TRIBAL
HOME
VISITING

TRIBAL MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING:

A REPORT TO CONGRESS

OPRE Report #2015-88
November 2015

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Frequently Used Acronyms

ACF	Administration for Children and Families
AIAN	American Indian or Alaska Native
CQI	Continuous Quality Improvement
DGIS	Discretionary Grants Information System
FS	Family Spirit
FY	Fiscal Year
HHS	U.S. Department of Health and Human Services
HIPPY	Home Instruction for Parents of Preschool Youngsters
HomVEE	Home Visiting Evaluation of Evidence
HRSA	Health Resources and Services Administration
MIECHV	Maternal, Infant, and Early Childhood Home Visiting Program
N	Sample size
NFP	Nurse Family Partnership
PAT	Parents as Teachers
PATH	Programmatic Technical Assistance for Tribal Home Visiting Center
P-CAP	Parent-Child Assistance Program
PIP	Positive Indian Parenting
SCA	SafeCare Augmented
SSA	Social Security Act
TA	Technical Assistance
TEI	Tribal Home Visiting Evaluation Institute

1 EXECUTIVE SUMMARY

The Tribal Home Visiting Program, part of the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV, the Federal Home Visiting Program), is an unprecedented expansion of culturally responsive services for vulnerable American Indian or Alaska Native (AIAN) families and children, strengthens tribal communities, and contributes to more comprehensive and integrated systems of care for families and young children. Since 2010, the Tribal Home Visiting Program expanded home visiting services in tribal communities, serving a total of 1,523 families and providing nearly 20,000 home visits. The Tribal Home Visiting Program serves some of the most vulnerable families who experience multiple challenges—such as substance abuse, domestic violence, and poverty—often attributed to historical trauma. Required grant activities are based on implementation science and closely mirror the high expectations of State Home Visiting grantees. These requirements ensure program services are responsive to unique community and family challenges and support high quality program implementation. This is evidenced by a majority (77 percent, n =10) of the 13 Cohort 1 grantees demonstrating overall improvement in the six legislatively mandated benchmark areas. Key predictors of positive child and family outcomes, such as increased prenatal care and screening rates for maternal depression and decreased rates of child maltreatment have improved. In addition to program improvements in benchmark areas, grantees built capacities for developing, implementing, and evaluating home visiting services. Capacity building efforts translate well beyond immediate home visiting services, benefitting the broader community through enhanced systems of care, workforce development, greater data collection capacities, and increased ability to advocate for and serve families and young children. Additionally, new ground is being broken in testing adaptations and enhancements to national home visiting models through locally designed rigorous evaluations that expand and strengthen the evidence base on home visiting with tribal communities. This report focuses primarily on the efforts of Tribal Home Visiting grantees. A separate report provides more details on the activities of State Home Visiting grantees.

TRIBAL HOME VISITING PROMOTES FAMILY RESILIENCY AND POSITIVE DEVELOPMENTAL TRAJECTORIES

Supporting families with young children is an essential component of a comprehensive system of care for the nation's children (Daro, 2009; Garner, 2013). Home visiting programs use home visits as a primary delivery strategy to support pregnant women, expectant fathers, and parents and caregivers of children from birth to kindergarten entry. Home visiting helps expectant families and families with young children provide stimulating early learning environments, nurturing relationships, and healthy family functioning for their children. These factors, in turn, have profound effects on children's physical, social-emotional, and cognitive development. A wide range of short- and long-term child and family outcomes improve, including positive cognitive and language outcomes for children, efficient family use of health services, positive changes in parenting attitudes and behaviors, and reduced child maltreatment and abuse (Daro, 2006; Wagner et al., 2001; Raikes et al., 2006; Guterman, 2001; Home Visiting Evaluation of Evidence [HomVEE], 2014).

The Tribal Home Visiting Program is well suited for addressing distinct challenges tribal communities face. Compared with the general U.S. population, AIAN communities disproportionately experience negative health outcomes, which may result from limited resources and access to services, unemployment, pervasive drug and alcohol abuse, poverty, and low educational attainment (CDC, 2011; King et al., 2009; Duran & Duran, 1995). Longitudinal studies also show that AIAN children often fall behind their peers across developmental domains at kindergarten entry, gaps that persist through elementary school (Demmert et al., 2006). These disparities are attributed to historical trauma—the collective emotional and psychological suffering endured by a massive group, manifesting throughout the life span of group members, and passed down through generations (Brave Heart et al., 2011). While tribal communities face these unique challenges, they also possess undeniable community assets and strengths. The Tribal Home Visiting Program leverages these assets and strengths by integrating community-based knowledge to promote positive child and family outcomes.

Overseen by the Administration for Children and Families (ACF) in collaboration with the Health Resources and Services Administration (HRSA), the following are the goals of the Tribal Home Visiting Program (HHS, ACF, Office of Child Care, no date):

1. Support the development of happy, healthy, and successful American Indian and Alaska Native (AIAN) 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 AIAN communities
3. Expand the evidence base around home visiting interventions within AIAN populations
4. Support and strengthen cooperation and promote linkages among various early childhood programs, resulting in coordinated and comprehensive early childhood systems

Tribal Communities Meet High Program Expectations

Congress authorized the Federal Home Visiting Program through a provision in the Patient Protection and Affordable Care Act of 2010 authorizing $1.5 billion in funding over five years. The Federal Home Visiting Program supports voluntary, evidence-based home visiting programs for expectant families and families with young children up to kindergarten entry. As an evidence-based policy initiative, the Federal Home Visiting Program prioritized funding to implement home visiting

models that have solid evidence of success. Additionally, legislation requires grantees to engage in several program activities, including: (1) completing needs and readiness assessments, (2) implementing evidence-based home visiting services, (3) collecting and reporting benchmark data, and (4) conducting rigorous evaluation of promising approaches.

Legislation set aside three percent of these funds for eligible Indian tribes, tribal organizations, and urban Indian organizations—hereafter referred to as the Tribal Home Visiting Program. This legislation specified that "to the extent practicable," tribal grantees adhere to the same high standards and expectations of the Federal Home Visiting Program with regard to required program activities (Sec. 511, SSA). HHS drew on this legislative language to ensure that the Tribal MIECHV program was implemented with high standards but also had flexibility to be tailored to the unique needs and realities of tribal grantees. One area that this "to the extent practicable" language supported flexibility in implementation was with respect to implementing evidence-based program models. While a systematic review of evidence of effectiveness for the Federal Home Visiting program identified program models with demonstrated effectiveness, it did not find any home visiting model to have evidence of effectiveness for tribal populations. With the exception of one program model,[1] program models deemed evidence-based for the Federal Home Visiting Program are considered promising approaches when used in tribal populations. Therefore, all tribal grantees are required to complete rigorous local evaluations to expand the knowledge base on home visiting in tribal communities.

REQUIRED GRANT ACTIVITIES BUILD GRANTEE CAPACITY AND ENSURE QUALITY

Required grant activities draw from implementation science to ensure quality program implementation. Grant activities were introduced to grantees in stages and in alignment with commonly identified phases of program implementation and associated drivers of high-quality program implementation. Required grant activities—from needs and readiness assessments, comprehensive implementation plans, to program monitoring efforts—ensure implementation and sustainability of high-quality home visiting services.

Provision of initial and ongoing technical assistance supports capacity building. Grantees received initial and ongoing technical assistance from multiple entities to assure necessary program infrastructures and capacities were in place.

[1] The Family Spirit home visiting intervention met criteria for evidence of effectiveness with tribal communities in a 2014 update of the HomVEE systematic review.

Technical assistance on a range of topics—from needs assessment, model selection, and implementation to performance measurement, evaluation, and continuous quality improvement — were also provided.

Grants are awarded though cooperative agreements to provide ongoing federal support. Funding for tribal grantees is provided in the form of cooperative agreements to ensure flexibility in meeting unique tribal needs and contexts and developing program infrastructure. The cooperative agreements with ACF allow for extensive federal support on grant administration and management, implementation and service delivery, data collection, continuous quality improvement, and rigorous evaluation plans.

Grantees engaged in comprehensive program planning efforts to develop implementation plans. Grantees engaged in thoughtful, iterative planning to build program infrastructures. This work included ongoing collaborations with community leaders and partner agencies to strengthen broader early childhood systems and provide coordinated services. They also hired and trained program staff, developed capacities to collect and report program performance data, and developed plans for continuous quality improvement. For many grantees, planning phases also included increasing community awareness of and support for home visiting as an effective strategy for improving the lives of families with young children. Additionally, each program completed a needs and readiness assessment to carefully select the model that would meet the needs of its community and ultimately improve the well-being of children and families. Grantees also worked with the developers of selected home visiting models to adapt and tailor models to their unique cultural contexts.

Development of performance measurement plans enhanced program capacities and infrastructures for data collection and program performance monitoring. Legislation requires grantees to establish quantifiable, measurable benchmarks to demonstrate program improvements in six areas:

1. Maternal and newborn health
2. Child injuries, child abuse, neglect, or maltreatment and emergency department visits

3. School readiness and achievement
4. Crime or domestic violence
5. Family economic self-sufficiency
6. Coordination and referrals for other community resources and supports

Development of performance measurement plans detailed the approach for collecting, analyzing, and reporting performance data in six benchmark areas. As part of this process, data collection and management protocols, analysis plans, and data systems capable of housing and linking data across programs were developed. Developing performance measurement plans and necessary systems of support was a new endeavor for many grantees and communities. As a result, program and community capacities were enhanced and benefited the Tribal Home Visiting Program, the broader community, and future community effort. For example, the program provided community members with significant opportunities for personal and professional growth. Grantees reported data on program performance measures using the Discretionary Grant Information System—Tribal Home Visiting, the first national data system for home visiting in tribal communities.

The Tribal and State Home Visiting Programs gave grantees the flexibility to develop locally meaningful performance measures. As noted above, legislation required grantees to demonstrate improvement in the six performance measurement areas by improving on a majority of the specific constructs that constitute each of these areas. Within each of the constructs, grantees were responsible for defining their own performance measures and developing a strategy for collecting the necessary data. Specifically, grantees determined performance indicators (including a unique numerator and denominator for each measure), the definition of improvement, target populations for each measure (e.g., pregnant mothers), the assessment or screening instrument to be used, and the data collection schedule.

This process supported ACF goals of encouraging local decision making and capacity building, but it required a time- and resource-intensive planning process for grantees. Locally meaningful performance measures also resulted in data that are difficult to summarize across grantees.[2] ACF is currently redesigning the performance measurement requirement based on lessons learned and grantee feedback from the first five years of the program. Under the new requirement, data will be collected and presented in a more standardized way across grantees.

[2] Chapter 9 as well as Appendix B provide a more detailed description of how data were summarized in this report.

EARLY PROGRAM SUCCESSES: GRANTEES EXPANDED HOME VISITING SERVICES, BUILT CAPACITIES, AND DEMONSTRATED OVERALL PROGRAM IMPROVEMENT

Highlights of early Tribal Home Visiting Program successes include the following:

1) Tribal Home Visiting Program's substantial expansion of home visiting services across diverse tribal communities and high-needs families
2) Grantees' capacity building for developing, implementing, and evaluating home visiting
3) Overall program improvement by a majority of the 13 grantees in the first cohort (77 percent, n = 10)

Grantees Expanded Home Visiting Services to High-Need Families across Diverse Communities

Diverse tribal communities across 14 states are served. Since 2010, a total of 25 tribal and American Indian or Alaska Native programs across 14 states received funding. These programs are located in many different settings, ranging from remote Alaskan villages to the rural Midwest and to major urban areas of the Southwest. Some serve a single tribe, while others serve multiple tribal communities or consortia of tribes. The Tribal Home Visiting Program currently reaches 15 rural grantees, three urban grantees, and seven grantees with a mix of rural and urban settings.

Some of the most vulnerable AIAN children and families are served. The MIECHV legislation prioritizes program services for vulnerable families in at-risk communities. Priority populations experiencing multiple challenges, such as substance abuse, poverty, and a history of child abuse or neglect, were successfully identified and served. Seventy-one percent of participants had a family income at or below federal poverty guidelines (at or below $11,670 for an individual or $23,850 for a family of four in 2014). In 2014, many adult participants were under 25 years old (43 percent), unemployed (59 percent), or without a bachelor's degree (96 percent). A majority of child participants (78 percent) were under three years old. Eighty-five percent of children and 78 percent of adults were American Indian or Alaska Native.[3]

Funds expand the reach of home visiting services in tribal communities. The Tribal Home Visiting Program is funded at escalating amounts over five years. As expected, grantees had successive increases in program reach and service capacity:

[3] Individual grantees had the authority to determine service eligibility, and some programs chose to serve families in their service area regardless of their AIAN status.

- In fiscal year (FY) 2014, 870 families were enrolled, over five times the number of families enrolled in 2012 (Figure 1-1).
- A total of 1,523 families were enrolled. This total includes 169 families in 2012, 484 in 2013, and 870 in 2014.
- Vulnerable families were provided with nearly 20,000 home visits over three years (Figure 1-2).

Figure 1-1. Growth in Participants

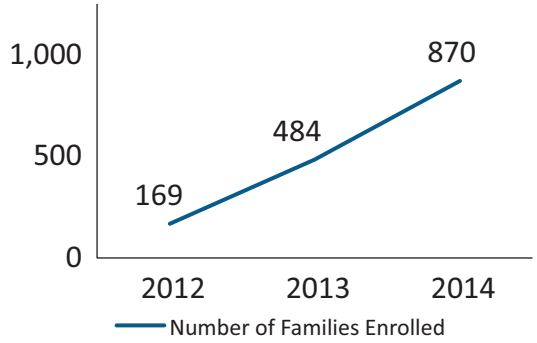
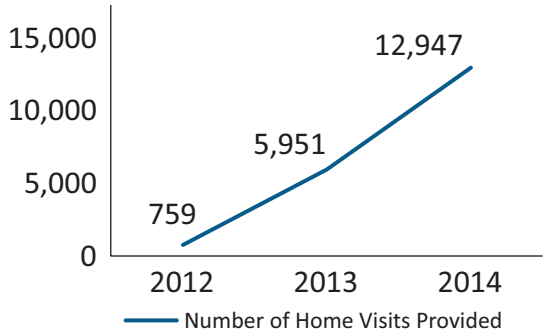


Figure 1-2. Growth in Home Visits



Grantees Developed Expansive Capacities to Implement and Evaluate Home Visiting in Tribal Communities

Home visiting models were adapted and enhanced for local implementation. To meet the needs of local communities, adaptations to existing home visiting models, sometimes with the help of the model developers, were developed and implemented. Some adaptations include allowing flexibility in home visit schedules and locations and incorporating tribal languages and traditional teachings into curriculum content.

Program and community capacities were developed to serve families and young children. The Tribal Home Visiting Program is designed as a systems-building initiative. Program activities promoted collaboration and coordination to provide effective services to meet family needs. The Tribal Early Learning Initiative, for example, is a partnership between ACF and four tribal grantees that are collaborating across their home visiting, child care, and Head Start/Early Head Start programs. Many beneficial coalitions and initiatives were also built to strengthen broader early childhood systems in communities. Additionally, in developing performance measurement plans, the capacity around data collection and program performance was enhanced and would benefit the communities beyond the life of the grants.

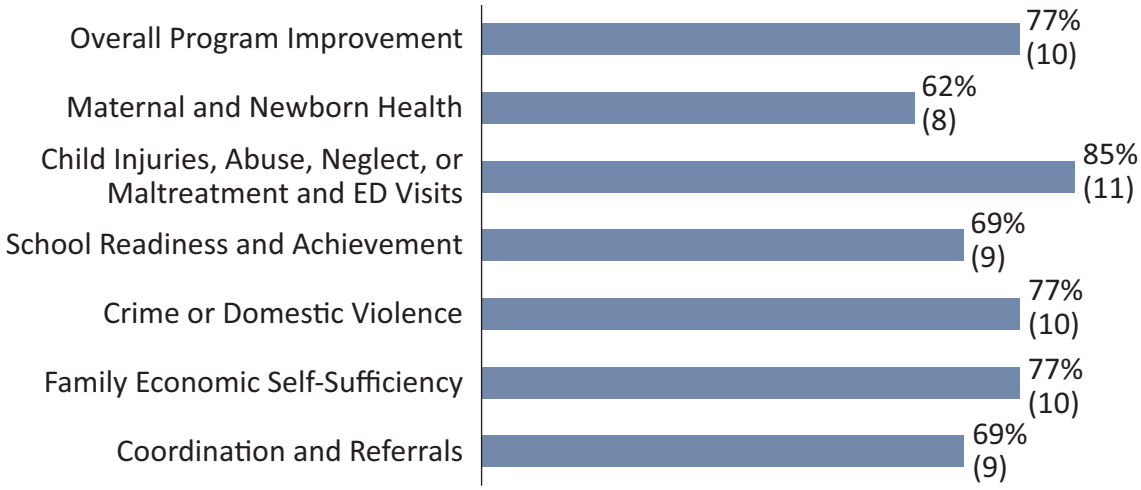
The evidence base for home visiting services with AIAN populations is being expanded and strengthened. Rigorous, locally designed evaluations are currently being implemented and will expand and strengthen the limited evidence base on the use of home visiting with AIAN populations. Given the known intergenerational

and long-term consequences of historical and ongoing trauma in AIAN communities, such as forced relocation and discrimination, improving this body of evidence will be invaluable in reducing disparities in access to high-quality health care and early education services. Through a collaborative process involving program leadership and community input, rigorous experimental designs are being used to evaluate the efficacy of home visiting services on multiple family and child outcomes. Results of these studies are expected in spring 2017. The impact of culturally enhanced or adapted program models using rigorous, locally designed evaluations is also being evaluated. Evaluation results from the first two cohorts of tribal grantees are expected to be available in spring 2017, following the last year of grant implementation.

Cohort 1 Grantees Demonstrated Improvement in Key Determinants of Positive Child and Family Outcomes

Impressive gains in program performance across the six legislatively mandated benchmark areas (Figure 1-3). A majority of the 13 Cohort 1 grantees (77 percent, n = 10) demonstrated overall program improvement in the three-year period. Overall program improvement is defined as improvement in at least four of the six benchmark areas.[4] Highlights of program improvements in the individual benchmark areas are provided on the following pages.

Figure 1-3. Percentage and Number of Grantees Improved Overall and in Individual Benchmark Areas (N = 13)



[4] For additional information on program improvement, see Appendix A.

Maternal and Newborn Health

- **Promotion of prenatal health care services to ensure positive birth outcomes.** A majority of grantees (77 percent, n = 10) improved performance measures for prenatal care. During FY 2012 through FY 2014, 89 percent of participants from seven grantees with similar performance measures initiated prenatal care by their first or second trimester.
- **Increased screening rates for maternal depressive symptoms.** Most grantees (77 percent, n = 10) improved screening rates for maternal depression. During FY 2012 through FY 2014, 12 grantees with similar performance measures screened 71 percent of participants for maternal depression.
- **Increased initiation and duration of breastfeeding, a practice linked to positive child outcomes.** Most grantees (62 percent, n = 8) improved on measures of initiation and duration of breastfeeding.

Reduced Child Injuries; Child Abuse, Neglect, or Maltreatment; and Reduction in Emergency Department Visits

- **Reduced rates of substantiated reports and first-time victims of child maltreatment.** Almost all grantees (92 percent, n = 12) reduced rates of substantiated reports and first-time victims of child maltreatment. During FY 2012 through FY 2014, the average rate of first-time victims of child maltreatment across grantees was 10 percent.
- **Decreased child injuries requiring medical treatment.** A majority of grantees (77 percent, n = 10) reduced rates of child injuries requiring medical treatment. During FY 2012 through FY 2014, the average rate of child injuries requiring medical treatment among eight grantees with similar performance measures was three percent.

School Readiness and Achievement

- **Improved parent well-being and reduced parenting stress to support positive parenting behaviors and healthy parent-child relationships that in turn predict school readiness and academic achievement** (Adi-Japha & Klein, 2009; Thompson, 2008; Adirim & Supplee, 2013). Almost all grantees (92 percent, n = 12) improved on measures of parent emotional well-being or parenting stress.
- **Improved rates of screenings to identify developmental delays and link families to necessary resources and supports.** During FY 2012 through FY 2014, nine grantees with similar performance measures screened an average of 51 percent of eligible children across developmental domains. This rate is

well above the national average of 31 percent for child screenings in 2011 and 2012 (Child and Adolescent Health Measurement Initiative, no date).

Reduced Crime or Domestic Violence

- **Increased screening rates for domestic violence and increased support for families when domestic violence is present.** Fifty-four percent of grantees improved on their screening for domestic violence, while 69 percent saw increases in safety plan completion for families experiencing domestic violence.

Family Economic Self-Sufficiency

- **Increased number of adults and children with health insurance.** Almost all grantees (85 percent, n = 11) saw increased rates of adults and children with health insurance. During FY 2012 through FY 2014, a majority of mothers and children (86 percent) from six grantees with similar performance measures had health insurance within 12 months of enrollment.

Coordination and Referrals with Other Community Resources and Supports

- **Improved collaboration and information sharing with other community agencies.** Almost all grantees (92 percent, n = 12) improved information sharing and collaborations with other community agencies.

In many cases, program data offers a limited view of the Tribal Home Visiting Program. The details of individual family successes—from a young mother enrolling in school and finding stable housing to early identification of a child's learning disability—can be lost when reporting on families overall. Additionally, the Tribal Home Visiting Program serves only a small fraction of the families in Indian Country, despite the increased reach. Individuals from over 50 tribal communities are being served, but these communities represent a small percentage of the 566 federally recognized tribal nations and the 37 Urban Indian Centers, tribal consortia, and other tribal organizations across the nation (Westat, 2014). The 2,697 adults and children served represents less than one percent of the 5.2 million individuals who identify themselves as American Indian and Alaska

Native, indicating a continued need for program expansion and sustained funding (Norris et al., 2012).

SUMMARY AND RECOMMENDATIONS

After four years of implementation, ACF recognizes the opportunity to strengthen the Tribal Home Visiting program and build on the solid foundation already established. Going forward, ACF will maintain high expectations for Tribal MIECHV grantees and support their success through continued efforts to develop and enhance early childhood systems in tribal communities, improvements to the performance measurement and continuous quality improvement system in close communication with tribal grantees, and promotion of a learning agenda to build knowledge of effective home visiting in tribal communities.

As exemplified by the Tribal Early Learning Initiative, and demonstrated by the tribal home visiting grantees, children and families are served best when collaborative relationships, partnerships, and referral networks are established for a solid early childhood system infrastructure. ACF will continue to emphasize this priority of early childhood systems building as the Tribal Home Visiting program continues.

As demonstrated in this report, the benchmarks process helped to build the capacity of grantees for monitoring the success of their programs. ACF will continue to emphasize efforts to support grantees in using performance measurement data to improve programs through modifications to the benchmark requirement that facilitate use of the data for continuous quality improvement and other priorities. These changes to the benchmarks requirement will be made in close communication with grantees, following expert guidance.

Finally, given the expectations for rigorous evaluation of home visiting in tribal communities, the Tribal Home Visiting program has helped to build local and tribal capacity for evaluation. ACF will continue to foster local grantee efforts to understand their own home visiting programs while supporting efforts to generate knowledge to inform the broader field of implementation science around adaptation and other important topics.

2 LEGISLATIVE LANGUAGE

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act of 2010 with a provision authorizing $1.5 billion in funding over five years for the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). Three percent of these funds were set aside for grants to eligible Indian tribes, consortia of tribes, tribal organizations, and urban Indian organizations. The portion of MIECHV dedicated to these entities is hereafter referred to as the "Tribal Home Visiting Program."

The following report is provided to Congress as outlined in Section 511 of the Social Security Act (Sec. 511, SSA). The legislation stipulates that, no later than December 31, 2015, a report to Congress must be submitted on programs conducted under the MIECHV program, including the Tribal Home Visiting Program. This report focuses primarily on the efforts of Tribal Home Visiting grantees. A separate report provides more details on the activities of State Home Visiting grantees.

The report shall contain information from three areas:

1. Extent to which eligible entities receiving grants under this section demonstrated improvements in each of the areas specified in the legislation
2. Technical assistance (TA) provided to grantees, including the type of assistance provided
3. Recommendations for such legislative or administrative action as the Secretary determines appropriate

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3 PURPOSE AND ORGANIZATION OF THE REPORT

The following explains the purpose of this report:

1. Describe the Tribal Home Visiting Program, grantees, and family and community contexts that influence implementation of the program
2. Highlight the expanded reach and availability of home visiting services in tribal communities as a function of the Tribal Home Visiting Program
3. Tell the story of program implementation across funding years, highlighting successes and areas of improvement
4. Describe technical assistance (TA) and systems of support provided to grantees
5. Summarize grantee performance measurement and grantee performance in legislatively mandated benchmark areas
6. Suggest recommendations for improving program reach, supports, and requirements

There are a total of six more chapters. Chapter 4 provides background on the influence of early childhood on healthy development and later-life outcomes and the critical role of home visiting in supporting at-risk families with young children. It also describes the context of home visiting in tribal settings. Chapter 5 gives an overview of program goals, funding, and activities. Chapter 6 summarizes the work of the 25 grantees, with special attention given to each of their unique communities and programs. The extensive support provided to grantees by the developers of home visiting models and two TA centers is described in Chapter 7. The next two chapters highlight grantee data describing families served (Chapter 8) and grantee program performance (Chapter 9). Chapter 10 concludes with a

LESSONS FROM THE FIELD

Throughout the report, you will see text boxes with **LESSONS FROM THE FIELD**, vignettes taken from informal group interviews with Cohort 1 grantees. These vignettes provide context to better understand findings from grantees' perspectives and highlight achievements not captured in benchmark data.

summary of findings, lessons learned, and recommendations for improvements to the program. The content of this report reflects data collected from several sources:[5]

- Demographic, service utilization, and performance measurement data submitted by the grantees to the Administration for Children and Families (ACF). Grantees submit data through the Discretionary Grant Information System, the first national reporting system of home visiting services provided to American Indian and Alaska Native (AIAN) populations.
- Informal group interviews with grantees on their experiences with program implementation and performance measurement.[6]
- Existing documents and reports on the Tribal Home Visiting Program and relevant published literature.

[5] Appendix A provides a more in depth description of Tribal Home Visiting data requirements and limitations.
[6] Informal group interviews were conducted with all 13 grantees funded in Cohort 1 of the Tribal Home Visiting Program in spring 2015. These group interviews included grantee home visitors, program administrators (Coordinators and Directors), and evaluators.

4 BACKGROUND

A STRONG START: THE SCIENCE OF EARLY CHILDHOOD

Experiences in the first five years of life, a period of tremendous growth and development, set the stage for long-term developmental outcomes and well-being (Shonkoff & Garner, 2012; Adirim & Supplee, 2013; National Research Council & Institute of Medicine, 2000). This early phase of life ideally includes relationships with responsive and supportive caregivers, who serve as children's first teachers, and exposure to high-quality learning experiences. A growing body of brain research points to these early years as a critical period for establishing positive parent–child relationships that result in healthy brain development and learning trajectories (Shonkoff & Garner, 2012; Bagot & Meaney, 2010; National Research Council & Institute of Medicine, 2000).

Children with attentive and supportive caregivers have better health outcomes and physical development, greater cognitive skills, and greater social-emotional competence and are better prepared to benefit from formal school experiences than children with less supportive caregivers (Adi-Japha & Klein, 2009; Thompson, 2008; Adirim & Supplee, 2013). Longitudinal studies also demonstrate that high-quality early learning experiences result in higher academic gains, greater adult earnings, and less crime (Lawrence, 1993; Reynolds et al., 2001; Farran, 2000; Schweinhart et al., 2004).

Early childhood interventions yield a high return on investment, both in human capital gains and economic returns (Doyle et al., 2009). A review of benefit-cost analysis studies showed a $1.26 to $17.07 cost saving for every dollar invested

in early childhood interventions (Karoly et al., 2005). Moreover, in one home visiting study, benefits were greater for higher-risk participants ($5.70 for every dollar invested) compared with lower-risk participants ($1.26 for every dollar invested) (Karoly et al., 2005). These findings suggest that (1) early childhood interventions have the potential to improve outcomes for children and families and yield great cost savings and (2) the programs serving higher-risk families yield the greatest benefits.

SUPPORTING FAMILIES AND YOUNG CHILDREN: THE ROLE OF HOME VISITING

Supporting families with young children is an essential component of a comprehensive system of care for our nation's children (Daro, 2009; Garner, 2013). Early and long-term development is closely tied to family functioning, early experiences with caregivers, and parental structuring of early learning environments (Shonkoff & Garner, 2012; World Health Organization, 2004). Adverse childhood experiences, from child abuse and neglect to family poverty and stress, predict a host of negative outcomes (Felitti et al., 1998; Duncan et al., 2010; Shonkoff & Garner, 2012). In helping families navigate the many demographic, parental, and family stressors they face, interventions support the development of adaptive skills and nurturing relationships that buffer against stress and prevent adverse childhood experiences (Garner, 2013).

Home visiting programs use home visits as a primary delivery strategy to support pregnant women, expectant fathers, and parents and caregivers of children from birth to kindergarten entry. Home visiting programs help expectant families and families with young children provide stimulating early learning environments, nurturing relationships, and healthy family functioning for their children. These factors, in turn, have profound effects on children's physical, social-emotional, and cognitive development. Services are provided by trained professionals, such as social workers, nurses, and parent educators. These trained professionals work with families to establish positive parenting practices and parent–child relationships while also addressing immediate individual family needs. As a result, they mitigate the poor developmental outcomes associated with family poverty and stress and provide vulnerable children and families with critical and lifelong protective factors (Lugo-Gil & Tamis-LeMonda, 2008; Pew Center on the States, 2011).

Home visiting improves a wide range of short- and long-term child and family outcomes, including positive cognitive and language outcomes for children, efficient family use of health services, positive changes in parenting attitudes

and behaviors, and reduced child maltreatment and abuse (Daro, 2006; Wagner et al., 2001; Raikes et al., 2006; Guterman, 2001; Home Visiting Evaluation of Evidence [HomVEE], 2014). Parent education and employment outcomes are also improved, and family economic self-sufficiency is increased (HomVEE, 2014). As a result, home visiting is a cost-effective prevention strategy, providing positive returns on investment through eventual reductions in health and education costs (Pew Center on the States, 2011).

As part of the Obama administration's early childhood initiative and continuum of high-quality early childhood services, the Tribal Home Visiting Program expands access to critical home visiting support services in tribal communities. Its aim is to expand the evidence base for home visiting for AIAN populations, supporting the development of a comprehensive system of care for our nation's Native children.

HOME VISITING IN TRIBAL COMMUNITIES

Tribal Communities Experience Unique Challenges

Although tribal communities are diverse, they share a distinct set of challenges. Compared with the general U.S. population, AIAN communities disproportionately experience negative health outcomes (Centers for Disease Control and Prevention [CDC], 2013). Health disparities may result from limited resources and access to services, loss of culture, unemployment, pervasive drug and alcohol abuse, poverty, and low educational attainment (CDC, 2011; King et al., 2009; Duran & Duran, 1995). In addition, health disparities within tribal communities are attributed to historical trauma—the collective emotional and psychological suffering endured by a massive group, manifesting throughout the life span of group members and passed down through generations (Brave Heart et al., 2011). Sources of historical trauma for indigenous peoples include colonization; prohibition of language, spiritual practices, and ceremonies; forced assimilation and removal of children to boarding schools; and other traumatic losses (Fisher & Ball, 2002; Brave Heart, 1998).

Tribal Communities Possess Assets and Strengths

While American Indian communities face an array of unique challenges, they also possess many undeniable community assets and strengths to support the healthy development of families and children. Community strengths may include cultural identity and traditions, intergenerational knowledge,

community ties and connectedness, language, spiritual ceremonies, and traditional childrearing practices (ACF, 2012; Whitbeck, 2006; Fisher & Ball, 2002; Krech, 2002; Hodge et al., 2009). The American Indian family, both immediate and extended, can provide children with a strong foundation for exploring individual and community identity, learning cultural teachings, and better understanding their roles within the family and the community as a whole. Tribal communities traditionally create "kin networks" to ensure that children receive support from birth by a large extended family. Naming ceremonies and other early-life activities serve to solidify the roles of extended family members in sharing these teachings and building the support for families and children as they grow and develop.

Home-Based Support for Families through Traditional Cultural Practices

Red Horse and colleagues (1978) suggest that family-focused human services interventions in tribal communities, as currently understood, are not independent of daily life for those with the greatest need but are inherently integrated as typical traditional cultural practices. Support networks, comprising of relatives and other community members, traditionally provide young families with informal visits to their homes to offer food, assistance, and well wishes (Red Horse, 1997; Red Horse et al., 1978). Research with urban Indian families has found that they are more likely than White families to receive this type of kin support (Limb et al., 2012). Today, many American Indians perceive informal services such as these to be more effective than formal services (Walls et al., 2006). While these informal supportive visits have continued in many tribal communities, many American Indian people may associate the formal "home visit" with different purposes, such as child welfare investigations. A visit from a county or state child protection worker could result in removal of children, frequently due to misunderstandings about childrearing practices rather than maltreatment (Unger, 1977; Mannes, 1995).

Formalized Home Visiting as a New Strategy in Tribal Communities

More recently, service systems have sought to provide supportive interventions within the home setting in tribal communities. Lay community health workers, charged with making in-home visits, are often used to support preventive services for American Indian populations. They have a proven ability to apply historical and cultural knowledge with formal health training to mobilize efforts across community resources (Satterfield et al., 2002). Child welfare visits have shifted to a model promoting family preservation and

support. In their report *The Context and Meaning of Family Strengthening in Indian America*, Besaw and colleagues (2004) contend that health care, human services, and educational programs driven, designed, and controlled by tribal communities show the best promise for effectiveness in Indian Country. In many ways, the home visiting services provided through the Tribal Home Visiting Program demonstrate this shift to formalized but supportive home-based programming.

An Opportunity to Support and Learn from Tribal Communities

While strong evidence shows that home visiting is an effective intervention strategy that fits within some cultural practices as described above, less is known about the effectiveness of these services in tribal settings. In 2009, prior to launching the Home Visiting Program, the ACF Office of Planning, Research and Evaluation began a systematic review of home visiting research. The review included an assessment of the current research evidence supporting the effectiveness of various home visiting program models (HomVEE, 2014). Through a parallel review process, the first Tribal HomVEE review determined that no models met the HHS criteria for evidence of effectiveness with tribal communities[7] (Del Grosso et al., 2011). Therefore, models that had evidence of effectiveness with other populations and that were deemed evidence-based by the original HomVEE review are considered promising approaches rather than evidence-based approaches when they are applied to tribal communities. Despite this distinction, the term "evidence-based" is used throughout the report to describe those home visiting models used by tribal grantees that have evidence of effectiveness, albeit with other populations.

Evidence-based home visiting services—which may include prescriptive strategies, fidelity monitoring, and data collection—remain a relatively new approach in many tribal settings. Tribal communities with experience implementing evidence-based programs have advocated strongly to ensure that these programs can be adapted or enhanced to fit specific community context. Examples of cultural enhancements to home visiting program models include cultural activities and events, storytelling, and integrated elements of traditional language. Research suggests that family-centered interventions rooted in indigenous cultural values and practices are most likely to be

[7] Since the initial Tribal HomVEE review, the Family Spirit home visiting model has been determined to meet criteria for effectiveness (Mraz Esposito et al., 2014).

implemented with fidelity and sustained over time in AIAN communities (Fisher & Ball, 2002).

With the integration of community-based knowledge, home visiting practices have the potential to align well with family support practices in tribal settings. Because evidence-based intervention remains a new strategy for many tribal communities, the Tribal Home Visiting Program provides a unique opportunity to support and learn as they implement these innovative services.

5 OVERVIEW OF THE TRIBAL HOME VISITING PROGRAM

DESCRIPTION OF THE PROGRAM

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act of 2010. In authorizing the creation of Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV, the Federal Home Visiting Program), the Affordable Care Act greatly expanded federal funding for voluntary, evidence-based home visiting programs for expectant families and families with young children up to age five in at-risk communities (Sec. 511, SSA). MIECHV provides an unprecedented opportunity for collaboration at the federal, state, tribal, and community levels to improve health and developmental outcomes for at-risk children. Three percent of these funds were set aside for grants to eligible Indian tribes, consortia of tribes, tribal organizations, and urban Indian organizations, awarded by the Secretary of the Department of Health and Human Services (HHS).

The Tribal Home Visiting Program is authorized by Section 511(h)(2)(A) of Title V of the Social Security Act, as amended by the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (Public Law (Pub.L.) 114-10). Legislation dictates that the requirements for tribal grants be consistent with those of MIECHV grants awarded to states "to the extent practicable," including conducting a needs assessment and establishing benchmarks.

HHS has historically allocated funding for the Tribal Home Visiting Program as follows:

- FY 2010, up to $3 million
- FY 2011, $7.5 million
- FY 2012, $10.5 million

- FY 2013, $12 million
- FY 2014, $12 million
- FY 2015, $12 million

The goals and requirements of the Tribal Home Visiting Program mirror those of the MIECHV grants awarded to states. The goals of the Tribal Home Visiting Program are the following (HHS, ACF, Office of Child Care, no date):

1. Support the development of happy, healthy, and successful American Indian and Alaska Native 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 AIAN communities
3. Expand the evidence base around home visiting interventions within AIAN populations
4. Support and strengthen cooperation and promote linkages among various early childhood programs, resulting in coordinated and comprehensive early childhood systems

Per the legislation, Tribal Home Visiting Program grantees prioritize services to the following AIAN populations:

- Families in at-risk communities identified through a needs assessment
- Low-income families
- Pregnant women under age 21
- Families with a history of child abuse or neglect
- Families with a history of substance abuse
- Families that have users of tobacco in the home
- Families with children with low student achievement
- Families with children with developmental delays or disabilities
- Families with individuals who are serving or have served in the Armed Forces, including those with multiple deployments

The Administration for Children and Families, through the Office of the Deputy Assistant Secretary for Early Childhood Development and the Office for Child Care, oversees the Tribal Home Visiting Program in collaboration with the

Health Resources and Services Administration (HRSA). ACF awards five-year[8] cooperative agreements through a competitive process. They are awarded with the anticipation that the federal government will be substantially involved and will provide training and technical assistance to grantees throughout the project period (ACF, 2012). This involvement aims to build the capacity of grantees to complete needs assessments, planning, benchmark data collection, and rigorous evaluation activities. The goal is to ensure effective program implementation, with fidelity to evidence-based models when appropriate.

There is a great need to expand and strengthen the evidence base for home visiting programs targeted to tribal populations and communities. As such, the priorities are to provide high-quality, culturally relevant, evidence-based services and draw from implementation science to build a knowledge base around home visiting with AIAN populations. The Tribal Home Visiting Program also emphasizes the fit between the selected home visiting model and community needs, priorities, capacities, culture, and context (HHS, ACF, Office of Child Care, 2014). As a federal investment, the program incorporates a distinctive approach, prioritizing tribal community decision-making on grant implementation and focusing on community capacity building. The intention is that the program will result in a coordinated system of early childhood home visiting in tribal communities and provide infrastructure and supports to ensure high-quality, evidence-based practice (ACF, 2012).

Since 2010, a total of 25 grantees have received federal grants through the Tribal Home Visiting Program to develop, implement, and evaluate home visiting programs in AIAN communities. Thirteen cooperative agreements were awarded in FY 2010, six were awarded in FY 2011, and another six were awarded in FY 2012. The grantees are diverse in size, location, organizational structure, capacity, and culture. They are located in many different settings, ranging from remote Alaska to the rural Midwest and to major Southwest and west coast urban areas. A number of grantees are tribal agencies located on reservations, while others represent tribal communities without reservation land. Some serve a single tribe, while others serve multiple tribal communities or represent a consortium of tribes (HHS, ACF, Office of Child Care, 2014). Several grantees are urban Indian organizations that serve a diverse urban Indian population representing hundreds of tribal affiliations.

[8] A short-term reauthorization of funding in 2014 made it possible to add an additional grant year to programs entering their fifth year of funding (Cohort 1 grantees), making them six-year grants.

ACTIVITIES SUPPORTED BY GRANT FUNDS

To ensure Tribal Home Visiting Program grantees achieve their goals, the cooperative agreements involve several of the following distinct activities:

- Conducting a needs and readiness assessment of the tribal community(ies)
- Engaging in collaborative planning efforts to address identified needs by developing capacity and infrastructure
- Providing high-quality, evidence-based home visiting services to pregnant women, expectant fathers, parents, and primary caregivers of young children from birth to kindergarten entry
- Developing a data system and mechanism to measure, track, and report on progress toward meeting legislatively mandated benchmarks
- Conducting rigorous local program evaluation activities

Using an implementation science–based approach, ACF staged these activities in a way that optimized the potential for grantees to put the right program into practice with adequate supports and infrastructure.

Needs and Readiness Assessments

During the first year of funding, grantees conducted a needs and readiness assessment that informed model selection and program planning. Needs assessments were used to do the following:

WHAT IS IMPLEMENTATION SCIENCE?

Implementation science is the systematic study of the activities involved in putting a particular program, such as an evidence-based program, into practice.

The science suggests that program implementation is a process with various stages, such as exploration, installation, and initial and full implementation. These stages are dynamic and nonlinear, meaning programs can move back and forth between the stages throughout the process. Implementation science also shows that various drivers, including facilitators and barriers, create opportunities and limitations to change.

Using an implementation science lens allows for a thoughtful and data-driven consideration of interventions applied in real-world contexts.

1. Identify and characterize the at-risk community(ies) by providing data on the health and well-being of individuals and families in the community, as well as information on community strengths, risks, and protective factors
2. Identify the quality and capacity of existing programs or initiatives for early childhood home visiting in the target community(ies)
3. Assess community(ies) capacity for providing substance abuse treatment and counseling services to individuals and families who need them
4. Assess community(ies) capacity to implement and integrate home visiting services into an early childhood system, including an assessment of existing or ongoing efforts or resources to develop a coordinated early childhood system at the community level

Comprehensive Implementation Planning

Through needs and readiness assessments (focus groups, interviews, community meetings, informal conversations, and surveys), grantees engaged stakeholders to design an implementation plan that would meet the needs of their communities. Upon completion, each tribal grantee engaged in collaborative planning efforts to develop a comprehensive implementation plan. Each plan includes a description of: (1) the community needs assessment used to identify the targeted community(ies); (2) a description of the home visiting program goals and objectives that aligned with the needs of the targeted communities; (3) the home visiting model(s) proposed to meet identified needs; (4) plans for effective implementation of the home visiting program, including anticipated technical assistance needs and continuous quality improvement (CQI) strategies; (5) a plan for meeting legislatively mandated benchmark requirements; (6) a rigorous evaluation plan; (7) a plan for the administration of the home visiting program; and (8) a budget and budget justification.

The flexibility, through legislation, to align requirements of the tribal program with the state program, to the greatest extent possible, allowed ACF to require grantees to choose a home visiting model that had been established as a promising approach for use in tribal communities and responded to the needs of their communities as identified through the assessment. In addition to outlining how the chosen model would address community needs, grantees described how the community participated in the selection and implementation of the home visiting model. Promising approaches are defined by the following (ACF, 2012):

1. A model studied by the Tribal HomVEE review but found not to meet criteria for evidence of effectiveness
2. A model studied by the larger HomVEE review and adapted to meet the needs of the tribal community
3. A model that was not studied by either the tribal or the larger HomVEE review and adapted to meet the needs of the tribal community
4. A model developed by the grantee to meet community needs, in partnership with a national organization or institution of higher education, for the purposes of the Tribal Home Visiting Program
5. An adapted or modified version of an approved model for the State Home Visiting Program that includes significant alterations to core components

Providing High-Quality Evidence-Based Home Visiting Services

Once a comprehensive implementation plan was completed, home visiting services were provided within the communities. Grantees partnered with the developers of the models to design and implement program adaptations or enhancements. They aimed to address unique community needs, interests, and contexts while maintaining fidelity to the model. Many of these enhancements incorporate local tribal culture into home visiting curricula and group socialization activities.

Benchmarks

The legislation requires grantees to establish quantifiable, measurable performance measures to demonstrate program improvements in six benchmark areas:

1. Maternal and newborn health
2. Child injuries; child abuse, neglect, or maltreatment; and reduction of emergency department visits
3. School readiness and achievement
4. Crime or domestic violence
5. Family economic self-sufficiency
6. Coordination and referrals for other community resources and supports

Grantees developed and implemented individualized performance measurement plans for monitoring program performance on these benchmarks. As part of this process, data collection and management

protocols, analysis plans, and data systems capable of housing and linking data across programs were also developed.

Rigorous Evaluation

In addition to monitoring performance on benchmarks, grantees are required to develop a plan for conducting a rigorous evaluation. These evaluations are intended to strengthen the evidence base for home visiting models and enhancements and contribute to the field. Evaluations examine the impact of the intervention on a targeted set of outcomes or the adoption, implementation, and enhancement of programs. Within the Tribal Home Visiting Program, evaluation rigor involves the principles stated below (James Bell Associates, 2012).

- **Credibility:** Is what is intended to be evaluated actually being evaluated, and does the proposed data collection and analysis appropriately answer the research questions of interest? For example, if the research question focuses on efficacy, an appropriate comparison group must be used.
- **Applicability:** Results can be generalized beyond this project, and the reader can believe the results accurately represent a population or context. For example, communities included in the evaluation must be appropriately representative of communities that qualify for home visiting grant funds.
- **Consistency:** The process and method are articulated in advance and closely followed. Evaluation plans should include specific measures, data collection procedures, and analysis plans. Consistency includes being consistent in data collection to reduce error and pre-specifying analysis plans to reduce bias.
- **Neutrality:** Results are as objective as possible, with an acknowledgement of the bias that may be brought to data collection, analysis, and interpretation of the results. To this end, the evaluation team must have the necessary independence from the project to ensure objectivity, regardless of the research question.

Tribal Home Visiting Program grantees developed rigorous and culturally appropriate evaluation plans to examine various questions of interest and to contribute to the broader knowledge base on home visiting in tribal communities. Some of the outcomes to be evaluated include child development, parental stress, cultural connectedness, family retention and engagement, parental empowerment, referral completions, and traditional parenting practices. Many grantees chose to focus their evaluations on cultural enhancements to the home visiting model. Evaluation results from the first two cohorts of tribal grantees

are expected to be available in fall 2017, following their last year of grant implementation.

Each of the Tribal Home Visiting Program grantees is unique in locale, community and families served, model chosen, and cultural adaptations or enhancements incorporated into the model. An overview of grantee locations, the home visiting models selected, and individual program descriptions (including families served, services provided, and grantee evaluations) are included in the following chapter.

6 DESCRIPTION OF THE GRANTEES

The 25 grantees participating in the Tribal Home Visiting Program represent diverse communities from across the country. Located in 14 states and six ACF regions, these tribal communities vary in size, governance structures, culture, and locale (Table 6-1). Although some grantees serve one tribe on a reservation, others serve multiple tribes on reservations or in a combination of reservations and urban communities. Other grantees represent federally recognized tribes that are not reservation based, including Alaska Native Corporations and their nonprofit entities. Figure 6-1 illustrates the regional location of grantees across the country.

Table 6-1. Grantee Service Population Locale

Locale	Number of Grantees
Rural	15
Urban	3
Rural and Urban	7

Home Visiting Models Selected by Grantees

As required, Tribal Home Visiting Program grantees selected models that were developed by a national organization or institution of higher education, had been in existence for at least three years, and met the needs of the community (Department of Health and Human Services, no date). In addition, the models include comprehensive program standards that ensure high-quality service delivery and continuous quality improvement. Table 6-2 describes each of the six selected home visiting models.

Figure 6-1. Map of Grantee Locations

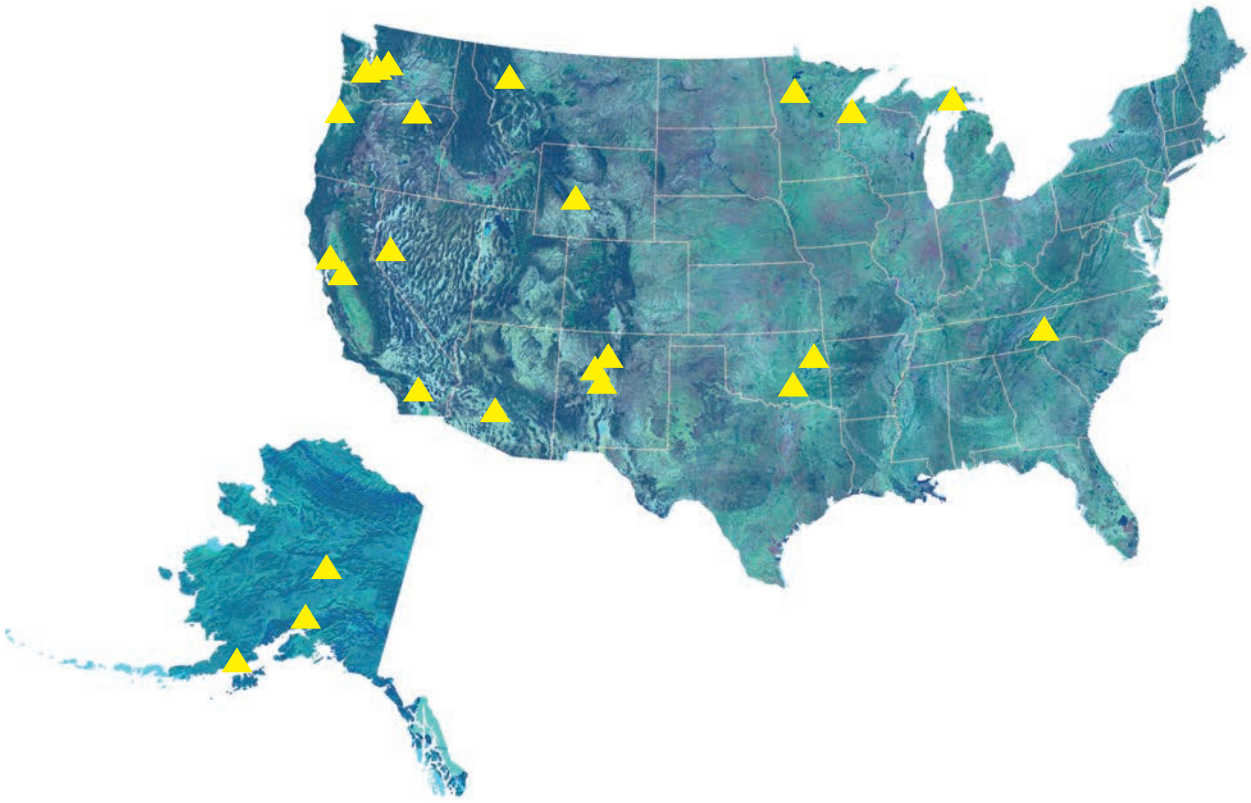


Table 6-2. Overview of Selected Home Visiting Models[9]

Model	Model Description
Parents as Teachers (PAT)	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. 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. 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.
Family Spirit	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. 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. 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.

Model	Model Description
Nurse Family Partnership (NFP)	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. 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.
SafeCare Augmented	SafeCare Augmented is an enhancement to SafeCare. It includes motivational interviewing and additional training for home visitors on identifying and responding to imminent child maltreatment and risk factors, such as substance abuse and depression. SafeCare Augmented was adapted for high-risk, rural communities. The original SafeCare model aims to prevent and address factors associated with child abuse and neglect. Eligible clients include families with a history of child maltreatment or families at risk for child maltreatment. SafeCare typically provides 18 to 22 weeks of training to parents with children from birth to age five. During 60- to 90-minute weekly or biweekly home visits, trained home visitors conduct baseline and follow-up assessments, observations, and trainings with parents. Trainings focus on three modules, each implemented over five to seven visits: (1) infant and child health, (2) home safety, and (3) parent–infant and parent–child interactions. During the parent trainings, home visitors explain the rationale for a particular concept, model the concept, observe the parent practicing the steps, and then provide feedback. Home visitors are not required to meet specific educational requirements.
Parent-Child Assistance Program (P-CAP)	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. 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.
Home Instruction for Parents of Preschool Youngsters (HIPPY)	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. 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. 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.

[9] Summaries for all models were retrieved from the HomVEE Web site (http://homvee.acf.hhs.gov/Models.aspx) with the exception of the overview of the Parent-Child Assistance Program. Information on this model was retrieved from the University of Washington Web site (http://depts.washington.edu/pcapuw/).

Each grantee carefully selected the home visiting model that would meet the needs of its community and, ultimately, improve the well-being of children and families (Table 6-3). About half of the grantees selected Parents as Teachers as their primary home visiting model. Other grantees chose Family Spirit, Nurse Family Partnership, SafeCare Augmented, Parent-Child Assistance Program, and Home Instruction for Parents of Preschool Youngsters. One grantee chose to implement two of these models.

Table 6-3. Home Visiting Models Selected by Grantees

Model	Number of Grantees
Parents as Teachers (PAT)	13
Family Spirit	6
Nurse Family Partnership (NFP)	4
SafeCare Augmented	1
Parent-Child Assistance Program (P-CAP)	1
Home Instruction for Parents of Preschool Youngsters (HIPPY)	1

Cultural Enhancements and Adaptations to Home Visiting Models

Most selected home visiting models are not designed for tribal populations; as a result many grantees have enhanced or adapted models to fit the culture and context of their communities. Examples of adaptations and enhancements include hiring culturally competent staff from the community, incorporating traditional parenting practices, and involving cultural leaders and elders throughout the program development and implementation process. Some grantees used grant funds to incorporate the following cultural elements into their programs:

- Cultural activities such as crafts, music, dance, food, and stories
- Tribal languages, ceremonies, and spiritual practices
- Topics such as storytelling, cultural values, tribal teachings, and traditions

Many grantees engaged local advisory groups to oversee the implementation of cultural enhancements and invited community elders and traditional specialists to participate in and facilitate group meetings. Some also modified their home visiting models by serving families with more than one child, using a curriculum from other home visiting models or programs, providing leadership development opportunities, and tailoring home visitor credentials and caseloads.

Populations Targeted by Grantees to Receive Services

Although target populations varied by grantee, they generally included pregnant mothers, primary caregivers, and children from birth to age five. Some grantees emphasized subpopulations such as infants, expectant fathers, and children receiving care from local health care systems. Grantees designated their own priority populations.

Descriptions of Tribal Home Visiting Program Grantees

Table 6-4 presents basic information about each of the 25 grantees, listed by cohort. The sections that follow detail the families served, services provided, and evaluation methods used by each grantee.

Table 6-4. Grantees by Cohort

Grantee	Program Type	State	Program Model
Cohort 1 (FY 2010–2016)			
Choctaw Nation of Oklahoma	Tribal Nation	Oklahoma	Parents as Teachers
Fairbanks Native Association, Inc.	Urban Indian Organization	Alaska	Parents as Teachers
Kodiak Area Native Association	Tribal Organization	Alaska	Parents as Teachers
Lake County Tribal Health Consortium, Inc.	Consortium of Indian Tribes	California	Parent-Child Assistance Program
Native American Community Health Center, Inc.	Urban Indian Organization	Arizona	Parents as Teachers
Native American Professional Parent Resources, Inc.	Urban Indian Organization	New Mexico	Parents as Teachers
Northern Arapaho Tribe	Tribal Nation	Wyoming	Parents as Teachers
Port Gamble S'Klallam Tribe	Tribal Nation	Washington	Nurse Family Partnership
Pueblo of San Felipe	Tribal Nation	New Mexico	Family Spirit
South Puget Intertribal Planning Agency	Consortium of Indian Tribes	Washington	Parents as Teachers
Southcentral Foundation	Tribal Organization	Alaska	Nurse Family Partnership
White Earth Band of Chippewa Indians	Tribal Nation	Minnesota	Nurse Family Partnership
Yerington Paiute Tribe	Tribal Nation	Nevada	Parents as Teachers

Grantee	Program Type	State	Program Model
Cohort 2 (FY 2011–2016)			
Confederated Salish and Kootenai Tribes	Tribal Nation	Montana	Parents as Teachers
Eastern Band of Cherokee Indians	Tribal Nation	North Carolina	Nurse Family Partnership
Native American Health Center, Inc.	Urban Indian Organization	California	Family Spirit
Riverside-San Bernardino County Indian Health, Inc.	Consortium of Indian Tribes	California	Parents as Teachers
Taos Pueblo	Tribal Nation	New Mexico	Family Spirit and Home Instruction for Parents of Preschool Youngsters
United Indians of All Tribes Foundation	Urban Indian Organization	Washington	Parents as Teachers
Cohort 3 (FY 2012–2017)			
Cherokee Nation	Tribal Nation	Oklahoma	Safe Care Augmented
Choctaw Nation of Oklahoma	Tribal Nation	Oklahoma	Parents as Teachers
Confederated Tribes of Siletz Indians	Tribal Nation	Oregon	Family Spirit
Inter-Tribal Council of Michigan, Inc.	Consortium of Indian Tribes	Michigan	Family Spirit
Red Cliff Band of Lake Superior Chippewa	Tribal Nation	Wisconsin	Parents as Teachers
Yellowhawk Tribal Health Center	Tribal Organization	Oregon	Family Spirit

COHORT 1 GRANTEES (FY 2010–2016)

Choctaw Nation of Oklahoma

The Choctaw Nation of Oklahoma is a non-reservation-based, federally recognized, integrated tribe with a tribal service area larger than Delaware, Massachusetts, Rhode Island, and the District of Columbia combined. The Choctaw Nation serves the second largest tribal area in the lower 48 states, spanning more than 11,784 square miles of rural land covered by rugged hills and

valleys. As a non-reservation-based tribe, the Choctaw Nation encompasses the Oklahoma Tribal Jurisdiction Area, which spans 10.5 counties. Five counties are served by their Cohort 1 home visiting program, Project Chahta Inchukka, and the remaining counties are served by a Cohort 3 grant (see the description under Cohort 3 Grantees).

Families Served	Services are provided to high-risk American Indian families with children from birth to 24 months. The program enrolls mothers or families with children under 12 months.
Services Provided	Project Chahta Inchukka uses the **PAT** home visiting model to serve families in its community. It also incorporates the National Indian Child Welfare Association's Positive Indian Parenting (PIP) program to provide cultural components that speak to the traditions of Native families.
Evaluation	Using a quasi-experimental comparison-group design, the evaluation examines parent knowledge of child development, child development outcomes, and immunization rates. The evaluation compares the outcomes for children and caregivers who receive home visiting with the outcomes for similar children and caregivers who do not participate in the program but receive pediatric care from the Choctaw Nation Health Care system.

Fairbanks Native Association

As an urban Indian organization, the Fairbanks Native Association (FNA) serves eligible families located in the Fairbanks North Star Borough (FNSB), the second-largest population center in the State of Alaska. FNSB spans 7,361 square miles of interior Alaska and experiences extreme seasonal temperatures as well as more than 22 hours of daylight during the summer solstice.

Families Served	The FNA Tribal Home Visiting Project serves mothers and their children from birth to five years.
Services Provided	FNA uses the **PAT** home visiting model with traditional songs, dance, stories, and activities integrated into the curriculum to enhance cultural relevance. Community elders are involved during group meetings and home visits, and staff members are trained in cultural competence to ensure that strategies and activities are consistent with the cultural values of the families being served.
Evaluation	The evaluation attempts to determine the impact of the culturally enhanced PAT program on attendance, retention, and engagement. The grantee is using a quasi-experimental comparison-group design, comparing the outcomes for mothers who participate in the new enhanced program with the outcomes for mothers who previously participated in the non-enhanced program.

Kodiak Area Native Association

The Kodiak Area Native Association (KANA) is a nonprofit tribal organization providing health and social services for AIAN families of the Koniag Region of Alaska, including Kodiak Island. The federally recognized tribes within the Koniag Region include the Native Village of Akhiok, the Native Village of Karluk, the Native Village of Larsen Bay, the Village of Old Harbor, the Native Village of Ouzinkie, and the Native Village of Port Lions. The Alutiiq (Russian-Aleuts) represent the predominant tribal culture in this area. Due to the rural locality of this region, the only way of traveling to villages on the island is by boat or plane.

Families Served	KANA's Cama'i Tribal Home Visiting Program serves prenatal women, expectant fathers, and children from birth to five years living in the Koniag Region.
Services Provided	KANA adopted the **PAT** home visiting model and added cultural enhancements to the curriculum such as traditional parenting skills, storytelling, language, crafts, food, music, and dancing. In addition, community elders are used in group connections and advisory roles.
Evaluation	Using a randomized case-control study design with a wait-list control group, the evaluation examines parenting behaviors and parent–child relationship outcomes for primary female guardians of children who are AIAN and up to 18 months old and are receiving home visiting services. The evaluation will also assess the social and emotional milestones of the child.

Lake County Tribal Health Consortium, Inc.

The Lake County Tribal Health Consortium (LCTHC) is a federal, Title I, tribally sanctioned organization located about 100 miles north of San Francisco and 50 miles east of the Pacific Ocean. For 11,800 years, Pomo people have inhabited the Pomo ancestral homeland located in Lake County, where seven of the 22 federally recognized Pomo tribes currently reside. Members of at least 111 other tribes also live in rural Lake County, representing 3.2 percent of the county's population.

Families Served	LCTHC's Gouk-Gumu Xolpelema Partnership with Parents Tribal Home Visiting Program provides services to tribal members with children from birth to five years living in Lake County, California.
Services Provided	LCTHC uses the **P-CAP** home visiting model in combination with the Nurturing Parenting curriculum to enhance services and allow for individualized parenting support.
Evaluation	The evaluation uses a quasi-experimental comparison-group design to examine differences in parenting stress and parenting practice outcomes for Native American mothers who participate in Nurturing Parenting versus those without P-CAP.

Native American Community Health Center, Inc.

The Native American Community Health Center (NACHCI) is an urban Indian organization serving AIAN individuals from more than 30 different tribes residing in the Phoenix metropolitan area and the surrounding county. The majority of American Indians living in the service area are Navajo.

Families Served	Services are provided to members of AIAN tribes living throughout the Phoenix metropolitan area with children ages birth to five.
Services Provided	NACHCI uses the **PAT** home visiting model with culturally enhanced group meeting activities. A traditional cultural specialist facilitates group activities that incorporate traditional concepts of families and methods of raising children. A community advisory board was established to guide the development and implementation of cultural enhancement and to advise on program implementation.
Evaluation	After the implementation of an enhanced family engagement strategy to incorporate cultural enhancements into group meetings, the evaluation examines whether family retention improves. The evaluation will compare retention rates before implementation of the enhancement with retention rates after implementation.

Native American Professional Parent Resources, Inc.

Native American Professional Parent Resources (NAPPR) is a community-based, nonprofit urban Indian organization serving 10 federally recognized tribes on rural reservations in New Mexico and approximately 28,500 urban AIANs living in the Albuquerque metropolitan area. NAPPR serves the Pueblo of Acoma, Sandoval County, and the To'hajiilee Chapter of Navajo Nation. Service communities are diverse in culture and language and include AIAN families from all parts of Indian Country.

Families Served	The NAPPR Tribal Home Visiting Program serves AIAN families with children from birth to age five residing within the service communities.
Services Provided	NAPPR uses the **PAT** home visiting model with cultural enhancements that include integrating traditional stories, language, and knowledge; increasing the cultural appropriateness of group meetings; and implementing a Native father component. NAPPR has also added a cultural staff-training component.
Evaluation	Using a quasi-experimental comparison-group design, the evaluation examines whether Native families who receive the culturally enhanced PAT program have greater cultural connectedness outcomes compared with Native families who receive the standard PAT program through Early Head Start.

Northern Arapaho Tribe

The Northern Arapaho Tribe is located on the Wind River Indian Reservation in the Wind River Basin of central Wyoming. Spanning over 2,000,000 acres of primarily plains and foothills, the reservation is shared by the Eastern Shoshone and the Northern Arapaho Tribes, two very distinct communities and cultures with separate but overlapping governmental entities.

Families Served	The Northern Arapaho Home Visiting Program serves: (1) unmarried pregnant teens and teen mothers, (2) women of any age who are pregnant and will be first-time mothers, (3) women who are pregnant less than six months after delivering an older child, (4) families with a child under age three who has been diagnosed with a serious medical condition or developmental delay, (5) women who are pregnant and have a medical condition that puts an infant at higher risk for maltreatment or neglect (e.g., alcoholism, drug abuse, psychiatric illness, chronic illness), and (6) parents who have a child or children under the age of three who have regained custody after court-ordered removal.
Services Provided	Home visiting services are provided using the **PAT** home visiting model with cultural enhancements to group meetings that incorporate historical, cultural, and traditional values. Elders and traditional people are involved as storytellers and guides for some activities.
Evaluation	Using a quasi-experimental comparison-group design, the evaluation examines levels of parenting stress in primary caregivers who receive PAT home visiting services compared with primary caregivers receiving services only through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program.

Port Gamble S'Klallam Tribe

The Port Gamble S'Klallam Tribe (PGST) lives on a reservation that consists of approximately 1,700 acres of forested residential and commercial land held in trust by the federal government. There is no private land ownership on the reservation. Rural and remote, the reservation is located 1.5 hours by car and ferry from Seattle and 45 minutes by car from Bremerton, where the majority of services and resources are available.

Families Served	The Port Gamble S'Klallam Tribe (PGST) Together for Children Tribal Home Visiting Program serves tribal families and their children from before birth to age five.
Services Provided	The program uses **NFP** for expectant mothers enrolling before week 28 of their pregnancies and the Brazelton Touchpoints program for pregnant mothers enrolling after week 28 of pregnancy or raising a child any age under five years. Enhancements to NFP include adapting the program to serve families with more than one child and adding culturally relevant photographs and S'Klallam-language words to written materials.
Evaluation	Using a single-case design, the evaluation measures changes in parental stress (for families receiving NFP), communication in child-rearing and parenting practices (for families receiving Touchpoints), and father involvement in parenting (for families participating in the tribally sponsored Fatherhood Is Sacred program in conjunction with home visiting services).

Pueblo of San Felipe

The Pueblo of San Felipe is a federally recognized tribe located in Sandoval County, New Mexico. Although it is situated between two urban centers, Albuquerque and Santa Fe, the Pueblo is rural and isolated. The Pueblo of San Felipe is active with ceremonial dances, pottery, farming, and other traditions. Tribal members primarily speak the Keres language (87 percent).

Families Served	Project Katishtya Eh-wahs Valued Always (KEVA) Tribal Home Visiting Program serves women who are first-time mothers, expectant teenage mothers, and families who are at risk for substance abuse that include a child up to age five.
Services Provided	The KEVA Tribal Home Visiting Program provides services using the **Family Spirit** home visiting model along with Circle of Security and a cultural parenting curriculum developed in collaboration with elders of the San Felipe Pueblo. The curriculum was developed to help teach young parents traditional parenting practices and customs that support healthy child development.
Evaluation	Using a qualitative within-person comparison design, the evaluation explores the achievement of parenting goals and the relationship between perceived goal attainment and the three program components: Family Spirit, Circle of Security, and the cultural parenting curriculum.

South Puget Intertribal Planning Agency

The South Puget Intertribal Planning Agency (SPIPA) is a tribally chartered nonprofit consortium organization that includes five tribes in the State of Washington: Chehalis, Nisqually, Shoalwater Bay, Skokomish, and Squaxin Island. The SPIPA Healthy Families Project serves six communities; four are rural, and two are urban.

Families Served	Services are provided to AIAN families, including expectant mothers, teenage parents, and parents of children up to age five.
Services Provided	The Healthy Families Project uses the **PAT** home visiting model with the PIP curriculum and cultural teachings incorporated into home visits. **PAT** was also modified to focus on prevention. Home visitors were hired from within the respective communities.
Evaluation	Using a single-case design, the evaluation examines the use of traditional Native American parenting practices among participating families.

Southcentral Foundation

Southcentral Foundation (SCF) is a nonprofit health care organization of Cook Inlet Region, Inc., an Alaska Native regional corporation, with a service area that includes the Municipality of Anchorage and the Matanuska-Susitna Borough. The population in the service area includes members of approximately 519 federally recognized tribes—all 229 federally recognized tribes in Alaska and approximately 290 other federally recognized tribes from across the country.

Families Served	SCF's Nutaqsiivik NFP Tribal Home Visiting Program serves pregnant, low-income, AIAN mothers who are at high social and a medical risk and live in the defined service areas.
Services Provided	SCF uses **NFP** adapted to address the needs and concerns of AIAN women in the targeted service area who have more than one child, are at high social or a medical risk, and receive health care services through the Anchorage Native Primary Care Center or the Benteh Nuutah Valley Native Primary Care Center.
Evaluation	The evaluation contains two components: (1) using a historical comparison-group design, comparing maternal and child health outcomes of participating families receiving the adapted NFP program to families who did not receive the adapted NFP program, and (2) using qualitative methods, exploring the cultural relevance and ability of the adapted NFP program to meet the needs of first-time mothers and mothers with multiple children.

White Earth Nation

The White Earth Nation (WEN) is a federally recognized tribe located on the White Earth Reservation in northwestern Minnesota. The reservation covers 1,300 square miles encompassing three counties, five incorporated cities, and five major villages. There are 9,188 people living on the White Earth Reservation, 4,029 identify themselves as American Indian.

Families Served	The White Earth home visiting program, Learning in the Family Environment (LIFE) Project and Parent Mentor Program, provides services to pregnant women, mothers, and caregivers who have children from birth to five years and who live on the White Earth Reservation.
Services Provided	The LIFE Project uses the **NFP** home visiting model for children from birth to age two and the White Earth Parent Mentor Program for children ages two to five. Cultural enhancements to the NFP model include using the Ojibwe language; books, stories, and materials that reflect activities that are culturally connected to the community; and storytelling and cultural and traditional values embedded in each lesson. The model was also modified to serve mothers with more than one child and adapted to include tailored requirements for nurse home visitor credentials, caseloads, and supervision.
Evaluation	Using a quasi-experimental interrupted time series design, the evaluation compares community resource access and service referral outcomes of mothers with multiple children who receive services through the NFP enhanced engagement strategy to outcomes for the same women prior to enrollment in the NFP program.

Yerington Paiute Tribe

The Yerington Paiute Tribe is a federally recognized tribe located in Lyon County, Nevada. Remote and rural in location, Lyon County comprises the Yerington Colony (22.34 acres adjacent to the City of Yerington) and the Yerington Paiute Reservation (also known as Campbell Ranch, which includes 1,633 acres located approximately 10 miles north of Yerington).

Families Served	The Yerington Paiute Tribe's Community Maternal Child Home Visiting Program serves AIAN pregnant women and parents and caregivers of children from birth to age five.
Services Provided	Services are provided using the **PAT** home visiting model, with enhancements to the curriculum including cultural education, smudging, Paiute language, cultural foods, and Paiute medicine. Group connections are enhanced using traditional activities such as crafts, storytelling, language, and information about other traditional events happening in the community.
Evaluation	The evaluation uses a single-case design to examine the relationship between participation in the enhanced PAT curriculum and changes in self-reported levels of stress and cultural engagement.

COHORT 2 GRANTEES (FY 2011–2016)

Confederated Salish and Kootenai Tribes

The Confederated Salish and Kootenai Tribes (CSKT) is a federally recognized union of three tribes—Bitterroot Salish, Pend d'Oreille, and Kootenai—located on the 1.317 million acre Flathead Reservation in northwestern Montana. The local Salish Kootenai College serves as a nationally recognized tribal college, drawing students and families from over 70 different tribes to the reservation.

Families Served	The CSKT Tribal Home Visiting Program serves pregnant women, expectant fathers, and primary caregivers of children from birth to age five.
Services Provided	CSKT uses the **PAT** home visiting model with cultural enhancements that include involving elders at monthly group meetings and holding seasonal and special cultural activities that incorporate tribal language and traditions. CSKT is also implementing a leadership-training enhancement for PAT participants.
Evaluation	Using a quasi-experimental comparison-group design, the evaluation will examine retention and personal goal outcomes of adult participants who receive home visiting with a leadership component versus those that receive home visiting without leadership training opportunities.

Eastern Band of Cherokee Indians

The Eastern Band of Cherokee Indians (EBCI) is a federally recognized tribe whose rural reservation encompasses more than 56,000 acres of mountainous land in the five westernmost counties of North Carolina. As of December 2011, EBCI had over 14,500 members, and enrollment had increased 38 percent since 1995. More than half of EBCI members live on tribal lands.

Families Served	The EBCI Nurse Family Partnership Program serves AIAN mothers and pregnant AIAN women.
Services Provided	Services are provided using the **NFP** home visiting model, with a key adaptation to serve mothers with more than one child. This adaptation was rooted in a cultural concept of inclusiveness. The desire to care for all women and children is intrinsic to the Cherokee culture.
Evaluation	The evaluation uses a historical comparison group to examine the impact of NFP on maternal and child health outcomes.

Native American Health Center, Inc.

The Native American Health Center (NAHC) is an urban, nonprofit health organization that implements services in homes, clinical settings, institutions, and community centers across Alameda County in California's San Francisco Bay Area. This area hosts one of the largest and most diverse urban AIAN populations in the United States, representing over 200 tribes and comprising 1.2 percent of the county population.

Families Served	NAHC's Strong Families Tribal Home Visiting Project provides services to AIANs who are pregnant (teens and adults) or are parents or caregivers of AIAN children from birth to age three living in Alameda County.
Services Provided	NAHC uses the **Family Spirit** home visiting model, enhanced and augmented by the PIP curriculum. Adaptations to the Family Spirit model were made to suit the urban, intertribal community. Information from the Alameda County's Comprehensive Perinatal Services Program Patient Information handouts on various perinatal health topics is also used to enhance the Family Spirit model.
Evaluation	Using a randomized case-control study design with a wait-list control group, the evaluation explores the impact of Family Spirit enhanced with PIP on parenting self-efficacy, responsivity, and the cultural connections of families.

Riverside-San Bernardino County Indian Health, Inc.

Riverside-San Bernardino County Indian Health is a federally recognized consortium of 10 sovereign Indian tribes located throughout California's Riverside and San Bernardino counties. The rural and urban service area includes 27,263 square miles encompassing 77 communities and is not restricted to the reservation areas. The consortium tribes are Agua Caliente, Cahuilla, Fort Mojave, Morongo, Pechanga, Ramona, San Manuel, Santa Rosa, Soboba, and Torres-Martinez.

Families Served	The Riverside-San Bernardino County Indian Health Home Visiting Program serves pregnant women and families with children from birth to five years.
Services Provided	Services are provided using the **PAT** home visiting model. Enhancements to services include implementing a geographic information system (GIS) for locating services and other resources to respond to family needs.
Evaluation	Using a stratified block randomization comparison-group design, the evaluation examines referral completion, parental empowerment, and child development outcomes among three groups: those receiving PAT enhanced with the GIS resource management system, those receiving PAT alone, and those receiving neither.

Taos Pueblo

Taos Pueblo is a federally recognized tribe located in north-central New Mexico. Approximately 1,500 enrolled tribal members live in and around the 100,000-acre rural reservation. Taos Pueblo has been home to the Taos Indians for over 1,000 years and is the oldest continuously inhabited community in the United States.

Families Served	The Taos Pueblo's Tiwa Babies Tribal Home Visiting Program serves families with children from birth to age five who reside on the Pueblo and within Taos County. Priority is given to families within the Tribal Home Visiting Program's designated priority populations.
Services Provided	Using the **Family Spirit** home visiting model along with **HIPPY**, the Tiwa Babies Tribal Home Visiting Program believes that culture is the cornerstone for healthy families and children. Adaptations to the Family Spirit model include incorporating the Tiwa language and reinforcing traditions for nurturing infants; achieving balance with mind, body, and spirit; and sharing food, clothes, and essentials with others in need.
Evaluation	The evaluation focuses on the impact of incentives on family retention and dosage. Using a randomized comparison-group design, the evaluation compares implementation outcomes for families that receive two different incentive packages.

United Indians of All Tribes Foundation

The United Indians of All Tribes Foundation is an urban Indian organization that serves AIAN families in King County, Washington. King County comprises 2,134 square miles and has a population of over 1.9 million people. It includes the Seattle metropolitan area and several other communities, a few of which are AIAN population bases. Residents of King County represent 41 tribal groupings and hundreds of individual tribes from across the United States and Mexico.

Families Served	The United Indians of All Tribes Foundation's Ina Maka Family Program (IMFP) serves AIAN women who are pregnant or have infants or young children.
Services Provided	Services are provided using the **PAT** home visiting model. Cultural enhancements to the curriculum include hiring culturally competent staff members who have a strong understanding of AIAN culture, incorporating elders into the program, using traditional storytelling, conducting naming ceremonies, integrating traditional foods into nutrition discussions, and referring participants to cultural activities such as powwows and drumming or dancing classes.
Evaluation	Using a randomized comparison-group design, the evaluation compares the parenting outcomes of IMFP participants who receive the IMFP surface level cultural enhancements (simple additions to curriculum materials) and deep level cultural enhancements (addressing participants' individual experiences around history, stressors, coping skills, and social supports) with those participants who receive only the surface level cultural enhancements.

COHORT 3 GRANTEES (FY 2012–2017)

Cherokee Nation

The Cherokee Nation of Oklahoma is a federally recognized tribe located on a Tribal Jurisdiction Area consisting of 9,234 square miles within the 14 counties of northeastern Oklahoma. The Cherokee Nation of Oklahoma has over 300,000 citizens, making it the country's largest tribal nation. American Indians residing in the Cherokee Nation Oklahoma Tribal Jurisdiction Area account for roughly 30 percent of Oklahoma's American Indian population and nine percent of the total state population.

Families Served	The Cherokee Nation provides home visiting services to American Indian families and children from birth to five years.
Services Provided	The Cherokee Nation selected the **SafeCare Augmented** home visiting model and uses the PIP curriculum to incorporate cultural activities. Cultural enhancements to group meetings include topics such as traditional parenting, storytelling, lessons of the cradleboard, harmony in child rearing, traditional behavior management, and lessons of mother nature. In addition to implementing PIP at monthly group meetings, the program will invite Cherokee elders to the meetings to pass down their parenting wisdom.
Evaluation	Using a quasi-experimental design with a naturally occurring comparison group, the evaluation examines parent, child, and childhood neglect and abuse outcomes of families who receive the SafeCare Augmented program compared with those who do not.

Choctaw Nation of Oklahoma

Receiving a second Tribal Home Visiting Program grant in Cohort 3, the Choctaw Nation serves five of the 10.5 counties through its Cohort 1 program (Project Chahta Inchukka) and the remaining counties through its Cohort 3 program (Project Chahta Vlla Apela). The target population and home visiting model are the same for both cohorts (see the description under Cohort 1 Grantees).

Confederated Tribes of Siletz Indians

The Confederated Tribes of Siletz Indians (CTSI) is a federally recognized confederation of 27 bands originating from northern California and southern Washington. Each of these tribes has a unique history, culture, and legal relationship with the federal government. CTSI's service area includes 11 counties in Oregon.

Families Served	The Siletz Tribal Home Visiting Program provides home visiting services to tribal members residing in service area counties, with a focus on young children (prenatal through age three), children ages three to five who are not attending Head Start, expectant mothers and fathers, families facing hardships and stress, families coping with alcohol and substance use, elders who are caregivers, and families with a history of child neglect or maltreatment.
Services Provided	The Siletz Tribal Home Visiting Program uses the **Family Spirit** home visiting model. Adaptations to the model include incorporating the Athabaskan language in natural family settings and training home visiting staff in Safe Sleep techniques.
Evaluation	CTSI plans to examine parent stress, self-efficacy, and knowledge of child development through a single-case design evaluation that assesses families before, during, and after participation in the Your Growing Child curriculum module of Family Spirit. The grantee also plans to explore traditional community understandings of child development through a qualitative evaluation.

Inter-Tribal Council of Michigan

The Inter-Tribal Council of Michigan (ITCM) is a nonprofit organization that functions as a coalition of federally recognized tribes. It spans 19 counties in Michigan and includes five rural tribal reservation communities, one non-reservation community, and one urban program. The seven sites implementing the Tribal Home Visiting Program grant include: (1) the Bay Mills Indian Community, (2) Nottawaseppi Band of Huron Potawatomi, (3) Keweenaw Bay Indian Community, (4) Lac Vieux Desert Indian Tribe, (5) Little Traverse Bay Bands of Odawa Indians, (6) Match-E-Be-Nash-She-Wish Potowatomi Gun Tribe, and (7) the American Indian Health and Family Services of Southwestern Michigan.

Families Served	ITCM's home visiting program, Partnership for Anishinaabe Binoojiiyensag Project, serves American Indian children who reside in the service area.
Services Provided	ITCM selected the **Family Spirit** home visiting model. Cultural adaptations to the model include: (1) adding an intense school readiness component by integrating evidence-informed early literacy tools and activities into visits with families of three to five-year olds; (2) adding content and demonstration activities to child development lessons for families with children ages two to five years (to support the development of early numeracy and letter recognition); (3) conducting Family Spirit prenatal lessons with mothers who want to begin the program before 28 weeks of gestation; (4) incorporating staff from a variety of professional backgrounds in home visits, including paraprofessionals, social workers, nurses, and early childhood development specialists; and (5) developing Ojibwe-, Odawa-, and Potawatomi-specific cultural adaptations and teachings.
Evaluation	Using a stepped wedge cluster randomization design, the evaluation examines child literacy and parenting outcomes of families who participate in services with early learning enhancements compared to families receiving standard Family Spirit home visiting services.

Red Cliff Band of Lake Superior Chippewa

The Red Cliff Band of Lake Superior Chippewa is a federally recognized tribe located on the rural Ojibwe reservation in northern Wisconsin. Sixty-four percent of members are children, youth, and young adults of childbearing age. Children from birth to age five are the fastest-growing segment of the population.

Families Served	The Zaagichigaazowin (ZHV) Home Visiting Program serves families who live on or within 15 miles of the Red Cliff Band of Lake Superior Ojibwe Reservation, with at least one primary caregiver who is a tribal member or is eligible for tribal membership.
Services Provided	Services are provided using the **PAT** home visiting model, with enhancements that include cultural teachings and activities, tribal programs and ceremonies, cradleboard-based teachings related to health and relationships. ZHV hires community-based doulas, individuals who specialize in supporting mothers during childbirth, to serve as PAT home visitors and child development specialists.
Evaluation	Red Cliff is using an interrupted time series design to examine whether participants in ZHV have better prenatal and perinatal health outcomes (prenatal alcohol use, smoking, breastfeeding, infant birth weight, vaginal or C-section birth, health events at birth, and prenatal care visits) than participants in a previous, less structured home visitation program. Red Cliff is also conducting a qualitative process evaluation to understand participant patterns of service use, quality of relationship with doula, and program fidelity.

Yellowhawk Tribal Health Center

The Yellowhawk Tribal Health Center (YTHC) is a nonprofit, tribally governed, fully accredited ambulatory health clinic providing services to the Confederated Tribes of the Umatilla Indian Reservation in rural Umatilla County, Oregon.

Families Served	Services are provided to children from birth to age five, first-time mothers under 21 years, and pregnant women of any age who meet the Oregon Maternity Case Management high-risk eligibility criteria. Families with members who served in the Armed Forces have high priority for receiving services.
Services Provided	The YTHC Tribal Home Visiting Program uses the **Family Spirit** home visiting model, with enhancements such as encouraging program participants to share important cultural teachings, incorporating lessons about cradleboards, incorporating lessons from the PIP curriculum, and using a multigenerational approach to involve elders and other community members.
Evaluation	YTHC plans to evaluate parental stress outcomes for those who receive brief boosters to the Family Spirit curriculum through a single-case design approach. The YTHC team also plans to explore community breastfeeding supports through a qualitative evaluation.

7 TECHNICAL ASSISTANCE PROVIDED

Tribal Home Visiting Program grantees receive initial and ongoing technical assistance from several entities through cooperative agreements with ACF federal staff, the developers of the home visiting models, the Programmatic Technical Assistance for Tribal Home Visiting Center (PATH), and the Tribal Home Visiting Evaluation Institute (TEI). Extensive TA and capacity building support are provided to grantees on a variety of the following topics:[10]

- Needs assessment and model selection
- Program startup and implementation
- Implementation fidelity monitoring
- Recruitment and retention of home visiting staff and clients
- Performance measurement and improvement
- Data collection and data systems
- Continuous quality improvement
- Program evaluation

"I think everything that ACF and our TA providers have offered has helped us to finish the work, and they know how to navigate through different phases. It's been challenging, but we've had the appropriate resources available to us to be able to get to the level we need to be at."
– Cohort 1 Tribal Grantee Program Coordinator

This coordinated support helped programs meet the grant requirements described in Chapter 5. Along with other program expertise and resources, this TA also provided a foundation for the growth in capacity and services described in the following chapter.

[10] Direct quotations included throughout this report are excerpts from informal interviews conducted with Cohort 1 grantees in spring 2015. Some quotations have been moderately edited for readability without altering their meaning.

SUPPORT FROM ACF FEDERAL STAFF MEMBERS

Tribal Home Visiting Program grantees engage in regular communication with ACF federal staff members regarding all grant-related activities. The cooperative agreements between grantees and ACF allow for extensive federal support on grant administration and management, implementation and service delivery, data collection, continuous quality improvement, and rigorous evaluation plans, among the many other facets of programming. Federal staff members from ACF support grantees in the form of monthly check-in calls, site visits, grantee meetings, and other as-needed communication. In addition, ACF staff members participate in conference calls, webinars, and meetings between grantees and the TA providers outlined in the rest of this chapter—model developers, providers of TA on program issues, and providers of TA on evaluation and data-related issues.

TA FROM MODEL DEVELOPERS

The developers of the program models provide training and support on program planning and implementation, adaptations to serve AIAN populations, data systems, methods for monitoring fidelity to the program model, and many other topics. Because each model developer's support structure is different, grantees considered the amount and type of TA available when selecting a home visiting model. Table 7-1 describes the TA available for each home visiting model used by tribal grantees.

Table 7-1. Technical Assistance Provided by Home Visiting Model

Model	Technical Assistance Provided[11]
Family Spirit	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. 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.
Home Instruction for Parents of Preschool Youngsters (HIPPY)	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. 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 action plans for quality improvement. HIPPY USA trainers contact their assigned programs monthly to discuss progress and provide assistance in solving implementation issues.

Model	Technical Assistance Provided[11]
Nurse Family Partnership (NFP)	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. 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.
Parent-Child Assistance Program (P-CAP)	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. 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.
Parents as Teachers (PAT)	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. 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.
SafeCare Augmented	The National SafeCare Training and Research Center (NSTRC) first works with interested programs to determine readiness to implement the model. Prior to training, NSTRC faculty and trainers prepare sites through conference calls and an in-person orientation visit to make sure the agency management and staff members to be trained understand the training and implementation process. NSTRC requires all SafeCare home visitors to complete a multiday workshop delivered by NSTRC trainers. Following the workshop, home visitors receive feedback on their implementation of SafeCare in the field from a SafeCare coach. NSTRC provides local programs TA in implementation and quality assurance for a minimum of one year after training. Home visitors implementing SafeCare Augmented also receive training in motivational interviewing from a member of the Motivational Interviewing Network of Trainers; ongoing training in motivational interviewing; and ongoing consultation from local experts in substance abuse, mental health, and intimate partner violence.

[11] The descriptions of TA provided by model developers were provided primarily by the HomVEE Web site (HHS, no date).

All program model developers worked with grantees during program planning and implementation. Model developers provided the training, monitoring, and support needed to implement the model with fidelity and provide high-quality services. The developers worked closely with grantees to design and implement acceptable adaptations to the models for AIAN populations while still maintaining the models' core elements. They also provide varying degrees of support for data collection activities.

TA FROM THE PROGRAMMATIC TECHNICAL ASSISTANCE FOR TRIBAL HOME VISITING CENTER

PATH provides TA on program implementation to support grantee capacity building and support the provision of high quality, culturally relevant home visiting services. Zero to Three in partnership with Arizona State University's Center for American Indian Projects, leads PATH.[12] The ACF Office of the Deputy Assistant Secretary for Early Childhood Development administers the PATH contract. The following are PATH's primary goals:

- Respond to the needs of the Tribal Home Visiting Program
- Support high-quality, evidence-based home visiting programs as part of a strong early childhood system that promotes the health and well-being of pregnant women, children from birth to kindergarten entry, and their families

PATH offers TA along a continuum of intensity to meet the unique challenges and strengths of individual grantees. There are three levels of intensity.

1. **Universal technical assistance (raising awareness and sharing information):** This level of TA provides recipients with up-to-date research and information pertaining to a variety of topics related to home visiting and early childhood development. Universal TA activities occur through the Web site, webinars, listservs, audio conference calls, grantee meetings, and the distribution of materials.
2. **Targeted technical assistance (building knowledge and skills):** This level of TA provides recipients a deeper level of knowledge on a particular topic or on needs common to multiple grantees. One such activity may be teaching about

EXAMPLES OF PROGRAMMATIC TECHNICAL ASSISTANCE

Assessment and Planning: Community needs and readiness assessment, strategic planning, community engagement, organizational capacity and leadership

Implementation: Adaptation and enhancement of home visiting models, implementation fidelity, culturally relevant practice, recruitment and retention of staff and families, referral and intake systems, continuous quality improvement, collaboration and partnership

Sustainability: Dissemination, fiscal leveraging and sustainability, workforce and professional development, coordination of early childhood systems

[12] PATH began in fall 2014. Walter R. McDonald and Associates, the Tribal Law and Policy Institute, and the FRIENDS National Resource Center previously provided programmatic technical assistance.

implementing and sustaining a home visiting strategy and then encouraging participants to describe how the strategy could be employed in their tribal community. Targeted TA is delivered through in-person grantee meetings, webinars, and conference calls.

3. **Intensive technical assistance (increasing grantee capacity and improving implementation outcomes):** With this level of TA, PATH works more intensely with individual grantees to move their work forward. TA providers customize this assistance to the context of the tribal community. PATH delivers this intensive TA through site visits to grantees as well as conference calls and Web meetings with grantee staff. PATH's TA uses relationship-based and adult learning principles, such as creating an environment that supports openness to learning and working in partnership with participants to establish mutual interests and goals.

TA FROM THE TRIBAL HOME VISITING EVALUATION INSTITUTE

TEI provides TA to all grantees on evaluation and other data-related grant activities, such as performance tracking and measurement; design, implementation, and analysis for a rigorous evaluation; CQI; data systems; and ethical dissemination and translation of evaluation findings. James Bell Associates, Inc., leads the TEI team in partnership with the Centers for American Indian and Alaska Native Health and the Tribal Early Childhood Research Center at the University of Colorado School of Public Health, Johns Hopkins University Center for American Indian Health, Michigan Public Health Institute, and MDRC. The ACF Office of Planning, Research and Evaluation administers the TEI contract.

Like PATH, TEI provides multiple levels of support to grantees. TEI delivers universal support through webinars, briefs, toolkits, grantee meetings, and facilitated peer learning opportunities and individualized TA through conference calls and Web meetings, site visits, and other in-person meetings.

TEI strives to build local capacity to collect and use data to improve services for children and families, achieve better outcomes for families and communities, and better understand program impact. TEI builds capacity in three primary areas.

1. **Performance measurement:** TA on benchmarks involves supporting grantees as they identify and operationalize performance measures; collect, analyze, and report data; and use data to understand program progress.

EXAMPLES OF EVALUATION TECHNICAL ASSISTANCE

Performance Measurement: Developing benchmark measurement plans; operationalizing performance measures; developing data collection protocols; developing, selecting, and modifying data systems; analyzing data; reporting benchmark data

Evaluation: Developing an evaluation question and design, understanding quasi-experimental designs, selecting culturally appropriate measures, developing an institutional review board application, evaluating cultural enhancements, disseminating evaluation findings

Continuous Quality Improvement: Developing an organizational culture that values and uses data, conducting Plan-Do-Study-Act cycles, using data to understand existing processes and drive program improvements, facilitating CQI peer learning communities

2. **Evaluation:** TA on evaluation involves assisting grantees in the development of an evaluation question and design that are both important and acceptable to the local community and of interest to the broader tribal home visiting field.
3. **Continuous quality improvement:** TEI provides assistance on CQI through hands-on, in-person training to grantee teams on using the Plan-Do-Study-Act cycle. This cycle is an iterative, four-stage problem-solving method for improving a process or carrying out change (Tews et al., 2008). CQI involves using data to systematically identify areas for improvement and to test and measure the effect of planned improvements.

TEI uses a capacity building approach that emphasizes relationship and skill building. TEI draws on the *Roadmap for Collaborative and Effective Evaluation in Tribal Communities* (Tribal Evaluation Workgroup, 2013) and incorporates the following core elements of effective support:

- Respect for tribal processes and decision making by recognizing tribal sovereignty and autonomy
- Approaches that support and incorporate substantial community input into evaluation and performance measurement
- Iterative, step-by-step processes informed by research on adult learning
- Consistent, long-term involvement with grantees
- Frequent and responsive contact through a variety of modalities
- Emphasis on and promotion of bidirectional learning
- Acknowledgment of indigenous ways of knowing and western science as equally relevant forms of knowledge

8 TRIBAL HOME VISITING SERVICES: BUILDING PROGRAMS TO REACH HIGH-NEED FAMILIES

Required program activities and support from federal staff and TA providers helped grantees successfully reach and serve vulnerable families and children in at-risk communities. Demographic and service data from FY 2012 through FY 2014 demonstrate significant increases in program capacities and increased service delivery to some of the highest-need families. The findings below describe these increases in program capacities and service delivery and the characteristics and demographics of the families served. Unless otherwise noted, findings represent data submitted by all 25 grantees for participants enrolled in FY 2014. Information from informal interviews conducted with the first cohort of grantees (13 grantees) is also integrated throughout the chapter.

INCREASED PROGRAM REACH AND CAPACITY

During FY 2012 through FY 2014, enrollment and home visits increased. Program capacities also improved but were not as easily captured in data. For example, grantees raised awareness and support for their programs and carefully built processes and infrastructure to deliver high-quality, community-based services.

The Tribal Home Visiting Program increased the reach of services in tribal communities. In 2014, 870 families were enrolled, over five times the number of families enrolled in 2012 (Figure 8-1). Grantees also increased the number of home visits provided annually, conducting 17 times more home visits in 2014 than 2012 (Figure 8-2). Within a short time period and with limited grantee experience in home visiting, a total of 1,523 unique families, which included 1,700 adult participants and 1,497 children, were enrolled. These families received nearly 20,000 home visits from 2012 to 2014.

Figure 8-1. Growth in Participants

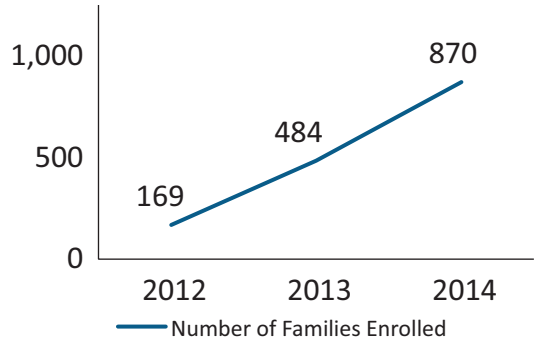
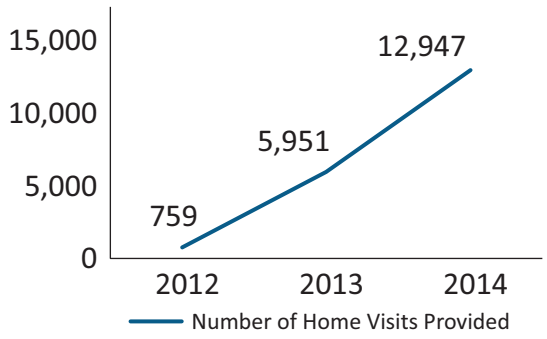


Figure 8-2. Growth in Home Visits



Grantees worked to build community awareness and acceptance of home visiting. Many grantees needed to address the negative history and assumptions related to home visiting in their communities. In some tribal communities, people associate home visits with child protection investigations. There were also struggles with the lack of community awareness of the need for early childhood development and education. The grantees confronted these challenges by providing consistent, quality services and engaging in outreach activities to inform the community of the program and address any concerns.

> *"If you had a nurse come into your home in years past, it was because your child was being taken away." - Cohort 1 Tribal Grantee Data Manager*

Building capacity and providing quality services that met community needs. The growth in services reflects, in part, the thoughtful preparation that each grantee undertook prior to implementation. For many grantees, the provision of evidence-based services and collection of program data required a new level of program capacity. To provide quality services, grantees engaged in extensive planning, including developing policies and procedures, creating data collection protocols, and conducting thorough training of staff. Program models were carefully adapted to ensure that services fit each unique community context and culture.

> *"For the very first time the staff began to see that what they do in the homes, what they document on the forms, and the tools that they use were really important because it eventually added up to that bigger, broader picture." - Cohort 1 Tribal Grantee Project Director*

PRIORITIZING THE HIGHEST-NEED FAMILIES

Grantees used home visiting services to reach families struggling with multiple challenges, including poverty, unemployment, limited education, and histories of substance abuse (See Lesson From the Field below) and child maltreatment. The needs of families served frequently matched those of "priority populations" outlined in the legislation. To address the critical needs of these families, approaches in the delivery of services needed to be creative and flexible.

LESSONS FROM THE FIELD

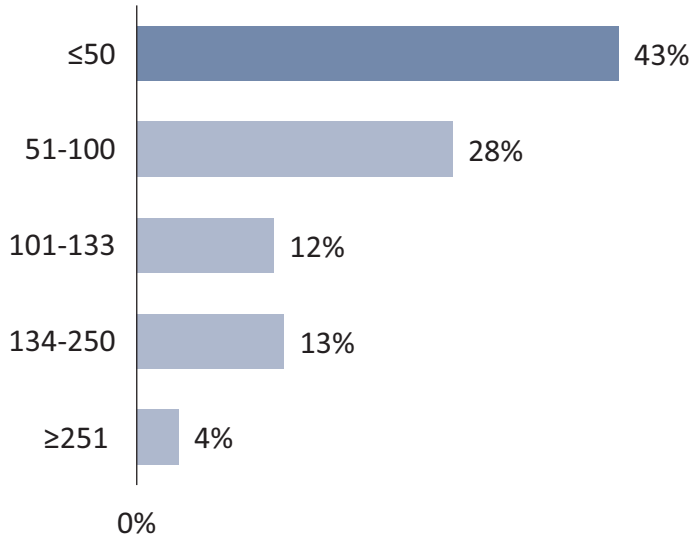
Tribal Home Visiting grantees are working hard to make a difference for families struggling with substance abuse.

> We are impressed with *"clients involved in a substance-using lifestyle who are willing when they find out they are pregnant to go to treatment. With our support they stay in recovery so that their babies have a chance at being born healthier. I think this has been huge in our community."*
> *- Cohort 1 Tribal Grantee Home Visitor*

Grantees serving families struggling with substance use may face extra challenges in meeting program requirements. Instead of screening out these families, however, grantees prioritize them and work creatively to keep them engaged. Grantees are committed to serving families struggling with substance abuse even if their engagement is sporadic.

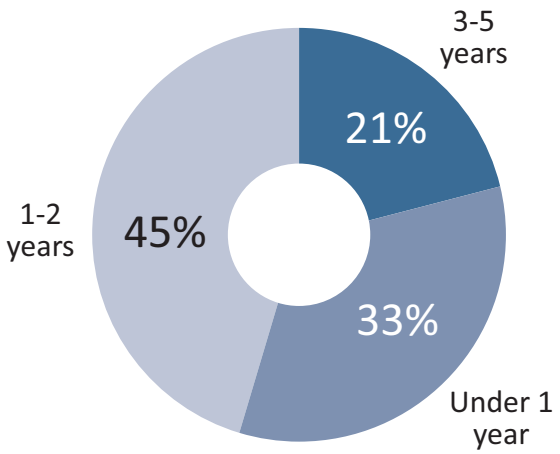
Families were often living in poverty. Seventy-one percent of participants had a family income at or below federal poverty guidelines (at or below $11,670 for an individual or $23,850 for a family of four in 2014). Almost half (43 percent) of the families were at or below 50 percent of the federal poverty guidelines (Figure 8-3).

Figure 8-3. Family Income Relative to Federal Poverty Guidelines, 2014[13]



Children in the critical ages of birth to five years served. Seventy-eight percent of child participants were under three years of age, and almost half (45 percent) were between one and two years (Figure 8-4). Eighty-five percent of children were American Indian or Alaska Native.[14]

Figure 8-4. Child Participant Age, 2014



[13] N = 956.

[14] Of the children that were not identified as AIAN, 11 percent identified as more than one race, four percent as White, and one percent as "other." Individual grantees had the authority to determine service eligibility, and some programs chose to serve families in their service area regardless of whether they were AIAN.

Caregivers were often young, single parents and pregnant women. In FY 2014, a majority (84 percent) of adult program participants were between the ages of 18 and 34 years (Figure 8-5). Thirty-one percent of adult participants were pregnant at enrollment, 59 percent were female caregivers, and 10 percent were male caregivers (Figure 8-6). Adult participants were mostly single (70 percent), and a quarter was married (Figure 8-7). Seventy-eight percent of adults served were American Indian or Alaska Native.

Figure 8-5. Adult Participant Age, 2014[15]

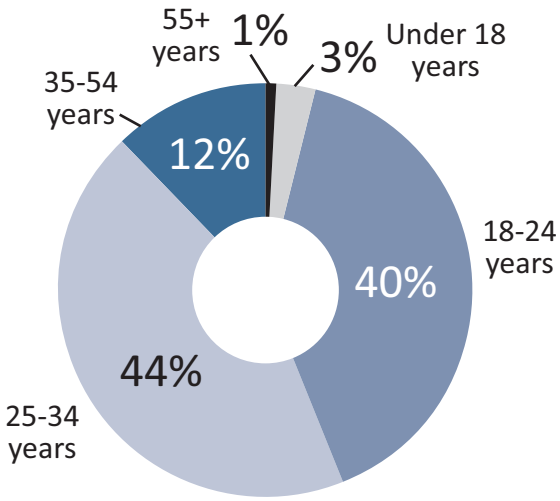


Figure 8-6. Type of Adult Participant, 2014[16]

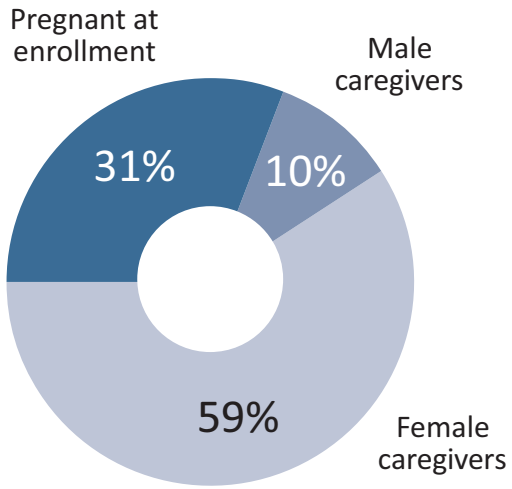
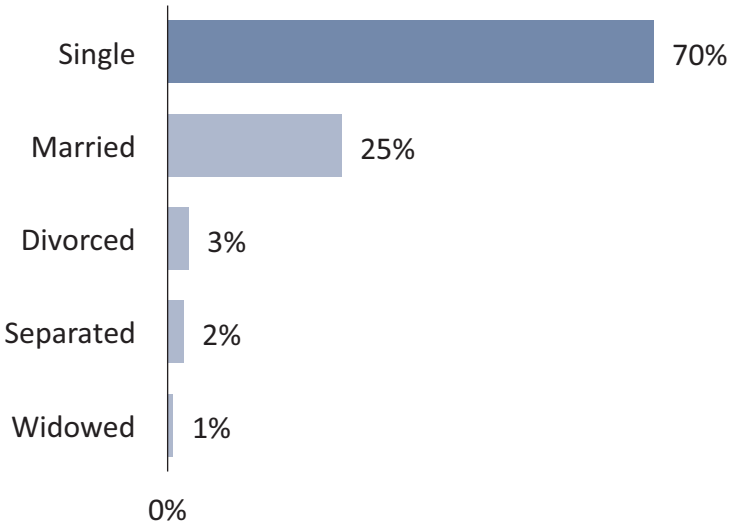


Figure 8-7. Participant Marital Status, 2014[17]



[15] N = 1,344. Excluded unknown.
[16] N = 1,441. Excluded unknown.
[17] N = 1,205. Excluded unknown.

A majority of caregivers were not employed and did not have a college education. Most adult participants were not employed (59 percent), and most were not students or trainees (85 percent) (Figures 8-8 and 8-9). The highest educational attainment for most adult participants was high school (36 percent) or less than high school (21 percent). Only 16 percent of adult participants had some college or training (without earning a degree), while eight percent had an associate's degree and four percent had a bachelor's degree or higher (Figure 8-10).

Figure 8-8. Participant Employment, 2014[18]

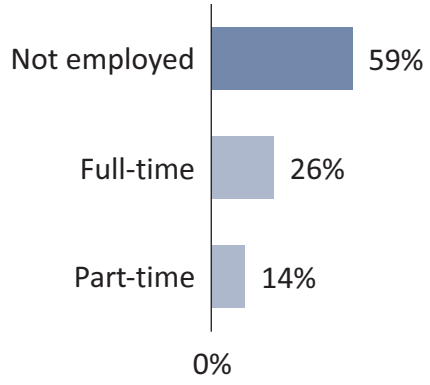


Figure 8-9. Participant Student Status, 2014[19]

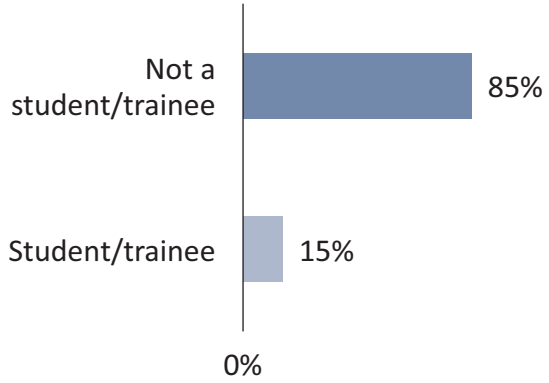
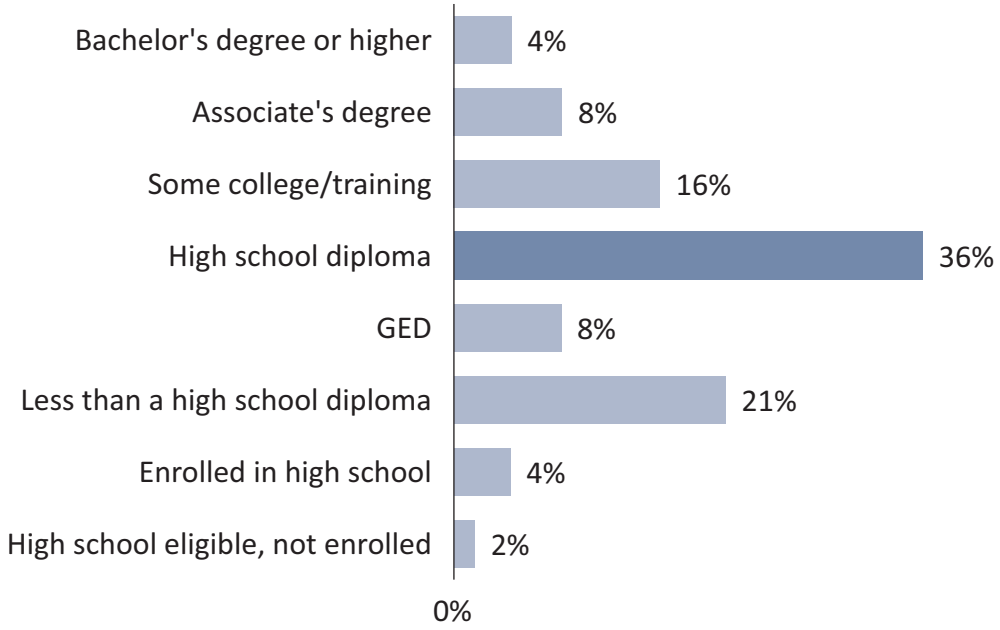


Figure 8-10. Participant Educational Attainment, 2014[20]

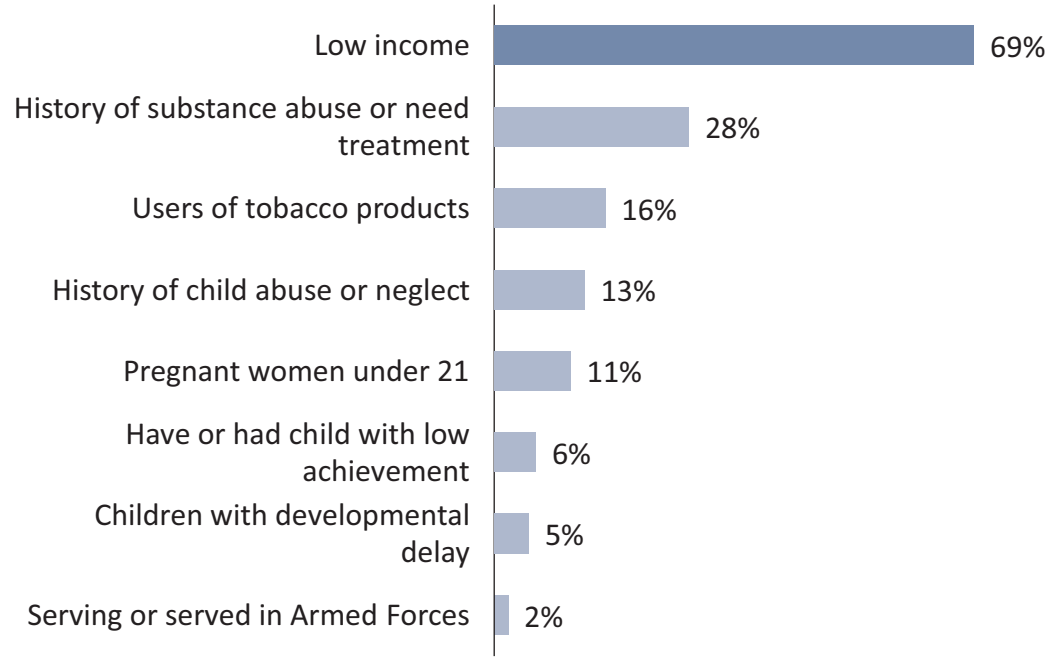


[18] N = 1,187. Excluded unknown.
[19] N = 1,093. Excluded unknown.
[20] N = 1,132. Excluded unknown.

Participants experienced multiple challenges. Most families that received home visiting services had multiple challenges. These challenges, whether they were past or current issues, were frequently priority areas defined by the Home Visiting Program legislation (Figure 8-11). Many families struggled with poverty, substance use, a history of child maltreatment, and children's academic and cognitive challenges. Sixty-nine percent of individuals newly enrolled during 2014 were considered low income as defined by an income at or below 100 percent of the federal poverty guidelines.[21] Over one-quarter of families newly enrolled in 2014 (28 percent) had a history of substance abuse or were in need of substance abuse treatment. Thirteen percent of newly enrolled participants had a history of child abuse or neglect. Families with these struggles were prioritized, but often the same challenges that brought families to home visiting also made it difficult for them to complete the program.

"Families come here for substance abuse treatment from the surrounding villages. When that treatment is completed, families go back to the village and they have to exit the program because home visitors are not able to go to the village and visit them." – Cohort 1 Tribal Grantee Program Director

Figure 8-11. Percentage of Newly Enrolled Families in Priority Populations, 2014 (N = 932)



[21] Figure 8-3 and Figure 8-11 differ slightly in their percentages related to poverty. Figure 8-3 (Family Income Relative to Federal Poverty Guidelines, 2014) reflects all families served in the year, and Figure 8-11 (Percentage of Newly Enrolled Families in Priority Populations, 2014) reflects families newly enrolled in 2014.

The success of grantee programs expanding services and serving high-need families was made possible through creative and flexible programing. In addition to having multiple risk factors, many families lived in home environments that complicated the delivery of home visiting. When the home was not the ideal place for a family to receive services, visits at the program office or in other neutral locations were provided. One program provided services in the office for homeless families or families whose housing situation was not amenable to services. In another program, a home visitor broke down barriers between the jail and tribal health programs to gain professional visitor status and work with incarcerated fathers of enrolled children. Grantees also demonstrated flexibility in serving additional family and/or household members that were present during home visits (See Lesson From the Field below). Throughout, grantees demonstrated a commitment to delivering services regardless of the challenges faced by each individual family. As will be clear in the following chapter, this commitment to families had important results for both program delivery and family outcomes.

LESSONS FROM THE FIELD

Home visiting often benefits multiple children and family members beyond those directly served by the program.

"I currently work with a family that has four children under the age of five. Of course we talk about all of them and do activities with all of them. You can't sit down on the floor with some kind of exciting book or activity and tell two of them to go away." – Cohort 1 Tribal Grantee Program Coordinator

Many home visiting programs work with families with multiple children and sometimes extended family members or friends living in the home. Home visitors report only on one index child, which cannot reflect the impact of home visiting on the family as a whole.

9 FULFILLING THE PROMISE OF THE TRIBAL HOME VISITING PROGRAM

In addition to expanding the reach of high-quality and culturally relevant home visiting in tribal communities, the Tribal Home Visiting Program aimed to improve the quality of home visiting programs to better serve vulnerable families in at-risk communities. To monitor program progress towards meeting this goal, grantees defined and monitored program performance measures in six benchmark areas. This section summarizes the Cohort 1 grantees' development of performance measurement plans and their program performance from FY 2012 to FY 2014.

MONITORING PROGRAM PERFORMANCE IN BENCHMARK AREAS

As required, tribal grantees adhered to the same high standards and expectations of the State Home Visiting Program with respect to monitoring program performance. Grantees developed performance measurement plans detailing their approach for collecting, analyzing, and reporting performance data in six legislatively mandated benchmark areas (Table 9-1). Each benchmark area includes multiple constructs. Constructs capture distinct topics relevant to each benchmark area. For example, one construct within the benchmark area of "Maternal and Newborn Health" is "Prenatal Care."

Table 9-1. Benchmark Areas and Number of Constructs

Benchmark Area	Number of Constructs
Maternal and Newborn Health	9
Child Injuries, Child Abuse, Neglect, or Maltreatment and Emergency Department Visits	7
School Readiness and Achievement	9
Crime or Domestic Violence	5
Family Economic Self-Sufficiency	3
Coordination and Referrals for Other Community Resources and Supports	5

GRANTEE PERFORMANCE MEASUREMENT PLANS

Developing Performance Measurement Plans and Grantee Capacities

Tribal grantees, like state grantees, selected and developed their own performance measures for each construct to ensure they were meaningful for their programs. As such, performance measures are not uniform across grantees. For example, to measure child injuries, some grantees measured *the percentage of children* with injuries requiring medical treatment. Other grantees measured *the number of incidents of child injuries* requiring medical treatment. In this example, the unit of measurement for some grantees is children, while the unit of measurement for others is incidents.

In developing performance measurement plans, grantees considered community and cultural contexts; service settings; availability of services in the community; and feedback from local community, tribal, and organizational leaders.

Grantees engaged in an iterative, or step-by-step, process to develop performance measurement plans. This process included multiple feedback cycles with community members and technical

"This was an opportunity to change how data was collected and managed and to build infrastructure. I saw it as something very advantageous for the tribe over the long term because that infrastructure is still going to be there moving forward." – Cohort 1 Tribal Grantee Evaluator

assistance providers. For grantees, this process raised concerns about a lack of screening and assessment measures formally validated with AIAN children or families. Grantees grappled with these and other issues as they developed plans that would provide their program with needed information and fulfill legislated requirements for demonstrating program improvement. Developing performance measurement plans and necessary systems of support was a new endeavor for many grantees and communities and resulted in enhanced program and community capacities. Program and community capacity building benefits the Tribal Home Visiting Program, the broader community, and future community efforts (See Lesson From the Field below). For example, the program provided community members with significant opportunities for personal and professional growth.

LESSONS FROM THE FIELD

Home visiting programs are building capacity throughout the community by providing an opportunity for professional and personal growth.

> *"Another thing is the growth of the staff. I'm really proud of that because I've seen them grow, not only as workers but as individuals, as parents, and even as a child, as a mother, as a wife, everything, and that's made me really happy."*
> *– Cohort 1 Tribal Grantee Project Coordinator*

One important but perhaps not always intentional result of the home visiting programs is the impact on the home visitors themselves. Most home visitors are from the community in which they serve. Becoming a home visitor allows these individuals to learn new professional skills, such as data collection, as well as apply their personal experiences to support families in their communities. This professional development sometimes extends to the enrollees. In at least one program, a mother who had recently graduated felt confident enough in what she had learned as a participant in the program to apply for a position as a home visitor. Even though this outcome and those like it are not tracked, the staff members are proud that an enrollee was inspired to translate her own personal and professional growth achieved through the program into helping other families in her community.

Data on program performance measures were reported using the Discretionary Grant Information System—Tribal Home Visiting, the first national data system for home visiting in tribal communities. This HRSA-administered online data system collects performance measure data to help government project officers monitor and support grantees.

Cohort 1 Grantee Program Performance

The following section summarizes program performance for Cohort 1 grantees (n = 13), organizations awarded grants in 2010 in benchmark areas from FY 2012 to 2014.[22]

Three primary data sources were used to summarize grantee program performance. Details for each of the data sources are provided below. The three primary data sources include the following:

1. ACF determinations of program improvement based on FY 2012 baseline and FY 2014 comparison data for each construct
2. Aggregation of FY 2012 through FY 2014 data for constructs with similar performance measures across at least five grantees
3. Informal interviews with Cohort 1 grantees on their experiences with program performance measures and data reporting

A NOTE ON DATA LIMITATIONS

Variability in grantee-defined performance measures limits discussions of program performance to the proportion of grantees that improved performance. Specific interpretations of program performance are relative to how an individual grantee defined its performance measures. For more information on limitations see Appendix C.

ACF Determinations of Program Improvement

Benchmark data, reported to ACF from the beginning of program implementation through December 2014, were used to determine grantee improvement. For each construct, grantees reported baseline data collected from when services began through FY 2013 and comparison data collected in FY 2014. ACF determined improvement for each construct using the following decision rules:

[22] Grantees began collecting benchmark data when they started providing services to families. Implementation start dates ranged from April 2012 to May 2013.

- To demonstrate improvement in a given construct, comparison values had to move in a positive direction or maintain a high level of performance.
- To demonstrate improvement in an individual benchmark area, improvements in at least half of the constructs within the benchmark area were required.
- To demonstrate overall program improvement, improvements in at least four of the six benchmark areas were required.

Due to variability in individually defined performance measures across grantees, the summary of grantee program performance is limited to reporting the number and percentage of grantees that demonstrated improvement in performance measures for constructs, improvement in benchmark areas, and overall improvement. Outside of indicating the number and percentage of grantees that demonstrated improvement, the specific interpretation of what improvement means is relative to how individual grantees defined their performance measures.

Data Aggregation for Select Constructs

To provide additional information on grantee program performance, data for constructs with similar performance measures were aggregated across grantees. Specifically, grantee-level data from FY 2012 through FY 2014 were combined across grantees to provide a snapshot of program performance on select constructs.[23] This process included a careful review of grantee-defined performance measures across all constructs to identify constructs with similar performance measures. Data were aggregated for a construct if sufficient alignment in performance measures existed across at least five grantees and it allowed for meaningful data aggregation and interpretation. It is important to note that the percentage and rates provided in the data aggregation do not represent all enrolled program participants included in the analysis. Grantees typically defined a smaller pool of eligible participants for particular measures. For example, many grantees only included women who had given birth in the last six months as eligible for maternal depression screening. Therefore, the percentage provided represents the percentage of women who had given birth in the past six months who were screened for maternal depression and not the percentage of all enrolled women who were screened for maternal depression.

Table 9-2 presents a list of the constructs and measures selected for data aggregation. Results from data aggregation appear throughout the findings on program improvement.

[23] Appendix B provides more information on the decisions and processes for aggregating benchmark data.

Table 9-2. Constructs and Measures Identified for Data Aggregation

Construct	Performance Measure
Prenatal Care	*Percentage of eligible participants initiating early prenatal care*
Screening for Maternal Depressive Symptoms	*Percentage of eligible participants screened for maternal depression*
Regular Visits to a Primary Healthcare Provider or Medical Home	*Percentage of eligible participants with visit to a primary healthcare provider or medical home*
Information Provided or Training on Prevention of Child Injuries	*Percentage of eligible participants who received information or training on prevention of child injuries*
Incidence of Child Injuries Requiring Medical Treatment	*Rate of child injuries requiring medical treatment*
First-Time Victims of Maltreatment for Children in Program	*Rate of first-time victims of maltreatment*
Child Screening Rates in Developmental Domains	*Percentage of eligible children screened in developmental domains*
Screening for Domestic Violence	*Percentage of eligible participants screened for domestic violence*
Household Income	*Percentage of eligible participants with increased household incomes or benefits*
Number of Families Identified for Necessary Services	*Percentage of eligible families screened for necessary services*
Number of Families that Required Services and Received a Referral to Available Community Resources	*Percentage of families identified for necessary services that received a referral*
Number of Completed Referrals	*Percentage of families receiving a referral that completed the referral*

Informal Interviews with Grantees

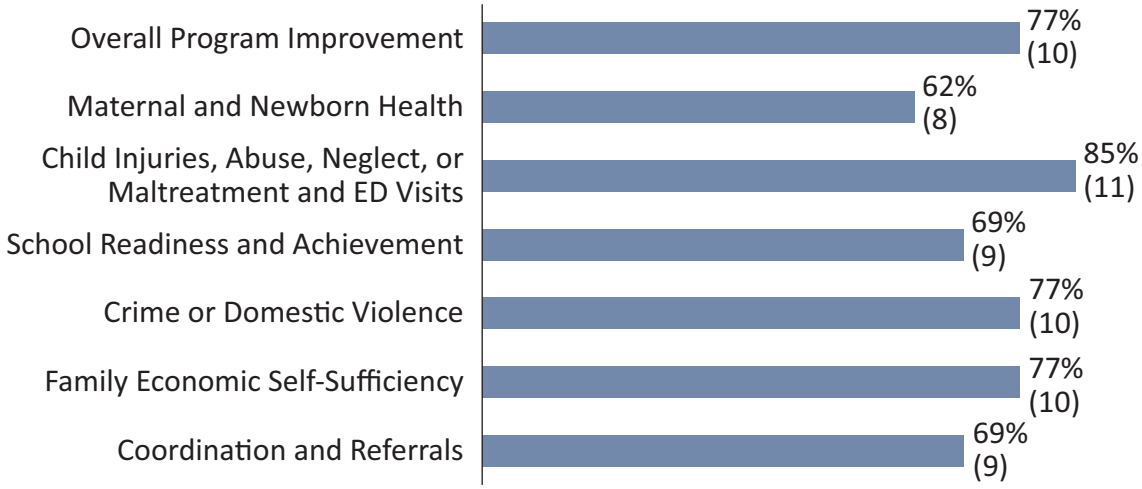
To contextualize grantee program performance and further understand grantee perspectives, this chapter summarizes findings from informal qualitative interviews with Cohort 1 grantees. During informal interviews, representatives for each grantee responded to a unique set of questions addressing issues most relevant to the measurement and programmatic issues of that grantee. Custom interview guides were developed for each interview. Interviews were audio recorded, transcribed, and coded for emerging themes. Grantee perspectives, experiences, and direct quotations provided throughout the report draw from interview data. Some quotations have been moderately edited for readability, but the original meaning and intent were maintained.

OVERALL IMPROVEMENT

The legislation and subsequent guidance establish expectations for grantee improvement in benchmark areas. Specifically, improvement within an individual benchmark area is defined as demonstrating improvement in at least half of performance measures for constructs within the benchmark area. Overall improvement is defined as improving in at least four of the six benchmark areas.[24]

A majority (77 percent, n = 10) of the 13 Cohort 1 grantees demonstrated overall improvement in the benchmark areas in the three-year period. Within each benchmark area, the percentage of grantees demonstrating improvement ranged from 62 percent to 85 percent (Figure 9-1).

Figure 9-1. Percentage and Number of Grantees Improved Overall and in Individual Benchmark Areas (N = 13)



INDIVIDUAL BENCHMARK AREA IMPROVEMENTS

A Healthy Foundation: Maternal and Newborn Health

The maternal and newborn health benchmark area includes constructs related to the health and well-being of mothers and children. Examples include access to a primary health care provider, adequate and timely prenatal care, maternal mental health screening, and initiation of breastfeeding. Program improvement across these constructs supports a wide range of positive maternal and child health outcomes.

[24] Appendix A describes how program improvement was defined.

Grantee Improvements in Maternal and Newborn Health

Increased participant use of a primary health care provider. Greater use of a primary health care provider or medical home translates to higher quality health care services and more equitable health outcomes across populations (Starfield et al., 2005).

Almost all grantees (92 percent, n = 12) improved performance measures for participant visits to a primary health care provider or medical home. During FY 2012 through FY 2014, 40 percent of eligible participants from 10 grantees with similar performance measures visited a primary health care provider or medical home. In some cases, parents were encouraged to access specialized medical screenings and services (See Lesson From the Field below).

LESSONS FROM THE FIELD

Home visiting supports maternal and child health.

Any parent knows it's hard to take care of a child when you are struggling with your own unmet needs. Because home visitors form such close relationships with the families they serve, they can be the first people to identify parents' unmet needs. In addition to identifying issues through screening protocols, home visitors can also discover other health-related issues and support families in accessing care. One home visitor was able to help a young mother get diagnosed with a fetal alcohol spectrum disorder (FASD), which opened up access to various benefits. As a result, she was able to get the support she needed to keep custody of her children.

"She is a great mom, a great mom—those kids get to be raised by their mom and stay in their home and not be subjected to our foster care system. That is a huge success."
– Cohort 1 Tribal Grantee Project Director

Promotion of key determinates of positive birth outcomes, such as early initiation of adequate prenatal care. Timely and adequate prenatal health care promotes positive birthing outcomes and reduces infants' risks for complications (CDC, 2006; Eckstrand et al., 2012).

A majority of grantees (77 percent, n = 10) improved performance measures of prenatal care. During FY 2012 through FY 2014, 89 percent of eligible participants from seven grantees with similar performance measures initiated prenatal care by the first or second trimester.

Increased screening rates for maternal depressive symptoms. Early identification of and referrals for maternal depression mitigates the negative child outcomes associated with maternal depression. Early identification and treatment is especially important for low-income populations, who are less likely to receive treatment for depression (Claessens et al., 2015; Olfson et al., 2002).

> *"For the depression screening, it's really good, it's really easy. The home visitors are comfortable administering it, and lots of times there are things that come out of it that we wouldn't know if it wasn't administered." – Cohort 1 Tribal Grantee Project Coordinator*

Most grantees (77 percent, n = 10) improved screening rates for maternal depression. During FY 2012 through FY 2014, 12 grantees with similar performance measures screened 71 percent of eligible participants for maternal depression. Maternal depression screenings were used to identify family needs and initiate important conversations about sensitive topics. Through this process, home visitors served as valuable sources of support and guidance for families. Grantees also provided staff training on administering maternal depression screenings and working with families when maternal depression is present to optimize the benefits of screening.

Increased initiation and duration of breastfeeding. Early initiation of breastfeeding is linked to positive child health outcomes, better long-term cognitive development, greater adult education, and higher adult incomes (Ip et al., 2007; Victora et al., 2015).

Most grantees (62 percent, n = 8) improved performance measures for initiation and duration of breastfeeding. Grantees engaged in significant program and community efforts to address social norms around breastfeeding. Several grantees noted that breastfeeding was not a common practice in their communities. Work with community partners (such as the local Special

Supplemental Nutrition Program for Women, Infants, and Children program [WIC] or the local library) and lactation counselors emphasized the importance of breastfeeding and provided mothers with private areas to breastfeed. One grantee also held a conference specifically focused on breastfeeding, hiring a Native American lactation consultant to speak with pregnant women and new mothers about the benefits of the practice.

> *"The culture with grandmothers and great grandmothers, was not to encourage breastfeeding for a lot of historical reasons. We have been able to reach our young moms and see a change in breastfeeding." – Cohort 1 Tribal Grantee Project Coordinator*

Table 9-3. At a Glance: Grantee Improvement in Maternal and Newborn Health (N = 13)

Construct *Sample Performance Measures*	Grantees Improved % (n)
Regular Visits to a Primary Healthcare Provider or Medical Home *Children and mothers who visit primary health care provider or medical home*	92 (12)
Prenatal Care *Receipt of timely and adequate prenatal care*	77 (10)
Screening for Maternal Depressive Symptoms *Screening among pregnant mothers, postpartum mothers, or all enrolled mothers*	77 (10)
Parental Use of Alcohol, Tobacco, and Illicit Drugs *Tobacco, alcohol, or illicit drug use among pregnant mothers or all enrolled mothers or screening and referral for substance use*	69 (9)
Preconception Care *Program provision of preconception care information, postpartum checkups, preventative exams, or vitamin use among postpartum mothers or all enrolled mothers*	69 (9)
Breastfeeding *Initiation of breastfeeding or duration of breastfeeding*	62 (8)
Maternal and Child Health Insurance Status *Children and mothers with health insurance*	46 (6)
Inter-Birth Intervals *Program provision of information on birth spacing, participant contraception use, or six to 12-month pregnancy spacing*	38 (5)
Well-Child Visits *Receipt of timely and adequate well-child visits or current on recommended immunizations*	31 (4)

Prevention of Adverse Experiences: Child Injuries; Abuse, Neglect, or Maltreatment; and Emergency Department Visits

This benchmark area includes constructs related to the prevention of adverse early childhood experiences. Constructs include training and information on prevention of child injuries; reductions in child injuries; and reductions in child abuse, neglect, or maltreatment and emergency department visits. Focused attention on these constructs prevents adverse early childhood experiences, which predict a wide variety of negative outcomes, including poor adult health and well-being (Felitti et al., 1998).

Grantee Improvements in Child Injuries, Abuse, Neglect, or Maltreatment and Emergency Department Visits

Reduced rates of substantiated reports and first-time victims of child maltreatment. Children exposed to adverse early experiences, including maltreatment, demonstrate a range of negative outcomes (Felitti et al., 1998; Duncan et al., 2010; Shonkoff & Garner, 2012). AIAN children are often overrepresented among child maltreatment victims, at more than 1.6 times national levels (HHS, 2007).

"There's been training, and home visitors are sent to conferences, so there's a heightened awareness of maltreatment and what to do and how to talk with families." – Cohort 1 Tribal Grantee Evaluator

Almost all grantees (92 percent, n = 12) reduced rates for substantiated reports and first-time victims of child maltreatment. During FY 2012 through FY 2014, the average rate of first-time victims of child maltreatment across grantees was 10 percent. Training and professional development were provided to home visitors on recognizing and addressing early warning signs of child maltreatment. Despite program improvements in reducing first-time child maltreatment rates, the average rate of 10 percent for first-time victims of child maltreatment needs to be considered in the context of the proportions of high-risk families some grantees serve. For some grantees, families are referred to home visiting programs due to existing reports of suspected or substantiated child abuse or maltreatment.

Provision of information or training on the prevention of child injuries and decreased child injuries requiring medical treatment. Unintentional injuries are a leading cause of death and disability among children and adolescents ages 0 to 19 (CDC, 2012). Fortunately, many child injuries can be prevented by providing parents with knowledge and/or training to improve the safety of home environments for children birth to five years.

Rates (69 percent, n = 9) of information sharing or training on preventing child injuries increased. During FY 2012 through FY 2014, 50 percent of eligible families from 12 grantees with similar performance measures received information or training on preventing child injuries. A majority (77 percent, n = 10) also reduced rates of child injuries. During FY 2012 through FY 2014, the average rate of child injuries requiring medical treatment among eight grantees with similar performance measures was three percent.

Continued progress toward reduced mother and child emergency department visits. More than half the grantees improved on measures of mother and child emergency department visits (39 percent and 54 percent of grantees, respectively), a finding that reflects specific community contexts. In remote villages, families do not typically visit primary care doctors or emergency departments due to limited transportation options. Additionally, some service populations regularly use emergency departments to access routine medical care. Because families are increasingly accessing primary care and other routine medical care, as demonstrated in the benchmark area of maternal and newborn health, improvement in emergency department visits may result.

Table 9-4. At a Glance: Grantee Improvement in Child Injuries; Abuse, Neglect, or Maltreatment; and Emergency Department Visits (N = 13)

Construct *Sample Performance Measures*	Grantees Improved % (n)
Reported Substantiated Maltreatment for Children in Program *Number of children or families with substantiated reports of maltreatment or number of substantiated reports of maltreatment*	92 (12)
First-Time Victims of Maltreatment for Children in Program *Number of children who are first-time victims of maltreatment*	92 (12)
Incidence of Child Injuries Requiring Medical Treatment *Number of children with injuries or number of incidents of injuries*	77 (10)
Information Provided or Training on Prevention of Child Injuries *Provision of information or training on prevention of child injuries*	69 (9)
Reported Suspected Maltreatment for Children in Program *Number of children or families with reports of suspected maltreatment or number of reports of suspected maltreatment*	69 (9)
Visits for Children to Emergency Department From All Causes *Number of children with visits to the emergency department or number of child visits to the emergency department*	54 (7)
Visits for Mothers to Emergency Department From All Causes *Number of mothers with visits to the emergency department or number of mother visits to the emergency department*	38 (5)

A Path to Success: School Readiness and Achievement

This benchmark area measures key predictors of school readiness and achievement. Constructs include supportive parenting behaviors, healthy parent–child relationships, and regular screenings to monitor child development across multiple domains. These constructs promote school readiness and achievement, ensuring a strong start on a child's path to academic success.

Grantee Improvements in School Readiness and Achievement

Improved parent well-being and reduced parenting stress. Parent emotional well-being and low parenting stress support healthy parent–child interactions that in turn predict school readiness and academic achievement (Adi-Japha & Klein, 2009; Thompson, 2008; Adirim & Supplee, 2013).

Almost all grantees (92 percent, n = 12) improved performance measures for parent well-being and stress. Programs often served as a vital source of social support for families, helping to relieve daily stresses and improve parent well-being (See Lesson From the Field below).

"I worked with a young lady who just had no one. She told me, 'You know, you were the mother that wasn't able to be there with me. I didn't have a mother and you were the mother when I was pregnant, you were there for me like a mother is supposed to be." – Cohort 1 Tribal Grantee Project Coordinator

Increased promotion of positive parenting behaviors and parent–child relationships, key predictors of school readiness and achievement. Longitudinal studies show that AIAN children often fall behind their peers across developmental domains at kindergarten entry, gaps that persist through elementary school (Demmert et al., 2006). Promotion of family environments that support children's learning and development helps close these early achievement gaps (National Research Council & Institute of Medicine, 2000).

Performance measures for supportive parenting behaviors and healthy parent–child relationships improved (69 percent, n = 9). The promotion of supportive learning environments requires an understanding of and respect for different cultural beliefs and priorities about parenting behaviors. A lack of culturally relevant tools for assessing supportive parenting behaviors initially presented a challenge to some tribal grantees. Grantees demonstrated flexibility and determination to overcome this challenge, taking the time to identify and use more culturally relevant tools, which often required training home visitors to implement newly identified assessment instruments.

LESSONS FROM THE FIELD

Home visitors can be a vital source of social support for young pregnant women.

"Home visitors are there and they're stepping in and filling a gap for something that is missing in the support system of these families. That's really huge." – Cohort 1 Tribal Grantee Project Coordinator

Providing social support is one of the most important things home visitors can do, and it is not always readily captured in the data. One young mother in a rural community had been in and out of the foster care system, leaving her with few social supports. Her grandmother, the only relative to whom she was connected, was unable to leave the house to attend doctor appointments or participate in other pregnancy-related activities. The home visitor was able to step in and support this mom throughout her pregnancy by consistently being there—by showing up.

Increased parent knowledge of child development and a child's developmental progress, a foundational step in promoting attentive and responsive parenting behaviors. Increased parent knowledge of children's developmental transitions and needs promotes supportive parenting behaviors that help children reach their full potential (Sanders & Morawska, 2014).

A majority of grantees (77 percent, n = 10) improved parents' knowledge of child development and their children's developmental progress improved (77 percent, n = 10). Grantees helped parents and communities recognize the tremendous amount of learning and development that takes place before kindergarten entry (See Lesson From the Field below). This concept was fairly new to some communities. Grantees worked with communities and tribal leaders to heighten their awareness of the importance of early learning and development.

Increased child screening rates in key developmental domains. Early identification of developmental delays and disabilities is critical to the well-being of children and families (American Academy of Pediatrics, 2009). It is estimated that only 20 to 30 percent of children with delays or disabilities are identified

before entering school. Early identification and intervention significantly improves developmental outcomes (American Academy of Pediatrics, 2009).

"Initially the child screenings were a bit of a struggle. There was a resistance to assessing children and screening children for developmental issues. It was a bit of a sensitive issue in the community." - Cohort 1 Tribal Grantee Evaluator

Grantees completed child screenings across multiple developmental domains, from children's general cognitive skills to physical health and development. Between 46 and 62 percent of grantees improved child screening rates, depending on the developmental domain under consideration. During FY 2012 through FY 2014, nine grantees with similar performance measures screened an average of 51 percent of eligible children across developmental domains. This rate is well above the national average of 31 percent for child screenings in 2011 to 2012 (Child and Adolescent Health Measurement Initiative, no date). Despite various challenges, above-average screening rates were achieved, including coordinating with other community agencies to prevent duplicate child screenings and overcoming initial family resistance.

LESSONS FROM THE FIELD

Home visiting programs raise community knowledge about child development.

A major success of the program is spreading *"the idea that parenting is something that you would think about and set goals for and strive toward as opposed to being just a reaction to a crying baby. It's moving that whole idea forward that you can plan to have a harmonious day with your young children and for yourself." – Cohort 1 Tribal Grantee Program Coordinator*

Many programs described child development as a new concept in their communities and highlighted the importance of introducing the concept more generally. Home visitors work with community members to explain the importance of this critical stage of child development. This effort has the potential for larger scale community impact.

Table 9-5. At a Glance: Grantee Improvement in School Readiness and Achievement (N = 13)

Construct *Sample Performance Measures*	Grantees Improved % (n)
Parent Emotional Well-Being or Parenting Stress *Assessment of parent health status, stress level, or depression*	92 (12)
Parent Knowledge of Child Development and Their Child's Developmental Progress *Parent global knowledge of child development or program provision of information on child's development*	77 (10)
Parenting Behaviors and Parent–Child Relationship *Quality of parenting behaviors or parent–child relationship*	69 (9)
Child Communication, Language, and Emergent Literacy *Completion of child screening by specified time point or receipt of necessary referral; assessment of developmentally appropriate child communication skills*	62 (8)
Child's General Cognitive Skills *Completion of child screening by specified time point or receipt of necessary referral; assessment of developmentally appropriate child problem-solving skills*	62 (8)
Child Physical Health and Development *Completion of child screening by specified time point or receipt of necessary referral; assessment of developmentally appropriate fine and gross motor development*	54 (7)
Child's Positive Approaches to Learning *Completion of child screening by specified time point or receipt of necessary referral*	54 (7)
Parent Support for Children's Learning and Development *Quality and quantity of parent support for children's learning and development*	54 (7)
Child's Social Behavior, Emotional Regulation, and Emotional Well-Being *Completion of child screening by specified time point or receipt of necessary referral; assessment of developmentally appropriate child social-emotional development*	46 (6)

Safe and Healthy Families: Crime or Domestic Violence

This benchmark area measures aspects of safe and healthy family functioning to support positive developmental trajectories. Grantees had a choice of measuring constructs related to either crime or domestic violence. All chose measures of domestic violence. These constructs include domestic violence screening and provision of support when domestic violence is present.

Grantee Improvements in Domestic Violence

Increased screenings for domestic violence. Children exposed to domestic violence display behavioral problems and have a significantly higher risk of becoming victims

of domestic violence later in life (Yates et al., 2003; Ehrensaft et al., 2003). Given the high prevalence of domestic violence in AIAN communities, with 39 percent of AIAN women reporting incidents of domestic violence, screening is an important first step in identifying families in need of extra resources and support (CDC, 2008).

A little over half of grantees (54 percent, n = 7) improved screening rates for domestic violence. During FY 2012 through FY 2014, 10 grantees with similar performance measures screened 59 percent of eligible families for domestic violence. Several strategies were used to effectively initiate conversations about domestic violence and provide support to families when domestic violence was present. For example, data collection timelines were developed that allowed time for relationships to develop between families and home visitors before broaching the topic. Home visitors often struggled to administer domestic violence screening tools, but training increased their confidence, skills, and comfort levels with the instruments. Some grantees experienced gaps in completing domestic violence screenings as they transitioned to new screening tools that worked better for their program staff and participants.

"A home visitor is not going to use a screening tool if they don't feel comfortable with it. If they aren't comfortable, then families aren't comfortable." – Cohort 1 Tribal Grantee Evaluation Specialist

I**ncreased support for families when domestic violence is present.** Social support, similar to the support provided by home visitors, reduces the negative impact of domestic violence on victims' mental health and promotes healthy child development (Coker et al., 2002).

Most grantees (69 percent, n = 9) increased their ability to successfully link families with resources for domestic violence through referrals and development of safety plans.

Table 9-6. At a Glance: Grantee Improvement in Domestic Violence (N = 13)

Construct *Sample Performance Measures*	Grantees Improved % (n)
Of Families Identified for Presence of Domestic Violence, Referrals Made to Relevant Services *Percentage of participants who receive necessary referral*	69 (9)
Of Families Identified for Presence of Domestic Violence, Families for Which a Safety Plan Was Completed *Percentage of families requiring a safety plan that completed the safety plan*	69 (9)
Screening for Domestic Violence *Percentage of women screened for domestic violence*	54 (7)

Increased Resiliency: Family Economic Self-Sufficiency

This benchmark area measures important aspects of family economic self-sufficiency. It includes constructs of household income, adult employment and education, and adult and child health insurance status. Supporting economic self-sufficiency promotes strong and resilient families that provide ongoing returns on program investments, both in economic terms and human capital (See Lesson From the Field below).

LESSONS FROM THE FIELD

Home visitors support the family's financial management skills.

> *"The home visitor went in and said, 'Let's do budgeting.' They sat down and did budgeting, and they learned how to do the checkbook and how to pay the bills and how to follow their budget, and now they have a new home." – Cohort 1 Tribal Grantee Project Coordinator*

Most families enrolled in the Tribal Home Visiting Program experience economic hardship that can make managing finances practically and emotionally difficult. Home visitors work creatively to support families in taking steps to improve their financial situation. They also help parents identify their goals, which may be to enroll in school, get a new job, or save money to get a home, and they work with families to break down the steps they need to take to achieve these goals.

Grantee Improvements in Family Economic Self-Sufficiency

Increased number of adults and children with health insurance. Individuals with health insurance tend to access more necessary health care services, such as preventive health care, in a timelier manner (Bovbjerg & Hadley, 2007). Additionally, health insurance coverage is associated with more positive health-related outcomes and reduced financial burdens for patients (Bovbjerg & Hadley, 2007).

Almost all grantees (85 percent, n = 11) saw increased rates of adults and children with health insurance. During FY 2012 through FY 2014, a majority of eligible mothers and children (86 percent) from six grantees with similar performance

measures had health insurance within 12 months of enrollment. These increases occurred despite some participants choosing to access health care through the Indian Health Service rather than purchase health insurance. In some grantee communities, families spend less money using the health care services provided by Indian Health Service than they would if they purchased insurance.

Improvements in participant income. Economic resources affect children's cognitive performance, primarily through their influence on parenting quality. Reduced economic strain supports parents' emotional well-being and positive parenting behaviors (McLoyd et al., 1994). Researchers have found that the effects of family economic resources on child cognitive outcomes are mediated by parenting quality (Lugo-Gil & Tamis-LeMonda, 2008).

"Families might have different perspectives of economic strain. The reality is, you don't see a lot of wealth here. So, you don't have a mindset that you might be poor or working poor. Everyone else is in the exact same boat." – Cohort 1 Tribal Grantee Evaluator

Most grantees (69 percent, n = 9) either improved family incomes or decreased family economic strain; however, improvements were modest. During FY 2012 through FY 2014, 19 percent of eligible families from the five grantees with similar performance measures increased their income and benefits. These modest gains reflect the economic hardships experienced throughout much of Indian Country. Importantly, this construct was measured through participant self-reports of economic strain. In some cases, the self-reports did not fully capture the extent of economic strain families faced. This finding was most notable in communities with high concentrations of economic strain, since concepts of economic difficulty are relative to individual family perspectives and experiences. Additionally, while these improvements are notable, they likely underrepresent the steps many families are taking toward greater economic self-sufficiency.

Increased adult employment or education. Compared with parents who have less education, parents with more education spend more time engaging in positive parenting practices to promote children's learning (Carneiro et al., 2013). Parents' upward mobility can strengthen parental structuring of cognitively and linguistically stimulating home environments (Fuller et al., 2015).

Increases in adult participant education or employment was measured in the majority (62 percent, n = 8) of participants. Home visitors worked closely with parents to meet individual goals, such as increasing employment hours, returning to school, or enrolling in a training program. Grantees noted that sometimes even small steps toward improved education would benefit children in the long term.

Table 9-7. At a Glance: Grantee Improvement in Family Economic Self-Sufficiency (N = 13)

Construct *Sample Performance Measures*	Grantees Improved % (n)
Health Insurance Status of Participating Adults and Children *Mothers and children, households, or mothers with health insurance*	85 (11)
Household Income *Income among household members, family members, caregivers, or mothers; level of perceived economic strain*	69 (9)
Employment or Education of Participating Adults *Adult participant enrollment in educational programs; educational attainment; adult participant employment, paid hours worked, paid plus unpaid hours for child care, or referrals for unemployed mothers*	62 (8)

Strengthening Systems of Care: Coordination and Referrals for Other Community Resources and Supports

This benchmark area measures program improvements related to strengthening systems of care and support for families with young children. It includes constructs on identifying family needs, linking families to community resources, and sharing information with other community agencies.

Grantee Improvements in Coordination and Referrals for Other Community Resources and Supports

Increased screening and referrals for necessary services. Community collaborations enhance program implementation by connecting families with other community resources and supports (Durlak & DuPre, 2008; Daro, 2009). This coordination is especially important in programs serving at-risk populations who require services beyond the expertise of a single program or home visitor.

Just over half of grantees (54 percent, n = 7) improved completion rates for targeted or comprehensive screenings to identify family needs. During FY 2012 through FY 2014, nine grantees with similar performance measures screened 70 percent of eligible families to identify needs for services. A majority of grantees (77 percent, n = 10) also improved referral rates for families that required services. During FY 2012 through FY 2014, 11 grantees with similar performance measures gave referrals to 75 percent of eligible families. Slightly over half of grantees (54 percent, n = 7) improved completion rates for referrals. During FY 2012 through FY 2014, 66 percent of families from 10 grantees with similar

performance measures accessed necessary services. The types of services needed and referrals made were tracked, which helped identify high-priority needs among families and gaps in available community resources. For example, one grantee discussed the high proportion of families in need of basic resources (See Lesson from the Field below), such as food or housing support and a lack of community resources to effectively respond to this need.

LESSONS FROM THE FIELD

Home visiting programs can respond quickly and with flexibility to meet family needs. In addition to making the referrals tracked in the data, many home visiting programs provide other basic need referrals. One enrolled father left a voicemail thanking his home visitor for connecting him to the local emergency food bank. With this connection, he was able to provide for his two little girls, which gave him a chance to put effort into finding a job. Now that the father is employed, the home visitor noticed that

> *the girls "are doing extraordinarily well. Their behavior just improved dramatically. Getting them connected with services and noticing small things such as vitamin D deficiency, just those little things that get overlooked."*
> *– Cohort 1 Tribal Grantee Program Coordinator*

Improved collaboration and information sharing with other community agencies. Interagency collaboration and information sharing promotes a system of coordinated and responsive services for families and young children, preventing service duplication and increasing accessibility (Cheminais, 2009). Additionally, agency collaborations heighten staff awareness of other community services and promote a shared sense of purpose among service providers.

Almost all grantees (92 percent, n = 12) improved information sharing and collaborations with other community agencies. Grantees worked extensively with other community agencies to coordinate services to more effectively meet family needs. In some communities, the grant facilitated a shift from agencies working in silos to working collaboratively to support children and families. Collaboration with early intervention service providers was particularly essential. Through

partnerships with these providers, children with developmental delays are identified earlier and can be directed to services during critical periods of early development. For example, one grantee conducts joint home visits with the community's early intervention provider for children needing extra support.

> *"I feel like the climate has changed a lot since we first started the Tribal Home Visiting Program. People used to operate in silos and now we bring all the programs to the table and partner to work on things together." – Cohort 1 Tribal Grantee Project Coordinator*

In addition, documenting program collaborations helped grantees identify areas in need of improvement. For example, one grantee realized a need to improve coordination with the tribal dental care program so home visitors could provide education on fluoride treatments and connect families to needed dental services. This coordination was supported at the federal level as well. ACF funded three grantees as they undertook a special initiative known as the Tribal Early Learning Initiative (TELI) to increase collaboration across home visiting, child care, and Head Start/Early Head Start programs.

Table 9-8. At a Glance: Grantee Improvement in Coordination and Referrals for Other Community Resources and Support (N = 13)

Construct *Sample Performance Measures*	Grantees Improved % (n)
Information Sharing: Number of Agencies With Clear Point of Contact in Collaborating Community Agency That Includes Regular Sharing of Information *Number of primary contacts in community agencies or amount of information sharing with community agencies*	92 (12)
Number of Families That Required Services and Received a Referral to Available Community Resources *Number of referrals for families, mothers, mothers and/or children, or caregivers and/or household members*	77 (10)
Number of Families Identified for Necessary Services *Completion of targeted or comprehensive screening to identify family needs*	54 (7)
Number of Completed Referrals *Number of participant self-reports of completion of referral*	54 (7)
Number of Memoranda of Understanding or Other Formal Agreements With Social Service Agencies in the Community *Number of memoranda of understanding with community agencies*	46 (6)

WHY IS IMPROVEMENT IN BENCHMARK AREAS IMPORTANT?

The benchmark areas are designed to measure the activities and outcomes of the Tribal Home Visiting Program. Improvements in these areas demonstrate support for vulnerable families and ensure a stronger start and more promising future for our nation's youngest children. As supported in the literature and research, these benchmark areas are critical in supporting a range of positive child and family outcomes. While select home visiting programs were previously implemented in tribal communities, the Tribal Home Visiting Program represents the first national effort to report on a shared set of benchmark areas, both to monitor program improvement and to strengthen the evidence base for home visiting programs serving tribal communities.

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10 FINDINGS, LESSONS LEARNED, AND RECOMMENDATIONS

The Tribal Home Visiting Program provides an invaluable opportunity for tribal grantees, ACF, and the broader field to better understand how to serve the unique needs of AIAN children and families. The 25 Tribal Home Visiting Program grantees have emerged as leaders in the home visiting field, providing critical services to some of the most vulnerable AIAN families in the country and greatly expanding the reach of home visiting across diverse community contexts. Grantees built enormous capacities for implementation of evidence-based practices, data collection, performance measurement, CQI, and rigorous evaluation in ways that also meet their individual community needs. They have also demonstrated the tremendous potential and abilities of tribal communities and organizations when provided with appropriate and timely structural supports. Grantees showed that they could meet and exceed high standards for measuring family outcomes and demonstrating performance improvements that are meaningful to their communities. After four years of intensive and thoughtful planning and implementation efforts, the successes and challenges of this effort can inform future federal programming and early childhood initiatives in tribal communities.

This chapter summarizes findings from grantee data and experiences, provides lessons learned from four years of program planning and implementation, and concludes with recommendations for improving the Tribal Home Visiting Program.

REPORT FINDINGS

There is much to be gained from the experiences and successes of the 25 Tribal Home Visiting Program grantees. Each program has built and delivered

services in creative ways to fit a unique context. From program data and grantee experiences, the following is evident:

- High-need families were served across diverse community contexts.
- Program capacity was built to successfully implement and evaluate evidence-based home visiting.
- Innovative, community-specific strategies were used to overcome challenges.
- Strong foundations were built for early childhood systems of care.

After three years of implementation, the performance data of 13 grantees also shows that improved program performance was demonstrated.

Grantees Served High-Need Families Across Diverse Community Contexts

Diverse communities were served. Tribal Home Visiting Program grantees are diverse in tribal culture, size, location, urbanicity, and degree of previous experience with home visiting. Grantees also varied in their selection of home visiting models and use of adaptations to those models (see Chapter 6, Description of Grantees). Because of this diversity, the most effective way to support grantees was through flexible and individualized guidance and TA.

Families with the greatest needs were served. Services for families experiencing a variety of challenges were prioritized. The majority of caregivers served by the Tribal Home Visiting Program were of low income, had not attended college, and were not currently employed or in school. Many families had experienced challenges with substance abuse and child abuse or neglect.

The reach of home visiting into communities increased. In 2014, 870 families were served, over five times the number of families served in 2012. The number of home visits provided was increased by more than 17 times in the same timeframe. Within a short time period and with limited experience in home visiting, grantees served a total of 1,523 unique families, including 1,700 adult participants and 1,497 children. These families received nearly 20,000 home visits from 2012 to 2014.

A small fraction of tribal communities and families were served, despite the increased reach of home visiting. Over 50 tribal communities are currently served, but this is only a small percentage of the 566 federally recognized tribal nations and the 37 Urban Indian Centers, tribal consortia, and other tribal organizations across the nation (Westat, 2014). Additionally, the 2,697

adults and children served represent less than one percent of the 5.2 million individuals who identify as American Indian and Alaska Native (Norris et al., 2012).

Grantees Built Program Capacity to Successfully Implement Evidence-Based Home Visiting

Programs participated in extensive planning efforts to ensure success. Grantees thoughtfully planned and executed a multiphase effort to build quality home visiting programs. A community needs assessment was conducted, and a home visiting model was selected to fit the needs. Grantees reviewed and accessed existing resources, and sometimes created new supports to prepare to launch the new programs. Prior to program implementation, staffs were trained and hired; and implementation, performance measurement, and evaluation plans were developed. Data systems were also developed or adapted. During initial implementation, policies and procedures were developed to support their home visitors, started collecting and monitoring benchmark data, and started using their data systems to regularly generate reports for CQI.

Extensive TA on implementation and evaluation was provided. Throughout the planning and implementation phases, grantees received support through substantial federal involvement and investment as well as intensive TA in program issues and evaluation. TA was received from home visiting model developers, PATH, and TEI (see Chapter 8, Technical Assistance Provided). Training and support were also pursued from other organizations on specific needs, such as motivational interviewing, supervision, and domestic violence.

Substantial capacity for performance measurement and evaluation was developed. Through federal investment and intensive technical assistance, a unique set of performance measures based on what was most meaningful and relevant to community and families was selected and developed. The grantees created community advisory groups to provide appropriate oversight and feedback during the development process. During this planning process, each grantee weighed a number of fundamental factors: whether the selected measure fit within its community and cultural context, whether the measure aligned with other aspects of its service delivery setting, and whether relevant services were available in its community. In addition, consideration had to be given as to whether the data collection for a given measure would be overly burdensome for participants or home visitors. Addressing these concerns, motivated grantees to make critical assessments and analyses and prompted

insights that extend beyond the work on the home visiting program. Many grantees shared that the benchmark development process fostered broader tribal capacity and contributed to a better understanding of the value of thoughtful, systematic measurement.

Each grantee also developed and implemented rigorous program evaluations. During this process, grantees considered program goals, community expectations and priorities, and federal requirements to create evaluations that were both locally meaningful and informative to the broader home visiting field. The original Tribal HomVEE report (Del Grosso et al., 2011) noted, "the research literature for home visiting in tribal communities is in its infancy" (p. 28). That report recommended a number of specific efforts for planning, adopting, sustaining, and evaluating tribal home visiting programs, including developing model specification and documentation, creating fidelity standards and measures, designing research on the feasibility of implementation, and making model adaptations. Over the past four years, Tribal Home Visiting Program grantees have made enormous strides toward addressing some of these efforts. Program evaluations will be completed, and final evaluation reports will be compiled over the next two years.

Absence of assessment measures validated in tribal communities was challenging. Grantees consistently struggled with a lack of screening and assessment instruments that had been validated for use with AIAN children or families. When identifying potential tools for screening and assessing families, grantees noted a lack of tools that had been rigorously validated in tribal settings. To respond to this challenge, grantees drew on the experience of the Tribal Early Childhood Research Center to determine if there had been any previous work with the measure in similar communities that may not have been noted in published research. In addition, grantees carefully examined tools with community members to identify any items that may not be appropriate within their particular setting.

Increased capacity supported tribal and organizational decision-making. The growth in program capacity to implement and assess evidence-based home visiting services will serve grantees as they seek to continue and expand early childhood interventions within their communities. While most grantees entered the Tribal Home Visiting Program without experience implementing home visiting services, all 25 now have extensive experience educating community members and leadership on a variety of topics that support decision-making and sustainability. These topics include the benefits of home visiting services and the value of developing data collection protocols and

performance measures. As a result of this increased program capacity, tribal communities are now more informed and better positioned to advocate for and serve children and families.

Grantees Used Innovative, Community-Specific Strategies to Overcome Challenges

Innovative strategies were used for serving AIAN families. A variety of creative strategies that are responsive to family needs and supported by community practices and values (See Lesson From the Field below) were used. Among many other innovations, grantee programs involved elders and community members in decision making, as program staff and advocates for the home visiting program. Through strategic group outreach activities, community awareness was also raised about child development topics and the array of services available. In order to better understand and develop an appropriate engagement approach to fit participant needs, grantees engaged in careful assessment of the current and historical challenges relevant to each potential participant group or tribal community focusing on respect for local customs and norms.

LESSONS FROM THE FIELD

The addition of group support often enhances home visiting services in tribal settings.

> *"For a lot of families that I work with, a big component is working through what their childhood experiences were like and making a concerted effort to have them be different for their children—just reconciling a lot of that past trauma and figuring out how to do it differently for their kids."*
> *– Cohort 1 Tribal Grantee Program Coordinator*

Home visiting can provide the necessary space for some parents to discuss the emotional suffering that may affect their own parenting. Many grantees use program funds to support supplementary programs such as Circles of Security or Positive Indian Parenting to directly address this issue. One grantee expressed that this piece is integral to improving the parent–child relationships in the families they serve.

Community-specific adaptations to home visiting models were developed and implemented. Most grantees incorporated some cultural adaptations or other enhancements to their selected models, which included incorporating traditional parenting practices, Native language, and cultural norms on successful child development.

These adaptations reflect the substantial adaptive strengths of tribal communities to identify and target culturally appropriate enhancements suited to their communities; however, they also reflect the challenge in establishing the effectiveness of additional home visiting models for AIAN populations. Another challenge on the topic of home visiting adaptations is the dearth of research evidence to inform and support rigorous measurement of cultural enhancements in a manner that will support replication.

Recruitment and retention challenges are being addressed. Grantees recognize and are intimately aware of the particular characteristics of the communities and families they serve. One major ongoing challenge is recruiting and retaining participants and families. For many AIAN families in both urban and rural areas, normal lifestyle patterns involve transitions between various locations throughout the year. Sometimes families travel between reservation land and cities or towns, or from villages to hunting or fishing camp settings to gather resources for subsistence and trade. Tribal Home Visiting Program grantees have respect for these cultural practices and contexts and make accommodations to home visiting model standards, such as the timing of participant contacts and scheduling of home visits.

In addition, grantees served some of the most vulnerable and high-risk families in their communities by addressing participants' immediate needs (such as transportation to treatment appointments, child welfare visitation, and visits to incarcerated parents) and by being flexible in arranging locations for home visits. The challenge of reaching and serving families and children with the greatest needs in the communities has been more than met. The grantees will draw upon the breadth of outreach and engagement experience gained over the past four years to continue to provide these essential services in the future.

Grantees Built Strong Foundations for Early Childhood Systems of Care

Coordination of early childhood systems was strengthened. Collaborative relationships, partnerships, and referral networks that represent a solid

early childhood system infrastructure have been established. By leading a community needs assessment and undertaking program outreach efforts early in implementation, grantees are now more aware of other service providers. Likewise, those programs are more aware of the benefits of home visiting. Community partners are incorporated into community advisory boards and in some cases are providing coordinated services to families.

Programs have embraced "systems thinking" for the benefit of the families. Service duplication is being reduced, and the ability of the community programs to meet family needs across the prenatal-to-school continuum is being maximized. One of the exciting parts of the Tribal Home Visiting Program is the Tribal Early Learning Initiative, a partnership between ACF and four grantees that are collaborating across home visiting, child care, and Head Start/Early Head Start programs. While these sites have been innovators in early childhood systems building in tribal communities, many grantees have built coalitions and transformed how their communities approach services to young children and their families. Home visitors often work beyond early childhood systems to advocate for their families (See Lessons From the Field below).

LESSONS FROM THE FIELD

Using "systems thinking" helps families increase self-sufficiency.

"We just had another one of our moms get a driver's license. I saw the proud picture about two weeks ago. In our area, transportation is such an issue; having a driver's license and a vehicle, it's pretty critical. It's life changing."
– Cohort 1 Tribal Grantee Evaluator

Transportation is a consistent challenge faced by most of the grantees. One program realized that many of the enrolled mothers and fathers did not have a driver's license because of outstanding fines. Program staff supported these individuals in writing letters to the Superior Court to ask for forgiveness or community service hours. In going beyond typical home visiting services, the program helped enrollees regain their licenses and learn new skills in interacting with the legal system.

Evidence of Progress: Grantees Improved Program Performance

Tribal grantees successfully implemented new home visiting programs within their communities and saw substantial performance improvement across all six legislatively mandated performance areas in a limited time period. Some successes from each domain are highlighted below.

Overall Program Improvement. A majority (77 percent) of the 13 Cohort 1 grantees demonstrated overall improvement in the benchmark areas in the three-year period.

Maternal and Newborn Health. Almost all grantees (92 percent) increased the health care utilization of children and mothers, while 77 percent improved maternal depression screenings and the receipt of timely or adequate prenatal care for pregnant mothers. Additionally, 62 percent saw improvements in breastfeeding. Family progress towards improved maternal and newborn health was encouraged. Given the short timelines for demonstrating improvement in family outcomes, family progress toward larger and more quantifiable outcomes is important to consider. Specifically, many family outcomes depend on changing complex behaviors that require time and a process of interim steps to achieve desired changes. While most grantees (69 percent) improved measures of parental use of alcohol, tobacco, and illicit drugs, others saw families taking important steps toward improvement. For example, one grantee did not see a reduction in the number of caregivers who smoked but saw a reduction in the number of cigarettes smoked per day, which represents a major step toward a larger change.

Child Injuries; Abuse, Neglect, or Maltreatment; and Emergency Department Visits. Almost all grantees (92 percent) saw decreases in the number of children who are first-time victims of maltreatment and the number of substantiated reports of children being victims to maltreatment. Fifty-four percent saw a reduction in visits for children to the emergency room, and 39 percent saw a reduction for mothers.

School Readiness and Achievement. There was a 77 percent improvement on measures of parent knowledge of child development, and 69 percent on measures of parenting behaviors and parent–child relationships. In addition, there was an improvement in screening rates for developmental delays: general cognitive skills (61 percent), positive approaches to learning (54 percent), and physical health and development (54 percent).

Domestic Violence. Fifty-four percent of grantees improved on their screening for domestic violence, while 69 percent saw increases in safety plan completion for families experiencing domestic violence.

Family Economic Self-Sufficiency. A majority of grantees (85 percent) saw increases in the number of adults and children with health insurance; 69 percent saw improvements in the household income of families in their program; and 62 percent saw increased adult participant education or employment.

Coordination and Referrals for Other Community Resources and Supports. Almost all (92 percent) of grantees improved on measures related to regular information sharing with community agencies, and 77 percent increased the number of families receiving referrals to available community resources.

LESSONS LEARNED

The lessons learned from implementing the Tribal Home Visiting Program for four years can hopefully guide ACF in the continued support of AIAN children, families, and communities.

Tribal Communities Can Meet and Exceed the Federal Home Visiting Program's High Expectations

The Tribal Home Visiting Program grantees demonstrated that tribal communities are capable of meeting the high standards and expectations of the Federal Home Visiting Program with respect to collecting and using data and demonstrating performance improvements. The legislation gave HHS the flexibility to align the requirements for the tribal program with the requirements for the state program "to the extent practicable." ACF and HRSA decided early on that this flexibility was important but should be used primarily to ensure that programs would be tribally driven and responsive to community needs; they did not want this flexibility to simplify or dilute the legislative goal of using and building on evidence and data. ACF set high expectations for the grantees and offered intensive TA and supports to grantees as they strived to meet them.

Tribal Grant Programs Are Successful When They Intentionally Emphasize Relationship Building and Capacity Building

When working with Native communities, relationships are critical at every level—among federal staff, grantees, TA providers, tribal leaders, evaluators, and other partners. ACF recognized the importance of relationships, starting with

structuring the grants as cooperative agreements. The cooperative agreement establishes the project as a partnership between the grantee and the federal government and clearly outlines the roles and responsibilities of each partner as well as the provision of ongoing assistance through substantial federal involvement. Although the cooperative agreement was new to many grantees, it has allowed for true relationship building and more intensive capacity building TA than is typical for a discretionary grant.

Some of the successful strategies for relationship building and optimizing TA opportunities include monthly calls between ACF, TA providers, and each grantee team; site visits conducted by ACF and TA providers at key points during the grant; frequent in-person grantee meetings and peer learning opportunities; and virtual communities of learning across grantees. Relationships are also important when it comes to carrying out grant evaluations and data requirements; grantees that have been most successful have fostered strong partnerships across program and evaluation staff to build capacity and comfort of all home visiting team members with data and evaluation.

Successful Evidence-Based Initiatives in Tribal Communities Must Build on Principles of Implementation Science

As an evidence-based policy initiative, the Tribal Home Visiting Program builds on the idea that broad replication of evidence-based (or promising) home visiting models will lead to corresponding impacts for children and families. Recognizing that these impacts could only be realized through developing capacity around implementation fidelity and quality, ACF based the design of the Tribal Home Visiting Program on the principles of implementation science. These principles posit that agencies typically progress through a set of common stages when implementing new programs and that targeting key drivers at different stages can promote fidelity and quality. For example, a key dimension of quality program implementation includes initial and ongoing staff support (See Lesson From the Field below). The Tribal Home Visiting Program is structured to include a planning year in which grantees conducted a needs and readiness assessment. This period provided sufficient time for grantees to explore and build the necessary infrastructure to carry out the program requirements. Providing specific policy guidance to grantees required careful use of the results from the needs and readiness assessments in selecting their models and to articulate a clear and detailed plan for the installation stage of implementation (including staff selection, training, professional development, and supervision) prior to beginning services.

LESSONS FROM THE FIELD

The success of a program often relies on the quality of support provided to the staff. Some grantees use formal approaches such as reflective supervision to support home visitors. Others use informal gatherings to ensure that home visitors have opportunities to process the tough, emotional work they do.

> *"There are so many issues that go beyond the routine nursing care we provide that right now we are not capturing…it's not just one family that has all these needs, it is many, many families, and home visitors bring home that burden of asking, 'Should I have left that mom there, did they get fuel, is the house freezing?'" – Cohort 1 Tribal Grantee Project Manager*

During initial implementation of home visiting programs and by utilizing guidance from model developers and federal partners, grantees developed policies and procedures to support home visitors and program staff, started collecting and monitoring benchmark data, and started using data systems to regularly generate reports for data-based decision making and CQI. TA providers have focused the work on building tribal capacity and infrastructure for program implementation, data collection, evaluation, and quality improvement. An implementation science-based approach has been critical to the success of grantees and the program.

Tribally and Community Driven Programming and Decision Making Are Key to Promoting Innovation

Many evidence-based and research-driven initiatives have not acknowledged the wishes, capacities, and desires of tribal communities. Too often, initiatives have been imposed on rather than driven by tribes. A critical lesson of the Tribal Home Visiting Program is the importance of supporting tribe- and community-driven programming and decision-making. ACF recognized that the program implemented by each grantee would only be successful if the tribal community "owned" the program. Promoting this level of program ownership was

fundamental to grantees' abilities to develop workable and innovative practice solutions tailored to the characteristics of the community, addressing immediate family needs, and fostering greater family engagement.

One strategy many grantees felt contributed to their success was to involve multiple community stakeholders—tribal leaders, elders, cultural leaders, parents, service providers, and other community members—at every stage of their projects. The involvement of the community and use of feedback loops have benefitted all components of these projects: conducting needs assessments, selecting a model, hiring home visitors, meeting family needs, selecting benchmarks performance measures, developing and carrying out evaluations, and examining and using data to drive improvement. This lesson builds on respect for tribal sovereignty as well as a recognition that each tribal community is unique in its culture, vision, goals, and strengths.

Evidence-Based Initiatives in Tribal Communities Can Be Strengthened by Support for Adaptation and Enhancement

Successful implementation of evidence-based models (particularly those developed for nontribal settings) often requires adaptation or enhancement when implemented in an AIAN community. For example, SAMHSA's Strategic Prevention Framework for effective, culturally appropriate and sustainable prevention activities describes a step-wise process for embedding best practices into the context of the community where the program will be implemented (Substance Abuse and Mental Health Services Administration, no date). ACF recognized the importance of supporting grantees in developing cultural and contextual adaptations. As such, ACF provided intensive programmatic and evaluation TA, which included facilitating grantee access to nationally recognized experts in research and evaluation with tribal communities.

Grantees designed enhancements and adaptations in partnership with community members, tribal and cultural leaders, and other important stakeholders. They worked in close partnership with model developers to identify the required "core components" of models and those that could be adapted or enhanced. When designing these innovations, grantees also considered which aspects of the culture or context were most appropriate for integration into the home visiting program. The enhancement or adaptation process has often been iterative and nonlinear, occurring throughout implementation. This process necessitates ongoing and consistent TA that can be flexible and responsive while also helping grantees to contribute to the evidence base for effective home visiting program adaptations for tribal communities.

A Systems-Building Emphasis Is Critical for Strengthening and Sustaining Tribal Early Childhood Programs

Congress envisioned the Tribal Home Visiting Program as a systems-building initiative. The legislative goals explicitly include the coordination of services for at-risk communities and the provision of comprehensive services to families. Because the success of home visiting programs depends on connecting families to needed assistance and because the families served by home visiting programs are likely receiving many health and early childhood services in the community, the grantees must ensure that their programs are not operating "in silos." Recognizing this critical component, ACF promoted systems building by requiring grantees to conduct a review of existing early childhood system infrastructure in their initial planning process. Grantees were required to designate community partners with which they would work in concert during the home visiting program implementation. ACF also set expectations for collaboration and partnership by requiring grantees to monitor ongoing development of agency memoranda of understanding and new agency partnership contacts as part of the performance measurement plans. This systems building emphasis has fostered ongoing grantee partnership efforts that contribute to the long-term sustainability of early childhood programming in grantee communities.

SUMMARY AND RECOMMENDATIONS

After four years of implementation, ACF recognizes the opportunity to strengthen the Tribal Home Visiting program and build on the solid foundation already established. Going forward, ACF will maintain high expectations for Tribal MIECHV grantees and support their success through continued efforts to develop and enhance early childhood systems in tribal communities, improvements to the performance measurement and continuous quality improvement system in close communication with tribal grantees, and promotion of a learning agenda to build knowledge of effective home visiting in tribal communities.

As exemplified by the Tribal Early Learning Initiative, and demonstrated by the tribal home visiting grantees, children and families are served best when collaborative relationships, partnerships, and referral networks are established for a solid early childhood system infrastructure. ACF will continue to emphasize this priority of early childhood systems building as the Tribal Home Visiting program continues.

As demonstrated in this report, the benchmarks process helped to build the capacity of grantees for monitoring the success of their programs. ACF will

continue to emphasize efforts to support grantees in using performance measurement data to improve programs through modifications to the benchmark requirement that facilitate use of the data for continuous quality improvement and other priorities. These changes to the benchmarks requirement will be made in close communication with grantees, following expert guidance.

Finally, given the expectations for rigorous evaluation of home visiting in tribal communities, the Tribal Home Visiting program has helped to build local and tribal capacity for evaluation. ACF will continue to foster local grantee efforts to understand their own home visiting programs while supporting efforts to generate knowledge to inform the broader field of implementation science around adaptation and other important topics

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APPENDIX A

GRANTEE BENCHMARK IMPROVEMENT

BACKGROUND

Following the submission of performance data by Tribal Home Visiting grantees, ACF assessed whether each grantee demonstrated improvement in each of the benchmark areas outlined in the legislation and determined next steps if grantees did not demonstrate improvement.

Legislative Requirements

The legislation that created the Maternal, Infant, and Early Childhood Home Visiting program requires grantees to address six outcome domains: (1) improved maternal and newborn health; (2) prevention of child injuries, child abuse, neglect, or maltreatment and reduction of emergency department visits; (3) improvement in school readiness and achievement; (4) reduction 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.

The legislation required state grantees to establish "quantifiable, measureable three and five-year benchmarks for demonstrating that the program results in improvements for the eligible families participating in the program" in these six domains (called "benchmark areas"). Per the statute, if grantees do not demonstrate improvement in at least four of the six benchmark areas after three years of implementation, they must develop a corrective action plan to improve their performance. State grantees who still fail to demonstrate improvement after completing their corrective action plans risk losing funding.

According to the legislation, Tribal Home Visiting Program grants are to be consistent with the grants to states "to the extent practicable." The statute requires that tribal grantees establish three and five-year benchmarks for demonstrating

improvement. On the other hand, the legislation does not explicitly require that tribal grantees must improve in four of the six benchmarks areas or that they develop a corrective action plan if they do not demonstrate improvement.

Interpretation of Requirements

As HRSA and ACF interpreted the legislation, tribal grantees are required to develop program performance measures related to each of the benchmark areas and to demonstrate quantifiable improvement using these performance measures. To develop performance measure requirements, the two federal agencies convened committees of experts to recommend aspects of each benchmark area that would be most important to measure. For example, in the area of improved maternal and child health, the experts recommended that grantees measure program performance in regard to promoting prenatal care, breastfeeding, well-child visits, and so on. For each of the benchmark areas, the experts identified two to nine different aspects (called "constructs") that they considered to be essential. In total, the experts identified at least 35 separate constructs across all six benchmark areas.

Based on these recommendations, ACF and HRSA required grantees to develop separate performance measures for each of the constructs and to collect the data necessary to track and assess their progress for each performance measure. For the Tribal Home Visiting Program, each grantee was required to develop and report on 36 separate performance measures—one for each of the constructs.[25]

Because both state and tribal grantees were expected to implement a variety of home visiting models and to do so within diverse systems and contexts, ACF and HRSA determined that grantees should have maximum flexibility in developing performance measures. While this flexibility reduced the ability of ACF and HRSA to track grantee progress on a uniform set of performance measures, the benefits of this approach won out (particularly as they related to model developers' existing data collection requirements).

ACF gave Tribal Home Visiting Program grantees the following broad guidance in 2011 about how improvement would be assessed after three years of program implementation:

- **Demonstrating improvement for a given construct (performance measure):** For each performance measure, grantees are required to report two data values, **a baseline value and a comparison value**. In order to demonstrate

[26] For one of the six benchmark domains, grantees had the choice to measure either crime (two constructs) or domestic violence (three constructs). All Tribal Home Visiting grantees selected domestic violence; therefore, they must measure three different constructs in this benchmark area and a total of 36 constructs across all six benchmark areas.

improvement for the given performance measure, the grantee is simply required to demonstrate quantifiable improvement.

- **Demonstrating improvement for a given benchmark area:** Grantees are required to demonstrate improvement in **at least half** of the constructs in a given benchmark area to demonstrate improvement for the benchmark area as a whole.
- **Demonstrating improvement overall:** To align with the legislative requirement for state grantees, ACF determined that tribal grantees must demonstrate improvement in at least **four of the six** benchmark areas to be assessed as has having demonstrated overall improvement.

ACF gave Cohort 1 Tribal Home Visiting Program grantees guidance in summer 2014 that they must report benchmark data to ACF using the following cross-sections that correspond to the federal reporting periods:

- **Baseline period:** Benchmark data collected between the date the first participant was enrolled (this will be unique to each grantee site) and September 29, 2013
- **Comparison period:** Benchmark data collected between September 30, 2013, and September 29, 2014 (the dates of the most recent reporting period)

Tribal Home Visiting Benchmark Data Reporting

ACF, in consultation with Tribal Home Visiting Program grantees and HRSA, developed a benchmarks reporting form for the grantees (Home Visiting Form 3, or HV Form 3) that was approved by the Office of Management and Budget in July 2014. The HV Form 3 for tribal grantees is similar to a form (HV Form 2) used by state grantees, but with slight modifications to allow for tribal grantees to report benchmark data with an added level of specificity.

ACF and HRSA directed the developers of the HRSA Discretionary Grants Information System (DGIS) to create a separate HV Form 3 module in the DGIS for Tribal Home Visiting Program grantees to submit their benchmark data. During the development phase, ACF had the option to adopt a feature in the system that would automatically calculate whether a grantee had improved on a particular construct. ACF decided not to include the automatic calculation feature, anticipating that in some cases it might be challenging to assess improvement.

Therefore, within the DGIS for HV Form 3, an “Improvement” field contains a drop-down box with a “Yes” or “No” option. Because the system does not automatically determine improvement, the grantee selects “Yes” or “No” based

on its assessment. Grantees must then provide a thorough explanation in the "Considerations for Improvement" field in DGIS to help ACF understand the degree of improvement or lack of improvement shown for each construct. Examples of the types of additional information provided by grantees in the "Considerations for Improvement" field may include the following:

- A discussion of factors that contributed to the program's success in demonstrating improvement
- A clear explanation of why the data do not show quantifiable measureable improvement
- An overview of data collection challenges or successes relevant to the construct
- An explanation of limitations of the data that influence improvement between baseline and comparison (for example, a small sample size, lack of families who reach a particular assessment time point, "ceiling effects" due to high performance at baseline)
- A description of programmatic challenges related to the construct, such as inadequate home visitor training, staff turnover, or poor community acceptance of a measure
- Contextual information about the community or issues affecting data collection or service provision, such as poor family retention due to summer subsistence activities

DISCUSSION

Decision Rules for Assessing Improvement

With this input from each grantee, ACF must make an official determination of improvement for each construct. When determining improvement from the federal perspective, ACF considered the data submitted along with the information provided in the "Considerations" field.

The following decision rules guided ACF in determining if a grantee demonstrated improvement for each construct and benchmark area. These rules generally align with HRSA's approach for assessing improvement for state grantees.

1. Grantees were assessed as having improved on a particular construct if their data values moved in a positive direction (or in a negative direction if that is the desired improvement). The overall level of performance and the magnitude of the improvement were not taken into account when assessing improvement. For example, a grantee that moved from a two percent screening rate to a three percent screening rate was assessed as improved, even though its overall level of performance was low, and the increase was minimal.

2. There are three exceptions to Rule #1:
   a. Grantees that did not have any data at baseline but performed at a very high level (90 percent or above/10 percent or below) at comparison were assessed as having improved. For example, if a grantee was unable to collect any baseline data related to screening of families for domestic violence but was able to collect data during the comparison period showing that 95 percent of families were screened for domestic violence, ACF gave the grantee credit for improvement.
   b. Grantees that had baseline data suggesting very high performance (90 percent or above/10 percent or below) and comparison data, while lower, also suggesting very high performance (90 percent or above/10 percent or below) were assessed as having improved. For example, if a grantee's baseline data indicated 100 percent screening for maternal depression and comparison data dropped to 95 percent, ACF gave the grantee credit for improvement.
   c. If the benchmark measure involved action to be taken by a grantee or a change in participant status based upon some criteria set by the grantee (screens positive for domestic violence, decrease in percentage of children screening positive for delays), but no enrollees met that criteria at either time point, the designation was improvement for that benchmark. For example, grantees that screened participants for domestic violence (Construct 4.1) but did not have any "positive" screens automatically received "Yes" for Constructs 4.2 and 4.3 ("of families identified, number of referrals made to relevant services" and "of families identified, number of families for which a safety plan was completed").
3. All performance measures in a benchmark area counted toward the overall assessment of improvement in that area, whether or not a grantee had a strong rationale for why the data did not demonstrate improvement. In some cases, a grantee was able to provide a compelling reason for why it was not able to demonstrate improvement for a given construct, but ACF did not disregard the construct in determining this grantee's improvement in a benchmark area.

Limitations

Though these rules are fair and defensible, the following issues are worth noting:

- **The data are imprecise.** Due to the nature of this kind of performance data, the precision of the data is not high. For example, a grantee may have no data at baseline and 80 percent screening at follow-up. Technically, the number increased, but values at comparison were not high enough to merit a determination of improvement. ACF may be criticized by grantees with relatively high rates of performance at baseline that do not reach the proposed cutoff of 90 percent. In addition, ACF's determinations may lead

some stakeholders to draw the conclusion that the performance data values have more precision than they actually possess.

- **With the exception of rules 2a and 2b, ACF did not take a grantee's overall level of performance on a construct into consideration when assessing improvement.** Under the proposed decision rules, a grantee that moved from a 25 percent to 35 percent screening rate will receive a "Yes" for improvement, but a grantee that moved from a 95 percent to 85 percent screening rate will receive a "No" for improvement. In other words, some grantees that demonstrate high overall levels of performance on a construct will be penalized and receive a "No" for improvement, whereas grantees that demonstrate low overall levels of performance, but show improvement, will receive a "Yes" for improvement
- **ACF did not take the number of participants served by a grantee into account when assessing improvement.** For example, imagine that Grantee A served 10 people in its baseline period and screened all 10 people; in its comparison period, it served 30 people and screened 25 people. Its performance data will show a decline from 100 percent to 83 percent, and it will be assessed as failing to demonstrate improvement. Alternatively, consider Grantee B, which served three people in its baseline period and screened only one person; in its comparison period it served six people, and it screened only three people. Its performance data will show an increase from 33 percent to 50 percent, and it will be assessed as demonstrating improvement. These scenarios raise a question of whether a grantee that serves more participants or substantially increases its number of participants should be held to the same standard as a grantee that serves a very low number of people.
- **ACF did not make accommodations for cases in which the grantee had very little control over the outcome of a performance measure.** Some situations may occur in which the grantee has little control over the outcome of a performance measure and may feel that it should not be penalized for a decrease in performance. However, under the decision rules used, ACF did not make accommodations for such cases.
- **There were inconsistences in how grantees structured their performance measures.** The grantees structured their performance measures differently, and these differences could have real implications for whether or not grantees are assessed as having improved.

The decision rules were based on a clear and straightforward interpretation of the legislative language. The legislation requires that grantees demonstrate "measureable, quantifiable improvement." These rules required grantees to do just that, while still appreciating the unique context of tribal grantees' programs and applying the legislative language that tribal grants are to be consistent with state grants "to the extent practicable."

APPENDIX

B IDENTIFYING CONSTRUCTS FOR DATA AGGREGATION

VARIABILITY IN PERFORMANCE MEASURES

As discussed in the report, grantees developed their own performance measurement plans detailing how they would measure, collect, and analyze data on the individual constructs within each of the six benchmark areas. While this flexibility permitted grantees to develop performance measures that were meaningful to their unique contexts and programs, it also resulted in widespread variability in performance measures across grantees. This variability stems from the following differences:

- The specific definition of each performance measure
- The type of measure used (outcome or process)
- The target population identified for inclusion in measurement
- The measurement time period
- The value type (rate, percentage, mean, count)
- The unit of analysis (incidents, participants)
- If applicable, specific definitions of the numerator and denominator
- The type of comparison (cohort, individual, cross-sectional)

METHOD OF DATA AGGREGATION

To provide additional insight on grantee program performance outside of determinations of improvement, data for select constructs were aggregated across grantees. Specifically, grantee-reported benchmark data in FY 2012 and FY 2014, representing program performance between 2012 and 2014,

were aggregated. The method of data aggregation involved summing values across select grantees and reporting years to provide an estimate of overall performance on select constructs. For example, for the construct on maternal depression screening, many grantees reported the percentage of eligible women screened by an established time point (for example, six months after enrollment, six months after delivery). To aggregate data for this specific construct, the FY 2012 numerators were totaled across grantees (for those with similarly defined performance measures) and the FY 2014 numerators across grantees (again, for those with similarly defined performance measures) to provide an aggregate numerator. The same process was completed with the FY 2012 and FY 2014 denominators to provide an aggregate denominator. The aggregate numerator was then divided by the aggregate denominator to provide an aggregate percentage of the number of women screened for maternal depression.

IDENTIFYING CONSTRUCTS WITH SIMILAR PERFORMANCE MEASURES

To allow for meaningful aggregation and interpretation of data across grantees, measures of a construct must demonstrate sufficient alignment across the bulleted items outlined above. The process of nominating and selecting constructs for data aggregation involved a careful review of the 13 Cohort 1 grantees' performance measures, and the bulleted items outlined above, for all of the benchmark constructs. Constructs were considered for data aggregation if there was sufficient alignment across performance measures for at least five grantees. Alignment was considered sufficient if there were slight variations in the target populations and measurement time periods (for example, women four months postpartum versus women six months postpartum).

IDENTIFIED CONSTRUCTS AND NUMBER OF GRANTEES REPRESENTED

This table summarizes the final selection of constructs for data aggregation, the performance measure for the construct, and the number of grantees represented in aggregated data.

Constructs Identified for Data Aggregation

Construct	Performance Measure	Number of Grantees Included in Aggregated Data
Prenatal Care	*Percentage of eligible participants initiating early prenatal care*	6
Screening for Maternal Depressive Symptoms	*Percentage of eligible participants screened for maternal depression*	12
Regular Visits to a Primary Healthcare Provider or Medical Home	*Percentage of eligible participants with visit to a primary healthcare provider or medical home*	8
Information Provided on Prevention of Child Injuries	*Percentage of eligible participants who received information or training on prevention of child injuries*	13
Incidence of Child Injuries Requiring Medical Treatment	*Rate of child injuries requiring medical treatment*	8
First-Time Victims of Maltreatment	*Rate of first-time victims of maltreatment*	12
Child Screening Rates in Developmental Domains	*Percentage of eligible children screened in developmental domains*	7 (child physical health and development), 9 (remaining domains)
Screening for Domestic Violence	*Percentage of eligible participants screened for domestic violence*	10
Household Income and Benefits	*Percentage of eligible participants with increased household income or benefits*	5
Families Identified for Necessary Services	*Percentage of eligible families screened for necessary services*	9
Families Referred for Necessary Services	*Percentage of families identified for necessary services that received a referral*	11
Completed Referrals	*Percentage of families receiving a referral that completed referral*	10

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APPENDIX C

LIMITATIONS OF BENCHMARK DATA

The program performance data presented in this report represent the grantees' extensive efforts in recruitment, retention, service provision, and data collection. However, as with all data, interpretation must be tempered with careful attention to their limitations. Some of the limitations of Tribal Home Visiting Program performance data include inconsistent and incomplete data, challenges related to culturally relevant measurement, small sample sizes, lack of comparison data, and insufficient time to demonstrate improvement. Performance measurement data can be a useful tool in understanding the growth and development of programs, but this information should not be confused with data that document program effect or impact. Documenting program impact requires a rigorous evaluation design and data from an equivalent comparison group.

A RANGE OF LOCAL CHALLENGES THAT LED TO SOMETIMES INCONSISTENT AND INCOMPLETE DATA

Data collection requirements presented new challenges for home visiting program staff. In some cases, grantees experienced setbacks in their data collection as they struggled to consistently collect necessary data while simultaneously delivering high quality services to families in the community. As a result, the data representing families served and services provided were likely underreported. Grantees are developing and implementing new strategies that promise to improve the consistency and completeness in data collection in the future. These strategies include integrating data collection discussions into regular home

visitor supervision, developing a custom data dashboard to facilitate real-time data checks, and incorporating a systematic review of data collection processes informed by home visitor experience. Additionally, grantees and TA providers have collaborated over the past year in the development of tools and strategies to improve data collection, which is intended to mitigate against this limitation in the future.

SERVICE PROVISION TO SMALL COMMUNITIES LED TO SMALL SAMPLE SIZES

Many of the tribal grantees are serving small communities. In some communities, the total number of families served is less than 50 families. This makes accurately measuring change difficult as just one family's data could substantially skew the performance data for the entire program. Grantees continue to strategize around measuring change in small communities. Some grantees look to collaboration around data collection across sites, and perhaps by model, as a potential approach to explore.

REQUIRED PERFORMANCE CONSTRUCTS DID NOT ACCOUNT FOR VARIATION IN MODEL OR PROGRAM FOCUS

The 36 required performance constructs provided a helpful but limited view of program success. Because grantees had flexibility to utilize different home visiting models, the target population, program goals, and curricula varied across the grantees. In some instances, models did not focus on particular required performance areas. For example, a grantee may have delivered services with fidelity but failed to demonstrate improvement in prenatal health because their model targeted children after birth.

LACK OF ASSESSMENT TOOLS VALIDATED WITH TRIBAL COMMUNITIES

Tribal grantees frequently needed to assess outcomes for which there were no instruments validated for use in tribal settings or with AIAN individuals. While grantees were thoughtful in determining which tool would be most useful given these limitations, there may be instances in which assessments of certain outcomes may be inaccurate. For instance, grantees expressed that existing measures of parent-child interaction and parenting often feel invalid in a tribal

setting. In AIAN communities, who provides care (parents, extended family members, other community members), how they interact with their children (non-verbal communication, through experiential learning, etc.), and what the home setting may look like may be different than in other contexts but may be appropriate caregiving.

BENCHMARK DATA CAN DEMONSTRATE PROGRAM IMPROVEMENT NOT *IMPACT*

The purpose of the benchmark requirement was not to measure impact or effectiveness but rather program improvement, and therefore a comparative design was not used. The goal of this type of performance measurement effort is to monitor program implementation and determine if grantees were making desired progress across a variety of indicators. Knowing whether a program "works," requires a different approach to program design and data collection. In order to assess impact or effect, outcome data must be collected on families and children that did not participate in the program. Therefore, the data included in this report should not be used to determine program efficacy.

SHORT TIMEFRAME FOR DEMONSTRATING IMPROVEMENT

For many grantees, this program was the first in their communities to require extensive data collection. For these programs, successfully meeting the requirements first necessitated an extensive period to plan and build the infrastructure necessary for data collection. While it was time well spent, for some grantees, the time expended building the infrastructure delayed data collection. Implementation planning, infrastructure building, and training of staff sometimes meant that grantees began services later than expected. As a result, the window of time programs had to demonstrate program improvement was often shorter than anticipated. It is possible that some grantee programs will show greater progress and improved services with the expected growth in program implementation experience and with more time to refine services.

When developing performance measures, grantees were acutely aware of and sometimes motivated by the need to demonstrate improvement within a short timeframe. This restricted the types of performance measures that were selected. For example, more process measures were selected, measures that don't capture incremental change were not always considered, and target

populations were narrowed to those who were likely to improve (e.g., families without insurance at intake, smokers at intake, families who score low on a particular measure at intake) which limited the number that could be reported and in many cases made the data challenging to interpret. There may be many indicators that are closely tied to home visiting processes and outcomes, feasible to measure, and appropriate for tribal communities, but they may not be sensitive to change within a short period of time.

APPENDIX

D DATA TABLES

DGIS DEMOGRAPHIC AND SERVICE UTILIZATION DATA

Participant Utilization of Program Services Number of Newly Enrolled Participants 2012-2014, Cohort 1												
	FY2012			FY2013			FY2014			TOTAL All Years		
Participant Type	Total N= 9**	M (SD)*	Min. Max.*	Total N= 13	M (SD)	Min. Max.	Total N= 13	M (SD)	Min. Max.	Total N= 35	M (SD)	Min. Max.
Families	169	18.78 (12.77)	4/40	464	35.69 (27.91)	6/96	434	33.38 (29.19)	4/90	1067	30.49	4/96
Participants	179	19.89 (12.44)	4/40	569	43.77 (37.42)	9/130	509	39.15 (33.26)	4/103	1257	35.91	4/130
Children	163	18.11 (12.99)	5/44	452	34.77 (27.07)	6/105	489	37.62 (31.2)	4/107	1104	31.54	4/107

*Note: Where Min.Max. or SD presented, refers to variability across grantees.**N's reported reflect the number of grantees reporting

Participant Utilization of Program Services Number of Newly Enrolled Participants 2012-2014, Cohort 2									
	FY2013			FY2014			TOTAL All Years		
Participant Type	Total N = 2	M (SD)	Min. Max.	Total N = 6	M (SD)	Min. Max.	Total N = 8	M (SD)	Min. Max.
Families	20	10 (4.24)	7/13	204	34 (31.23)	9/89	224	28.0	7/89
Participants	20	10 (4.24)	7/13	207	34.5 (32.29)	9/92	227	23.38	7/92
Children	13	6.5 (6.36)	2/11	202	33.67 (44.83)	8/124	215	26.88	2/124

Participant Utilization of Program Services Number of Newly Enrolled Participants 2012-2014, Cohort 3			
	FY2014		
Participant Type	Total Newly Enrolled N = 6	M (SD)	Min. Max.
Families	232	38.67 (68.27)	2/176
Participants	216	36.0 (61.84)	2/160
Children	178	29.67 (51.59)	0/132

Participant Utilization of Program Services Number of Participants Served 2012-2014, Cohort 1									
	FY2012			FY2013			FY2014		
Participant Type	Total Served N = 9	M (SD)*	Min. Max.	Total Served N = 13	M (SD)	Min. Max.	Total Served N = 13	M (SD)	Min. Max.
Families	169	18.78 (12.77)	4/40	593	45.62 (39.32)	6/132	887	68.23 (60.69)	10/226
Participants	179	19.89 (12.44)	4/40	702	54 (45.97)	9/137	1000	76.92 (62.18)	12/226
Children	163	18.11 (12.99)	5/44	571	43.92 (36.88)	6/137	957	73.62 (52.67)	11/195

Participant Utilization of Program Services Number of Participants Served 2012-2014, Cohort 2						
	FY2013			FY2014		
Participant Type	Total Served N = 2	M (SD)	Min. Max.	Total Served N = 6	M (SD)	Min. Max.
Families	20	10 (4.24)	7/13	222	37 (31.5)	9/89
Participants	20	10 (4.24)	7/13	225	37.5 (32.5)	9/92
Children	13	6.5 (6.36)	2/11	221	36.83 (43.56)	8/124

Participant Utilization of Program Services Number of Participants Served 2012-2014, Cohort 3			
	FY2014		
Participant Type	Total Served N = 6	M (SD)	Min. Max.
Families	232	38.67 (68.27)	2/176
Participants	216	36 (61.84)	2/160
Children	178	29.67 (51.59)	0/132

Participant Utilization of Program Services Percentage of Participants Pregnant at Enrollment, Male Caregivers, Female Caregivers, Cohort 1									
	FY2012			FY2013			FY2014		
Participant Type	Total %	M (SD)	Min. Max.	Total %	M (SD)	Min. Max.	Total %	M (SD)	Min. Max.
Pregnant at Enrollment	31.84 N = 57	26.73 (23.42)	0/77.5	37.68 N = 107	31.36 (19.14)	0/64	27.50 N = 275	28.33 (15.39)	7.69/55.88
Male Caregivers	8.38 N = 15	11.75 (14.83)	0/35.29	9.18 N = 57	11.21 (13.83)	0/38.24	13.30 N = 133	13.13 (13.83)	0/40.66
Female Caregivers	59.78 N = 107	61.52 (21.75)	22.5/100	53.14 N = 330	57.43 (17.71)	36/100	59.2 N = 592	58.54 (12.62)	41.67/84

Participant Utilization of Program Services Percentage of Participants Pregnant at Enrollment, Male Caregivers, Female Caregivers, Cohort 2						
	FY2013			FY2014		
Participant Type	Total %	M (SD)	Min. Max.	Total %	M (SD)	Min. Max.
Pregnant at Enrollment	55 N = 11	65.38 (48.95)	30.77/100	42.22 N = 95	33.23 (34.51)	0/100
Male Caregivers	0 N = 0	n/a	n/a	5.33 N = 12	3.34 (4.04)	0/9.78
Female Caregivers	45 N = 9	34.62 (48.95)	0/69.23	52.44 N = 118	63.43 (33.51)	0/100

Participant Utilization of Program Services Percentage of Participants Pregnant at Enrollment, Male Caregivers, Female Caregivers, Cohort 3			
	FY2014		
Participant Type	Total %	M (SD)	Min. Max.
Pregnant at Enrollment	34.72 N = 75	60.63 (41.11)	0/100
Male Caregivers	.93 N = 2	2.19 (5.06)	0/12.5
Female Caregivers	64.35 N = 139	37.18 (37.47)	0/87.5

Participant Utilization of Program Services Number of Home Visits Provided, Cohort 1												
	FY2012			FY2013			FY2014			Total All Years		
	Total N= 9	M (SD)	Min. Max.	Total N= 13	M (SD)	Min. Max.	Total N= 13	M (SD)	Min. Max.	Total N= 35	M (SD)	Min. Max.
Number of Home Visits Provided	759	84.33 (80.18)	8/257	5831	448.54 (384.32)	29/1226	9819	755.31 (699.04)	33/2727	16409	468.83	8/2727

Participant Utilization of Program Services Number of Home Visits Provided, Cohort 2									
	FY2013			FY2014			Total All Years		
	Total N= 2	M (SD)	Min. Max.	Total N= 6	M (SD)	Min. Max.	Total N= 8	M (SD)	Min. Max.
Number of Home Visits Provided	120	60 (49.5)	25/95	1710	285 (227.58)	44/526	1830	228.75	25/526

Participant Utilization of Program Services Number of Home Visits Provided, Cohort 3			
	FY2014		
	Total N = 6	M (SD)	Min. Max.
Number of Home Visits Provided	1418	236.33 (335.23)	2/799

Service Utilization Across Models Family Retention, Cohort 1									
	FY2012			FY2013			FY2014		
	Total N = 9	M (SD)	Min. Max.	Total N = 13	M (SD)	Min. Max.	Total N = 13	M (SD)	Min. Max.
Currently receiving services	158	17.56 (13.4)	3/40	478	36.77 (31.86)	6/101	633	48.69 (40.78)	8/155
Completed program	0	0	0/0	5	.38 (.77)	0/2	22	1.69 (3.50)	0/13
Stopped services before completion	3	.33 .5	0/1	86	6.62 (8.97)	0/31	204	15.69 (18.76)	1/69
Other	8	.89 (2.32)	0/7	16	1.23 (3.14)	0/11	28	2.15 (6.34)	0/23
Attrition Rate	2%			14.5%			23%		

Service Utilization Across Models Family Retention, Cohort 2						
	FY2013			FY2014		
	Total N = 2	M (SD)	Min. Max.	Total N = 6	M (SD)	Min. Max.
Currently receiving services	20	10 (4.24)	7/13	185	30.83 (27.06)	8/77
Completed program	0	0	0	0	0	0
Stopped services before completion	0	0	0	36	6 (6.6)	0/15
Other	0	0	0	1	.17 (.41)	0/1
Attrition Rate	0%			16.2%		

Service Utilization Across Models Family Retention, Cohort 3			
	FY2014		
	Total N = 6	M (SD)	Min. Max.
Currently receiving services	204	34 (61.02)	2/156
Completed program	0	0	0
Stopped services before completion	7	1.17 (2.04)	0/5
Other	21	3.5 (8.09)	0/20

Participant Characteristics Age Distribution of Adult Program Participants											
	15-17	18-19	20-21	22-24	25-29	30-34	35-44	45-54	55-64	65+	Unknown
Pregnant Women	%* (Min. Max.) 6.3 N = 27 (0/20)	%* (Min. Max.) 10.6 N = 46 (0/50)	%* (Min. Max.) 17.1 N = 74 (0/60)	%* (Min. Max.) 21.3 N = 92 (0/75)	%* (Min. Max.) 27.3 N = 118 (0/85.71)	%* (Min. Max.) 12.3 N = 53 (0/50)	%* (Min. Max.) 4.9 N = 21 (0/16.67)	%* (Min. Max.) .2 N = 1 (0/10)	%* (Min. Max.) 0 N= 0	%* (Min. Max.) 0 N = 0	%* (Min. Max.) 2.9 N = 13 (0/40)
Female Caregivers	%* (Min. Max.) 1.8 N = 14 (0/6.25)	%* (Min. Max.) 5.6 N = 44 (0/20)	%* (Min. Max.) 12.0 N = 95 (0/60)	%* (Min. Max.) 19.6 N =155 (0/43.75)	%* (Min. Max.) 30.3 N = 240 (0/44.44)	%* (Min. Max.) 15.3 N =121 (0/100)	%* (Min. Max.) 11.9 N = 94 (0/33.33)	%* (Min. Max.) 2.0 N = 16 (0/10)	%* (Min. Max.) 1.1 N =9 (0/20)	%* (Min. Max.) .4 N = 3 (0/2.5)	%* (Min. Max.) 6.7 N = 57 (0/50)
Male Caregivers	%* (Min. Max.) .8 N = 1 (0/14.29)	%* (Min. Max.) 4.2 N = 5 (0/25)	%* (Min. Max.) 7.5 N = 9 (0/33.33)	%* (Min. Max.) 16.7 N = 20 (0/100)	%* (Min. Max.) 25.8 N = 31 (0/100)	%* (Min. Max.) 20.0 N = 24 (0/50)	%* (Min. Max.) 13.3 N = 16 (0/25)	%* (Min. Max.) 7.5 N = 9 (0/25)	%* (Min. Max.) 3.3 N =4 (0/25)	%* (Min. Max.) .8 N = 1 (0/16.67)	%* (Min. Max.) 18.4 N = 27 (0/100)

*Note: Min.Max.s are Min.Max. in % to give picture of proportion of participants in certain categories across grantees.

Participant Characteristics Age Distribution of Child Participants				
	Under 1 N =437	1-2 Years N =595	3-5 Years N =279	Unknown N =45
Index Children	% (Min.Max.) 33.33 (0/100)	% (Min.Max.) 45.39 (0/75)	% (Min.Max.) 21.28 (0/50)	% (Min.Max.) 3.32 (0/100)

Participant Characteristics Race of Program Participants							
	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Pacific Islander	White	More than one Category Selected	Unrecorded
Adult Program Participants	% (Min. Max.) 78.3 N = 1021 (49.24/100)	% (Min. Max.) .3 N = 4 (0/6.25)	% (Min. Max.) .7 N = 9 (0/3.8)	% (Min. Max.) .2 N = 3 (0/4)	% (Min. Max.) 10 N = 131 (0/26.47)	% (Min. Max.) 10.4 N = 136 (0/46.7)	% (Min. Max.) 9.5 N = 137 (0/72.83)
Index Children	% (Min. Max.) 84.6 N = 1009 (44.64/100)	% (Min. Max.) .1 N = 1 (0/3.57)	% (Min. Max.) .4 N = 5 (0/3.88)	% (Min. Max.) .2 N = 2 (0/.78)	% (Min. Max.) 4.2 N = 50 (0/12.82)	% (Min. Max.) 10.6 N = 126 (0/52.63)	% (Min. Max.) 12 N = 163 (0/83.06)

Participant Characteristics Ethnicity of Program Participants			
	Hispanic or Latino	Non-Hispanic or Latino	Unrecorded
Adult Program Participants	% (Min.Max.) 7.1 N = 91 (0/100)	% (Min.Max.) 92.9 N = 1190 (0/100)	% (Min.Max.) 11.1 N = 160 (0/100)
Index Children	% (Min.Max.) 7.1 N = 91 (0/100)	% (Min.Max.) 92.9 N = 1190 (0/100)	% (Min.Max.) 11.1 N = 160 (0/100)

Participant Characteristics Marital Status of Adult Program Participants						
	Divorced	Married	Separated	Single, Never Married	Widowed	Unknown/ did not report
Adult Program Participants	% (Min.Max.) 2.99 N = 36 (0/22.22)	% (Min.Max.) 24.9 N = 300 (0/62.5)	% (Min.Max.) 2.24 N = 27 (0/5.88)	% (Min.Max.) 69.79 N = 841 (37.5/100)	% (Min.Max.) .08 N = 1 (0/.62)	% (Min.Max.) 16.38 N = 236 (0/70)

Participant Characteristics Educational Attainment of Adult Program Participants									
	Enrolled in high school	High school eligible, not enrolled	Less than a high school diploma	High school diploma	GED	Some college/ training	Technical training certification of Associate's Degree	Bachelor's Degree or Higher	Unknown/ Did not report
Adult Program Participants	%* (Min. Max.) 4.33 N = 49 (0/50)	%* (Min. Max.) 1.59 N = 18 (0/12.5)	%* (Min. Max.) 20.85 N = 236 (0/50)	%* (Min. Max.) 36.48 N = 413 (0/61.82)	%* (Min. Max.) 8.22 N = 93 (0/33.33)	%* (Min. Max.) 15.81 N = 179 (0/55.56)	%* (Min. Max.) 8.3 N = 94 (0/50)	%* (Min. Max.) 4.42 N = 50 (0/20)	%* (Min. Max.) 21.44 N = 309 (0/74.38)

Participant Characteristics Insurance Status of Program Participants					
	No insurance coverage	Medicaid/SCHIP	TRICARE	Private or other health insurance coverage	Unknown/ Did not report
Adult Program Participants	% (Min.Max.) 18.2 N = 222 (0/87.5)	% (Min.Max.) 68.9 N = 839 (0/100)	% (Min.Max.) 0 N = 0	% (Min.Max.) 12.9 N = 157 (0/80)	% (Min.Max.) 15.5 N = 223 (0/73.75)
Index Children	% (Min.Max.) 10.5 N = 130 (0/100)	% (Min.Max.) 81.8 N = 1014 (0/100)	% (Min.Max.) 0 N = 0	% (Min.Max.) 7.7 N = 95 (0/26.79)	% (Min.Max.) 8.6 N = 117 (0/42.27)

Participant Characteristics Employment and Educational/Training Status of Adult Program Participants							
	Employment Status				Educational/Training Status		
	Employed full time	Employed part time	Not employed	Unknown	Student/ trainee	Not a student/ trainee	Unknown
Adult Program Participants	% (Min.Max.) 26.37 N = 313 (0/51.02)	% (Min.Max.) 14.32 N = 170 (0/29.41)	% (Min.Max.) 59.31 N = 704 (36.73/83.33)	% (Min.Max.) 17.63 N = 254 (0/79.38)	% (Min.Max.) 14.9 N = 163 (0/50)	% (Min.Max.) 85.1 N = 930 (50/100)	% (Min.Max.) 24.1 N = 348 (0/78.13)

Participant Characteristics Household Income Status in Relation to Federal Poverty Guidelines							
	50% and under	51-100%	101-133%	134-250%	251-300%	>300%	Unknown
Households	% (Min. Max.) 42.9 N = 410 (0/100)	% (Min. Max.) 28.1 N = 269 (0/58.54)	% (Min. Max.) 12.2 N = 117 (0/28.57)	% (Min. Max.) 13.1 N = 125 (0/80)	% (Min. Max.) 1.9 N = 18 (0/20)	% (Min. Max.) 1.8 N = 17 (0/14.71)	% (Min. Max.) 27.7 N = 366 (0/100)

Participant Characteristics Primary Language Exposure for Index Children					
	English	Spanish	Tribal languages	Other	Unknown
Index Children	% (Min.Max.) 98.2 N = 1178 (36.36/100)	% (Min.Max.) .3 N = 4 (0/10.53)	% (Min.Max.) 1.4 N = 17 (0/63.64)	% (Min.Max.) 0 N = 0	% (Min.Max.) 11.6 N = 157 (0/90.15)

Program Reach across Priority Populations New Enrollees in Priority Population Categories, Cohort 1								
	Low income	Pregnant women under 21	History of child abuse or neglect	History of substance abuse	Users of tobacco products	Have children with low student achievement	Have children with developmental delay or disabilities	Serving or formerly served in armed forces
2012 New enrollees	% (Min.Max.) 60.3 N = 108 (17.65/100)	% (Min.Max.) 12.8 N = 23 (0/37.5)	% (Min.Max.) 16.2 N = 29 (0/50)	% (Min.Max.) 21.2 N = 38 (0/75)	% (Min.Max.) 17.3 N = 31 (0/50)	% (Min.Max.) 2.2 N = 4 (0/50)	% (Min.Max.) 14.5 N = 26 (0/50)	% (Min.Max.) 1.7 N = 3 (0/25)
2013 New enrollees	% (Min.Max.) 49.2 N = 280 (0/100)	% (Min.Max.) 13.7 N = 78 (0/41.18)	% (Min.Max.) 15.6 N = 89 (0/70.59)	% (Min.Max.) 19.7 N = 112 (0/45.45)	% (Min.Max.) 15.3 N = 87 (0/76.47)	% (Min.Max.) 5.8 N = 33 (0/35.29)	% (Min.Max.) 10.5 N = 60 (0/52.94)	% (Min.Max.) 3.0 N = 17 0/8.82)
2014 New enrollees	% (Min.Max.) 61.3 N = 312 (28.57/100)	% (Min.Max.) 9.2 N = 47 (0/75)	% (Min.Max.) 13.6 N = 69 (0/39.29)	% (Min.Max.) 25 N = 127 (0/68.42)	% (Min.Max.) 16.7 N = 85 (0/56.25)	% (Min.Max.) 8.4 N = 43 (0/36.84)	% (Min.Max.) 6.5 N = 33 (0/17.86)	% (Min.Max.) 2.6 N = 13 (0/5.56)

Program Reach across Priority Populations New Enrollees in Priority Population Categories, Cohort 2								
	Low income	Pregnant women under 21	History of child abuse or neglect	History of substance abuse	Users of tobacco products	Have children with low student achievement	Have children with developmental delay or disabilities	Serving or formerly served in armed forces
2013 New enrollees	% (Min.Max.) 100 N = 20 (100/100)	% (Min.Max.) 25 N = 5 (0/71.43)	% (Min.Max.) 35 N = 7 (14.29/46.15)	% (Min.Max.) 25 N = 5 (23.08/28.57)	% (Min.Max.) 30 N = 6 (14.29/38.46)	% (Min.Max.) 10 N = 2 (0/15.38)	% (Min.Max.) 10 N = 2 (0/15.38)	% (Min.Max.) 0 N = 0
2014 New enrollees	% (Min.Max.) 72.9 N = 151 (33.33/100)	% (Min.Max.) 11.1 N = 23 (0/34.62)	% (Min.Max.) 7.2 N = 15 (0/35)	% (Min.Max.) 29.5 N = 61 (0/55.56)	% (Min.Max.) 13.5 N = 28 (0/55.56)	% (Min.Max.) 1.4 N = 3 (0/11.11)	% (Min.Max.) 2.4 N = 5 (0/15)	% (Min.Max.) 1.4 N = 3 (0/2.17)

DGIS PERFORMANCE MEASUREMENT DATA

Program Performance Domain 1 Percentage of Grantees Demonstrated Improvement in Benchmark Areas, Maternal and Newborn Health		
Construct	Improvement	
	Yes/ N (%)	No/ N (%)
Prenatal Care	10 (77)	3 (23)
Alcohol, Tobacco, and Illicit Drugs	9 (69)	4 (31)
Preconception Care	9 (69)	4 (31)
Inter-Birth Interval	5 (39)	8 (62)
Maternal Depressive Symptoms	10 (77)	3 (23)
Breastfeeding	8 (62)	5 (39)
Well-Child Visits	4 (31)	9 (69)
Maternal and Child Health Insurance Status	6 (46)	7 (54)
Regular Visits to a Primary Healthcare Provider or Medical Home	12 (92)	1 (8)

Program Performance Domain 1 Percentage of Grantees Demonstrated Grantee Defined Improvement	
Construct	Grantee Defined Improvement
	% (Percentage range) (Number of grantees reporting; N)
Early Initiation of Prenatal Care	89.5 (73.08-100) (6 grantees; N = 381)
Screening for Maternal Depressive Symptoms	71 (29.73-100) (12 grantees; N = 469)
Mothers and Children Obtained Maternal and Child Health Insurance by 12 months post enrollment	85.92 (56.25-100) (6 grantees; N = 966)
Regular Visits to a Primary Healthcare Provider or Medical Home for Mother and/or child	40.48 (27.17-100) (8 grantees; N = 914)

Program Performance Domain 2 Percentage of Grantees Demonstrated Improvement in Benchmark Area Child Injuries, Child Abuse, Neglect or Maltreatment		
Construct	Improvement	
	Yes	No
Visits for Children to Emergency Department	7 (54%)	6 (46%)
Visits for Mothers to Emergency Department	5 (39%)	8 (62%)
Information/Training on Prevention of Child Injuries	9 (69%)	4 (31%)
Incidence of Child Injuries	10 (77%)	3 (23%)
Reported Suspected Maltreatment	9 (69%)	4 (31%)
Reported Substantiated Maltreatment	12 (92%)	1 (8%)
First Time Victims of Maltreatment	12 (92%)	1 (8%)

Program Performance Domain 2 Percentage of Grantees Demonstrated Grantee Defined Improvement	
Construct	Grantee Defined Improvement
	% (Percentage range) (Number of grantees reporting; N)
Information/Training on Prevention of Child Injuries	50.05 (5.88-96.43) (13 grantees; N = 949)
Incidence of Child Injuries	3.56 (0-50) (8 grantees; N = 702)
First Time Victims of Maltreatment	9.93 (0-66.67) (12 grantees; N = 745)

Program Performance Domain 3 Percentage of Grantees Demonstrated Improvement in Benchmark Areas, School Readiness and Achievement		
Construct	Improvement	
	Yes	No
Parent Support for Child Learning and Development	7 (54%)	6 (46%)
Parent Knowledge of Child Development	10 (77%)	3 (23%)
Parenting Behaviors/Parent-Child Relationship	9 (69%)	4 (31%)
Parent Emotional Well-Being/Parenting Stress	12 (92%)	1 (8%)
Child Communication, Language, and Emergent Literacy	8 (61%)	5 (39%)
Child Cognitive Skills	8 (62%)	5 (39%)
Child Positive Approaches to Learning	7 (54%)	6 (46%)
Child Social Behavior/Emotional Well-Being	6 (46%)	7 (54%)
Child Physical Health and Development	7 (54%)	6 (46%)

Program Performance Domain 3 Percentage of Grantees Demonstrated Grantee Defined Improvement	
Construct	Grantee Defined Improvement % (Percentage range) (Number of grantees reporting; N)
Child Communication, Language, and Emergent Literacy	55.36 (27.97-96.55) (9 grantees; N = 681)
Child Cognitive Skills	55.49 (27.97-96.55) (9 grantees; N = 692)
Child Positive Approaches to Learning	49.13 (6.25-96.55) (9 grantees; N =743)
Child Social Behavior/Emotional Well-Being	42.53 (16.8-91.49) (9 grantees; N =696)
Child Physical Health and Development	68.06 (32.81-96.55) (7 grantees; N = 695)

Program Performance Domain 4 Percentage of Grantees Demonstrated Improvement in Benchmark Areas, Crime or Domestic Violence		
Construct	Improvement	
	Yes	No
Screening for Domestic Violence	7 (54%)	6 (46%)
Referrals for Domestic Violence Services	9 (69%)	4 (31%)
Domestic Violence – Safety Plan	9 (69%)	4 (31%)
Arrests*	NA	NA
Convictions*	NA	NA

*No grantees selected arrests or convictions as a benchmark performance measure.

Program Performance Domain 4 Percentage of Grantees Demonstrated Grantee Defined Improvement	
Construct	Grantee Defined Improvement % (Percentage range) (Number of grantees reporting; N)
Screening for Domestic Violence	59.32 (30.23-100) (10 grantees; N =617)

Program Performance Domain 5 Percentage of Grantees Demonstrated Improvement in Benchmark Areas, Family Economic Self-Sufficiency		
Construct	Improvement	
	Yes	No
Income and Benefits	9 (69%)	4 (31%)
Employment of Education	8 (62%)	5(39%)
Health Insurance Status	11 (85%)	2 (15%)

Program Performance Domain 5 Percentage of Grantees Demonstrated Grantee defined Improvement	
Construct	Grantee Defined Improvement
	% (range) (# of grantees reporting; N)
Income and Benefits	19.34 (0-79.19%) (5 grantees; N= 305)

Program Performance Domain 6 Percentage of Grantees Demonstrated Improvement in Benchmark Areas, Coordination and Referrals for Other Community Resources & Supports		
Construct	Improvement	
	Yes	No
Identification for Necessary Services	7 (54%)	6 (46%)
Referrals for Necessary Services	10 (77%)	3 (23%)
Receipt of Necessary Services	7 (54%)	6 (46%)
Information Sharing	6 (46%)	7 (54%)
Number of MOUs	12 (92%)	1 (8%)

Program Performance Domain 6 Percentage of Grantees Demonstrated Grantee defined Improvement	
Construct	Grantee Defined Improvement % (Percentage range) (Number of grantees reporting; N)
Identification for Necessary Services	73.65 (8-100) (9 grantees; N =892)
Referrals for Necessary Services	75.5 (4-100) (11 grantees; N = 804)
Receipt of Necessary Services	66.25 (46.15-100) (10 grantees; N = 806)
Number of MOUs	395 (Count: 0-200) (11 grantees; N/A)
Information Sharing	717 (Count: 13-200) (12 grantees; N/A)

Program Performance Overall Percentage of Grantees Demonstrated Improvement Overall
Improvement
Yes= 10 (76.9%)
N = 3 (23.1%)

Program Performance Percentage of Grantees Demonstrated Improvement by Benchmark Area	
Benchmark Area	Improvement (%)
Maternal and Newborn Health	N = 8 (62)
Child Injuries, Child Abuse, ED Visits	N = 11 (85)
School Readiness and Achievement	N = 9 (69)
Crime or Domestic Violence	N = 10 (77)
Family Economic Self-Sufficiency	N = 10 (77)
Coordination and Referrals for Other Community Resources & Supports	N = 9 (69)

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APPENDIX E

SUMMARY OF TRIBAL MIECHV BENCHMARK PERFORMANCE MEASURES

INTRODUCTION AND OVERVIEW

The Tribal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, administered by the Administration for Children and Families (ACF) in collaboration with the Health Resources and Services Administration, aims to improve health and developmental outcomes for mothers and children through implementation of evidence-based home visiting models. Funding requirements stipulate that grantees demonstrate quantifiable and measurable improvements across the following federal benchmark domains:

1. Maternal, newborn, and child health
2. Child injuries; child abuse, neglect, or maltreatment; and emergency department visits
3. School readiness and achievement
4. Crime or domestic violence
5. Family economic self-sufficiency
6. Coordination and referrals for other community resources and supports

To measure and demonstrate performance improvement across the benchmark domains, grantees were required to develop benchmark plans that describe the process to be used in identifying quantifiable, measurable performance measures.

For over two years, Tribal Home Visiting[26] grantees worked with the Administration for Children and Families and members of the Tribal Home Visiting Evaluation

[26] Throughout this document, "Home Visiting" refers specifically to the Maternal, Infant, and Early Childhood Home Visiting Program.

Institute (TEI) to develop strong performance measurement plans. TEI provided intensive individualized technical assistance to ensure that grantees meet federal requirements and the requirements of the home visiting model developers, develop performance measures that are meaningful to programs and communities, and collect data that can be used internally to continuously improve the quality of their home visiting programs.

This summary provides an overview of all 25 approved Tribal Home Visiting Program benchmark plans as of May 1, 2014. Information was gathered from each plan, including the stated performance measure, the type of measure (outcome or process), the data source (client, home visitor, or administrative records), the target population, the tool or measure selected by the grantee, and the measurement period. Information was also collected on the type of comparisons used to demonstrate improvement (individual, cohort, or cross-sectional comparison of data), the direction of improvement needed to determine success, the unit of analysis, and the type of scoring. This summary describes the grantees' benchmark plans across and within constructs. It includes a description of themes within each benchmark domain and a discussion of alignment—or the degree of similarity—of grantee measurement choices within each construct.

SUMMARY ACROSS MEASURES

Home visiting grantees were given the flexibility to develop performance measures that were meaningful to their programs and appropriate for the community context. As a result, across grantees, different indicators were selected to represent each construct and were measured using a variety of tools across a range of time points. While this approach has strengths, allowing for varying dimensions of each construct to be captured, it complicates the ability to summarize grantee performance measures across programs, constructs, and benchmark domains. This section explores the alignment across grantee-developed performance measures. The degree of alignment is an important consideration because it impacts the ability to summarize and draw conclusions from grantee performance measurement results. The information is summarized below.

Summary of Benchmark Domains

Benchmark Domain 1: Maternal, Child, and Newborn Health

- In seven of the nine maternal and newborn health constructs, the majority of grantees chose outcome measures to examine performance.

- In a majority of cases, grantees are collecting maternal and newborn health data through self-report. For example, just one of 25 grantees collects administrative data to track prenatal care, and three grantees (12 percent) rely on administrative data to track well-child visits.
- Grantees use a variety of screening instruments to examine substance use (Construct 1.2) and maternal depression (Construct 1.5). Grantees use seven different screeners for alcohol, tobacco, or other drugs and six maternal depression assessments.

Benchmark Domain 2: Child Injuries; Child Abuse, Neglect, or Maltreatment; and Emergency Department Visits

- With the exception of information/training on prevention of child injuries (Construct 2.3), the vast majority of grantees are using outcome measures to assess program performance related to prevention of childhood injuries and child maltreatment.
- Grantees are using a combination of administrative data and participant self-report to track child maltreatment outcomes. Over half the grantees (56 percent, n=14) are tracking reports of suspected maltreatment with administrative data. Sixty percent (n=15) are tracking substantiated reports and first-time victims of maltreatment through administrative records.

Benchmark Domain 3: School Readiness and Achievement

- A majority of grantees are using outcome measures in three of the four constructs that examine parent knowledge and behavior (Constructs 3.1–3.4). Grantees are collecting these data through a variety of parenting measures, including six unique measures to track parent support of child learning and development (Construct 3.1) and eight different measures to assess parent knowledge of child development (Construct 3.2).
- The majority of grantees are using process measures to assess program performance for all five constructs focused on child behavior and development (Constructs 3.5–3.9).
- The Ages and Stages Questionnaire-3 (ASQ-3) and Ages and Stages Questionnaire: Social and Emotional (ASQ:SE) are the most commonly used developmental screening tools.
- Grantees most commonly track performance by reporting rates of screening, while some track referrals to service providers or discussion of screening results.

Benchmark Domain 4: Crime or Domestic Violence

- Performance measurement guidelines allowed grantees to choose to measure either crime or domestic violence. All 25 grantees chose to assess domestic violence in their benchmark plans.
- All grantees use process measures to track the three domestic violence constructs.
- While all grantees chose to examine screening for domestic violence, programs use a variety of screening instruments. Grantees use seven different domestic violence screening instruments, and five grantees chose to use a nonstandardized measure.

Benchmark Domain 5: Family Economic Self-Sufficiency

- All grantees use outcome measures to assess economic self-sufficiency (Construct 5.1–5.3). In all but one case, this information is provided through participant self-report.
- Grantees chose to measure income and benefits (Construct 5.1) in a variety of ways. Just under half of grantees (48 percent, n=12) use a standardized self-report measure of economic security rather than income. Forty-four percent (n=11) are examining changes in income.
- Grantees chose to examine employment or education (Construct 5.2) in a variety of ways. The largest number of grantees (40 percent, n=10) chose to measure the number of hours spent participating in either educational or employment activities.

Benchmark Domain 6: Coordination and Referrals for Other Community Resources

- All grantees chose to use process measures to examine identification for services, referrals, number of MOUs, and information sharing (Constructs 6.1–6.4), and all grantees chose an outcome measure to examine receipt of services (Construct 6.5).
- Grantees use a variety of approaches for identifying necessary services (Construct 6.1). A majority (60 percent, n=15) screen for a comprehensive array of needs. Other grantees focus on a limited set of needs (16 percent, n=4) or on a single need (24 percent, n=6).
- Grantees are measuring information sharing in a variety of ways. The majority of grantees (84 percent, n=21) are determining whether the home visiting program has a clear point of contact within the partnering agency.

Summary of Benchmark Constructs With the Highest Degree of Similarity

- **Breastfeeding:** Grantees consistently chose to use an outcome measure for this construct. The majority of performance measures capture duration of breastfeeding (84 percent, n=21) rather than initiation of breastfeeding (16 percent, n=4).
- **Well-Child Visits:** All grantees chose to assess this construct with an outcome measure (n=25). The majority of these outcome measures focus on adherence to a recommended well-child visit schedule (88 percent, n=22).
- **Child and Mother Visits to Emergency Department:** All but one grantee (94 percent) are using an outcome measure to capture visits to the emergency department, relying on parent self-report of visits.
- **Information/Training on Prevention of Child Injuries:** All grantees are using a process measure to capture information and training on the prevention of child injuries, with most (92 percent, n=23) focusing on the provision of information about child injuries.
- **Child Injuries:** All grantees are using an outcome measure for child injuries. Most grantees are relying on parent self-report (96 percent, n=24) of injuries.
- **Child Communication, Language, and Emergent Literacy:** Most grantees (92 percent, n=23) are using the ASQ-3 to screen for developmental concerns related to child communication.
- **Child Cognitive Skills:** Most grantees (92 percent, n=23) are using the ASQ-3 to screen for delays related to child cognitive skills.
- **Number of Memoranda of Understanding (MOU) To Increase Coordination of Resources and Referrals:** All grantees are counting the number of MOUs developed between the home visiting program and outside partners.

Summary of Benchmark Constructs With the Highest Degree of Diversity

- **Alcohol, Tobacco, and Illicit Drugs:** Grantees are divided in their use of a process or outcome measure to assess this construct. Fifty two percent (n=13) chose an outcome measure, and the remainder (48 percent, n=12) chose a process measure. Grantees use a variety of tools to screen for substance use. Grantees use seven different measures focused on either a single substance or a combination of alcohol, tobacco, and illicit drugs.
- **Inter-Birth Intervals:** There is considerable variation in the use of a process or outcome measure for this construct. Over half of grantees (56 percent, n=14)

are using a process measure, such as provision of information. Forty-four percent (n=11) are using an outcome measure, including contraception use or pregnancy spacing.

- **Parent Support for Child Learning and Development:** While most grantees chose to use an outcome measure (92 percent, n=23), there is significant variation in the instruments they chose to measure this construct. Grantees selected six different measures.
- **Child Physical Health and Development:** Over half (64 percent, n=16) of grantees are using a process measure to assess child physical health and development. There is significant variation in the defined performance measures.
- **Screening for Domestic Violence:** While all grantees are screening for domestic violence, they are using a wide range of screening tools. Grantees use seven unique screening instruments.

CONSTRUCT-SPECIFIC SUMMARIES

Below is a brief summary of grantee performance measures across the 36 benchmark constructs, including how they aligned across type of measure (process or outcome), focus of performance measure, target population, and tools/measures used.

Benchmark Domain 1: Maternal, Newborn, and Child Health

Construct 1.1: Prenatal Care

- All 25 grantees are using an outcome measure to assess prenatal care among pregnant participants.
- The majority of the performance measures focus on the adequacy of prenatal care (64 percent, n=16), with a minority focused on the onset of prenatal care (32 percent, n=8). One grantee is measuring both adequacy and onset (4 percent).
- Of the 16 grantees that are measuring adequacy, most (88 percent, n=14) are measuring the percentage of recommended prenatal care visits received; two (13 percent) are measuring the completion of visits within a specified timeframe (e.g., receipt of one visit in each trimester).
- Of the eight grantees measuring the onset of prenatal care, half (n=4) are measuring onset during the first trimester and half (n=4) are measuring onset more generally.
- Ninety-six percent (n=24) of grantees are using self-report to capture these data, with the remaining four percent (n=1) using administrative data.

Construct 1.2: Alcohol, Tobacco, and Illicit Drugs

- Over half of grantees (52 percent, n=13) are relying on outcome measures to measure substance use, while 48 percent (n=12) are using process measures. Performance measures focus on the use of tobacco (48 percent, n=12); alcohol (24 percent, n=6); or some combination of alcohol, tobacco and illicit drugs (28 percent, n=7).
- Over half of grantees are using a standardized tool to collect the data. However, there is very little alignment across the standardized tools identified: 16 percent (n=4) are using the Life Skills Progression (LSP); 12 percent (n=3) are using the CAGE; and eight percent (n=2) are using the Alcohol Use Disorders Identification Test (AUDIT). Instruments used by one grantee each include UNCOPE, CRAFFT, Drug Abuse Screening Test (DAST), and Institute for Health and Recovery Integrated Screener (IHRIS).
- A majority (68 percent, n=17) of grantees are assessing all mothers/caregivers enrolled, while a minority (32 percent, n=8) are targeting only pregnant mothers for this performance measure.

Construct 1.3: Preconception Care

- Seventy-six percent (n=19) of grantees are using outcome measures to capture preconception care, while 24 percent (n=6) are using process measures.
- Performance measures focus on postpartum checkups (36 percent, n=9), provision of information on preconception care (24 percent, n=6), routine preventive or well-women exams (16 percent, n=4), folic acid or other vitamin supplement use (8 percent, n=2), contraception use (8 percent, n=2), or report of a medical home (8 percent, n=2).
- More than half (56 percent, n=14) of these performance measures target only postpartum mothers, with the remaining measures targeting all mothers or caregivers enrolled (44 percent, n=11).

Construct 1.4: Inter-Birth Intervals

- Fifty-six percent (n=14) of grantees are using process measures, and 44 percent (n=11) are using outcome measures to assess this construct.
- Of those grantees using a process measure, the majority (86 percent, n=12) are focusing on the provision of information related to birth spacing; two grantees (14 percent) are examining completion of a reproductive life plan.

- Of those using an outcome measure, 64 percent (n=7) are tracking contraception use, 27 percent (n=3) focus on pregnancy spacing, and one grantee is tracking receipt of a postpartum or well-woman exam (9 percent).
- Twenty-eight percent (n=7) of grantees are assessing this construct among postpartum women, whereas 72 percent (n=18) are assessing all mothers/ caregivers.

Construct 1.5: Maternal Depressive Symptoms

- All 25 grantees are relying on process measures to capture screening of maternal depressive symptoms, with 96 percent (n=24) focusing on the rates of screenings and four percent (n=1) on referral rates for those participants screened positive for depressive symptoms.
- Forty percent (n=10) of the performance measures target only postpartum mothers enrolled in the program; 56 percent (n=14) of performance measures target all mothers; and four percent (n=1) target only pregnant mothers.
- The most common tools identified for the screening of depressive symptoms include the Edinburg Postnatal Depression Scale (EPDS) (72 percent, n=18), followed by the Patient Health Questionnaire-9 (PHQ-9) (12 percent, n=3), Patient Health Questionnaire-2 (PHQ-2) (8 percent, n=2), Center for Epidemiologic Studies Depression Scale (CES-D) (8 percent, n=2), the IHRIS (4 percent, n=1), and LSP (4 percent, n=1).

Construct 1.6: Breastfeeding

- All 25 grantees are using outcome measures to assess improvement in breastfeeding.
- While the majority (84 percent, n=21) of performance measures focus on the duration of breastfeeding, there is variation in how duration is operationalized. Most grantees are tracking the average number of weeks mothers spend breastfeeding (48 percent, n=12), while others focus on the duration of breastfeeding at less than two months (8 percent, n=2) and at six months (28 percent, n=7) postpartum.
- In addition to duration, 16 percent (n=4) of grantees are measuring whether mothers initiated breastfeeding at all.

Construct 1.7: Well-Child Visits

- One hundred percent of grantees are measuring well-child visits using an outcome measure (n=25).

- Twenty-two out of 25 grantees (88 percent) are measuring adherence to a recommended well-child visit schedule, while three grantees (12 percent) are measuring immunizations.
- Most grantees (88 percent, n=22) are using self-report to capture well-child visits, while a minority (12 percent, n=3) are using administrative data (e.g., electronic health records).

Construct 1.8: Regular Visits to a Primary Healthcare Provider or Medical Home

- All 25 grantees are using an outcome measure to assess this construct.
- Seventy-six percent (n=19) are tracking visits to a primary care provider, 20 percent (n=5) are assessing report of a medical home, and four percent (n=1) are tracking postpartum care.
- Forty-eight percent of grantees (n=12) are targeting the mother and child, 40 percent (n=10) are targeting all mothers/caregivers, eight percent (n=2) are focusing on the child alone, and four percent (n=1) are targeting only postpartum mothers.

Construct 1.9: Maternal and Child Health Insurance Status

- Grantees are predominantly using outcome measures to assess improvement in maternal and child health insurance status (92 percent outcome, n=23; 8 percent process, n=2).
- All grantees using process measures are tracking referrals made by home visitors to insurance providers (8 percent, n=2).
- Of those using outcome performance measures, most focus on the health insurance status of both the mother and child (86 percent, n=20), with a few tracking the status of the mother only, the child only, or the number of months insured (for each, 4 percent, n=1).

Benchmark Domain 2: Child Injuries; Child Abuse, Neglect, or Maltreatment; and Emergency Room Visits

Construct 2.1: Visits for Children to Emergency Department

- All but one grantee (96 percent, n=24) is relying on outcome measures to assess improvement in visits for children to the emergency department (ED).
- Measures focus on the number of children with visits to the ED (48 percent, n=12) or the incidents/number of visits to the ED (44 percent, n=11), demonstration of knowledge through pre/posttests (4 percent, n=1), or

provision of information about when to seek treatment for a child in the ED (4 percent, n=1).

- Only one grantee (4 percent) is using administrative data for this construct. Others are using self-report (88 percent, n=22) or program documentation (8 percent, n=2).

Construct 2.2: Visits for Mothers to Emergency Department

- All but one grantee (96 percent, n=24) is using outcome measures to assess visits for mothers to the ED.
- Measures focus on the number of mothers with visits to the ED (56 percent, n=14), incidents/number of visits to the ED (40 percent, n=10), or provision of information about when to seek treatment in the ED (4 percent, n=1).
- Most grantees are collecting data via self-report through interview questions and program forms (96 percent, n=24). Only one grantee is using administrative data (i.e., hospital or health records).
- All but one grantee (96 percent) are targeting all mothers/caregivers; the remaining grantee is targeting only pregnant mothers (4 percent).

Construct 2.3: Information/Training on Prevention of Child Injuries

- All 25 grantees are using process measures to track the provision of information and training on the prevention of child injuries through program documentation.
- The vast majority of measures focus on the provision of information about the prevention of child injuries (92 percent, n=23). Two grantees (8 percent) are focusing on the completion of a home safety checklist with families.

Construct 2.4: Child Injuries

- All 25 grantees are using an outcome measure to capture child injuries.
- The measures focus on the number of children with injuries (72 percent, n=18) and the number of incidents of injuries (26 percent, n=7).
- Most grantees are collecting data via parent self-report (96 percent, n=24). One grantee is using administrative data (health records) (4 percent).

Construct 2.5: Reported Suspected Maltreatment

- All 25 grantees are relying on outcome measures for reports of suspected child maltreatment.
- The measures focus on the number of children with reports of suspected maltreatment (76 percent, n=19) and the number of reports of suspected

maltreatment (24 percent, n=6). Over half of the grantees (56 percent, n=14) are receiving administrative data from the child welfare agency. Ten grantees (40 percent) are relying on parent self-report, and one grantee is using program documentation (4 percent).

Construct 2.6: Reported Substantiated Maltreatment

- All 25 grantees are using an outcome measure to track substantiated reports of child maltreatment.
- The measures focus on the number of children with substantiated reports of maltreatment (80 percent, n=20) and the number of substantiated reports of maltreatment (20 percent, n=5).
- Sixty percent of grantees are using administrative data from the child welfare agency (n=15), and 40 percent are relying on parent self-report (n=10).

Construct 2.7: First-Time Victims of Maltreatment

- All 25 grantees are using an outcome measure to assess first-time victims of child maltreatment.
- All grantees are focusing on the number of children who are first-time victims of child maltreatment.
- Sixty percent of grantees are collecting administrative data from the child welfare agency (n=15), and 40 percent are relying on parent self-report (n=10).

Benchmark Domain 3: School Readiness and Achievement

Construct 3.1: Parent Support for Child Learning and Development

- Ninety-two percent (n=23) of grantees are using outcome measures to track performance in parent support for child learning and development. Eight percent (n=2) are using a process measure.
- Grantees are using an array of instruments, with the most common instrument selected for this construct being the Home Observation for the Measurement of the Environment (HOME) (28 percent, n=7). Other instruments selected include the Life Skills Progression (LSP) (12 percent, n=3), Parenting Interactions with Children Checklist of Observations Linked to Outcomes (PICCOLO) (12 percent, n=3), University of Idaho Survey of Parenting Practices (UISPP) (12 percent, n=3), Ages and Stages Questionnaire-3 (ASQ-3) (8 percent, n=2), and Keys to Interactive Parenting Scale (KIPS) (8 percent, n=2).

Construct 3.2: Parent Knowledge of Child Development

- Seventy-two percent (n=18) of grantees are using outcome measures to asses parent knowledge of child development. Twenty-eight percent (n=7) are using process measures.
- The instrument chosen most frequently was the ASQ-3 (24 percent, n=6), followed by the HOME (20 percent, n=5). Other instruments selected include the Family Spirit Knowledge Assessment (12 percent, n=3), KIPS (8 percent, n=2), LSP (8 percent, n=2), and UISPP (8 percent, n=2). An additional three instruments have been selected by one grantee each.
- All grantees selecting process performance measures focused on the provision of information about the child's developmental progress (i.e., home visitor reviewing the results of the ASQ-3 with the parent) (28 percent, n=7).

Construct 3.3: Parenting Behaviors/Parent-Child Relationship

- Most grantees (88 percent, n=22) are using outcome measures to assess improvement in parenting behaviors or the parent–child relationship. Twelve percent (n=3) are using process measures.
- Grantees are using a variety of instruments including the HOME (24 percent, n=6), KIPS (12 percent, n=3), LSP (12 percent, n=3), PICCOLO (16 percent, n=3), and UISPP (12 percent, n=3). An additional six measures have been selected by one grantee each.
- Grantees selected the following process measures: discussion of developmental screening results (4 percent, n=1), completion of parental stress assessment (4 percent, n=1), and participation in group sessions focused on parent–child attachment (4 percent, n=1).

Construct 3.4: Parent Emotional Well-Being/Parenting Stress

- Over half (52 percent, n=13) of the 25 grantees are using process measures to assess parent emotional well-being or parenting stress.
- Thirty-two percent (n=8) are measuring the percentages that were screened for depression, and 24 percent are measuring the level of depression (n=6). Twenty percent (n=5) are tracking the percentage that completed assessments of parenting stress, and 16 percent (n=4) are measuring the level of parental stress. One grantee (4 percent) is tracking referrals made to mental health providers.
- A wide variety of tools are being used to assess this construct, including the Edinburg Postnatal Depression Scale (EPDS) (48 percent, n=12), the Parenting Stress Index (20 percent, n=5), the Patient Health Questionnaire (20 percent,

n=5), the Protective Factors Survey (8 percent, n=2), the LSP (4 percent, n=1), and the Parental Stress Scale (4 percent, n=1).[27]

- Twenty-eight percent (n=7) of grantees are assessing parent emotional well-being or parenting stress for postpartum women only, whereas 72 percent (18) are assessing the construct for all mothers or caregivers.

Construct 3.5: Child Communication, Language, and Emergent Literacy

- Seventy-two percent (n=18) of grantees are using process measures to assess child communication, language, and emergent literacy, and 28 percent (n=7) are using outcome measures.
- Ninety-two percent (n=23) chose to use the ASQ-3; one grantee selected the Survey of Wellbeing in Young Children (SWYC) (4 percent); and one selected the Newborn Behavioral Observation instrument (NBO) (4 percent).
- Of the grantees using a process measure, 89 percent (n=16) are tracking developmental screenings, four percent (n=1) are tracking referrals, and four percent (n=1) are tracking whether the results of the developmental screening were discussed.

Construct 3.6: Child Cognitive Skills

- Of the 25 grantees, 72 percent (n=18) are using process measures to assess child cognitive skills and 28 percent (n=7) are using outcome measures.
- Ninety-two percent (n=23) chose to use the ASQ-3; one grantee selected the SWYC (4 percent); and one selected the NBO (4 percent).
- Of the grantees using process measures, 89 percent (n=16) are tracking developmental screenings, four percent (n=1) are tracking referrals, and four percent (n=1) are tracking whether the results of the developmental screening were discussed.

Construct 3.7: Child Positive Approaches to Learning

- To assess improvement in positive approaches to learning among children, 68 percent of grantees are using process measures (n=17) and 32 percent (n=8) are using outcome measures.
- Sixty-four percent are tracking screening for developmental delay (n=16), 32 percent (n=8) are measuring developmental outcomes, and one grantee is tracking referrals (4 percent).

[27] Some grantees used more than one instrument, so the total exceeds 100 percent.

- Among tools selected by grantees to measure this construct, 88 percent chose the ASQ-3 (n=22). The following measures were selected by one grantee each: Ages and Stages Questionnaire: Social-Emotional (ASQ-SE) (4 percent), the NBO (4 percent), and the SafeCare Infant Planned Activities Training (4 percent).

Construct 3.8: Child Social Behavior/Emotional Well-Being

- Most grantees (80 percent, n=20) are using process measures to assess child social behavior/emotional well-being; the remaining five grantees (20 percent) are using outcome measures.
- Of those using process measures 18 out of 20 (90 percent) are examining screening rates; the remaining two grantees (10 percent) are tracking referrals.
- The most common tool used to assess child social behavior/emotional well-being is the ASQ-SE (60 percent, n=15). The ASQ-3 was the second most commonly selected tool, with 28 percent of grantees (n=7) selecting this tool. The following tools were selected by one grantee (4 percent) each: NBO, Child Behavior Checklist, and Baby Pediatric Symptoms Checklist/Preschool Pediatric Symptom Checklist.

Construct 3.9: Child Physical Health and Development

- Of the 25 grantees, 64 percent (n=16) are using process measures to assess child physical health and development, and 36 percent (n=9) are using outcome measures.
- There is a wide range of performance measures for this construct. Of those using a process measure, grantees are measuring screenings for gross and fine motor development using the ASQ-3 (81 percent, n=13); more general assessments of health and physical development (13 percent, n=2); screenings for height, weight, and head circumference (13 percent, n=2); and receipt of intervention services (4 percent, n=1).
- Of those using an outcome measure, three grantees (33 percent) are measuring general health and physical development; three grantees (33 percent) are tracking height, weight, and head circumference; and one grantee (11 percent) is tracking immunizations.
- Fifteen grantees (60 percent) are using the ASQ-3. The following instruments are used by one grantee (4 percent) each: NBO, SWYC, PAT Health Record, and Infant Health Form. The remaining grantees (24 percent, n=6) are not using a standardized measure.

Benchmark Domain 4: Crime or Domestic Violence

Construct 4.1: Screening for Domestic Violence

- All 25 grantees chose to report on the domestic violence constructs (screenings, referrals, and safety plans) rather than crime (arrests and convictions).
- One hundred percent of grantees are using process measures, capturing screening for domestic violence.
- Most of the process measures track the number of women screened for domestic violence (92 percent, n=23). Eight percent are tracking the number of screenings conducted (n=2).
- Grantees are using a wide range of tools to screen for domestic violence: 28 percent (n=7) are using the Women's Experience with Battering instrument (WEB); 28 percent (n=7) are using the Adult Abuse Screener (AAS); 12 percent (n=3) are using the Nurse Family Partnership Relationship Assessment Form; eight percent (n=2) are using the Woman Abuse Screening Tool (WAST); four percent (n=1) are using the Domestic Violence Ended instrument; four percent (n=1) are using the IHR Integrated Screening Tool; and four percent (n=1) are using the DV/IPV Questionnaire. Five grantees (20 percent) are using a program form or a nonstandardized instrument.

Construct 4.2: Referrals for Domestic Violence Services

- All 25 grantees are relying on process measures to assess improvement in referrals for domestic violence services for those participants who screen positive for domestic violence.
- Eighty-eight percent of grantees (n=22) are reporting on the percentage of participants referred for domestic violence services, while 12 percent (n=3) are reporting on the number of referrals made.

Construct 4.3: Domestic Violence Safety Plan

- All 25 grantees are using process measures to track the completion of domestic violence safety plans created for those participants who screen positive for domestic violence.
- Eighty-eight percent of grantees (n=22) are reporting on the percentage of participants with safety plans, while 12 percent (n=3) are reporting on the number of safety plans completed.

Benchmark Domain 5: Family Economic Self-Sufficiency

Construct 5.1: Income and Benefits

- All 25 grantees are using an outcome performance measure, relying on participant self-report.
- Half of grantees (48 percent, n=12) are using a self-report measure of economic security as a proxy for income. Forty-four percent (n=11) are measuring income: 12 percent (n=3) from all sources of income and 32 percent (n=8) from income and benefits alone.
- Two grantees (8 percent) are capturing receipt of concrete supports.
- Grantees are assessing household/family members (48 percent, n=12), mothers/caregivers (48 percent, n=12), or pregnant women only (4 percent, n=1).

Construct 5.2: Employment or Education

- One hundred percent (n=25) of grantees are using outcome measures, relying on participant self-report.
- Grantees are using a wide variety of performance measures for this construct. Fifty-six percent (n=14) are tracking employment and education combined, 28 percent (n=7) are measuring education, and 16 percent (n=4) are tracking employment alone.
- Performance measures focusing on employment and education combined are measuring the total number of hours spent working, in job training, or educational activities (40 percent, n=10) and the number of enrollees participating in employment or educational activities (16 percent, n=4).
- Performance measures that assess education alone measure attainment of a diploma, GED, or certification (20 percent, n=5) and participation in educational activities (8 percent, n=2).
- Performance measures capturing employment alone assess paid hours worked (12 percent, n=3) and employment status (4 percent, n=1).
- Grantees are targeting household/family members (40 percent, n=10), mothers/caregivers (25 percent, n=14), or pregnant women only (4 percent, n=1).

Construct 5.3: Health Insurance Status

- All 25 grantees are assessing health insurance status using an outcome measure, primarily through participant self-report (96 percent, n=1).
- Most grantees are assessing health insurance status of mothers and children (80 percent, n=20), followed by household status (8 percent, n=2), child's status (8 percent, n=2), and the status of the mother alone (4 percent, n=1).

Benchmark Domain 6: Coordination and Referrals for Other Community Resources and Supports

Construct 6.1: Identification for Necessary Services

- All grantees are using process measures for identification of necessary services.
- Sixty percent (n=15) of grantees are focusing on comprehensive screening of needs, 24 percent (n=6) on screening for a single need, and 16 percent (n=4) on screening for a limited set of needs (e.g., domestic violence, maternal depression, developmental delay).
- Forty eight percent (n=12) of grantees are assessing multiple family or household members. The same number of grantees (n=12) is focusing on the mother or caregiver, and four percent (n=1) are focused on screening of children.

Construct 6.2: Referrals for Necessary Services

- All grantees are using process measures, with program documentation providing information on rates of service referrals.
- Eighty-four percent (n=21) are tracking the number of families referred, and 16 percent (n=4) are tracking the number of individual referrals made.

Construct 6.3: Number of MOUs

- All 25 grantees chose to report on a process measure for the number of MOUs with community agencies, and all are reporting a simple count of MOUs at two time points.

Construct 6.4: Information Sharing

- All 25 grantees are using process measures to report on information sharing with community agencies, with 24 of 25 grantees (96 percent) reporting a simple count and one grantee (4 percent) reporting a percentage.
- The majority of grantees proposed having a clear point of contact in another agency (84 percent, n=21) as the indicator for this construct. Other indicators for this construct include agencies with which the grantee shares information (4 percent, n=1), collaborative meetings (4 percent, n=1), agencies with which the client has authorized release and exchange of information (4 percent, n=1), and agencies that receive referrals from home visitors (4 percent, n=1).

Construct 6.5: Receipt of Necessary Services

- All 25 grantees are measuring completion of referrals to external service providers, which is defined as an outcome measure.
- Sixty percent (n=15) of grantees are assessing the number of completed referrals, while 40 percent (n=10) are assessing the number of families who received necessary services.

Definitions of Key Terms[28]

Term	Definition
Benchmark	An indicator used to track quantifiable improvement. Benchmarks may also be called measures or performance measures.
Construct	The concept to be measured. In the case of Tribal MIECHV, the 36 benchmark constructs were predetermined.
Benchmark domain	Each benchmark construct is grouped into six benchmark areas: (1) improvements in 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 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.
Process measure	Process measures capture program services and activities, programmatic policies, and procedures implemented.
Outcome measure	Outcome measures track change at the individual child, family, and system level. Outcome data are often collected to assess improvements or changes in participant knowledge, attitudes, skills, or behaviors.
Alignment	The degree of similarity between grantee benchmark measures.

[28] Key term definitions draw from (1) U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child care (2014). *Tribal Maternal, Infant, and Early Childhood Home Visiting Program Guidance for Submitting a Needs Assessment and Plan for Responding to Identified Needs*; and (2) U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning Research and Evaluation (2011). *Design Options for Home Visiting Measurement Brief: Selecting Data Collection Measures for MIECHV Benchmarks.* http://www.mdrc.org/sites/default/files/img/DOHVE%20Measurement%20Brief.pdf.

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