OPRE Report #2020-164

Assessing the Research on Early Childhood Home Visiting Models Implemented with Tribal Populations

Part 1: Evidence of Effectiveness

Updated December 2020

Contract Number:
GS-10F-0050L/
HHSP23320150115G
Mathematica Reference Number:
50096.02.152.059.000

Submitted to:
Amanda Clincy Coleman, Project Officer
Shirley Adelstein, Project Officer
Office of Planning, Research and Evaluation
Administration for Children and Families
U.S. Department of Health and Human Services

Submitted by:
Project Director: Emily Sama-Miller
Mathematica
1100 First St., NE, 12th Floor
Washington, DC 20002-4221
Telephone: (202) 484-4512
Facsimile: (202) 863-1763

Assessing the Research on Early Childhood Home Visiting Models Implemented with Tribal Populations

Part 1: Evidence of Effectiveness

Original Report Published: February 2011

Updated August 2011, November 2012, September 2013, September 2014, August 2017, and December 2020

Rebecca Coughlin
Ilse Argueta
Andrea Mraz Esposito
Emily Sama-Miller

Contents

Tables

Overview

A. Introduction

A portion of the federal funds that support early childhood home visiting for families and young children are designated specifically to support early childhood home visiting in tribal populations. Therefore, it is critical for policymakers and program administrators to know what research has revealed about early childhood home visiting in these communities. This two-part report represents an effort to compile and summarize the findings of that research.

The Home Visiting Evidence of Effectiveness (HomVEE) project is a systematic review of early childhood home visiting research. (Detailed information and results are available at https://homvee.acf.hhs.gov.) To assess the evidence of effectiveness of models of potential relevance to tribal communities with tribal populations, HomVEE conducted a systematic review focusing specifically on research relevant to tribal communities.

Part 1 of this report provides details on the impact and implementation research findings about the 36 early childhood home visiting models included in this review, including the evidence of effectiveness of those models with tribal populations.

Part 2 contains information that is specific to the adaptation, development, and implementation of early childhood home visiting models in tribal communities. The report highlights four different strategies used by models to provide culturally relevant services to tribal families and children by adapting existing models and developing new ones. Part 2 also discusses challenges reported with implementing and delivering early childhood home visiting to tribal populations. The review of challenges includes discussions around meeting enrollment targets, sustaining participation, the lack of reporting on model fidelity, and challenges to implementing models in rural areas. Part 2 closes with an overview of lessons learned and considerations for supporting the development and strengthening of research on early childhood home visiting models implemented with tribal populations.

B. Primary research questions

- What research is available about early childhood home visiting with tribal populations, and what does it say about how early childhood home visiting is implemented with tribal populations and how it affects them?
- What lessons can be drawn from this research about developing, implementing and adapting models for tribal populations?
- What next steps does this research suggest for model developers and researchers working on early childhood home visiting with tribal populations?

C. Purpose

The statute authorizing the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program (Social Security Act, Title V, § 511 (42 U.S.C. § 711)) sets aside 3 percent of the total appropriation (authorized in § 511(j)) for grants to federally recognized tribes (or consortia of tribes), tribal organizations, or urban Indian organizations. The statute (§ 511(h)(2)(A)) requires the tribal grants to be consistent to the greatest extent practicable with the requirements of the MIECHV Program grants to states and territories (authorized in § 511(c)). The Tribal MIECHV Program aims to support the

development of tribal children and families through implementing high quality, culturally relevant early childhood home visiting models that have demonstrated evidence of effectiveness.

The Office of Planning. Research, and Evaluation at the Administration for Children and Families, U.S. Department of Health and Human Services (HHS) contracts with Mathematica to conduct the HomVEE review. HomVEE conducted its initial systematic review focusing specifically on research relevant to tribal communities in fall 2010. As the research literature on early childhood home visiting models studied with tribal populations grows, HomVEE updates the review.

D. Methods

HomVEE's review of research with tribal populations involved the following steps:

- Conducted a broad literature search, including database searches and a call for research, to identify early childhood home visiting models implemented in tribal communities or researched in a study that included a sizable share (10 percent or more) of tribal participants. This search included literature on early childhood home visiting models implemented among tribal populations outside the United States.
- Used a two-step screening process to screen manuscripts for relevance.
- Rated the quality of manuscripts about impact studies with eligible designs based on their ability to produce unbiased estimates of a model's effects. Reviewers assessed the research design and methodology of the impact study described in each manuscript using a standard protocol and assigned each manuscript a rating of high, moderate, or low.[1]
- Assessed the evidence of effectiveness for each model to determine if the model met the HHS criteria for "an evidence-based early childhood home visiting service delivery model" in tribal populations.
- Reviewed implementation information for each model.
- Addressed potential conflicts of interest for all project staff and subcontractors.
- Updated the report assessing the research on early childhood home visiting models with tribal populations with new evidence of effectiveness and implementation information.

E. Key findings and highlights

HomVEE's review of research with tribal populations included 98 manuscripts about 36 early childhood home visiting models. Of these, 57 described results from impact studies, and 41 described results from implementation or outcomes studies.

- One early childhood home visiting model included in this review, **Family Spirit**, met HHS criteria for an "evidence-based early childhood home visiting service delivery model" for tribal populations.
- Of the 36 early childhood home visiting models included in the review, 23 (64 percent) were evaluated specifically for their impact on tribal families and children. The remaining models had

[1] **Manuscripts** describe study results. Manuscripts may be published or unpublished research, such as journal articles, book chapters, or working papers. A single study may produce one or many manuscripts. Typically, one manuscript reports on only one study, although in rare cases one manuscript may report on several studies, if it describes evaluations of multiple interventions or the same intervention evaluated in multiple distinct (non-overlapping) samples. A **study** evaluates a distinct implementation of an intervention (that is, with a distinct sample, enrolled into the research investigation at a defined time and place, by a specific researcher or research team).

research that included tribal participants, but the models were not evaluated specifically for their impacts on tribal populations.

- Thirty-nine percent of manuscripts about impact studies (22 manuscripts) included in HomVEE's review of research in tribal communities reported findings from a study that was of moderate or high quality. Eight of these manuscripts specifically examined the effect of a model with tribal populations.

The manuscripts included in HomVEE's review of research with tribal populations offer important lessons about developing, adapting, and implementing early childhood home visiting for use with tribal populations. The lessons, which could be useful to the Tribal MIECHV Program grantees or other tribal organizations interested in implementing early childhood home visiting, include the following:

- Collaborate with tribal communities from the onset, beginning in the pre-implementation phases and continuing throughout service delivery
- Recruit culturally competent staff
- Use data to inform quality improvement
- Consider modifying the model to meet the needs of communities and individuals

Based on issues HomVEE identified in the manuscripts they reviewed, the following practices could support developing and replicating early childhood home visiting models for tribal communities:

- Model developers could provide details about model specifications and minimum requirements
- Model developers could create fidelity standards for features of a model
- Researchers could examine the challenges of implementation and whether and how those implementing early childhood home visiting models can meet these challenges

Models could provide details about how they adapt early childhood home visiting models, including how they engage with early childhood home visiting model developers to design, implement, and evaluate adaptations. To help overcome the obstacles to conducting research with tribal populations identified in the manuscripts reviewed, HomVEE suggests that evaluators consider doing the following:

- Take a utilization-focused approach to participatory evaluation
- Use rigorous research methods to evaluate promising models
- Use more culturally relevant measures
- Apply lessons from the annual HomVEE review of research in the general population, such as adjusting for multiple comparisons to reduce the risk of identifying statistically significant findings by chance

This page has been left blank for double-sided copying.

I. Introduction

The statute authorizing the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program (Social Security Act, Title V, § 511 (42 U.S.C. § 711)) sets aside 3 percent of the total appropriation (authorized in Section 511(j)) for grants to federally recognized tribes (or a consortia of tribes), tribal organizations, or urban Indian organizations. The statute (Section 511(h)(2)(A)) requires that the tribal grants, to the greatest extent practicable, be consistent with the requirements of the MIECHV Program grants to states and territories (authorized in Section 511(c)).

The overall goals of the MIECHV Program grants to states and territories are to strengthen and improve maternal and child health programs, improve service coordination for at-risk communities, and identify and provide comprehensive early childhood home visiting services to families who reside in at-risk communities. The MIECHV Program awards grants to implement evidence-based models that promote outcomes such as improvements in prenatal, maternal, and newborn health; improvements in child health and development; improvements in parenting skills; improvements in school readiness and child academic achievement; reductions in crime or domestic violence; improvements in family economic self-sufficiency; and improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families. The Tribal MIECHV Program mirrors the state program to the maximum extent practicable, with the goal of supporting the development of American Indian and Alaska Native (AIAN) children and families through a coordinated, high quality, evidence-based early childhood home visiting strategy.[2] The Tribal MIECHV Program is designed to support the implementation of high quality, culturally relevant early childhood home visiting models that have demonstrated evidence of effectiveness.

The Office of Planning, Research, and Evaluation at the Administration for Children and Families (ACF), U.S. Department of Health and Human Services (HHS), contracts with Mathematica to conduct the Home Visiting Evidence of Effectiveness (HomVEE) project, a systematic review of early childhood home visiting models. HomVEE reviews the literature and assesses the evidence of effectiveness of early childhood home visiting models that serve families with pregnant women and children from birth to kindergarten entry. HomVEE provides states and other stakeholders with information about which early childhood home visiting models have shown evidence of effectiveness as required by statute. It also presents detailed information about the samples of families who participated in the research, the findings reported in each manuscript, and the implementation guidelines for each early childhood home visiting model. A summary of the findings is available in the *Early Childhood Home Visiting Models: Reviewing Evidence of Effectiveness* brief, available at https://homvee.acf.hhs.gov/publications/HomVEE-Summary. Detailed findings are available at http://homvee.acf.hhs.gov/.

A. HomVEE's review of research with tribal populations

To assess the evidence of effectiveness of effectiveness of models of potential relevance to tribal communities, HomVEE conducted a systematic review in fall 2010 focusing specifically on research relevant to tribal communities.[3] Our search for relevant research included consideration of research and

[2] As of the 2017 update, the HomVEE reports and briefs on interventions implemented with tribal populations also includes research conducted with Native Hawaiians.

[3] For the purposes of HomVEE's review of research with tribal populations, we included manuscripts in which at least 10 percent of sample members were tribal participants. Our definition of tribal included participants who

evaluation conducted in indigenous communities outside of the United States. Although there is tremendous variation among Native and indigenous communities within the United States and across the globe, they share similarities such as traditional culture, historical trauma from colonization, and health disparities. Lessons learned from implementing and evaluating culturally relevant early childhood home visiting in indigenous settings outside the United States can provide useful information to tribal communities as they make decisions about early childhood home visiting and its evaluation in their own communities.

A key difference between HomVEE's review of research with tribal populations and HomVEE's annual review of research with the general population is how HomVEE decides which manuscripts to review. HomVEE organizes its annual review around early childhood home visiting models and reviews only manuscripts about a set of early childhood home visiting models selected through a prioritization process, including any versions of those prioritized models (such as adaptations or supplements).[4] HomVEE's review with tribal populations, on the other hand, reviews all eligible manuscripts, regardless of which early childhood home visiting model the manuscripts study. As a result, the review of research with tribal populations includes manuscripts about some early childhood home visiting models that have not yet been comprehensively examined by HomVEE's annual review.

This report is the sixth update to the original review. As of this update, HomVEE identified 57 manuscripts that described results from impact studies of early childhood home visiting models with tribal populations, as well as 41 manuscripts about implementation or outcomes studies, for a total of 98 manuscripts about 36 early childhood home visiting models (see Box 1).

Given the lack of models that have evidence of effectiveness with tribal populations, HomVEE sought to identify lessons learned from the existing literature. To make the most of the available information, HomVEE extracted descriptive information from each relevant manuscript about the participant outcomes that researchers evaluated. This helped HomVEE to gain a better understanding of

Box 1. Overview of manuscripts identified in HomVEE's review of research with tribal populations

HomVEE's review of research with tribal populations identified a total of 57 manuscripts about impact studies related to tribal populations. Among those, 39 percent (22 manuscripts) were about studies determined to have sufficiently rigorous designs to contribute to the evidence base.

- Of the 22 manuscripts that received high or moderate ratings, 7 manuscripts had participant samples composed entirely of tribal participants and 1 manuscript reported impacts for a subgroup composed entirely of tribal participants. Of the manuscripts in which the tribal participants were 10 percent or more of the sample analyzed, only 1 manuscript reported findings specifically for a tribal subgroup.
- Of 20 early childhood home visiting models that have impact research with tribal populations, 1 model , Family Spirit®, meets HHS criteria for an "evidence-based early childhood home visiting service delivery model" for tribal populations.
- In addition to the 57 manuscripts about impact studies, the review also includes 41 manuscripts about implementation or outcomes studies. ◢

identified as Native Hawaiians or Other Pacific Islanders, or who identified as members of indigenous groups in other countries.

[4] The home visiting literature commonly refers to "versions" as adaptations and/or enhancements. More information about HomVEE's prioritization process is available at https://homvee.acf.hhs.gov/publications/methods-standards.

what types of outcomes researchers have, and have not, studied. HomVEE gathered descriptive information about early childhood home visiting models of potential relevance to tribal communities. More research is needed on these models. However, Indian tribes (or a consortia of tribes), tribal organizations, or urban Indian organizations, including the Tribal MIECHV Program grantees, might find this information useful in determining whether these existing models would be a good fit for their communities and whether implementing the model in their communities would be feasible. To respect tribal sovereignty, HomVEE does not name specific tribal communities when summarizing findings. When a study identifies a specific tribal community as participants in the study, HomVEE names the community in tables that reference the study. HomVEE summarized lessons learned across manuscripts on three topics: (1) the adaptation of existing models and the development of new models culturally relevant to tribal families and children, (2) the implementation challenges programs faced and the programs' strategies for overcoming them, and (3) the challenges evaluators faced conducting studies of the models.

This report, Part 1, describes the findings from this review of research on early childhood home visiting models implemented with tribal populations or evaluated with tribal families or children. Section I introduces HomVEE's review of this research, and Section II presents the findings from HomVEE's review of research with tribal populations. In Section II, Part A describes the manuscript ratings and evidence of effectiveness for models included in the review, and Part B summarizes the types of findings reported in the manuscripts and describes the characteristics of the early childhood home visiting models. Appendix A describes the review process HomVEE used to identify, screen, and assess the research literature on early childhood home visiting models implemented with tribal populations. Appendix B presents detailed information about each model included in the review, including its evidence of effectiveness, a summary of findings, model description, and a list of manuscripts about that model that are included in HomVEE's review of research with tribal populations. Appendix C presents study characteristics from manuscripts that received high- and moderate-ratings and reported findings from impact studies. Appendix D is a list of all manuscripts included in this review and the model they discuss.

A companion report, Part 2, *Assessing the Research on Early Childhood Home Visiting Models Implemented with Tribal Populations—Part 2: Lessons Learned about Implementation and Evaluation*,[5] describes the lessons learned across the reviewed manuscripts, with a focus on cultural relevance and implementation, followed by proposed considerations for building the research literature on early childhood home visiting with tribal populations. This report and its companion report are available at https://homvee.acf.hhs.gov/tribal.

[5] Mraz Esposito, A., Yanez, A., Coughlin, R., & Sama-Miller, E. (2020). Assessing the research on early childhood home visiting models implemented with tribal populations—Part 2: Lessons learned about implementation and evaluation. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

This page has been left blank for double-sided copying.

II. Descriptive Information about Early Childhood Home Visiting Models studied with Tribal Populations

HomVEE's review of early childhood home visiting models implemented with tribal populations (including indigenous communities outside the United States) began with a thorough search of the research literature on early childhood home visiting in fall 2010. Mathematica, under contract to ACF, issued a call for tribal-specific research in fall 2010 to identify additional research, reviewed the literature, assessed the quality of manuscripts examining impact studies, and evaluated the strength of evidence for specific early childhood home visiting models. The first report was published in February 2011. The report was updated annually through 2014, and again in 2017. The current update includes manuscripts released through September 2018 or received through the HomVEE call for research that closed in early January 2019. As the research literature on early childhood home visiting with tribal populations grows, HomVEE periodically conducts additional literature searches to identify new early childhood home visiting research. These activities mirror those conducted for the annual HomVEE review that focuses on the general population. The activities are described in detail in Appendix A. More information about the review process is available on the HomVEE website (https://homvee.acf.hhs.gov/publications/methods-standards).

A. HomVEE's Review of Research in Tribal Communities

In this section, we describe the ratings for each of the manuscripts HomVEE reviewed, as well as the evidence of effectiveness of the early childhood home visiting models included in the review.

1. Manuscript ratings[6]

This update added 8 manuscripts about impact studies of early childhood home visiting models evaluated with tribal populations: 4 randomized control trials (RCTs), 2 single-case design studies (SCDs), and 2 non-experimental comparison group design (NED) studies.[7] Overall, this report includes 57 manuscripts about impact studies. Among these, 39 used an RCT design, 2 used an SCD, and the remaining 16 used an NED (Table II.1).

[6] This update of HomVEE's report on research with tribal populations relies on HomVEE's Version 1 Procedures and Evidence Standards, which were revised in late 2020. HomVEE's Version 2 standards, which are being released simultaneously with this report, may be applied to future updates. Both versions of the standards are available at https://homvee.acf.hhs.gov/publications/methods-standards. There are minor differences between the terminology used in the Version 1 and Version 2 standards. This report uses terminology that is consistent with the Version 2 standards.

[7] Non-experimental comparison group designs (NEDs) use a nonrandom process to assign sample members to an intervention group and a comparison group. Sample members can be assigned through statistical techniques that are designed to match sample members in each group, so each group has similar measurable characteristics on average; or they can be assigned based on convenience, by assigning people to groups because they are nearby or available or otherwise convenient to include.

Table II.1. Number of manuscripts about impact studies, by study design and rating

Study design reported in manuscript	Total number of manuscripts included in HomVEE's review of research in tribal communities
Total number of manuscripts about RCTs	**39**
RCT manuscripts with a high rating	10
RCT manuscripts with a moderate rating	9
RCT manuscripts with a low rating	20
Total number manuscripts about SCDs	**2**
SCD manuscripts with a high rating	**1**
SCD manuscripts with a moderate rating	0
SCD manuscripts with a low rating	1
Total number of manuscripts about NEDs	**16**
NED manuscripts with a moderate rating[a]	2
NED manuscripts with a low rating	14
Total number of manuscripts about impact studies	57

Source: HomVEE analysis.

[a]According to standards for the HomVEE review, an NED can receive only a moderate or low study-quality rating.

NED = non-experimental comparison group design study; RCTs = randomized controlled trials; SCD = single-case design study.

About 40 percent of manuscripts about impact studies included in HomVEE's review of research in tribal communities reported on well-designed research. HomVEE defines well-designed impact studies as those whose designs suggest that some or all of the findings were due to the home visiting model and not to other factors. Of the 39 manuscripts that reported findings from RCTs, 10 received a high rating,[8] 9 received a moderate rating,[9] and 20 received a low rating[10] (see Appendix D for a list of all manuscripts about impact studies). The 20 manuscripts that reported findings from RCTs and received a low rating were most commonly rated low because of (1) high attrition and (2) intervention and comparison groups that differed on key baseline characteristics. Three manuscripts about impact studies rated low due to the presence of a confounding factor. Of the two manuscripts about SCDs, one received a high rating,[11] and one received a low rating.[12] This manuscript received a low rating because the design did not have the required number of phases to meet HomVEE standards for a design of this type. Of the 16 manuscripts that reported findings from NEDs, 2 received a moderate rating.[13] The other 14 received a low rating because (1) the intervention and comparison groups differed on key baseline characteristics or

[8] RCTs that received a high rating Bair-Merritt et al., 2010; Barlow et al., 2013, 2015; Caldera et al., 2007; Duggan et al., 1999, 2007; Duggan, Fuddy, et al., 2004; Duggan, McFarlane, et al., 2004; El-Kamary et al., 2004; and Silovsky et al., 2011.

[9] RCTs received a moderate rating were Barlow et al., unpublished [2014]; Boyd, 1997b; Campbell & Silva, 1997; Fergusson et al., 2005; Johns Hopkins University, 2005; King et al., 2005; Pfannenstiel, 2015; Walker et al., 2015; and Walkup et al., 2009.

[10] RCTs received a low rating were Anand et al., 2007; Barlow et al., 2006; Booth-LaForce et al., 2018; Boyd, 1997a; Daro et al., 1998; Harvey-Berino & Rourke, 2003; Karanja et al., 2010; le Roux et al., 2010, 2011, 2013, 2014; Livingstone et al., 1999; McCurdy et al., 2001, 2005; McFarlane et al. 2013; Rotheram-Borus et al., 2014, 2015; Spieker et al., 2012, 2014; and Tomayko et al., 2016.

[11] Chomos et al., 2018b.

[12] Chomos et al., 2018a.

[13] Culp et al., 2004, 2007.

(2) information on baseline characteristics was not presented and equivalence could not be established.[14] In addition, 4 NEDs had confounding factors, which automatically results in a low rating. Part 2 of this report discusses challenges with conducting evaluation research with tribal populations in more depth.

Eight of the 22 manuscripts about well-designed research that included a tribal population specifically examined the effect of a model with tribal populations. (The remaining 14 manuscripts had samples that were neither 100 percent tribal nor did the manuscripts report findings separately by tribal community affiliation.) Four manuscripts about well-designed research[15] investigated **Family Spirit** and included samples made up entirely of tribal participants. (Three manuscripts focused on the same study and sample). Two additional manuscripts included study samples that were 100 percent tribal; a high-rated manuscript that examined the impact of **Nurse-Family Partnership (NFP)** in a tribal community,[16] and a moderate-rated manuscript that examined the impact of the **Bureau of Indian Affairs' Baby Family and Child Education Program (Baby FACE program)** among tribal participants living in six states across the United States.[17] (The Baby FACE program is a version of Parents as Teachers.) A manuscript about the **Healthy Starts** trial received a moderate rating and examined a sample made up entirely of indigenous participants in Australia and New Zealand.[18] One moderate-rated manuscript examined **Early Start** (New Zealand).[19] The sample examined in the manuscript included parents who identified themselves as members of the indigenous population of New Zealand; these participants constituted 42 percent (or 76 individuals) of the intervention group and 36 percent (or 75 individuals) of the comparison group. Selected findings were reported for the subgroup of families in which at least one parent identified as a member of the indigenous population of New Zealand.[20] (See Appendix B for descriptions of the early childhood home visiting models implemented with tribal populations included in this review.)

The remaining 14 of the 22 manuscripts about well-designed research did not report findings by tribal community affiliation. After determining the quality of 14 manuscripts that received a high- and moderate rating with samples that were not 100 percent tribal, HomVEE examined the impact of models on tribal populations by looking for subgroup analyses conducted with tribal populations. The following models have well-designed research, but the manuscripts do not report findings by tribal community affiliation, so HomVEE could not determine the evidence of effectiveness of the models with tribal participants.

- HomVEE identified research about two trials of Healthy Families America®, which we present separately by the population they served:

[14] Coughlin et al., unpublished; Dew et al., 2004; Ernst et al., 1999; Fatti et al., 2013; Grimwood et al., 2012; Kartin et al., 2002; Krysik & LeCroy, 2007; McCalman et al., 2014; Nelson et al., 2013; Pfannenstiel, 2006; Pfannenstiel & Lente-Jojola, 2011; Praat, 2011; and Sawyer et al., 2013, 2014.
[15] Barlow et al., 2013, 2014, 2015; Walkup et al., 2009
[16] Chomos et al., 2018b.
[17] Pfannenstiel, 2015.
[18] Walker et al., 2015. This trial is known as Healthy Starts in Australia and Te Piripohotanga in New Zealand. Throughout this report, we refer to this trial as the Healthy Starts trial.
[19] Fergusson et al., 2005.
[20] Appendix B only includes findings for the indigenous population subgroup reported in this manuscript. Findings for the full sample are on the HomVEE website in the Early Start report.

  - **Healthy Families America®/Hawaii Healthy Start.** Five manuscripts[21] that received a high rating and one manuscript[22] that received a moderate rating examined Healthy Families America/Hawaii Healthy Start. All six manuscripts examined the same sample of participants randomized to Hawaii Healthy Start or a comparison group. The sample consisted of 33 percent Native Hawaiian or Pacific Islander participants in the intervention group and 34 percent in the comparison group. **None of the manuscripts reported findings by tribal community affiliation, so HomVEE could not determine the evidence of effectiveness of Hawaii Healthy Start with Native Hawaiian or Pacific Islander participants.**
  - **Healthy Families America/Healthy Families Alaska.** Two manuscripts[23] that received a high rating and one manuscript[24] that received a moderate rating examined Healthy Families Alaska, a statewide Healthy Families America model. All three of these manuscripts examined the same sample receiving Healthy Families Alaska. The sample consisted of 23 percent Alaska Native participants in the intervention group and 20 percent in the comparison group. **The manuscript did not report findings separately by tribal community affiliation, so HomVEE could not determine the evidence of effectiveness of Healthy Families Alaska with Alaska Native participants.**

- **Oklahoma Community-Based Family Resource and Support (CBFRS).**[25] Two manuscripts[26] that received moderate ratings examined the Oklahoma CBFRS model. These two manuscripts examined the same sample receiving Oklahoma CBFRS. **The overall sample consisted of 13 percent tribal participants. The manuscripts did not report findings by tribal community affiliation, so HomVEE could not determine the evidence of effectiveness of Oklahoma CBFRS with tribal participants.**
- **Parents as First Teachers (PAFT-New Zealand).**27 Two manuscripts 28 that received moderate ratings examined PAFT, an adaptation of the Parents as Teachers (PAT)® model for implementation in New Zealand. In both manuscripts, at least 10 percent of the sample examined in the manuscript reported speaking an indigenous language.29 **Neither manuscript reported the findings by tribal community affiliation, so HomVEE could not determine the evidence of effectiveness of PAFT with the indigenous participants.**
- **SafeCare® Augmented.** One manuscript30 that received a high rating examined SafeCare Augmented, a supplemented version of the SafeCare model that included motivational interviewing, as well as training for home visitors on identifying and z to imminent child maltreatment and risk factors of substance abuse, depression, and intimate partner violence. The sample examined in the manuscript included tribal participants; these participants constituted 15 percent (or 7 individuals) of

[21] Bair-Merritt et al., 2010; Duggan, Fuddy, et al., 2004; Duggan, McFarlane, et al., 2004; Duggan, McFarlane et al., 1999, and El-Kamary et al., 2004
[22] King et al., 2005.
[23] Caldera et al., 2007; Duggan et al., 2007.
[24] Johns Hopkins University, 2005.
[25] Implementation support is not currently available for the model as reviewed.
[26] Culp et al., 2004, 2007.
[27] As of 2016, implementation support is no longer available for PAFT (New Zealand.)
[28] Boyd 1997b; Campbell & Silva, 1997.
[29] The manuscripts did not report the participants' tribal community, but it was reported in a related report: Livingstone, I. D. (1998). *Parents as First Teachers pilot project: Summary report: Evaluation of pilot project*. Wellington, New Zealand: Ministry of Education.
[30] Silovsky et al., 2011.

the intervention group and 7 percent (or 4 individuals) of the comparison group. **The manuscripts did not report findings by tribal community affiliation, so HomVEE could not determine the evidence of effectiveness of SafeCare Augmented with tribal participants.**

2. Evidence of effectiveness of the early childhood home visiting models

One early childhood home visiting model included in this review, **Family Spirit**, met HHS criteria for an "evidence-based early childhood home visiting service delivery model" for tribal populations. Four manuscripts about Family Spirit—which included samples made up entirely of tribal participants (three manuscripts focused on the same study and sample)—received a high or moderate rating. Across the four manuscripts there were favorable, statistically significant impacts in three domains.[31] At least one of the findings was sustained at least one year after model enrollment, and results were published in a peer-reviewed journal.[32]

Box 2. Definition of an "evidence-based early childhood home visiting service delivery model" in tribal populations

A model that meets the HHS criteria for an "evidence-based early childhood home visiting service delivery model" with tribal populations does so based on research from either (1) a sample composed entirely of tribal participants or (2) at least two distinct subgroups composed entirely of tribal participants.

The other eight models with manuscripts that received a high or moderate rating did not meet HHS' evidence-based criteria for tribal populations for a range of reasons (Table II.2). Box 2 and Appendix A provides more information about HHS criteria for an "evidence-based early childhood home visiting service delivery model" in tribal populations.

Table II.2. Reasons models with well-designed research did not meet HHS' evidence-based criteria for tribal populations

Reason	Model
Effects were reported separately for a sample composed entirely of tribal participants or for a tribal subgroup, but the findings have not been replicated in another domain or sample composed entirely of tribal participants	• Baby FACE program • Early Start (New Zealand)
Sample was composed entirely of tribal participants, but there were no statistically significant impacts (nor were impacts sustained for at least one year after model enrollment, which is required for RCTs)	• Healthy Starts trial • Nurse-Family Partnership
Findings were not reported separately for tribal populations	• Healthy Families America (including Hawaii Healthy Start and Healthy Families Alaska) • Oklahoma Community-Based Family Resource and Support (CBFRS) • SafeCare Augmented
Findings were not reported separately for tribal populations and there were no favorable impacts	• Parents as First Teachers (New Zealand)

[31] Barlow et al., 2013, 2014, 2015; Walkup et al., 2009.

[32] If a model meets HHS' evidence-based criteria based on findings from randomized controlled trial(s) only, then two additional requirements apply. First, one or more favorable (statistically significant) impacts must be sustained for at least one year after program enrollment. Second, one or more favorable (statistically significant) impacts must be reported in a peer-reviewed journal. More information is available at https://homvee.acf.hhs.gov/publications/methods-standards.

Table II.2 *Continued*

Source: HomVEE review of 98 manuscripts about 36 early childhood home visiting models implemented with tribal populations.

Note: Models and had high- or moderate-quality manuscripts about impact studies included in HomVEE's review of research with tribal populations.

Early Start (New Zealand), Healthy Families America, Nurse-Family Partnership, Oklahoma CBFRS, and SafeCare Augmented meet the HHS evidence-based criteria for the annual review in the general population. The Baby FACE program does not meet HHS criteria for either review because all favorable, statistically-significant impacts occurred in the same domain and sample. Parents as First Teachers (New Zealand) does not meet HHS criteria for either review because no favorable impacts were found.

Appendix B provides detailed information about the effects found in the above models implemented in tribal populations.

Seven of the eight modes families in HomVEE's review of research with tribal populations that had well-designed research were also included in the overall HomVEE review. Detailed information on the effects found in research on these models implemented in the general population is available on the HomVEE website:

- **Early Start (New Zealand)** (https://homvee.acf.hhs.gov/effectiveness/Early%20Start%20(New%20Zealand)/In%20Brief)
- **Family Spirit** (https://homvee.acf.hhs.gov/effectiveness/Family%20Spirit®/In%20Brief)
- **Healthy Families America (which includes Hawaii Healthy Start and Healthy Families Alaska)** (https://homvee.acf.hhs.gov/effectiveness/Healthy%20Families%20America%20(HFA)®/In%20Brief)
- **Nurse-Family Partnership** (https://homvee.acf.hhs.gov/effectiveness/Nurse-Family%20Partnership%20(NFP)®/In%20Brief))
- **Oklahoma CBFRS** (https://homvee.acf.hhs.gov/effectiveness/Oklahoma's%20Community-Based%20Family%20Resource%20and%20Support%20(CBFRS)%20Program/In%20Brief)
- **Parents as First Teachers (PAFT), a version of PAT** (https://homvee.acf.hhs.gov/effectiveness/Parents%20as%20Teachers%20(PAT)®/In%20Brief)
- **SafeCare Augmented, a version of SafeCare** (https://homvee.acf.hhs.gov/effectiveness/SafeCare®/In%20Brief)

B. Descriptive information about early childhood home visiting models evaluated with tribal populations

In this section we summarize descriptive information and implementation details about the 36 early childhood home visiting models evaluated across all manuscripts in HomVEE's review of research with tribal populations. (These models are listed in Table III.1.) HomVEE collected descriptive information from the 57 manuscripts about impact studies and 41 manuscripts about implementation or outcomes studies identified through the literature search and screening process for the review.[33] Most manuscripts included some information about the early childhood home visiting model being evaluated, or documented lessons learned about implementation. Much of the information HomVEE was able to extract about implementation can help inform tribes, communities, and states about what is needed to implement

[33] Because the original review in 2010 identified so few manuscripts, HomVEE decided the review of research with tribal populations would include outcomes studies that had ineligible study designs for the impact review (such as pre-post or correlational) but that were otherwise relevant in the implementation review process.

a given model. For example, how intensive are the services? What skills and educational levels must home visitors have to implement the model? What are the staff training and supervision requirements?

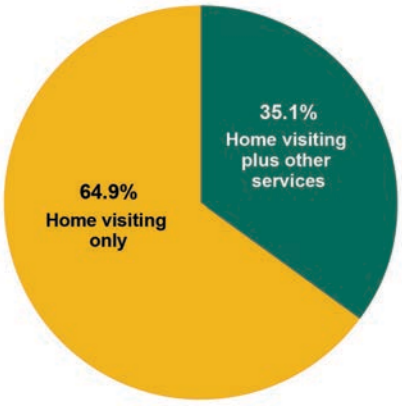
Below, we describe the features of early childhood home visiting models that manuscripts typically reported on: model goals, service delivery, frequency and duration of home visits, population of focus, location, type of implementing agency, and home visitor qualifications and training. Appendix B provides detailed information about each early childhood home visiting model and lists the manuscripts from which HomVEE gathered the information. Additional information about the characteristics of impact studies described in manuscripts that received a high or moderate rating is on the HomVEE website or in Appendix C.

Model goals. All models had goals related to family and child outcomes. Additionally, in the manuscripts we reviewed, six models identified other types of goals. One model, the **Home Activity Program for Parents and Youngsters Rural Outreach Project**, specifically aimed to increase access to early intervention services among families living in remote, rural areas and to change health risk habits among American Indian women. The **Aboriginal Peer-Led Home Visiting Programme** worked to address, among other things, housing, family stress, and self-management and coping strategies. Research about seven models—the **Aboriginal Peer-Led Home Visiting Programme**; the **Baby Basket program**, the **Baby One program**; the **Family and Child Education program**; **Family Spirit**; **Healthy Children, Strong Families**; and the **Indian Family Wellness Project**—explicitly described a goal of the model to provide culturally relevant services for tribal families, in support of the ultimate goal of improving parent and child outcomes.

Box 3. Other services offered

Thirteen models included other services, such as parent group meetings and center-based options. One model included a community-wide component in addition to home visits. Another model delivered home visits in conjunction with home remediation services to improve indoor air quality (for example, installing vents or replacing furnaces).

Figure II.1. Attributes of reviewed early childhood home visiting models evaluated with tribal populations



Source: HomVEE review of 98 manuscripts about 36 early childhood home visiting models implemented with

Service delivery. All early childhood home visiting models used home visits as the primary mode of service delivery, but 35 percent of models also included other services (see Box 3 and Figure II.1).

Number, frequency, and duration of home visits. The number, frequency, and duration of home visits varied by model (Table II.3). Home visitation frequency ranged from weekly to only one over the course of the entire model. Most models offered home visits weekly, biweekly, or monthly. Most manuscripts did not include information about the number or length of home visits, but of the models for which manuscripts reported this information, the number of home visits over the course of participation tended to be few (5 or fewer) or many (more than 15). Most models that had manuscripts reporting this information offered home visits that lasted between one and two hours. Early childhood home visiting models varied in duration, ranging from 10 weeks to three to five years, with most lasting either less than one year or more than two years.

Population of focus. The early childhood home visiting models focused on recruiting participants based on the age of their children, as well as the presence of specific risk factors. Nineteen of the 36 models (53 percent) began offering services to families at birth or in early infancy and continued to offer services to families with children up to age 2 to 5 years. Two models offered services up to age 8, and one served children up to age 12 (Table II.4).

In addition to age, models focused on a variety of populations of focus. Eight models specifically sought to engage pregnant women, and one focused on women postnatally. Some models were available to any family meeting the age of focus and living in pre-specified geographic locations (such as rural reservations). Other models, however, engaged families with specific risk factors. For example, **Obesity Prevention + Parenting Support** focused on mothers whose body mass index was over 25. **Home Remediation and Household Education** focused on families with children who had lung disease. **Family Spirit** engaged adolescents and women up to age 19 (another manuscript about the same program included women up to age 22 at conception). **Oklahoma CBFRS** focused on first-time mothers living in rural counties. The **Parent-Child Assistance Program** engaged mothers who were either pregnant or less than six months postpartum who self-reported heavy substance use and were ineffectively engaged in community services. The **Healthy Starts trial** focused on infants living in a household with someone who smokes. Appendix B provides detailed information about study participants from manuscripts about each model.

Table II.3. Frequency and length of home visits and overall duration for reviewed early childhood home visiting models evaluated with tribal populations[a]

Home visitation frequency	Number (percentage) of models evaluated with tribal populations
Weekly or biweekly	14 (38)
Monthly	7 (19)
Less than monthly	3 (8)
Not specified	19 (51)
Number of home visits	
5 or fewer	5 (14)
6 to10	3 (8)
11 to15	0 (0)
More than 15	4 (11)
Not specified	25 (68)
Length of home visit	
Less than 1 hour	2 (5)
1 to 2 hours	7 (19)
2 or more hours	0 (0)
Not specified	26 (70)
Duration of program	
Less than 1 year	8 (22)
1 year	2 (5)
More than 1 to 2 years	5 (14)
More than 2 years	9 (24)
Not specified	13 (35)

Source: HomVEE review of 98 manuscripts about 36 early childhood home visiting models implemented with tribal populations.

[a] For all categories, more than one may apply to an individual model. As a result, totals sum to more than 100 percent.

Table II.4. Age of study participants at program enrollment in reviewed early childhood home visiting models evaluated with tribal populations

Age of study participants at program enrollment[a,b]	Number (percentage) of models evaluated with tribal populations
Pregnant women	14 (38)
0 to 12 months	6 (16)
Children up to age 3	5 (14)
Children up to age 5	11 (30)
Not specified	8 (22)

Source: HomVEE review of 98 manuscripts about 36 early childhood home visiting models implemented with tribal populations.

[a] More than one category may apply to an individual model. As a result, total sums to more than 100 percent.

[b] These categories are not mutually exclusive, and the ages of study participants were categorized based on the information available in the manuscript. If a manuscript indicated that a participant was less than one year old, that manuscript contributed to a model being counted in the "0 to 12 months" category but not the "children up to age 3" category. If a manuscript indicated that participants were between the ages of 0 and 3 years, that manuscript contributed to a model being counted in the "children up to age 3" category but not the "0 to 12 months" category. Sometimes, it was clear that a model served families that would screen in but was not clear whether it served pregnant women as well as families with young children (such as a model focused on reducing Sudden Infant Death Syndrome). We placed manuscript of this type in the final row of the table.

Table II.5. Type of agency implementing reviewed early childhood home visiting models evaluated with tribal populations

Type of implementing agency[a]	Number (percentage) of models evaluated with tribal populations
Elementary school	2 (5)
Non-profit or nongovernmental organization	7 (19)
Non-tribal public agency	16 (43)
Private agency	1 (3)
Tribal entity	5 (14)
Not specified	8 (22)

Source: HomVEE review of 98 manuscripts about 36 early childhood home visiting models implemented with tribal populations.

[a] More than one category may apply to an individual model. As a result, total sums to more than 100 percent.

Location of services and types of implementing agencies. HomVEE's review of research in tribal communities included manuscripts about models specifically examined with tribal populations and those about studies whose sample included a proportion of tribal participants (see Box 4).

One manuscript described a study that gave priority to implementing agencies with service areas that included Indian reservations. The manuscripts included in this review about **Healthy Families America**, **Healthy Families Alaska**, **Healthy Families Arizona**, and **Hawaii Healthy Start**; the **Nurse-Family Partnership**; **Oklahoma CBFRS**; the **Parent-Child Assistance Program**; and **SafeCare Augmented** did not describe studies about models that specifically sought to engage tribal communities, but the studies themselves included tribal participants.

Of the 36 models included in this report, 20 were implemented and evaluated in the United States and 16 were implemented outside of the United States (including 2 models that were also implemented in the United States). Figure II.2 is a map that shows how many models were implemented and evaluated in

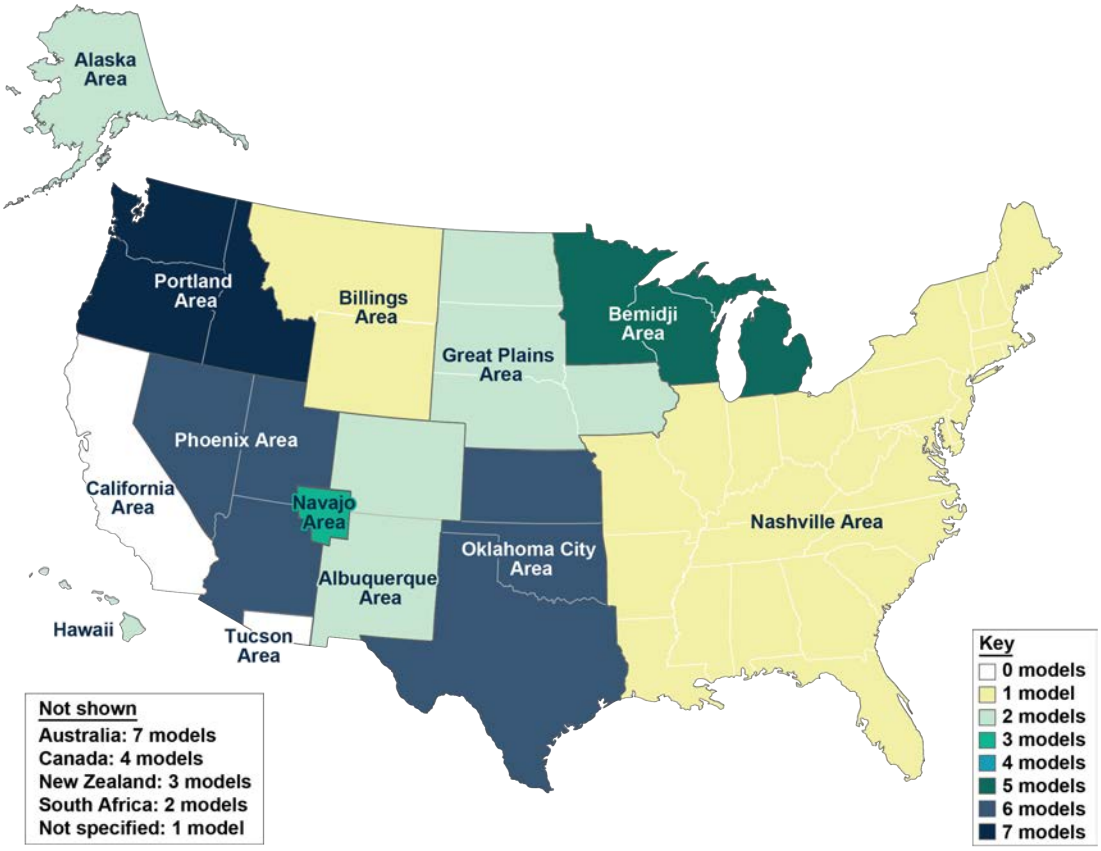
each of the Indian Health Service Areas in the United States.[34] Inside the United States, the areas best represented in HomVEE's review of research with tribal populations are the Portland Area, with 7 models, and the Oklahoma City and Phoenix Areas, each with six models. They are followed by the Bemidji Area, where five models in HomVEE's review of research with tribal populations were implemented and evaluated. No models in this review were implemented or evaluated in the California or Tucson Areas. Of the models and evaluated outside of the United States, seven were in Australia, four in Canada, three in New Zealand, and two in South Africa. Appendix B provides more details about where each model was implemented and evaluated.

Box 4. Proportion of models studied with tribal populations

Descriptive information was extracted from 98 manuscripts about 36 early childhood home visiting models. Almost 64 percent (23) of these models were examined specifically with tribal populations.

Across models, services were delivered by a range of implementing agencies, including health providers (and hospitals), social services agencies, elementary schools, and Head Start programs (Table II.5).

Figure II.2. Location of reviewed early childhood home visiting models evaluated with tribal populations



Source: HomVEE review of 98 manuscripts about 36 early childhood home visiting models implemented with tribal populations.

Note: If a manuscript about a given model reported study sites in more than one location, the model is included in counts for all locations that apply.

[34] For more information about the 12 geographic service areas, see https://www.ihs.gov/locations/.

Home visitor qualifications and training. Manuscripts that included information about home visitor qualifications and training focused on requirements other than formal education (Box 5 and Table II.6). Of the 9 models for which manuscripts reported formal education requirements, 5 models had manuscripts that indicated that home visitors were required to have at least a bachelor's degree. In contrast, manuscripts about 26 of the 36 models (72 percent) described other requirements for home visitors, most commonly relevant experience, that the home visitor be of the same tribal community, or some other requirement (for example, strong communication skills or being an established member of the community being served).[35]

Manuscripts described training requirements for most models, and nearly all (70 percent) mandated that home visitors complete some kind of training, including initial training and other and professional development (Table II.7). Some models required intensive training. For example, home visitors implementing the **Baby FACE program** participated in a five-day initial training and three-day follow-up. Home visitors implementing the **Obesity Prevention + Parenting Support program** participated in 120 hours of training, and those implementing **Family Spirit** participated in more than 80 hours. To support home visitors during service delivery, many models offered that programs could have ongoing consultation with model developers to ensure that staff implemented the model consistently over time. Manuscripts about five models specified that technical assistance was available to home visitors (Table II.7).

Box 5. Characteristics of home visitors

Manuscripts about three-quarters (28) of the 36 early childhood home visiting models did not describe education requirements for home visitors. Manuscripts specified other requirements for home visitors, placing greater value on home visitors who were members of the community being served, had strong interpersonal skills, and had relevant personal and professional experience.◢

Table II.6. Home visitor qualifications in reviewed early childhood home visiting models evaluated with tribal populations[a]

Education	Number (percentage) of models evaluated with tribal populations
High school degree	3 (8)
Associate's or bachelor's degree	5 (14)
Master's degree	1 (3)
Not specified	28 (76)
Other requirements	
Race/ethnicity (indigenous or member of same tribe as participants)	8 (22)
Native language	2 (5)
English language	2 (5)
Paraprofessional	4 (11)
Relevant experience	14 (38)
Other[b]	9 (24)
Not specified	10 (27)

Source: HomVEE review of 98 manuscripts about 36 early childhood home visiting models implemented with tribal populations.

[35] While models may have various staff requirements, HomVEE only reports qualification and training information described in the reviewed manuscripts. This information about staff qualifications and training may or may not align with the models' current requirements.

Table II.6. *Continued*

[a] More than one category may apply to an individual model. As a result, total sums to more than 100 percent. Categories are based on information described in the manuscripts HomVEE reviewed; actual requirements of early childhood home visiting models may differ from what the manuscripts described.

[b] The "Other" category includes requirements such as good communication or interpersonal skills, cultural competency, ability to maintain confidentiality, and ability to maintain boundaries between personal and professional life.

Table II.7. Home visitor training and technical assistance in reviewed early childhood home visiting models evaluated with tribal populations

Training[a]	Number (percentage) of models evaluated with tribal populations
No training	1 (3)
Initial training	24 (65)
Additional trainings	16 (43)
On-the-job training	4 (11)
Supplemental training activities and professional development opportunities	5 (14)
Not specified	10 (27)
Technical assistance	
Technical assistance available	5 (14)
Not specified	32 (86)

Source: HomVEE review of 98 manuscripts about 36 early childhood home visiting models implemented with tribal populations.

[a] More than one category may apply to an individual model. As a result, total sums to more than 100 percent.

C. Outcome domains examined in manuscripts that received high or moderate ratings

In this section we discuss the outcome domains analyzed in the 22 manuscripts about high- or moderate-quality impact studies about 9 early childhood home visiting models in HomVEE's review of research with tribal populations. The impact studies included in this review reported findings in multiple domains (Box 6 and Figure II.3). It is important to note that some of these studies may have a narrower focus than the model as a whole. Also, early childhood home visiting models included in HomVEE's review of research with tribal populations may focus on a broader range of outcomes than authors examined in this subset of studies that included a tribal population. Some models focused broadly on improving outcomes across a range of domains, as in the following examples:

Box 6. Common outcome domains

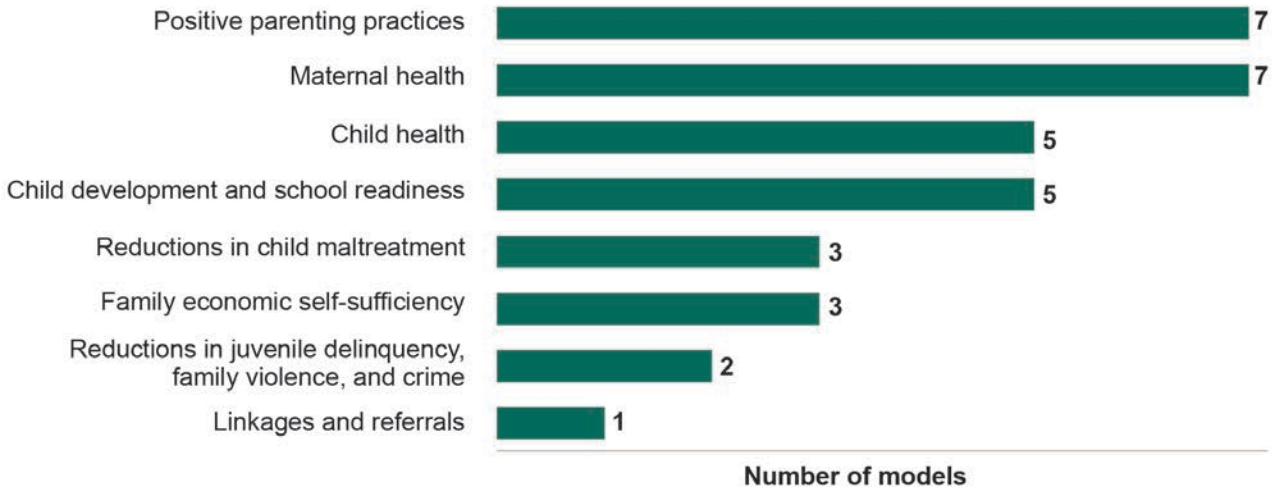
Manuscripts included in HomVEE's review of research with tribal populations commonly reported findings in four domains:

- Positive parenting practices (7 models)
- Maternal health (7 models)
- Child development and school readiness (5 models)
- Child health (5 models)

- **Healthy Families America** manuscripts reported findings in seven of HomVEE's eight domains: Child development and school readiness; child health; family economic self-sufficiency; maternal health; positive parenting practices; reductions in child maltreatment; and reductions in juvenile delinquency, family violence, and crime.

- **Parents as First Teachers (New Zealand)** manuscripts reported findings in five domains: Child development and school readiness, child health, family economic self-sufficiency, maternal health, and positive parenting practices.
- **SafeCare Augmented** manuscripts reported findings in five domains: Family economic self-sufficiency, maternal health, linkages and referrals, reductions in child maltreatment, and reductions in juvenile delinquency, family violence, and crime.

Figure II.3. Outcome domains assessed in well-designed research about reviewed early childhood home visiting models evaluated with tribal populations



Source: HomVEE's review of 22 manuscripts about well-designed impact studies on nine models included in HomVEE's review of research with tribal populations. The other 27 models did not have any well-designed impact studies.

Other manuscripts narrowly focused on findings in a specific domain. For example, manuscripts included in HomVEE's review of research with tribal populations about **Nurse-Family Partnership** focused on maternal health, (though this model generally focuses on other domains that were not measured in the studies), and manuscripts included about the **Baby FACE program** focused on child development and school readiness and positive parenting practices. Appendix B provides detailed information about the domains measured for each model.

This page has been left blank for double-sided copying.

III. Summary

With this update, HomVEE's review of research with tribal populations includes 98 manuscripts that are eligible for review. These manuscripts describe research on 36 early childhood home visiting models implemented with tribal populations (Table III.1). Appendix B provides detailed information about the effectiveness and implementation research we reviewed for each model. Part 2 of this report, in a separate volume, analyzes information from the manuscripts we reviewed to identify lessons learned about implementation and evaluation of research on early childhood home visiting in tribal populations, and includes considerations for developing and researching early childhood home visiting models with tribal populations.[36]

Of the 36 models included in this review, one —Family Spirit—meets HHS criteria for being an "evidence-based early childhood home visiting service delivery model" for tribal populations. The reasons the remaining 35 models did not meet criteria for tribal populations varied. For 15 models, the review included only implementation studies and did not identify or include any impact research. Of the 21 models with any impact research, more than half (12 models) did not have any *well-designed* impact research. Of the 8 models that had well-designed impact research but did not meet HHS' evidence-based criteria, one-third (3 models) had no favorable findings, another one-third (3 models) were not evidence based because the findings were not presented separately for tribal populations,[37] and 2 were not evidence based because the findings were not replicated in another sample or domain.

In addition to examining impact research, this report also summarizes descriptive information and implementation details about the 36 models. This information is from a review of all 98 manuscripts, including 57 about impact studies and 41 about implementation or outcomes studies. Of the 36 models HomVEE reviewed, researchers studied 23 (64 percent) specifically with tribal populations. The remaining 13 models families have research with study samples that included at least 10 percent tribal participants, but the research did not focus exclusively on a tribal population.

All 36 models included in this review focused on improving outcomes for families and young children. Additionally, 7 models had a specific goal to deliver services that were culturally relevant to tribal families. One model aimed to increase access to services for American Indian women living in remote and rural areas. Twenty of the 36 models were implemented in the United States and 15 were implemented outside of the United States. The United States is well represented in the research; the only Indian Health Service Areas not included in any manuscripts were the California Area and Tucson Area.

The populations that were the focus of the models in the review varied.[38] Some models focused on participant age or geographic area. Others focused on participants with specific risk factors (such as mothers with high body mass indexes, children with lung disease, or mothers struggling with substance

[36] Mraz Esposito, A., Yanez, A., Coughlin, R., & Sama-Miller, E. (2020). Assessing the research on early childhood home visiting models implemented with tribal populations—Part 2: Lessons learned about implementation and evaluation. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

[37] Additionally, one of these three interventions that did not report favorable findings also did not report findings separately for tribal populations.

[38] The information we included in this report draws only on information from the 98 manuscripts, and not all implementation details were available.

abuse). Twenty of the 36 models began offering services to families during a woman's pregnancy, at the time of a child's birth, or before the child's first birthday.

The manuscripts presented varied descriptions of how home visits were delivered (number, frequency, and duration), the qualifications specified for home visitors, and the amount of training and technical assistance provided to home visitors. However, many of the manuscripts HomVEE reviewed did not include information about the home visits or home visitors.

Table III.1. Early childhood home visiting models included in HomVEE's review of research with tribal populations

Model name
Aboriginal peer-led home visiting programme
Attachment and Biobehavioral Catch-up – Infant
Baby Basket program
Baby One Program
Early intervention services
Early Start (New Zealand)
Even Start
Family Spirit
Halls Creek Community Families Program
Healthy Children, Strong Families
Healthy Families America (HFA)
Healthy Starts trial/Te Piripohotanga NZ
Home Activity Program for Parents and Youngsters (HAPPY) Rural Outreach Project
Home remediation and household education
Indian Family Wellness Project
Inter-Tribal Council of Michigan's (ITC of MI) Healthy Start project (Maajtaag Mnobmaadzid)
Kheth'Impilo Community-Based Adherence Support
Nurse-Family Partnership (NFP)®
Australian Nurse-Family Partnership Program (ANFPP)[39]
Obesity Prevention + Parenting Support
Oklahoma Community-Based Family Resource and Support Program
Parent-Child Assistance Program (PCAP)
ParentChild+® Core Model
Parents as Teachers/PAT
Bureau of Indian Affairs' Baby Family and Child Education Program (Baby FACE)[40]
Parents as First Teachers (New Zealand) [41]
Perinatal Intervention Program
Philani Outreach Programme
Promoting First Relationships®
SafeCare®

[39] ANFPP is a version of Nurse-Family Partnership (NFP)
[40] Baby FACE is a version of Parents as Teachers/PAT
[41] Parents as First Teachers (PAFT) is a version of Parents as Teachers/PAT

Table III.1. *Continued*

Model name
SafeCare Augmented®[42]
SHARE-ACTION
South Australia Family Home Visiting Programme
Sudden Infant Death Syndrome Risk Factor Education Program
Toddler Overweight and Tooth Decay Prevention Study (TOTS)
Universal Health Home Visit offered through Families First

Note: Unless otherwise indicated, the only version of a given model that had impact research conducted with a tribal population is the version listed in the table.

[42] SafeCare Augmented is a version of SafeCare[43] More information about HomVEE's annual review process for the general population is available at https://homvee.acf.hhs.gov/publications/methods-standards.

This page has been left blank for double sided copying.

Appendix A:

HomVEE review process for research with tribal populations

This page has been left blank for double sided copying.

For its review of research with tribal populations, HomVEE includes research about early childhood home visiting models in which the study population includes 10 percent or more tribal participants. The main review activities are the same as those used for HomVEE's annual review in the general population.[43] For HomVEE's review of research in tribal communities, the literature is searched and screened each year. In years when the volume of unreviewed research is large enough, and project resources are available, manuscripts identified since the last review of research in tribal communities are rated, and the evidence is assessed and reported in an updated set of products about research with tribal populations. To conduct a thorough and transparent review of the tribal early childhood home visiting research literature, HomVEE performed seven main activities:

1. Conducted a broad literature search.
2. Screened manuscripts for relevance.
3. Rated the quality of manuscripts about impact studies.
4. Assessed the evidence of effectiveness for each model.
5. Reviewed implementation information for each model, including those without impact studies.
6. Addressed potential conflicts of interest.
7. Updated HomVEE's report assessing the research on early childhood home visiting models with tribal populations with new evidence of effectiveness and implementation information.

We describe each activity below.

1. Literature search

HomVEE conducted a broad search for literature on early childhood home visiting models implemented in tribal communities or research with samples that included a sizeable share (10 percent or more) of tribal participants. To increase the chance for identifying research that would be relevant to tribal communities, literature on early childhood home visiting models conducted in indigenous communities outside the United States was included. The populations that were the focus of the models included pregnant women or families with children from birth to kindergarten entry. HomVEE limited the search to research on models that used early childhood home visiting as the primary service delivery strategy and offered home visits to most or all participants. Models that provided services primarily in centers and used only supplemental home visits were excluded. The search was also limited to research on early childhood home visiting models that aimed to improve outcomes in at least one of eight domains specified in the statute:

- Child development and school readiness
- Child health
- Family economic self-sufficiency
- Linkages and referrals
- Maternal health
- Positive parenting practices
- Reductions in child maltreatment

[43] More information about HomVEE's annual review process for the general population is available at https://homvee.acf.hhs.gov/publications/methods-standards.

- Reductions in juvenile delinquency, family violence, and crime

HomVEE's literature search included three main activities:

- **Database searches.** HomVEE searched on relevant keywords in a range of research databases. Keywords included terms related to the service delivery approach, population served, and outcome domains of interest. In addition to the key terms included in the general HomVEE literature search, this search included keywords aimed at identifying research conducted in tribal communities or with tribal families and children, including tribe, tribal, Indian, Native American, Alaska Native, Native Hawaiian, Aboriginal, indigenous, and First Nation(s). The keyword search was limited to manuscripts published since 1989 and was updated annually through 20182018.
- **Call for research .** HomVEE issued a tribal-specific call for research in 2010 and issues an annual call for research for research on early childhood home visiting models. In screening results from both types of calls, HomVEE looks for models implemented in tribal communities or evaluated with tribal families and children.
- **Website searches.** In 2010 through 2012, HomVEE used a custom Google engine to search more than 50 government, university, research, and nonprofit websites for unpublished reports and papers. HomVEE dropped this activity in subsequent years, as results largely overlapped with the results from the database searches and call for research.

For the original report published in February 2011, HomVEE identified 213 unduplicated manuscripts of early childhood home visiting models implemented with tribal populations, including 5 unduplicated manuscripts through the call for research.[44] At the time of this report, HomVEE's review of research with tribal populations identified 1,038 unduplicated manuscripts.

2. Screening manuscripts

HomVEE used a two-step screening process. In Step 1, all manuscripts identified through the literature search were screened, and all citations that were not manuscripts or were not relevant were screened out (Table A.1). The citations that were not manuscripts included newspaper articles, literature reviews, and editorials. Many of the off-topic manuscripts examined medical interventions, such as programs to treat diabetes among older adults (such manuscripts might sometimes have the words "home" and "visit" near each other in the abstract). Others were summaries of child maltreatment rates and might have described a home visit but were not examining to early childhood home visiting models.

In Step 2, HomVEE examined the remaining citations for relevance and screened out studies for the following reasons; some manuscripts were screened out for multiple reasons (Table A.1):

- The study that the manuscript examines did not use an eligible design. Eligible designs for HomVEE's review of research with tribal populations are: randomized controlled trials [RCTs], single-case designs, regression discontinuity designs, non-experimental comparison group design studies [NEDs], implementation studies, and outcomes studies).

[44] Of the 213 unduplicated manuscripts identified through the literature search on tribal early childhood home visiting models, 154 had been identified during the general HomVEE literature search conducted in 2009. 2010 was the only year HomVEE released a call for tribal research that was separate from the general HomVEE call for research.

- The manuscript did not examine an early childhood home visiting model. (For example, the manuscript examined a grant program and its grantees, a medical intervention delivered in the home by nurses, or legislation.)
- The program did not serve an eligible population (pregnant women and families with children from birth to kindergarten entry from tribal or indigenous communities, in a country that is high income or upper-middle income as defined by the World Bank).
- Early childhood home visiting was not the primary service delivery strategy studied in the intervention. (For example, models that provide services primarily in centers, with supplemental home visits, are excluded.)
- The manuscript did not examine any findings in HomVEE's eight eligible outcome domains.
- The manuscript was not published in English.
- The manuscript was published before 1989.
- The manuscript did not present findings from primary research. Primary research includes authors' own analyses of secondary data, but it does not include manuscripts that do not report original findings. Examples of the latter are literature reviews or meta-analyses.

Table A.1. Results of the tribal literature search and screening process (manuscripts published from 1989 through September 2018)

Screening disposition	Total number of manuscripts in this report
Total number of unduplicated manuscripts identified through the literature search	1,038
Screening S1step	
Screened in	261
Screened out	777
Non-studies	80
Off-topic studies[a]	697
Screening S2step	
Screened in	98
Screened out [b]	163
The manuscript examines a study that did not use an eligible design.	26
The manuscript did not examine an early childhood home visiting model.	15
The program did not serve an eligible population (pregnant women and families with children from birth to kindergarten entry, from a tribal population).	51
Home visiting was not the primary service delivery strategy.	56
The manuscript did not examine any findings in HomVEE's eight eligible outcome domains.	6
The manuscript was not published in English.	2
The manuscript was published before 1989.	3
The manuscript did not present findings from primary research.	27

Source: HomVEE tribal literature search conducted in October 2018 to identify manuscripts released through the end of September 2018 and the HomVEE call for research that closed in early January 2019.

[a]Off-topic manuscripts include manuscripts about medical studies unrelated to early childhood home visiting as well as other unrelated content (for example, education topics or elder care with a home visitation component).

[b]Some manuscript were screened out for multiple reasons.

Although many manuscripts have been identified through the literature search, far fewer have been eligible for review. At the conclusion of the screening process for the original version of this review in fall 2010, 9 manuscripts about impact studies and 10 about implementation or outcomes studies were screened in and included in the review. At the time of the prior update,[45] HomVEE's review of research with tribal populations had examined a total of 49 manuscripts about impact studies and 27 about implementation or outcomes studies. This review added 8 more manuscripts about impact studies: 4 RCTs, 2 single case design studies, and 2 NEDs. It also added 14 manuscripts about implementation or outcomes studies. Thus, the current report is based on reviews of manuscripts about 57 impact studies and 41 implementation or outcomes studies, for a total of 98 manuscripts about 36 early childhood home visiting models.

3. Rating the quality of impact studies

The HomVEE review rated manuscripts about studies on their ability to produce unbiased estimates of a model's effect on its participants. Assessing whether a model is effective requires a study design that can establish that findings are caused by the model or, in other words, that the study has *internal validity.* To link a model and findings, a study tries to establish two conditions: (1) the intervention condition, or being offered services of the early childhood home visiting model, and (2) the counterfactual condition, or what would have happened had the same individuals not been offered the services of the early childhood home visiting model. The ideal—and impossible—method for determining the counterfactual is to observe the same participants simultaneously participating in the intervention and counterfactual conditions. This is not possible, so studies use a counterfactual comparison group to represent what would have happened to the intervention group in the absence of the early childhood home visiting model. A study has the potential for strong internal validity if the initial characteristics of the comparison group are very similar to those of the intervention group. If the groups are not similar initially, one cannot be certain whether differences in findings that emerge between the groups are due to the effect of the early childhood home visiting model or to initial differences between the two groups.

HomVEE's rating system helps distinguish between manuscripts about studies in which we have higher confidence that the observed findings were caused by the early childhood home visiting model and manuscripts in which the observed findings may be the result of differences between the intervention and comparison conditions. Only study designs where the selection process for these conditions is completely controlled by the researcher—including RCTs, single-case designs, and regression discontinuity designs—can receive the highest rating. HomVEE's review of tribal research includes manuscripts about impact studies that use three designs: RCTs, single-case designs, and NEDs.[46]

- RCTs assign participants to the intervention or comparison groups by chance and have the potential for strong internal validity. The primary advantage of randomly assigning participants is that the randomization process balances the groups, on average, for characteristics that are known, such as race and ethnicity and education, and characteristics that may be unknown, such as patience or motivation. When groups are similar on known and unknown characteristics before entering the

[45] Mraz Esposito, A., Coughlin, R., Malick, S., SamaMiller, E., Del Grosso, P., Kleinman, R., & Paulsell, D. (2017). *Assessing the research on home visiting program models implemented in tribal communities—Part 1: Evidence of effectiveness.* Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

[46] To date, none of the manuscripts that were eligible for HomVEE's review of research with tribal populations examined studies that used a regression discontinuity design. Details of HomVEE's standards for those designs are available on the HomVEE website: http://homvee.acf.hhs.gov/.

intervention, any post-intervention differences between the groups that are too large to be due to chance are likely attributable to the early childhood home visiting model. However, certain factors—such as the number of participants who drop out of the study—can compromise the balance between the groups and weaken researchers' ability to draw causal conclusions. In the HomVEE review, manuscripts about an RCT can receive a high, moderate, or low rating depending on the presence of these factors.

- NEDs use a nonrandom process to assign participants to intervention or comparison groups. The nonrandom process of selecting groups can result in groups that are not balanced on known and/or unknown characteristics. If the groups are different before the study begins, the comparison group is not a good representation of what would have happened to the intervention group without the model. The HomVEE review standards require that NEDs establish baseline equivalence between the two groups on three types of measures: outcomes measured at baseline, race and ethnicity, and socioeconomic status. HomVEE determined that these measures were key for establishing a reasonable comparison. Regardless of how balanced the intervention and comparison groups are on measured characteristics, however, the weakness of a NED is that it can never rule out differences in unmeasured characteristics. Therefore, the conclusions from a NED are suggestive of an intervention's effectiveness but cannot definitively determine causality. In the HomVEE review, a NED can receive a moderate or low rating.
- Single-case designs often involve repeated, systematic measurement of an outcome before, during, and after the active manipulation of an independent variable (for example, toggling exposure to early childhood home visiting model on and off). These designs can provide a strong basis for understanding whether an early childhood home visiting model caused the observed findings; they are widely used in applied and clinical psychology and education. In this design an individual "case," such as a person or family, receives services from the early childhood home visiting model, and that case serves as its own comparison. The outcome must be measured repeatedly within and across different conditions or levels of the independent variable (early childhood home visiting). This differs from the pre-post design, which simply examines data once before and once after participation in a program.

Trained reviewers assessed the research design and methodology of each study examined in the manuscript using a standard protocol. Each manuscript was assigned a rating of high, moderate, or low to indicate the capacity of its study's design to provide unbiased estimates of model impacts. In brief:

- The high rating is reserved for manuscripts examining random assignment studies with low attrition of sample members and no later reassignment or compromised randomization, as well as for single-case and regression discontinuity designs that meet the standards of the What Works Clearinghouse.[47]
- The moderate rating applies to manuscripts examining any of the following:
  - Random assignment studies that, because of flaws in their design, execution, or analysis (for example, high sample attrition), do not meet all the criteria for the *high* rating
  - NEDs that establish baseline equivalence on selected measures

[47] The What Works Clearinghouse, established by the Institute for Education Sciences in the U.S. Department of Education, reviews education research. The version of its standards used for this update of the HomVEE review of research with tribal populations is available at https://ies.ed.gov/ncee/wwc/Docs/referenceresources/wwc_procedures_v2_1_standards_handbook.pdf.

  - Single-case and regression discontinuity designs that meet What Works Clearinghouse design standards with reservations
- The low rating is given to manuscripts examining studies that do not meet all the criteria for either the high or the moderate rating.

Additional information about the review criteria is available on the HomVEE website (https://homvee.acf.hhs.gov/publications/methods-standards).

4. Assessing evidence of effectiveness

After completing all impact reviews for research evaluated with a tribal population, HomVEE identified manuscripts about each model that received a high or moderate rating and reported findings in at least one of the eligible domains, and evaluated the evidence to determine if the model met the criteria for "an evidence-based early childhood home visiting service delivery model" in tribal populations.

To meet the HHS criteria for an "evidence-based early childhood home visiting service delivery model," models must meet at least one of the following criteria:

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

In both cases, the impacts considered must either (1) be found for the full sample for the study or (2) if found for subgroups but not for the full sample for the study, be replicated in the same domain in two or more studies using non-overlapping analytic study samples. Additionally, following the MIECHV-authorizing statute, if the model meets the above criteria based on findings from RCTs only, then two additional requirements apply. First, one or more favorable (statistically significant) impacts must be sustained for at least one year after program enrollment. Second, one or more favorable (statistically significant) impacts must be reported in a peer-reviewed journal.[48]

To meet the HHS criteria for an "evidence-based early childhood home visiting service delivery model" in tribal populations, a model must meet the above criteria based on research from either (1) a sample composed entirely of tribal participants or (2) at least two distinct subgroups composed entirely of tribal participants (see Box A.1).

Box A.1. Definition of an "evidence-based early childhood home visiting service delivery model" in tribal populations

A model that meets the HHS criteria for an "evidence-based early childhood home visiting service delivery model" with tribal populations does so based on research from either (1) a sample composed entirely of tribal participants or (2) at least two distinct subgroups composed entirely of tribal participants. ◢

5. Implementation reviews

To provide descriptive information about the early childhood home visiting models of potential relevance to tribal communities, HomVEE aimed to collect information from the identified manuscripts about model requirements, including information about prerequisites for implementation and program frequency and duration. HomVEE also extracted information about implementation experiences from the manuscripts reviewed. For example, HomVEE collected information on lessons learned about hiring and training

[48] Section 511(d)(3)(A)(i)(I).

qualified staff, developing and/or adapting model to be culturally relevant for tribal communities, and addressing implementation challenges. These implementation experiences are discussed in the companion report, available at http://homvee.acf.hhs.gov/tribal.[49]

6. Addressing conflicts of interest

All members participating in the HomVEE search, screening, and review signed a conflict-of-interest statement in which they declared any financial or personal connections to developers, studies, or products being reviewed, and confirmed their understanding of the process by which they must inform the project director if such conflicts arise. The project leadership team assembled signed conflict-of-interest forms for all project staff and subcontractors and monitored for possible conflicts over time. Any member found to have a potential conflict of interest concerning a particular early childhood home visiting model was excluded from the review process for manuscripts about that model.

7. Updating the review

HomVEE released its first report assessing the research on early childhood home visiting models with tribal populations in February 2011. HomVEE updated the report each year through 2014, and again in 2017. This report represents the sixth update.

Based on the tribal search and screening process, HHS identifies whether sufficient new research with tribal populations exists and whether project resources can support an update to the review. At the time of the update, HomVEE reviews each manuscript and assesses the evidence of effectiveness (steps 3 through 6 above). Findings from newly identified manuscripts are added to the previous body of research, and the updated report represents the cumulative findings from HomVEE's review of all manuscripts identified to date.

[49] Mraz Esposito, A., Yanez, A., Coughlin, R., & Sama-Miller, E. (2020). Assessing the research on early childhood home visiting models implemented with tribal populations—Part 2: Lessons learned about implementation and evaluation.

This page has been left blank for double sided copying.

Appendix B:

Overview of early childhood home visiting models identified in HomVEE's review of research with tribal populations

This page has been left blank for double sided copying.

CONTENTS

A. Introduction

This appendix presents descriptive information about each of the 36 early childhood home visiting models included in HomVEE's review of research with tribal populations and the associated manuscripts. This appendix is organized by model. Three sets of models are related: Nurse-Family Partnership and a version, the Australian Nurse-Family Partnership Program; Parents as Teachers/PAT and two versions, Bureau of Indian Affairs' Baby Family and Child Education Program (Baby FACE program) and Parents as First Teachers (New Zealand); and SafeCare and a version, SafeCare Augmented. Related versions of models are grouped together. Therefore, the appendix summarizes 36 models organized into 32 groups. For each model, we include the following information:

Evidence of effectiveness. A statement about whether the model is evidence based for tribal populations and, if not, the reasons why. A model that meets the HHS criteria for an "evidence-based early childhood home visiting service delivery model" with tribal populations does so based on research from either (1) a sample composed entirely of tribal participants or (2) at least two distinct subgroups composed entirely of tribal participants. For more information, see Step 4 ,"Assessing evidence of effectiveness," in Appendix A of this report.

Extent of evidence. The number of manuscripts examining impact studies that were eligible for review and the ratings they received.[50]

Summary of findings. A summary statement of the number of favorable and unfavorable findings and their domain. If there are any manuscripts that received at least a moderate rating, the summary statement is followed by a list of the HomVEE domains and the number of findings reviewed in each domain.[51]

Description. Descriptive information about the model based on HomVEE's review of implementation information across all manuscripts on that model that were eligible for HomVEE's review of research in tribal communities (including those about implementation studies, impact studies, and outcomes studies). This information is based on information available from the manuscripts; when manuscripts did not include the information, it is not reported in the HomVEE review.

Details of manuscripts included in HomVEE's review of research in tribal communities. Information about each manuscript included in HomVEE's review for each model, including the citation, study design, and manuscript rating. For manuscripts that contained at least one finding that received a high or moderate rating, these details also describe domains measured and where to learn more about the manuscript.

[50] HomVEE assigns each manuscript it reviews about an impact study a rating of high, moderate, or low. These ratings reflect the extent to which the study's design could provide unbiased estimates of the intervention's impacts. For additional information on how HomVEE assigns ratings, see https://homvee.acf.hhs.gov/review-process/Producing%20Study%20Ratings.

[51] For more information about HomVEE domains, see https://homvee.acf.hhs.gov/outcomes.

1. Aboriginal peer-led home visiting programme

Evidence of effectiveness:
This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.
Extent of evidence:
No manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.
Summary of findings:
HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of the Aboriginal Peer-Led Home Visiting Programme identified no such manuscripts

Description	
Frequency and length of home visits	Not specified
Duration of program	Ten action learning sets were facilitated over a 13-month period.
Study participants	Participants were Aboriginal clients; inclusion criteria were engagement with peer support workers (PSWs) and the presence of one or more children ages birth–4 years.
Location of services	Western Australia
Type of implementing agency	Western Australia non-government family support agency
Home visitor qualifications	Selection criteria for home visitors (Peer Support Workers, or PSWs) included a positive standing in the community, willingness to support parents with young children in their community, stable residency in the local area, and good communication skills with the ability to maintain confidentiality. PSWs were not required to have prior educational parenting support skills.
Home visitor training and technical assistance	Regular education and training for PSWs included mentoring, early childhood and family support education, and reflective practice sessions to reflect on practice and discuss topics that frequently came up during home visits. The non-Aboriginal support officer assisted the newly recruited workers to develop visiting strategies. This training continued with the Aboriginal education support officer.
Goals	Not specified
Components	Home visiting only
Content	This was a culturally secure, peer-led, home-visiting intervention for Aboriginal families and children that aimed to address the impacts of social determinants of health. PSWs engaged with clients to provide support to address lack of housing, family stress and fragmentation, as well as to help clients develop self-management and coping strategies.

B1. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Munns, A., Toye, C., Hegney, D., Kickett, M., Marriott, R., & Walker, R. (2016). The emerging role of the urban-based Aboriginal peer support worker: A Western Australian study. *Collegian*, *23*(4), 355-361.	Implementation	N/A	N/A	N/A
Munns, A., Toye, C., Hegney, D., Kickett, M., Marriott, R., & Walker, R. (2017). Peer-led Aboriginal parent support: Program development for vulnerable populations with participatory action research. *Contemporary Nurse*, 53(5), 558-575.	Implementation	N/A	N/A	N/A
Munns, A., Toye, C., Hegney, D., Kickett, M., Marriott, R., & Walker, R. (2018). Aboriginal parent support: A partnership approach. *Journal of Clinical Nursing*, 27(3-4), e437-e450.	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

N/A = not applicable

2. Attachment and Biobehavioral Catch-up – Infant

Evidence of effectiveness:
This model does not meet criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations, but does meet the criteria for the general population. The model does not meet criteria for tribal populations because no manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.
Extent of evidence:
No impact manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.
Summary of findings:
HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of Attachment and Biobehavioral Catch-up – Infant (ABC-Infant) identified no such manuscripts.

Description	
Frequency and length of home visits	10 sessions over an unspecified length of time; length of individual session not specified
Duration of program	Not specified
Study participants	Not specified, but families were referred because of involvement with Child Protective Services.
Location of services	Hawaii
Type of implementing agency	Public and private agencies
Home visitor qualifications	All but one of the clinicians had a master's degree.
Home visitor training and technical assistance	Home visitors received training about "in-the-moment" coaching.
Goals	The ABC-Infant intervention seeks to address the attachment and regulatory problems of infants who have experienced early adversity, including maltreatment, by focusing on parenting behavior such as (1) providing sensitive, nurturing care when children are distressed; (2) following children's lead with positive affect or regard when children are not distressed; and (3) avoiding behavior that might frighten children.
Components	Home visitors, called clinicians, implement ABC-Infant in families' homes by encouraging the parental behaviors of focus through manual-guided discussions, video feedback, and in-the-moment comments.
Content	In-the-moment commenting uses real-time feedback to highlight times when parents engage in behaviors the intervention focuses on by (1) describing the specific behaviors of the parents; (2) linking behaviors to intervention targets; and (3) indicating the long-term findings of the parent's behaviors. Most feedback consists of positive responses to the behaviors being focused on, but can also be constructive and respond to negative parental behaviors.

B2. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Caron, E., Bernard, K., & Dozier, M. (2015). In vivo feedback predicts parent behavior change in the Attachment and Biobehavioral Catch-up intervention. Unpublished manuscript.	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

N/A = not applicable

3. Baby Basket program

Evidence of effectiveness:
This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because there were no manuscripts about impact studies that received a high or moderate rating.
Extent of evidence:
One manuscript about an impact study was eligible for HomVEE's review of research with tribal populations; it received a low rating.
Summary of findings:
HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of the Baby Basket program identified no such manuscripts.

Description	
Frequency and length of home visits	3 visits; length of individual session not specified
Duration of program	Prenatally to age 6 months
Study participants	Pregnant indigenous women from the Murri community in Queensland, Australia.
Location of services	Queensland, Australia
Type of implementing agency	Apunipima Cape York Health Council
Home visitor qualifications	Not specified.
Home visitor training and technical assistance	No training is provided to those who deliver the Baby Basket program.
Goals	The Baby Basket program seeks to improve knowledge about healthy choices concerning diet, tobacco, and alcohol as well as improving interaction with health services, particularly for antenatal and postnatal clinic visits among indigenous women. This is intended to lead to (1) better maternal health, (2) reduced complications, (3) increased proportion of normal-weight babies, and (4) thriving infants. Ultimately, the intervention seeks to reduce the gap in life expectancy between indigenous and non-indigenous Australians.
Components	To achieve these goals, pregnant or postnatal women receive three baskets of goods that correspond with the formative stages in their maternal cycle including (1) antenatal at pregnancy diagnosis, (2) delivery or around the time of childbirth, and (3) postpartum when the baby is 6 months old. Baskets are provided at home visits as well as visits to the clinic.
Content	The home visitors deliver the baskets and use the contents to inform conversations about infant and maternal health and wellness. Basket 1 contains a safe baby sleeper; information on healthy pregnancy to address health behaviors such as smoking, drinking, and healthy diet; a booklet on pregnancy, birth, and the postnatal period written by indigenous health workers and midwives; and a fresh food voucher. Basket 2 includes diapers and clothes for the baby and personal hygiene items for the mother. Basket 3 includes postnatal information, toys, a toothbrush, and toothpaste.

B3. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
McCalman, J., Searles, A., Edmunds, K., Jongens, C., Wargent, R., Bainbridge, R., . . . Doran, C. (2014). Evaluating the Baby Basket program in North Queensland: As delivered by Apunipima Cape York Health Council, 2009 to 2013, qualitative and quantitative evaluation. Victoria, Australia: Lowitja Institute.	NED	Low	N/A	N/A
McCalman, J., Searles, A., Bainbridge, R., Ham, R., Mein, J., Neville, J., Campbell, S., & Tsey, K. (2015). Empowering families by engaging and relating Murri way: A grounded theory study of the implementation of the Cape York Baby Basket program. *BMC Pregnancy & Childbirth*, *15*(1), 1.	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript . For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

N/A = not applicable

4. Baby One Program

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Extent of evidence:

No manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of the Baby One Program identified no such manuscripts.

Description	
Frequency and length of home visits	Not specified
Duration of program	18 months (recommended)
Study participants	Not specified
Location of services	Cape York, Queensland, Australia
Type of implementing agency	Apunipima Cape York Health Council
Home visitor qualifications	All staff who conducted home visits were Indigenous Healthworkers (IHWs).
Home visitor training and technical assistance	Indigenous Healthworkers initially received quarterly trainings and workshops that later moved to biannual face-to-face training workshops.
Goals	The program aims to improve children's long-term health by focusing on early health.
Components	Home visiting only
Content	The Baby One Program is an Indigenous Healthworker-led family visiting intervention that begins at the start of the pregnancy and continues until the child is 2 years and 10 months old.

B4. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Campbell, S., McCalman, J., Redman-MacLaren, M., Canuto, K., Vine, K., Sewter, J., & McDonald, M. (2018). Implementing the Baby One Program: A qualitative evaluation of family-centred child health promotion in remote Australian Aboriginal communities. *BMC Pregnancy and Childbirth*, *18*(1), 73.	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported onlyfor manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

N/A = not applicable

5. Early intervention services

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies received a high or moderate rating.

Extent of evidence:

No manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of Early Intervention Services identified no such manuscripts.

Description	
Frequency and length of home visits	Not specified
Duration of program	Not specified
Study participants	Families with infants and toddlers enrolled in early intervention services and living in the Navajo Nation (in Arizona and New Mexico).
Location of services	Navajo Nation in New Mexico and Arizona
Type of implementing agency	Not specified
Home visitor qualifications	Not specified
Home visitor training and technical assistance	Not specified
Goals	The Individuals with Disabilities Education Act (IDEA) includes a program for infants and toddlers with disabilities (the manuscript refers to this as Part H of IDEA; in current statute this is Part C). The program for infants and toddlers with disabilities is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for infants and toddlers with disabilities, birth through age 2 years, and their families. For a state to participate in the program, it must assure that early intervention will be available to every eligible child and its family.
Components	Families enrolled in the early intervention services received home visits.
Content	Not specified

B5. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Bailey, D., Applequist, K., & North, C. U. (1997). Parent perceptions of home visitors: A comparative study of parents who are American Indian and non-Indian parents. Washington, DC: U.S. Department of Education.	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported onlyfor manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

N/A = not applicable

6. Early Start (New Zealand)

The findings reported below are for a subgroup made up of Māori participants, and have not been replicated in a distinct subgroup consisting entirely of tribal participants. The HomVEE website only includes findings from replicated subgroups, therefore these findings are not presented in the Early Start (New Zealand) report on the HomVEE website alongside the findings from the full sample described in the manuscript.

Evidence of effectiveness:

This model does not meet criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations, but does meet the criteria for the general population. The model does not meet criteria for tribal populations because although effects were reported separately for a tribal subgroup, the findings have not been replicated in a non-overlapping sample.[52]

Extent of evidence:[53]

One manuscript about an impact study was eligible for HomVEE's review of research with tribal populations; it received a moderate rating.

Summary of findings:

Early Start (New Zealand) showed favorable effects for the Child Development and School Readiness, Positive Parenting Practices, and Reductions in Child Maltreatment domains. The following table summarizes findings examined across manuscripts that received high or moderate ratings.

Domain	Findings
Child Development and School Readiness	Favorable: 2 No effect: 2 Unfavorable or ambiguous: 0
Child Health	Favorable: 0 No effect: 3 Unfavorable or ambiguous: 0
Family Economic Self-Sufficiency	*Not measured*
Linkages and Referrals	*Not measured*
Maternal Health	*Not measured*
Positive Parenting Practices	Favorable: 2 No effect: 1 Unfavorable or ambiguous: 0
Reductions in Child Maltreatment	Favorable: 1 No effect: 1 Unfavorable or ambiguous: 0
Reductions in Juvenile Delinquency, Family Violence, and Crime	*Not measured*

[52] To meet HHS criteria for an "evidence-based early childhood home visiting service delivery model" for tribal populations, findings must be reported (1) in a sample composed entirely of tribal participants or (2) at least two distinct subgroups composed entirely of tribal participants.

[53] These counts include only those manuscripts with studies in which at least 10 percent of study participants were from tribal or indigenous communities.

Description	
Frequency and length of home visits	4 levels of service intensity; started with up to 3 hours per week; graduated to 1 hour of contact per 3 months
Duration of program	To age 5 years
Study participants	At-risk families with newborn children up to age 5
Location of services	Christchurch area of New Zealand
Type of implementing agency	Early Start Project Ltd., a charitable nongovernmental organization
Home visitor qualifications	Home visitors with educational backgrounds in nursing, social work, early childhood education, teaching, or related fields; home visitors were also required to have an awareness of cultural issues, experience with high-risk families, and evidence of good interpersonal skills and sound judgment.
Home visitor training and technical assistance	Home visitors underwent four weeks of initial training and received a minimum of 20 hours of in-service training per year; the Ministry of Development and Family and Community Services provided technical assistance.
Goals	Early Start is a voluntary early childhood home visiting program designed to improve child health; reduce child abuse; improve parenting skills; support parental physical and mental health; encourage family economic well-being; and encourage stable, positive partner relationships.
Components	Early Start provides services through home visiting. Families are offered several additional services based on need: infant and child safety awareness; linkages to supportive services in the community, including budget, health, and relationship services; advice and support concerning healthy lifestyle choices, including family and child nutrition; and household and time management services.
Content	All Early Start families receive services based on four established curricula: (1) Partnership in Parenting Education (PIPE) "Listen, Love, Play," which focuses on listening, trust, language, problem solving, feelings, and how babies learn; (2) Triple P Positive Parenting Program®, which focuses on positive parenting practices and means to address childhood behavior problems; (3) Getting Ready for School, focused on 4-year-olds; and (4) Incredible Years.

B6. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Fergusson, D. M., Horwood, L. J., Grant, H., & Ridder, E. M. (2005). *Early start evaluation report.* Christchurch, NZ: Early Start Project Ltd.	RCT	Moderate	Child Development and School Readiness[+], Child Health, Positive Parenting Practices[+], Reductions in Child Maltreatment[+]	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV014620

[a] Domains listed under "Outcome domains measured" include domains for all outcomes reported by the manuscript . For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts received low ratings.

[-] Unfavorable effect reported in this domain.

[+] Favorable effect reported in this domain.

RCT = randomized controlled trial.

N/A = not applicable

7. Even Start

Evidence of effectiveness:
This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because there were no manuscripts about impact studies eligible for HomVEE's review of research with tribal populations.
Extent of evidence:
No manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.
Summary of findings:
HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of Even Start identified no such manuscripts.

Description	
Frequency and length of home visits	1 home visit per week; 1- to 2-hour visits
Duration of program	Not specified
Study participants	One community sought to engage families with at least one American Indian parent and at least one American Indian child younger than age 8; engaged families also exhibited other risk factors, such as low income, low adult literacy, single or teen parent, and chronic unemployment. The other community had two eligibility requirements for families: (1) at least one American Indian child younger than age7 and (2) at least one parent who needs adult education.
Location of services	Two communities: • Cherokee Nation in Tahlequah, Oklahoma • Makah Indian Tribe in Neah Bay, Washington
Type of implementing agency	Community 1: Tribal Services Department of the Cherokee Nation Community 2: not specified
Home visitor qualifications	At minimum, a high school degree; one community hired home visitors with an associate degree or higher.
Home visitor training and technical assistance	Home visitors received a variety of trainings, including training offered by Head Start agencies, regional workshops, and weekly Child Development Associate classes; in one community that used the Parents as Teachers curriculum, home visitors completed Parents as Teachers trainings.
Goals	Even Start (also known as the Even Start Family Literacy Program and the William F. Goodling Even Start Family Literacy Program) had three primary goals: (1) to help parents improve their literacy or basic educational skills, (2) to help parents become full partners in educating their children, and (3) to assist children in reaching their full potential as learners.
Components	Services included weekly home visits plus additional services. The program in Oklahoma offered monthly center-based parent meetings that included parent education and offered opportunity for social gatherings. The program in Washington offered play groups five days per week. Parents were offered classes in accounting, marketing, and computer instruction.
Content	Even Start projects had to combine four core components: (1) early childhood education, (2) adult literacy, (3) parenting education, and (4) interactive literacy activities between parents and their children. The content of the visits varied by community. In Oklahoma home visits primary focused on parent education, specifically academic areas tested on the GED tests, and child development (including content from seven areas: language naming, language comprehension, cognitive matching, cognitive counting, fine motor skills, gross motor skills, and personal and social skills). The program in Washington used the Parents as Teachers curriculum for child development topics.

B7. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
– Levin, M., Moss, M., Swartz, J., Khan, S., & Tarr, H. (1997). *National evaluation of the Even Start Family Literacy program: Report on Even Start projects for Indian tribes and tribal organizations.* Bethesda, MD: Abt Associates and Fu Associates.	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript . For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

N/A = not applicable

8. Family Spirit

Evidence of effectiveness:

This model meets the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations and for the general population.

Extent of evidence:

Five manuscripts about impact studies were eligible for review; 2 received high ratings, 2 received moderate ratings, and 1 received a low rating.

Summary of findings:

Family Spirit showed favorable effects for the Child Development and School Readiness, Maternal Health, and Positive Parenting Practices domains. The following table summarizes findings examined across manuscripts that received high or moderate ratings.

Domain	Findings
Child Development and School Readiness	Favorable: 10 No effect: 30 Unfavorable or ambiguous: 0
Child Health	*Not measured*
Family Economic Self-Sufficiency	*Not measured*
Linkages and Referrals	*Not measured*
Maternal Health	Favorable: 5 No effect: 48 Unfavorable or ambiguous: 0
Positive Parenting Practices	Favorable: 7 No effect: 11 Unfavorable or ambiguous: 0
Reductions in Child Maltreatment	*Not measured*
Reductions in Juvenile Delinquency, Family Violence, and Crime	*Not measured*

	Description
Frequency and length of home visits	• Manuscripts 1 and 2: 25 home visits over 9 months; 1.5-hour visits. • Manuscripts 3, 4, and 5: weekly visits during pregnancy, biweekly visits for the first four months postpartum, monthly from 4 to 12 months postpartum, and bimonthly from 12 to 36 months postpartum.
Duration of program	• Manuscripts 1 and 2: 28 weeks' gestation to 6 months postpartum. • Manuscripts 3, 4 and 5: less than 32 weeks' gestation to age 3 years
Study participants	• Pregnant American Indian adolescents ages 12 to 19 at conception and at 28 weeks or earlier gestation. One study examined by the manuscript enrolled women up to age 22. Two manuscripts enrolled participants at 32 weeks or earlier gestation.
Location of services	• Manuscripts 1 and 2: Four American Indian health service catchment areas on the Navajo and White Mountain Apache reservations in New Mexico and Arizona; • Manuscripts 3, 4, and 5: Four tribal communities across three reservations in Arizona.
Type of implementing agency	Not specified

	Description
Home visitor qualifications	Bilingual American Indian women who had a job history in tribal health and human services, passed a background screening, and had been teen mothers themselves or had a special interest in this population.
Home visitor training and technical assistance	The home visitors participated in more than 80 hours of training and were tested to ensure they had mastered lesson content and delivery strategies before delivering services. In two manuscripts, ongoing training occurred bimonthly throughout the study.
Goals	The Family Spirit program was developed to address newborn care and maternal life skills among young American Indian pregnant and parenting mothers living on reservations. The program's goals are to (1) increase mothers' parenting knowledge and involvement, infants' social and emotional behavior, and the quality of the home environment; and (2) reduce stress, depression, and substance use among mothers.
Components	Families participating in Family Spirit participate in home visits.
Content	The program was modeled on Healthy Families America (HFA), a national program founded on 12 research-based principles to ensure quality of home visiting interventions for at-risk families. The content of the home-visiting intervention was derived from extensive community input on what teen parents needed to learn and was based on the *American Academy of Pediatrics Guide to Baby Care: Caring for Your Baby and Young Child: Birth to Age 5*. Cultural adaptations—including style, graphics, delivery, and content—were achieved through a community-based participatory process.

B8. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Barlow, A., Mullany, B., Neault, N., Billy, T., Hastings, R., Lorenzo, S., ... Walkup, J. T. (2014). A randomized controlled trial of a paraprofessional-delivered, home-visiting intervention: Three-year outcomes for American Indian teen mothers and their children. Manuscript under review.	RCT	Moderate	Child Development and School Readiness	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV040826
Barlow, A., Mullany, B., Neault, N., Compton, S., Carter, A., Hastings, R., Billy, T., CohoMescal, V., Lorenzo, S., & Walkup, J. T. (Jan 2013). Effect of a paraprofessional home-visiting intervention on American Indian teen mothers' and infants' behavioral risks: A randomized controlled trial. The American Journal of Psychiatry, 170(1), 83-93.	RCT	High	Child Development and School Readiness+, Maternal Health+, Positive Parenting Practices+	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV029496
Barlow, A., Mullany, B., Neault, N., Goklish, N., Billy, T., Hastings, R., ... Walkup, J. T. (2015). Paraprofessional-delivered home-visiting intervention for American Indian teen mothers and children: 3-Year outcomes from a randomized controlled trial. American Journal of Psychiatry, 172(2), 154-162.	RCT	High	Child Development and School Readiness+, Maternal Health+, Positive Parenting Practices+	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV047724
Barlow, A., Varipatis-Baker, E., Speakman, K., Ginsburg, G., Friberg, I., Goklish, N., … M., Walkup, J. (2006). Home-visiting intervention to improve child care among American Indian adolescent mothers: A randomized trial. Archives of Pediatrics & Adolescent Medicine, 160(11), 1101-1107.	RCT	Low	N/A	N/A
Walkup, J. T., Barlow, A., Mullany, B. C., Pan, W., Goklish, N., Hasting, R., C… Reid, R. (2009). Randomized controlled trial of a paraprofessional-delivered in-home intervention for young reservation-based American Indian mothers. Journal of the American Academy of Child & Adolescent Psychiatry, 48(6), 591-601.	RCT	Moderate	Child Development and School Readiness+, Maternal Health, Positive Parenting Practices+	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV004065

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript . For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

- Unfavorable effect reported in this domain.

+ Favorable effect reported in this domain.

RCT = randomized controlled trial.

N/A = not applicable

9. Halls Creek Community Families Program

Evidence of effectiveness:
This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.
Extent of evidence:
No manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.
Summary of findings:
HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. . HomVEE's review of research with tribal populations of the Halls Creek Community Families program identified no such manuscripts.

Description	
Frequency and length of home visits	Not specified
Duration of program	Not specified
Study participants	Parents of young Aboriginal families.
Location of services	Kimberly region of western Australia
Type of implementing agency	Health and community agencies
Home visitor qualifications	Several of the Community Care Workers (CCWs) had completed counselling courses and were able to provide support to the families with whom they worked.
Home visitor training and technical assistance	• Manuscript 1: Home visitors, called peer support workers (PSWs), received training from a child health nurse on educational topics such as child safety and nutrition as well as client engagement strategies. • Manuscript 2: Education and training sessions were provided to community care workers every four to six weeks.
Goals	The Halls Creek Community Families Program focused on improving the health, development, and well-being of children by (1) providing young families with support and (2) helping parents develop culturally relevant solutions to parenting issues. Specifically, the program worked to strengthen Aboriginal culture within families by facilitating effective communication, promoting child safety, and connecting parents with community services to advocate for prevention and early intervention activities.
Components	Families were offered home visits conducted by Aboriginal PSWs.
Content	The program seeks to develop partnerships between Aboriginal PSWs and parents by encouraging both groups to collaboratively identify culturally relevant solutions to parenting issues that address a range of social and health issues affecting Aboriginal child and maternal health. This includes (1) high rates of parental discord, (2) family breakdown, (3) preventable childhood illness, (4) child safety, and (5) nutrition.

B9. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Munns, A., & Walker, R. (2015). The Halls Creek Community Families Program: Elements of the role of the child health nurse in development of a remote Aboriginal home visiting peer support program for families in the early years. *Australian Journal of Rural Health*, *23*(6), 322–326.	Implementation	N/A	N/A	N/A
Munns, A., & Walker, R. (2018). The relevance of Aboriginal peer-led parent support: Strengthening the child environment in remote areas. *Comprehensive Child and Adolescent Nursing*, *41*(3), 199-212.	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript . For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts received low ratings.

N/A = not applicable

10. Healthy Children, Strong Families

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies received a high or moderate rating.

Extent of evidence:

One manuscript about an impact study was eligible for HomVEE's review of research with tribal populations; it received a low rating.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of Healthy Children, Strong Families identified no such manuscripts.

Description	
Frequency and length of home visits	Monthly one-hour sessions
Duration of program	12 months
Study participants	American Indian families; adult-child dyads with children ages 2 to 5 years old.
Location of services	Wisconsin
Type of implementing agency	University of Wisconsin researchers in partnership with four AIAN communities in Wisconsin
Home visitor qualifications	Home mentors were tribal members or individual who had longstanding employment in the community.
Home visitor training and technical assistance	All mentors received an initial training to administer the intervention.
Goals	Obesity reduction, family wellness, improved child health, increased adult health-related self-efficacy, and increased perceived health status.
Components	Home visiting plus other components
Content	The Healthy Children, Strong Families intervention delivers a healthy lifestyle toolkit delivered over 12 culturally appropriate lessons. Topics covered eating more fruits and vegetables, reducing soda and sugar consumption, increasing physical activity, and watching less television.

B10. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Tomayko EJ, Prince RJ, Cronin KA, & Adams AK. (2016). The Healthy Children, Strong Families intervention promotes improvements in nutrition, activity and body weight in American Indian families with young children. *Public Health Nutrition, 19*(15), 28.	RCT	Low	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript . For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts received low ratings.

RCT = randomized controlled trial.

N/A = not applicable

11. Healthy Families America (HFA)

Evidence of effectiveness:

This model does not meet criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations, but does meet the criteria for the general population. The model does not meet criteria for tribal populations because findings were not reported separately for tribal populations.[54]

Extent of evidence:

15 manuscripts about impact studies were eligible for review; 7 received high ratings, 2 received moderate ratings, and 6 received low ratings.

Summary of findings: [55]

Healthy Families America showed favorable effects for the Child Development and School Readiness, Child Health, Positive Parenting Practices, Reductions in Child Maltreatment, and Reductions in Juvenile Delinquency, Family Violence, and Crime domains. The following table summarizes findings examined across manuscripts that received high or moderate ratings.

Domain	Findings
Child Development and School Readiness	Favorable: 5 No effect: 7 Unfavorable or ambiguous: 0
Child Health	Favorable: 2 No effect: 21 Unfavorable or ambiguous: 0
Family Economic Self-Sufficiency	Favorable: 0 No effect: 6 Unfavorable or ambiguous: 0
Linkages and Referrals	*Not measured*
Maternal Health	Favorable: 0 No effect: 33 Unfavorable or ambiguous: 0
Positive Parenting Practices	Favorable: 3 No effect: 45 Unfavorable or ambiguous: 0
Reductions in Child Maltreatment	Favorable: 5 No effect: 81 Unfavorable or ambiguous: 0
Reductions in Juvenile Delinquency, Family Violence, and Crime	Favorable: 1 No effect: 15 Unfavorable or ambiguous: 0

[54] To meet HHS criteria for an "evidence-based early childhood home visiting service delivery model" for tribal populations, findings must be reported (1) in a sample composed entirely of tribal participants or (2) in a subgroup of tribal participants and the subgroup findings must be replicated in a distinct subgroup.

[55] Findings reported for populations in which at least 10 percent of study participants were from tribal or indigenous communities.

	Description
Frequency and length of home visits	One home visit per week until the child was 6 months old, then local programs determined the frequency of the visits; 1-hour visits.
Duration of program	Prenatally or at birth to age 3 or 5 years.
Study participants	Families with the following risk factors: single parenthood, low income, childhood history of substance abuse, mental health issues, domestic violence, or parental dysfunction.
Location of services	• Manuscript 1: Walworth County in Wisconsin, Pottawatomie County in Oklahoma, and Las Vegas • Manuscript 2: Arizona • Manuscript 3, 4, and 5: Alaska • Manuscript 6 through 17: Hawaii.
Type of implementing agency	Not specified
Home visitor qualifications	Specific educational requirements for direct-service staff were not given. Healthy Families America (HFA) recommended selecting staff based on their personal characteristics; willingness to work in, or experience working with, culturally diverse communities; experience working with families with multiple needs; and ability to maintain boundaries between personal and professional life. Some Hawaii Healthy Start studies referenced home visitors as being trained paraprofessionals with supervisors having obtained their master's degree and having at least three years of clinical and administrative experience in human services or a bachelor's degree with five years of relevant experience.
Home visitor training and technical assistance	Home visitors delivering Healthy Families Arizona were required to participate in an annual two-day statewide institute. Problem areas identified through quarterly reports were followed up by focused training and technical assistance. Hawaii Healthy Start referenced continuing staff training on relevant topics for both home visitors and supervisors. Home visitors receive a five- or six-week core training before enrolling families to their caseload.
Goals	HFA aims to (1) reduce child maltreatment; (2) increase utilization of prenatal care; (3) improve parent-child interactions and school readiness; (4) ensure healthy child development; (5) promote positive parenting; (6) promote family self-sufficiency and decrease dependency on welfare and other social services; (7) increase access to primary care medical services; and (8) increase immunization rates. Healthy Families Arizona is a state-based program guided by six community-based statewide steering committees (focused on training, policies and procedures, credentialing, excellence, community partnerships, and advocacy). Hawaii Healthy Start tailors its services according to family functioning to meet certain goals such as (1) no major crisis in the past 30 days, (2) regular use of a medical provider, (3) identifying of a positive source of support other than the home visitor, and (4) consistent participation in the home visits.
Components	To achieve its goals, enrolled families participate in home visits that include screenings and assessments.
Content	HFA is based upon a set of critical elements that serve as the framework for program development and implementation. HFA program components are theoretically rooted in a strength-based approach that recognizes that all families have strengths and that programs should build on these strengths rather than focus on correcting weaknesses.

B11. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Bair-Merritt, M. H., Jennings, J. M., Chen, R., Burrell, L., McFarlane, E., Fuddy, L., & Duggan A. K. (2010). Reducing maternal intimate partner violence after the birth of a child: A randomized controlled trial of the Hawaii Healthy Start home visitation program. *Journal of the American Medical Association*, *164*(1), 16–23.	RCT	High	Reductions in juvenile delinquency, family violence, and crime[+]	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV014584
Caldera, D., Burrell, L., Rodriguez, K., Crowne, S. S., Rohde, C., & Duggan, A. (2007). Impact of a statewide home visiting program on parenting and on child health and development. *Child Abuse & Neglect, 31*(8), 829–852.	RCT	High	Child development and school readiness[+]; Child health[+]; Positive parenting practices[+]; Reductions in child maltreatment	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV003774
Daro, D., McCurdy, K., & Harding, K. (1998). *The role of home visitation in preventing child abuse: An evaluation of the Hawaii Healthy Start project*. Unpublished manuscript.	RCT	Low	N/A	N/A
Dew, B., & Breakey, G. (2004). *Can a modest intervention prevent a major problem? Evidence from a child abuse prevention program*. Unpublished manuscript.	NED	Low	N/A	N/A
Duggan, A., Caldera, D., Rodriguez, K., Burrell, L., Rohde, C., & Crowne, S. S. (2007). Impact of a statewide home visiting program to prevent child abuse. *Child Abuse & Neglect, 31*(8), 801–827.	RCT	High	Child health; Maternal health; Positive parenting practices[+]; Reductions in child maltreatment[+]	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV003775
Duggan, A., Fuddy, L., Burrell, L., Higman, S. M., McFarlane, E., Windham, A., & Sia, C. (2004). Randomized trial of a statewide home visiting program to prevent child abuse: Impact in reducing parental risk factors. *Child Abuse & Neglect*, *28*(6), 623–643.	RCT	High	Maternal health; Reductions in juvenile delinquency, family violence, and crime	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV012831

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Duggan, A., McFarlane, E., Fuddy, L., Burrell, L., Higman, S. M., Windham, A., & Sia, C. (2004). Randomized trial of a statewide home visiting program: Impact in preventing child abuse and neglect. *Child Abuse & Neglect, 28*(6), 597–622.	RCT	High	Child health; Positive parenting practices; Reductions in child maltreatment[+]	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV012830
Duggan, A. K., McFarlane, E. C., Windham, A. M., Rohde, C. A., Salkever, D. S., Fuddy, L., . . . Sia, C. (1999). Evaluation of Hawaii's Healthy Start program. *Future of Children*, *9*(1), 66–90; discussion 177–178.	RCT	High	Child health[+], Family economic self-sufficiency, Maternal health, Positive parenting practices[+], Reductions in child maltreatment	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV014665
Duggan, A., Windham, A., McFarlane, E., Fuddy, L., Rohde, C., Buchbinder, S., et al. (2000). Hawaii's Healthy Start program of home visiting for at-risk families: Evaluation of family identification, family engagement, and service delivery. Pediatrics, 105(1, pt. 3), 250–259.	Implementation	N/A	N/A	N/A
El-Kamary, S. S., Higman, S. M., Fuddy, L., McFarlane, E., Sia, C., & Duggan, A. K. (2004). Hawaii's Healthy Start home visiting program: Determinants and impact of rapid repeat birth. *Pediatrics*, *114*(3), e317–e326.	RCT	High	Maternal health	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV003728
Feres-Lewin, C. (2000). An analysis of the governance and administrative elements of a public-private partnership approach to community-based education. Las Vegas: University of Nevada). DAI, 61 (05A), 247-1689.	Implementation	N/A	N/A	N/A
Johns Hopkins University. (2005). *Evaluation of the Healthy Families Alaska program.* Report to Alaska State Department of Health and Social Services, Alaska Mental Health Trust Authority. Baltimore, MD: Author.	RCT	Moderate	Family economic self-sufficiency, Maternal health	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV014203

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
King, T. M., Rosenberg, L. A., Fuddy, L., McFarlane, E., Sia, C., & Duggan, A. K. (2005). Prevalence and early identification of language delays among at-risk three year olds. *Journal of Developmental & Behavioral Pediatrics*, *26*(4), 293–303.	RCT	Moderate	Child development and school readiness	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV004008
Krysik, J., & LeCroy, C. W. (2007). The evaluation of Healthy Families Arizona: A multisite home visitation program. *Journal of Prevention & Intervention in the Community*, *34*(1), 109–127.	NED	Low	N/A	N/A
McCurdy, K. (2001). Can home visitation enhance maternal social support? *American Journal of Community Psychology*, *29*(1), 97–112.	RCT	Low	N/A	N/A
McCurdy, K. (2005). The influence of support and stress on maternal attitudes. *Child Abuse & Neglect*, *29*(3), 251–268.[a]	RCT	Low	N/A	N/A
McFarlane, E., Burrell, L., Crowne, S., Cluxton-Keller, F., Fuddy, L., Leaf, P., & Duggan, A. (2013). Maternal relationship security as a moderator of home visiting impacts on maternal psychosocial functioning. Prevention Science, *14*(1), 25–39.	RCT	Low	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.
[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts received low ratings.
[-] Unfavorable effect reported in this domain.
[+] Favorable effect reported in this domain.
RCT = randomized controlled trial; NED = non-experimental comparison group design (NED).N/A = not applicable

12. Healthy Starts trial/Te Piripohotanga NZ

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because there were no favorable and statistically significant impacts.

Extent of evidence:

One manuscript about an impact study was eligible for HomVEE's review of research with tribal populations; it received a moderate rating.

Summary of findings:

The Healthy Starts Trial showed no favorable effects. The following table summarizes findings examined across manuscripts that received high or moderate ratings.

Domain	Findings
Child Development and School Readiness	*Not measured*
Child Health	Favorable: 0 No effect: 12 Unfavorable or ambiguous: 0
Family Economic Self-Sufficiency	*Not measured*
Linkages and Referrals	*Not measured*
Maternal Health	Favorable: 0 No effect: 2 Unfavorable or ambiguous: 0
Positive Parenting Practices	Favorable: 0 No effect: 14 Unfavorable or ambiguous: 0
Reductions in Child Maltreatment	*Not measured*
Reductions in Juvenile Delinquency, Family Violence, and Crime	*Not measured*

Description	
Frequency and length of home visits	3 home visits
Duration of program	Birth to 3 months old
Study participants	Indigenous Australian and New Zealand Māori mothers with infants from birth to age 5 weeks
Location of services	Darwin, Australia, and Auckland, New Zealand
Type of implementing agency	Not specified
Home visitor qualifications	Not specified
Home visitor training and technical assistance	Home visitors received training on motivational interviewing and program delivery.
Goals	The Healthy Starts trial was a family-centered secondhand smoke intervention that sought to reduce acute respiratory illness among indigenous infants in Australia and New Zealand by reducing their exposure to secondhand smoke.
Components	The intervention was administered through three face-to-face home visits conducted over the first three months of the infants' lives.
Content	All mothers (and present family members) who smoked received behavioral coaching about the dangers of secondhand smoke exposure to children, positive role modeling, and strategies for overcoming obstacles to making smoke-free changes. Those who smoked also received either brief advice or more intensive counseling to quit and were offered free nicotine replacement therapy and/or a quitline referral.

B12. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Walker, N., Johnston, V., Glover, M., Bullen, C., Trenholme, A., Chang, A., . . . Thomas, D. (2015). Effect of a family-centered, secondhand smoke intervention to reduce respiratory illness in indigenous infants in Australia and New Zealand: A randomized controlled trial. *Nicotine & Tobacco Research*, *17*(1), 48–57.	RCT	Moderate	Maternal health, Child health, Positive parenting practices	Appendix C

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

RCT = randomized controlled trial.

13. Home Activity Program for Parents and Youngsters (HAPPY) Rural Outreach Project

Evidence of effectiveness:

This model does not meet criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population. The model does not meet criteria for tribal populations because no manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Extent of evidence:

No manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of the Home Activity Program for Parents and Youngsters (HAPPY) Rural Outreach Project identified no such manuscripts.

	Description
Frequency and length of home visits	1 home visit per month; length of individual sessions not specified
Duration of program	Not specified
Study participants	Children from birth through age 2 and their families.
Location of services	Nevada
Type of implementing agency	Nevada Department of Human Resources
Home visitor qualifications	Paraprofessionals.
Home visitor training and technical assistance	Training for home visitors included training on project components and intervention adaptations. Staff at sites that used the computerized curriculum participated in hands-on training and were required to generate appropriate home activity packages to demonstrate proficiency with the software. Ongoing technical assistance was available to staff. Ongoing technical assistance was available to staff.
Goals	The HAPPY Rural Outreach Project was designed to meet the needs of families with children with developmental delays who lived in remote, rural areas of Nevada where daily home- or center-based services were not practical. The outreach project was a collaborative effort of the Nevada Departments of Education and Human Resources, colleges within the University of Nevada, Reno, rural Nevada Inter-Tribal Council Head Starts, rural Nevada Head Starts, rural community service providers, and rural local education agencies.
Components	Families participating in HAPPY received monthly home visits, quarterly progress reviews, and semi-annual assessments by a child development specialist; initial in-home evaluations, and regular video and telephone consultation with speech, physical, occupational therapists and other related service personnel; and recommendations of individualized early intervention and therapeutic activities to be done by the parents with their children in the home.
Content	Not specified.

B13. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Nevada State Department of Human Resources, Early Childhood Services. (1997). *HAPPY Rural Outreach Project. Final report.* Reno, NV: Author.				

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript . For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts received low ratings.

N/A = not applicable

14. Home remediation and household education

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Extent of evidence:

No manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of Home Remediation and Household Education identified no such manuscripts.

	Description
Frequency and length of home visits	One visit three months after the intervention; length of individual sessions not specified
Duration of program	Not specified
Study participants	Households with children between ages 1 to12 years with lung disease who were treated for respiratory problems in the past 12 months.
Location of services	Yukon-Kuskokwim Delta and Bristol Bay, Alaska
Type of implementing agency	Not specified
Home visitor qualifications	Home-based education is delivered by environmental health professionals; follow-up in-home visits are delivered by respiratory therapists or case managers. Home remediation services are delivered by building professionals from the tribal regional housing authority.
Home visitor training and technical assistance	Not specified
Goals	The Home Remediation and Household Education Program aimed to improve long-term respiratory health and school success in children with chronic lung conditions.
Components	Home visiting plus other services
Content	Home remediation and guided discussions about burning dry wood, home ventilation systems, gasoline storage, household cleaning practices, and smoking outside the home. Three months after the intervention, a respiratory therapist or case manager made a home visit to provide additional education about respiratory triggers and asthma medication use and compliance.

B14. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Singleton, R., Salkoski, A. J., Bulkow, L., Fish, C., Dobson, J., Albertson, L., ... Hennessy, T. W. (2018). Impact of home remediation and household education on indoor air quality, respiratory visits and symptoms in Alaska Native children. *International Journal of Circumpolar Health*, *77*(1), 1422669.	Implementation	N/A	N/A	N/A

a Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

N/A = not applicable

15. Indian Family Wellness Project

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Extent of evidence:

No manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of the Indian Family Wellness Project identified no such manuscripts.

	Description
Frequency and length of home visits	Not specified
Duration of program	Not specified
Study participants	American Indian families enrolled in the Siletz Tribal Head Start Program.
Location of services	Oregon
Type of implementing agency	Head Start programs
Home visitor qualifications	Tribal members.
Home visitor training and technical assistance	Staff attended a nine-month undergraduate-level research methods class for a full day twice a month, taught by the project methodologist.
Goals	The Indian Wellness Project was a federally funded research project with the dual goals of developing a culturally grounded, family-centered preventive intervention and facilitating the development of tribal research infrastructure.
Components	The intervention had two components: home visitation and parent/child curricula. The program, delivered through Head Start centers, included a classroom component designed to build relationships among intervention staff, Head Start staff, and families. Families then participated in parent group meetings and home visits.
Content	The curricula for parents and children were based on six tribal stories/legends and focused on reintroducing the practice of storytelling. The stories selected for the intervention were made into brief videos (narrated by tribal elders), in which footage interposed scenes of stories being told with historical photographs, tribal artwork, and scenes of cultural events.

B15. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Fisher, P. A., & Ball, T. J. (2002). The Indian Family Wellness Project: An application of the tribal participatory research model. *Prevention Science*, *3*(3), 235–240.	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript . For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

N/A = not applicable

16. Inter-Tribal Council of Michigan's (ITC of Mi) Healthy Start project (Maajtaag Mnobmaadzid)

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies received a high or moderate rating.

Extent of evidence:

One manuscript about an impact study was eligible for HomVEE's review of research with tribal populations; it received a low rating.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of the Inter-Tribal Council of Michigan's (ITC of Mi) Healthy Start project (Maajtaag Mnobmaadzid) identified no such manuscripts.

	Description
Frequency and length of home visits	Not specified
Duration of program	Not specified
Study participants	Pregnant American Indian women living in seven tribal locations, and one urban center in Michigan.
Location of services	Seven tribal locations and one urban center in Michigan
Type of implementing agency	Health and social services providers
Home visitor qualifications	Not specified
Home visitor training and technical assistance	Not specified.
Goals	Healthy Start-Home Visiting was authorized under Title III, Part D, Section 330H of the Public Health Service Act; (42 USC 254 c-8). The Healthy Start Initiative provided program funds to local agencies committed to community-driven strategies to mitigate the causes of infant mortality, low birth weight, and other poor perinatal outcomes. The purpose of Healthy Start-Home Visiting was to address significant disparities in perinatal health, especially disparities experienced by at-risk populations. The program also aimed to enhance the capacity of a community's perinatal and women's health service system. The ITC of Mi Healthy Start project (Maajtaag Mnobmaadzid) aimed to improve birth outcomes among American Indians living in Michigan.
Components	During visits with families, staff referred clients to appropriate services, and then followed up with clients and providers to ensure that adequate care was provided.
Content	Not specified.

B16. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Coughlin, R. L., Kushman, E., Copeland, G., & Wilson, M. L. (2010). Pregnancy and birth outcome improvements for American Indians in the Healthy Start project of the Inter-Tribal Council of Michigan, 1998–2008: An 11-year cohort study. Unpublished manuscript.	NED	Low	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findingsreported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

NED = non-experimental comparison group design.

N/A = not applicable

17. Kheth'Impilo Community-Based Adherence Support

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies received a high or moderate rating.

Extent of evidence:

Two manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations; both received a low rating.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of the Kheth'impilo Community-Based Adherence Support model identified no such manuscripts.

	Description
Frequency and length of home visits	Weekly for the first month, then monthly; length of individual sessions not specified Manuscript 1: After child was stable, visits occurred quarterly Manuscript 2: If antiretroviral treatment (ART) clinic visits were delayed, visit frequency increased
Duration of program	Not specified
Study participants	Families with children starting ART for human immunodeficiency virus (HIV) and living in one of four provinces in South Africa.
Location of services	Four South African provinces: Western Cape, Eastern Cape, KwaZulu-Natal, and Mpumalanga
Type of implementing agency	Nongovernmental organization supported public ART clinics
Home visitor qualifications	The minimum qualifications for home visitors, called patient advocates, included a high school degree, and fluency in both English and the local language.
Home visitor training and technical assistance	Home visitors, called patient advocates, participated in training covering HIV and tuberculosis infection and treatment, and psychosocial issues affecting adherence to treatment; one manuscript reported that the training was three weeks long.
Goals	The intervention is designed to provide adherence and psychosocial support to families with children living with HIV. The primary goal is to achieve virologic suppression.
Components	The program consists of home visits and group workshops.
Content	During the initial visit, the patient advocate, assesses a family's tuberculosis and HIV-testing status, food security, substance use, domestic violence risk, social assistance grant eligibility, and adherence challenges. A multidisciplinary team discusses the family's challenges and develops strategies to facilitate adherence. The patient advocate works with the child's caregiver to implement the adherence strategies, discusses psychosocial problems, supervises medication administration, and conducts adherence checks.

B17. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Fatti, G., Shaikh, N., Eley, B., & Grimwood, A. (2013). Improved virological suppression in children on antiretroviral treatment receiving community-based adherence support: A multicentre cohort study from South Africa. *AIDS Care*. Advance online publication.	NED	Low	N/A	N/A
Grimwood, A., Fatti, G., Mothibi, E., Malahlela, M., Shea, J., & Eley, B. (2012). Community adherence support improves programme retention in children on antiretroviral treatment: A multicentre cohort study in South Africa. *Journal of the International AIDS Society*, *15*(2), 17381.	NED	Low	N/A	N/A

Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section beforee the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

NED = non-experimental comparison group design (NED).

N/A = not applicable

18. Nurse-Family Partnership (NFP)®

The HomVEE review of research with tribal populations included research from two models related to Nurse-Family Partnership: Nurse-Family Partnership itself and the Australian Nurse-Family Partnership Program (ANFPP)).The next two sections discuss each in turn.

a. Nurse-Family Partnership

Evidence of effectiveness:

Nurse-Family Partnership (NFP) does not meet criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations, but does meet the criteria for the general population. The model does not meet criteria for tribal populations because there were no favorable and statistically significant impacts.

Extent of evidence:

One manuscript about an NFP impact study was eligible for review; it received a high rating.

Summary of findings:

Nurse-Family Partnership (NFP) showed no favorable effects. The following table summarizes findings examined across manuscripts that received high or moderate ratings.

Domain	Findings
Child Development and School Readiness	*Not measured*
Child Health	*Not measured*
Family Economic Self-Sufficiency	*Not measured*
Linkages and Referrals	*Not measured*
Maternal Health	Favorable: 0 No effect: 2 Unfavorable or ambiguous: 0
Positive Parenting Practices	*Not measured*
Reductions in Child Maltreatment	*Not measured*
Reductions in Juvenile Delinquency, Family Violence, and Crime	*Not measured*

	Description
Frequency and length of home visits	Manuscript 2: Weekly prenatal visit during first month following enrollment, then every 2 weeks until birth. After the child's birth, the first six visits are weekly, then visits shift to every 2 weeks until the final 4 months of enrollment. Visits are monthly for the final 4 months.
Duration of program	Through child's second birthday
Study participants	Diverse, multiracial, multiethnic first-time mothers.
Location of services	Oklahoma and Washington Manuscript 2: NFP sites across the United States
Type of implementing agency	State health department; Tribal Maternal, Infant, and Early Childhood Home Visiting Program Manuscript 2: not specified
Home visitor qualifications	Home visitors were registered nurses. Study 2: not specified
Home visitor training and technical assistance	Manuscript 2: Home visiting nurses were supervised by NFP supervisors, training and technical assistance were not specified.
Goals	The intervention aims to reduce risk factors and improve birth outcomes and maternal and child health, and reduce overall parental stress. Study 2: not specified
Components	Manuscript 2: home visiting only
Content	Nurse home visitors focus on six domains: (1) personal health, (2) environmental health, (3) family and friends; (4) maternal role, (5) use of health care and human services, and (6) maternal life course development. Manuscript 2: not specified

B18. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Chomos, J. C., Evans, W. P., Bolan, M., Merritt, L., Meyer, A., & Novins, D. K. (2018b). Using single-case designs to evaluate components of tribal home-visitation programs: Tribal community two. *Infant Mental Health Journal*, *39*(3), 335-346.	Single subject	High	Maternal health	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV073858
Holland, M. L., Olds, D. L., Dozier, A. M., & Kitzman, H. J. (2018). Visit attendance patterns in nurse-family partnership community sites. *Prevention Science, 19*(4), 516-527.	Implementation	N/A	N/A	N/A
Jones, B. (2015). *Association of home visiting dosage on preterm birth in Oklahoma* (Doctoral dissertation). *ProQuest Dissertations and Theses.* (1728035306)	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

N/A = not applicable

b. Australian Nurse-Family Partnership Program (ANFPP)*

**ANFPP is a version of Nurse-Family Partnership (NFP)*

Evidence of effectiveness:
ANFPP does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.
Extent of evidence:
No manuscripts about impact studies about ANFPP were eligible for HomVEE's review of research with tribal populations.
Summary of findings:
HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of ANFPP identified no such manuscripts.

	Description
Frequency and length of home visits	During pregnancy: Weekly visit for the first 4 weeks, then biweekly until the child's birth. After birth: weekly visits for the first 6 weeks, then biweekly visits until 21 months, then monthly visits until 2 years.
Duration of program	Prenatally to age 2 years
Study participants	Aboriginal and Torres Strait Islander mothers and infants
Location of services	Alice Springs, Northern Territory, Central Australia
Type of implementing agency	Aboriginal community-controlled primary care service; health care agency
Home visitor qualifications	Home visitors were registered nurses.
Home visitor training and technical assistance	Not specified beyond an initial training
Goals	Improve pregnancy and birth outcomes, child health and development, and mothers' economic self-sufficiency.
Components	The intervention consists of home visits beginning prenatally and continuing to the child's second birthday.
Content	Nurse home visitors focus on six domains: (1) personal health, (2) environmental health, (3) family and friends, (4) maternal role, (5) use of health care and human services, and (6) maternal life course development.

B19. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Nguyen, H., Zarnowiecki, D., Segal, L., Gent, D., Silver, B., & Boffa, J. (2018). Feasibility of implementing infant home visiting in a Central Australian Aboriginal community. *Prevention Science*, *19*(7), 966-976.	Implementation	N/A	N/A	N/A
Runciman, C. (2016). Implementing the Nurse-Family Partnership with Aboriginal and Torres Strait Islander clients. *International Journal of Birth & Parent Education, 3*(2), 37-41.	Implementation	N/A	N/A	N/A
Zarnowiecki, D., Nguyen, H., Hampton, C., Boffa, J., & Segal, L. (2018). The Australian Nurse-Family Partnership Program for Aboriginal mothers and babies: Describing client complexity and implications for program delivery. *Midwifery*, *65*, 72-81	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscripts. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

N/A = not applicable

19. Obesity Prevention + Parenting Support

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies received a high or moderate rating.

Extent of evidence:

One manuscript about an impact study was eligible for HomVEE's review of research with tribal populations; it received a low rating.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of Obesity Prevention + Parenting Support identified no such manuscripts.

Description	
Frequency and length of home visits	Not specified
Duration of program	16 weeks
Study participants	American Indian mother-child pairs who met the following criteria: (1) the family had a child between the ages of 9 months and 3 years, (2) the child was walking, (3) the mother had a body mass index over 25, and (4) the mother agreed to keep all intervention appointments.
Location of services	St. Regis Mohawk community of Akwesasne located along the St. Lawrence River in northern New York State, and Ontario and Quebec, Canada
Type of implementing agency	St. Regis Mohawk Health Services
Home visitor qualifications	An indigenous peer educator.
Home visitor training and technical assistance	The peer educator participated in an intensive 120-hour initial in-service education program conducted by the study's principal investigator and a family therapist or parenting consultant from the St. Regis Mohawk tribe. After the initial training, monthly staff development sessions were conducted.
Goals	The intervention was designed to promote parenting skills that facilitate healthy attitudes and interactions about eating and activity and ultimately to promote short- and long-term weight regulation for children.
Components	To achieve the program's goals, enrolled families participated in home visits.
Content	The curriculum emphasized the child's psychological and behavioral goals, logical and natural consequences, mutual respect, and encouragement techniques, and specifically focused on how improved parenting skills could facilitate the development of appropriate eating and exercise behaviors in children.

B20. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Harvey-Berino, J., & Rourke, J. (2003). Obesity prevention in preschool Native-American children: A pilot study using home visiting. *Obesity Research*, *11*(5), 606–611.	RCT	Low	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

RCT = randomized controlled trial.

N/A = not applicable

20. Oklahoma Community-Based Family Resource and Support Program

Evidence of effectiveness:

This model does not meet criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations, but does meet the criteria for the general population. The model does not meet criteria for tribal populations because findings were not reported separately for tribal populations.[56]

Extent of evidence:

Two manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations; both received a moderate rating.

Summary of findings: [57]

Oklahoma's Community-Based Family Resource and Support (CBFRS) program showed favorable effects for the Child Health, Maternal Health, and Positive Parenting Practices domains. The following table summarizes findings examined across manuscripts that received high or moderate ratings.

Domain	Findings
Child Development and School Readiness	*Not measured*
Child Health	Favorable: 0 No effect: 3 Unfavorable or ambiguous: 0
Family Economic Self-Sufficiency	*Not measured*
Linkages and Referrals	*Not measured*
Maternal Health	Favorable: 3 No effect: 0 Unfavorable or ambiguous: 0
Positive Parenting Practices	Favorable: 2 No effect: 5 Unfavorable or ambiguous: 0
Reductions in Child Maltreatment	*Not measured*
Reductions in Juvenile Delinquency, Family Violence, and Crime	*Not measured*

[56] To meet HHS criteria for an "evidence-based early childhood home visiting service delivery model" for tribal populations, findings must be reported (1) in a sample composed entirely of tribal participants or (2) in a subgroup of tribal participants and the subgroup findings must be replicated in a distinct subgroup.

[57] Findings reported for populations in which at least 10 percent of study participants were from tribal or indigenous communities.

Description	
Frequency and length of home visits	Weekly during the first month, then biweekly until birth; weekly during first 3 months, then biweekly; 1-hour visits
Duration of program	Prenatally to age 1 year
Study participants	First-time mothers living in rural counties.
Location of services	12 rural counties in Oklahoma
Type of implementing agency	Administered by Oklahoma State Department of Health and implemented by county health departments
Home visitor qualifications	The home visitors had a bachelor's or master's degree in child development or were attending college and had five years of experience working with children and families; the race and ethnicity of the home visitors mirrored the demographics of the counties in which they worked.
Home visitor training and technical assistance	Home visitors participated in more than 40 hours of preservice training and received ongoing training.
Goals	The intervention was designed to enhance maternal and child health and development. Specifically, the program sought to positively affect mothers' parenting knowledge and skill, use of community services, family planning, household safety, and child immunization. The program also aimed to increase mothers' knowledge of the effects of second-hand smoke on their children and decrease the number of cigarettes smoked.
Components	The program consisted of home visits beginning prenatally and continuing to the child's first birthday.
Content	The program followed a standardized curriculum that covered (1) maternal and child health, (2) child growth and development, and (3) parenting skills. Curriculum topics included characteristics of newborns and growing infants, bonding and attachment, play activities that emphasized touching and talking with the infant, healthy and safe living environments, and guidance and discipline.

B21. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Culp, A. M., Culp, R. E., Anderson, J. W., & Carter, S. (2007). Health and safety intervention with first-time mothers. *Health Education Research*, *22*(2), 285–294.	NED	Moderate	Child Health, Maternal Health[+]	https://homvee.acf.hhs.gov/study-detail?title=WWHV003731
Culp, A. M., Culp, R. E., Hechtner-Galvin, T., Howell, C. S., Saathoff-Wells, T., & Marr, P. (2004). First-time mothers in home visitation services utilizing child development specialists. *Infant Mental Health Journal*, *25*(1), 1–15. doi:10.1002/imhj.10086.	NED	Moderate	Positive Parenting Practices[+]	https://homvee.acf.hhs.gov/study-detail?title=WWHV003715

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received a low rating.

[+] Favorable effect reported in this domain.

NED = non-experimental comparison group design (NED.)

21. Parent-Child Assistance Program (PCAP)

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies received a high or moderate rating.

Extent of evidence:

Two manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations; both received a low rating.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of the Parent-Child Assistance Program (PCAP) identified no such manuscripts.

	Description
Frequency and length of home visits	Manuscript 1: Weekly for 6 weeks and then twice monthly; length of individual visits is not specified. Manuscript 8: 36 months
Duration of program	Birth to age 3
Study participants	Women who were pregnant or no more than six months postpartum who self-reported heavy substance use and were not engaged effectively (or at all) with community services.
Location of services	Washington State; Edmonton, Alberta, Canada
Type of implementing agency	University of Washington; community-based public health agency
Home visitor qualifications	Paraprofessionals.
Home visitor training and technical assistance	Home visitors receive initial and ongoing training and weekly individual supervision by program supervisor or manager.
Goals	PCAP's primary goal is to prevent exposure to alcohol and drugs for future babies by helping clients (1) complete substance use treatment, (2) maintain abstinence from substances, (3) engage in family planning, (4) enhance the health and well-being of their children, (5) connect with community services, and (6) increase their economic stability.
Components	To achieve this goal, enrolled mothers receive at least two home visits per month over the course of three years.
Content	Home visitors, called case managers, work individually with mothers to identify personal, realistic, and appropriate goals using principles of motivational interviewing. They define the steps necessary to achieve these goals and monitor progress. They facilitate integrated service delivery among providers, offer regular home visitation, transport clients and children to important appointments, and work actively within the context of the extended family.

B22. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Ernst, C., Grant, T., Streissguth, A., & Sampson, P. (1999). Intervention with high-risk alcohol and drug-abusing mothers: II. Three-year findings from the Seattle model of paraprofessional advocacy. *Journal of Community Psychology*, 27(1), 19-38.	NED	Low	N/A	N/A
Grant, T. M., Ernst, C. C., Streissguth, A., & Stark, K. (2005). Preventing alcohol and drug exposed births in Washington State: Intervention findings from three Parent-Child Assistance Program sites. *American Journal of Drug & Alcohol Abuse*, *31*(3), 471–490.	Implementation	N/A	N/A	N/A
Grant, T., Christopher Graham, J., Ernst, C. C., Michelle Peavy, K., & Brown, N. N. (2014). Improving pregnancy outcomes among high-risk mothers who abuse alcohol and drugs: Factors associated with subsequent exposed births. *Children and Youth Services Review*, *46*, 11–18.[a]	Implementation	N/A	N/A	N/A
Grant, T., Huggins, J., Graham, C., Ernst, C., Whitney, N., & Wilson, D. (2011). Maternal substance abuse and disrupted parenting: Distinguishing mothers who keep their children from those who do not. *Children and Youth Services Review*, *33*(11), 2176–2185.	Implementation	N/A	N/A	N/A
Kartin, D., Grant, T. M., Streissguth, A. P., Sampson, P. D., & Ernst, C. C. (2002). Three-year developmental outcomes in children with prenatal alcohol and drug exposure. *Pediatric Physical Therapy*, *14*(3), 145–153.[a]	NED	Low	N/A	N/A
Mills, R. M., Siever, J. E., Hicks, M., Badry, D., Tough, S. C., & Benzies, K. (2009). Child guardianship in a Canadian home visitation program for women who use substances in the perinatal period. *Canadian Journal of Clinical Pharmacology/Journal Canadien De Pharmacologie Clinique*, *16*(1), e126–139.	Implementation	N/A	N/A	N/A
Shaw, M. R., Grant, T., Barbosa-Leiker, C., Fleming, S. E., Henley, S., & Graham, J. C. (2015). Intervention with substance-abusing mothers: Are there rural-urban differences? *American Journal on Addictions*, *24*(2), 144–152.	Implementation	N/A	N/A	N/A

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Rasmussen, C., Kully-Martens, K., Denys, K., Badry, D., Henneveld, D., Wyper, K., & Grant, T. (2012). The effectiveness of a community-based intervention program for women at-risk for giving birth to a child with Fetal Alcohol Spectrum Disorder (FASD). *Community Mental Health Journal*, *48*(1), 12-21.	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript . For information about domains with favorable impacts, see the "Summary of findings" section before the description.
[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received a low rating.
NED = non-experimental comparison group design (NED)..
N/A = not applicable

22. ParentChild+® Core Model

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population. The model does not meet criteria for tribal populations because no manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Extent of evidence:

No manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of the ParentChild+ Core Model identified no such manuscripts.

	Description
Frequency and length of home visits	2 times per week; 30-minute visits
Duration of program	Age 2 to 3 years
Study participants	Families with children ages 2 and 3 years with multiple risk factors, such as low levels of education, teen parents, low income, isolation, or single-parent households.
Location of services	Manuscripts 1 and 2: Western Manitoba, Canada
Type of implementing agency	Manuscripts 1 and 2: Nonprofit organization that provides child and family services
Home visitor qualifications	Home visitors had to be able to write well enough to prepare a written report on each home visit and to administer certain assessments; the intervention developer encouraged sites to hire former program parent-participants and/or community residents as home visitors.
Home visitor training and technical assistance	Home visitors were required to participate in a 16-hour training workshop provided by the site coordinator. In-service training for home visitors was provided by site coordinators during weekly supervision meetings.
Goals	The ParentChild+ Core Model focuses on (1) promoting positive parenting skills and building positive parent child interaction, (2) enhancing the child's conceptual and social-emotional development, and (3) developing early literacy skills. The ParentChild+ Core Model home visitors use a light touch approach that is non-didactic and empowers parents. The program aims to enhance the quality (including enhanced vocabulary, reduced discouragements, and increased encouragements used by the parent) and quantity of parent-child interaction to promote children's cognitive and social-emotional development and language and early literacy skills.
Components	Enrolled families participate in home visits and receive toys and books, referrals to community services, and assistance with transition to the next educational step for the children.
Content	Not specified.

B23. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Gfellner, B. M., McLaren, L., & Metcalfe, A. (2008). The Parent-Child Home Program in Western Manitoba: A 20-year evaluation. *Child Welfare*, *87*(5), 49–67.	Implementation	N/A	N/A	N/A
McLaren, L. (1988). Fostering mother-child relationships. *Child Welfare*, *67*(4), 353–365.	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received a low rating.

N/A = not applicable

23. Parents as Teachers/PAT

The HomVEE review of research with tribal populations included research from three models related to Parents as Teachers/PAT: Parents as Teachers/PAT itself, the Bureau of Indian Affairs' Baby Family and Child Education Program (Baby FACE program), and Parents as First Teachers (New Zealand).The next three sections discuss each in turn.

a. Parents as Teachers/PAT

Evidence of effectiveness:
This model does not meet criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations, but does meet the criteria for the general population. The model does not meet criteria for tribal populations because no manuscripts about impact studies included in the review for tribal populations received a high or moderate rating.
Extent of evidence:
One manuscript about an impact study was eligible for HomVEE's review of research with tribal populations; it received a low rating.
Summary of findings:
HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of Parents as Teachers/PAT identified no such manuscripts.

	Description
Frequency and length of home visits	Not specified
Duration of program	The study phase lasted about 2 years (25.5 months), but the manuscript reviewed by HomVEE did not report how long the program did or did not continue beyond the study period.
Study participants	Not specified
Location of services	Rural Nevada
Type of implementing agency	Tribal entity
Home visitor qualifications	Not specified
Home visitor training and technical assistance	Not specified
Goals	This program focused on reducing parental stress.
Components	Home visiting only
Content	Parents as Teachers/PAT curriculum and culturally-based practices to increase participants' connectivity to their culture and their community.

B24. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Chomos, J. C., Evans, W. P., Bolan, M., Merritt, L., Meyer, A., & Novins, D. K. (2018a). Using single-case designs to evaluate components of tribal home-visitation programs: Tribal community one. *Infant Mental Health Journal*, *39*(3), 335-346.	Single subject	Low	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received a low rating.

N/A = not applicable

b. Bureau of Indian Affairs' Baby Family and Child Education Program (Baby FACE)*

**Baby FACE is a version of Parents as Teachers/PAT*

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no favorable, statistically-significant impacts were reported in a peer-reviewed journal.[58]

Extent of evidence:

Three manuscripts about impact studies were eligible for review; 1 received a moderate rating and 2 received a low rating.

Summary of findings:

Baby FACE showed favorable effects for the Child Development and School Readiness and Positive Parenting Practices domains. The following table summarizes outcomes in the manuscript that received a moderate rating.

Domain	Findings
Child Development and School Readiness	Favorable: 1 No effect: 10 Unfavorable or ambiguous: 0
Child Health	*Not measured*
Family Economic Self-Sufficiency	*Not measured*
Linkages and Referrals	*Not measured*
Maternal Health	*Not measured*
Positive Parenting Practices	Favorable: 2 No effect: 4 Unfavorable or ambiguous: 0
Reductions in Child Maltreatment	*Not measured*
Reductions in Juvenile Delinquency, Family Violence, and Crime	*Not measured*

[58] If evidence-criteria are based solely on findings from randomized controlled trial(s), one or more favorable and statistically significant impact must be sustained for at least one year after program enrollment and one or more favorable and statistically significant impacts must be reported in a peer-reviewed journal. More information is available at https://homvee.acf.hhs.gov/review-process/HHS%20Criteria%20for%20Evidence-Based%20Models

	Description
Frequency and length of home visits	Biweekly visits to each family for 60 minutes if there is one child, 90 minutes if there are two children.
Duration of program	Manuscript 1: The average length of program enrollment was based on age of child at enrollment, as follows: • Enrollment during pregnancy: 41 months • Enrollment at birth to 3 months old: 37 months • Enrollment before 6 months old: 34 months[a] • Enrollment when the child was between 6 months and one year old: 30 months • Enrollment greater when the child was more than one year old: 20 months
Study participants	American Indian families with children from birth to age 8 located on rural reservations; American Indian families with children from pre-birth to kindergarten located on rural reservations. American Indian families with children from birth to age 3 (some sites offered services up to age 5).
Location of services	Manuscripty 2 (Pfannenstiel et al. 2006): 28 reservations across the United States Manuscript 4 (Pfannenstiel 2015): The original 20 study sites were located in six states, with multiple sites in the states with large numbers of Bureau of Indian Education (BIE) schools- Arizona, New Mexico, and South Dakota. Reservations across the United States, including locations in Cheyenne River, Chinle, Eastern Navajo, Fort Defiance, Minneapolis, Oklahoma, Pima, Portland, Shiprock, and Southern Pueblos.
Type of implementing agency	• Manuscript 3: Elementary schools • Manuscript 4: BIE schools in the Bureau of Indian Affairs
Home visitor qualifications	The minimum qualifications for the position of the parent educator included a high school degree or General Education Development (GED) diploma, the ability to read and write in English, and working toward a Child Development Associate credential or an associate degree. In the study examined in manuscript two, almost half of the parent educators reported that their highest level of education is a bachelor's degree, 38 percent had an associate degree and 13 percent had some college. In addition, 37 percent of parent educators who staffed the program throughout the grant period were American Indian and from the same tribe as the local community. American Indian staff are preferred.
Home visitor training and technical assistance	• Manuscript 3: New Baby FACE staff members were offered a five-day implementation training and a three-day follow-up. Parent educators were offered two or three training conferences per year on implementing the Baby FACE program. Parent educators also had access to technical assistance offered by program technical assistance coordinators. • Manuscript 4: The initial training included two sessions of training in which they reviewed home visitation curricula; supervisors also participated in the initial 2-day training and received specific training about supervising staff delivering this program. Parent educators also received four professional development sessions and monthly conference calls. Each Baby FACE program received seven on-site technical assistance visits.

Description	
Goals	Baby FACE is the home visiting component of the Bureau Of Indian Affairs' Family And Child Education Program (FACE). Baby FACE seeks to (1) increase healthy pregnancies and improve birth outcomes (when services are delivered prenatally); (2) increase parents' knowledge of their children's emerging development and age-appropriate child development; (3) improved parenting capacity, parenting practices, and parent child relationships; (4) promote early detection of developmental delays and health issues; (5) improve family health and functioning; (6) increase integration of language and culture; (7) improve child health and child cognitive development; (8) improve child socio-emotional development and protective home environment and (9) improve environment for home literacy activity.
Components	To achieve these goals, families participated in home visits that included screenings of children's development. It also included group parent meetings, referrals through a resource network, and a center-based component delivered through elementary schools.
Content	The program implemented the Parents as Teachers' Born to Learn curriculum, which was adapted to each tribal community's culture. The home visitors established trusting relationships with the families and provided services and support for families experiencing multiple crises. Other successful strategies included providing parent-child activities, developmental information, children's books, and resources to meet basic needs such as diapers and gas cards. Home visitors also taught parents to observe, monitor and support their children's development on an ongoing basis. The program provided age-appropriate books were provided to all children in a household who were 5 years of age or younger. Manuscript 1: Baby FACE was a modification of two national models: Parents as Teachers and the National Center for Family Literacy.

[a] The manuscript defines this category as less than 6 months and defines the other categories as mutually exclusive.

B25. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Pfannenstiel, J., Yarnell, V., & Seltzer, D. (2006). *Family and Child Education program (FACE): Impact study report.* Overland Park, KS: Research & Training Associates, Inc.	NED	Low	N/A	N/A
Yarnell, V., Lambson, T., & Pfannenstiel, J. C. (2008). *BIE Family and Child Education Program.* Overland Park, KS: Research & Training Associates, Inc.	Implementation	N/A	N/A	N/A
Lambson, T., Yarnell, V., & Pfannenstiel, J. (2006). *BIA Baby FACE program evaluation study: 2005 report.* Overland Park, KS: Research & Training Associates, Inc.	Implementation	N/A	N/A	N/A

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Pfannenstiel, J. (2015). Evaluation of the i3 validation of improving education outcomes for American Indian children. Unpublished manuscript. Overland Park, KS: Research & Training Associates.	RCT	Moderate	Child Development and School Readiness+ Positive Parenting Practices+	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV058030

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

- Unfavorable effect reported in this domain.

+ Favorable effect reported in this domain.

RCT = randomized controlled trial

N/A = not applicable

c. Parents as First Teachers (New Zealand)*

**Parents as First Teachers (PAFT) is a version of Parents as Teachers/PAT*

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because there were no favorable and statistically significant impacts.

Extent of evidence:

Five manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations; 2 received a moderate rating and 3 received a low rating.

Summary of findings: [59]

Parents as First Teachers (PAFT) (New Zealand) showed no favorable effects. The following table summarizes findings examined across manuscripts that received high or moderate ratings.

Domain	Findings
Child Development and School Readiness	Favorable: 0 No effect: 11 Unfavorable or ambiguous: 0
Child Health	Favorable: 0 No effect: 10 Unfavorable or ambiguous: 0
Family Economic Self-Sufficiency	Favorable: 0 No effect: 19 Unfavorable or ambiguous: 1
Linkages and Referrals	*Not measured*
Maternal Health	Favorable: 0 No effect: 1 Unfavorable or ambiguous: 0
Positive Parenting Practices	Favorable: 0 No effect: 10 Unfavorable or ambiguous: 0
Reductions in Child Maltreatment	*Not measured*
Reductions in Juvenile Delinquency, Family Violence, and Crime	*Not measured*

[59] Findings reported for populations in which at least 10 percent of study participants were from tribal or indigenous communities.

Description	
Frequency and length of home visits	A minimum of 25 visits over the course of the program; 1-hour visits
Duration of program	Prenatally to age 3 years
Study participants	Families with children ages birth to 3 years who are at-risk of poor educational outcomes, such as families with low incomes, young mothers, single parents, and parents with limited support, including Māori and Pasifika families, indigenous populations of New Zealand and the Pacific Island nations.
Location of services	Locations throughout New Zealand
Type of implementing agency	Administered by the Ministry of Education and implemented by local contracted providers
Home visitor qualifications	Parent educators were required to have a degree in early childhood education or an equivalent qualification, or work experience in education, health or social work.
Home visitor training and technical assistance	Staff received an average of 5.2 days of professional development every six months. Preservice training was not specified.
Goals	PAFT is based on the Parents as Teachers model and is designed to support families' in their efforts to foster their children's development, to enhance children's school readiness, to promote children's health, to prevent child abuse and neglect, and to support parents' involvement in their children's education.
Components	To achieve these goals, families participate in home visits and group meetings.
Content	The PAFT program uses two curricula: an adapted version of the Parents as Teachers' Born to Learn curriculum and Āhuru Mōwai, a curriculum developed for the program that is based on Māori traditional beliefs and child-rearing practices. The home visits include rapport building, child assessment, discussion of parenting issues and child development, a parent-child activity and a summary of the session.

B26. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Boyd, A. (1997a). Parents as First Teachers pilot project evaluation (PAFT): Report on South Auckland area. Wellington, New Zealand: Ministry of Education.	RCT	Low	N/A	N/A
Boyd, A. (1997b). Parents as First Teachers pilot project evaluation (PAFT): Report on Whangarei region: Final complete draft. Wellington, New Zealand: Ministry of Education.	RCT	Moderate	Child development and school readiness; Positive parenting practices	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV037116
Campbell, K. I., & Silva, P. A. (1997). Parents as First Teachers pilot programme evaluation: Age three assessments. Final report to the Ministry of Education on the Dunedin and Gisborne/East Coast areas. Wellington, New Zealand: Ministry of Education.	RCT	Moderate	Child development and school readiness; Child health; Family economic self-sufficiency; Maternal health; Positive parenting practices	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV037119
Durning, P. (1997). Parents as First Teachers [Ko Nga Matua Hei Kaiako Tuatahi]: Pilot PAFT process report. Wellington, New Zealand: Royal New Zealand Plunket Society.	Implementation	N/A	N/A	N/A
Farquhar, S. (2003). Parents as First Teachers: A study of the New Zealand PAFT programme. Wellington, New Zealand: ChildForum Research.	Implementation	N/A	N/A	N/A
Livingstone, I. D. (1999). Parents as First Teachers: Supplement to the summary report of the evaluation of the pilot project: Report to the Ministry of Education on consolidated cross-site analysis. Wellington, New Zealand: Ministry of Education.	RCT	Low	N/A	N/A
Praat, A. (2011). Parents as First Teachers evaluation: Phase II report. Wellington, New Zealand: Centre for Social Research and Evaluation.	NED	Low	N/A	N/A
Praat, A., Davie, S., & McGray, S. (2010). Parents as First Teachers evaluation: Phase one report. Wellington, New Zealand: Centre for Social Research and Evaluation.	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received a low rating.

[-] Unfavorable effect reported in this domain.

[+] Favorable effect reported in this domain.

RCT = randomized controlled trial, NED = non-experimental comparison group design.N/A = not applicable

24. Perinatal Intervention Program

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population no manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Extent of evidence:

No manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of the Perinatal Intervention Program identified no such manuscripts.

Description	
Frequency and length of home visits	The program offered two home visits: one prenatally and one postpartum; length of individual visits is not specified
Duration of program	Prenatally to age 1 year
Study participants	American Indian women of childbearing age.
Location of services	Manuscripts 1 and 2: Milwaukee, Wisconsin
Type of implementing agency	Manuscripts 1 and 2: Community health agency
Home visitor qualifications	Culturally competent staff with knowledge and assessment skills to address infant mortality and a desire to interact with members of the community of focus.
Home visitor training and technical assistance	Not specified.
Goals	The perinatal intervention program was designed to encourage earlier entry to prenatal care and change of health risk habits among American Indian women. Program objectives included the need to (1) identify pregnancies early; (2) decrease the interval between diagnosis of pregnancy and initial maternity care visit; (3) increase the numbers of prenatal visits per patient; (4) provide health education (including topics on pregnancy, nutrition, preterm labor, smoking cessation, prepared childbirth, breastfeeding, immunizations, well-child checks, and infant safety); and (5) develop a system to ensure uninterrupted prenatal care when traveling between city and reservation.
Components	Women participating in the program received two home visits (one before to delivery and one postpartum). Additional contact occurred by telephone, during drop-in or scheduled visits to the nurse's or outreach worker's offices, through outreach programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children, during medical appointments, and during program offerings to the community (such as Lamaze™ childbirth education classes).
Content	Not specified

B27. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Davis, C. L., & Prater, S. L. (2001). A perinatal intervention program for urban American Indians part 1: Design, implementation, and outcomes. *Journal of Perinatal Education*, *10*(3), 9–19.	Implementation	N/A	N/A	N/A
Prater, S. L., & Davis, C. L. (2002). A perinatal intervention program for urban American Indians: Part 2: The story of a program and its implications for practice. *Journal of Perinatal Education*, *11*(2), 23–32.	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

25. Philani Outreach Programme

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because there were no manuscripts about impact studies that received a high or moderate rating.

Extent of evidence:

Six manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations; all received low ratings.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating.. HomVEE's review of research with tribal populations of the Philani Outreach Programme identified no such manuscripts.

Description	
Frequency and length of home visits	• Manuscript Study 2: 20-minute to 1-hour visits • Manuscript 6: Recommends 4 antenatal and 4 postnatal home visits, but on average 6 antenatal and 5 postnatal visits were made, with visits lasting 31 minutes each.
Duration of program	• Manuscripts 1 and 2: 1 year • Manuscript 6: Prenatally to 6 months postpartum
Study participants	• Manuscripts 1 and 2: Any family living in a neighborhood in Xhosa townships surrounding Cape Town, South Africa, that was a focus of the program, with a child age 5 years or younger and classified as malnourished (defined as weighing less than 2 standard deviations below his or her weight-for-age norm, including all newborns weighing less than 2,500 grams at birth) • Manuscript 3: Available to all pregnant women, but specifically sought to engage pregnant women living with HIV • Manuscript 4: Available to at-risk (living with HIV, a history of alcohol abuse, depression, or previous low birth weight) pregnant women at least 18 years of age • Manuscript 5: Pregnant mothers in South African townships near Cape Town older than age 18 • Manuscript 6: Pregnant women in 24 Cape Town neighborhoods
Location of services	Neighborhoods in townships surrounding Cape Town, South Africa
Type of implementing agency	The Philani Child Health & Nutrition Project, an international nongovernmental organization
Home visitor qualifications	The program sought mentor mothers who (1) had children who were thriving, (2) demonstrated strong communication and interpersonal skills, (3) were committed to community service, and (4) showed an organized and disciplined approach to tasks. One manuscript noted that community health workers were women with a 10th- to 12th-grade education and were community role models. Manuscript y 6 reported that home visitors were paraprofessionals with the same educational and socioeconomic background as the study participants and from nearby neighborhoods.

Description	
Home visitor training and technical assistance	• Manuscripts 1 and 2: Mentor Mothers received four phases of training: (1) observing experienced mentor mothers, (2) attending a month of training, (3) learning how to help mothers bond with their children and improve the consistency of healthy daily routines, and (4) implementing their first round of home visits independently in their neighborhoods; • Manuscripts 3, 4, 5, and 6: Home visitors participated in a month long training. Two of these studies noted trainings were related to cognitive-behavioral change strategies and role planning. Supervisors provided monthly in-service trainings; • Manuscript 6 also reported home visitors having biweekly observations.
Goals	The Philani Outreach Programme aims to build community relationships and encourage pregnant women and mothers to engage in healthy practices to improve maternal and child nutrition and health.
Components	Families participate in regular home visits.
Content	During prenatal visits, the home visitor discusses the importance of maternal nutrition, regular prenatal clinic appointments, HIV testing, preventing of the transmission of HIV, and the cessation of alcohol use. After the child is born, the home visitor weighs the participating child during visits and discusses his or her progress with the mother. The home visitor also makes sure that the mother has the social grants she might be entitled to and that she understands proper nutrition and hygiene. The home visitor stresses the importance of breastfeeding, the proper time to introduce solids, frequent feeding, and a mixed diet including vegetables and fruit. The home visitor also checks to see if immunizations are up to date and if the child has been dewormed.

B28. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscripts rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
le Roux, I. M., le Roux, K., Comulada, W. S., Greco, E. M., Desmond, K. A., Mbewu, N., & Rotheram-Borus, M. J. (2010). Home visits by neighborhood mentor mothers provide timely recovery from childhood malnutrition in South Africa: Results from a randomized controlled trial. *Nutrition Journal*, 9(56).	RCT	Low	N/A	N/A
le Roux, I. M., le Roux, K., Mbeutu, K., Comulada, W. S., Desmond, K. A., & Rotheram-Borus, M. (2011). A randomized controlled trial of home visits by neighborhood mentor mothers to improve children's nutrition in South Africa. *Vulnerable Children and Youth Studies, 6*(2), 91-102.	RCT	Low	N/A	N/A
Le Roux, I. M., Rotheram-Borus, M., Stein, J., & Tomlinson, M. (2014). The impact of paraprofessional home visitors on infants' growth and health at 18 months. *Vulnerable Children and Youth Studies*, *9*(4), 291–304.[a]	RCT	Low	N/A	N/A
le Roux, I. M., Tomlinson, M., Harwood, J. M., O'Connor, M. J., Worthman, C. M., Mbewu, N., . . . Rotheram-Borus, M. J. (2013). Outcomes of home visits for pregnant mothers and their infants in South Africa: A cluster randomized controlled trial. *AIDS*, *27*(9), 1461–1471.	RCT	Low	N/A	N/A

Citation	Study design	Manuscripts rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Rotheram-Borus, M., Tomlinson, M., le Roux, I. M., Harwood, J. M., Comulada, S., O'Connor, M. J., . . . Worthman, C. M. (2014). A cluster randomised controlled effectiveness trial evaluating perinatal home visiting among South African mothers/infants. *PLOS ONE*, *9*(1): e105934.	RCT	Low	N/A	N/A
Rotheram-Borus, M. J., Tomlinson, M., Le Roux, I., & Stein, J. A. (2015). Alcohol use, partner violence, and depression: A cluster randomized controlled trial among urban South African mothers over 3 years. *American Journal of Preventive Medicine,* 49(5), 715-725.	RCT	Low	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received a low rating.

RCT = randomized controlled trial.

N/A = not applicable

26. Promoting First Relationships®

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies received a high or moderate rating.

Extent of evidence:

Five manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations; all received low ratings.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of Promoting First Relationships (PFR) identified no such manuscripts.

Description	
Frequency and length of home visits	Weekly with 10 sessions; 60- to 75-minute visits
Duration of program	10 weeks
Study participants	Caregivers of toddlers who are experiencing state dependency (with foster care or change in primary caregiver). Manuscript 2: To be eligible for the study, families had to have at least one parent or guardian who 1) was at least 18 years old; (2) spoke English; (3) was the primary caregiver for an AIAN child aged 10-30 months; (4) had telephone access; (5) was not in a treatment facility or shelter; (6) was not hospitalized or imprisoned; (7) was willing to have researchers come to their home; and (8) lived on or near the reservation.
Location of services	Washington State
Type of implementing agency	Local agencies; The University of Washington
Home visitor qualifications	Home visitors were mental health professionals who were either earning or had already obtained their master's degree.
Home visitor training and technical assistance	Manuscript 2: Community providers of mental health services received training that involved 90 hours over 6 months. This included a 3-day workshop, observations of home visits, shadowing, understanding the intervention curriculum, and weekly reflection groups. Manuscript 3: Over 3 weeks, trainees watched hour-long training videos (a series of 11) and met twice weekly (by video conference) with their trainer to discuss the content.
Goals	Promoting First Relationships (PFR) is a home visiting program delivered to caregivers (birth or foster/kin) of toddlers recently transitioned to their care because of child welfare placement decisions, and is intended to improve parenting and toddler outcomes. PFR providers focus on increasing parenting sensitivity using attachment theory-informed, strength-based consultation strategies in conjunction with video feedback.
Components	To achieve its goals, 10 home visits are offered in conjunction with video recording of caregiver-child interactions.
Content	PFR focuses on instruction for caregivers to understand child behavioral cues for nurturance, improve caregiver's understanding of toddler's behavior, and increase caregivers' sensitivity. Caregivers review video recordings of their interactions with the focal children, receive feedback from the home visitor on those interactions, and review handouts and instructional videos on various topics such as attachment and healthy relationships.

B29. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Oxford, M., Booth-LaForce, C., Echo-Hawk, A., Lallemand, O., Parrish, L., Widner, M., Petras, A., . . . the CATCH Project Team. (2018). *Promoting First Relationships®: Implementing a home visiting research program in two tribal communities.* Unpublished manuscript submitted to HomVEE.	Implementation	N/A	N/A	N/A
Nelson, E. M., & Spieker, S. J. (2013). Intervention effects on morning and stimulated cortisol responses among toddlers in foster care. *Infant Mental Health Journal*, *34*(3), 211–221.[a]	NED	Low	N/A	N/A
Spieker, S. J., Oxford, M. L., & Fleming, C. B. (2014). Permanency outcomes for toddlers in child welfare two years after a randomized trial of a parenting intervention. *Children & Youth Services Review,* 44, 201–206.	RCT	Low	N/A	N/A
Spieker, S. J., Oxford, M. L., Kelly, J. F., Nelson, E. M., & Fleming, C. B. (2012). Promoting First Relationships: Randomized trial of a relationship-based intervention for toddlers in child welfare. *Child Maltreatment*, *17*(4), 271–286.	RCT	Low	N/A	N/A
Booth-LaForce, C., and Oxford, M. L. (2018). Randomized controlled trial of the Promoting First Relationships® preventive intervention for primary caregivers and toddlers in an American Indian community. Unpublished manuscript submitted to HomVEE.	RCT	Low	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts received a low rating.

RCT = randomized controlled trial; NED = non-experimental comparison group design.

N/A = not applicable

27. SafeCare®

The HomVEE review of research with tribal populations included research from two models related to SafeCare: SafeCare itself, and SafeCare Augmented. The next two sections discuss each in turn.

a. SafeCare®

Evidence of effectiveness:
SafeCare does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.
Extent of evidence:
No manuscripts about impact studies about SafeCare were eligible for HomVEE's review of research with tribal populations.
Summary of findings:
HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of SafeCare identified no such manuscripts.

Description	
Frequency and length of home visits	At least weekly home visits
Duration of program	About 6 months
Study participants	Families with children up to age 12, irrespective of untreated substance abuse.
Location of services	Six child protective services administrative regions of Oklahoma
Type of implementing agency	Community-based agencies contracted by the state child welfare system
Home visitor qualifications	Home visitors had bachelor's degrees and supervisors had master's degrees. Coaches were recruited from existing agency staff.
Home visitor training and technical assistance	Home visitors had pre-service training and additional trainings. Trainings provided basic motivational interviewing skills and domestic violence safety planning.
Goals	SafeCare aims to reduce first-time, repeated, and recidivistic child abuse and neglect among clients by offering training in 12 distinct service areas.
Components	Home visiting only
Content	SafeCare offers training in 12 key topic areas: (1) parent child interaction, (2) stress reduction for parents, (3) basic skills training for children, (4) money management training, (5) social support, (6) home safety training, (7) -multisetting behavior management, (8) infant and child health and nutrition, (9) problem solving, (10) marital discord counseling, (11) alcohol abuse referral, and (12) a variety of pre- and postnatal prevention services for young and unwed mothers.

B30. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Chaffin, M., Bard, D., Bigfoot, D. S., & Maher, E. J. (2012). Is a structured, manualized, evidence-based treatment protocol culturally competent and equivalently effective among American Indian parents in child welfare? *Child Maltreatment*, *17*(3), 242-252.	Implementation	N/A	N/A	N/A
Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). A statewide trial of the SafeCare home-based services model with parents in Child Protective Services. *Pediatrics*, *129*(3), 509-515.	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received a low rating.

RCT = randomized controlled trial.

N/A = not applicable

b. SafeCare Augmented®*

**SafeCare Augmented is a version of SafeCare*

Evidence of effectiveness:

SafeCare Augmented does not meet criteria established by HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations, but does meet the criteria for the general population. The model does not meet criteria for tribal populations because findings were not reported separately for tribal populations.[60]

Extent of evidence:

One manuscript about an impact study about SafeCare Augmented was eligible for HomVEE's review of research with tribal populations; it received a high rating.

Summary of findings: [61]

SafeCare Augmented showed favorable effects for the Linkages and Referrals and Reductions in Child Maltreatment Domains. The following table summarizes findings examined across manuscripts that received a high or moderate rating.

Domain	Findings
Child Development and School Readiness	*Not measured*
Child Health	*Not measured*
Family Economic Self-Sufficiency	Favorable: 0 No effect: 4 Unfavorable or ambiguous: 0
Linkages and Referrals	Favorable: 1 No effect: 0 Unfavorable or ambiguous: 0
Maternal Health	Favorable: 0 No effect: 6 Unfavorable or ambiguous: 0
Positive Parenting Practices	*Not measured*
Reductions in Child Maltreatment	Favorable: 1 No effect: 8 Unfavorable or ambiguous: 0
Reductions in Juvenile Delinquency, Family Violence, and Crime	Favorable: 0 No effect: 3 Unfavorable or ambiguous: 1

[60]To meet HHS criteria for an "evidence-based early childhood home visiting service delivery model" for tribal populations, findings must be reported (1) in a sample composed entirely of tribal participants or (2) in a subgroup of tribal participants and the subgroup findings must be replicated in a distinct subgroup.

[61] Findings reported for populations in which at least 10 percent of study participants were from tribal or indigenous communities.

Description	
Frequency and length of home visits	At least weekly home visits; length of individual visits is not specified
Duration of program	About 6 months
Study participants	Families with children ages birth to 5 years and a history of child maltreatment or risk factors for child maltreatment.
Location of services	A rural county in a southwestern state
Type of implementing agency	Not specified
Home visitor qualifications	Home visitors were required to have completed a bachelor's degree.
Home visitor training and technical assistance	Home visitors were required to complete a five-day workshop delivered by the National SafeCare Training and Research Center. Home visitors were also trained in basic motivational interviewing and domestic violence safety training.
Goals	SafeCare Augmented is designed to improve caregiving and parent-child interactions, and ultimately to reduce the incidence of child maltreatment.
Components	SafeCare Augmented supplements the regular SafeCare intervention with the addition of motivational interviewing, as well as training of the home visitors on identifying and responding to imminent child maltreatment and risk factors of substance abuse, depression, and intimate partner violence. To achieve its goals, home visits are offered at least weekly for about six months.
Content	SafeCare Augmented focuses on three areas: (1) infant and child health care, (2) home safety, and (3) parent child interaction. During visits, home visitors conduct ongoing measurement of observable behaviors, model skills, observe and provide feedback on parents' practice, and train parents.

B31. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Silovsky, J. F., Bard, D., Chaffin, M., Hecht, D., Burris, L., Owora, A., . . . Lutzker, J. (2011). Prevention of child maltreatment in high-risk rural families: A randomized clinical trial with child welfare outcomes. *Children and Youth Services Review*, *33*(8), 1435–1444.	RCT	High	Family economic self-sufficiency; Linkages and Referrals[+]; Maternal health; Reductions in child maltreatment[+]; Reductions in juvenile delinquency, family violence, and crime[-]	HomVEE website: https://homvee.acf.hhs.gov/study-detail?title=WWHV027968

[a] Domains listed under "Outcome domains measured" include domains for all findingsreported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts received a low rating.

[-] Unfavorable effect reported in this domain.

[+] Favorable effect reported in this domain.

RCT = randomized controlled trial.

N/A = not applicable

28. SHARE-ACTION

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies received a high or moderate rating.

Extent of evidence:

One manuscript about an impact study was eligible for HomVEE's review of research with tribal populations; it received a low rating.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of the SHARE-ACTION program identified no such manuscripts.

Description	
Frequency and length of home visits	Not specified
Duration of program	Not specified
Study participants	Aboriginal households from the Six Nations Reserve in Ohsweken, Canada, comprising a male and/or female parent with at least one child living in the same household.
Location of services	Six Nations Reserve, Canada
Type of implementing agency	Not specified
Home visitor qualifications	Not specified
Home visitor training and technical assistance	Aboriginal health counselors were trained to assess and set dietary and physical activity goals for each household member.
Goals	The SHARE-ACTION program was designed to reduce energy intake and increase physical activity among Aboriginal families by influencing participants' health behavior, modeling health behaviors, and reinforcing healthy lifestyle changes.
Components	To achieve its goals, the program included regular home visits by Aboriginal health counselors who were trained to assess and set dietary and physical activity goals for each household member. In addition, families received weekly deliveries of spring water.
Content	Not specified.

B32. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
1. Anand, S. S., Davis, A. D., Ahmed, R., Jacobs, R., Xie, C., Hill, A., . . . Yusuf, S. (2007). A family-based intervention to promote healthy lifestyles in an Aboriginal community in Canada. *Canadian Journal of Public Health. Revue Canadienne de Santé Publique*, *98*(6), 447–452.	RCT	Low	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript . For information about domains with favorable impacts, see the "Summary of findings" section beforee the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received a low rating.

RCT = randomized controlled trial.

N/A = not applicable

29. South Australia Family Home Visiting Programme

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies received a high or moderate rating.

Extent of evidence:

Two manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations; both received low ratings.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of the South Australia Family Home Visiting Programme (SA-FHV) identified no such manuscripts.

Description	
Frequency and length of home visits	24 visits, ranging from weekly to monthly. Length of individual visits is not specified.
Duration of program	Two-years postnatally
Study participants	Socially disadvantaged mothers in South Australia
Location of services	Adelaide, Australia; Rural regions of South Australia
Type of implementing agency	State-wide community child health service; South Australian Department of Health
Home visitor qualifications	Home visitors were registered nurses with additional qualifications in community child health nursing.
Home visitor training and technical assistance	Nurses receive extensive initial training in how to deliver the SA-FHV. They also receive training about child protection and notification, and participate in a 3-month practice program.
Goals	The SA-FHV aimed to improve the quality of relationship between the mother and infant; provide guidance about infant health, safety, and development; assist families in providing a safe and supportive environment for their children; and connect families to community resources and networks.
Components	Home visiting only
Content	Six modules covering relationship building and developmentally-appropriate topics, the content is flexible to accommodate the mothers' needs.

B33. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Sawyer, M. G., Frost, L., Bowering, K., & Lynch, J. (2013). Effectiveness of nurse home-visiting for disadvantaged families: results of a natural experiment. *BMJ Open*, *3*(4), e002720.	NED	Low	N/A	N/A
Sawyer, M. G., Pfeiffer, S., Sawyer, A., Bowering, K., Jeffs, D., & Lynch, J. (2014). Effectiveness of nurse home visiting for families in rural South Australia. *Journal of Paediatrics and Child Health*, *50*(12), 1013-1022.	NED	Low	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript . For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received a low rating.

NED = non-experimental comparison group design.

N/A = not applicable

30. Sudden Infant Death Syndrome Risk Factor Education Program

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Extent of evidence:

No manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of the Sudden Infant Death Syndrome (SIDS) Risk Factor Education Program identified no such manuscripts.

Description	
Frequency and length of home visits	Not specified
Duration of program	Not specified
Study participants	Postnatal women from the Aberdeen Area of the Indian Health Service and a community hospital in North Dakota.
Location of services	The Aberdeen Area of the Indian Health Service and a community hospital in North Dakota
Type of implementing agency	Community hospital
Home visitor qualifications	Not specified
Home visitor training and technical assistance	Not specified
Goals	This intervention aimed to improve parental knowledge of SIDS risk factors and thus reduce child deaths from SIDS. To achieve its goals, program developers created baby blankets with nine risk factors for SIDS printed on them.
Components	Services were delivered through a home visiting program for American Indian mothers and families.
Content	Nursing or home visiting staff distributed the blankets to families and reviewed the information on the blankets.

B34. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Burd, L., Peterson, M., Face, G. C., Face, F. C., Shervold, D., & Klug, M. G. (2007). Efficacy of a SIDS risk factor education methodology at a Native American and Caucasian site. *Maternal & Child Health Journal*, *11*(4), 365–371.	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript . For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received a low rating.

N/A = not applicable

31. Toddler Overweight and Tooth Decay Prevention Study (TOTS)

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies received a high or moderate rating.

Extent of evidence:

One manuscript about an impact study was eligible for HomVEE's review of research with tribal populations; it received a low rating.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of the Toddler Overweight and Tooth Decay Prevention Study (TOTS) identified no such manuscripts.

Description	
Frequency and length of home visits	Manuscript 1: 8 clusters of 3 visits each (one of which must be in the home) over a 24-month period. Length of individual visits is not specified. Manuscript 2: 15 visit clusters; length of individual visits is not specified.
Duration of program	Prenatally to age 2 years
Study participants	Expectant mothers and their families from American Indian tribes in the Northwest
Location of services	American Indian tribes in the Northwest
Type of implementing agency	Not specified
Home visitor qualifications	Community health workers from tribal communities
Home visitor training and technical assistance	Manuscript 1: Community health workers received training in the delivering one-to-one counseling to reduce sugar-sweetened beverage consumption and promote water consumption, using principles of home visiting and outreach, behavior change, and motivational enhancement. Manuscript 2: Not specified
Goals	The goals of TOTS were to (1) increase breastfeeding initiation and duration, (2) limit the introduction of sugar-sweetened beverages to infants and toddlers, and (3) promote the consumption of water for thirst among toddlers. The TOTS supplement also included the following goals: (1) promoting the appropriate introduction of solid foods, (2) decreasing sedentary behavior among infants and toddlers, and (3) increasing infant and toddler motor and movement skills.
Components	Services included a community-wide intervention and a family intervention delivered through home visits.
Content	The first two visit clusters were intended to establish rapport, solidify contact guidelines between participants and their assigned community health workers, and collect baseline data. In the original TOTS, community health workers created a client-specific plan for initiating and maintaining breastfeeding along with water and sugar-sweetened beverage interventions in clusters 1–3. Clusters 4–7 consisted of implementing and monitoring the intervention and the final cluster covered closure activities. In the TOTS enhancement, clusters 3 and 4 focused on promoting breastfeeding and connecting families to community resources. Clusters 5 and 6 focused on feeding issues and maintaining breastfeeding, Clusters 7–15 consisted of introducing solid foods, discussing sugar sweetened beverage consumption, and introducing physical activity topics.

B35. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Karanja, N., Aickin, M., Lutz, T., Mist, S., Jobe, J. B., Maupome, G., & Ritenbaugh, C. (2012). A community-based intervention to prevent obesity beginning at birth among American Indian children: Study design and rationale for the PTOTS study. *Journal of Primary Prevention*, *33*(4), 161–174.[c]	Implementation	N/A	N/A	N/A
Karanja, N., Lutz, T., Ritenbaugh, C., Maupome, G., Jones, J., Becker, T., & Aickin, M. (2010). The TOTS community intervention to prevent overweight in American Indian toddlers beginning at birth: A feasibility and efficacy study. *Journal of Community Health*, *35*(6), 667–675.	RCT	Low	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received low ratings.

[c] This manuscript describes a supplement to the Toddler Overweight and Tooth Decay Prevention Study intervention that includes additional nutrition and physical activity components.

RCT = randomized controlled trial.

N/A = not applicable

32. Universal Health Home Visit offered through Families First

Evidence of effectiveness:

This model does not meet the criteria established by the HHS for an "evidence-based early childhood home visiting service delivery model" for tribal populations or for the general population because no manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Extent of evidence:

No manuscripts about impact studies were eligible for HomVEE's review of research with tribal populations.

Summary of findings:

HomVEE reports results from manuscripts that have at least one finding that receives a high or moderate rating. HomVEE's review of research with tribal populations of the Universal Health Home Visit offered through Families First identified no such manuscripts.

Description	
Frequency and length of home visits	The program offered one home visit; length of individual visits is not specified.
Duration of program	Visit to occur within 2 weeks of child's birth.
Study participants	Families of all newborn infants in New South Wales, Australia; one of the goals of the model was to identify and engage vulnerable families, including Aboriginal families.
Location of services	New South Wales, Australia
Type of implementing agency	New South Wales Department of Health
Home visitor qualifications	Child and family health nurses.
Home visitor training and technical assistance	Not specified.
Goals	The Universal Health Home Visit offered through Families First aims to connect at-risk families to child and family services.
Components	The model offers one home visit to all newborn infants within two weeks of birth. The other services provided are not specified.
Content	During the home visit, the nurses assess the family's needs, provide support and parent education, and refer families to a range of health and community support services.

B36. Details of manuscripts included in HomVEE's review of research with tribal populations

Citation	Study design	Manuscript rating	Outcome domains measured[a,b]	Where to learn more about study characteristics[b]
Widdup, J., Comino, E. J., Webster, V., & Knight, J. (2012). Universal for whom? Evaluating an urban Aboriginal population's access to a mainstream universal health home visiting program. *Australian Health Review*, *36*(1), 27–33.	Implementation	N/A	N/A	N/A

[a] Domains listed under "Outcome domains measured" include domains for all findings reported by the manuscript. For information about domains with favorable impacts, see the "Summary of findings" section before the description.

[b] Reported only for manuscripts that received high or moderate ratings; not reported for manuscripts that received a low rating.

N/A = not applicable

This page has been left blank for double sided copying.

Appendix C:

Study characteristics for high- and moderate-rated manuscripts "about impact studies in HomVEE's review of research with tribal populations

This page has been left blank for double sided copying.

Citation	Bair-Merritt, M. H., Jennings, J. M., Chen, R., Burrell, L., McFarlane, E., Fuddy, L., et al. (2010). Reducing maternal intimate partner violence after the birth of a child: A randomized controlled trial of the Hawaii Healthy Start home visitation program. *Journal of the American Medical Association, 164*(1), 16 23.
Study Characteristics	
Study participants	Families were recruited to the study from November 1994 to December 1995. Hawaii Healthy Start Program staff screened the medical records of mothers from one of four Oahu communities delivering children at Kapiolani Maternity Hospital for risk factors for child abuse and neglect. Mothers found to be at risk, or those whose records did not contain sufficient information to screen out, were screened further using the Kempe Family Stress Checklist; eligible families were those in which either parent scored 25 or greater. Of the 897 families who were eligible to participate in the study, 730 (81 percent) agreed to participate and were randomly assigned to the intervention group (n = 395), the main comparison group (n = 290), or a testing comparison group (n = 45). This study includes data from all three follow-up years of the Hawaii Healthy Start randomized controlled trial. Specifically, the sample includes 373 families from the intervention group and 270 families from the main comparison group. At baseline, 24 percent of intervention group and 21 percent of comparison group mothers were age 18 or younger, 45 percent of intervention group and 48 percent of comparison group mothers were ages 19 to 25, and 31 percent of mothers in both groups were age 26 or older. Sixty-four percent of intervention group mothers and 69 percent of comparison group mothers were high school graduates. The racial composition of the intervention group was 34 percent Native Hawaiian or Pacific Islander, 28 percent Asian or Filipino, 10 percent Caucasian, and 28 percent of unknown primary ethnicity. The comparison group consisted of 33 percent Native Hawaiian or Pacific Islander, 28 percent Asian or Filipino, 13 percent Caucasian, and 26 percent of unknown primary ethnicity.
Setting	Six Healthy Start Program sites operated by three community-based organizations in Oahu, Hawaii.
Home visiting services	Home visiting services were designed to provide three to five years of home visiting, with weekly visits for most or all of the child's first year of life, and visits of gradually decreasing frequency thereafter depending on family need. Home visitors endeavored to establish trusting relationships with families, help them resolve immediate crises, and help them build on existing strengths to improve their ability to function independently. Visitors helped families develop problem-solving skills, connected them to needed services, and aimed to develop an individual service plan with each family every six months and help the family reach six-month goals. The actual frequency of visits, however, was lower than that specified by the model, with families receiving an average of 13 visits in the child's first year of life (Duggan et al., 1999). Family participation rates declined over time, with 90 percent participating when the child was 3 months of age, 70 percent at 6 months, 49 percent at 12 months, and 25 percent when the child was 36 months old.
Comparison condition	The main comparison group was tested annually to measure outcomes. A second "testing" comparison group was evaluated only at Year 3 to ascertain the effect of repeated testing on observed outcomes (Duggan et al., 2004).
Funding source	The parent study, evaluation of the Hawaii Healthy Start Program, was supported by grants R40 MC 00029 and R40 MC 00123 from the Federal Maternal and Child Health Bureau; the Robert Wood Johnson Foundation; the Annie E. Casey Foundation; the David and Lucile Packard Foundation; the Hawaii State Department of Health; and grant P30MH38725 from the National Institutes of Health. Dr. Bair-Merritt is funded in part by Career Development Award K23HD057180 sponsored by the National Institute of Child Health and Human Development.
Author affiliation	None of the study authors are developers of this model.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV0145844

Citation	Barlow, A., Mullany, B., Neault, N., Billy, T., Hastings, R., Lorenzo, S., Kee, C., Lake, K., Redmond, C., Carter, A., & Walkup, J. T. (2014). ***A randomized controlled trial of a paraprofessional delivered, home visiting intervention: Three year outcomes for American Indian teen mothers and their children***. **Manuscript in submission.**
Study Characteristics	
Study participants	American Indian adolescent females ages 12 to 19 years at conception and at 32 weeks or earlier gestation who resided in one of four participating communities were recruited. The study sample included 322 participants who were randomly assigned to either the Family Spirit group (159) or the comparison group (163). The average age of participants at baseline was 18.1 years. Sixty percent lived with their parents and slightly more than half lived in two or more homes within the past year. Seventy-seven percent of participants were pregnant with their first child. During pregnancy, 14 percent of participants drank alcohol, 19 percent smoked cigarettes, and 13 percent used marijuana.
Setting	The program was implemented in four tribal communities across three reservations in Arizona.
Home visiting services	Family Spirit is an early childhood home visiting model for young American Indian pregnant and parenting mothers staffed by American Indian paraprofessionals. The model's goals are to increase mothers' parenting knowledge and involvement, mothers' psychosocial functioning, and children's emotional and behavioral outcomes. The curriculum includes 43 lessons that cover parenting skills, infant development, and maternal psychosocial development. The frequency of the visits depends upon the stage of the model. One-hour home visits are provided weekly during pregnancy, biweekly visits for the first four months following the child's birth, monthly from 4 to 14 months postpartum, and then bimonthly until the child's third birthday. The study did not specify the dosage of services that intervention participants actually received.
Comparison condition	Participants in the comparison group received transportation to and from prenatal and well-baby visits, information on child care and community resources, and referrals for services.
Funding source	Support for this research was provided by the National Institute on Drug Abuse.
Author affiliation	Ms. Barlow is part of the team that developed this model. Dr. Walkup was affiliated with the Center for American Indian Health at the Johns Hopkins Bloomberg School of Public Health, where the team that developed this model is based.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV040826
Citation	Barlow, A., Mullany, B., Neault, N., Compton, S., Carter, A., Hastings, R., Billy, T., Coho-Mescal, V., Lorenzo, S., & Walkup, J. (2013). Effect of a paraprofessional home visiting intervention on American Indian teen mothers' and infants behavioral risks: A randomized controlled trial. *American Journal of Psychiatry*, *170*(1), 83–93.
Study Characteristics	
Study participants	Expectant American Indian adolescents ages 12 to 19 years at conception and at 28 weeks' or earlier gestation who resided in one of four participating communities were potentially eligible for participation. To increase recruitment, the eligibility criteria were expanded to include a gestational period of 32 weeks or earlier. The study sample included 322 participants who were randomly assigned to either the Family Spirit group (159) or the comparison group (163). The average age of participants at baseline was 18.1 years. Sixty percent lived with their parents and slightly more than half lived in two or more homes within the past year. Seventy-seven percent of participants were pregnant with their first child. During pregnancy, 14 percent of participants drank alcohol, 19 percent smoked cigarettes, and 13 percent used marijuana.
Setting	The model was implemented in four tribal communities across three reservations in Arizona.

Citation	**Barlow, A., Mullany, B., Neault, N., Billy, T., Hastings, R., Lorenzo, S., Kee, C., Lake, K., Redmond, C., Carter, A., & Walkup, J. T. (2014). *A randomized controlled trial of a paraprofessional delivered, home visiting intervention: Three year outcomes for American Indian teen mothers and their children*. Manuscript in submission.**
Home visiting services	Family Spirit is an early childhood home visiting model for young American Indian pregnant and parenting mothers staffed by American Indian paraprofessionals. The model's goals are to increase mothers' parenting knowledge and involvement, mothers' psychosocial functioning, and children's emotional and behavioral outcomes. The curriculum includes 43 lessons that cover parenting skills, infant development, and maternal psychosocial development. The frequency of the visits depends upon the stage of the model. One-hour home visits are provided weekly during pregnancy, biweekly visits for the first four months following the child's birth, monthly between 4 and 14 months postpartum, and then bimonthly until the child's third birthday.
Comparison condition	Participants in the comparison group received transportation to prenatal and well-baby visits, information on child care and community resources, and referrals for services.
Funding source	Support for this research was provided by the National Institute on Drug Abuse.
Author affiliation	Ms. Barlow is part of the team that developed this model. Dr. Walkup was affiliated with the Center for American Indian Health at the Johns Hopkins Bloomberg School of Public Health, where the team that developed this model is based.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV029496

Citation	**Barlow, A., Mullany, B., Neault, N., Goklish, N., Billy, T., Hastings, R., Lorenzo, S., Kee, C., Lake, K., Redmond, C., Carter, A., & Walkup, J. T. (2015). Paraprofessional delivered home visiting intervention for American Indian teen mothers and children: 3 year outcomes from a randomized controlled trial. *American Journal of Psychiatry, 172*(2), 154 162.**
Study Characteristics	
Study participants	From 2006 to 2008, expectant women who were at less than or equal to 32 weeks gestation, age 12-19 at conception, self-identified as American Indian, and resided in one of the four participating reservation communities were recruited into the study. Eligible participants were randomized by site, age, and history of previous live births. The sample consisted of 322 women, 159 in the intervention group and 163 in the comparison group. Note that the study does not use a consistent analytic sample across different outcomes. The sample sizes shown here are relevant for maternal outcomes only, the sample sizes for child outcomes differ.
Setting	Four southwestern reservation communities.
Home visiting services	The Family Spirit intervention consisted of 43 lessons delivered by Native American paraprofessionals from within participating communities. The lessons focused on parenting skills and maternal behavioral and psychosocial risks. The lessons were conducted in each participant's home and the visits lasted approximately one hour each. The visits occurred weekly through pregnancy, biweekly until 4 months postpartum, monthly between 4-12 months postpartum, and bimonthly between 12-36 months postpartum.
Comparison condition	Participants in the comparison group received transportation to and from prenatal and well-baby visits, information on child care and community resources, and referrals for services.
Funding source	Supported by National Institute on Drug Abuse grant R01 DA-019042 (principal investigator, J. Walkup).
Author affiliation	The corresponding author is one of the model developers.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV047724
Citation	Boyd, A. (1997b). *Parents as First Teachers pilot project evaluation (PAFT): Report on Whangarei region: Final complete draft.* Wellington, New Zealand: Ministry of Education.
Study Characteristics	
Study participants	PAFT served first-time mothers with infants less than eight weeks old. Participants in the Whangarei region included 190 participants (101 intervention ; 89 comparison). Approximately 90 percent of children lived in a nuclear family. English was the most commonly spoken language (95 percent of participants); a small proportion of families reporting regularly speaking Samoan, Māori, and Tongan in the home. Forty-five percent of families were supported by father's earnings; 20 percent from both parents equally; 12 percent from the mother supplementing family earnings; and 15 percent were supported by the government.
Setting	Four areas in New Zealand: Whangarei, South Auckland, Gisborne and Dunedin. The study's findings are based solely on Whangarei, but the information on model implementation applies to the entire trial.

Citation	**Barlow, A., Mullany, B., Neault, N., Goklish, N., Billy, T., Hastings, R., Lorenzo, S., Kee, C., Lake, K., Redmond, C., Carter, A., & Walkup, J. T. (2015). Paraprofessional delivered home visiting intervention for American Indian teen mothers and children: 3 year outcomes from a randomized controlled trial. *American Journal of Psychiatry, 172*(2), 154 162.**
Home visiting services	PAFT is a strengths-based, primary prevention parent education and support program for families with children under three years of age that is designed to enhance children's health, development and school readiness. PAFT is based on the Parents as Teachers (PAT) model, adapted to meet the needs of New Zealand. PAFT uses an adapted form of PAT's Born to Learn curriculum and Āhuru Mōwai, a Māori specific curriculum developed for PAFT. PAFT services include: (1) information on child development provided during each home visit, including monthly developmental milestones and guidance on how to foster children's intellectual, social, language and motor-skill development; (2) periodic screening of the child's sensory and motor development to detect possible delays (if delays were detected, referrals were made to appropriate sources of support); (3) monthly visits by parent educators to the family's home; (4) monthly group meetings arranged by parent educators as a venue where parents could share experiences and discuss topics of interest; and (5) resources for parents and children, including books and learning materials.
Comparison condition	Comparison group mothers received only annual contact with program staff, via mailings, to maintain contact and update addresses.
Funding source	The New Zealand Ministry of Education.
Author affiliation	None of the study authors are developers of this model.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV037116
Citation	Caldera, D., Burrell, L., Rodriguez, K., Crowne, S. S., Rohde, C., & Duggan, A. (2007). Impact of a statewide home visiting program on parenting and on child health and development. *Child Abuse & Neglect, 31*(8), 829–852.
Study Characteristics	
Study participants	Between January 2000 and July 2001, 388 families who screened positive on a Healthy Families Alaska (HFAK) protocol for risk factors associated with poor health and social outcomes and received scores of 25 or higher on the Kempe Family Stress Checklist were recruited during pregnancy or at the time of birth (Duggan et al., 2007). Of these families, 364 consented to participate and were randomly assigned to the intervention group (n = 179) or the comparison group (n = 185). Of these, 325 families completed a baseline interview. The sample was 22 percent Alaska native, 55 percent Caucasian, 8 percent multiracial, and 15 percent other race. 58 percent of families were below poverty level, 58 percent of mothers had graduated from high school, and 73 percent had worked in the year prior to enrollment (Johns Hopkins University, 2005). The average age of mothers at baseline was 23.5 years. This study reports the second-year follow-up results of the HFAK evaluation, with a sample size of 138 intervention group primary caregivers and 140 comparison group primary caregivers. Most of the analyses are limited to families in which the biological mothers had custody of the index child at follow-up (249 families), with additional outcomes obtained from medical records (268 families). The findings included in this study were also described in an earlier report (Johns Hopkins University, 2005).
Setting	This study included six HFAK sites, two in Anchorage and one each in Wasilla, Fairbanks, Juneau, and Kenai.

Citation	**Barlow, A., Mullany, B., Neault, N., Goklish, N., Billy, T., Hastings, R., Lorenzo, S., Kee, C., Lake, K., Redmond, C., Carter, A., & Walkup, J. T. (2015). Paraprofessional delivered home visiting intervention for American Indian teen mothers and children: 3 year outcomes from a randomized controlled trial. *American Journal of Psychiatry, 172*(2), 154 162.**
Home visiting services	Families in the intervention group were assigned to receive visits monthly until their child's birth and weekly thereafter. By design, families receive gradually less frequent visits as they reach critical milestones, ranging to quarterly visits at the highest level of functioning. Families were enrolled in the intervention until they functioned sufficiently to "graduate" or until their child turned 2. In practice, home visits were less frequent than intended, with only 4 percent of families receiving 75 percent or more of their designated frequency of visits and completing the full two years. Home visits were intended to emphasize preparing for child growth, development, and critical milestones; screening and referral for developmental delays; promoting a safe environment; positive parent-child interactions; establishing a "medical home" for the child; and supporting the family during crises. The model also emphasized the development of an individual family support plan (IFSP) or setting and monitoring progress toward individual family goals.
Comparison condition	Families assigned to the comparison condition received referrals to other community services.
Funding source	Alaska Mental Health Trust Authority and the Alaska State Department of Health and Social Services.
Author affiliation	None of the study authors are developers of this model.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV003774
Citation	Campbell, K. I., & Silva, P. A. (1997). *Parents as First Teachers pilot programme evaluation: Age three assessments. Final report to the Ministry of Education on the Dunedin and Gisborne/East Coast areas.* Wellington, New Zealand: Ministry of Education.
Study Characteristics	
Study participants	PAFT served first-time mothers with infants less than eight weeks old. The study included two samples: one from the Dunedin area and one from the Gisborne/East Coast area (characteristics are presented separately). Participants in the Dunedin area included 267 families, including 133 in the intervention group and 134 in the comparison group. Overall, 84 percent of parents in the sample were married. Eighty-four percent of fathers and 61 percent of mothers were working in paid employment. Most participants (87 percent) spoke only English in the home. Participants in the Gisborne/East Coast area included 208 families, including 108 in the intervention group and 100 in the comparison group. Overall, 77 percent of parents in the sample were married. Ninety percent of fathers and 48 percent of mothers were working in paid employment. Nearly all participants (99 percent) spoke English; about a third (28 percent) also spoke other languages in addition to English.
Setting	Four areas in New Zealand: Whangarei, South Auckland, Gisborne and Dunedin. The study's findings are based solely on Dunedin and Gisborne, but the information on model implementation applies to the entire trial.

Citation	**Barlow, A., Mullany, B., Neault, N., Goklish, N., Billy, T., Hastings, R., Lorenzo, S., Kee, C., Lake, K., Redmond, C., Carter, A., & Walkup, J. T. (2015). Paraprofessional delivered home visiting intervention for American Indian teen mothers and children: 3 year outcomes from a randomized controlled trial. *American Journal of Psychiatry, 172*(2), 154 162.**
Home visiting services	PAFT, a strengths-based, primary prevention parent education and support program for families with children under three years of age, was designed to enhance children's health, development and school readiness. PAFT was based on the Parents as Teachers (PAT) model, adapted to meet the needs of New Zealand. PAFT used an adapted form of PAT's Born to Learn curriculum and Āhuru Mōwai, a Māori specific curriculum developed for PAFT. PAFT services include: (1) information on child development provided during each home visit, including monthly developmental milestones and guidance on how to foster children's intellectual, social, language and motor-skill development; (2) periodic screening of the child's sensory and motor development to detect possible delays (if delays were detected, referrals were made to appropriate sources of support); (3) monthly visits by parent educators to the family's home; (4) monthly group meetings arranged by parent educators as a venue where parents could share experiences and discuss topics of interest; and (5) resources for parents and children, including books and learning materials.
Comparison condition	Comparison group mothers received only annual contact with program staff, via mailings, to maintain contact and update addresses.
Funding source	The New Zealand Ministry of Education.
Author affiliation	None of the study authors are developers of this model.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV037119

Citation	Chomos, J. C., Evans, W. P., Bolan, M., Merritt, L., Meyer, A., & Novins, D. K. (2018). Using single case design to evaluate components of tribal home visitation programs: Tribal community two. Infant Mental Health Journal, 39(3), 335 346.
Study Characteristics	
Study participants	The study includes mothers who receive the Nurse-Family Partnership (NFP) intervention. NFP enrolls pregnant women up to the 28th week of pregnancy and serves them and the child until the child is 2 years old. Ten mothers provided consent to participate in the single case design study, of which five mothers have complete data. The study presents visual analyses for one participant.
Setting	The study took place in a small tribe in Washington State.
Home visiting services	Both intervention conditions (B phases in the ABAB design of this multiple baseline study) include two specialized home visiting sessions with NFP facilitators and exercises addressing stress-management issues. The exercises could be the same or different during the two intervention conditions. The study assessed two outcomes. For the overall stress measure, a total of four sessions took place during the first intervention phase and three sessions during the second intervention phase. For the parent feeling average measure (an assessment of feelings over the past 24 hours), a total of five sessions took place during the first intervention phase and seven sessions during the second intervention phase. Each intervention phase lasted approximately two weeks.
Comparison condition	Within the multiple baseline study design, baseline sessions lasted about two weeks in length, with a total of six sessions for the overall stress analysis and seven sessions for the parent feeling average analysis.
Funding source	ACF cooperative agreements to the University of Colorado Denver (grant 90PH0017), Yerington Paiute Tribe (grant 90TH0009), Port Gamble S'Klallam Tribe (Grant 90TH0002), and Yellowhawk Tribal Health Center (grant 90TH0022).
Author affiliation	None of the study authors are developers of this model.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV073858

Citation	Culp, A. M., Culp, R. E., Anderson, J. W., & Carter, S. (2007). Health and safety intervention with first time mothers. *Health Education Research, 22*(2), 285 294.
Study Characteristics	
Study participants	The study sample included 205 first-time pregnant women enrolled in Oklahoma's Community-Based Family Resource and Support (CBFRS) program. The study reported characteristics of the 156 women who remained enrolled in the intervention through completion. Mothers were, on average, 17.4 weeks pregnant at enrollment and 20 years old at the birth of their child. Most mothers were white (69 percent). Other participants were African American, Native American, Hispanic, or another race/ethnicity. On average, mothers had between 11 and 12 years of education and most were low-income. Most mothers were single (68 percent), 30 percent were married, and 2 percent were divorced or separated. Fifty-nine percent of mothers participated in Medicaid.
Setting	The model was implemented in five rural counties in Oklahoma.
Home visiting services	The model consisted of prenatal home visits until the child's first birthday. Home visits focused on teaching mothers about maternal and child health, child development, home safety, and parenting skills. The content and intensity of the model varied depending upon the stage of the intervention and the age of the child. Home visitors could tailor the standardized curriculum by selecting topics that addressed families' specific concerns or interests. During the prenatal phase, home visitors presented topics focused on maternal health, parenting roles, and education and employment goals. During postnatal visits they mostly focused on child development, parenting roles, and child health. In both prenatal and postnatal visits, home visitors spent the smallest proportion of their time discussing other topics, such as crisis management, environmental health, and friends and family. During pregnancy, the model was designed for weekly home visits in the first month of the intervention, followed by biweekly visits until the child's birth for a total of eight prenatal visits. After the child's birth, home visits were intended to occur weekly during the first three months of the child's life and biweekly for the remaining nine months, for a total of 30 postnatal visits. Each visit was intended to last about one hour.
Comparison condition	Similar rural counties in Oklahoma served as comparison. Comparison participants received standard health department services that did not include home visits.
Funding source	Funding was provided by the Office of Child Abuse Prevention, Oklahoma State Department of Health.
Author affiliation	None of the study authors are developers of this model.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV003731
Citation	Culp, A. M., Culp, R. E., Hechtner-Galvin, T., Howell, C. S., Saathoff-Wells, T., & Marr, P. (2004). First-time mothers in home visitation services utilizing child development specialists. *Infant Mental Health Journal*, *25*(1), 1–15. doi:10.1002/imhj.10086.
Study Characteristics	
Study participants	The study sample included 205 first-time pregnant women enrolled in Oklahoma's CBFRS program. The study reported characteristics of the 156 women who remained enrolled in the intervention through completion. Mothers were, on average, 17.4 weeks pregnant at enrollment and 20 years old at the birth of their child. Most mothers were white (69 percent). Other participants were African American, Native American, Hispanic, or another race/ethnicity. On average, mothers had between 11 and 12 years of education and most were low-income. Most mothers were single (68 percent), 30 percent were married, and 2 percent were divorced or separated. Fifty-nine percent of mothers participated in Medicaid.
Setting	The intervention was implemented in five rural counties in Oklahoma.

Citation	Culp, A. M., Culp, R. E., Anderson, J. W., & Carter, S. (2007). Health and safety intervention with first time mothers. *Health Education Research, 22*(2), 285 294.
Home visiting services	The intervention consisted of prenatal home visits until the child's first birthday. Home visits focused on teaching mothers about maternal and child health, child development, home safety, and parenting skills. The content and intensity of the intervention varied depending upon the stage of the intervention and the age of the child. Home visitors could tailor the standardized curriculum by selecting topics that addressed families' specific concerns or interests. During the prenatal phase, home visitors presented topics focused on maternal health, parenting roles, and education and employment goals. During postnatal visits they mostly focused on child development, parenting roles, and child health. In both prenatal and postnatal visits, home visitors spent the smallest proportion of their time discussing other topics, including crisis management, environmental health, and friends and family. During pregnancy, the intervention was designed for weekly home visits in the first month of the intervention, followed by biweekly visits until the child's birth for a total of eight prenatal visits. After the child's birth, home visits were intended to occur weekly during the first three months of the child's life and biweekly for the remaining nine months, for a total of 30 postnatal visits. Each visit was intended to last about one hour.
Comparison condition	Similar rural counties in Oklahoma served as comparison. Comparison participants received standard health department services that did not include home visits.
Funding source	Funding was provided by the Office of Child Abuse Prevention, Oklahoma State Department of Health.
Author affiliation	None of the study authors are developers of this model.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV003715
Citation	Duggan, A., Caldera, D., Rodriguez, K., Burrell, L., Rohde, C., & Crowne, S. S. (2007). Impact of a statewide home visiting program to prevent child abuse. *Child Abuse & Neglect, 31*(8), 801–827.
Study Characteristics	
Study participants	Between January 2000 and July 2001, 388 families who screened positive on a Healthy Families Alaska (HFAK) protocol for risk factors associated with poor health and social outcomes and received scores of 25 or higher on the Kempe Family Stress Checklist were recruited during pregnancy or at the time of birth (Duggan et al., 2007). Of these families, 364 consented to participate and were randomly assigned to the intervention group (n = 179) or the comparison group (n = 185). Of these, 325 families completed a baseline interview. The sample was 22 percent Alaska native, 55 percent Caucasian, 8 percent multiracial, and 15 percent other race. Fifty-eight percent of families were below poverty level, 58 percent of mothers had graduated from high school, and 73 percent had worked in the year before enrollment (Johns Hopkins University, 2005). The average age of mothers at baseline was 23.5 years. This study reports the second-year follow-up results of the HFAK evaluation, with a sample size of 138 intervention group primary caregivers and 140 comparison group primary caregivers. Most of the analyses are limited to families in which the biological mothers had custody of the index child at follow-up (249 families), with additional outcomes obtained from medical records (268 families). The findings included in this study were also described in an earlier report (Johns Hopkins University, 2005).
Setting	This study included six HFAK sites, two in Anchorage and one each in Wasilla, Fairbanks, Juneau, and Kenai.

Citation	Culp, A. M., Culp, R. E., Anderson, J. W., & Carter, S. (2007). Health and safety intervention with first time mothers. *Health Education Research, 22*(2), 285 294.
Home visiting services	Families in the intervention group were assigned to receive visits monthly until their child's birth and weekly thereafter. By design, families receive gradually less frequent visits as they reach critical milestones, ranging to quarterly visits at the highest level of functioning. Families were enrolled in the intervention until they functioned sufficiently to "graduate" or until their child turned 2. In practice, home visits were less frequent than intended, with only 4 percent of families receiving 75 percent or more of their designated frequency of visits and completing the full two years. Home visits were intended to emphasize preparing for child growth, development, and critical milestones; screening and referral for developmental delays; promoting a safe environment; positive parent-child interactions; establishing a "medical home" for the child; and supporting the family during crises. The intervention also emphasized the development of an individual family support plan (IFSP) or setting and monitoring progress toward individual family goals.
Comparison condition	Families assigned to the comparison condition received referrals to other community services.
Funding source	Alaska Mental Health Trust Authority and Alaska State Department of Health and Social Services.
Author affiliation	None of the study authors are developers of this model.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV003775
Citation	Duggan, A., Fuddy, L., Burrell, L., Higman, S. M., McFarlane, E., Windham, A., et al. (2004). Randomized trial of a statewide home visiting program to prevent child abuse: Impact in reducing parental risk factors. *Child Abuse & Neglect, 28*(6), 623–643.
Study Characteristics	
Study participants	Families were recruited to the study from November 1994 to December 1995. Hawaii Healthy Start Program staff screened the medical records of mothers from one of four Oahu communities delivering children at Kapiolani Maternity Hospital for risk factors for child abuse and neglect. Mothers found to be at risk, or those whose records did not contain sufficient information to screen out, were screened further using the Kempe Family Stress Checklist; eligible families were those in which either parent scored 25 or greater (Duggan, 2004a). Of the 897 families who were eligible to participate in the study, 730 (81 percent) agreed to participate and were randomly assigned to the intervention group (n = 395), the main comparison group (n = 290), or a testing comparison group (n = 45). A total of 684 families completed a baseline interview (373 families in the intervention group, 270 families in the main comparison group, and 41 in the testing group comparison). At baseline, mothers were, on average, age 23.7 years (intervention group) and 23.3 years (comparison group). Sixty-three percent (intervention group) and 67 percent (comparison group) of participating families lived below the poverty line. The racial composition of the intervention group was 34 percent Native Hawaiian or Pacific Islander, 28 percent Asian or Filipino, 10 percent Caucasian, and 27 percent of unknown primary ethnicity. The main comparison group consisted of 33 percent Native Hawaiian or Pacific Islander, 28 percent Asian or Filipino, 14 percent Caucasian, and 26 percent of unknown primary ethnicity. This study reports results from the first two follow-ups of the Hawaii Healthy Start randomized controlled trial. Follow-up interviews were completed for 88 percent of families in years 1 and 2, and 83 percent of participating families were included in both follow-ups.
Setting	Six Healthy Start Program sites operated by three community-based organizations in Oahu, Hawaii.

Citation	Culp, A. M., Culp, R. E., Anderson, J. W., & Carter, S. (2007). Health and safety intervention with first time mothers. *Health Education Research, 22*(2), 285 294.
Home visiting services	Home visiting services were designed to provide three to five years of home visiting, with weekly visits for most or all of the child's first year of life, and visits of gradually decreasing frequency thereafter depending on family need. Home visitors endeavored to establish trusting relationships with families, help them resolve immediate crises, and help them build on existing strengths to improve their ability to function independently. Visitors helped families develop problem-solving skills, connected them to needed services, and aimed to develop an individual service plan with each family every six months and help the family reach six-month goals. The actual frequency of visits, however, was lower than that specified by the model, with families receiving an average of 13 visits in the child's first year of life, and 51 percent of families not actively participating in the intervention by the time the child was 12 months old. Families still active at the end of Year 1 received an average of 22 visits in the first year.
Comparison condition	The main comparison group was tested annually to measure outcomes. A second "testing" comparison group was evaluated only at Year 3 to ascertain the effect of repeated testing on observed outcomes (Duggan et al., 2004).
Funding source	Maternal and Child Health Bureau (R40 MC 00029 [formerly MCJ 240637] and R40 MC 00123 [formerly MCJ 240838]); The Robert Wood Johnson Foundation (18303); The Annie E. Casey Foundation (94-4041); The David and Lucile Packard Foundation (93-6051, 94-7957, 97-8058, and 98-3448); the Hawaii State Department of Health (99-29-J); and the National Institute of Mental Health, Epidemiological Center for Early Risk Behaviors, P30MH38725.
Author affiliation	None of the study authors are developers of this model.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV012831

Citation	Duggan, A., McFarlane, E., Fuddy, L., Burrell, L., Higman, S. M., Windham, A., et al. (2004). Randomized trial of a statewide home visiting program: Impact in preventing child abuse and neglect. *Child Abuse & Neglect, 28*(6), 597 622.
Study Characteristics	
Study participants	Families were recruited to the study from November 1994 to December 1995. Hawaii Healthy Start Program staff screened the medical records of mothers from one of four Oahu communities delivering children at Kapiolani Maternity Hospital for risk factors for child abuse and neglect. Mothers found to be at risk, or those whose records did not contain sufficient information to screen out, were screened further using the Kempe Family Stress Checklist; eligible families were those in which either parent scored 25 or greater (Duggan, 2004a). Of the 897 families who were eligible to participate in the study, 730 (81 percent) agreed to participate and were randomly assigned to the intervention group (n = 395), the main comparison group (n = 290), or a testing comparison group (n = 45). A total of 684 families completed a baseline interview (373 families in the intervention group, 270 families in the main comparison group, and 41 in the testing group comparison). At baseline, mothers were, on average, age 23.7 years (intervention group) and 23.3 years (comparison group). Sixty-three percent (intervention group) and 67 percent (comparison group) of participating families lived below the poverty line. The racial composition of the intervention group was 34 percent Native Hawaiian or Pacific Islander, 28 percent Asian or Filipino, 10 percent Caucasian, and 27 percent of unknown primary ethnicity. The main comparison group consisted of 33 percent Native Hawaiian or Pacific Islander, 28 percent Asian or Filipino, 14 percent Caucasian, and 26 percent of unknown primary ethnicity. This study reports results from the three follow-ups of the Hawaii Healthy Start randomized controlled trial. In each follow-up year, interviews were completed for 88 percent of families. Eighty-one percent of participating families completed all three follow-up interviews. Data were also collected from home observations, administrative records from child protective services, and pediatric medical records.
Setting	Six Healthy Start Program sites operated by three community-based organizations in Oahu, Hawaii.
Home visiting services	Home visiting services were designed to provide three to five years of home visiting, with weekly visits for most or all of the child's first year of life, and visits of gradually decreasing frequency thereafter depending on family need. Home visitors endeavored to establish trusting relationships with families, help them resolve immediate crises, and help them build on existing strengths to improve their ability to function independently. Visitors helped families develop problem-solving skills, connected them to needed services, and aimed to develop an individual service plan with each family every six months and help the family reach six-month goals. The actual frequency of visits, however, was lower than that specified by the model, with families receiving an average of 13 visits in the child's first year of life, and 51 percent of families not actively participating in the intervention by the time the child was 12 months old. Families still active at the end of Year 1 received an average of 22 visits in the first year (Duggan et al., 1999).
Comparison condition	The main comparison group was tested annually to measure outcomes. A second testing comparison group was evaluated only at Year 3 to ascertain the effect of repeated testing on observed outcomes (Duggan et al., 2004).
Funding source	Maternal and Child Health Bureau (R40MC00029 [formerly MCJ 240637] and R40 MC 00123 [formerly MCJ 240838]; The Robert Wood Johnson Foundation (18303); The Annie E. Casey Foundation (94-4041); The David and Lucile Packard Foundation (93-6051, 94-7957, 97-8058, and 98-3448); National Institute of Mental Health, Epidemiological Center for Early Risk Behaviors, P30MH38725; the Hawaii State Department of Health (99-29-J); and the National Institute of Mental Health, Epidemiological Center for Early Risk Behaviors, P30MH38725.
Author affiliation	None of the study authors are developers of this model.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV012830

Citation	Duggan, A. K., McFarlane, E. C., Windham, A. M., Rohde, C. A., Salkever, D. S., Fuddy, L., et al. (1999). Evaluation of Hawaii s Healthy Start program. *Future of Children, 9*(1), 66 90; discussion 177 178.
Study Characteristics	
Study participants	Families were recruited to the study from November 1994 to December 1995. Hawaii Healthy Start Program staff screened the medical records of mothers from one of four Oahu communities delivering children at Kapiolani Maternity Hospital for risk factors for child abuse and neglect. Mothers found to be at risk, or those whose records did not contain sufficient information to screen out, were screened further using the Kempe Family Stress Checklist; eligible families were those in which either parent scored 25 or greater (Duggan, 2004a). Of the 897 families who were eligible to participate in the study, 730 (81 percent) agreed to participate and were randomly assigned to the intervention group (n = 395), the main comparison group (n = 290), or a testing comparison group (n = 45). A total of 684 families completed a baseline interview (373 families in the intervention group, 270 families in the main comparison group, and 41 in the testing group comparison). At baseline, mothers were, on average, age 23.7 years (intervention group) and 23.3 years (comparison group). Sixty-three percent (intervention group) and 67 percent (comparison group) of participating families lived below the poverty line. The racial composition of the intervention group was 34 percent Native Hawaiian or Pacific Islander, 28 percent Asian or Filipino, 10 percent Caucasian, and 27 percent of unknown primary ethnicity. The main comparison group consisted of 33 percent Native Hawaiian or Pacific Islander, 28 percent Asian or Filipino, 14 percent Caucasian, and 26 percent of unknown primary ethnicity. This study reports results from the first two follow-ups of the Hawaii Healthy Start randomized controlled trial. Follow-up interviews were completed for 88 percent of families in years 1 and 2, and 83 percent of participating families were included in both follow-ups.
Setting	Six Healthy Start Program sites operated by three community-based organizations in Oahu, Hawaii.
Home visiting services	Home visiting services were designed to provide three to five years of home visiting, with weekly visits for most or all of the child's first year of life, and visits of gradually decreasing frequency thereafter depending on family need. Home visitors endeavored to establish trusting relationships with families, help them resolve immediate crises, and help them build on existing strengths to improve their ability to function independently. Visitors helped families develop problem-solving skills, connected families to needed services, and aimed to develop an individual service plan with each family every six months and help the family reach six-month goals. The actual frequency of visits, however, was lower than that specified by the model, with families receiving an average of 13 visits in the child's first year of life, and 51 percent of families not actively participating in the intervention by the time the child was 12 months old. Families still active at the end of Year 1 received an average of 22 visits in the first year.
Comparison condition	The main comparison group was tested annually to measure outcomes. A second testing comparison group was evaluated only at Year 3 to ascertain the effect of repeated testing on observed outcomes (Duggan et al., 2004).
Funding source	From 1991 to 1994, this evaluation received funding from: the Robert Wood Johnson Foundation, the Annie E. Casey Foundation, The David and Lucile Packard Foundation, the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services, and the Hawaii Department of Health; the Hawaii Medical Association committed office space and an administrative home for fieldwork staff.
Author affiliation	None of the study authors are developers of this model.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV014665

Citation	El Kamary, S. S., Higman, S. M., Fuddy, L., McFarlane, E., Sia, C., & Duggan, A. K. (2004). Hawaii s Healthy Start home visiting program: Determinants and impact of rapid repeat birth. *Pediatrics, 114*(3), e317 e326.
Study Characteristics	
Study participants	Families were recruited to the study from November 1994 to December 1995. Hawaii Healthy Start Program staff screened the medical records of mothers from one of four Oahu communities delivering children at Kapiolani Maternity Hospital for risk factors for child abuse and neglect. Mothers found to be at risk, or those whose records did not contain sufficient information to screen out, were screened further using the Kempe Family Stress Checklist; eligible families were those in which either parent scored 25 or greater (Duggan, 2004a). Of the 897 families who were eligible to participate in the study, 730 (81 percent) agreed to participate and were randomly assigned to the intervention group (n = 395), the main comparison group (n = 290), or a testing comparison group (n = 45). A total of 684 families completed a baseline interview (373 families in the intervention group, 270 families in the main comparison group, and 41 in the testing group comparison). At baseline, mothers were, on average, age 23.7 years (intervention group) and 23.3 years (comparison group). Sixty-three percent (intervention group) and 67 percent (comparison group) of participating families lived below the poverty line. The racial composition of the intervention group was 34 percent Native Hawaiian or Pacific Islander, 28 percent Asian or Filipino, 10 percent Caucasian, and 27 percent of unknown primary ethnicity. The main comparison group consisted of 33 percent Native Hawaiian or Pacific Islander, 28 percent Asian or Filipino, 14 percent Caucasian, and 26 percent of unknown primary ethnicity. This study reports results from the three follow-ups of the Hawaii Healthy Start randomized controlled trial. In each follow-up year, interviews were completed for 88 percent of families. Eighty-one percent of participating families completed all three follow-up interviews.
Setting	Six Healthy Start Program sites operated by three community-based organizations in Oahu, Hawaii.
Home visiting services	Home visiting services were designed to provide three to five years of home visiting, with weekly visits for most or all of the child's first year of life, and visits of gradually decreasing frequency thereafter depending on family need. Home visitors endeavored to establish trusting relationships with families, help them resolve immediate crises, and help them build on existing strengths to improve their ability to function independently. Visitors helped families develop problem-solving skills, connected them to needed services, and aimed to develop an individual service plan with each family every six months and help the family reach six-month goals. The actual frequency of visits, however, was lower than that specified by the model, with families receiving an average of 13 visits in the child's first year of life, and 51 percent of families not actively participating in the intervention by the time the child was 12 months old. Families still active at the end of Year 1 received an average of 22 visits in the first year.
Comparison condition	The main comparison group was tested annually to measure outcomes. A second testing comparison group was evaluated only at Year 3 to ascertain the effect of repeated testing on observed outcomes (Duggan et al., 2004).
Funding source	Maternal and Child Health Bureau (grant R40 MC 00029, formerly grant MCJ-240637, and grant R40 MC 00123, formerly grant MCJ-240838), the Robert Wood Johnson Foundation (grant 18303), the Annie E. Casey Foundation (grant 94–4041), the David and Lucile Packard Foundation (grants 93–6051, 94–7957, 97–8058, and 98–3448), and the Hawaii State Department of Health (grant 99-29-J).
Author affiliation	None of the study authors are developers of this model.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV003728
Citation	Fergusson, D. M., Horwood, L. J., Grant, H., & Ridder, E. M. (2005). *Early Start evaluation report.* Christchurch, New Zealand: Early Start Project Ltd.

Citation	El Kamary, S. S., Higman, S. M., Fuddy, L., McFarlane, E., Sia, C., & Duggan, A. K. (2004). Hawaii s Healthy Start home visiting program: Determinants and impact of rapid repeat birth. *Pediatrics, 114*(3), e317 e326.
Study Characteristics	
Study participants	The intervention enrolled 206 families. Mothers were 25 years old and fathers were 27 years old, on average. Children were enrolled as infants and were eligible for up to 5 years. Twenty-five percent of mothers and 31 percent of biological fathers identified as Māori, an indigenous population of New Zealand. Mothers were on average 19 years old during their first pregnancy, and 14 percent had been pregnant before age 16. About 14 percent of mothers who had a previous child reported that the child was in foster care, and 35 percent of current male partners were reported to have assaulted their partners. Most parents (71 percent of mothers and 78 percent of fathers) lacked formal education credentials. Nearly two-thirds of families (64 percent) were headed by a single parent, most families (88 percent) received public assistance, and 40 percent had income that was considered inadequate or very inadequate to meet the costs of daily living.
Setting	The intervention was located in Christchurch, New Zealand.
Home visiting services	Early Start (New Zealand) consisted of home visits and parenting classes. Community nurses referred clients to the intervention based on an oral assessment. Referred families participated in a one-month assessment period during which they could learn about the intervention without making a long-term commitment and program staff could conduct a more in-depth needs assessment. After this one-month period, families that did not exhibit a high need received a telephone call every three months. Home visits for other families focused on two family plans. A family support plan described common issues to address over the next three months (such as child abuse or neglect) and steps to address them. Second, families prepared an individual family plan that delineated their goals for the same period. The home visitors used a collaborative, problem-solving approach in working with families to carry out these plans. The frequency of home visits corresponded with the families' need. High-need families (Level 1) received one to two hours of home visits per week. Moderate-need families (Level 2) received up to one hour of home visits every two weeks. Low-need families (Level 3) received up to one hour of home visits per month. Graduate-level families (Level 4) received up to one-hour of contact with a worker by telephone or through a home visit every three months. All families began at Level 1 and moved to other levels based on their individual progress. Services were offered for up to five years. Early Start families participated in the intervention for a median duration of 14 months. Almost three-fourths (74 percent) of families actively received services after 12 months, 65 percent were active after 24 months, and 60 percent still received services at 36 months.
Comparison condition	The comparison group had access to the full range of other health, welfare, and related services available in Christchurch.
Funding source	The Department of Child, Youth and Family, Ministry of Health, Canterbury District Health Board, Christchurch City Council, Trustbank Community Trust, and Health Research Council of New Zealand.
Author affiliation	One co-author is the general manager of Early Start.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV014620
Citation	Johns Hopkins University. (2005). *Evaluation of the Healthy Families Alaska program.* Report to Alaska State Department of Health and Social Services, Alaska Mental Health Trust Authority. Baltimore, MD: Author.

Citation	El Kamary, S. S., Higman, S. M., Fuddy, L., McFarlane, E., Sia, C., & Duggan, A. K. (2004). Hawaii s Healthy Start home visiting program: Determinants and impact of rapid repeat birth. *Pediatrics, 114*(3), e317 e326.
Study Characteristics	
Study participants	Between January 2000 and July 2001, 388 families who screened positive on a Healthy Families Alaska (HFAK) protocol for risk factors associated with poor health and social outcomes and received scores of 25 or higher on the Kempe Family Stress Checklist were recruited during pregnancy or at the time of birth (Duggan et al., 2007). Of these families, 364 consented to participate and were randomly assigned to the intervention group (n = 179) or the comparison group (n = 185). 325 families completed a baseline interview. The sample was 22 percent Alaska native, 55 percent Caucasian, 8 percent multiracial, and 15 percent were other race. 58 percent of families were below poverty level, 58 percent of mothers had graduated from high school, and 73 percent had worked in the year before enrollment (Johns Hopkins University, 2005). The average age of mothers at baseline was 23.5 years. This study reports the second-year follow-up results of the HFAK evaluation, with a sample size of 138 intervention group primary caregivers and 140 comparison group primary caregivers. Most of the analyses of interview data reported by the authors are limited to biological mothers with custody of the index child at follow-up (249 families). Additional findings are reported from medical records (268 families), child protective services reports (309 families), and observational data (~237 families). Note: Information on sample size was received through communication with the author.
Setting	This study included six HFAK sites, two in Anchorage and one each in Wasilla, Fairbanks, Juneau, and Kenai.
Home visiting services	Families in the intervention group were assigned to receive visits monthly until their child's birth and weekly thereafter. By design, families receive gradually less frequent visits as they reach critical milestones, ranging to quarterly visits at the highest level of functioning. Families were enrolled in the intervention until they functioned sufficiently to "graduate" or until their child turned 2. In practice, home visits were less frequent than intended, with only 4 percent of families receiving 75 percent or more of their designated frequency of visits and completing the full two years. Home visits were intended to emphasize preparing for child growth, development, and critical milestones, screening and referral for developmental delays, promoting a safe environment, positive parent-child interactions, establishing a "medical home" for the child, and supporting the family during crises. The program also emphasized the development of an individual family support plan (IFSP) or setting and monitoring progress toward individual family goals.
Comparison condition	Families assigned to the comparison condition received referrals to other community services.
Funding source	Alaska Mental Health Trust Authority; Alaska State Department of Health and Social Services
Author affiliation	None of the study authors are developers of this model.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV014203

Citation	King, T. M., Rosenberg, L. A., Fuddy, L., McFarlane, E., Sia, C., & Duggan, A. K. (2005). Prevalence and early identification of language delays among at risk three year olds. *Journal of Developmental & Behavioral Pediatrics, 26*(4), 293 303.
Study Characteristics	
Study participants	Families were recruited to the study from November 1994 to December 1995. Hawaii Healthy Start Program staff screened the medical records of mothers from one of four Oahu communities delivering children at Kapiolani Maternity Hospital for risk factors for child abuse and neglect. Mothers found to be at risk, or those whose records did not contain sufficient information to screen out, were screened further using Kempe's Family Stress Checklist; eligible families were those in which either parent scored 25 or greater. Of the 897 families who were eligible to participate in the study, 730 (81 percent) agreed to participate and were randomly assigned to the intervention group (n = 395), the main comparison group (n = 290), or a testing comparison group (n = 45). This study focuses on 304 intervention group children and 209 comparison group children who had available medical records and developmental testing results at age 3 and whose mothers completed at least one interview. At baseline, mothers were, on average, age 23.7 years (intervention group) and 22.9 years (comparison group). Sixty-two percent (intervention group) and 64 percent (comparison group) of participating families lived below the poverty line. The racial composition of the intervention sample was 34 percent Native Hawaiian or Pacific Islander, 27 percent Asian or Filipino, 11 percent Caucasian, and 29 percent of unknown primary ethnicity. The comparison group consisted of 33 percent Native Hawaiian or Pacific Islander, 28 percent Asian or Filipino, 12 percent Caucasian, and 28 percent of unknown primary ethnicity.
Setting	Six Healthy Start Program sites operated by three community-based organizations in Oahu, Hawaii.
Home visiting services	Home visiting services were designed to provide three to five years of home visiting, with weekly visits for most or all of the child's first year of life, and visits of gradually decreasing frequency thereafter depending on family need. Home visitors endeavored to establish trusting relationships with families, help them resolve immediate crises, and help them build on existing strengths to improve their ability to function independently. Visitors helped families develop problem-solving skills, connected them to needed services, and aimed to develop an individual service plan with each family every six months and help the family reach six-month goals. The actual frequency of visits, however, was lower than that specified by the model, with families receiving an average of 13 visits in the child's first year of life, and 51 percent of families not actively participating in the program by the time the child was 12 months. Families still active at the end of Year 1 received an average of 22 visits in the first year (Duggan et al., 1999).
Comparison condition	The main comparison group was tested annually to measure outcomes. A second testing comparison group was evaluated only at Year 3 to ascertain the effect of repeated testing on observed outcomes (Duggan et al., 2004).
Funding source	Maternal and Child Health Bureau (R40 MC 00029, formerly MCJ 240637, and R40 MC 00123, formerly MCJ 240838); The Robert Wood Johnson Foundation (18303); The Annie E. Casey Foundation (94-4041); The David and Lucile Packard Foundation (93-6051, 94-7957, 97-8058, and 98-3448); and the Hawaii State Department of Health (99-29-J). Dr. King's effort was also supported by a National Research Service Award from the Health Resources and Services Administration, Bureau of Health Professions (5 T32 HP 10004).
Author affiliation	None of the study authors are developers of this model.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV004008

Citation	Pfannenstiel, J. (2015). Evaluation of the i3 validation of improving education outcomes for American Indian children. Unpublished manuscript.
Study Characteristics	
Study participants	Families were recruited to the study from the catchment areas of 20 Bureau of Indian Education (BIE) schools that had not implemented the Family and Child Education (FACE) program before (one of the programs withdrew from the grant after two years and is not included in the study). Data from families from 19 of the schools were included in the non-experimental comparison group design (NED) study; one site with more eligible families than space in the program was also included in a randomized controlled trial (RCT). The NED study included a total of 1,329 participants: 853 in the intervention group, 476 in the comparison group. In the NED (which included the sample analyzed in the RCT) 49 percent of children in the intervention group and 55 percent of children in the comparison group were male. Twenty-five percent of mothers in the intervention group and 21 percent of mothers in the comparison group had completed less than high school education. Most children were from two-parent households. Seventy-three percent families in the intervention and comparison groups received Supplemental Nutrition Assistance Program benefits. Within the RCT, a total of 129 families were randomized, with 63 families assigned to receive Baby FACE, and 66 assigned to the business-as-usual comparison group.
Setting	The study included 20 BIE school catchment areas located across Arizona, Idaho, New Mexico, North Carolina, South Dakota, Washington state.
Home visiting services	Baby FACE is based on the Parents as Teachers model. Those assigned to the intervention group received home visits by certified parent educators, developmental screenings, group meetings with other parents known as Family Circle, and referrals to community resources. Initial home visits focused on the foundational topics of the model; then, home visitors could decide the curriculum they would use based on the family's goals and needs.
Comparison condition	Individuals in the comparison group did not receive services from parent educators, but could have sought and accessed community resources or existing programs on their own.
Funding source	Institute of Education Sciences U.S. Department of Education, grant U396B100189.
Author affiliation	The study author is not a model developer or distributor. The author was contracted by the implementers to independently evaluate Baby FACE.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV058030

Citation	Silovsky, J. F., Bard, D., Chaffin, M., Hecht, D., Burris, L., Owora, A., Beasley, L., Doughty, D., & Lutzker, J. (2011). Prevention of child maltreatment in high risk rural families: A randomized clinical trial with child welfare outcomes. *Children and Youth Services Review*, *33*(8), 1435 1444.
Study Characteristics	
Study participants	The study participants included 105 parents who were at least 16 years of age, had at least one child age 5 years or younger, and had at least one of the following risk factors: parental substance abuse, mental health issues, or intimate partner violence. Participants were randomly assigned to an intervention condition, SafeCare Augmented (SafeCare with the addition of Motivational Interviewing, as well as training of the home visitors on identification and response to imminent child maltreatment and risk factors of substance abuse, depression, and intimate partner violence) or a comparison condition, services as usual (standard home-based mental health services). Sixty-eight percent of participants in the intervention group and 74 percent in the comparison group were white, 15 percent of participants in the intervention and 14 percent in the comparison group were African American, 15 percent of participants in the intervention group and 7 percent in the comparison group were American Indian, and 2 percent of participants in the intervention group and 4 percent in the comparison group were Hispanic. The average age of intervention group participants was 25.9 years and of comparison participants was 27.7 years. All participants were female. Most study participants had a high school degree or equivalent or less education (60 percent of the intervention group and 55 percent of the comparison group). More than half of participants were employed at least part-time (54 percent of the intervention group and 56 percent of the comparison group).
Setting	The study was conducted in a rural county in the Southwest.
Home visiting services	SafeCare is a home-based model that focuses on parenting behavior related to child health, home safety and cleanliness, and parent-child bonding. Home visitors typically provide 18 to 20 weeks of training to parents with children from birth to age 5. During one-to two-hour weekly home visits, trained home visitors conduct baseline and follow-up assessments, observations, and trainings with parents. For this study, SafeCare was augmented. The enhanced model consisted of the regular SafeCare model with the addition of Motivational Interviewing (Miller & Rollnick, 2004), as well as training of the home visitors on identification and response to imminent child maltreatment and risk factors of substance abuse, depression, and intimate partner violence.
Comparison condition	The comparison condition was the standard provision of home-based mental health services. Services as usual utilized standard community mental health program approaches and included individual and family therapy as well as case management services. Goal setting and intervention planning varied among families and was designed to fit the specific family's needs, such as parenting, anger management, substance abuse, depression, and anxiety
Funding source	No information was available in the study about the funding source.
Author affiliation	The developer of SafeCare, John Lutzker, is a study author.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV027968

Citation	Walker, N., Johnston, V., Glover, M., Bullen, C., Trenholme, A., Chang, A., Morris, P., Segan, C., Brown, N., Fenton, D., Hawthorne, E., Borland, R., Parag, V., Von Blaramberg, T., Westphal, D., & Thomas, D. (2015). Effect of a family centered, secondhand smoke intervention to reduce respiratory illness in indigenous infants in Australia and New Zealand: A randomized controlled trial. *Nicotine & Tobacco Research, 17*(1), 48 57.
Study Characteristics	
Study participants	Mothers were recruited by community workers through antenatal clinics and identification through hospital birth records and randomized in a 1:1 ratio to the intervention or comparison group. The study used blocked randomization in which families were stratified by country (Australia or New Zealand). Overall, 321 eligible mother/infants were randomized (n = 161 intervention , n = 160 comparison). Post-randomization—but before baseline data collection and before implementation began—28 dyads dropped out, leaving 145 mothers in the intervention group and 148 in the comparison group; all of these mothers completed the baseline assessment. At 4-month follow-up, 134 mothers were in the intervention group and 132 in the comparison l group; at 12 months, 126 were in the intervention group and 128 in the comparison group. Eligibility criteria were: (1) infant from birth to age 5 weeks; (2) mother self-identified as Māori or Australian Aboriginal/Torres Strait Islander; (3) mother was at least 16 years old; (4) mother was a current smoker or at least one other household member was a smoker; (5) mother permanently resided with the infant; (6) mother lived in Darwin/Greater Darwin area in Australia or in the Counties Manukau District Health Board region in New Zealand; (7) infant was a singleton or the first born if a multiple delivery; and (8) mother spoke English and/or Māori. At baseline—excluding 28 mothers/infants who were assigned but did not contribute to baseline data—about three-fourths of the mothers were from New Zealand; mothers (in both countries) were, on average, 26 years old; infants were about 6 weeks old; and most mothers (about 75 percent) at most had a secondary school level of education. Most mothers identified as current smokers (intervention = 72 percent, comparison = 60 percent). About 80 percent of mothers breastfed at least partially.
Setting	Darwin, Australia, and Auckland, New Zealand
Home visiting services	The intervention group received usual care plus three home visits during the infant's first three months. All mothers (and other present family members) who smoked received behavioral coaching about the dangers of secondhand smoke exposure to children, smoking restrictions in the home and car, positive role modeling, and strategies to overcoming obstacles to making smoke-free changes. Those who smoked also received brief advice on quitting, or more intensive counseling depending on how receptive the participant was, and free nicotine replacement therapy and/or a quitline referral (unless the participant was clearly not interested in these options). The intervention was based on Māori and Aboriginal holistic health models. Both the intervention and comparison groups also received brief health promotion messages from community workers at baseline and when infants were 4 and 12 months old. Messages focused on immunization, infant nutrition/breastfeeding, and safe infant sleeping.
Comparison condition	The comparison group received usual care from hospital and primary care providers. Both the intervention and comparison groups also received brief health promotion messages from community workers at baseline and when infants were 4 and 12 months old. Messages focused on immunization, infant nutrition/breastfeeding, and safe infant sleeping.
Funding source	Two authors have consulted for manufacturers of smoking cessation medications. All authors declared that they did not receive support from any companies for the paper and that the trial was designed, conducted, and analyzed by researchers independent of all funders. The funding sources for the trial or paper are not reported.

Citation	**Walker, N., Johnston, V., Glover, M., Bullen, C., Trenholme, A., Chang, A., Morris, P., Segan, C., Brown, N., Fenton, D., Hawthorne, E., Borland, R., Parag, V., Von Blaramberg, T., Westphal, D., & Thomas, D. (2015). Effect of a family centered, secondhand smoke intervention to reduce respiratory illness in indigenous infants in Australia and New Zealand: A randomized controlled trial. *Nicotine & Tobacco Research, 17*(1), 48 57.**
Author affiliation	Authors David Thomas, Anne Chang, and Vanessa Johnston conceived the original idea for the trial. Others were involved in the trial. Authors are affiliated with universities and/or public health entities.
Link to manuscript	This study is not on the HomVEE website.
Citation	Walkup, J. T., Barlow, A., Mullany, B. C., Pan, W., Goklish, N., Hasting, R., Cowboy, B., Fields, P., Baker, E. V., Speakman, K., Ginsburg, G., & Reid, R. (2009). Randomized controlled trial of a paraprofessional-delivered in-home intervention for young reservation-based American Indian mothers. *Journal of the American Academy of Child & Adolescent Psychiatry, 48*(6), 591–601.
Study Characteristics	
Study participants	Expectant reservation-based American Indian mothers ages 12 to 22 years with 28 weeks or less of gestation were eligible for participation. Randomized participants ranged in age from 14 to 22 years, with a median age of 18. All were American Indian, primarily Navajo (65 percent), White Mountain Apache (18 percent), or from mixed tribes. At enrollment, 8 percent were married, and 10 percent had one or more children. Slightly more than a third (39 percent) of the sample completed high school, a general equivalency diploma, or some college, and 12 percent were employed. Sixty-eight percent of the participants were living with their male partners, and 72 percent were living with their parents or the baby's father's parents.
Setting	The model was implemented in four American Indian health service catchment areas on the Navajo and White Mountain Apache reservations in New Mexico and Arizona.
Home visiting services	The Family Spirit model was developed to address newborn care and maternal life skills among young American Indian pregnant and parenting mothers living on reservations. The model's goals were (1) to increase mothers' parenting knowledge and involvement, infants' social and emotional behavior, and the quality of the home environment; and (2) to reduce stress, depression, and substance use among mothers. Families in Family Spirit participated in home visits. The model was modeled on Healthy Families America (HFA), a national model founded on 12 research-based principles to ensure quality of home visiting interventions for at-risk families. The content of the home-visiting intervention was derived from extensive community input on what teen parents needed to learn and was based on the *American Academy of Pediatrics Guide to Baby Care: Caring for Your Baby and Young Child: Birth to Age 5*. Cultural adaptations—including style, graphics, delivery, and content—were achieved through a community-based participatory process.
Comparison condition	Comparison participants received a breastfeeding/nutrition education intervention over the course of 23 visits from paraprofessionals.
Funding source	Support for this research was provided by the Substance Abuse Mental Health Services Administration, the Ford Foundation, the Annie E. Casey Foundation, and the C.S. Mott Foundation.
Author affiliation	Ms. Barlow is part of the team that developed this model. Dr. Walkup was affiliated with the Center for American Indian Health at the Johns Hopkins Bloomberg School of Public Health, where the team that developed this model is based.
Link to manuscript	https://homvee.acf.hhs.gov/study-detail?title=WWHV004065

Appendix D.

List of manuscripts consulted for HomVEE's review of research with tribal populations

This page has been left blank for double sided copying.

Citation	Model[a]
Anand, S. S., Davis, A. D., Ahmed, R., Jacobs, R., Xie, C., Hill, A., . . . Yusuf, S. (2007). A family-based intervention to promote healthy lifestyles in an Aboriginal community in Canada. *Canadian Journal of Public Health. Revue Canadienne de Santé Publique*, *98(*6), 447–452.	SHARE-ACTION
Bailey, D., Applequist, K., & North, C. U. (1997). Parent perceptions of home visitors: A comparative study of parents who are American Indian and non-Indian parents. Washington, DC: U.S. Department of Education.	Early intervention services
Bair-Merritt, M. H., Jennings, J. M., Chen, R., Burrell, L., McFarlane, E., Fuddy, L., & Duggan, A. K. (2010). Reducing maternal intimate partner violence after the birth of a child: A randomized controlled trial of the Hawaii Healthy Start home visitation program. *Journal of the American Medical Association*, *164*(1), 16–23.	Healthy Families America/HFA - Hawaii Healthy Start
Barlow, A., Mullany, B., Neault, N., Billy, T., Hastings, R., Lorenzo, S., . . . Walkup, J. T. (2014). A randomized controlled trial of a paraprofessional delivered, home-visiting intervention: Three-year outcomes for American Indian teen mothers and their children. Manuscript in submission.	Family Spirit
Barlow, A., Mullany, B., Neault, N., Compton, S., Carter, A., Hastings, R., . . . Walkup, J. (2013). Effect of a paraprofessional home visiting intervention on American Indian teen mothers' and infants' behavioral risks: A randomized controlled trial. *American Journal of Psychiatry*, *170*(1), 83–93.	Family Spirit
Barlow, A., Mullany, B., Neault, N., Goklish, N., Billy, T., Hastings, R., . . . Walkup, J. T. (2015). Paraprofessional-delivered home-visiting intervention for American Indian teen mothers and children: 3-Year Outcomes From a randomized controlled trial. *American Journal of Psychiatry*, *172*(2), 154–162.	Family Spirit
Barlow, A., Varipatis-Baker, E., Speakman, K., Ginsburg, G., Friberg, I., Goklish, N., . . . Walkup, J. (2006). Home-visiting intervention to improve child care among American Indian adolescent mothers: A randomized trial. *Archives of Pediatrics & Adolescent Medicine*, *160*(11), 1101–1107.	Family Spirit
Booth-LaForce, C., and Oxford, M. L. (2018). Randomized controlled trial of the Promoting First Relationships® preventive intervention for primary caregivers and toddlers in an American Indian community. Unpublished manuscript submitted to HomVEE.	Promoting First Relationships[a]
Boyd, A. (1997a). Parents as First Teachers pilot project evaluation (PAFT): Report on South Auckland area. Wellington, New Zealand: Ministry of Education.	Parents as First Teachers/PAT (Parents as First Teachers/PAFT- New Zealand)
Boyd, A. (1997b). Parents as First Teachers pilot project evaluation (PAFT): Report on Whangarei region: Final complete draft. Wellington, New Zealand: Ministry of Education.	Parents as First Teachers/PAT (Parents as First Teachers/PAFT- New Zealand)
Burd, L., Peterson, M., Face, G. C., Face, F. C., Shervold, D., & Klug, M. G. (2007). Efficacy of a SIDS risk factor education methodology at a Native American and Caucasian site. *Maternal & Child Health Journal*, *11*(4), 365–371.	SIDS risk factor education program
Caldera, D., Burrell, L., Rodriguez, K., Crowne, S. S., Rohde, C., & Duggan, A. (2007). Impact of a statewide home visiting program on parenting and on child health and development. *Child Abuse & Neglect*, *31*(8), 829–852.	Healthy Families America/HFA - Healthy Families Alaska
Campbell, K. I., & Silva, P. A. (1997). Parents as First Teachers pilot programme evaluation: Age three assessments. Final report to the Ministry of Education on the Dunedin and Gisborne/East Coast areas. Wellington, New Zealand: Ministry of Education.	Parents as First Teachers/PAT (Parents as First Teachers/PAFT- New Zealand)

Citation	Model[a]
Campbell, S., McCalman, J., Redman-MacLaren, M., Canuto, K., Vine, K., Sewter, J., & McDonald, M. (2018). Implementing the Baby One Program: A qualitative evaluation of family-centred child health promotion in remote Australian Aboriginal communities. *BMC Pregnancy and Childbirth*, *18*(1), 73.	Baby One Program
Caron, E., Bernard, K., & Dozier, M. (2015). In vivo feedback predicts parent behavior change in the Attachment and Biobehavioral Catch-up intervention. Unpublished manuscript.	Attachment and Biobehavioral Catch-up – Infant (ABC-Infant)
Chaffin, M., Bard, D., Bigfoot, D. S., & Maher, E. J. (2012). Is a structured, manualized, evidence-based treatment protocol culturally competent and equivalently effective among American Indian parents in child welfare? *Child Maltreatment*, *17*(3), 242-252.	SafeCare/Project 12-Ways
Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). A statewide trial of the SafeCare home-based services model with parents in Child Protective Services. *Pediatrics*, *129*(3), 509-515.	SafeCare/Project 12-Ways
Chomos, J. C., Evans, W. P., Bolan, M., Merritt, L., Meyer, A., & Novins, D. K. (2018a). Using single-case designs to evaluate components of tribal home-visitation programs: Tribal community one. *Infant Mental Health Journal*, *39*(3), 335-346.	Parents as Teachers/PAT
Chomos, J. C., Evans, W. P., Bolan, M., Merritt, L., Meyer, A., & Novins, D. K. (2018b). Using single-case designs to evaluate components of tribal home-visitation programs: Tribal community two. *Infant Mental Health Journal*, *39*(3), 335-346.	Nurse Family Partnership/NFP
Coughlin, R. L., Kushman, E., Copeland, G., & Wilson, M. L. (2010). Pregnancy and birth outcome improvements for American Indians in the Healthy Start project of the Inter-Tribal Council of Michigan, 1998–2008: An 11-year cohort study. Unpublished manuscript.	Inter-Tribal Council of Michigan's (ITC of MI) Healthy Start project (Maajtaag Mnobmaadzid)
Culp, A. M., Culp, R. E., Anderson, J. W., & Carter, S. (2007). Health and safety intervention with first-time mothers. *Health Education Research*, *22*(2), 285–294.	Oklahoma Community-Based Family Resource and Support Program
Culp, A. M., Culp, R. E., Hechtner-Galvin, T., Howell, C. S., Saathoff-Wells, T., & Marr, P. (2004). First-time mothers in home visitation services utilizing child development specialists. *Infant Mental Health Journal*, *25*(1), 1–15. doi:10.1002/imhj.10086.	Oklahoma Community-Based Family Resource and Support Program
Daro, D., McCurdy, K., & Harding, K. (1998). The role of home visitation in preventing child abuse: An evaluation of the Hawaii Healthy Start project. Unpublished manuscript.	Healthy Families America/HFA - Hawaii Healthy Start
Davis, C. L., & Prater, S. L. (2001). A perinatal intervention program for urban American Indians part 1: Design, implementation, and outcomes. *Journal of Perinatal Education: An ASPO/Lamaze Publication*, *10*(3), 9–19.	Perinatal intervention program
Dew, B., & Breakey, G. (2004). Can a modest intervention prevent a major problem? Evidence from a child abuse prevention program. Unpublished manuscript.	Healthy Families America/HFA - Hawaii Healthy Start
Duggan, A., Caldera, D., Rodriguez, K., Burrell, L., Rohde, C., & Crowne, S. S. (2007). Impact of a statewide home visiting program to prevent child abuse. *Child Abuse & Neglect*, *31*(8), 801–827.	Healthy Families America/HFA - Healthy Families Alaska
Duggan, A., Fuddy, L., Burrell, L., Higman, S. M., McFarlane, E., Windham, A., et al. (2004). Randomized trial of a statewide home visiting program to prevent child abuse: Impact in reducing parental risk factors. *Child Abuse & Neglect*, *28*(6), 623–643.	Healthy Families America/HFA - Hawaii Healthy Start

Citation	Model[a]
Duggan, A., McFarlane, E., Fuddy, L., Burrell, L., Higman, S. M., Windham, A., & Sia, C. (2004). Randomized trial of a statewide home visiting program: Impact in preventing child abuse and neglect. *Child Abuse & Neglect*, *28*(6), 597–622.	Healthy Families America/HFA - Hawaii Healthy Start
Duggan, A. K., McFarlane, E. C., Windham, A. M., Rohde, C. A., Salkever, D. S., Fuddy, L., . . . Sia, C. C. (1999). Evaluation of Hawaii's Healthy Start program. *Future of Children*, *9*(1), 66–90; discussion 177–178.	Healthy Families America/HFA - Hawaii Healthy Start
Duggan, A., Windham, A., McFarlane, E., Fuddy, L., Rohde, C., Buchbinder, S., . . . Sia, C. (2000). Hawaii's Healthy Start program of home visiting for at-risk families: Evaluation of family identification, family engagement, and service delivery. *Pediatrics*, *105*(1, Pt. 3), 250–259.	Healthy Families America/HFA - Hawaii Healthy Start
Durning, P. (1997). Parents as First Teachers [Ko Nga Matua Hei Kaiako Tuatahi]: Pilot PAFT process report. Wellington, New Zealand: Royal New Zealand Plunket Society.	Parents as First Teachers/PAT (Parents as First Teachers/PAFT- New Zealand)
El-Kamary, S. S., Higman, S. M., Fuddy, L., McFarlane, E., Sia, C., & Duggan, A. K. (2004). Hawaii's Healthy Start home visiting program: Determinants and impact of rapid repeat birth. *Pediatrics*, *114*(3), e317–e326.	Healthy Families America/HFA - Hawaii Healthy Start
Ernst, C. C., Grant, T. M., Streissguth, A. P., & Sampson, P. D. (1999). Intervention with high-risk alcohol and drug-abusing mothers: II. Three-year findings from the Seattle model of paraprofessional advocacy. *Journal of Community Psychology*, *27*(1), 19–38.	Parent-Child Assistance Program (PCAP)
Farquhar, S. (2003). Parents as First Teachers: A study of the New Zealand PAFT programme. Wellington, New Zealand: ChildForum Research.	Parents as First Teachers/PAT (Parents as First Teachers/PAFT- New Zealand)
Fatti, G., Shaikh, N., Eley, B., & Grimwood, A. (2013). Improved virological suppression in children on antiretroviral treatment receiving community-based adherence support: A multicentre cohort study from South Africa. *AIDS Care*. Advance online publication.	Kheth'Impilo's Community-Based Adherence Support (CBAS)
Feres-Lewin, C. (2000). An analysis of the governance and administrative elements of a public-private partnership approach to community-based education. (Doctoral Dissertation, University of Nevada, Las Vegas, 2000; 0506 Advisor: Chair Teresa S. Jordan). Dissertation Abstracts International, 61 (05A), 247–1689.	Healthy Families America/HFA
Fergusson, D. M., Horwood, L. J., Grant, H., & Ridder, E. M. (2005). *Early Start evaluation report*. Christchurch, New Zealand: Early Start Project Ltd.	Early Start (New Zealand)
Fisher, P. A., & Ball, T. J. (2002). The Indian Family Wellness Project: An application of the tribal participatory research model. *Prevention Science*, *3*(3), 235–240.	Indian Family Wellness Project
Gfellner, B. M., McLaren, L., & Metcalfe, A. (2008). The Parent-Child Home Program in Western Manitoba: A 20-year evaluation. *Child Welfare*, *87*(5), 49–67.	ParentChild+® Core Model
Grant, T. M., Ernst, C. C., Streissguth, A., & Stark, K. (2005). Preventing alcohol and drug exposed births in Washington state: Intervention findings from three Parent-Child Assistance Program sites. *American Journal of Drug & Alcohol Abuse*, *31*(3), 471–490.	Parent-Child Assistance Program (PCAP)
Grant, T., Christopher Graham, J., Ernst, C. C., Michelle Peavy, K., & Brown, N. N. (2014). Improving pregnancy outcomes among high-risk mothers who abuse alcohol and drugs: Factors associated with subsequent exposed births. *Children and Youth Services Review*, *46*, 11–18.	Parent-Child Assistance Program (PCAP)

Citation	Model[a]
Grant, T., Huggins, J., Graham, C., Ernst, C., Whitney, N., & Wilson, D. (2011). Maternal substance abuse and disrupted parenting: Distinguishing mothers who keep their children from those who do not. *Children and Youth Services Review*, *33*(11), 2176–2185.	Parent-Child Assistance Program (PCAP)
Grimwood, A., Fatti, G., Mothibi, E., Malahlela, M., Shea, J., & Eley, B. (2012). Community adherence support improves programme retention in children on antiretroviral treatment: A multicentre cohort study in South Africa. *Journal of the International AIDS Society*, *15*(2), 17381.	Kheth'Impilo's Community-Based Adherence Support (CBAS)
Harvey Berino, J., & Rourke, J. (2003). Obesity prevention in preschool Native-American children: A pilot study using home visiting. *Obesity Research*, *11*(5), 606–611.	Obesity Prevention plus Parenting Support
Holland, M. L., Olds, D. L., Dozier, A. M., & Kitzman, H. J. (2018). Visit attendance patterns in nurse-family partnership community sites. *Prevention Science, 19*(4), 516-527.	Nurse Family Partnership/NFP
Johns Hopkins University. (2005). *Evaluation of the Healthy Families Alaska program*. Report to Alaska State Department of Health and Social Services, Alaska Mental Health Trust Authority. Baltimore, MD: Author.	Healthy Families America/HFA - Healthy Families Alaska
Jones, B. (2015). Association of home visiting dosage on preterm birth in Oklahoma (Doctoral dissertation). ProQuest Dissertations and Theses. (1728035306)	Nurse Family Partnership/NFA - Children First
Karanja, N., Aickin, M., Lutz, T., Mist, S., Jobe, J. B., Maupome, G., & Ritenbaugh, C. (2012). A community-based intervention to prevent obesity beginning at birth among American Indian children: Study design and rationale for the PTOTS study. *Journal of Primary Prevention*, *33*(4), 161–174.[b]	TOTS
Karanja, N., Lutz, T., Ritenbaugh, C., Maupome, G., Jones, J., Becker, T., & Aickin, M. (2010). The TOTS community intervention to prevent overweight in American Indian toddlers beginning at birth: A feasibility and efficacy study. *Journal of Community Health*, *35*(6), 667–675.	TOTS
Kartin, D., Grant, T. M., Streissguth, A. P., Sampson, P. D., & Ernst, C. C. (2002). Three-year developmental outcomes in children with prenatal alcohol and drug exposure. *Pediatric Physical Therapy*, *14*(3), 145–153.	Parent-Child Assistance Program (PCAP)
King, T. M., Rosenberg, L. A., Fuddy, L., McFarlane, E., Sia, C., & Duggan, A. K. (2005). Prevalence and early identification of language delays among at-risk three year olds. *Journal of Developmental & Behavioral Pediatrics*, *26*(4), 293–303.	Healthy Families America/HFA - Hawaii Healthy Start
Krysik, J., & LeCroy, C. W. (2007). The evaluation of Healthy Families Arizona: A multisite home visitation program. *Journal of Prevention & Intervention in the Community*, *34*(1), 109–127.	Healthy Families America/HFA - Healthy Families Arizona
Lambson, T., Yarnell, V., & Pfannenstiel, J. (2006). *BIA Baby FACE program evaluation study: 2005 report.* Overland Park, KS: Research and Training Associates, Inc.	Parents as Teachers/PAT (Bureau of Indian Affairs' Baby Family and Child Education (Baby FACE) Program)
le Roux, I. M., le Roux, K., Comulada, W. S., Greco, E. M., Desmond, K. A., Mbewu, N., & Rotheram-Borus, M. J. (2010). Home visits by neighborhood mentor mothers provide timely recovery from childhood malnutrition in South Africa: Results from a randomized controlled trial. *Nutrition Journal*, *9*(56).	Philani
le Roux, I. M., le Roux, K., Mbeutu, K., Comulada, W. S., Desmond, K. A., & Rotheram-Borus, M. (2011). A randomized controlled trial of home visits by neighborhood mentor mothers to improve children's nutrition in South Africa. *Vulnerable Children & Youth Studies*, *6*(2), 91–102.	Philani

Citation	Model[a]
Le Roux, I. M., Rotheram-Borus, M., Stein, J., & Tomlinson, M. (2014). The impact of paraprofessional home visitors on infants' growth and health at 18 months. *Vulnerable Children and Youth Studies*, *9*(4), 291–304.	Philani
le Roux, I. M., Tomlinson, M., Harwood, J. M., O'Connor, M. J., Worthman, C. M., Mbewu, N., . . . Rotheram-Borus, M. J. (2013). Outcomes of home visits for pregnant mothers and their infants in South Africa: A cluster randomized controlled trial. *AIDS*, *27*(9), 1461–1471.	Philani
Levin, M., Moss, M., Swartz, J., Khan, S., & Tarr, H. (1997). National evaluation of the Even Start Family Literacy program: Report on Even Start projects for Indian tribes and tribal organizations. Bethesda, MD: Abt Associates and Fu Associates.	Even Start
Livingstone, I. D. (1999). Parents as First Teachers: Supplement to the summary report of the evaluation of the pilot project: Report to the Ministry of Education on consolidated cross-site analysis. Wellington, New Zealand: Ministry of Education.	Parents as First Teachers/PAT (Parents as First Teachers/PAFT- New Zealand)
McCalman, J., Searles, A., Bainbridge, R., Ham, R., Mein, J., Neville, J., Campbell, S., & Tsey, K. (2015). Empowering families by engaging and relating Murri way: a grounded theory study of the implementation of the Cape York Baby Basket program. *BMC Pregnancy & Childbirth*, *15*(1), 1.	Baby Basket Program
McCalman, J., Searles, A., Edmunds, K., Jongens, C., Wargent, R., Bainbridge, R., . . . Doran, C. (2014). Evaluating the Baby Basket program in North Queensland: As delivered by Apunipima Cape York Health Council, 2009 to 2013, qualitative and quantitative evaluation. Victoria, Australia: Lowitja Institute.	Baby Basket Program
McCurdy, K. (2001). Can home visitation enhance maternal social support? *American Journal of Community Psychology*, *29*(1), 97–112.	Healthy Families America/HFA - Hawaii Healthy Start
McCurdy, K. (2005). The influence of support and stress on maternal attitudes. *Child Abuse & Neglect*, *29*(3), 251–268.	Healthy Families America/HFA - Hawaii Healthy Start
McFarlane, E., Burrell, L., Crowne, S., Cluxton-Keller, F., Fuddy, L., Leaf, P., & Duggan, A. (2013). Maternal relationship security as a moderator of home visiting impacts on maternal psychosocial functioning. *Prevention Science*, *14*(1), 25–39.	Healthy Families America/HFA - Hawaii Healthy Start
McLaren, L. (1988). Fostering mother-child relationships. *Child Welfare*, *67*(4), 353–365.	ParentChild+® Core Model
Mills, R. M., Siever, J. E., Hicks, M., Badry, D., Tough, S. C., & Benzies, K. (2009). Child guardianship in a Canadian home visitation program for women who use substances in the perinatal period. *Canadian Journal of Clinical Pharmacology/Journal Canadien De Pharmacologie Clinique*, *16*(1), e126–139.	Parent-Child Assistance Program (PCAP)
Munns, A., Toye, C., Hegney, D., Kickett, M., Marriott, R., & Walker, R. (2016). The emerging role of the urban-based Aboriginal peer support worker: A Western Australian study. *Collegian*, *23*(4), 355-361.	Aboriginal peer-led home visiting programme
Munns, A., Toye, C., Hegney, D., Kickett, M., Marriott, R., & Walker, R. (2017). Peer-led Aboriginal parent support: Program development for vulnerable populations with participatory action research. *Contemporary Nurse*, *53*(5), 558-575.	Aboriginal peer-led home visiting programme
Munns, A., Toye, C., Hegney, D., Kickett, M., Marriott, R., & Walker, R. (2018). Aboriginal parent support: A partnership approach. *Journal of Clinical Nursing*, *27*(3-4), e437-e450.	Aboriginal peer-led home visiting programme
Munns, A., & Walker, R. (2015). The Halls Creek Community Families Program: Elements of the role of the child health nurse in development of a remote Aboriginal home visiting peer support program for families in the early years. *Australian Journal of Rural Health*, *23*(6), 322–326.	Halls Creek Community Families Program

Citation	Model[a]
Munns, A., & Walker, R. (2018). The relevance of Aboriginal peer-led parent support: Strengthening the child environment in remote areas. *Comprehensive Child and Adolescent Nursing*, *41*(3), 199-212.	Halls Creek Community Families Program
Nelson, E. M., & Spieker, S. J. (2013). Intervention effects on morning and stimulated cortisol responses among toddlers in foster care. *Infant Mental Health Journal*, *34*(3), 211–221.	Promoting First Relationships
Nevada State Department of Human Resources, Early Childhood Services. (1997). *HAPPY Rural Outreach Project. Final report.* Reno, NV: Author.	Home Activity Program for Parents and Youngsters (HAPPY) Rural Outreach Project
Nguyen, H., Zarnowiecki, D., Segal, L., Gent, D., Silver, B., & Boffa, J. (2018). Feasibility of implementing infant home visiting in a Central Australian Aboriginal community. *Prevention Science*, *19*(7), 966-976.	Nurse Family Partnership/NFP (Australian Nurse-Family Partnership Program (ANFPP))
Oxford, M., Booth-LaForce, C., Echo-Hawk, A., Lallemand, O., Parrish, L., Widner, M., Petras, A., . . . the CATCH Project Team. (2018). *Promoting First Relationships®: Implementing a home visiting research program in two tribal communities.* Unpublished manuscript submitted to HomVEE.	Promoting First Relationships
Pfannenstiel, J., Yarnell, V., & Seltzer, D. (2015). *Evaluation of the i3 validation of improving education outcomes for American Indian children.* Overland Park, KS: Research & Training Associates, Inc.	Parents as Teachers/PAT (Bureau of Indian Affairs' Baby Family and Child Education (Baby FACE) Program)
Pfannenstiel, J., & Lente-Jojola, D. (2011). The Family and Child Education (FACE) program and school readiness: A structural model approach in an American Indian reservation context. *Journal of American Indian Education*, *50*(2), 84–96.	Parents as Teachers/PAT (Bureau of Indian Affairs' Baby Family and Child Education (Baby FACE) Program)
Pfannenstiel, J., Yarnell, V., & Seltzer, D. (2006). *Family and Child Education program (FACE): Impact study report.* Overland Park, KS: Research & Training Associates, Inc.	Parents as Teachers/PAT (Bureau of Indian Affairs' Baby Family and Child Education (Baby FACE) Program)
Praat, A. (2011). *Parents as First Teachers evaluation: Phase II report*. Wellington, New Zealand: Centre for Social Research and Evaluation.	Parents as First Teachers/PAT (Parents as First Teachers/PAFT- New Zealand)
Praat, A., Davie, S., & McGray, S. (2010). *Parents as First Teachers evaluation: Phase one report*. Wellington, New Zealand: Centre for Social Research and Evaluation.	Parents as First Teachers/PAT (Parents as First Teachers/PAFT- New Zealand)
Prater, S. L., & Davis, C. L. (2002). A perinatal intervention program for urban American Indians: Part 2: The story of a program and its implications for practice. *Journal of Perinatal Education*, *11*(2), 23–32.	Perinatal intervention program
Rasmussen, C., Kully-Martens, K., Denys, K., Badry, D., Henneveld, D., Wyper, K., & Grant, T. (2012). The effectiveness of a community-based intervention program for women at-risk for giving birth to a child with Fetal Alcohol Spectrum Disorder (FASD). *Community Mental Health Journal*, *48*(1), 12-21.	Parent-Child Assistance Program/PCAP - First Steps

Citation	Model[a]
Rotheram-Borus, M., Tomlinson, M., le Roux, I. M., Harwood, J. M., Comulada, S., O'Connor, M. J., . . . Worthman, C. M. (2014). A cluster randomised controlled effectiveness trial evaluating perinatal home visiting among South African mothers/infants. *PLOS ONE 9*(1): e105934.	Philani
Rotheram-Borus, M. J., Tomlinson, M., Le Roux, I., & Stein, J. A. (2015). Alcohol use, partner violence, and depression: A cluster randomized controlled trial among urban South African mothers over 3 years. *American Journal of Preventive Medicine*, *49*(5), 715-725.	Philani
Runciman, C. (2016). Implementing the Nurse-Family Partnership with Aboriginal and Torres Strait Islander clients. *International Journal of Birth & Parent Education, 3*(2), 37-41.	Nurse Family Partnership/NFP (Australian Nurse-Family Partnership Program/ANFPP)
Sawyer, M. G., Frost, L., Bowering, K., & Lynch, J. (2013). Effectiveness of nurse home-visiting for disadvantaged families: Results of a natural experiment. *BMJ Open*, *3*(4), e002720.	South Australia Family Home Visiting Programme/SA-FHV
Sawyer, M. G., Pfeiffer, S., Sawyer, A., Bowering, K., Jeffs, D., & Lynch, J. (2014). Effectiveness of nurse home visiting for families in rural South Australia. *Journal of Paediatrics and Child Health*, *50*(12), 1013-1022.	South Australia Family Home Visiting Programme/SA-FHV
Shaw, M. R., Grant, T., Barbosa-Leiker, C., Fleming, S. E., Henley, S., & Graham, J. C. (2015). Intervention with substance-abusing mothers: Are there rural-urban differences? *American Journal on Addictions*, *24*(2), 144–152.	Parent-Child Assistance Program (PCAP)
Silovsky, J. F., Bard, D., Chaffin, M., Hecht, D., Burris, L., Owora, A., . . . Lutzker, J. (2011). Prevention of child maltreatment in high-risk rural families: A randomized clinical trial with child welfare outcomes. *Children and Youth Services Review*, *33*(8), 1435–1444.	SafeCare (SafeCare Augmented)
Singleton, R., Salkoski, A. J., Bulkow, L., Fish, C., Dobson, J., Albertson, L., ... Hennessy, T. W. (2018). Impact of home remediation and household education on indoor air quality, respiratory visits and symptoms in Alaska Native children. *International Journal of Circumpolar Health*, *77*(1), 1422669.	Home remediation and household education
Spieker, S. J., Oxford, M. L., & Fleming, C. B. (2014). Permanency outcomes for toddlers in child welfare two years after a randomized trial of a parenting intervention. *Children & Youth Services Review, 44*, 201–206. doi:10.1016/j.childyouth.2014.06.	Promoting First Relationships
Spieker, S. J., Oxford, M. L., Kelly, J. F., Nelson, E. M., & Fleming, C. B. (2012). Promoting First Relationships: Randomized trial of a relationship-based intervention for toddlers in child welfare. *Child Maltreatment*, *17*(4), 271–286.	Promoting First Relationships
Tomayko, E. J., Prince, R. J., Cronin, K. A., & Adams, A. K. (2016). The Healthy Children, Strong Families intervention promotes improvements in nutrition, activity and body weight in American Indian families with young children. *Public Health Nutrition*, *19*(15), 2850-2859.	Healthy Children, Strong Families
Walker, N., Johnston, V., Glover, M., Bullen, C., Trenholme, A., Chang, A., . . . Thomas, D. (2015). Effect of a family-centered, secondhand smoke intervention to reduce respiratory illness in indigenous infants in Australia and New Zealand: A randomized controlled trial. *Nicotine & Tobacco Research*, *17*(1), 48–57.	Healthy Starts Australia/Te Piripohotanga NZ
Walkup, J. T., Barlow, A., Mullany, B. C., Pan, W., Goklish, N., Hasting, R., . . . Reid, R. (2009). Randomized controlled trial of a paraprofessional-delivered in-home intervention for young reservation-based American Indian mothers. *Journal of the American Academy of Child & Adolescent Psychiatry*, *48*(6), 591–601.	Family Spirit
Widdup, J., Comino, E. J., Webster, V., & Knight, J. (2012). Universal for whom? Evaluating an urban Aboriginal population's access to a mainstream universal health home visiting program. *Australian Health Review*, *36*(1), 27–33.	Families First (Australia)

Citation	Model[a]
Yarnell, V., Lambson, T., & Pfannenstiel, J. C. (2008). *BIE Family and Child Education Program.* Overland Park, KS: Research & Training Associates, Inc.	Parents as Teachers/PAT (Bureau of Indian Affairs' Baby Family and Child Education (Baby FACE) Program)
Zarnowiecki, D., Nguyen, H., Hampton, C., Boffa, J., & Segal, L. (2018). The Australian Nurse-Family Partnership Program for Aboriginal mothers and babies: Describing client complexity and implications for program delivery. *Midwifery*, *65*, 72-81.	Nurse Family Partnership/NFP (Australian Nurse-Family Partnership Program (ANFPP))

Citations shaded in tan were added in this update of the tribal report.

[a] If a manuscript examines a version of a model, the model is listed first followed by the version is in parentheses.

[b]This study describes an enhancement to the Toddler Overweight and Tooth Decay Prevention Study intervention that includes additional nutrition and physical activity components.

This page has been left blank for double-sided copying.

Mathematica

Princeton, NJ • Ann Arbor, MI • Cambridge, MA
Chicago, IL • Oakland, CA • Seattle, WA
Tucson, AZ • Woodlawn, MD • Washington, DC

EDI Global, a Mathematica Company

Bukoba, Tanzania • High Wycombe, United Kingdom

mathematica.org