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HOME VISITING

A Promising Early Intervention Service Delivery Strategy

Statement of
Linda G. Morra, Director
Intergovernmental and Management Issues
Human Resources Division

Before the
Subcommittee on Government Activities
and Transportation, Committee on
Government Operations
House of Representatives

HOME VISITING: A PROMISING EARLY INTERVENTION SERVICE DELIVERY STRATEGY

Summary Statement of
Linda G. Morra
Director, Intergovernmental and
Management Issues

The Subcommittee on Government Activities and Transportation of the House Committee on Government Operations is considering legislation to sell government-owned land in the District of Columbia to Columbia Hospital for Women. Columbia Hospital has proposed establishing a National Women's Health Resource Center, that will provide clinical, research, education, and advocacy programs of local and national significance. To aid in the deliberations, GAO was asked to testify on home visiting as a way to deliver preventive health and social services to women and their families.

From an analysis of the literature and case studies, GAO has concluded that home visiting is a promising service delivery strategy to improve birth outcomes, prevent child maltreatment, and improve child health and development. Home visiting can be particularly useful for women at risk of poor outcomes, such as teenage mothers, substance-abusing women, and women living in rural areas where transportation to services can be a barrier. It can provide services directly in the home or link women to other needed services provided elsewhere. Home visiting combines coaching, counseling, teaching, referrals, and sometimes hands-on care.

Not all programs that have used home visiting have been successful at achieving their objectives. GAO identified characteristics that strengthen program design in a recent report (Home Visiting: A Promising Early Intervention Strategy for At-Risk Families [GAO/HRD-90-83], July 1990).

More research is needed to identify the most cost-effective ways to improve birth outcomes and maternal and child health and well-being. At least five issues need further research: (1) For what populations and outcomes is home visiting most cost-effective? (2) Should home visiting be universal or targeted? (3) What type of home visitor--professional or paraprofessional--is most effective? (4) What service configurations are most cost beneficial? (5) What curriculum or structured plan of services is most effective?

Madam Chairwoman and Members of the Committee:

We are pleased to be here today to assist in your deliberations on the issue of conveying certain federal real property in the District of Columbia to Columbia Hospital for Women. The intent of this proposal is to establish a National Women's Health Resource Center that will provide clinical, research, education, and advocacy programs of national, as well as local, significance. Within this context, you asked the General Accounting Office to discuss home visiting as a strategy for delivering preventive health and social services to women and their families.

My remarks today are based on our July 1990 report, Home Visiting: A Promising Early Intervention Strategy for At-Risk Families (GAO/HRD-90-83). To assess the scope, nature, and effectiveness of home visiting, we reviewed the literature and interviewed experts here and abroad in the areas of medical, social, and educational interventions. Through case studies of eight home visiting programs in Great Britain, Denmark, and five U.S. states, we identified design characteristics important for developing and operating effective programs.

Home visiting is a promising strategy for delivering early intervention services, especially for vulnerable populations. In addition to working with families in their homes, home visitors can help them access other, center-based services. Such combined

services can improve the health and well-being of pregnant and parenting women and their children. Home visiting is particularly valuable for women at risk of poor outcomes, such as low-birthweight babies. But more research is needed on the most cost-effective ways to provide early intervention services and structure home visiting services.

HOME VISITING A PROMISING SERVICE DELIVERY STRATEGY FOR AT-RISK FAMILIES

Home visiting involves coaching, counseling, teaching, referrals to other service providers, and sometimes hands-on health care. It focuses on establishing a relationship of trust and support that motivates a woman and her family to seek and remain in care. It is not a program, but a strategy for getting early and preventive health, social support, or educational services to families.

Visits to the home can reach the "hard-to-reach" woman, such as substance-abusing women, pregnant teens, or families living in rural locations where public transportation is limited and services few. Home visits can help such women overcome the barriers they often face in getting services they need and are entitled to. Helping families access preventive services such as center-based prenatal care can be less costly than paying for the consequences of poor birth outcomes. Such outcomes can include a

low-birthweight baby who needs extended neonatal intensive care, and possibly additional medical care and special education services due to long-term disabilities.

What happens on a home visit? The activities can vary greatly, depending on the needs of the family and the program objectives. As part of our study, we accompanied home visitors on their rounds in each of the eight programs we visited. In South Carolina, we saw a home visitor work with an 8-1/2-month pregnant 13-year-old, a victim of abuse who had run away, time and again, from foster homes. For this young girl, the home visitor provided practical guidance, such as what to do if alone when going into labor, and offered emotional support. In Chicago, we observed a home visitor advise a teen mother on the best developmental activities for her baby and on how to apply for college aid. In Austin, Texas, a home visitor tutored a child with delayed speech development and her mother in activities designed to improve her speech and development. The visitor also discussed scheduling the child for a center-based speech assessment at the University of Texas. In Great Britain, a home visitor checked two gypsy children for scabies (parasitic mites that burrow under the skin), following up on a previous clinic visit.

So far, no single model of home visiting has been shown to be most effective. Goals, services, providers, and clients served tend to vary (see table 1).

Table 1: Examples of Programs Using Home Visiting To Serve At-Risk Families

Goals --	Improved parenting skills Enhanced child development Improved birth outcomes
Services --	Information delivery Referrals to other service providers Emotional support Health care
Providers --	Nurses Paraprofessionals Teachers Social workers
Clients --	Pregnant and/or parenting teens High-risk newborns Developmentally delayed children Families at risk of child maltreatment

Some services are primarily home-based, while others operate as part of a home- and center-based program. One home-based program in Elmira, N.Y., used nurses for prenatal and postnatal home visiting to improve birth outcomes and infant health. The Resource Mothers for Pregnant Teens program in South Carolina used paraprofessional home visitors to reduce infant mortality and morbidity and improve the teens' parenting skills. Home visiting has been a part of numerous successful center-based early intervention programs to improve child development and later school success. Such programs include the High/Scope Perry Preschool

Program, the Infant Health and Development Program, and the Brookline, Massachusetts, Early Education Project. Home visitors have reached many types of clients: premature or low-birthweight infants, low-income pregnant women, teen mothers, and developmentally delayed preschoolers.

Many states and localities use home visiting to improve women and children's health and well-being. Researchers have identified over 4,500 programs in the United States that use home visiting. Twenty-four states now reimburse pre- or postnatal providers of home visiting services through Medicaid. The Congress has shown interest in home visiting, having recently passed several pieces of legislation concerning it. The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) authorized new home visiting demonstration grants, although no fiscal year 1990 funds were appropriated. In addition, the Child Abuse Prevention, Adoption, and Family Services Act of 1988 (P.L. 100-294) encouraged the use of home visiting to prevent child maltreatment.

Evaluation evidence has demonstrated that home visiting can be beneficial--given certain conditions that I will discuss in a moment. Home-visited women have had healthier babies, have been reported less frequently for child abuse and neglect, and have sought more appropriate pediatric care for their children. Home-visited children have had improved cognitive development, compared to children not home visited.

Not all programs that use home visiting, however, succeed. Some have had little impact in achieving their stated objectives. In our recent report, we identified characteristics that strengthen the design and implementation of home visiting services. Briefly, they include:

1. Developing clear objectives that are used to focus and manage the program;

2. Carefully planning service delivery, so that the skills of the home visitors match the services to be provided and the client population's needs;

3. Working through an agency that is capable of arranging for, or delivering, a wide range of services needed by the client population; and

4. Developing strategies to secure funding over time, to allow for service continuity.

One program that puts many of these principles to work is the Roseland/Altgeld Adolescent Parent Project in Chicago. Using a home- and center-based approach, it serves low-income pregnant teens and teenage mothers who lack a family or other "support system." In selecting their target population, this program's managers were careful and realistic. They designed home visiting

services with a specific group of teen mothers to reach--those who needed and could benefit from extra support. But they also recognize their limitations. Program staff refer pregnant and parenting teens with severe mental and emotional disorders to other, more intensive programs where they might be better served. Additionally, program managers determine whether they are meeting program objectives by routinely monitoring program activities, such as whether project infants receive a minimum number of well-baby pediatric visits.

MORE RESEARCH NEEDED ON MOST EFFECTIVE SERVICE DESIGNS

Consensus on the effectiveness of home visiting as an early intervention strategy is growing. The Public Health Service Expert Panel on the Content of Prenatal Care recently highlighted home visiting as a recommended part of prenatal care for women at risk.[1] In addition, the Office of Technology Assessment recommended encouraging the development of nurse home visitor programs for women at risk of poor birth outcomes or of child maltreatment.[2] While support for home visiting is growing, we

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[1]Expert Panel on the Content of Prenatal Care, Caring for Our Future: The Content of Prenatal Care (Washington, D.C., U.S. Public Health Service, Department of Health and Human Services, 1989).

[2]Office of Technology Assessment, Healthy Children: Investing in the Future, OTA-H-345 (Washington, D.C., U.S. Government Printing Office, 1988).

believe that more research is needed to determine the most cost-effective ways to reach and help women and children at risk of adverse outcomes.

We see at least five issues where more research on home visiting is needed.

1. For what populations and desired outcomes is home visiting the most cost-effective strategy? Can center-based services achieve the same result at less cost?

2. Would home visiting be more effective if it was universally available to all pregnant women or parents, or should it be targeted to particular families according to certain risk criteria?

3. What type of home visitor--professionals or paraprofessionals--are best suited to provide specific services for specific populations?

4. What are the costs, benefits, and relative cost-effectiveness of using different types of providers and providing home visiting services that vary in intensity and duration?

5. What curriculum or structured plan for services is most effective with particular populations?

The British model of home visiting is one that could be evaluated experimentally in the United States. In Great Britain, specially trained nurse home visitors function as part of the medical team, which also includes physicians and midwives. Their services are part of the National Health Service, which provides comprehensive medical care for all residents of Great Britain. All families with young children are eligible for their services, which are provided without charge. The health visitor follows each child from birth through age 5, with a combination of home and center visits. The health visitor meets the pregnant woman before birth and begins home visiting within 14 days of delivery. Health visitors educate families about breast-feeding, infant immunizations, accident prevention, and appropriate pediatric health care. They monitor the child's development, so that potential problems, such as poor hearing, can be identified and addressed as soon as possible.

Key elements of the British model could be tested on an experimental basis in the United States. In addition to the research issues highlighted above, clinical trials could address

-- the costs and benefits of combining supportive home visiting with medical care, where the home visitor functions as part of the medical team, and

-- whether a nonnurse could fill this role.

CONCLUSION

Many states and localities use home visiting, and there are indications that their numbers will grow. Home visiting holds promise as a strategy to reach some high-risk women and their children. It can link them to the services they need and promote positive health and social behaviors.

But some of this effort may be wasted if programs are not well designed and managed. The framework for designing and managing programs outlined in our home visiting report provides some guidance. Answering other research questions will help to further target where and with whom home visiting can be most effective.

Madam Chairwoman, this concludes my statement. I would be pleased to respond to any questions you or other members of the Committee may have regarding our work.