



Tribal Home Visiting Programs

Review of the Evidence

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The Patient Protection and Affordable Care Act, signed into law in 2010, established a new program designed to improve outcomes for at-risk pregnant women and mothers and children from birth through age 5: the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). MIECHV offers funding to states and territories for home visiting services. Three percent of MIECHV funds must be set aside for grants to federally recognized tribes, tribal organizations, or urban American Indian organizations. MIECHV is an evidence-based policy initiative and the authorizing legislation requires that at least 75 percent of grant funds to states and territories must be spent on home visiting program models that meet the U.S. Department of Health and Human Services (DHHS) criteria for evidence of effectiveness. Tribal grantees are to meet these requirements for state and territory grantees “to the greatest extent practicable.” Because no models to date have met criteria for evidence of effectiveness for American Indians and Alaska Natives (AIAN), the tribal grantees may use promising approaches, rather than evidence-based models, and are rigorously evaluating those approaches.

The Administration for Children and Families (ACF), Office of Planning, Research, and Evaluation, part of the DHHS, in collaboration with the Health Resources and Services Administration, contracted with Mathematica Policy Research to conduct a systematic review of home visiting research. Mathematica conducted the review under the guidance of a DHHS interagency working group. This review, known as the Home Visiting Evidence of Effectiveness (HomVEE) project, determines which home visiting program models have sufficient evidence to meet the DHHS criteria for an “evidence-based early childhood home visiting service delivery model.”

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

One component of the review focuses specifically on studies relevant to tribal communities. The review includes studies of home visiting program models implemented in tribal communities in the U.S., implemented in indigenous communities outside the U.S., or evaluated with AIAN or indigenous families and children.

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

The HomVEE Review

The HomVEE team uses a systematic process for its review of tribal program models. The team first conducts a broad literature search, screens impact studies for relevance, and rates the quality of the studies for each program model. The team then examines the impacts in high- and moderate-rated studies on AIAN and indigenous

populations, identifying program models that meet the DHHS criteria, and reviewing implementation information for each model. This process is conducted annually.

Conducting the literature search and screening studies for relevance: The HomVEE team conducts a broad

search for literature on home visiting program models used in tribal communities or that include substantial proportions of AIAN families. The search includes literature on home visiting programs in indigenous communities outside the United States. The search is supplemented with studies submitted to HomVEE through an annual call for studies. The team screens the studies for relevance. As of September 2013, the team determined that 41 studies were eligible for the review: 24 causal or impact studies and 17 implementation or descriptive outcome studies.¹

Rating the studies: The HomVEE team rates the causal studies on their ability to produce unbiased estimates of a program model's effects. This rating system helps the team distinguish between more- and less-rigorous studies; the more rigorous the study, the more confidence we have that its findings were caused by the program model itself, rather than by other factors. Of the 24 causal studies determined to be eligible for the review, 4 received a high rating, 6 received a moderate rating, and 14 received a low rating. Low ratings were mostly due to high attrition—participants leaving the study—and not demonstrating that the treatment group (which could receive the home visiting services) and the comparison group (which could not) were similar on key characteristics at the beginning of the study.

Examining the impacts in high- and moderate-rated studies on AIAN and indigenous populations: After rating the quality of the studies, the team examined high-

and moderate-rated impact studies for results specific to AIAN and indigenous samples. Of the 10 high- or moderate-rated impact studies, 8 did not report findings by ethnicity, so the HomVEE team could not isolate the impact of the home visiting models on AIAN or indigenous participants. That is, even though the studies included AIAN or indigenous participants, the results were not specific to this group. Two studies, one on Early Start (New Zealand) and one on Family Spirit, did report findings by ethnicity. The Early Start (New Zealand) study showed favorable effects on a Māori subgroup in the domains of child development and school readiness, positive parenting practices, and reductions in child maltreatment. The Family Spirit study showed favorable effects in the domains of child development and school readiness, maternal health, and positive parenting practices.

Identifying evidence-based models: The HomVEE team examined the Early Start and Family Spirit studies in light of DHHS's criteria for an "evidence-based" model for delivering early childhood home visiting services to AIAN populations.² The Early Start (New Zealand) studies did not meet these criteria for AIAN populations because the findings only apply to a subgroup—the Māori—and have not been replicated with another sample. The Family Spirit studies also did not meet the criteria; one study of this program model was rated high and the full sample was made up of AIAN people, but the study was not published in a peer-reviewed journal, as required by the statute.

Implementation Findings

The team gathered information about program implementation from all 41 studies of 21 home visiting models screened in for the review of home visiting in tribal populations.

Target outcomes: Program models commonly focused on outcomes in three domains: child health (12 models), child development and school readiness (11 models), and positive parenting practices (13 models). Other program models were more narrowly focused on specific areas such as prenatal care or the promotion of healthy behaviors among expectant mothers.

Service delivery: All program models used home visits as the primary mode of service delivery, per the scope of the review. Of the program models where information about frequency of visits and length of the model was available, most (8 models) offered weekly or monthly home visits for anywhere from 16 weeks to 5 years. Fourteen program models also included other services, such as parent group meetings and center-based options. One program model used a community-based intervention in addition to home visits.

Target populations: Eleven program models aimed to enroll families during the prenatal period or early

infancy, continuing with services until children reached kindergarten or beyond. One program model targeted families with toddlers, and another targeted families with preschool-age children. Seven program models were restricted to a specific location (such as rural reservations) or community, and all targeted families with certain risk factors (such as teen parents or children at risk for obesity).

Location of services and types of implementing agencies: Six program models specifically targeted families living on reservations, while seven others targeted AIAN families living on or off reservations. Fourteen program models were located in the United States; seven were located in other countries, including Canada (3), New Zealand (2), South Africa (1), and Australia (1).

Staff qualifications and training: Thirteen program models did not have education requirements for staff, placing greater value on home visitors who were members of the community being served, had strong interpersonal skills, and had experience with the targeted families. Only three program models required home visitors to have a bachelor's degree. However, nearly all (15) mandated that home visitors complete pre-service and/or in-service training.

Lessons Learned

Although the review can provide only limited information about the effectiveness of specific program models, it can offer lessons on program development and implementation that may be valuable to tribes, tribal organizations, or urban AIAN organizations.

- Program models often used culturally relevant home visiting approaches that directly served the needs of tribal communities, building on the communities' cultural strengths and customs. Program staff frequently came from these communities or were otherwise culturally competent.

- Staff were able to recruit participants into the home visiting programs, but nearly all faced substantial loss of participants from the program.
- Program models in remote areas faced challenges such as the need to travel long distances to reach participants' homes and to coordinate with other service providers.
- Home visitors struggled to deliver the planned content to families with pressing needs and found that participants frequently did not keep appointments.
- Overcoming implementation challenges required programs to be flexible, seek cooperation and support from the community, and hire culturally sensitive staff.

Moving Forward

Conducting research in tribal communities presents a unique set of challenges. The HomVEE team identified three main obstacles: achieving a high response rate, finding measures that were valid and relevant for AIAN populations, and addressing tribal members' concerns about denying services to any tribal members in a comparison group design. Future research should continue evaluating promising program models using rigorous

research methods; use more focused, valid, and reliable measures; and measure the long-term effects of promising program models.

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

Endnotes

¹ Due to the small number of studies identified in year 1, the HomVEE team, in consultation with ACF, included descriptive outcome studies to learn more about the implementation of home visiting models in year 1 of the review. These studies were not included in subsequent years of the review.

² See <http://homvee.acf.hhs.gov/document.aspx?rid=4&sid=19&mid=6> for details on these criteria.