

TRIBAL HOME VISITING

Culture, Collaboration, and Innovation:

How Tribal Home Visiting Programs
Are Working to Improve Outcomes for
Children, Families, and Communities





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EXECUTIVE SUMMARY

Over the past seven years, American Indian and Alaska Native (AI/AN) tribes, tribal organizations, and urban Indian organizations have been implementing home visiting programs to support healthy pregnancies and child development among high-risk families. This work is supported by grants from the Tribal Home Visiting Program, administered by the U.S. Department of Health and Human Services, Administration for Children and Families (ACF).

Home visiting programs complement the support provided by extended families, health care providers, social service agencies, faith-based organizations, and others. The home visitor is a nurse, social worker, or paraprofessional who assesses families' needs and helps them reach their goals by providing information about parenting, health and child development, and linkages to other community services and resources. Home visitors develop strong, supportive relationships with parents to help them achieve positive outcomes for their families.

Studies have shown that high-quality home visiting programs can improve a wide range of child and family outcomes, especially among high-risk families. These outcomes include child cognitive outcomes, more efficient family use of health services, positive changes in parenting attitudes and behaviors, and reduced child maltreatment and abuse. Home visiting can also improve parent education and employment outcomes and increase family economic self-sufficiency (Del Grosso, Kleinman, Esposito, Martin, & Paulsell, 2011).

Tribal Home Visiting Program Grantees

The Tribal Home Visiting Program was created in 2010 as part of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, which included a 3% set-aside for grants to tribes, tribal organizations, and urban Indian organizations. This action was taken due to concerns that existing home visiting approaches may not adequately address the particular needs and circumstances of AI/AN communities. AI/AN families face a unique set of challenges due to historical and intergenerational trauma and disparities in health care and education services, coupled with high exposure to risk factors such as poverty and substance abuse. At the same time, AI/AN communities have strengths that a well-designed home visiting strategy can build upon, such as cultural traditions, sense of community, and intergenerational ties.

Three cohorts totaling 25 tribal grantees were awarded five- to six-year cooperative agreements under the Tribal Home Visiting Program: Cohort 1 (fiscal year [FY] 2010–2015), Cohort 2 (FY 2011–2016) and Cohort 3 (FY 2012–2017). Upon successful completion of their

TRIBAL HOME VISITING PROGRAM

Overarching Goals

1. Support the development of happy, healthy, and successful AI/AN children and families through a coordinated home visiting strategy that addresses critical maternal and child health, development, early learning, family support, and child abuse and neglect prevention needs;
2. Implement high-quality, culturally relevant, evidence-based home visiting programs in AI/AN communities;
3. Expand the evidence base around home visiting interventions with AI/AN populations; and
4. Support and strengthen cooperation and coordination and promote linkages among various programs that serve pregnant women, expectant fathers, young children, and families, resulting in coordinated, comprehensive early childhood systems in grantee communities.

grants, 15 grantees from the first two cohorts applied for and were awarded Implementation and Expansion Grants for FY 2017–2022. Please see Appendix 2 for a full listing of Tribal Home Visiting grantees.

The report describes the key findings and lessons learned from the first two cohorts of grantees, based on their final grant reports. It provides a description of the 19 grantees, which include 9 tribal nations, 3 consortia of tribes, 5 urban Indian organizations and 2 tribal organizations; detailed information about the Tribal Home Visiting approach; and examples of how Tribal Home Visiting programs have supported improvements in local early childhood systems.

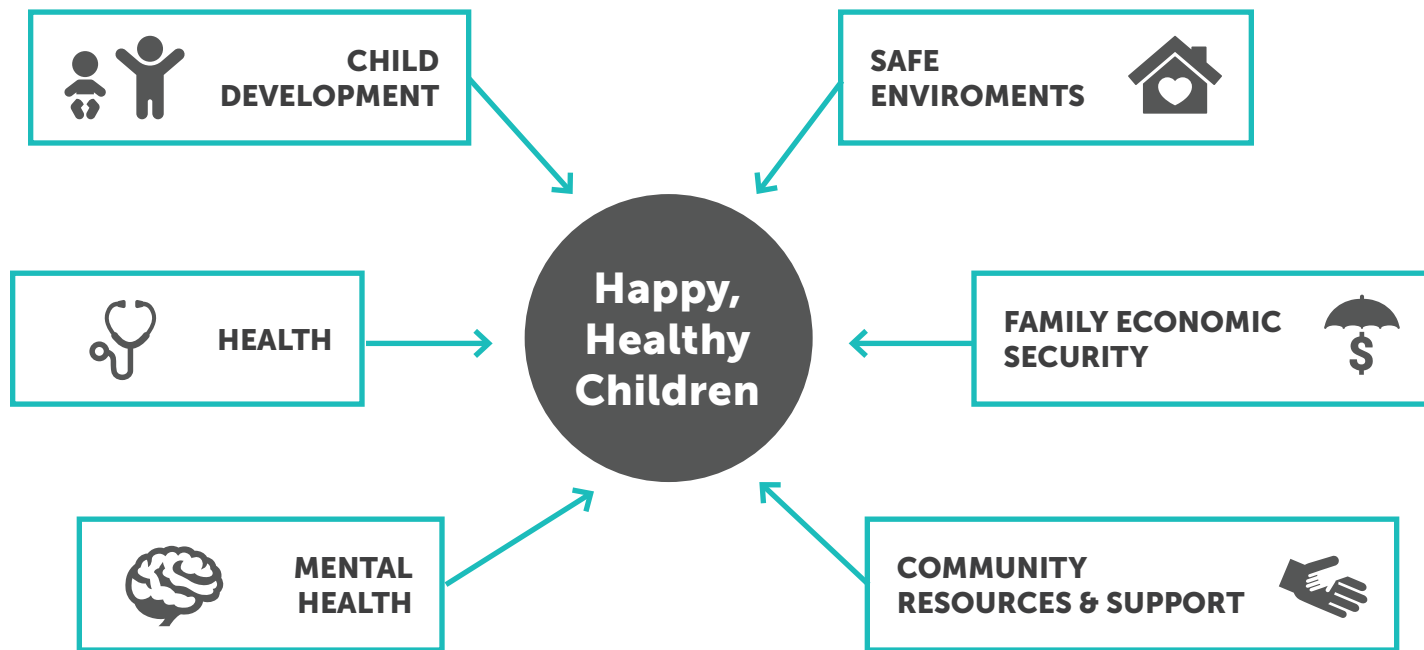
The Tribal Home Visiting Approach

The Tribal Home Visiting Program grants were designed to increase tribal capacity to provide high-quality home visiting services, contribute to the development of comprehensive and coordinated local early childhood systems, and enhance the research base on home visiting with AI/AN families.

During the first year, each grantee conducted a community needs assessment, as well as an assessment of its organizational readiness to develop, operate, and evaluate an evidence-based home visiting program. The grantee developed a plan based on these assessments and began to build capacity to respond to identified needs. Upon approval of the plan, the grantees received funding for implementation for Years 2–5.

Figure 1

Tribal Home Visiting Goal Areas



Training and technical assistance (TA) were provided to grantees from multiple sources throughout the grant period. This was essential, because most grantees were creating home visiting programs for the first time, as well as adapting evidence-based models to address the needs of AI/AN families. The grantees also needed support to evaluate their programs, create performance measures, and plan for and make continuous quality improvements (CQIs). The four primary sources of TA were ACF federal staff, Programmatic Assistance for Tribal Home Visiting (PATH), Tribal Evaluation Institute (TEI), and the home visiting model developers.

This report describes the grantees' experiences in three areas of work, as illustrated below. Many of the activities were overlapping and often recurring over the course of the grants.

Areas

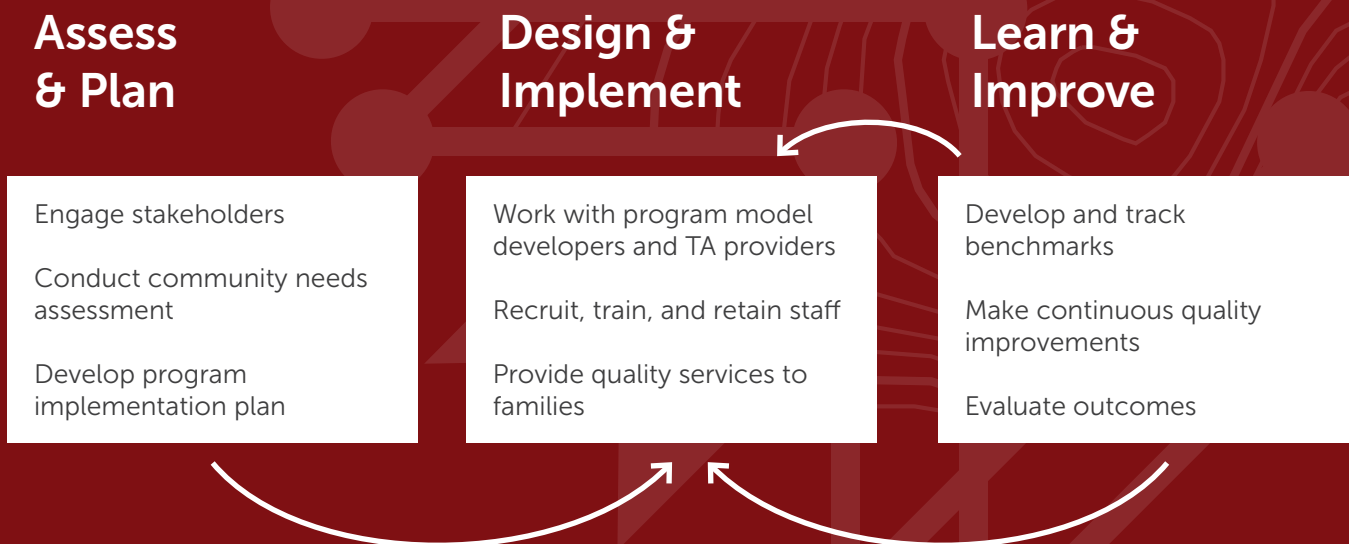
Assessment and Planning

The grantees' first year of work was focused on creating a foundation for home visiting in their communities. This involved collecting demographic and service data and engaging with a broad range of stakeholders in a comprehensive community needs assessment and development of an implementation plan for the home visiting program.

Most grantees found that the connections they made during this initial phase of work helped create the ongoing infrastructure required to meet families' needs. This was true for all types of tribal communities, be they urban or rural, reservation-based or not. Furthermore, the addition of a home visiting program often helped strengthen a community's overall early childhood system.

Figure 2

Areas of Work in Tribal Home Visiting Grant Implementation



The community needs assessment was also an important tool to help grantees develop their programs in ways that honor and elevate the cultural assets of their tribal communities. They viewed the healthy development of children and families as inextricably linked to their future health and prosperity. Today's children will be tomorrow's leaders, and maintaining strong connections to culture was paramount to every tribe's future.

The community needs assessment helped grantees select a home visiting model that best suited local needs and circumstances. It also helped identify cultural enhancements and adaptations that could be made to ensure the model's fit with the community. This was an important aspect of the grant because, at the time when grantees were making model selection decisions, no home visiting models previously implemented in tribal communities had met the criteria for evidence of effectiveness established for the MIECHV program.

The grantees' implementation plans included developing a home visiting program through identifying goals, objectives, and strategies based on findings from their community needs and readiness assessments, coupled with the particular features of the home visiting models they chose to use. Implementation plan development also included the creation of a benchmarks performance measurement plan and a plan for rigorous evaluation.

Program Design and Implementation

Across program models, the grantees shared similar goals for serving families related to health, mental health, child development, safe environments, family economic security, and community resources and supports. While specific program strategies varied based on the program model, all grantees addressed the recruitment, training, and retention of qualified staff; methods for engaging and enrolling families; and the provision of high-quality services.

Throughout the implementation process, the grantees paid close attention to the cultural aspects of serving AI/AN families. The programs integrated cultural teachings and traditions as sources of guidance. They encouraged and supported cultural activities for families in the community. They addressed historical trauma resulting from forced relocations, prohibition of language and traditions, removal of children to boarding schools, and other losses.

In addition, the grantees recognized the important influence of extended families and intergenerational relationships in tribal cultures. Home visitors actively welcomed the participation of caregivers beyond biological parents.

Program design and implementation also took into account the intensive needs and issues in many high-risk families, such as high rates of unemployment, poverty, poor health, substance abuse, and domestic violence. These issues were especially challenging within the context of communities that often lacked sufficient economic, health, and social resources to address them.

Evaluation and Improvement

For home visiting programs to be effective in improving outcomes for young children and their families, services must be of high quality, and MIECHV legislation required a demonstration of program improvement through achievement of legislatively mandated benchmarks. Grantees developed plans to collect data on these benchmarks, as well as a CQI process to help achieve them. The legislatively mandated benchmarks focused on six areas:

1. improved maternal, newborn, and child health;
2. prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency room visits;
3. improvements in school readiness and child academic achievement;
4. reductions in crime or domestic violence;
5. improvements in family economic self-sufficiency; and
6. improvements in the coordination and referrals for other community resources and supports.

Local evaluations, using rigorous research methods to answer research questions operationalized by each grantee, were also a grant requirement. With support from TEI and others, grantees participated in ongoing research and program evaluation activities to help expand the knowledge base around designing and delivering high-quality, evidence-based home visiting services to AI/AN families. Grantees were required to comply with regulations related to tribal oversight and approval of strategies for protection on human subjects.

Supporting System Improvements

Tribal Home Visiting Programs operate within the context of local systems of services for young children and their families. These systems, formal and informal, typically include federally supported programs such as child care, Head Start, and child nutrition programs, along with state, tribal, and local initiatives. Although the local early childhood systems vary in their stage of development and are often challenged by a scarcity of resources, these systems have been an important factor in the implementation of Tribal Home Visiting Programs. Likewise, the introduction of home visiting programs has helped strengthen local systems, often providing a catalyst for collaboration.



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Tribal Home Visiting Programs supported local system improvements in at least three major ways. The first was their participation in and/or initiation of local collaborative groups to improve the effectiveness and efficiency of service delivery for families with young children. The programs sometimes used memoranda of agreement to specify the nature of the collaboration and roles of each party. These strategies have helped form an infrastructure across agencies for ongoing collaboration, greater effectiveness, and less duplication.

The second system-level improvement was developing methods to more effectively link families to the resources they need. Many home visiting programs developed proactive approaches for identifying the necessary resources to meet a family's needs, making timely referrals and following up to ensure that the family was connected and satisfied with the service. When appropriate, home visitors accompanied the family to appointments and actively coordinated services across programs. Some home visiting programs shared locations with other organizations that serve pregnant women and families with young children in order to facilitate service referrals and coordination.

The third improvement was ongoing information dissemination to help embed home visiting in tribal communities. Many of these grantee efforts were aimed at increasing awareness and utilization of their programs. Equally important was sharing information to inform the field surrounding evidence-based interventions targeting Native populations, gain the support of tribal and community leadership, and provide data that could be used for system planning and policy development.

Conclusions

There are many valuable lessons to be learned from the final reports submitted by grantees in Cohorts 1 and 2 of the Tribal Home Visiting Program. Taken as a whole, they reflect a deep commitment to families with young children; a recognition of and respect for the importance of culture; and the ability to create innovations that help children, families, and communities thrive. Five major findings are summarized here:

1. *Home visiting programs have been a welcome addition to the early childhood systems that serve AI/AN families.* The parenting education, support, and referrals provided by home visitors increased the capacity of local systems and complemented the work of health care providers, Head Start programs, child care programs, WIC (Women, Infants, and Children), TANF (Temporary Assistance for Needy Families), and others. The Tribal Home Visiting Programs added a new dimension of support to families while supporting family participation in existing programs.

The grantees participated in, and added value to, existing interagency collaborations, and also initiated new collaborations. These included jointly sponsored playgroups and family events, development of materials and curricula, shared professional development, co-locating home visiting staff with other programs, and coordinating referrals.

Beyond service providers, Tribal Home Visiting Programs have reached out and gained the crucial support of tribal elders and leaders, reinforcing a widely shared belief that providing children a good start in life is vital to the future health and prosperity of the tribal community.

2. *It is critical and feasible to make cultural adaptations and enhancements to evidence-based home visiting models to make them more appealing and effective in tribal communities.* The large majority of grantees reported positive experiences with model developers who welcomed the opportunity to improve the effectiveness of their models





with tribal populations. Even though the model adaptation process was often time consuming, grantees found it worth their while because of the highly favorable responses from families.

The enhancements included adding cultural content to existing curricula, identifying or developing supplementary curricula, and initiating or connecting families with cultural events in their communities. Sometimes, adapting the model meant applying the flexibility needed to meet families where they are, such as meeting a parent at an office or other public place until he or she feels ready to invite the home visitor into the home.

3. *The essence of home visiting lies in the trust that develops over time between home visitors and the families they serve.* This relationship enables parents to set and meet goals for their families, engage in activities that further their children’s development, and have someone to turn to for advice and assistance when needed.

Building relationships requires consistency in staffing home visitor positions, but this was the area in which grantees reported great challenges. Two thirds of grantees said they had significant problems with staff recruitment and retention that interfered with program implementation. These problems included a shortage of qualified people in the area and competition with other employers who offered better compensation. Another factor was the stressful nature of serving high-need families, especially in communities with few resources to which they could refer. The stress increased with staff turnover, leaving more work for the remaining workers until replacements were hired. The result was often a temporary reduction or lapse in services to families. Some families dropped out of the program at that point, and those who stayed had to build relationships with new workers.

4. *Most grantees are developing sound practices of rigorous evaluation and using the results to improve their individual programs and further the development of tribal home visiting overall.* The level of rigorous evaluation expected was new to most grantees, but they were eager to get started. They chose methodologies that they believed would work best in their communities and developed locally tailored evaluation questions. A few grantees were able to deliver quantifiable conclusions. Most, however, reported inconclusive outcomes or questioned the validity of the results due to issues such as sample size limitation. The grantees did, however, begin to build capacity for rigorous evaluation, increase community and program recognition of the value of scientific research, and learn valuable lessons that provided programmatic benefits.

Moving forward, grantees suggested more training for program staff on data collection and analysis; more time on the front end to adequately recruit and engage participating families; a longer data collection period to increase sample size, establish a stable baseline, and ensure validity and more conclusive results; a focus on service delivery for a period of time before adding the major task of rigorous evaluation; and a better understanding of the time and budget commitment needed.

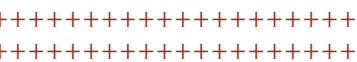
5. *Competing priorities have challenged the implementation of Tribal Home Visiting Programs.* The grantees had to juggle multiple goals within the grant, including meeting the needs of high-risk families, maintaining high-quality services and model fidelity, implementing culturally relevant practices, participating in research to expand the evidence base around home visiting, and collaborating with other programs to develop stronger early childhood systems. While grantees appreciated the value of each of these goals, many felt pulled in too many directions and unable to do all that was required

of them. This, in turn, threatened the quality and effectiveness of programs and the outcomes for children and families.

One grantee expressed the concern of many grantees, stating: "Between monthly calls, home visits, reporting requirements, data collection, reflective supervision time, curriculum review, and CQI, there is a lot placed on the home visitors simply from a time constraint. We need to consider hours per week we expect staff to obligate to each duty, and make sure that those numbers can add up to a regular work week."

In summary, this synthesis of final reports from the grantees provides a strong foundation for the further development of Tribal Home Visiting Programs. The grantees have created innovative and culturally relevant approaches tailored to AI/AN children, families, and communities. Building on this knowledge and experience, future investments in Tribal Home Visiting Programs are likely to be well received and put to good use in these communities.

INTRODUCTION



Children's earliest experiences play a critical role in their immediate and long-term health and well-being. Advances in neuroscience have revealed that the first years of life are a peak time for brain development. This is when the rapid formation of synapses between brain cells is creating the basic architecture for hearing, vision, learning, language, and emotions. Studies consistently show that children who grow up with nurturing caregivers in safe, engaging environments are more likely to be healthy, do well in school, and prosper as adults (National Research Council and Institute of Medicine, 2000).

To support the healthy development of our youngest children, tribal communities are moving to build comprehensive and coordinated systems of early childhood services. The overall goal of these community-based systems is to help all individuals reach their full potential, as well as make the most effective and efficient use of available resources. They are proactive and preventive in nature, helping parents develop the knowledge and relationships they need to raise happy and healthy children. The systems also have extensive referral networks in place to address the diverse needs of children and families at risk.

A key component of local early childhood systems is home visiting, a practice that delivers services in the homes of families who are expecting or have young children. These services include information about parenting, health, and child development; linkages to other community services and resources; and other social supports. The home visitor, who may be a nurse, social worker, or paraprofessional, develops a strong relationship with the parents (or other primary caregivers) to help them achieve positive outcomes for their families.



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Research findings and reviews of evidence-based home visiting programs indicate that high-quality home visiting programs can improve a wide range of child and family outcomes, including child cognitive outcomes, more efficient family use of health services, positive changes in parenting attitudes and behaviors, and reduced child maltreatment and abuse. Home visiting can also improve parent education and employment outcomes and increase family economic self-sufficiency (Home Visiting Evidence of Effectiveness, 2014). Though the evidence base for home visiting is more limited in tribal settings (only one home visiting model meets standards for evidence of effectiveness in AI/AN populations), home visiting is seen by tribal leaders as a highly promising intervention.

In many ways, home visiting programs are an extension of the support that tribal communities have been providing to pregnant women and families with young children for generations. They are intended to complement—not replace—the support provided by extended families, faith groups, local health and social service providers, and others.

While home visiting programs can be helpful to all families, they are of particular benefit to families with the greatest needs. Therefore, the grantees were required to give priority to high-risk groups among the eligible families in their community as identified through their community needs assessment. Examples of the priority populations identified included low-income families, pregnant teens, families who have a history of child abuse or neglect or have had interactions with child welfare services, families who have a history of substance abuse or need substance abuse treatment, and families who include individuals who are serving or have formerly served in the U.S. Armed Forces.

The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)

The MIECHV program, administered by the Health Resources and Services Administration (HRSA) in collaboration with the Administration for Children and Families (ACF), responds to the diverse needs of children and families in communities at risk and provides an opportunity for significant collaboration and partnership at the federal, state, tribal, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

The goals of the MIECHV program are to: (1) strengthen and improve the programs and activities carried out under [Title V of the Social Security Act](#); (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for eligible families who reside in at-risk communities. HRSA administers MIECHV grants to states and territories, while ACF administers grants to Indian tribes (or a consortium of Indian tribes), tribal organizations, or urban Indian organizations to conduct an early childhood home visiting program. The legislation sets aside 3% of the total MIECHV appropriation for grants to tribal entities and requires that the tribal grants, to the greatest extent practicable, be consistent with the requirements of the MIECHV grants to states and territories, including conducting a needs assessment and establishing benchmarks

The Tribal Home Visiting Program

During the establishment of the MIECHV program, there were concerns that existing home visiting approaches may not adequately address the particular needs and circumstances of tribal communities. American Indian/Alaska Native (AI/AN) individuals in the United States face a unique set of challenges. Disparities in health care and education services, coupled with historical and intergenerational trauma and high exposure to risk factors, are prominent in tribal communities and especially troubling for the youngest and most vulnerable children.

These challenges are more than individual or family problems. They may affect the future prosperity of tribes as a whole and perpetuate disadvantage and disparity for generations to come.

At the same time, AI/AN communities have strengths and assets that a well-designed home visiting strategy can elevate and build upon. These include strong cultural identity and traditions, a shared history and sense of community, and intergenerational ties that offer guidance and support for families raising young children.

The goals of the Tribal Home Visiting Program include the following:

- supporting the development of happy, healthy, and successful AI/AN children and families through a coordinated home visiting strategy that addresses critical maternal and child health concerns, early learning, family support, and child abuse and neglect prevention;
- implementing high-quality, culturally relevant, evidence-based home visiting programs in AI/AN communities;
- expanding the evidence base around home visiting interventions with Native populations; and
- supporting and strengthening cooperation and coordination and promoting linkages among various programs that serve pregnant women, expectant fathers, young children, and families, resulting in coordinated, comprehensive early childhood systems in grantee communities.

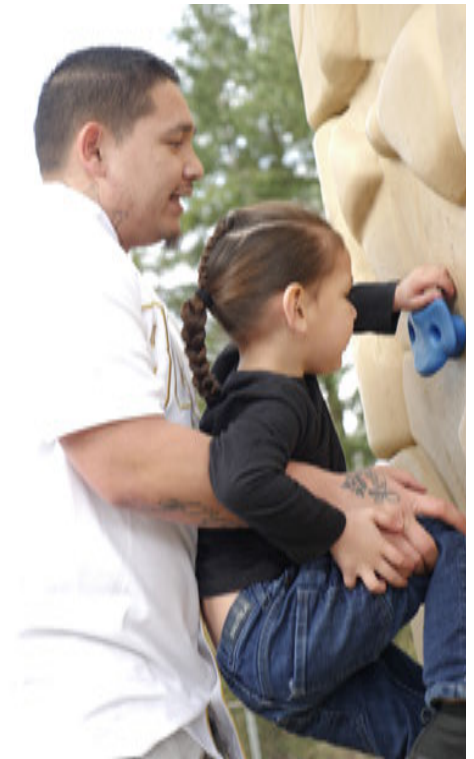


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Between 2010 and 2016, ACF funded three cohorts of Tribal Home Visiting Program grantees, totaling 25 grants. These particular grants are “cooperative agreements,” a type of federal assistance that incorporates substantial federal involvement and technical assistance. Nineteen of these grants have now ended, and their submitted final reports are the basis for this report.

Purpose and Scope of This Report

This report summarizes the experiences and insights of the first two cohorts of Tribal Home Visiting Program grantees. It provides (1) the methods by which information for the report was collected and synthesized; (2) a description of the 19 grantees; (3) detailed information on the Tribal home visiting approach; and (4) examples of how Tribal Home Visiting Programs have supported improvements in local early childhood systems. The last section of the report highlights key findings, lessons learned, and other insights that can help inform future efforts in Tribal home visiting.

METHODOLOGY

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This report was developed under a contract between the ACF and ZERO TO THREE. The goals of the project were to review and synthesize the experiences of the first two cohorts of Tribal Home Visiting Program grantees, identify lessons learned, and share insights to help inform future efforts in home visiting in AI/AN communities.

The work plan for the report identified the sections and subsections from the grantee final reports to be reviewed, referencing the relevant questions contained in the “Tribal Maternal, Infant, and Early Childhood Home Visiting Program: Guidance for Submitting an Annual or Final Report to the Secretary” (U.S. Department of Health and Human Services, Administration for Children and Families, 2016d). The review also considered pertinent information from

earlier guidance documents and previously published reports about the Tribal Home Visiting Program. These references are included at the end of the report.

The ACF provided final reports from 18 grantees from Cohorts 1 and 2. (One grantee received a no-cost extension on its grant, and a final report was not available at the time of this writing.) The writers began with an overall review of the final reports to assess the amount, quality, and organization of information provided. Because the questions were open ended, there was significant variation in the scope and detail of responses among the grantees. In addition, the quality of information provided was affected by the longevity of the staff person writing the report. Therefore, in consultation with ZERO TO THREE, the writers focused on themes and trends that could be gleaned across grantees.

The writers conducted a detailed analysis of the responses to the final report questions related to each subsection or topic. This process included:

- summarizing the final report instructions for each subsection, as well as any specific guidance on that topic provided during the grant period to frame responses;
- documenting the range and frequency of grantee experiences on each topic to the extent possible, based on the information provided;
- identifying successful strategies reported by grantees when implementing the various aspects of the program;
- identifying challenges reported by grantees and the methods used to address them;
- summarizing grantee feedback and lessons learned; and
- providing key findings, lessons learned, and implications for future Tribal Home Visiting Program development.

The writers provided a draft report to ZERO TO THREE and the ACF for review, discussion, and revision, which are reflected in this final document.

DESCRIPTION OF TRIBAL HOME VISITING GRANTEES

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This report focuses on the first two cohorts of Tribal Home Visiting Program grantees, involving a total of 19 grantees. Both cohorts received grants for a five- to six-year period, with the first beginning in FY 2010 and the second beginning in FY 2011. A third cohort that began in FY 2012 is ongoing (see Appendix 1).

Grantee Characteristics

The grantees in Cohorts 1 and 2 represented a wide range of urban, rural, and even remote areas spread across 11 states and hundreds of different tribes (see Table 1). There is a mix of representation from reservation, nonreservation, and combination areas. The grantees serve tribes that range from having a couple dozen births a year to a few thousand a year.

There is also diversity in the types of grantee organizations, which include tribal nations, urban Indian organizations, consortia of tribes, and tribal organizations. For example, The Kodiak Area Native Association is a nonprofit corporation that provides health and social services for AI/AN people of the Koniag Region. The Port Gamble S'Klallam Tribe is a sovereign nation tribal government with full governmental control of land and resources. Its program was

implemented by the Tribe’s Children and Family Services Behavioral Health Division under its Family Preservation Program. Some grantees are tribally chartered or tribally governed health centers, with other examples identified later in this report.

Community Characteristics

Tribal populations face a similar variety of health, education, and resource challenges rooted in poor social conditions. Research has shown that AI/AN groups, overall, are the most at-risk minorities for many health problems and have experienced a lower health status than that of the general population. AI/AN children face a higher risk of abuse and neglect.

However, AI/AN populations have strong cultural traditions and intergenerational ties. They have great capacity to support the healthy development and well-being of young children and families. Each grantee began by conducting an individual needs and readiness assessment to best determine the type of program needed for their unique situation.

Grantees reported some common assets and challenges that are important to consider in the planning and implementation of home visiting programs. These include:

- the cultural strengths of extended families and communities, multigenerational relationships, cultural identity, language, and spiritual practices;
- tribal sovereignty, which affirms the right of tribes to decide how to implement programs that maintain their values and promote the well-being of their members;
- historical trauma due to forced relocations, prohibition of language and traditions, removal of children to boarding schools, and other losses; and
- social and economic disparities in terms of health, education, employment and income, and higher rates of alcohol and substance abuse.

Many grantees had challenging geographical issues to overcome in order to serve families. For instance, the Kodiak Area Native Association served families

Table 1

Tribal Home Visiting Grantees Cohorts 1 and 2 (Total = 19)

Type of Organization

Tribal Nation	9
Consortium of Tribes	3
Urban Indian Organization	5
Tribal Organization	2

Type of Location

Rural	11
Urban	3
Both rural and urban	5
Reservation	8
Non-reservation	8
Both on and off reservation	3

Grantees by State

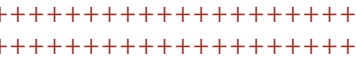
Alaska	3
Arizona	1
California	3
Minnesota	1
Montana	1
Nevada	1
New Mexico	3
North Carolina	1
Oklahoma	1
Washington	3
Wyoming	1

living in remote Alaskan villages on Spruce Island, which is accessible only by plane or boat. Grantees who served families in remote areas addressed issues of distance, infrastructure, and transportation by being flexible and entrepreneurial. In Kodiak’s case, home visitors often hopped on the weekly mail plane to reach families situated on the island.

While grantees in urban areas may have had easier access to resources and services, they often faced challenges integrating culture into their programs due to the hundreds of different tribes in these communities, each with their own unique history and cultural background. For example, the AI/AN relocation efforts of the 1950s resulted in more than 200 tribes currently being served by the Native American Health Center in the San Francisco Bay area. Isolation from their homelands has meant a loss of individual culture for many community members. The Native American Health Center’s home visiting program tries to bridge this gap by exposing families to a wealth of cultural resources provided by the urban Indian community.

In other cases, some grantees represent multiple small communities or a mix of urban and rural areas. For instance, one grantee, Riverside-San Bernardino County Indian Health, covers an area of nearly 30,000 square miles that includes a consortium of nine tribes across 77 communities. The Lake County Tribal Health Consortium serves more than 100 diverse tribes scattered through 12 small towns, three rancherias, an Indian colony, and two incorporated cities.

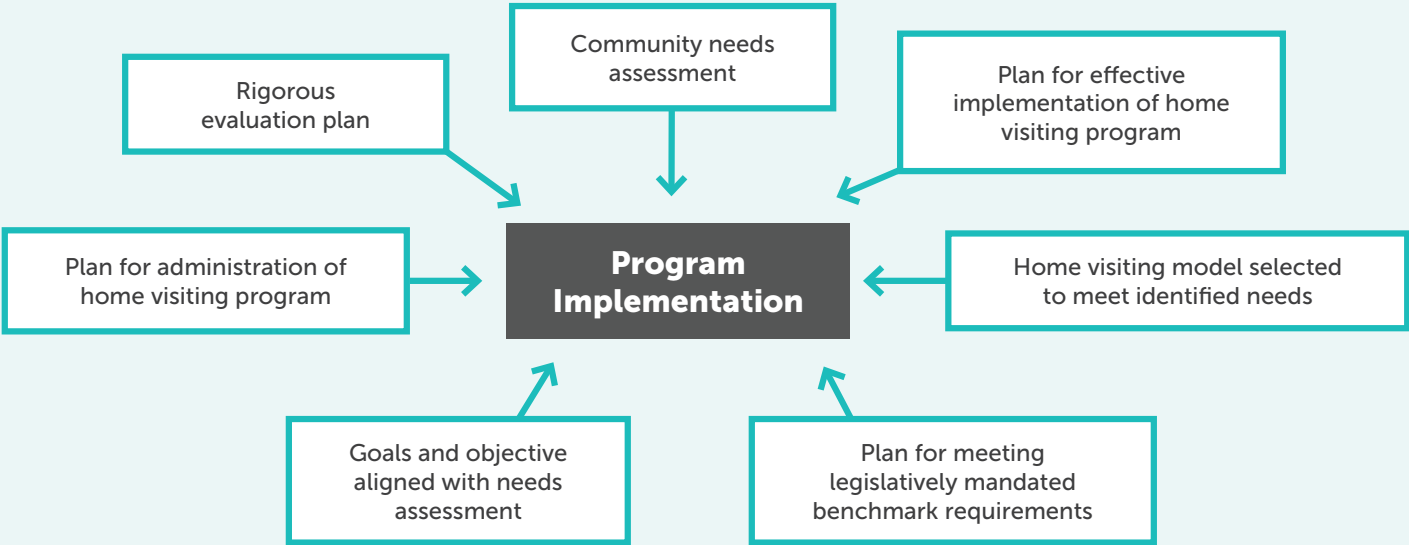
THE TRIBAL HOME VISITING APPROACH



The Tribal Home Visiting Program is designed to support efforts on multiple levels, including building local capacity to provide high-quality home visiting services, contributing to the development of comprehensive and coordinated local early childhood systems, and

Figure 3

Components of Grantee Comprehensive Implementation Plan



enhancing the research base on home visiting with AI/AN families.

During the first year, each grantee conducted a comprehensive community needs assessment, as well as an assessment of its organizational readiness to develop, operate, and evaluate an evidence-based home visiting program. The grantee then developed a comprehensive implementation plan and began to build capacity to respond to identified needs. The required components of the implementation plan are outlined in Figure 3. Upon approval of the plan, the grantees received funding for implementation for Years 2–5.



Photo © LCTHC

Grant funding and technical assistance (TA) support the following activities:

- conducting a needs assessment of the tribal community (or communities) that considers community characteristics and the quality and capacity of existing home visiting programs and other supportive services, is coordinated with other relevant needs assessments, and involves community stakeholders as appropriate;
- collaborative planning efforts to address identified needs by developing the capacity and infrastructure to fully plan for, adopt, implement, and sustain high-quality home visiting programs that are part of coordinated early childhood systems;
- providing high-quality, evidence-informed home visiting services to pregnant women, expectant fathers, and parents and primary caregivers of young children from birth to kindergarten entry;
- supporting quality implementation by collecting and reporting performance data on the six legislatively mandated benchmark areas to determine improvement and engage in continuous quality improvement (CQI) activities; and
- conducting rigorous local research and evaluation activities that may include examining the effectiveness of home visiting models in serving tribal populations, adaptations of home visiting models for tribal communities, or questions regarding the implementation or infrastructure necessary to support the implementation of home visiting programs in tribal communities.

This section describes grantee experiences in the central activities of their grants: community engagement and trust building, development of goals and objectives, home visiting model selection and implementation, serving families, supporting home visitors and other staff, supporting quality program implementation, and program evaluation.

Community Engagement and Trust Building

Gaining the trust and participation of the community was key to the successful implementation of Tribal Home Visiting Programs. Through the initial community needs assessment and the development of ongoing relationships, the programs created networks of support and referrals for families. Grantees also cultivated relationships with other organizations that could provide additional resources and services to the families served by home visiting programs.

Comprehensive Community Needs Assessment

As a requirement of the first year of their cooperative agreements, grantees conducted a comprehensive community needs and readiness assessment prior to program implementation. The two primary components of this process were an assessment of community needs and an analysis of the capacity of systems to meet these needs.

Qualitative and quantitative data were collected through various data collection methods, including online surveys, focus groups, and personal interviews. Collecting the data and completing the needs assessment helped grantees identify and characterize their target communities. This process provided information on community strengths and risk and protective factors.

Data collection focused on topics such as the rates of use of various forms of public assistance, crime, education levels, and substance abuse. Grantees were then required to assess their capacity to provide needed services and treatments as well as to implement home visiting services into an early childhood system.

The needs assessment process helped grantees develop their program and choose the most appropriate home visiting model for their community, and it served to engage and involve communities from the outset.

In their final reports, grantees reflected on their methods for involving and retaining the support of the broader community, lessons learned in the process, and the overall significance of receiving community buy-in.

Predominantly, the grantees found that the assessment process was helpful in engaging with the community and involving them in the development of their programs. Many found that this early engagement helped create a sense of ownership and investment by the community in the program. Most grantees reported an immediate response by community stakeholders once their input was sought. Stakeholders were families, community and tribal leaders, and other service providers.

Often, the stakeholders continued to support the program because of the early involvement. In some cases, families who participated in early activities gained trust, stayed involved, and encouraged others to enroll in the program. The needs assessment process was also effective for several grantees in securing the support of tribal and community leadership, as well as involving other service providers. These leaders and professionals served on councils, helped secure resources, and provided referrals.

"These relationships proved critical to later referral bridges," said one grantee. "We can see a direct connection between the agencies involved at the needs assessment period to the agencies we continue to receive steady referrals from today."

PROGRAM GOALS IDENTIFIED BY GRANTEES

The following is a compilation of program goals most frequently identified by grantees, across program models and locations. These were implemented using a variety of locally tailored strategies that involved home visits, group activities, and referrals to needed services.

Health and mental health

Improve maternal, infant, and child health with pre- and post-natal care and instruction, including preconception planning and care; prenatal care; breastfeeding; maternal and child health care and insurance; healthy behaviors (nutrition, exercise, substance use); social and emotional well-being of children and parents; and screening for maternal depression.

Child learning and development

Ensure that primary caregivers support early learning and school readiness, focusing on parent-child interactions; parent knowledge, skills, and practices; child developmental assessments; culturally relevant child-rearing practices; involvement of fathers and extended families; early intervention for developmental delays; and appropriate methods of discipline and dealing with challenging behaviors.

Safe environment

Ensure that parents are providing a safe environment for their children, including caregiver training in injury prevention and home safety; prevention of child maltreatment; and prevention of domestic violence among primary caregivers.

Family economic security

Improve the socioeconomic status of participating families through concrete supports in time of need; setting and reaching individual and family goals; support for employment, continuing education, and improved self-sufficiency; and assistance with finding and paying for child care.

Community resources and supports

Ensure that families have the ability to access the community resources they need through screening and referring families for additional services; improving parent knowledge of resources and confidence to access them; networking and collaboration among agencies serving families; community awareness of and referrals to home visiting programs; support for traditional values and traditions; and the involvement of tribal elders and leaders.

Strategies for Ongoing Community Engagement

Once the initial buy-in was established, most grantees worked on building and strengthening relationships and collaborative partnerships with community and tribal leaders and other service providers. Many found that earning the support of tribal leadership and tribal elders was the key to getting support from other community members and organizations. All grantees agreed that engaging their respective communities was necessary to build a strong program.

Several grantees discussed the importance of their advisory councils in maintaining community engagement and connections. Council membership typically included representatives from other local agencies serving families, as well as interested persons from the community at large. In some cases, getting consistent community participation in advisory councils was a challenge. A few reported low attendance at council meetings, especially early in the grant cycle. Having meetings at more convenient locations and offering incentives mitigated some of those issues.

Some grantees made a point of attending various social and cultural events to connect with potential clients and other service providers. Some participated in community groups, coalitions, and networks to maintain strong ties with other organizations.

“Our direct outreach and connection to other service providers were critical both for program recruitment and finding resources for the families we serve,” said one grantee. “We seek out programs that serve a significant portion of AI/AN families and share our information with them. Because the services we offer are so unique, many providers are very interested in learning about our programs.”

Another grantee described staff efforts to build a network of cross-referrals with other service providers and developed a resource directory, actively reaching into the community. Staff went a step further by obtaining certifications that would be helpful at community events. For instance, some staff are now child safety technicians certified to fit car seats, while the program coordinator is certified in the a local “safe sleep” program. These certifications allowed staff to meet community needs and gain trust and support at the point of contact. Many grantees also chose to open its group activities to the entire community, not just to parents already enrolled in the home visiting program.



Involving tribal elders early and often proved to be pivotal for grantees. They found that once the Elders embraced the importance and validity of the programs, their communities tended to follow suit. One grantee said the following:

“ Tribal Elders and the Tribal council offered input, guidance, and valuable support at several key junctures. These two groups demonstrated a belief in the process that was steadfast and loyal. Even with all the bumps and challenges, they saw the potential and kept pushing forward. That was so valuable. The team would not have survived without that level of commitment.”

Grantees used a variety of strategies for involving tribal elders. For example, having regular dialogue with Elders led to better relationships with tribal communities. One consortium of tribes found a Board of Elders that represented each of the tribes—an important factor in their success. Another grantee recruited grandmothers, who were also tribal elders, as mentors for new mothers in the program.

Grantees Goals and Objectives

Upon completion of their community needs assessments, the grantees developed implementation plans for Grant Years 2 through 5. The plans included goals, objectives, and a program design based on the community needs identified. Programs were designed that coupled the particular features of the home visiting models with adaptations, supplements, and enhancements to address the priorities identified in the needs assessment process and specific community context. Across program models, the grantees shared similar goals for serving families related to health, mental health, child development, safety, family economic security, and community resources and supports, as summarized below.

Each grantee created a logic model as a tool for developing program goals, objectives, and implementation strategies throughout Years 2–5 of their projects. The grantees articulated through the visualization of a logic model the following considerations:

- the specific needs, strengths, and aspirations of the families to be served;
- the short- and long-term outcomes for families and communities that the program aimed to achieve and the indicators by which progress would be measured;
- the underlying assumptions and theories about change that guided the program;
- the strategies, activities, and resources to be utilized to achieve the desired outcomes; and
- the methods for gathering data and evaluating the program over time.

Model Selection and Implementation

In their implementation plans, grantees were required to describe the home visiting models they chose to use, how each chosen model responded to identified needs, and how the community would be involved in the selection and implementation of the models. As noted in the Home Visiting Evidence of Effectiveness (HomVEE) systematic review report titled “Assessing the Evidence of Effectiveness of Home Visiting Models Implemented in Tribal Communities” (<http://homvee.acf.hhs.gov/TribalReport.pdf>), no home visiting models previously implemented in tribal communities were found to meet the criteria for evidence of effectiveness established for the MIECHV Program. (In 2014, after grantees had selected

models, one model was determined to meet these criteria.) As a result, grantees were able to select:

- one of the models that was studied by the Tribal HomVEE review but found not to meet criteria for evidence of effectiveness;
- one of the models that was studied by the larger HomVEE review but found not to meet criteria for evidence of effectiveness, adapted to meet the needs of the tribal community;
- a model that was not studied by either the Tribal or the larger HomVEE review, adapted to meet the needs of the tribal community;
- an adapted or modified version of an evidence-based model for the MIECHV Program that includes significant alterations to core components; or
- any of the models found to meet evidence-based criteria through the larger HomVEE review, adapted to meet the needs of the Tribal community.

This section of the report summarizes the grantees' experiences in working with the model developers, how they tailored and adapted the models to their communities, and their methods for assuring fidelity. The five models selected by the grantees were: Family Spirit, Home Instruction for Parents of Preschool Youngsters (HIPPY), Nurse-Family Partnership (NFP), Parents as Teachers (PAT), and the Parent-Child Assistance Program (PCAP). A description of each model, along with the grantees who selected the model, is provided in Appendix 3.

Working With Model Developers

The model developers provided various kinds of TA to grantees, based on the stage of implementation and needs of the community. The TA was based on the core elements of the model and included required trainings, consultation, and support on planning, service delivery, cultural adaptations, data systems, adhering to fidelity, and other issues.

In their final reports, many grantees described the relationships with model developers as collaborative, with each party learning from the other. This was especially true when it came to making program adaptations, where the model developers offered home visiting program expertise and the grantees provided knowledge and wisdom about their communities,



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families, and traditions. Across models, grantees found the developers to be open to and even encouraging of adaptations, as in the following example comment:

Because the PAT model had limited validity testing as it pertained to use with Native American families, each program was assigned a Native American TA [liaison] for assistance and practice of the model. Our TA [liaison] provided our program with outstanding direction and assisted in helping our program network with other tribes who have similar questions and concerns. The model also provided enough flexibility to substitute activities and approaches in measurement to align more with Native American mores.

Grantees found that the usefulness of model selection and implementation TA was directly related to the knowledge, style, and responsiveness of the individuals providing it. Across models, most grantees reported having positive and helpful relationships with model developers. Comments such as this one were common: *"Our PAT region's liaison is continually available by phone and email to answer questions and provide support. She has been a great resource for our program."*

Peer-learning opportunities within and across models were highly valued by many grantees. For example, one grantee identified the staff's participation in NFP's Tribal Community of Practice, which took place via conference calls/webinars and in person, as being helpful. They valued the experience because: *"there has been good discussion regarding the formative work that has guided the tribal partners. It is also an opportunity to share success stories as well as struggles and gain feedback from others on how they have tried to overcome similar situations."*

Another grantee noted the importance of maximizing the TA provided by the model developer. *"It is important for programs to know that the model developer actually works for them, and it is appropriate to work with them to make sure the program's needs are being met. This perspective, we believe, played an important role in the access we've had throughout the program."*

Challenges in working with a few model developers arose due to differing personalities, dissimilar expectations, or other issues. A couple of grantees commented that, in hindsight, they wished they had used TA from the model developer a little more often. As reflected in the other comments shared, the relationship between the program and model developer is an important one that needs to be built and maintained over time.

Adapting Models to Tribal Communities

The importance of culture in home visiting was consistently highlighted in the grantee final reports. All grantees referenced addressing culture in some manner. Specific examples of cultural adaptations are included in relevant sections throughout this report, such as this excerpt from a grantee that implemented their home visiting program using the Family Spirit model:

Overall, the entire Family Spirit program (content, staff, goals, and outcomes) fits with the community's priorities, and we have seen tremendous gains with children and families because of the partnership with Family Spirit.... In regard to the linguistic modifications to the Family Spirit curriculum, staff are allowed to interpret lesson content into the native language. Whether families' language preferences reflect [the native language or] English, or both languages as their first choice to receive the curricula lessons, staff are able to easily meander between languages and clearly deliver lesson content.

Similar experiences were reflected in interviews with eight grantees conducted by Deborah Stark (2016). Stark, a PATH Project consultant, identified at least three types of approaches that have been used by grantees to weave home visiting into community culture. They include:

- intentional enrichments, where grantees seek natural ways to integrate the home visiting model into the culture of their community, such as hiring Native staff and consulting with tribal cultural leaders;
- progressive enhancements, where grantees progressively add enhancements to the model, such as using the Native language, incorporating crafts and storytelling, and connecting families to traditional cultural events; and

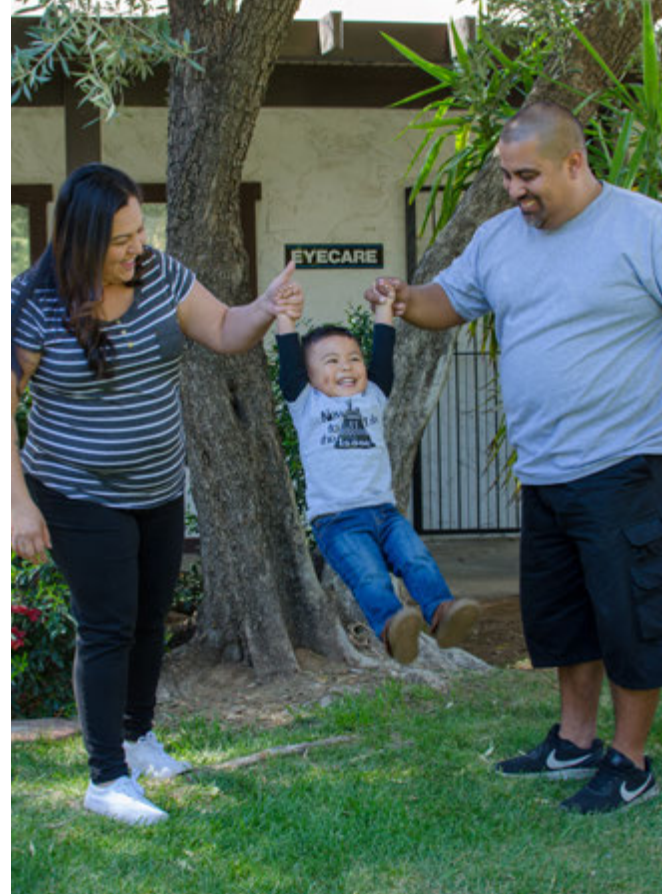


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- structured adaptations, where grantees make significant changes to the home visiting model and consult with the model developer to review and approve the changes.


Stark elaborated on these approaches in the issue brief “Cultural Enrichments, Enhancements, and Adaptations of Tribal Home Visiting Programs.” She observed that Native communities *“know best the significance of honoring and incorporating culture, traditions, and values into the delivery of services. They know the importance of considering the protective factors inherent in their cultures, looking at where these factors have been eroded over time, and designing interventions that help to rebuild the knowledge to conduct the types of activities that will bring about strong, resilient children and families in their community”* (p. 3).

Fidelity to the Model

Implementing a home visiting program with fidelity means providing the service to families in the manner it was intended. Each model outlines core components and provides guidance for delivery of services. Many grantees recognized that implementing the model with fidelity was critical to achieving optimal outcomes for families. Grantees reported a variety of strategies for maintaining fidelity, including:

- training and guidance from model developers to ensure adherence to the particular principles and standards of each model;
- policy and procedure manual development and updates;
- observation and shadowing of home visits and parenting groups;
- case conferences involving clinical and administrative supervisors and home visitors;
- reflective supervision;
- phone calls to randomly chosen families by the program director to get feedback;



- 
- ongoing data reported by home visitors and reviewed and utilized by supervisors and directors to ensure benchmarks around fidelity are being met; and
 - case record reviews to ensure adequate documentation and provide further training or direction if needed.

Many, if not all, grantees have struggled with finding the time necessary to do the above activities in a consistent and timely manner, while at the same time being responsive to the families they serve.

All of the models involve considerable data collection and reporting requirements to ensure fidelity of implementation and program quality. Some models require their affiliates to input data directly into their own data management system. Overall, data collection and reporting requirements of the models are significant. In addition, the similar requirements of the Tribal Home Visiting Program, which are discussed in a later section, add complexity and time to data collection and reporting expected of each grantee. The value of this time-consuming effort was realized when grantees used the data for program improvements, as in the following example:

Upon conducting a file review, the program coordinator found that the percentage of families receiving family-centered assessments within 90 days of enrollment was significantly below the requirement. This concern was addressed at the next staff meeting. The assessment tool the grantee had chosen asks the home visitor to rate the family in eight areas. Home visitors expressed being uncomfortable rating families on items such as "Relationship with Boyfriend, Father of Baby, or Spouse" and "Attitudes to Pregnancy." In response, program staff reviewed the other approved family-centered assessments and selected the Protective Factors Survey. Since changing the measurement instrument, the grantee met the family-centered assessment completion requirement.

Several grantees noted the tension between following the model as prescribed and responding to what families need in the moment. The following is one example of how a program was grappling with balancing the home visiting curriculum with responding to the needs identified during the home visit:

Staff have had many discussions about the appropriateness of teaching a lesson from the curriculum when the family has many more pressing issues that need to be addressed immediately. As an advocate for these families, home visitors have found themselves working to help stabilize the families before initiating the curriculum. Staff try to teach a lesson bi-weekly for needy families, and provide other types of support during other home visits.

Serving Families

Tribal Home Visiting Programs can serve pregnant women, expectant fathers, and parents of children from birth through kindergarten entry. Other primary caregivers are also eligible, such as grandparents or other relatives of the child, foster parents, and non-custodial parents who have an ongoing relationship with the child.

While home visiting programs can be helpful to all families, they are of particular benefit to families with the greatest needs. Therefore, the grantees were required to give priority to high-risk groups among the eligible families in their community as identified through their community needs assessment. Examples of the priority populations identified included low-income families, pregnant teens, families who have a history of child abuse or neglect or have had interactions with child welfare services, families who have a history of substance



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abuse or need substance abuse treatment; and families who include individuals who are serving or have formerly served in the U.S. Armed Forces.

For Tribal Home Visiting Programs, paying close attention to the cultural aspects of serving AI/AN families was also important. The programs integrated cultural teachings and traditions as sources of guidance for parenting. In addition, the grantees recognized the important influence of extended families and intergenerational relationships in tribal culture. Home visitors welcomed the participation of caregivers beyond biological parents.

Recruitment

Grantees found that recruiting families into a new program required sustained effort over time. One grantee, a well-established service provider, observed that “even for families familiar with our organization, home visiting can sound intimidating, and it is difficult to communicate its many benefits via written material or in a few short sentences.”

When the grantee was a large organization, referrals between divisions were helpful in reaching eligible families. One such organization systematized the referral process by conducting a chart review for all pregnant women served by its primary care clinic and offering home visiting services to those who were eligible. The program initially offered the home visiting services by phone, with disappointing results. They then made the decision to meet women in person at the clinic during a prenatal appointment, which resulted in higher rates of enrollment.

A grantee with a large catchment area and multiple locations experienced barriers educating other programs about their new home visiting services. The organization met the challenge by basing the home visitors at their various clinic locations. This co-location boosted awareness of the program and increased family enrollment.

Grantees also found that successful recruitment depended, in large part, on the rapport that the recruiter had with potential families. For example, one health center grantee hired a home visitor who had been employed at the agency as a medical assistant and who had worked closely with staff and families. The grantee said, “Her efforts to recruit clients and provide the much-needed home visiting component for ‘wrap-around services’ for families has been invaluable.”

The value of having rapport with families was also noted by another grantee, who found that their strongest recruitment tool was word of mouth from trusted sources, including supportive elders, home visiting staff, and families who have participated in the program.

To varying degrees, all grantees have worked to create active referral networks within the larger community. These typically include tribal organizations, as well as other agencies serving tribal members. For example, one grantee collaborated with other organizations to co-host parent support groups, which raised the visibility of home visitors among families and increased family recruitment and engagement.



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Another grantee has had similar results since it initiated weekly home visits at a residential treatment center for women in recovery who are pregnant or have young children. The collaboration has proven to be an excellent environment to provide consistent support to mothers for the duration of their treatment and an opportunity to follow some of the mothers who graduated the treatment program and stayed in the area.

All of the grantees have used a variety of materials and media to increase community awareness and understanding of their programs. Most grantees found that these tools were a valuable supplement to their outreach efforts but that they did not replace the more powerful face-to-face connections with families, service providers, and other community members.

Family Engagement and Retention

Once families were enrolled, grantees focused on how to keep them fully involved. Many of the families who were served experienced circumstances that made it difficult to participate, such as having to return to a full-time job after the child's birth or having to move away to find work. Some families' lives were seriously disrupted by poverty, homelessness, domestic violence, and substance abuse.

In addition, the grantees had to grapple with the inherent challenges of starting and staffing new programs and the impacts this had on retaining families. Frequent staff turnover—the causes of which are discussed later in this report—interfered with building the trust and familiarity needed between home visitors and the families they served, and vacancies resulted in less staff time available per family. Under these circumstances, it was not uncommon for a family to drop out of a program when their home visitor left, especially if there had not been a planned transition to a new staff person.

Grantees used numerous strategies to overcome these obstacles and keep families engaged. Program staff strived to maintain frequent and regular contact, including face-to-face home visits, group activities, phone calls, and texting. They were also assertive in their follow-up when families missed meetings.

"One day a month our staff will 'drop in' to see clients who may be missing appointments, not calling or texting back, or for some reason have not been visited," a grantee reported. "We receive consent from clients at enrollment to 'drop in' and have discovered several clients who re-engage after these outreach visits."

Many grantees used group activities to create a sense of community among families and help parents develop ongoing friendships and support systems. The activities have also been a powerful tool for recruiting and retaining families in the program, as described here by a grantee:

To engage families and overcome trust barriers, the program started weekly playgroups in three communities, which resulted in a drastic increase in recruitment. The home visitors were able to engage families in the group, allowing moms to interact with one another while their children played together in a guided setting. Refreshments and a social atmosphere helped reduce barriers to trust. The program continued the weekly playgroups with enrolled families to further the relationship-building piece. This led to retention of families, as each week they had the playgroup to look forward to, followed by their home visits.

Offering incentives for participation is another common engagement strategy. “A cultural norm of most Native American cultures is the giving of gifts when visiting someone,” said one grantee. “Our program embraced this aspect of our culture through the offering of incentives of either a fuel voucher or necessary baby items at home visits and group events. These items were always greatly welcomed by the families and much appreciated.” Two grantees provided “baby boxes” to pregnant women, coupled with helpful information about caring for babies. First developed in Finland to reduce infant mortality, each sturdy cardboard box is lined with a mattress and is the perfect size for a sleeping infant. The box is then filled with clothes, blankets, and other things parents will need for their newborns.

Many grantees regularly sought input from families on the activities and programming they offered. One grantee described creating a Parent Advisory Group for the dual purpose of getting programmatic input and supporting the development of parent leaders. They asked that members come to meetings ready to work, participate, and provide input. Over time, the parents took on tasks such as helping develop parts of the curriculum and providing expertise if they had a job skill that could be of assistance to the program.

Another grantee decided to reduce caseload size to improve family retention and outcomes:

Developing and strengthening our relationships with families continues to be our priority. This includes a strong commitment to addressing high-risk issues as they arise. Based on the number of high-risk clients we serve, this necessitates increasing our focus on each family and ensuring that home visitors are able to provide high-quality services.

Supporting Home Visitors and Other Staff

The foundation of successful home visiting includes trust, rapport, and continuity of relationships between program staff and the families they serve. A good “fit” is required between the staff person’s skills and attitudes and the program’s philosophy and practices. The staff need a strong sense of purpose and process, coupled with a high level of flexibility in meeting families where they are. Staff also need skillful supervisors and experienced home visitors to serve as role models. The recruitment, training, and retention of qualified staff can be challenging, especially when developing a new program, with staff requirements varying across various home visiting models.





Recruitment and Retention

About one third of the grantees reported mostly positive experiences in recruiting and retaining program staff, including home visitors, supervisors, program coordinators and directors, and data managers. The grantees cited a number of factors that contributed to their success:

- careful hiring, with clear communication about the requirements of the job, the nature of the relationship between home visitors and families, and the desired qualities of staff to be respectful, open minded, nonjudgmental, and willing to learn;
- whenever possible, hiring qualified staff who are members of the Tribe or at least familiar with the Tribe and its culture;
- offering wages that reflect the responsibilities of the position and are competitive with similar positions in the area;
- providing a good work environment, addressing practical needs (transportation, mobile phones, laptops, office space, etc.), as well as cooperative and supportive relationships among staff members; and
- providing quality leadership, supervision, and support that includes team building, regularly scheduled one-on-one reflective supervision, clinical consultation when needed, recognition of staff and program achievements, and opportunities for staff to continue to learn and advance in the field. One grantee gave employees time to be used for education or physical exercise, with free access to local fitness centers.

Reflective supervision is an important element of all home visiting program models. Reflective supervision helps staff to process their experiences and gain insights on how to better serve families, as well as to take care of themselves, thus preventing staff burnout and turnover. Reflective supervision is typically provided individually on a monthly basis and can also be offered in a group format. This was a new approach for most grantees and one that has taken time to learn and practice.

Many grantees viewed reflective supervision as a key piece of an overall strategy to support and retain staff. One grantee observed the following:

[T]he provision of additional training, fully implemented reflective supervision, and adequate support has helped to prevent Home Visitor turnover. The job of Home Visitor can be very stressful so providing stress management training, reflective supervision and a supportive work environment where requests for assistance can be honored and met, has been vital to the overall success of the project.

About two thirds of the grantees reported problems in staff recruitment and/or retention that adversely affected program implementation. Some of the challenges occurred primarily during the start-up phase of programs, but many recurred over the course of the grant. Beyond the staff attrition that occurred for personal reasons, the most common issues included the following:

- difficulty in filling positions due to a shortage of qualified people in the area, competition with other employers who offer better compensation, and/or issues with the grantee's hiring process, such as delayed hiring, especially in larger organizations;

- staff who left when the jobs were not what they expected or when they were otherwise frustrated by the job's demands during the initial start-up phase of establishing the program;
- stressful demands of the job, such as those described by one grantee:

The position is a difficult one serving many high-risk families who may be experiencing complex issues... complicated by having no resources for housing and little or no Native-specific substance abuse treatment facilities and perinatal treatment centers in the county. Additionally, the position is responsible for conducting assessments, data collection and case documentation in a time sensitive manner for their caseloads of 12—or more if there are vacant positions.

and

- staff attrition that began when grantees were notified that their grants would not be renewed and other funds were not available to continue the positions.

When these issues occurred, grantees took a variety of actions to resolve or at least reduce recruitment and retention problems, including:

- adopting a more rigorous hiring process to ensure that the candidate is the right fit for the job;
- involving staff in program planning and decision making to create a sense of ownership and buy-in;
- holding staff retreats that include team building, celebrating successes, and teaching and practicing self-care; and



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- developing an Employee Retention Program, which supports employees through a number of activities designed to understand what motivates an employee to stay or leave and proactively addressing the reasons.

Professional Development

Grantees demonstrated a strong commitment to the ongoing learning and development of their staff, including participation in the orientation and training required by their respective model developers. Home visitors also received trainings and certifications in additional topics over time. The topics included assessments (e.g., Ages and Stages Developmental Screening, Edinburgh Postnatal Depression Screening, the Women’s Experience with Battering Scale); issues relating to the care of newborns (e.g., car seats, safe sleep, CPR and first aid); and a host of other perinatal, early childhood, and family issues.

The grantees also supported in-depth training on enhancements and supplemental curriculum implemented as part of their program. The following were among those most often mentioned:

- Brazelton Touchpoints Center, which offers training for home visitors on enhancing early childhood social–emotional development and family mental health;
- Circle of Security Parenting, an 8-week parenting program that helps parents learn how to respond to their children’s needs in a way that enhances their attachment and often leads to positive changes in the child’s behavior;
- Fatherhood Is Sacred/Motherhood Is Sacred, two 12-week programs that offer participants the opportunity to gain a deeper understanding of the importance of responsible fatherhood/motherhood as reflected in Native American values and beliefs;
- Johns Hopkins Center for American Indian Health, which conducts week-long institutes every summer and winter that are designed to introduce indigenous health leaders to public health approaches to address health disparities in tribal communities;
- motivational interviewing, a method that works on facilitating and engaging intrinsic motivation within the client in order to change behavior; and
- Positive Indian Parenting, an 8- to 10-week curriculum that provides practical and culturally specific training for AI/AN parents. The curriculum draws on the strengths of traditional Indian parenting practices and empowers Indian families to reclaim their right to their heritage of positive parenting.

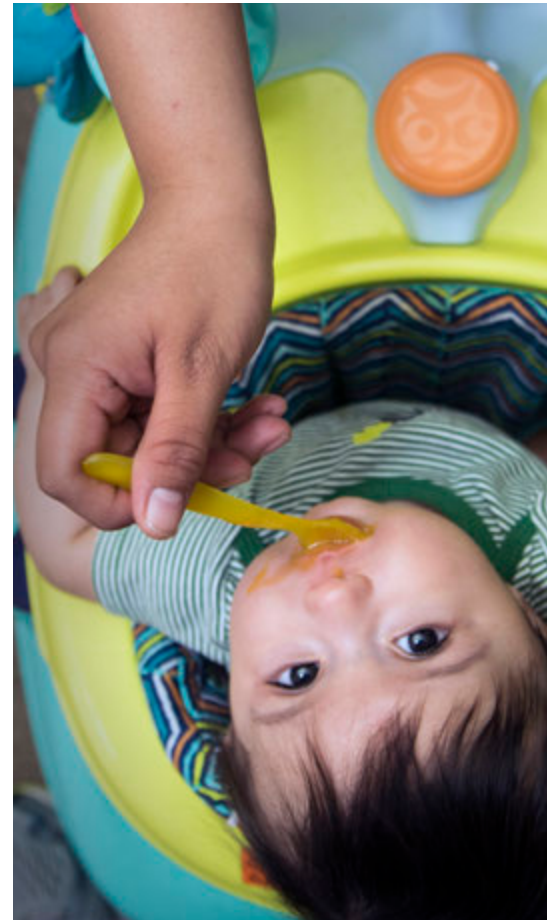


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Supporting Quality Program Implementation

Benchmark Performance Measurement Requirements

Grantees were required to collect data on legislatively mandated benchmark performance measures by adopting data systems and mechanisms to measure, track, and report on improvement in the six benchmark areas listed below:

1. improved maternal, newborn, and child health;
2. prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency room visits;
3. improvements in school readiness and child academic achievement;
4. reductions in crime or domestic violence;
5. improvements in family economic self-sufficiency; and
6. improvements in the coordination and referrals for other community resources and supports.

Most grantees shared overall improvements in the benchmark areas across the three-year period of measurement. Some reported improvements across all six benchmark areas.

In their final reports, grantees described their successes and challenges with the benchmarking process. Most had limited experience with this level of data collection and reporting. In the beginning of their projects, many struggled to fully understand the time, knowledge, and resources needed to execute this portion of the grant requirements. Several reported being overwhelmed by the scope of the process, while all faced some sort of challenges.

The most significant challenges reported were staff turnover; the need for initial and ongoing training for home visitors; time and resources to accurately collect and input data; obtaining the right software to manage and extrapolate information; client attrition during the specified collection periods; accuracy of the client's reporting; technology and Internet access in remote locations; and the struggle to match ACF-established benchmarks with their individual cultures as well as their selected evidence-based models.

Because many of the benchmark constructs required data collection during home visits, the home visitor was the person responsible for collecting these data. The challenge most frequently reported by home visitors was managing the volume of paperwork and time it took to complete data collection with accuracy. This challenge made it difficult for both home visitors and clients. Home visitors often struggled to prioritize a client's immediate needs with collecting data on time. Given all the paperwork, some clients lost interest, lacked trust, or did not have the literacy skills needed to complete the required instruments. This frequently led to missing or questionable data. Though grantees managed to primarily meet the challenges or continued working to make improvements, most of them suggested looking for ways to streamline or reduce the amount of data collected so more time could be effectively spent delivering the program content and services.

In response to the process, a common theme expressed by grantees was the desire to have benchmarks that more accurately reflected their individual cultures and communities. In some communities, for example, visits to the emergency room are often the best way to get health care services for infants rather than something to be discouraged. One grantee



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reported families dropping out and then re-enrolling due to normal seasonal population trends, which led to benchmark inaccuracies. Others noted that the sample size available for developing the performance measures was too small.

A few grantees expressed concern that the performance measures did not adequately take into account the impact that other systems and circumstances have on measures of individual-level change. One example was a mother who was unable to breastfeed because of a medication she needed to take. Another grantee noted that housing instability is a big issue that can take years to solve. “While we do not have a measure tied specifically to housing, almost every measure is affected when a family is homeless,” said the grantee. “We put a lot of effort into supporting families in finding both temporary and permanent housing. Collecting this information would provide context for the included measures and better illustrate our program.”

Working to meet the mandated benchmark requirements was a time-consuming, labor-intensive component for the Tribal Home Visiting Programs. However, it produced results that gave programs a quantitative picture of their work and provided insight to make key improvements and better serve their clients.

Continuous Quality Improvement

CQI is a systematic approach to specifying the processes and outcomes of a program or set of practices through regular data collection and the application of changes that may lead to improvements in performance. Grantees were required to use CQI methods to track and improve program implementation. All tribal home visiting grantees participated in training on CQI and received support from TA providers when conducting their CQI projects. In their final reports, grantees described their experiences with Plan-Do-Study-Act (PDSA) cycles and related CQI tools and strategies they utilized. CQI tools referenced included team charters, creating an Aim Statement, process mapping, Root cause analysis (fishbone diagram), affinity diagrams, developing improvement theories (“if/then” statements), and work plans for CQI projects.

Only a few grantees had any prior experience with CQI or PDSA cycles, and none had in-depth experience. The majority were encouraged and excited to have their respective teams engage in CQI activities following the training workshop.

Time proved to be the biggest overall challenge for all the grantees in performing CQI. Nearly all grantees reported that it was a time-consuming process. When factoring events that frequently occurred affecting implementation, such as staff turnover, implementation demands, and meeting the needs of clients, CQI was simply not a high priority.

Though finding time to go through the CQI process was often difficult, grantees were pleased they had committed to the process. Several chose to continue PDSA cycles because they saw the resulting improvements to program performance. Notable benefits resulting from CQI projects in some programs resulted in changes in policies and procedures to improve program implementation, better working relationships across the home visiting team, an increased client base, and stronger community buy-in.

Multiple grantees reported that CQI helped keep their teams focused on the big picture of helping their clients maintain reasonable goals. Some noted that the process was effective in showing both the staff and community the ways that data can be useful. One grantee summarized the benefits of CQI as follows:

The simple CQI tools, including flowcharts, run charts and graphs, helped the team better understand and visualize the home visiting processes and data. The data separated what is thought to be happening from what is really happening. It also established a baseline which allowed the team to set goals and work toward the goals. The team was able to see whether the change that was implemented lead to improvements. The CQI process helped to emphasize the importance for data collection and provided the team with a reason for why data needs to be collected.

Program Evaluation

A significant requirement for Tribal Home Visiting Program grantees was participating in rigorous research and program evaluation activities to build the knowledge base around successful strategies for implementing and sustaining high-quality, evidence-based home visiting in tribal communities. This section focuses on the main themes and lessons learned regarding the evaluation process.

Engaging in this level of rigorous evaluation was new to most grantees, but they were open to learning. Grantees chose methodologies they believed would work best in their communities and were aligned with the program models they were using.

With few exceptions, grantees described positive, capacity-building experiences. Grantees saw their communities and programs come to recognize the value of scientific research and learned valuable lessons that provided programmatic benefits. One grantee reported:

We learned a great deal about conducting a rigorous evaluation in our community. We encountered challenges associated with how small and isolated our communities are, along with the biases created by historical trauma. We worked through these challenges and changed the perceptions of the communities' leadership and members. It was overall a very fulfilling experience for us.

Many grantees experienced challenges and limitations that may have affected their individual outcomes. Some grantees reported that the evaluation process made it clear that cultural enhancements mattered in their communities and that their programs were positively affecting families. The evaluation process was successful in that it helped grantees see and report to their organizational and tribal leadership that they were meeting the programmatic goals of reaching and helping at-risk AI/AN families. For many, this success served as evidence that their respective home visiting programs are needed.

Common evaluation challenges among the grantees were small sample sizes, a lack of necessary financial and personnel resources, family recruitment and retention, time, data management systems, and tribal regulations. Here too, staff turnover was a factor for some grantees, as reflected in this comment:

A challenge in retaining participants (in the study) was the changes in staff that occurred. Participants were starting or had already formed a connection with a home visitor and then that person would be gone. This included both the dismissal of a home visitor and the choice by others to take different jobs. The value of that personal connection was not fully appreciated and the impacts on retention were quite negative.



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Grantees also reported having families who lacked literacy and comprehension skills, moved often, or were unavailable for extended periods because of cultural traditions and activities, making them difficult or impossible to locate in the data collection time frame. Responding to urgent needs of high-risk clients also posed a challenge for home visitors in completing data collection and assessments within the evaluation time frame.

Some grantees cited cultural factors, including the effects of historical trauma on trust, as noted earlier. Many AI/AN families were skeptical of sharing information until some level of trust was built. Even then, there were methodological challenges, as one grantee explained:

Although qualitative methods were considered more appropriate than quantitative for [our community], they were not a perfect fit. Indigenous ways of knowing in [our community] do not entail interviewing people, or breaking people’s stories into codes. Nor do they rely on people from outside the [community]. As noted by Simonds and Christopher (2013), gathering data from an Indigenous person does not necessarily indicate that Indigenous knowledge has been gathered.

By the end of their grant cycles, many grantees could report successfully getting tribal and community leadership buy-in to the value of quantitative data. Staff members and home visitors who, in many cases, reported being overburdened with the volume and scope of work in the evaluation process began to commit to the approach once they saw results and developed a better understanding of the intent of the rigorous evaluation activities.

Grantee suggestions for moving forward included more training for program staff members on both data collection (especially for the home visitors) and data analysis; more time on the front end to adequately recruit and engage participating families; a longer data collection period to increase sample size, establish a stable baseline, ensure validity and support more conclusive results; and providing a better understanding of the time and budget commitment needed. Many felt that it would be prudent to focus on service delivery until the program and caseload were established before undertaking rigorous evaluation.

HOW TRIBAL HOME VISITING CAN SUPPORT SYSTEMS IMPROVEMENTS

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Tribal Home Visiting Programs operate within the context of local systems of services for young children and their families. These systems, formal and informal, typically include federally supported programs, such as child care, Head Start, and child nutrition programs, and other state, tribal, and local initiatives. Hence, a major goal of the grant was “supporting and strengthening cooperation and coordination and promoting linkages among various programs that serve pregnant women, expectant fathers, young children, and families, resulting in coordinated, comprehensive early childhood systems” in grantee communities.



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Although the local early childhood systems vary in their stage of development and are often challenged by a scarcity of resources, they have been an important factor in the implementation of Tribal Home Visiting Programs. Likewise, the introduction of home visiting programs has helped strengthen local systems, often providing a catalyst for collaboration.

This section of the report highlights three major areas in which Tribal Home Visiting Program grantees supported improvements in local early childhood systems: (1) collaborative groups and agreements; (2) service linkages and coordination; and (3) information sharing.

Collaborative Groups and Agreements

Tribal Home Visiting Programs have joined and/or initiated local collaborative groups that aim to improve the effectiveness and efficiency of service delivery for families with young children. The programs sometimes utilize memoranda of agreement to specify the nature of the collaboration and roles of each party. These strategies have helped form an infrastructure for ongoing collaboration among groups sharing common interests and goals.

Many of these collaborative groups focus specifically on early childhood development. These groups are typically composed of key stakeholders who provide services in the community to pregnant women and families with young children. Some grantees participating in these groups observed a shift from operating in silos to working collaboratively. One grantee attributed the shift to consistent meetings where all programs have the opportunity to voice their vision for a coordinated early childhood system.

In some of the larger multiservice organizations, collaboration was also an internal issue. One large grantee created an advisory team to oversee three distinct but related home visiting programs under one umbrella. By joining forces, they developed a more complete array of higher quality services. This tactic also lent itself to more effective strategies in recruiting and retaining clients.

Tribal Home Visiting Programs have also participated in collaborative groups focused on issues affecting the broader community. One example is a grantee that served a community where housing was a pressing problem and home visitors spent considerable time helping families address that issue. The program coordinator was able to strengthen relationships with housing providers by serving on the board of a countywide advocacy and outreach coalition and attending monthly meetings where agencies kept each other informed about housing and other resources.

In some cases, the Tribal Home Visiting Program was the initiator of a collaborative group. One grantee described being a catalyst for the formation of a local coalition of both tribal and non-tribal early childhood development programs. The coalition works to solve problems and organize early childhood activities and events, aiming for a comprehensive network of support, resources, and referrals for families.

One grantee described the far-reaching benefits of their collaborations:

By involving all our partners in the community, both Tribal and non-tribal, we have been able to have a program reach far beyond the home visiting services offered. We have shared training opportunities and resources with our partners. We have shared new learnings from national and state conferences with our collaboratives that influenced the projects undertaken. As one partner for the county's Family Resource Center stated, "The Tribal Home Visiting program has not only strengthened our Tribal community, but it's strengthened our whole community."

Service Referrals and Coordination

A high priority for Tribal Home Visiting Programs has been effectively linking the families they serve to other resources they need. This has been facilitated by participating in collaborative groups, as described earlier, and by other strategies noted in the following text.

One grantee reported success in reaching tribal families who were uncomfortable with outside programs. The grantee now acts as a bridge between county programs and Native families, providing better access to resources for its clients. The grantee collaborates regularly with Temporary Assistance for Needy Families (TANF) and with child support, family assistance, and family care coordinators, as well as others. The program even shares office space with the local children and family services. These programs have become some of the grantee's strongest referring partners.

Co-location was also a successful strategy for a grantee that operates local health clinics throughout a large service area. By basing a home visitor in each of its clinics, the program greatly improved intra-agency communication and referrals. The grantee also built strong referral relationships with WIC and TANF, which helped provide quicker access to resources when they were most needed.

Another grantee has been working to build a strong, more integrated agency where clients are shared across programs to make their lives easier and improve overall well-being. The home visiting program is also a part of a collaborative group that connects local agencies that meet a variety of needs and monitor school readiness. The home visiting program became part of a countywide school readiness initiative and was added to the list of key referral options for other service providers.

"Child passports" were developed and implemented by one grantee to enhance linkages and coordination across programs. For families, the passport provided a guide to child development and resources, with contact information for the various programs. It also included space for keeping track of child health visits, immunizations, height, weight, and other health-related issues. This made it easier for families to share up-to-date information across the various agencies they worked with, which, in turn, helped agencies better coordinate their efforts for each family.

A large multiservice grantee built referral relationships with 210 service-providing organizations through its extensive outreach. The program won a number of state awards, including the Health Equity Award from the state Public Health Association in recognition of its partnerships in maternal child health. Program staff served on various steering committees related to early childhood and worked closely with the state Office of Children's Services.

Information Dissemination

Sharing information was an ongoing strategy used by grantees to embed home visiting in tribal communities. Many of these efforts were aimed at increasing awareness and utilization of their programs. Equally important was sharing information to inform the field surrounding evidence-based interventions targeting Native populations, gaining the support of tribal and community leadership, and providing data that could be used for system planning and policy development.

ACF provided dissemination tools and guidance to help grantees collect and share information about Tribal Home Visiting Program findings, lessons learned, and individual success stories within their communities and to larger audiences. For the individual programs to get started and grow, they were provided with guidance on how to strategically think about dissemination.

All grantees took a similar overall approach. They created print materials such as brochures, flyers, fact sheets, pamphlets, newsletters, and posters and blanketed their service areas. These materials included a basic introduction to the program and how to get involved. They were largely directed at families and the community as a whole.

In addition, each grantee created presentations and reports that included technical information meant to keep various leaders, partners, and stakeholders up to date on the status of the program. Most reported that the regular and consistent dissemination of information to these key players was effective in deepening their understanding of home visiting and building and keeping their support.



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Other methods included tapping into local newspaper and radio, billboard advertising, using social media platforms, creating and digitally sharing compelling success stories, and presenting at conferences and workshops on state and national levels. In addition to presentations made at ACF-sponsored annual grantee meetings, many grantees also made presentations at a wide range of national conferences, including the following:

- American Evaluation Association Conference
- American Public Health Association Annual Conference
- Annual Research & Policy Conference on Child, Adolescent, and Young Adult Behavioral Health
- Brazelton Touchpoints National Forum
- Communities Collaborative Brain Development Annual Conference
- Congressional Baby Caucus Briefing on “Creating a Path for Our Children: Early Learning in Native Communities”
- Indian Health Service Medical Providers Best Practices and GPRA Measures Conference
- International Meeting on Indigenous Child Health
- National Congress of American Indians Mid-year Conference
- National Summit on Quality in Home Visiting
- Native Children’s Research Exchange conference
- Native Indian Child Care Association conference
- PEW Summit on Home Visiting
- Protecting Our Children: National American Indian Conference on Child Abuse and Neglect
- Research and Evaluation on Self-Sufficiency Annual Conference (ACF/OPRE)
- Society of American Indian Dentistry 25th Anniversary Conference
- ZERO TO THREE: National Training Institute

While tribal leaders and community partners were receptive to program information in the form of statistics and data, most grantees found that prospective clients were more interested in success stories. Examples of family successes resonated and therefore served as an effective catalyst for building many of the programs. Some successes were shared through the production of digital stories shared via online platforms.

Ultimately, all the grantees found some level of success in the dissemination process. Efforts to inform their individual communities helped to initiate and advance all of the programs. All of them continued to update and share information via their preferred platforms throughout the duration of the grant.

CONCLUSIONS

There are many valuable lessons to be learned from the final reports submitted by grantees in Cohorts 1 and 2 of the Tribal Home Visiting Program. Taken as a whole, they reflect a deep commitment to families with young children; a recognition of and respect for the importance of culture; and the ability to collaborate and create innovations that help children, families, and communities thrive. Five major findings are summarized below:

1. *Home visiting programs have been a welcome addition to the early childhood systems that serve AI/AN families.* The parenting education, support, and referrals provided by home visitors increased the capacity of local systems alongside the work of health care providers, Head Start programs, child care programs, WIC, TANF, and others. The Tribal Home Visiting Programs added a new dimension of support to families while reinforcing family participation in existing programs.

The grantees participated in and added value to existing interagency collaborations. They also initiated new collaborations, which included jointly sponsored play groups and family events, development of materials and curricula, shared professional development, co-locating home visiting staff with other programs, and coordinating referrals. Beyond service providers, Tribal Home Visiting Programs have reached out and gained the crucial support of tribal elders and leaders, reinforcing a widely shared belief that providing children a good start in life is vital to the future health and prosperity of the tribal community

2. *It is critical and feasible to make cultural adaptations and enhancements to evidence-based home visiting models to make them more appealing and effective in tribal communities.* The large majority of grantees reported positive experiences with model developers who welcomed the opportunity to improve the effectiveness of their models with tribal populations. Even though the model adaptation process was often time consuming, grantees found it worth their while because of the highly favorable responses from families.

The enhancements included adding cultural content to existing curricula, identifying or developing supplementary curricula, and initiating or connecting families with cultural events in their communities. Sometimes enhancing the model meant applying the flexibility needed to meet families where they are, such as meeting a parent at an office or other public place until she feels ready to invite the home visitor into her home.

3. *The essence of home visiting lies in the trusting relationship that develops over time between home visitors and the families they serve.* This relationship enables parents to set and meet goals for their families, engage in activities that further their children's development, and have someone to turn to for advice and assistance when needed.

Despite the central importance of home visitors and their supervisors, this was the area in which grantees reported the greatest challenges. Two thirds said they had significant problems with staff recruitment and retention that interfered with program implementation. These included a shortage of qualified people in the area and competition with other employers who offered better compensation. Another factor was the stressful nature of serving high-need families, especially in communities with few resources to which to refer them. The stress increased when staff turned over, leaving more work for the remaining workers until replacements were hired. The result was often a temporary reduction or lapse in services to families. Some families dropped out of the program at that point, and those who stayed had to build relationships with new workers.



4. *While many grantees had not previously participated directly in program evaluation, most began developing sound practices of rigorous evaluation and using the results to improve their individual programs and to further develop Tribal Home Visiting Programs overall.* The level of rigorous evaluation expected was new to most grantees, but they were eager to get started. They chose methodologies that they believed would work best in their communities and developed locally tailored evaluation questions. A few grantees were able to deliver quantifiable conclusions. Most, however, reported non-conclusive outcomes or questioned the validity of the results. The grantees did, however, begin to build capacity for rigorous evaluation, increased community and program recognition of the value of scientific research, and learned valuable lessons that provided programmatic benefits.

Moving forward, grantees suggested more training for program staff on data collection and analysis; more time on the front end to adequately recruit and engage participating families; a longer data collection period to increase sample size, establish a stable baseline, ensure validity, and provide more conclusive results; a focus on service delivery for a period of time before adding the major task of rigorous evaluation; and a better understanding of the time and budget commitment needed.

5. *Competing priorities often challenged the implementation of Tribal Home Visiting Programs.* The grantees had to juggle multiple goals within the grant, including meeting the needs of high-risk families, maintaining high-quality services and model fidelity, implementing culturally relevant practices, participating in research to expand the evidence base around home visiting, and collaborating with other programs to develop stronger early childhood systems. While grantees appreciated the value of each of these goals, many felt pulled in too many directions and unable to do all that was required of them. This, in turn, threatened the quality and effectiveness of programs and the outcomes for children and families.

One grantee expressed the concern of many grantees this way: “Between monthly calls, home visits, reporting requirements, data collection, reflective supervision time, curriculum review, and CQI, there is a lot placed on the home visitors simply from a time constraint. We need to consider hours per week they expect staff to obligate to each duty and make sure that those numbers can add up to a regular work week.”

In summary, the experiences of the grantees provide a strong foundation for the further development of Tribal Home Visiting Programs. The programs and model developers have created innovative and culturally relevant approaches tailored to AI/AN children, families, and communities. Building on this knowledge and experience, future investments in Tribal Home Visiting Programs are likely to be well received and put to good use in these communities, which value their children and want them to succeed.



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Appendix 1: Tribal Home Visiting Grantees (2010–2017) Development and Implementation Grants

Grantee	Type of Organization	State
Cohort 1 (FY 2010-2016)		
Choctaw Nation of Oklahoma	Tribal Nation	Oklahoma
Fairbanks Native Association, Inc.	Urban Indian Organization	Alaska
Kodiak Area Native Association	Tribal Organization	Alaska
Lake County Tribal Health Consortium, Inc.	Consortium of Indian Tribes	California
Native American Community Health Center, Inc.	Urban Indian Organization	Arizona
Native American Professional Parent Resources, Inc.	Urban Indian Organization	New Mexico
Northern Arapaho Tribe	Tribal Nation	Wyoming
Port Gamble S'Klallam Tribe	Tribal Nation	Washington
Pueblo of San Felipe	Tribal Nation	New Mexico
South Puget Intertribal Planning Agency	Consortium of Indian Tribes	Washington
Southcentral Foundation	Tribal Organization	Alaska
White Earth Band of Chippewa Indians	Tribal Nation	Minnesota
Yerington Paiute Tribe	Tribal Nation	Nevada
Cohort 2 (FY 2011-2016)		
Confederated Salish and Kootenai Tribes	Tribal Nation	Montana
Eastern Band of Cherokee Indians	Tribal Nation	North Carolina
Native American Health Center, Inc.	Urban Indian Organization	California
Riverside-San Bernardino County Indian Health, Inc.	Consortium of Indian Tribes	California
Taos Pueblo	Tribal Nation	New Mexico
United Indians of All Tribes Foundation	Urban Indian Organization	Washington
Cohort 3 (FY 2012-2017)		
Cherokee Nation	Tribal Nation	Oklahoma
Choctaw Nation of Oklahoma	Tribal Nation	Oklahoma
Confederated Tribes of Siletz Indians	Tribal Nation	Oregon
Inter-Tribal Council of Michigan, Inc.	Consortium of Indian Tribes	Michigan
Red Cliff Band of Lake Superior Chippewa	Tribal Nation	Wisconsin
Yellowhawk Tribal Health Center	Tribal Organization	Oregon

Appendix 2: Tribal Home Visiting Grantees (2016–2021)

Grantee	Type of Organization	State
Implementation and Expansion Grants		
Choctaw Nation of Oklahoma	Tribal Nation	Oklahoma
Confederated Salish and Kootenai Tribes	Tribal Nation	Montana
Eastern Band of Cherokee Indians	Tribal Nation	North Carolina
Lake County Tribal Health Consortium, Inc.	Consortium of Indian Tribes	California
Native American Community Health Center, Inc.	Urban Indian Organization	Arizona
Native American Health Center, Inc.	Urban Indian Organization	California
Native American Professional Parent Resources, Inc.	Urban Indian Organization	New Mexico
Navajo Nation	Tribal Nation	Arizona
Port Gamble S'Klallam Tribe	Tribal Nation	Washington
Pueblo of San Felipe	Tribal Nation	New Mexico
Riverside-San Bernardino County Indian Health, Inc.	Consortium of Indian Tribes	California
South Puget Intertribal Planning Agency	Consortium of Indian Tribes	Washington
Southcentral Foundation	Tribal Organization	Alaska
Taos Pueblo	Tribal Nation	New Mexico
Turtle Mountain Band of Chippewa Indians	Tribal Nation	North Dakota
United Indians of All Tribes Foundation	Urban Indian Organization	Washington
White Earth Band of Chippewa Indians	Tribal Nation	Minnesota
Development and Implementation Grants		
Cook Inlet Tribal Council	Tribal Nation	Alaska
Crow Creek Tribal Schools	Tribal Organization	South Dakota
Confederated Tribes of Siletz Indians	Tribal Nation	Oregon
Inter-Tribal Council of Michigan, Inc.	Consortium of Indian Tribes	Michigan
Red Cliff Band of Lake Superior Chippewa	Tribal Nation	Wisconsin
Yellowhawk Tribal Health Center	Tribal Organization	Oregon

Appendix 3: Home Visiting Models Used by Grantees in Cohorts 1 and 2

(Source: Tribal Maternal, Infant, and Early Childhood Home Visiting: A Report to Congress, OPRE Report #2015-88, November 2015)

Program Model	Family Spirit
<p>Description</p>	<p>Family Spirit is designed for Native American mothers and their children. It aims to promote mothers' parenting, coping, and problem-solving skills to address factors such as demographic challenges, family-of-origin problems, and personal stressors.</p> <p>The curriculum, which incorporates traditional tribal teachings, consists of 63 independent lessons in six domains. When the full curriculum is appropriate, Family Spirit recommends initiating the program with weekly visits at 28 weeks gestation and tapering to bimonthly visits until the child's third birthday.</p> <p>Paraprofessional health educators conduct the visits, which are typically 45 to 90 minutes in duration. Family Spirit recommends that health educators come from the participating community and have familiarity with tribal culture, traditions, and language.</p>
<p>Technical Assistance Provided by Model Developer</p>	<p>The Family Spirit team at the Johns Hopkins University Center for American Indian Health works with organizations interested in implementing Family Spirit. This team assesses an organization's readiness and capacity to implement the model and addresses any identified gaps. The Center provides staff training on the curriculum and program implementation for health educators, supervisors, and other program staff.</p> <p>In addition, frequent ongoing trainings for staff on topics such as maternal and child health, home visiting strategies, and case management are offered. It also conducts other TA activities during required quarterly meetings and on an as-needed basis.</p>
<p>Tribal Home Visiting Grantee(s) Using This Model</p>	<p>Native American Health Center, Inc. (California)</p> <p>Pueblo of San Felipe (New Mexico)</p> <p>Taos Pueblo (New Mexico)</p>

Appendix 3 (continued)

Program Model Home Instruction for Parents of Preschool Youngsters (HIPPY)	
Description	<p>Home Instruction for Parents of Preschool Youngsters aims to promote school readiness and support parents as their children’s first teachers by providing instruction in the home. The program model is designed for parents who lack confidence in their abilities to prepare their children for school, including parents with past negative school experiences or limited financial resources.</p> <p>HIPPY offers weekly, hour-long home visits for 30 weeks a year and two-hour monthly or bi-monthly group meetings. HIPPY sites are encouraged to offer the three-year program model serving three to five-year olds but can also offer a two-year program model.</p> <p>A HIPPY site typically draws the home visiting paraprofessionals from the same population that is served. A professional program coordinator at each site oversees implementation and supervises the home visitors.</p>
Technical Assistance Provided by Model Developer	<p>Organizations receive training, support, and TA with fidelity monitoring, evaluation and research, resource development, strategic alliances, and advocacy efforts. New programs receive two site visits that include home visitor training, orientation with agency administrators and collaborators, assistance with public relations events, and onsite coordinator training.</p> <p>Existing programs receive annual site visits to troubleshoot programmatic issues, offer training to coordinators and home visitors, and assess program intervention fidelity. Trainers communicate with the sites leading up to each annual visit and provide a report with recommendations and act on plans for quality improvement. HIPPY USA trainers contact their assigned programs monthly to discuss progress and provide assistance in solving implementation issues.</p>
Tribal Home Visiting Grantee(s) Using This Model	<p>Taos Pueblo (New Mexico)</p>

Appendix 3 (continued)

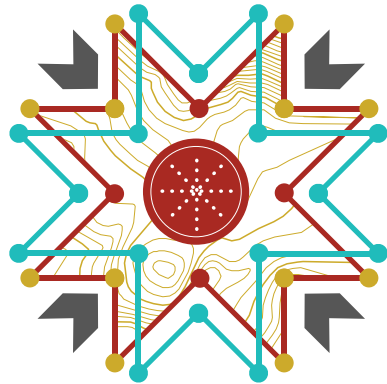
Program Model	
Description	<p>The Nurse-Family Partnership is designed for first-time, low-income mothers and their children. It includes one-on-one home visits by a trained public health registered nurse. The visits begin early in the woman’s pregnancy (with program enrollment no later than the 28th week of gestation) and conclude when the woman’s child reaches age two.</p> <p>NFP is designed to improve (1) prenatal health and outcomes, (2) child health and development, and (3) family economic self-sufficiency and/or maternal life-course development.</p>
Technical Assistance Provided by Model Developer	<p>The NFP National Service Office provides ongoing coaching and consultation to NFP nursing supervisors through nurse consultants. The Office has established a regional service team consisting of a program developer, nurse consultant, and regional quality coordinator, including staff dedicated to supporting tribal programs.</p> <p>Organizations can access technical support in the following nine areas: orientation to the program model and its implementation and evaluation requirements; community planning; selection of implementation agency or entity; staff recruitment, retention, consulting development, education, and coaching; program implementation; continuous quality improvement; research; evaluation; and contracts.</p>
Tribal Home Visiting Grantee(s) Using This Model	<p>Eastern Band of Cherokee Indians (North Carolina)</p> <p>Port Gamble S’Klallam Tribe (Washington)</p> <p>Southcentral Foundation (Alaska)</p> <p>White Earth Band of Chippewa Indians (Minnesota)</p>

Appendix 3 (continued)

Program Model	
Description	<p>The Parent-Child Assistance Program is an evidence-based home visitation case management model for mothers who abuse alcohol or drugs during pregnancy. Its goals are to help mothers build healthy families and prevent future births of children exposed prenatally to alcohol and drugs.</p> <p>PCAP’s primary aims are: (1) to assist substance-abusing pregnant and parenting mothers in obtaining alcohol and drug treatment, staying in recovery, and resolving myriad complex problems related to their substance abuse; (2) to ensure that the children are in safe, stable home environments and receiving appropriate health care; (3) to link mothers to community resources that will help them build and maintain healthy, independent family lives; and (4) to prevent the future births of alcohol- and drug-affected children.</p>
Technical Assistance Provided by Model Developer	<p>The University of Washington provides initial training on the P-CAP model, as well as annual trainings and Web-based refresher trainings as needed on site-specific topics. In addition, the P-CAP model developer is informed of program progress and TA needs through quarterly reports and phone calls. The program coordinator for the grantee using the P-CAP model has been invited to participate in Washington State’s P-CAP supervisors meeting to discuss challenges and successes in implementation.</p> <p>The model developer supports the implementation and adaptation of the model to tribal communities and recommends that the grantee share its experience implementing the model at professional conferences, at webinars, and through journal articles. Additional TA includes field observation and practice, as well as training on evaluation.</p>
Tribal Home Visiting Grantee(s) Using This Model	Lake Country Tribal Health Consortium (California)

Appendix 3 (continued)

Program Model	
Description	<p>The goals of Parents as Teachers are to provide parents with child development knowledge and parenting support, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children’s school readiness.</p> <p>The PAT model includes one-on-one home visits, monthly group meetings, developmental screenings, and a resource network for families. Parent educators conduct the home visits using structured visit plans and guided planning tools. Local sites offer at least 12 hour-long home visits annually, with more for higher-need families. PAT serves families for at least two years between pregnancy and kindergarten entry.</p> <p>Although not a tribally focused model, PAT has been adapted and delivered in more than 100 tribal communities in the United States. More than 10,000 American Indian families have been served with the model.</p>
Technical Assistance Provided by Model Developer	<p>Guidance, training, and professional development opportunities are available to PAT affiliate programs through the national office’s Affiliations and Program Support department. PAT also has staff members dedicated to supporting tribal programs.</p> <p>PAT provides foundational and model implementation training; kindergarten entry training for programs serving children ages three to five; training on administering developmental, hearing, and vision screenings; and training for professionals working with special populations.</p>
Tribal Home Visiting Grantee(s) Using This Model	<p>Choctaw Nation of Oklahoma</p> <p>Confederated Salish-Kootenai Tribes of Montana</p> <p>Fairbanks Native Association, Inc. (Alaska)</p> <p>Kodiak Area Native Association (Alaska)</p> <p>Native American Community Health Center, Inc. (Arizona)</p> <p>Native American Professional Parent Resources, Inc. (New Mexico)</p> <p>Northern Arapaho Tribe (Wyoming)</p> <p>Riverside-San Bernadino County Indian Health, Inc. (California)</p> <p>South Puget Intertribal Planning Agency (Washington)</p> <p>United Indians of All Tribes Foundation (Washington)</p> <p>Yerington Paiute Tribe (Nevada)</p>



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