TRIBAL
HOME
VISITING

TRIBAL MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING:

A REPORT TO CONGRESS

OPRE Report #2015-88
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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

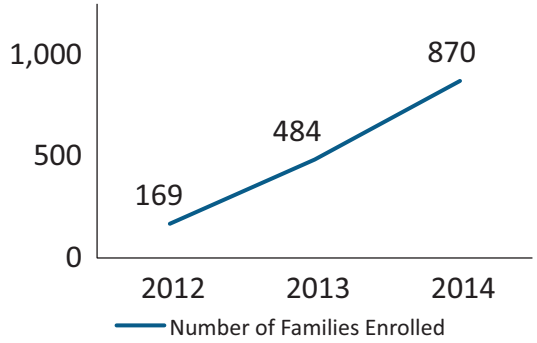
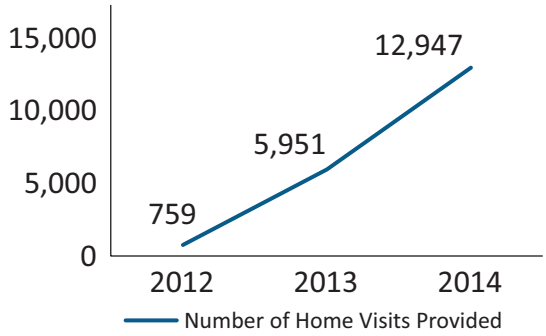


Figure 1-2. Growth in Home Visits



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.

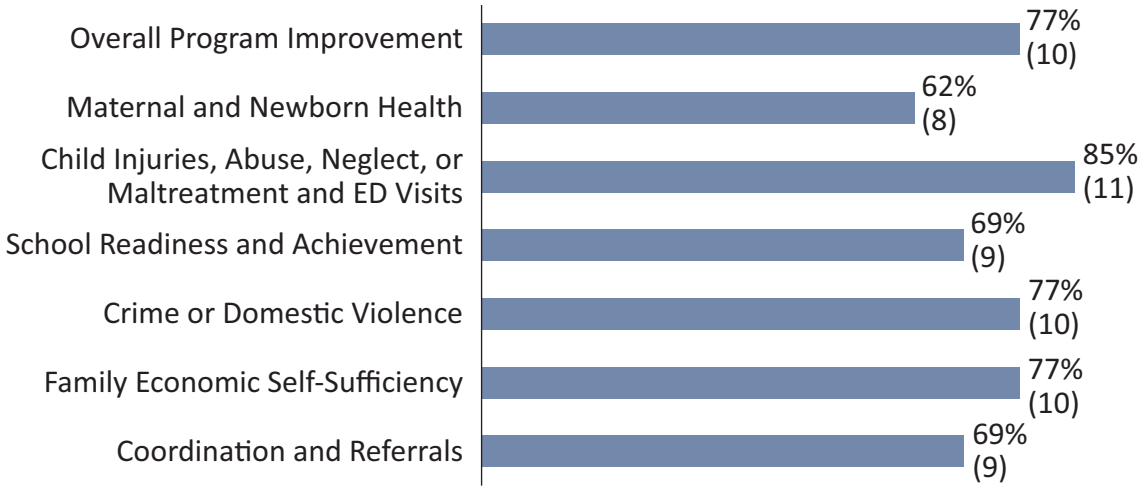
The evidence base for home visiting services with AIAN populations is being expanded and strengthened. Rigorous, locally designed evaluations are currently being implemented and will expand and strengthen the limited evidence base on the use of home visiting with AIAN populations. Given the known intergenerational

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.

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