

Panelists:

Patricia Del Grosso

Dr. Aleta Meyer

Dr. Lana Beasley

Ivelisse Cruz

Please note: The following is a direct transcription and has not been edited.

Patricia Del Grosso: Good morning. Thank you for being here with us today. Especially I am sure lots of folks had to go over, change their travel plans and do all that sort of thing to get here. So, I want to welcome you to our session today on building the evidence-base for home visiting models adapted or enhanced for diverse populations. My name is Patricia Del Grosso. I am Researcher at Mathematica Policy Research. I currently work on the Supporting Evidence-Based Home Visiting programs to Prevent Child Maltreatment evaluation that's funded by the Children's Bureau. I also played a role on the home visiting evidence of effectiveness systematic review that included a review of the evidence base for Tribal Home Visiting. So, I am excited to have the opportunity to facilitate this session. I think it will be an interesting range of discussions.

Before I get started I need to just go over some logistics. This session is being tape recorded as they announced earlier today but, I have a statement to read. So, as a remainder the audio for this session will be digitally recorded and once formatted for accessibility standards will be made available through the Summit website. In lieu of written consent, participants who ask questions or provide comments during the session will be giving their permission or consent to this recording. If you have any questions about the recording, please feel free to talk to someone on the Summit staff. You'll probably be hearing that same statement at every session you go today. So, this is your first. Okay, so here is an overview of our plan for this morning. I am going to begin by just introducing the panel and introducing the topic. Each panelist will then present, we will break for a minute or two between panelists, but, we'll really save questions and discussions for the end of the sessions starting around ten O'clock. Okay it's great.

So today we are going to be describing existing efforts to adapt an enhanced home visiting models for diverse populations and when I refer to home visiting, I am referring to programs serving pregnant women and families generally with children up to about age five and they use home visits as the primary means of service delivery. Programs typically aim to improve outcomes in areas such a maternal health, child health, prevention of child maltreatment, child development, school readiness and so on. In recent years, policy makers have placed increasing emphasis on the use of evidence based programs to address social challenges. The maternal, infant and early childhood home visiting program authorized by the Affordable Care Act of 2010 is providing about \$1.5 billion to states over the next five years to provide comprehensive evidence-based home visiting services to pregnant women and families with children birth to age five. As the field of home visiting grows and begins reaching more families, there is a need to

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understand the impact of these programs on diverse populations as well as to understand the efficacy and effectiveness of cultural adaptations of models. However, today we know that little research really exists in this area. So, during today's panel we will share some recent research efforts that are beginning to explore this topic and build the evidence-base. Castro & colleagues have described a continuum of approaches to cultural adaptations.

At one end of the continuum is the case for no alterations. Proponents of this approach say that evidence-based models are applicable for all subgroups and that, deviations from fidelity erode intervention effectiveness. In the middle of the spectrum are adaptations, proponents of adaptation suggests that they can improve client engagement and increase the effectiveness of programs with subgroups. Adaptations can include modifications, these are changes or considerations for language, context and culture and enhancements, which are additions to the models that do not modify the core elements of those models. So, we will be discussing examples of both modifications and enhancements today. At the other end of the spectrum are those that reject evidence-based models in favor of locally designed models and sort of in between there is using evidence to inform those locally designed models. Proponents of this approach might say that evidence-based models are not appropriate for all target populations and locally designed models can emphasize a community's unique values, traditions believes and practices. The question of whether adaptation should or should not be made is not really an issue we are going to discuss today. Rather we are going to describe how select agencies have and initiatives have gone about making these types of adaptations and what lessons they are beginning to learn.

Several different approaches or frameworks are emerging in the literature around preparations that should take place before implementing adaptations. These frameworks have a number of things in common and so for our purposes today I again pulled from Castro & colleagues who describe five important steps. Conduct a Needs Assessment of the target population, use assessment data to select an evidence-based model and identify needed adaptations, make necessary changes to the model while maintaining fidelity to core elements, pilot test the adapted model and refine the adapted model. As our next presenters discuss the process they undertook to adapt Safe Care, I think you will see how they applied this type of framework to their work. Okay, so anyone have any questions or comments before we get started with our panelists? So, at this point I would like to introduce Dr. Lana Beasley, who holds Assistant Professorships at both Oklahoma State and the University of Oklahoma Health Sciences Center and Ms. Ivelisse Cruz, who is the Safe Care Program Supervisor from the Latino Community Development Agency. Together they will describe a collaboration between the center on child abuse and neglect at the Oklahoma's Health Sciences Center and the Latino Community Development Agency to culturally adapt Safe Care for the Oklahoma Community.

Dr. Lana Beasley: Thank you. Welcome everyone. I know we are the first persons to speak to you. So, we appreciate you are here and you are not out eating breakfast. Well I am really excited to speak on this topic because this is something we really passionate about and I think you are probably going to be able to tell that as you hear Ivelisse

speaking as well. I have to tell you, we had the most fun creating this presentation and it's amazing to me how the more time I spend with our agencies, the more I learn about the program and what difference it makes. So, I think you are going to be really pleased with some of the information you are going to hear today. But, first I want to start off just giving a brief overview of what Safe Care is and to take a step back, since 2001 Oklahoma has been really systematically not only developing, implementing, but, also evaluating.

And expanding evidence-based home visitation child maltreatment prevention programs and Safe Care is a model that we have been using since 2001. Safe Care really was designed and in use within the State of Oklahoma, because what we noticed is that we had great programs for children that were low risk for child maltreatment or families and we had great programs when families, we lovingly term frequent fliers to child welfare, so those families that we see again and again get involved in the system. But, we didn't have a program for somewhere in the middle. So, really those high risk families and when I say high risk, I am talking about families that research shows have things like domestic violence, severe mental health issues and also really played with substance abuse in the families. And so these are really the families that we were trying to target so that we could create in the State of Oklahoma a continuum of care, because we know not every program is made for every family and we noticed a gap in with the services that we had.

So Safe Care is a home based model for child maltreatment prevention and high risk families with children ages zero to five. So, again we also wanted to capture a different age of children. We had Nurse Family Partnership that was great at capturing families when mothers were pregnant and we had other programs that were good at capturing really young children. But, we didn't have that sort of zero to five age range, so we thought this would be a good model to bring into Oklahoma. I think one of the best things about Safe Care that we've noticed is that it is a skills based approach. So, providers go into the home and really get their hands dirty. They get in there, they teach skills and we see families create change. So, that's very exciting to see this model actually be implemented into the homes. But, it really addresses the behaviors most proximal to child maltreatment and these, the core factors, which we are going to talk about at the end of the presentation some components that we have added more recently, but, it really addresses child health, home safety and the parent-child interaction, those were the three main components.

So now that you have an idea of what Safe Care is, I want to talk about what we did and from day-1 when we decided to adapt, one of the things we noticed is that Oklahoma had a very much growing maternal population and that was needs services for a variety of reasons, but, we weren't able to serve them because we did not have an adapted model. So, really the first year of the grant, I mean we spent a lot of time doing a lot of research and I will say I had no idea on the onset and we are creating all the committees how much work adaptation was, but, I also didn't understand how much fun it would be either. Now I am always saying let's try to grant, to adapt for another population because it really is wonderful to emerge yourself in a culture and really make changes and see that

actually come to life. But, first we knew we had to adapt the current material such as expanding health to include home remedies and we knew that we couldn't go into a home where there were home remedies being used and just say don't do that, just don't, just don't do that. That just wasn't enough. We had to explain, I mean if it was a home remedy and for example I can think of one following fun now that what families often times do in the Latino population is contraindicative in terms of health for the child.

So, that was something we had to learn about and emerge ourselves, there was a lot of meaning with physicians and of course Ivelisse was I think over every week, which is sad, we don't to mean this often. But, it was wonderful to really hear about why cultures do things and how we could come to them in a way that would keep them open, because to walk in our room and tell them to start doing something is not appropriate. To walk into a room and educate them in a way that they can embrace it is beautiful and that's what we tried to do throughout the model. So we knew we had to create additional culturally coherent materials and I think that's the key word and we also realized we had to develop practice guidelines from day one. So, we had to see and be able to look two or three years forward and say what is this going to look like when we are finished, what are we working towards and I think that that was a key component. I mean Ivelisse is going to speak in just a few minutes really about what those guidelines were and she is going through those in detail.

But, we also wanted to provide culturally coherent training material, so we wanted to make sure that we were training providers in a way that was culturally coherent and we realized very quickly after meeting with the Latino Community Development Agency Ivelisse and Patty that there are different cultures within a culture and so it wasn't enough just to say, okay, we've read all these great articles, we are going to do this to work with everyone and it's not the case. And so everyone had to come to the table with an open mind and so we had to also provide a material as well. So, we reviewed the literature and really looked at cultural considerations, but, the entire review of the literature was very much impacted by our medians with the Latino Community Development Agency. So, I remember I would say I've read this and I was so excited and they are like no, that doesn't apply to put that article away. So, they really guided us and so it wasn't just that I was writing literature, but, we all, we also were getting feedback on this is the supply, so I think that's really important.

We also identified cultures and subcultures, again that I mentioned earlier very important to do. We identified factors that potentially impact service delivery, barriers and challenges. Ivelisse is going to speak to this more, but, there are different laws in different states and so some of our families are much more afraid of getting services outside of the home because of their status and in the place that they live and so I think that's important to know. Also the servicers are able to get their children depends on if they have a social security card, etc. , so all of this definitely impacts what we do in these homes, so we have to be aware of that and then again creating that guideline for end products that she is going to talk about beautifully. So, Ivelisse and I may step up here to help with the computer.

Ivelisse Cruz: Yes, into multitask, but, I am thinking in Spanish and English and this would not go well, but, anyway I am really pleased to be here and share with you a little bit about our experience in Oklahoma was a program. When they first talked to me about the program they were just in this process of adapting and with the changes, they were really excited. But, then when we actually got the materials we just realized, this is not really quite yet right. We had different translation, different sites try to help us and they send information in their translation so we got materials from different states.

But, our population on Oklahoma is more from Mexico and Central America, so it was not at the same Spanish and even some of us, we will not understand what they will try to say and that was probably we are suppose to provide the services. So, that was our first task. We needed to read everything, we translate, we try to change the vocabulary so it will be easier to understand. But, another factor was that it was high reading level, most of our families, they would not even have completed elementary school, most of them will have fourth grade, fifth grade. So, it was like we have really great material, but, they will not care what you are saying. So, we needed to work on that like how we can have adapt these, how we can make it more approachable to the families and I will show you some examples later on.

So we came with a solution before I was certified as the supervisor and the coach I needed to do the home visit into. So, I was a home visitor and here I am trying to explain to mom. We think the fun was low rhythm level and I am sitting on the floor playing with her kid, trying to train her was probably on child interaction, but, she don't know how to read at all. So, it was like I cannot give this to her. She will not get this, so I just talk to them and they have been really helping on flexible to whatever recommendations. So, it was like I need to put some pictures and we did that and the mom will never read the information. She will just look at the picture and she will say, oh, so I need to respond to my child or I need to smile. So, that was the way we approach that. So, it has been really fun, it has been a great experience. Lot of challenges, but, you have been great not only getting our minds put together, but, also getting the feedback from families because they have been really open to tell us what they like, what they don't like and they have been really helpful in that area.

The other thing that we needed to put in consideration was for the Hispanic culture, it's not about the family only like mom, dad and the kids. We need to be open to ask, the grandmother is sitting in the base. She is just watching what you are saying and there will be, they have to challenge you sometimes like, ah, that's not the way the raised me. Oh, why you are doing this or why you are teaching this to my kid. So, we needed to be up to you know like yes, family is the most important unit, but, we have also the extended family not only uncles, aunts and the grandparents, but, we have the grandparents, we had the neighbors because that's my best friend, she knows better and we also have all other Latinos something about the Hispanic culture. I am pretty sure you are aware of that like even if you are not from the same country, you are Latino, you are my friend and we can be really good friends. So, they preferred the advice from the Latino person called me into their houses and English speaking person that broadly will have a lot of knowledge, but, they will not trust.

The other thing is like we need to put in consideration, it was like the level of acculturation. We had some of our first generation families in Oklahoma. We also have some second generation, third generation, so it's not distinct for all the families what they really know, what they really perceive that's the right thing for me, for my family like what language they speak like most of the families as I said are there from Mexico and Central America are first generation that will only speak Spanish.

So the kids are the one translating for them. But, in third generation families you will have this kid that was raised here in this state; her first language is also English. So, we needed to have the materials not only in Spanish, but, and there is basically, actually we realized materials in English too, so we can complement and that will show what is better for them. About the tradition belief that she was talking about, it was really important to take into the health material not only their belief, but, the home remedies. They will prefer to take tea, but, also they will do some things that probably will put in danger to child. So, we needed to talk about that putting a respectful way, so we needed to take that into consideration. One of the things that they were really excited when we prepared to help manual for them, we actually included this and when we went back to talk to them about how they feel about it, they were really excited like so they really have said this or they really believe this is good like can I keep, you know, go in these but, we are trying to educate them what was appropriate or not like for example first of all in *[indiscernible] [00:19:12]* we take the kids, either feed just two days and we have the chicken syndrome. So, it was the way we presented it that they were more receptive and they were like asking questions, so that really helped. I guess I am *[indiscernible] [00:19:27]*...

Also it was really funny when they approached us, they were talking about the prowess and that's really common within first generation and second generation families. They are always using prowess and storytelling and that's part of our facular and about culture. So, they wanted us to integrate that, so we actually came out with a list of prowess, I left the list there. Well I will show you later. So, because we wanted to have that accessible so they must come on prowess. We have the English version or at least the closest translation that we could get and then how we are going to use at the providers. But, we want also the providers to know what was the family are really trying to tell them. So, it was not only having the knowledge to just throw away a prowess while we were working with the family, but, what the families are really to tell you when they are talking to you and answering your questions or giving you feedback. So, it was really neat.

About racism and discrimination, we have families with different regions here in the state. It's not only that they were here pursuing the American dream. We have families that were here for health issue or another family here was here in jeopardy, so they want to try to help the other family member and they got stuck in here and they couldn't get back to their country. So, there are so many reasons for people to be here. We have natural citizens, we have legal residents, we have people with some kind of Visa, we have also the legal population and whenever you are approaching these families, it's a refining approach like you have your documents out, they updated. You can go and get services. If you are at familiarizes, a familiar area that are familiar in size, I got stuck. But, if you

know the system, you can get resources and you will know where to go, how to do it, but, if you don't have your papers and you need health services for your child you will be afraid to go to the hospital, so that was something that we needed to face and start to call the families. About religion, our culture is really minded about God has a will for us and we need to respect that like how they will think like sometime for example, the child will fall or get hurt and they will say something like that's got to be a, like you were punished by god because you are disobeying.

So, I will take that into consideration and we are providing services so we can help those families, you know, to talk with their kids and when I was talking about racism and discrimination too, the other thing is like because some of our families, they are illegal they will be exploring the jobs, they will not have adequate housing so that pulling jeopardy to job. There were different instance we needed to help the families to go through. It's not only just providing a service, but, also taking consideration of all these when we are working with them. About relationship, it's totally different approach, I don't know if any of you have been working with the Latinos. But, that's something that because we are Latino, we will have enough hugging and touching and kissing, with Americans we do. But, working with people from Central America has been different especially because they are more shy they will not look at you into the eyes and all of them will do that, but, we needed to be mindful like from where they are, how the work relates.

So, we always led a consumer guidelines when we are providing services, so you will have a family there as soon as you walk in to the door they want to hug you, kiss you and I am glad that you are here and you are like, oh, and this is my supervisor, nice to meet you and they will kiss her too. But, you also have families that that would not even look at you in the eyes. That is not they are getting what you are saying, it's just that they want to respect you, they want to show respect and we needed to be mindful of that too. Any questions so far? So on this exciting part and these are some of the changes we do for example, for the sudden infant death syndrome, the right, the left side is the English version that we've got and it was like that's the much information, they will not read this. So, it was like let's put some pictures and then I found, oh, I went the wrong way. See I said before that I will not be good at navigating and talking at the same time. We got stuck.

Patricia Del Grosso: Is that it?

Ivelisse Cruz: Oh, there you go. I found that picture and I love it. It was like, this is really neat. You have everything in one picture and it's just in small words and not too much word, so...

So, how they can keep the child safe see, I did it again. How will you handle that? Then this is the health check place that we use it with the family before you are sexually, I didn't bring that, probably was a flowchart and they needed to go with the arrows like from here, you will go here and you will decide you will the treat child at home. You know you will go to the doctor or you will go to ER. I was like, just looking at the chart

it was like yeah, if I provide they can follow these, but, the families knew it's kind of complicated. So, we just decided to do it, going down the page. I first check if this is something that is an emergency, if not then you can skip to the next step, it's now then you can skip to the next step. Later when we are working with the families we actually got feedback from this providers working with the family. They were like this is too much. It's too much work, now we are giving that at the pictures yeah, and they were like we need to simplify this and this was actually the feedback from one of our provider, she was like we need less words than this and it seems to be really working with the family, they really like it more. So, we have both options. Some family will like to read more, other not. So, they actually pick whatever works for them, whatever fits them.

Next, this is for the financial interaction that was very less size what we got up first. I translated that, but, then it was like we still need some pictures so they will remember what they need. So, that was, we did it. And this is the one that I was talking about the steps. It's like be prepared, okay, so I just, all the stuff together that you need and so we just did that with each of the step and we did that with all the forms that we have given to the finance and we have those abilities increased in it.

Dr. Lana Beasley: Yeah. We got the manuals if you want maybe want to listen more...

Ivelisse Cruz: Yes, oh I actually left them there. So, you will have an idea. You know, actually this is, there with it. This is the English health menu that we got that you know one and it was a lot of information, really good information, but, it was like our families cannot, actually they will not see to relate this. If I am having an emergency with my child, I don't think about flipping the book and checking. So, what we did, we just added the images and we added a chart about help. Now we need to change it, but, also for HL or in this that we were talking about. We added a picture. So, even if they have an emergency, they just can flip over the book and just look for it and they will know what they are looking for. And we have a case actually with one of our families. She was third generation, so she needed to read in English, she couldn't read any Spanish. But, after we gave her the manual it was like, oh, we need the English one for that. So, and we gave her this and she was like no, can I keep the Spanish one. So, just reading from here, but, she just in this one, so she will find information, sorry, well but, here, so it has been really a nice process. Lot of challenge, but, at the same time it has been fun to see how everybody is involved. This is an ongoing process and it's the team effort. We are working together and trying to make the changes necessary that will best fit for our families.

The other thing that it was challenge for us is what's, when we were training the providers. First, I took my training in English. I was funny, I was saying it was in English. We had the role-playing scenarios, so it was fun. But, they was like, okay, what I will do when I have the Spanish speaking family, because all the materials were in English. So, they was like, if I am training my providers I will then, not to be thinking English, Spanish and translating back and forth. It's about I just have to have the materials in Spanish or the language that you will need. So, we prepared all the materials and then we provided the training in English, but, I was translating and then we were

doing the role-plays in Spanish so the providers can feel a sense what it will be to have the family. They have a fun experience when I was doing the training. My boss actually was with me just from Mexico and I was doing the health scenario and suddenly she just pop out with some home remedy that was always, they are doing that thing there. And it was like I am from Puerto Rico so I knew what she was doing, the remedy. So, I just go on there, a scenario and everybody was like, oh, you did that. It was like I know what you are talking about. But, it was like a good point for us because it was like we really need to do this, feeding our families and training is not just providing the information. We want our providers to be ready whenever they are facing the challenge and when they had the family sitting in front of them, they come with these greater things.

But, they would, and of course we have providers from different countries too, so it was only the Spanish from the families, but, then we have providers from South America, Central America and I was the supervisor for Puerto Rico, so it was Caribbean Spanish. So, even well the translation I did I used a word *zafacón*—anyone knows here what that means? That’s “trash can” and whenever you are a dietician and you are the A,B,C’s they will tell you “Z, *zafacón*,” so thought it was a universal word. So, I did a translation for the materials and I put that word, no one there knew what I was talking about. So, I learned it is *bote de basura*. I remember that now. So, it was really a challenge for me and I thought I was using the universal Spanish.

And the other thing was like, and we were talking before the session again was the translation because we realized that we are not fitting our community. We tried so hard to find a translator there in Oklahoma, but, it didn’t work. We had different people translating and we were sending papers everywhere like paying for a day and then it didn’t work, it didn’t fit our family. So, we were adapting everything again and retranslating. So, at the end again this talk was a translation and it was kind of difficult because it was a lot of work to do, at the same time we were training the providers and seeing the families, but, at least it work out fine but, one of the things you want to do is to get a good translator whenever you had that coming from and one side really fits your needs. Now we have a really person just up into feedback whenever we feel that the word is not proper, we can get back with her and then she used to use the right word later on. So, it has been a really nice thing right now.

The others in the provider’s request, they were asking for more specific outlines. They already, you know, outlines, okay, were kind of no detail. He was more like you are suppose to do all these things in one session and the next session you are suppose to do these and they provides us and we are like, huh, huh, that doesn’t work for us. Tell me exactly what you want from me. So, we went and we just adapted all the outlines. We did the specific outlines for them also with the feedback, the action has to be more direct and specific. They run a more concrete information. It was not like jus some general region, the other direction, go on to these things, they want a specific direction.

With the hiring process, that was another thing that we needed to face. It was like making the decision between person with a bachelor or master degree versus a person without a degree. Person with more experience than with less experience and at least for

Oklahoma it has been, the better feed has been people with less experience and not a degree, because one of the things is more important is that they will be willing to get feedback and they will be willing to follow direction. We have a specific that we are going to follow and people with masters or bachelor or more experienced, they will think that they know the best way to do it. I was really hard, because it's the same thing we are doing with the family. We have to training the skills, we are practicing, we are giving feedback. So, if you are not willing to do it, how you plan to impact as a family, because you are doing the same thing with them and about the cultural trainer, we actually did two cultural trainings for all our providers. Lorena Barros from Ohio actually provides that training and then she is actually creating a manual for each one of the providers, so that's had been really great, so...

Dr. Lana Beasley: So, now we are going to talk a little bit about some of our results. I am going to talk quickly because I know we are running out of time. But, I think this is a really nice graph to see and prior to training and after training and provider knowledge in all of our core areas. So, healthcare, home safety, parent-child and parent-infant and all of the training is just phenomenal. I felt like I knew a lot about child development. You know, I've got a PhD, I went to school where I felt like, and I have learned so much from this material. So, I really think that the material comes to life and training and the providers really learn how to impact family, so I think this is a nice representation. And I know Ivelisse spoke about cultural sensitivity and coherency and so we are really happy with these results as well. So, you can see an overall experience, the value of the time, the amount learned, all extremely high at a four and we are seeing really high ratings of this training. And then just the overall quality of Safe Care training in general, you can see out of five being excellent, really high rating and so we are very happy and this all reflects to again how closely coherent our training. So, how well the providers accept the material is going to be a direct implication for how they represent that in the homes with families. So, I think this was our first step in saying yes, this is going well.

And this is a measure, and we call the working alliance. I don't know if any of you have used these in homes, but, it's really evaluating that provider and participant relationship. So, we collect this on the provider and the participant as well. We are also getting ready to, and produce the publication and we are going to do some matching to see how that fit is. But, this is some of our preliminary data and you can see this fantastic report. So, a green on steps to benefit the family, very high scores, almost perfect. The total mean score was 6.82. I am confident in ability to help, mutually agreed up on goals. These are the things that we want to see in the home, because when you see a relationship like this you are going to see change. And so I think we are very happy with these results and then here are the participant reports as well. So, families are saying we agree and it will benefit the family, I am confident in the ability to help, we trust one another, which we know is huge and then working towards goals is correct so again really good results.

And we also do something called a satisfaction survey, so we want to find out from families how satisfied are they with our curriculum. And you can see in all these categories we are getting close to a 100%, so I am strongly agree on all our questions across the board. But, some of the things we are seeing and health for example is caring

from my child, his health has become easier. I've recognized that my child is ill has become easier. Again key components we know to preventing medical neglect. So, if they are able to recognize that their child is sick and get them treatment we know we are going in the right direction. And home safety, which I think can be a huge prevention measure and my home is safer since I did the module, I am better able to identify and get rid of hazards in the home, things again that we want to see. I kind of remember, there is also a portion where they can write in, some of the information they learned. I remember one family wrote in and they said I feel like my home is finally safe for my children. I didn't know how to make it safe, now I know how and that same family went on to talk about I learned a new way to talk to my children. I can remember another family said from where I am from, we discipline children harshly.

And I am trying to represent because you know the translation sometimes it's a little different. Now I know that there is a better way to interact with my child and I just think that really represents what the family, we are really reaching the families. So, they are saying this wasn't necessarily culturally what I was tied, but, it was presented in a way that now I know I am educated and there is a better way. So, we are seeing that again and again from families who are saying these things. So, it's very exciting and that's again how we are getting those really good results in parent-child interaction.

Ivelisse Cruz: The satisfaction survey was not enough for us. We decided it was a good idea just to send someone out of the program just to meet with the families, talk to them and interview them. And we got some of the comments they made on those interviews and it was really exciting to see how this really help them and it was totally, you know, out of the program and it was not just writing something down. They were able to talk freely about what they think, what they feel and how this really helped them and you know that thing is like, as far as the program I need to go out and chat with my providers and he has been really neat, just to see how the families are helping, seeing the changes like they will say something like my child will never safe and you can see he is sitting there and playing. And you can actually see the changes and it has been amazing with the house especially like first time parents. They are so excited and now they know how to handle their child when they are sick. They know what to look, what are signs and it's not that we are training them like doctor or nurses, but, at least they can recognize the signs and they feel safe and confident that they can take care of the children.

Dr. Lana Beasley: So, just overall and these are some of the things that we are getting feedback from this, and again those qualitative interviews that we did and we are continuing to do this one really. I can remember the one story that I read on an interview is that a mom just told this beautiful story and she said, "I feel like when my daughter is standing up on her wedding day, she will have a better life for her and children because she will know how to raise them differently" and I thought that was beautiful. She said because I've made changes and it's going to impact who she marries and how she treats her children. So, I just think again this, we just seen this a very well received program that we are very excited about.

Just really quickly I want to go over some of our lessons learned in future directions. There have been many lessons learned we've talked about today, but, one of them is the importance of the addition of visuals in manuals. We are actually adding visuals in all of our manuals now because we've realized now being very aware of their reading level, if families can't you're your material it's not going to reach the family. Language of training, we just assume we do the training in English, people spoke English. So, we went in that day thinking we are going to talk in English and realized there is a lot of work for someone to translate from English to Spanish and back and forth. So, we were really taxing the providers and learning the material, so that was a very important lesson learned.

Also one of the things I am not sure if we talked about yet with the idea of formal versus informal language and the assessments. So, we do a lot of assessment to make sure what we are doing is helping families and to get those longer-term outcomes and we realized that a lot of our measures were either formal, informal and mix somewhere in the middle. And this isn't always appropriate to have an informal measure with the first generation family. So, we had to do some retranslation or explanation of this is, assessments is going to be done in an informal language, we just want to be respectful this was how it's translated, so making sure that we were aware of that to the respectful families. And I talked a little bit and I know that I had very much time, one of the future models that we've actually created and we are piling right now is the healthy relationships curriculum. It's been very well accepted so far and we are very excited. One of the things we noticed with our families is that they are fighting with everyone.

So, they are getting kicked out of their home because they are fighting with their landlord. They don't get TANF anymore, which is one of the benefits in our state because they fought with their TANF workers. They are not getting any kind of moneys to help their families. They are fighting with family members and they are also causes domestic violence often times. And then so we realized we needed to take a step back and really help these families learn how to have health relationships and we are very excited with our curriculum, it has fantastic pictures. We just blew pictures out of the water with this curriculum we learned an important lesson. And then also future analysis, we are going to be looking at child maltreatment outcome. So, we have the luxury of having a good relationship with child welfare and so overtime we will be looking at what we consider the goal standard of child abuse prevention work to see are we getting future referrals for these families. So, we are very excited about looking at that in the future. Thank you.

Patricia Del Grosso: Are there any questions for Lana and Ivelisse before we move on?

Audience-1: Some of the adaptations are you preferring them back into mainstream Safe Care from the things that, you know, the realization that there might be different literacy levels for things or pictures or things that you are not likely to get under the...

Dr. Lana Beasley: Absolutely.

Patricia Del Grosso: Lana, can you just repeat the question because it's low.

Dr. Lana Beasley: Yeah. One of the things that was asked is are we, I think it's migrating back, so the changes that we made to the Latino Adaptation, are we using those ideas for the English version as well and absolutely. One of the things was the pictures, yes. We are planning on making changes to the manual to make sure, you know, corporate pictures. The healthy relationship curriculum was also done in the other version and we've also added another component called BAMO for depression. So, and we haven't made that translation yet to, because we can't translate everything at once. This is a lot of work we've realized. But, we thought the healthy relationships we had to translate first. So, absolutely, we are seeing, we were learning a lot of lessons that we can use in our urban trials, in our role trials as well, so yes we've been lucky. Go ahead.

Patricia Del Grosso: And can you just speak into the microphone since we are being recorded, thank you.

Audience -2: Sure. You guys are doing some awesome work, it's really impressive. I have a question. So, we've done some cultural adaptation work with TFC-BT and one of the things that...

Dr. Lana Beasley: Can you say what that is?

Audience -2: I am sorry, Trauma-Focused Cognitive Behavioral Therapy. One of the things that when we did our satisfaction surveys, you know, the whole issue of respect, oh, I love this, I love this, I love this, it's a hundreds of hundred and so people are really happy. I am, and I love that you did some of the qualitative work to get a little more deeply into the information. Did you get anything, any suggestions that they had for change? You know like, so one of the things we asked is what did you like least and what would you change to make things better?

Dr. Lana Beasley: Absolutely. I think Ivelisse can speak to that even better than me.

Ivelisse Cruz: Actually that's helping one of the most important part of our work with the community, because they know this is the research they have been willing to give us feedback. For example, with the health manual we just have two sessions. The first one is more like prevention and then the other half will behalf different emphasis and what to do and one of the them was looking at it and she was like, well why you didn't put a page width column in the middle so we will know where to go then we just put a index and we assume they will know where to locate and then she was like no, that doesn't work. Put a color page there so we will know and that's the change that we are working on and even with the forms, like I said before like she couldn't read, so it was more like we added picture so she will see what we were talking about. So, they feel confident telling us what to fix, what they don't like and we still looking up, this is our own gone process so they know and we were still asking questions, but, they feel confident that they will tell us what they don't like and we have taken that seriously and we change this.

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Dr. Lana Beasley: I do think we have been lucky though. I think in terms of cultural coherency I think it's gone really well. I don't know if any family that we've offended and I think those qualitative interviews are key in getting feedback, because you hear specifically how we've impacted and I expect because we see this with our urban trial, some families don't like the material, later they will tell us they just weren't ready for it. And so I think part of that is really knowing the questions to ask and I think we all need to pay more attention to qualitative work, because the longer I am in the field the more I realize. It's great to have this great quantitative data. But, if we don't have a story to go with it to really make sense of the numbers, we are missing something and so I like that you brought that up, thank you.

Patricia Del Grosso: Thank you both so much. It's really interesting and like I said we will turn back to more questions in a minute. Okay, so as I mentioned earlier I will be presenting findings from the Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment evaluation, what we call the EBHV evaluation, so I won't have to say that every time.

EBHV is funded by the Children's Bureau or before I begin I like to acknowledge our Federal Project Officer Melissa Lim Brodowski and her team for their ongoing support and I'd like to acknowledge my colleagues on this evaluation.

So let me tell you a little bit about EBHV and how the Oklahoma team actually fits into this. In 2008 ACF's Children's Bureau funded 17 grantees in 15 states to select home visiting program models that were evidence-based and that was as defined for purposes of the grant to leverage the grant funds to build infrastructure to implement, scale up and sustain their selected programs with fidelity to their evidence-based models and to participate in local and cross site evaluations. Our grantees are engaging partner organizations to build infrastructure and implement and sustain home visiting programs over a five year grant period.

Most of the grantees are private non-profit organizations or their state agencies. Seven grantee, the grantees work within diverse organizational settings to support the implementation of their home visiting models. So, seven of the grantees are actually implementing the home visiting model, seven contract with our partner with one or more agencies to deliver services and that would be the example in Oklahoma where they are actually partnering with another agency and four of our state agencies that are managing statewide home visiting initiatives.

The EBHV grantees are implementing their selected home visiting models or implementing newly selected home visited models and seven are supporting existing programs or expanding implementation to new geographic areas.

Grantees are implementing five different models and here is just a brief overview of those models. Most grantees are implementing one model, but, three grantees are implementing multiple models and those are often those state level home visiting initiatives, statewide initiatives.

Mathematica and Chapin Hall at the University of Chicago were funded by the Children's Bureau to conduct a six year cross site evaluation. The evaluation is designed to identify successful strategies for adapting, implementing and sustaining high quality home visiting programs. The evaluation includes five domains, these includes system change, fidelity cost, child and family outcomes and process. The findings that I will present here today have come from our process study where we are really interested in learning how the grantees planned and implemented their grant initiatives. So, in spring 2010, Mathematica and Chapin Hall conducted site visits to ten grantees and 10, telephone interviews with the remaining seven grantees to learn about the first two years of the grant period, so that was 2008 to 2010. The first year of the grant was a planning year. So, most grantees were really just beginning to implement their models or implemented changes or expand their models when we conducted the data collection.

So this was during spring 2010 and I know these programs have been evolving kind of as we speak. But, we learned the grantees were implementing or planning the following types of enhancements, so these were really sort of additions to the models that they were working with. Two grantees had planned to add a mental health consultant or a social worker to this, to support home visitors. So, this was someone who was a part of the team in addition to their regular supervisor who could really provide some of that mental health consultation and addressing family's needs. One grantee hired a program specific interpreter and they wanted someone who was dedicated fulltime to this evidence-based model. The interpreter attended all of the model trainings and they received some additional training in facilitating rather than triangulating the relationship between the family and the home visitor, which was a concern that some of the providers had expressed. Three grantees were enhancing the models with additional services for families.

These included things like a parent training on maternal attachment, a group meeting for expected mothers on health issues and additional services based on family's needs, for example, families with depression or parent-child attachment issues. And then we have two grantees that were adapting or enhancing models for new populations. So, it was focused specifically on things like the Oklahoma team has talked to us about. So, the University of Oklahoma Health Sciences Center who I already heard from today obviously are working with Safe Care to develop a culturally competitive version of the model for Latino families. The other is the Minnesota Department of Health who is working with Nurse Family Partnership to add supplemental materials to the model to make it well suited to serve tribal communities in the state. And the Minnesota Department of Health including the Office of Minority and Cultural Health representative from a few of the states tribes who were identified as leaders for the project and representatives from Nurse Family Partnership are working collaboratively on the project.

Some examples of the modifications that were being planned by the Minnesota Department of Health and again this is, some of these may have changed overtime. So, this was as of 2010. They were working on using, the Nurse Family Partnership uses

public health nurses as the home visitors and so they were going to be using registered nurses instead of bachelor level nurses when they couldn't, could not identify bachelor level nurses in their communities, which was identified as a challenge. They were planning to have two to three part-time nurse home visitors per tribe. They were carrying very small case loads of about eight clients each whereas typically an FP nurses carry, will have a case load of about 25 families. They wanted one part-time nurse supervisor per tribe.

Usually supervisors will see up to eight nurses, but, in this case it might be someone part-time who is working with three or four nurses rather than trying to supervise across tribes. They had a tailored planning, they were planning a tailored Nurse Family Partnership training in Minnesota. Typically all training is held in FP's National Service Office in Colorado. And lastly they were developing and using specific cultural supplements to the visit guidelines. For example, home visitors are encouraging and supporting the presence of multigenerational family members during home visits, which is something we also heard Lana and Ivelisse speak about.

So we identified the three main take away messages related to adaptations that the EBHV grantees planned or implemented. One was the role of model developers or purveyors when planning and implementing these adaptations. Nearly all of the grantees that were making these types of changes were working very closely with the model purveyors. Grantees occasionally proposed enhancements to respond to implementation challenges. For example, the grantee that hired the bilingual or the interpreter and had them trained in the model, they weren't able to identify bilingual home visitors. And that was a challenge that they were facing in their community and so they came up with this modification as a way to address that.

Another issue that came up was that model purveyors did not approve all of the proposed enhancements. So, grantees sometimes had to address their plans. For example, one of the grantees that had planned, that planned, that's adding the mental health consultant to the team had originally wanted that person to also go into the homes, so who will be a third or a second visitor that would go in every now and again. So, normally the regular home visitor has that relationship with the family, but, on an as needed basis or every couple of months a mental health consultant goes into work specifically with the family on those issues. The model purveyor had concerns about the impact on the relationship between the home visitor and the family by adding that third person to the relationship. So, the grantee was planning to then have that person some the home visitors and be able to provide them any training or consultation that they needed that they could take back to the families rather than going into the homes directly.

In the remaining years of the EBHV grant, we expect to learn more about how these adaptations are really rolling out in the field. As I said this was early, this is the planning phase or the beginning of implementation phase. So, I think we will have a, we will learn a lot more about how these are working. The local evaluations will capture lessons learned and they will add to the literature through process studies and child and family outcome studies and the national cross site evaluation that Mathematica is conducting.

We will continue to document adaptations and enhancements through our process study and other study components. For more information don't hesitate to contact me. There is actually, there is more information about the EBHV initiative and the specific grantees and the national cross site evaluation on the project website, which is supporting ebhv.org and the information I presented today has drawn from a forthcoming report and when that's released it will be on the project website. I also point to another resource that we have.

As part of the EBHV initiative there is a pure learning network and back in April 2010 there was a pure learning network call that's actually recorded and available on the project website on cultural adaptations and actually the Minnesota team presented that, so it's a nice way to hear from them as well. Okay, any questions? Okay. Well at this point I like to turn it over to Dr. Aleta Meyer. She is a Senior Social Science Research Analyst at the Office of Planning, Research and Evaluation within ACF at DHHS. She is going to describe researching designs being proposed by their tribal maternal, infant and early childhood home visiting program grantees. These grantees will contribute to the knowledge base regarding cultural adaptation and enhancements of home visiting in tribal communities. I make it just it up here.

Dr. Aleta Meyer: Okay. So, how many of you have heard about the maternal, infant, early childhood home visiting program that's in the States of United States that's going on, that it's funding about the Affordable Care Act, okay. So, there is a tribal set aside, within that three 3% of that is set aside. Four grants, two tribal organizations, tribal or, so urban tribal organizations and tribes and so there are 13 grantees have been funded for the past year, it's a five year grant process and five more were added on this year and so I am going to be talking about the rigorous evaluation component that is in the legislation. So, because there is an knowledge base on what is effective in tribal communities, all of them need to be involved in rigorous evaluation, which as you might imagine is quite a hat for me to be wearing as the person who is cheerleading them on this process and trying as much as possible to frame the experiences and opportunity to really tell the story of what this grant experience has been and how these home visiting programs and under what situations and under what circumstances they have been helpful for the families in the community. So, it's been quite a challenge and I am pretty excited about it.

So this past year the grantees have been involved in a, doing a comprehensive needs assessment and they have been doing many things to build their capacity to implement home visiting programs and they also build a implementation plan at the end of June on what they would do for the next four years and so part of that implementation was what program are you going to select that's addresses the needs that you identified in your needs assessment and then how might you adapt that program before your specific, for your community and then what are your some of your initial research plans for that. So, just I sort of underplayed this, but, I think this is an important, a very substantial contribution that she has made. But, she was, I think you were the lead, weren't you on the tribal home visiting results. So, a systematic review was done of all the research that has been done on travel home visiting to determine if there were programs that could say

people yes, we have a, we feel confident that this would be effective in tribal communities. And none of the models that were, none of the studies that were submitted met the criteria for being able to then say well this is an evidence-based model. And there were number of challenges with that, a lot of the samples had too much attrition. There were great research designs and great methods put in place and great measures. But, there is a lot of people who weren't followed up with or somehow the sample is too small to say that it was rigorous.

And even so there were a lot of very important lessons that were learned from that that are in this report and I didn't include it in my PowerPoint, but, I will make sure that you get that information. So one of the important things about this was that we thought maybe there might be a shortlist that programs could then pick and implement in their communities, but, none of them, there is no kind of list like there is with the state program. So, they are all going to be doing rigorous evaluation. And so we wanted to help them think about was that what they put in place should help to under, help them understand the impact of the program in their community and that there will be some way to understand causality around that. And so we've been spending a lot of time on this particular energy of we can do it. We can do something that will help us feel confident that this works. An interesting discussion that we've had is what's the difference between program evaluation and research and so we felt that it was important to identify what we met by program evaluation and so it's the use of good quality research methods to systematically study a phrase and help improve social programs including subsidization and design, their implementation and administration, their outcomes effectiveness and their efficiency. And so that is the way that we are describing evaluation.

So, it's a use of research methods and I won't, we could have a whole session on how you define those two terms and we are not going to do that right now unless you guys want to go there later. One activity we have done with all the grantees is called PICO and it's, I will tell you what those letters stand for and it's an example of how to come up with a good research question to help you understand the impact of your program. And so PICO stands for the Target Population as described in your needs assessment, so that's the 'P', 'I' is the Intervention of program you are interested in evaluating, 'C' is the Comparison that you are going to use to understand how well home visiting works for your communities, so what will be the contrast well you'll be comparing that program to and 'O' stands for the Outcomes, the short and long-term outcomes of your home visiting intervention and this is a model that's been used in the Permanency Innovations Initiative and there were couple of awesome sessions scheduled for yesterday talking about how they use that and I think there are some today, but, it's been helpful also with our tribal grantees in terms of picking out the research questions.

So here is an example. So, the urban American Indian children named 05 living below the poverty level, so that's the population they wanted to focus on. These families receive parents and teachers and home visitation, with home visitation services. So, they demonstrate greater school readiness compared to children whose families receive usual services. So, this intervention will be a example of where the intervention was selected

to address school readiness for children living below the poverty level and that's their theory of change. So, that would be one example of it and you can think of different types of things depending on what your priorities were in your community. So, in this, for the implementation plan that they submitted at the end of June, they needed to, for their evaluation activities for the next year they needed to describe how they were going to look at process and feasibility, how they were going to modify the program components.

A lot of the stuff very much of the sort of things that you guys were describing, which I think that you would be excellent presenters at the upcoming thing in Seattle, so I will be talking to you about that later because we have some, there is some very interesting issues around traditional language in the native communities. So, there isn't, there are very few people who are fluent in the language, but, the values are really wanting to develop that language fluency in the children and families, but, it's skipping a few generations and how to do that and how about in communities where there is a lot of resistance by the tribal leaders perhaps on writing down the language and so that's a whole bunch of challenges right there.

Patricia Del Grosso: By showing and telling in proverbs.

Dr. Aleta Meyer: Oh yes, yeah. That, all those things that you described are very significant, but, I thought something that was sort of different was the lack of fluency in the traditional language in a lot of these communities, but, a valuing of wanting to bring that language back and feeling like bringing back that language will provide a lot of the good parenting practices that would then be the goals of home visiting programs. And so this, so this coming year they are going to get ready to do an evaluation study. So, they won't be doing it until year three. So, they will be getting their IRB put in place, they will be or getting their IRB approved. Their research approved by IRB, they will be getting that evaluation plan in place. I don't know how many of you have ever done a research study on the first time a program was implemented. Has anybody here ever tried to do that the first time you implement the program and you do this great research design and what do you find out about the effectiveness. Maybe not very much, because it was the first time they implemented the program.

So one of the challenges we are dealing with right now is that as they roll out and start to try the program this year and get confident in that sort of thing, we are going to, we are losing, you can say we are losing numbers of people that were in the study sample. So, it's kind of an interesting thing to a way, but, that's one of the things we are dealing with. So, they needed to present in their implementation plan how they are going to begin community participation and tribal oversight in their evaluation plan, who their evaluation partners are with their methodological expertise's, the history of their partnership, their relevant expertise. They needed to describe the current knowledge base around the intervention that they've picked. So, what do we know about parents' teachers or Family Spirit or Nurse Family Partnership or healthy families. What's known about how that program will work, it might work with your community and how you are going to adapt it for your community and how would that feed into your goals, your

research questions for an evaluation and then presenting a four year plan for that. And so we like them to link their evaluation questions with the existing research. So, how, what you do add to the existing body of evidence and I didn't talk about benchmarks and I think that could, benchmarks as a piece of legislation where they are gathering information on six different health domains starting this year and it's, so it's not evaluation per say but, it is a measurement piece that is there.

So, the question should reflect community priorities, cultural context for the needs of the target population and they need to consider the feasibility of answering these questions within available resources. So, these would be some example evaluation questions. So, does the home visiting intervention to create substance abuse more than existing services. So, one thing we know after having these implementation designs and I am not surprised at all is all of the studies that are being proposed when they are using a comparison design will have treatment as usual or services as usual as the comparison. They won't be getting home visiting or getting nothing at all. Does it culturally adapted to home visiting intervention and to better health and parenting outcomes and a home visiting intervention that is not culturally adapted and does that onset the home visiting intervention demonstrated clear change in the pattern of parenting practices compared to the pattern of parenting practices before the intervention. So, what kind of research design would you need for that question, anybody familiar with that sort?

So that's a single case design where you will use a multiple base design, where you will use multiple baseline measurement and you would be comparing the person to themselves overtime. And so we have a number of grantees that are extremely interested in the single case design because of, you know, the smaller sample sizes that you don't have to have a comparison group people that don't get services, but, then if you have a single case design you really increase the rigor that's needed in your measurement because you've got to be able to do more observational measures, you've got to be able to do them repeatedly maybe over the course of two weeks, five observations to make sure that you got a study measurement of something and then once the intervention starts then you can attribute that change to that. Okay, so potential designs include an assignment wait list control in single case design and so, this will be an example of a Quasi-Experimental Design, does the home visiting intervention decrease substance abuse more than existing services or if you are comparing the home visiting intervention that's adapted to one that's not and so you've got the X demonstrates the treatment and then you would fall them overtime.

So, that would, might be one type of comparison and this would be a single case design, which is an extreme over of simplification. We just had a number of our grantees, six of our grantees went to a small sample methodology conference in Fairbanks, Alaska last week that was specific to American Indian Alaska native populations and so there they learned a lot about different sorts of methodologies. It was almost too much. It was too much about statistics I just found out, which I am sort of bummed about. But, I think that are, this initiative is going to move the single case research design in places it's never been because there is a number of challenges, but, I think there is a lot of benefit that if we could do the rigorous type of research with a smaller sample size, there is so many

issues that we could address. So, I am still quite optimistic about that and we are going to be trying that. So, that would, so this is, I would say probably half of the grantees are seriously considering a single case design. So, they had to describe their data collection analysis and talk about who was their partner for doing, you know, internal research. I have to apologies. I, my house was hit by a, by the, a tree fell on my car this weekend and all kinds of stuff and then couldn't sleep last night, so my language is a little messed up today.

So, I apologies, I can't remember what our piece, institutional review board, there we go, sorry. But, so they had to talk about how they are doing both of these processes and I guess the thing I want to highlight at the end is that we have extremely high expectations and hopes for the rigorous evaluation that these grantees will do and we have put a number of support entities in place. We are going to have, we just had a competition for a tribal research center on early childhood where they will be working with the grantees on building their research capacities so that after this experience they will be in a better position to do research and evaluation on things that they might identify as their own priorities. We also are going to be funding a tribal evaluation institute, which will be providing individualized technical, research technical assistants for each of the 18 grantees on their specific research and evaluation plans and then looking across the grantees overtime for some common themes and so that institute will be, a number of the grantees are using parents' teachers as I mentioned and exploring with them might they want to do something where they pull their data using similar design across the different places.

I was talking yesterday about wow, I wonder if you could have like a cross sign signal, a cross site single case design where you don't just have three, you know, kids that you followed over or three parents that you followed overtime when you get the same pattern in a rigorous way. But, you do that same type of study in four different sites and it might be some really powerful stuff. And, so we have a lot of expectation, but, there is a lot of support and it's a exciting activity and I am, I really feel confident that through the process of doing this that they will be doing research and evaluation that it helps contribute to our understanding of how to adapt and how to understand, how the programs work in communities where they were initially developed. And while it's focused on American Indian or Alaska Native, I think it's an great opportunity for learning about what might work in all kinds of other groups and I think that these, I am really hopeful that we will have a whole new generation of native researchers who are really excited and able to do, to lead these efforts and not always have to hire an outside evaluator, that kind of thing.

Let's see, and there will be, we will be disseminating this knowledge. We are all, we are hoping that a lot of their stuff would make it into a systematic review and let's see, one final thing is that we've really, I mentioned the sample, the attrition of participants and the studies and then overtime you can't compare because there are so few people. We've tried very hard and we are trying very hard to get the grantees to really think about that as not a given, not saying, oh yeah, we are going to have high sample attritions so we just have to accept that and plan for that. But, instead think about what are all the things you

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could do that as people move in and out of communities, move, you know, come to the urban area and encourage to have their baby and then move back to the tribe, to their village, how to follow up with people and sort of think through how to retain those families up front rather than thinking of it as a given and I think that if we can do this, this will be really cool. So thank you very much and now let's move for questions.

Patricia Del Grosso: Great, thank you. Thank you, Aleta. Are there any questions? And again I will just ask you to come to the microphone since we will, since we are being recorded here.

Audience-3: Well I'd like to but--Well this was so fascinating, it's really great to hear this. My question related to the tribal work, one of them is will you give the programs a chance to do sort of a pilot year before you start evaluating them?

Dr. Aleta Meyer: That's what this year is, yes. So, we like them to, there will be, they are going to be doing feasibility kind of issues around implementation as well as feasibility around their measurement. They won't do the pilot if you mean, will they look to see if they get those proximal income, outcomes.

Audience -3: Not just let them settle in before you do outcomes.

Dr. Aleta Meyer: Yes, yes. I do, yes.

Audience-3: I am also curious are they gravitating towards a particular model that seems more congruent with tribal cultures? It's sort of like many of them are picking PIT for example.

Dr. Aleta Meyer: Yeah. I think PIT did a excellent job reaching out to the grantees and being very approachable and accessible. They really like to curriculum that reach across the broader range in ages and they didn't need nurses per say to implement the program. I, some of them in the implementation plans, it's, there is not a clear link between their needs assessment and the program they have picked and so I know that my colleagues are going to be going back and talking with them about getting clear about that match, because sometimes they may have picked an intervention because of convenience and that's so much connected to that. So, the parents' teachers I think did a excellent job reaching out. I know that Nurse Family Partnership has made some great concessions or changes in their fundamental assumptions about who they will implement their program with. So, with South Central Foundation they are going to let them implement the program with the second time mothers. That's good for those of you who are familiar with an FB, that's a big deal, yeah.

Audience-3: I know that many tribes actually work in Tribal Consortia and get to this cross site piece a little bit where the sample is so small in each individual community that they actually do programs across ten or 13 tribal communities. Do you have them in your grantees? That's my guess.

Dr. Aleta Meyer: Oh yes.

Audience-3: And so are they trying to do their evaluations across their communities?

Dr. Aleta Meyer: They maybe. Some of them might be doing that for a, they might be doing staged implementation where you would be doing some of the multiple baseline design with groups as oppose to with individuals and I would say that most of the grantees were very clear that they understand and want to rigorous evaluation and they have their initial ideas and their plans, but, nobodies plans are solidified. So, I expect that we will, that they will be doing that type of thing.

Audience-3: And finally truth of advertising, I work with Patricia and I meg, I agree some, I've visited the Minnesota Tribal Adaptation that's going on and I do know especially Minnesota and other upper Midwest communities. There is a lot of reservation urban back and forth...

Dr. Aleta Meyer: Yes.

Audience-3: So, it was really exciting to hear that you would follow the family not so much inset you, but, trace them back and forth no matter where they go.

Dr. Aleta Meyer: Right. And so they have to be able to put the resources into their grants, you know, to do that. So, it's not something that people don't, not do it because they don't want to. It's like oh my gosh, we need to hire a staff person who is in charge of sample, of maintaining the sample and so we've been, I would say Family Spirit. The investigators John Walkup and Allison Barlow that have been working with that program had provided had provided a lot of technical assistants on that issue specifically of how do you follow families who move in and out of the community overtime.

Audience-3: I've also done research on HIV for Latinos, especially my grant communities they actually track them between say North Carolina and Florida where they maintain their cases and keep them open across states to support that migration, so...

Patricia Del Grosso: Any other questions? If not, I have some, so, one issue that I kind of thought about is I was reviewing some of your presentations was this issue of being able to build an evidence-based on this Safe Care Adaptation. And then how broadly can that be disseminated? Is it specific to that cultural group or sub cultural group in Oklahoma for example or in a specific tribe or is it, is that evidence-based, you know, can it be applied to other cultural groups? And I didn't know if you have kind of thoughts about that or you get any feedback on that from field?

Dr. Lana Beasley: I think that's a really nice question. I think that's something that we thought about from day-1 and because it's costly to adapt material and I think the goal should be how well we can use it after we spend this time and money and effort to actually adapt it. So, one of the things we actually created was we created, I want to call it an adaptation manual for a lack of a better word. But, it was almost like guidelines for

thinking about other cultures, because what we realized is we, and Safe Care is also implemented in California, it's also being implemented in Colorado right now, some of the other sites.

Ivelisse Cruz: New Jersey.

Dr. Lana Beasley: New Jersey and these all have possible Latino populations and California has a very strong Latino population. So, we really created guidelines for other subcultures and so that someone could read that and start to understand some of the things they need to take in to consideration. One of the other things that we realized is that we needed to teach providers how to walk-in and be open mind and I think Ivelisse talked about this really well when she was speaking, but, not to go in thinking well this family is from Central America, so I am going to do X,Y and Z. But, instead say I am going to walk into the home and really look to see what this family has in their home and I think it was so wonderful I think learning from Latino agency, because I was a provider before I did research and it's just amazing the kind of work they do and you know we talk about attrition, they don't have it. Families want to stay in their program forever and that was the biggest issues. Wait a minute, this program only last this many months. No, we have families a lot longer then, they become part of our family. So, I think we can learn a lot from what people already know about keeping families in a program and actually getting them to engage and we've just had really good rates of engagement and I think, and part of that is because being culturally sensitive also creating a model that is really able to move with the family and be considered of their needs.

Dr. Aleta Meyer: Well I would say that that's definitely one of the dissemination activities is how can we provide lots of information and detail about what the tribes are learning and doing so that other folks can read that information and imply it to their own situation. I don't, I think that the question about transferring the program is something that the program developers have got to think a lot about.

Patricia Del Grosso: And another thing I thought about Aleta, you raised the issue of how important measurement would be particularly for their single case designs. Has that been an issue finding measurement tools or that are reliable with these things?

Dr. Aleta Meyer: Yeah. Well we say one of the main activities for the Tribal Research Center and early childhood will be to continue doing work on measures that really need to be adapted for different cultures and for different tribal communities and it's an issue in the general population and we don't really know how to measure, I mean do we really know how to measure how much vegetables people ate in the last 24 hours, you know do we really know how to measure. It's a tough one and so then you add to it that these are in communities where the measurement work hasn't even started. This is a huge challenge.

Dr. Lana Beasley: And I think we spoke a little bit about cultural sensitivity, I talked about formal versus informal language. We can have a whole presentation on assessment because I think this is something that is constantly changing and I think our feasibility

trial we learned a lot and so we are making changes. We also collect a lot of our data via computer and we realize in different cultures and computers can't be scarier than others. We thought we could just go in with the computer and things will be fine. We've realized that some of these families needs some reassurance in the Latino population of using that computer and so there are, I think there are ton of issues and we deal with them on a daily basis. But, I do think we are learning a lot and I am excited to talk about lessons learned at the end of our longer, yes the longer study.

Audience-4: So, talking about measurement, so you are going to go in there, is Ivelisse?

Ivelisse Cruz: Ivelisse.

Audience-4: Ivelisse. You are going to go in there and you automatically are going to assess because of your cultural background and integrate things and in a tailored way you are not going to automatically assume you are a Latino so you will believe in A, B, C and believe in 1, 2, 3. How you are measuring the degree to, which cultural modifications are being made because across different therapist you would or providers you would imagine that they are going to be different, you know, and different families. You know, level of acculturation, you are not going to do the same thing with someone who is first generation versus third generation. So, I am kind of wondering in terms of measurement how you are assessing that, because that will be an important thing to find out how much is necessary and then we were trying to adapt the different groups in different regions with different levels of acculturation, you know, trying to figure out how much you'd have to do?

Dr. Lana Beasley: I've loved that you asked that because we've been talking more and more about how do we measure that, because what I call what they do is magic. That's the only thing I can say. I was like, they are magic. They walk in and they have this instinct of knowing how to adapt and how much. I remember the first time Ivelisse told me, I walk into a home and I can see how important religious is. So, they have candles and they are lighting candles. So, like they get this, they understand how do we capture that. I think what we are moving toward and what we are talking about is starting to do more qualitative interviews with the providers. That's what we are working towards, so to start to ask some questions and start to understand. We don't have a measure per say to look at this. I think we are in the works of developing it, but, there is nothing out there. If you know something that I haven't found, please come and talk to me and tell me about it. But, I don't, we don't know the measure and so we are trying to develop our own and also realizing we are probably going to have to get some good qualitative data to go with that and so we are working on that to better understand how cultures do this. I am American Indian and I've done some adaptation work for the American Indian population. This is the same sort of idea of there are these cultures, within a culture and everything is different. So, it's complicated, but, I think we can work towards having a better understanding like you are saying, but, I don't have the answer yet.

Audience-4: Not really, so I was hoping you would...

Patricia Del Grosso: I guess the last issue, I just wanted to bring up was sort of the role of model developers and purveyors in the process. I know your team is working very closely, but, maybe if you could just speak to that a little bit about sort of the role of, in that process.

Dr. Lana Beasley: It's funny because when you spoke about it, I didn't even, I don't even think about John Lescher was the Developer. It was first Project in 12-Ways and he adapted to Safe Care. I don't think of him is being the part, I just think he was being part of our team. So, I would, I guess I was saying that's helpful, so we related we are to the project, to the developer of the model and so he is constantly on phone calls and he is just part of our team and I think that that's been really important because like I said Safe Care now had, we are developing a few more, but, it's three specific targets that we have and it started out as Project 12-Ways. So, meeting with him and seeing how the model has changed overtime helps us decide how to change the model in the future. So, I would say the more contact the better and that's what we found with our project because they developed the model, they understand in a way that we will never be able to understand it, so that's kind of our involvement.

Dr. Aleta Meyer: So, we have completely overloaded the program developers with the combination of the State Program and the Tribal Program and I think not maybe all of them, but, because that relationship is so important and how do you have that relationship with 18 tribes in 50 states and I personally think it's a completely, that role of that professional group in child welfare and in prevention is really not understand, I don't think we really know how to build that and I wonder if that isn't, so at a broader prospective not just home visiting, I wonder if that isn't part of the what gets in the way of practices getting to use, to everyday use because the people who developed them aren't the same people who would need to be doing all that other work and it's something I've encouraged Brian Dickens, the Organizer of this meeting to think about seriously as something to maybe work on between now and the next time as, because there is some really interesting attentions there because you could argue that well they are just getting rich off of it and I keep thinking well it's paying their rent to, you know, it's not like you can do the work that John Lescher does without having, for him to be able to make a living as well. So, some really interesting challenges around all of that and different purveyors are very different. So, I think it's a very interesting issue and I think if they had enough time for all of them to derive as much focused attention as John Lescher that would be wonderful as he asked with yours. But, let's imagine that he had six more that occurred right now with six different communities, would he'll able to stretch himself that way and that's definitely something that has been an broader issue in them, Maternal and Affordable Care Act home visiting program.

Dr. Lana Beasley: Yeah. I think a lot of the literature talks about sort of not changing those core elements, but, those core elements aren't always defined and obvious...

Dr. Aleta Meyer: We didn't do research on core elements.

Dr. Lana Beasley: Right.

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Dr. Aleta Meyer: It's not like we researched each little piece and then put them together in something. There are methodologies for doing that, but, that's...

Dr. Lana Beasley: Strictly haven't been done, so yeah, it raises a lot of challenges.

Patricia Del Grosso: Is there anything else? Thank you all for coming this morning and thanks to your presenters. Enjoy the rest of the conference.