored since 1990 (Head Start, Upward Bound, Even Start, Job Corps, etc.) – will produce disappointing findings.

b. Meanwhile, such an evaluation will miss the opportunity to identify any program models that do produce important, lasting impacts on participants' lives. This is the key evidence needed for HHS, through its planned competitive grant process, to evolve the Program from its initial state (with likely weak impact) toward increasing effectiveness over time.

The proposed evaluation plan does include valuable analyses to identify possible reasons for variation in impact across program sites. While we fully agree with including such analyses, it is important to recognize that they are exploratory (nonexperimental) in nature, and will not produce – nor substitute for – strong evidence about the impact of specific models.

3. Thus, we urge HHS to modify the proposed evaluation plan to estimate model-specific impacts rather than whole-Program impacts. In addition to generating the key evidence needed for Program improvement, we believe such an approach is appropriate because of the vast diversity of the seven models in their structure, goals, and populations served (e.g., some serve families during the prenatal/neonatal period, whereas others serve families with children ages 4-5). A model-specific evaluation plan could tailor study design and outcome measures to the model being evaluated (e.g., measuring prenatal smoking vs. kindergarten vocabulary). Such an approach, implemented effectively, could build evidence about each model's impact under real-world implementation conditions, across multiple sites, as well as identify factors influencing impact across those sites (per the exploratory analyses noted above). We note that the other major evidence-based initiatives recently enacted into law (e.g., DoED's Investing in Innovation Fund, CNCS's Social Innovation Fund) include model-specific rather than whole-program impact evaluations. We urge HHS to do the same.



President, Coalition for Evidence-Based Policy