MUSE

REPORT | March 2024

Understanding Planning for Tribal Home Visiting Implementation

A Report From the Multi-Site Implementation Evaluation of Tribal Home Visiting

OPRE Report 2024-030

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A Note on Terminology

This report uses "Indigenous" and "Native" interchangeably to refer to peoples whose connections to place, modes of governance, and knowledge predate the colonialization of what is now the United States. This report also uses "Tribal" at times to remain consistent with federal guidance and program language used to describe Tribal Maternal, Infant, and Early Childhood Home Visiting (Tribal MIECHV). We use these terms to describe diverse peoples and populations collectively, primarily to protect the anonymity of project partners. We acknowledge that these terms are rooted in settler colonial language and may not be preferred across partner communities. If it were not for our concerns for partner privacy and data confidentiality, we would use specific nation, community, or band names as well as other names people use themselves.

This report benefits from and makes numerous references to "Indigenous knowledge." We follow Anishinaabe scholar Deborah McGregor's (2004, p. 391) understanding of Indigenous knowledge as "something one does, rather than simply something one knows." In this report, authors approach Indigenous thought and experience as rooted in and activated by place and practice rather than as a delimited or definable body of knowledge. Further, it may be more appropriate to think of Indigenous knowledge as plural, or as Indigenous knowledges. The authors of this report view Indigenous knowledge not as counter or opposed to settler colonial knowledge (e.g., Western science) but rather as co-occurring and at times coproduced.

In the data used for this report, "culture" was used in myriad ways to reference countless concepts related to knowledge, heritage, identity, practice, language, place, and much more. Therefore, in this report, we use the term "culture" as it was used in the data analyzed in this report, without providing a specific definition. It is important to note that in our use, culture is fluid, dynamic, and unbounded, meaning that people and places are not constrained to a certain "culture" and can mobilize or inhabit various cultural beliefs and practices simultaneously and sometimes in contradictory ways.

Finally, this report treats colonialism, and specifically the colonization of Indigenous Peoples in the United States, as ongoing under the condition of settler colonialism. In settler states, colonizers (settlers) have settled permanently in Indigenous territories creating what historian Patrick Wolfe (2006) describes as a structure of relations founded on a logic of eliminating Indigenous Peoples. But, in the context of settler colonialism, this report highlights Indigenous

"survivance," a concept developed by Anishinaabe writer Gerald Vizenor (1998, p. 15) to emphasize the continued presence of Native people as "more than survival." Survivance, in other words, draws attention to forms of Native presence—values, relations, and knowledge—that are neither wholly a response to nor determined by settler colonialism.

As we have crafted this approach to the terminology we use, we have benefited greatly from the guidance provided in the following resources:

- *Indigenous Evaluation Toolkit* produced by Seven Directions, A Center for Indigenous Public Health at University of Washington (Eakins et al., 2023)
- *Elements of Indigenous Style* by the late Opaskwayak Cree scholar Gregory Younging (2018)
- *Terminology style guide* produced by the Native-led nonprofit organization Native Governance Center (n.d.)

Glossary

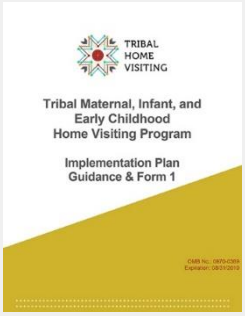
- **American Indian/Alaska Native (AI/AN)** is a term commonly used in federal law and public health contexts to refer to Indigenous people in the United States. This report acknowledges that this term is based in settler colonial language and was not chosen by Indigenous communities.
- **Elder** refers to a significant figure in many Indigenous communities. Specifically, Elder designates the social status attributed to a person who carries knowledge about cultural norms and values. This report capitalizes Elder throughout the text, apart from direct quotations, and acknowledges that capitalizing Elder may not be preferred across all Indigenous communities.
- **Equity,** in this report, describes practices that strive to remove systemic and avoidable disparities in health and well-being. Equitable practices acknowledge that people's life circumstances are shaped by inequitable social systems and require different (at times "unequal") approaches to achieving equal and desired life outcomes. This report defines equity with guidance from The Milken Institute School of Public Health at The George Washington University (2020).
- **Implementation science** can be defined as "the study of methods to promote the systematic uptake of research findings and other evidence-based practices [EBPs] into routine practice" (Eccles & Mittman, 2006, para. 2). As distinct from clinical research, implementation science tends to focus on "rates and quality of use of EBPs rather than their effects" (Bauer et al., 2015, "Discussion," p. 2).
- **Indigenous,** in this report, refers to people with ancestral and cultural origins in the territories that make up what is now the United States. The term "Indigenous" encompasses, but is not limited to, American Indians and Alaska Natives. Capitalizing Indigenous distinguishes it from the lowercase "indigenous," which is sometimes used to refer to things originating or growing in a place (e.g., a plant indigenous to a particular region).
- **Inequity** refers to "policies and practices that create an unequal distribution of money, power, and resources among communities based on race, gender, class, place and other factors" (American Public Health Association, 2022, para. 1). Inequities, including those related to health, may be so "deeply embedded in the fabric of society" that they are taken for granted as naturally occurring (Baciu et al., 2017, p. 102).
- **Native**, capitalized, refers to Indigenous people from distinct Indigenous Nations and should not be confused with its broader meaning of "local inhabitant."

- **Rigor** refers, in this report, to evaluative practices that enhance the usefulness of findings by furthering confidence in their validity. Rigor may look different depending on the context of evaluation, including across Indigenous and non-Indigenous communities, institutions, and cultures (Tribal Evaluation Workgroup, 2013). Rigor can also be used to specify generalizability, or the broad application of findings across populations, settings, or circumstances (Administration for Children and Families, 2021).
- **Trauma-informed care**, in this report, refers to the Substance Abuse and Mental Health Services Administration's 2014 definition, "a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper et al., 2010, p. 82).
- **Tribal** is used as a descriptor of Indigenous or Native peoples to be consistent with language used by the Tribal MIECHV program. This report capitalizes Tribal throughout the text, apart from direct quotations, and acknowledges that capitalizing Tribal may not be preferred across all Indigenous communities.
- **Tribal MIECHV programs** are home visiting programs funded by the Administration for Children and Families through Tribal Maternal, Infant, and Early Childhood Home Visiting (MIECHV).
- **Tribal sovereignty** describes what Chickasaw scholar Amanda Cobb (2005, p. 118) calls the inherent power of a Native Nation to "self-govern, to determine its own way of life, and to live that life…free from interference."

Definitions of Terms Used in Tribal MIECHV

The definitions here are direct quotes from the Implementation Plan Guidance (document provided in appendix A) that was provided by the Administration for Children and Families (ACF) to Tribal MIECHV programs as a guide to the development of the implementation plans.

Implementation Plan Guidance



Throughout the report, we use this text box, with a gold stripe at the top, to indicate that the material contained within is a direct quote from the Implementation Plan Guidance.

"**Adaptations.** For the purposes of the Tribal MIECHV program, an acceptable adaptation of an evidence-based model or promising approach includes changes to the model that have not Been tested with rigorous impact research and are determined by the model developer to alter core components related to program impacts, are aligned with Tribal MIECHV program requirements, and are agreed to by the model developer and ACF in partnership with the grantee." (Implementation Plan Guidance, p. 40)

"**Enhancements.** For the purposes of the Tribal MIECHV program, an acceptable enhancement of an evidence-based model or promising approach includes changes or additions to the model that have not been tested with rigorous impact research but are determined by the model developer not to alter the core components related to program impacts, are aligned with Tribal MIECHV program requirements, and are agreed to by the model developer and ACF in partnership with the grantee." (Implementation Plan Guidance, p. 43)

"**Evidence-based home visiting models.** For the purposes of the Tribal MIECHV program, the term evidence-based home visiting model is used to describe both models that meet the U.S. Department of Health and Human Services criteria for evidence of effectiveness in tribal communities and models that are considered promising approaches." (Implementation Plan Guidance, p. 43)

"**Supplements.** For the purposes of the Tribal MIECHV program, an acceptable supplement to an evidence-based model or promising approach is the addition of a supportive or complementary curriculum or strategy to an evidence-based home visiting model. The supplement may or may not have been tested with rigorous impact research but must be determined by the model developer not to alter the core components related to program impacts, aligned with Tribal MIECHV program requirements, and agreed to by the model developer and ACF in partnership with the grantee." (Implementation Plan Guidance, p. 46)

Acronyms

- **AI/AN:** American Indian/Alaska Native
- **FPO:** Federal Program Officer
- **MIECHV:** Maternal, Infant, and Early Childhood Home Visiting
- **TA:** Technical assistance
- **TWG:** Technical Workgroup

Acknowledgments

First and foremost, the MUSE team would like to recognize our 17 MUSE study partners. This study would not be possible without their partnership. The ongoing investments of our study partners have made MUSE more rigorous, more impactful, and much more fun. We thank our partners for their curiosity, their invaluable input, and the grace with which they handled study setbacks as we went through the pandemic. This report benefits immeasurably from the inspired and diligent efforts that Tribal MIECHV program staff put into their implementation plans. We are grateful they shared them for analysis. Although we cannot recognize these partners by name, their work and words are the soul of this report.

We also would like to acknowledge our federal partners, Aleta Meyer and Nicole Denmark from the Office of Planning, Research, and Evaluation, for their ongoing guidance. Their reviews refined the focus of the analysis and enhanced the clarity of this report. Additionally, the MUSE team is grateful for the feedback and support we have received from the MIECHV Tribal Home Visiting program team at the Administration for Children and Families (ACF), including Moushumi Beltangady, Carrie Peake, and Farha Marfani. We thank them for sharing their deep institutional memory and for their commitment to ensuring the report accurately reflects the complex work of Tribal MIECHV programs. Finally, we are grateful to Shirley Adelstein (ACF), Alicia Heim (Health Resources and Service Administration) and Kerry Cassidy Norton (Health Resources and Service Administration), whose reviews increased the resonance of this report to a broader audience.

The report has been improved by ongoing support from the James Bell Associates Communications Department, specifically the patient guidance of Doreen Major Ryan and the visual expertise and creativity of Kristine Neurauter.

We would also like to thank all members of the MUSE Technical Workgroup for reviewing analysis plans relevant to this report. Finally, we are grateful to the members of the MUSE Dissemination Committee for reviewing and approving this report for dissemination. Your efforts are critical to meeting the study's principle to honor data sovereignty.

Overview

Introduction

Although home visiting has a strong evidence base that demonstrates impacts generally, less is known about home visiting model implementation and effectiveness in Indigenous communities. Tribal Maternal, Infant, and Early Childhood Home Visiting's (Tribal MIECHV) emphasis on expanding the evidence base is critical because most home visiting models that meet the U.S. Department of Health and Human Services (HHS) criteria[1] for evidence of effectiveness were not created or tested with Indigenous communities. As part of the larger shift to evidence-based policymaking at the federal level, it is important to better understand program implementation in settings that have not been the focus of effectiveness studies. One aim of the Multi-Site Implementation Evaluation of Tribal Home Visiting (MUSE) was to examine how Tribal MIECHV programs planned for implementation when evidence of effectiveness for home visiting models was insufficient or absent or lacked relevance for the context.

Primary Research Questions

This report addresses the first of MUSE's three aims:

1. Identify and describe primary influences shaping Tribal MIECHV program planning.
2. Identify and describe how Tribal MIECHV programs are being implemented.
3. Explore supports and challenges to home visiting implementation in Tribal communities.

Purpose

This report describes how Tribal MIECHV programs were planned and what influenced the planning process. It also offers general findings and recommendations for using evidence-based policy meaningfully and ethically in Indigenous communities.

[1] To meet HHS criteria for an evidence-based early childhood home visiting service delivery model, models must meet at least one of the following criteria: (1) at least one high- or moderate-rated impact study of the model finds favorable (statistically significant) impacts in two or more of the eight outcome domains or (2) at least two high- or moderate-rated impact studies of the model (using nonoverlapping analytic study samples) find one or more favorable (statistically significant) impacts in the same domain (U.S. Department of Health and Human Services, n.d.-a).

General Findings

- Tribal MIECHV programs planned to use equity-focused Indigenous practices to support child and community well-being through home visiting.
- Programs built on Implementation Plan Guidance and model guidance to plan their home visiting programs.
- Additional and augmented implementation approaches and concepts may be required to adequately support evidence-based program implementation in Native communities.

This report offers further refined findings by chapter as well as detailed recommendations based on these findings related to Tribal MIECHV implementation support; implementation research; and home visiting research, practice, and policymaking.

Methods

MUSE is a mixed-methods study that integrates quantitative and qualitative methodologies to examine how Tribal MIECHV programs operate in diverse contexts. Through a community-engaged approach, MUSE partnered with Tribal MIECHV programs to design and carry out a study that will return meaningful findings to partnering communities and to the Administration for Children and Families (ACF). This report addresses Aim 1 of MUSE and provides findings generated through content analysis of 17 Tribal MIECHV program implementation plans written in 2016–2017.

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Executive Summary

Report at a Glance

This report describes how Tribal MIECHV programs were planned and what influenced the planning process. Report findings, generated through analysis of Tribal MIECHV implementation plans (2017), enhance understanding of the impacts of evidence-based policy on Tribal MIECHV program planning. The report also offers recommendations for using evidence-based policy meaningfully and ethically in Indigenous communities.

Home visiting programs support expectant families and families with young children. Those programs that are federally funded seek to influence outcomes across various domains, including maternal and child health, child development and school readiness, and positive parenting practices (U.S. Department of Health and Human Services [HHS], n.d.-b). Although home visiting has a strong evidence base that demonstrates impacts generally, less is known about model implementation and effectiveness in Indigenous communities. This report analyzes Tribal Maternal, Infant, and Early Childhood Home Visiting (Tribal MIECHV) programs' implementation plans from 2016 to 2017 to better understand how programs planned for implementation when evidence of effectiveness for home visiting models was insufficient or absent or lacked relevance for the context.

Tribal MIECHV Program

Through the Tribal MIECHV program, the Administration for Children and Families (ACF) provides funding to develop, implement, and evaluate home visiting programs in American Indian/Alaska Native (AI/AN) communities. Funds are awarded to Tribes, consortia of Tribes, Tribal organizations, and urban Indian organizations. The program was designed to support Tribes and Tribal organizations in promoting the health and well-being of AI/AN families through evidence-based home visiting; expand the evidence base on home visiting in AI/AN communities; and contribute to coordinated, comprehensive early childhood systems.

Effectively expanding the evidence base on home visiting in AI/AN communities requires recognition that Indigenous communities in the United States are politically, culturally, and geographically diverse. There are 574 federally recognized Tribes in the United States (U.S. Department of the Interior, n.d.) that represent an array of cultures, traditions, world views, and modes of governance (Sarche & Spicer, 2008; Tribal Evaluation Workgroup, 2013). AI/AN communities are also geographically diverse. Tribal MIECHV programs reflect this diversity and span 13 states serving 11 rural, 5 urban, and 7 mixed communities (Administration for Children and Families, 2021).

Tribal MIECHV's emphasis on expanding the evidence base is critical because most home visiting models that meet the HHS criteria[2] were not created or tested with Indigenous communities. As part of the larger shift to evidence-based policymaking at the federal level, it is important to better understand program implementation in settings that have not been the focus of effectiveness studies. Studying Tribal MIECHV programs' implementation planning sheds light on how federally funded programs approached implementation when the types of evidence (e.g., results from randomized controlled trials) prioritized in evidence-based policy, such as MIECHV legislation, are insufficient or do not exist for the implementing community.

Multi-Site Implementation Evaluation of Tribal Home Visiting

This report presents findings from an analysis of the implementation plans developed by a cohort of Tribal MIECHV grant recipients. The analysis was conducted as part of the Multi-Site Implementation Evaluation of Tribal Home Visiting (MUSE), led by James Bell Associates in partnership with the Centers for American Indian and Alaska Native Health at the University of Colorado Anschutz Medical Campus.

MUSE is a mixed-methods study; it integrates quantitative and qualitative methodologies to examine how Tribal MIECHV programs operate in diverse contexts. Through a community-engaged approach, MUSE partnered with Tribal MIECHV programs to design and conduct a

[2] To meet HHS criteria for an evidence-based early childhood home visiting service delivery model, models must meet at least one of the following criteria: (1) at least one high- or moderate-rated impact study of the model finds favorable (statistically significant) impacts in two or more of the eight outcome domains or (2) at least two high- or moderate-rated impact studies of the model (using nonoverlapping analytic study samples) find one or more favorable (statistically significant) impacts in the same domain (U.S. Department of Health and Human Services, n.d.-a).

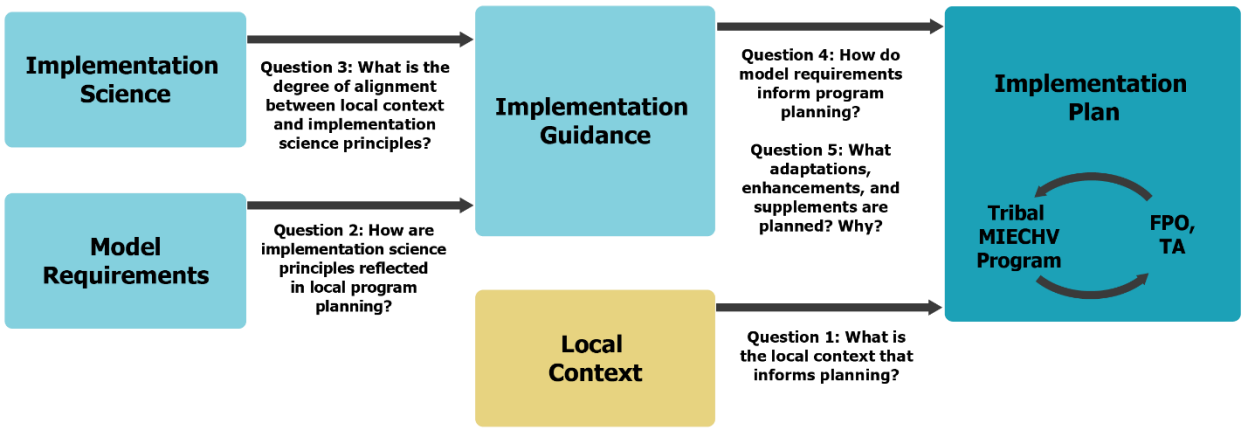
study that will return meaningful findings to partnering communities and ACF. The study builds on the rigorous local evaluations of 17 Tribal MIECHV programs in a prior 5-year funding period, as well as the Mother and Infant Home Visiting Program Evaluation, the Roadmap for Collaborative and Effective Evaluation in Tribal Communities (Tribal Evaluation Workgroup, 2013), and implementation science. MUSE has three aims:

1. Identify and describe primary influences shaping Tribal MIECHV program planning.
2. Identify and describe how Tribal MIECHV programs are being implemented.
3. Explore supports and challenges to home visiting implementation in Tribal communities.

This report presents findings for Aim 1, based on a systematic qualitative analysis of Tribal MIECHV program implementation plans as a secondary data source (exhibit 1).

Exhibit 1. MUSE Aim 1 Analytic Approach

The MUSE team developed an analytic approach for Aim 1 analysis (exhibit 1) linking Aim 1 research questions to several interrelated influencing domains: implementation science, model requirements, local context, and the Implementation Plan Guidance provided by funders.



FPO = federal project officer; **TA** = technical assistance; **MIECHV**= Maternal, Infant, and Early Childhood Home Visiting.

About This Report

This report describes how Tribal MIECHV programs were planned and what influenced the planning process. It also offers general findings and recommendations for using evidence-based policy meaningfully and ethically in Indigenous communities.

The report is organized by the following chapters.

Chapter 1. Introduction

Chapter 2. Research Methods for Identifying and Describing Influences on Planning Tribal MIECHV Programs describes the MUSE study and the analytic approach, data source, and methods used for this report.

Chapter 3. Ripples in a Pond: Planning Home Visiting as an Investment in Community by Community focuses on home visiting as critical to connecting children and families to community resources and (re)invigorating Indigenous knowledge and practice.

Chapter 4. Rigorous Indigenous Frameworks: Incorporating Equity Into Tribal MIECHV Program Planning focuses on Tribal MIECHV programs' attention to inequity and injustice in both historical and contemporary forms and their strategies to advance equity for families and staff.

Chapter 5. Supporting Cultural Values and Fit: Applying Flexibility and Using Multiple Sources of Evidence in Tribal MIECHV Program Planning investigates how Tribal MIECHV programs modify home visiting model delivery for families in Native communities.

Chapter 6. Strengthening Ties: Serving Families, Engaging Community, and Building Trust describes the family, home visitor, and community domains and how programs envision the families they will serve during planning.

Chapter 7. Findings, Recommendations, and Implications summarizes findings and provides recommendations based on the analysis of Tribal MIECHV implementation plans.

General Findings and Recommendations

MUSE study findings for Aim 1 analysis culminate in the three general findings presented below and detailed in subsequent chapters. For this executive summary, we have included a set of recommendations related to each general finding and addressed to individuals serving in the following roles: Tribal MIECHV implementation support staff (e.g., Tribal MIECHV program staff, technical assistance providers); implementation researchers; and home visiting researchers, practitioners, and policymakers. This strategy is intended to clarify who might be most able to act on a given recommendation but not to limit any person's engagement with a particular recommendation. We recognize that individuals can work across these roles and hope that others may find inspiration in the recommendations as well.

The recommendations are based on findings from secondary data analysis of implementation plans written by 17 Tribal MIECHV awardees between 2016 and 2017. Changes have occurred since then. For example, implementation frameworks have increasingly focused on equity, and Tribal MIECHV implementation support staff have made significant adjustments to the support they provide to awardees, including to Implementation Plan Guidance provided. We offer the following recommendations not to dismiss these important changes. Rather, we hope they amplify these efforts and suggest additional ways to align home visiting implementation with Indigenous community priorities.

Finally, the recommendations are intended to support readers as they begin thinking through opportunities to apply the findings to their work and are not meant as directives. We recognize that the recommendations may not be appropriate in all settings; even when appropriate, they may not be applicable given constraints such as resources.

Tribal MIECHV programs planned to use equity-focused Indigenous practices to support child and community well-being through home visiting. Implementation plans called attention to the effects of historical harm and contemporary inequity on the community and on child, family, and home visitor relationships and well-being. Programs planned to advance equity in multiple ways, including by (re)building trusting relationships between community members and agencies, supporting staff in trauma-informed ways, and weaving cultural (re)engagement throughout program implementation. Given this finding, we recommend the following.

Tribal MIECHV implementation support staff might consider—

- Adding experience with inequity to the list of family and community at-risk designations in Implementation Plan Guidance. Such action could highlight the structural components that sustain risk and need.
- Incorporating strengths-based perspectives into designations of priority service populations (e.g., young mothers interested in their child's development) rather than emphasizing need and risk.
- Focusing on connectedness and community goals and outcomes along with individual behavior change throughout service delivery supports and evaluation.
- Learning from Native staff what supports recruitment and retention of Native staff and applying those supports.
- Strengthening trauma-informed approaches for families and staff, especially approaches developed by and for Indigenous communities.

Implementation researchers might consider—

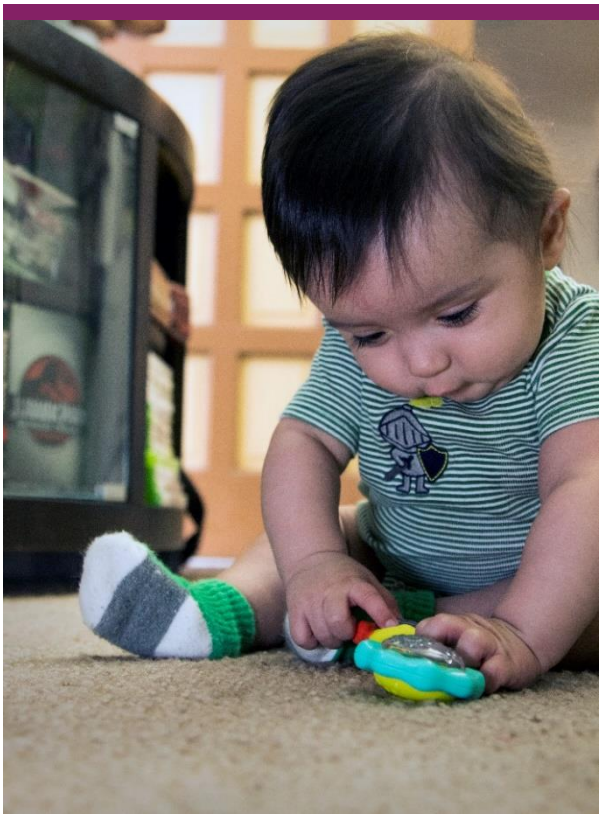
- Incorporating social theories, especially Indigenous theories and frameworks and those pertinent to understanding (in)equity, throughout implementation science. Such effort could enhance the applicability of implementation frameworks in Indigenous communities and beyond and contribute to anti-racist frameworks and equity within implementation science (e.g., Shelton et al., 2021).

- Studying trust, and the repair of trust, as a primary driver or foundational influence for implementation.

Home visiting researchers, practitioners, and policymakers might consider—

- Studying how child–family–community relationships influence home visiting implementation.
- Evaluating the feasibility and effectiveness of home visiting service delivery strategies used to broaden service populations and caregiver participation (e.g., fathers, grandparents).

Programs built on Implementation Plan Guidance and model guidance to plan their home visiting programs. Implementation plans reflected implementation science principles prioritized in the guidance, emphasizing needs assessment, evidence-based models, and fidelity. Programs balanced model requirements with community context and strengths-based approaches and recognized the importance of flexibility for successful implementation. Given this finding, we recommend the following.



Tribal MIECHV implementation support staff might consider—

- Enhancing the relevance of future implementation guidance by incorporating Indigenous concepts (e.g., about children, family, community). Participatory processes could help ensure that guidance addresses Indigenous concepts and implementation science principles that are most meaningful to Tribal MIECHV programs. Such integration could lead to the development of new tools, strategies, and approaches.
- Expanding opportunities to amplify Tribal MIECHV programs' innovations and implementation strategies to support cross-site learning. Several plans mentioned using implementation strategies learned through peer-learning program planning opportunities.
- Supporting Tribal MIECHV programs to rebuild the trust necessary to (re)invigorate home visiting in Native communities.

Additional and augmented implementation approaches and concepts may be required to adequately support evidence-based program implementation in Native communities. Implementation science emphasizes the use of theories, models, and frameworks (Nilsen, 2015). Although analysis of implementation plans showed significant influence of Indigenous and experience-based knowledge, few available implementation theories, models, and frameworks emerge from or reference Indigenous knowledge, especially at the time these plans were written. Given this finding, we recommend the following.

Implementation researchers might consider—

- Recognizing how implementation frameworks that emphasize the present and future at the expense of the past may not adequately account for the ways historical harms and enduring Indigenous practices shape planning. Findings suggest that successful implementation may mean returning strategically to organizational and/or community histories to address both harms from the past and longstanding practices that sustain community well-being.

Home visiting researchers, practitioners, and policymakers might consider—

- Continuing to learn more about Indigenous home visiting programs and how they work.
- Developing and testing strategies for incorporating flexibility into the design of models to make implementation more practical, effective, and sustainable in diverse settings. It may be particularly important to clarify core components of models that are best implemented with fidelity and define thresholds for modifications.
- Assessing how screeners used in home visiting could be modified or augmented to advance more strengths-based and trauma-informed assessments of caregivers and children.
- Following White House guidance (White House, 2022) to apply Indigenous knowledge to better understand maternal and infant health, and home visiting in Tribal communities.

Chapter 1 | Introduction

Arising from the success of the evidence-based medicine movement of the 1980s, the 2000s ushered in an era of evidence-based policymaking in the United States. The prioritization of evidence-based policy is characterized by increasing reliance on evidence generated through research aimed at demonstrating the efficacy of interventions and the prioritized funding and use of those interventions that are shown to be effective (Baron, 2018). The Maternal, Infant and Early Childhood Home Visiting (MIECHV) legislation was an example of this shift toward evidence-based policymaking established in the Foundations for Evidence-based Policymaking Act of 2018.

The requirements of evidence-based policy—that interventions have evidence of effectiveness—posed a problem for Tribal MIECHV programs. Although strong evidence indicates that home visiting is an effective intervention strategy for working with families, less is known about the value of these services in Indigenous communities. In fact, studies showed that evidence-based home visiting services, which may include prescriptive curricula, intensive training, fidelity monitoring, and data collection, remained a relatively new approach in many Tribal settings at the time of planning and may be challenging to adopt in the context of Tribal sovereignty and self-determination (Spicer et al., 2012).

Although little evidence existed to facilitate a systematic review of home visiting effectiveness in Indigenous communities, Tribal MIECHV programs were directed to plan and implement evidence-based home visiting models. Federal staff working on Tribal MIECHV acknowledged the lack of evidence of effectiveness in Tribal communities and responded by focusing resources and requirements on supporting implementation practices that demonstrated effectiveness. These practices included community needs assessment, structured planning, and continued performance monitoring. The goal of these requirements was to support quality implementation of home visiting in Tribal communities.

Concerns continue in Tribal MIECHV around using home visiting models that were created and tested with non-Indigenous populations, including whether home visiting models can be implemented as designed and whether intentional support is necessary for translating evidence-based models for diverse community contexts. The Multi-Site Implementation Evaluation of Tribal Home Visiting (MUSE) was an opportunity to better understand how programs plan for implementation when evidence of effectiveness is insufficient or absent or lacks relevance for the context.

This report offers findings, generated through analysis of Tribal MIECHV implementation plans (2016–2017), to enhance understanding of the impacts of evidence-based policy on Tribal MIECHV program planning. Analysis directly addressed Aim 1 of MUSE: **to identify and describe primary influences shaping Tribal MIECHV program planning.** These are the goals of this report:

- Amplify the planning efforts of Tribal MIECHV programs to facilitate sharing of information and strategies.
- Inform ongoing planning efforts of home visiting programs.
- Influence the development of future planning guidance, requirements, and technical assistance (TA), which is the provision of information, tools, training, or other supports, on home visiting implementation planning.
- Broaden the implementation knowledge base by, for example, incorporating forms of evidence and knowledge often underrepresented or valued within the evidence-based policy.
- Inspire lines of inquiry for subsequent phases of MUSE analysis, which will include mixed-method assessments of Aims 2 and 3.

Home Visiting

Home visitation is an evidence-based strategy to support families with young children. In general, it seeks to influence outcomes across eight domains: child development and school readiness; child health; family economic self-sufficiency; linkages and referrals; maternal health; positive parenting practices; reductions in child maltreatment; and reductions in juvenile delinquency, family violence, and crime (U.S. Department of Health and Human Services, n.d.-b). A common principle across home visiting programs is that a supportive, engaging intervention with parents in their own homes will foster longstanding improvements in parenting and family practices in education, health, and socialization (Weiss, 1993), which will in turn support better health and development outcomes for children. Although home visiting has shown promising impacts across several health and well-being domains for a general population, less is known about the implementation and effectiveness in Native communities more specifically.

Tribal MIECHV Program

Tribal MIECHV is designed to develop and strengthen Tribal nations' capacity to support and promote the health and well-being of American Indian/Alaska Native (AI/AN) families, expand the evidence base around home visiting in Native communities, and support and strengthen cooperation and linkages between programs that provide services to AI/AN children and their families. MIECHV, authorized under the Patient Protection and Affordable Care Act of 2010

(Fernandes-Alcantara, 2018), is evidence-based policy directed at improving the health and development outcomes of children. Through Tribal MIECHV, the Administration for Children and Families (ACF) provides funding to Indian Tribes (or consortia of Tribes), Tribal organizations, or urban Indian organizations to conduct a needs assessment; provide high-quality, evidence-based home visiting services; establish benchmarks; collaboratively plan to support a program that is part of a coordinated early childhood system; and engage in rigorous research and evaluation. This report describes the primary influences shaping Tribal MIECHV program planning.

Tribal MIECHV Programs

As of February 2023, there were 29 Tribal MIECHV grant recipients. Tribal MIECHV programs represent a small yet diverse portion of the Native communities across the United States.[3] Grant recipients include, but are not limited to, Native nations that share geography with the United States in rural areas (both on reservations and off reservations) as well as nonprofit Tribal health organizations that serve rural reservation and urban communities not on reservations. Tribal MIECHV programs serve culturally diverse populations. As such, the following material that reflects on cultural practices, including the planning and implementing of cultural modifications to models, should be understood as complex and dynamic rather than as monolithic and static.

Tribal MIECHV programs are funded through a cooperative agreement mechanism by the U.S. federal government. The cooperative agreement mechanism is a type of grant that incorporates, from the outset, an ongoing relationship between grant recipients and the federal agency funding the project. For Tribal MIECHV, federal staff from the funding agency (ACF) provide and facilitate extensive and ongoing TA. This TA included drafting and providing Implementation Plan Guidance to Tribal MIECHV programs.

Most of the Tribal MIECHV programs featured in this report received an initial grant between 2010 and 2016 to establish their home visiting programs. These programs were required to complete a rigorous evaluation of their home visiting program (Tribal Evaluation Institute, 2020). Tribal MIECHV grant recipients were then encouraged to draw on what they learned in

[3] Along with the variability across sovereign Tribal nations, urban and other off-reservation Tribal communities have unique strengths and needs, which are significant given that most AI/AN individuals (78 percent) live in urban communities (Norris et al., 2012). Despite the differences among communities, similarities also exist. AI/AN communities are characterized by resilience, relational worldviews, traditional child-rearing practices, close-knit extended family networks and supports, and reliance on traditional ways of knowing (LaFromboise et al., 2006; Sarche & Spicer, 2008; Tribal Evaluation Workgroup, 2013).

these evaluations to plan subsequent phases of implementation. After the initial evaluation phase, ACF's funding announcement required programs to participate in either a local efficacy study or MUSE. All 17 Tribal MIECHV programs funded in 2016 opted to participate in MUSE. We refer to these partnering programs as "Tribal MIECHV programs" in this report.

In this report, we use "Tribal MIECHV programs" as the authors of program implementation plans even though people, not programs, write plans. We elected this strategy because the specific identities, roles, and number of authors for each implementation plan were unique to that plan and unknown to the MUSE research team. In the remainder of this report, we refer to the authors of the implementation plans reviewed as "programs." The authors represented by "Tribal MIECHV program" in the report should be taken as a diverse group of individuals. Therefore, individual authorship of implementation plans should not be assumed and likely represents a group of collaborators at each site. Author groups may include individuals who are Indigenous and non-Indigenous.

MIECHV Legislation

The MIECHV program is one of the first federally funded evidence-based policy initiatives (Adirim and Supplee, 2013). The authorizing legislation greatly expanded federal funding for voluntary, evidence-based home visiting programs and required that most funding (75 percent) be reserved for implementation of home visiting models that have been designated as evidence-based. In response, the U.S. Department of Health and Human Services (HHS) established criteria for evidence of effectiveness and launched the Home Visiting Evidence of Effectiveness (HomVEE) systematic review, a synthesis and critical assessment of the quality and strength of the available evidence of home visiting models.

MIECHV includes several program requirements that support high-quality implementation such as strong organizational capacity, high-quality staff supervision, and implementation with fidelity to model developers' standards. The legislation also required that grant recipients demonstrate improvement in six benchmark domains. Additionally, the program required continuous quality improvement activities. MIECHV's emphasis on data use and continuous learning is intended to support effective implementation and to improve participant outcomes. MIECHV also supports research and evaluation to expand the evidence base for home visiting. Up to one-quarter of MIECHV funds can be spent on implementing promising approaches that do not yet qualify as evidence-based models (Health Resources and Services Administration, 2016). Grant recipients that selected promising approaches were required to conduct a rigorous evaluation.

The Tribal MIECHV program was established in the MIECHV authorizing legislation and funded with a 3 percent set-aside of the total program budget.[4] Although Tribal communities have a lengthy history of home visiting in various forms, evidence-based home visiting—which includes required curricula and service delivery strategies, fidelity monitoring, and data collection—is a relatively new approach in many Tribal settings (Lyon et al., 2015). In response to this historical context, the legislation specified that Tribal MIECHV awards be consistent with MIECHV awards granted to states "to the extent practicable." This provision left flexibility for ACF to tailor Tribal MIECHV program requirements to the diverse community contexts in which the grant program operates.

ACF determined flexibility was needed in the implementation of evidence-based models. The initial HomVEE systematic review identified seven home visiting models that met the criteria for evidence of effectiveness.[5] 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 (Del Grosso et al., 2011).[6] Therefore, models that had evidence of effectiveness with other populations and that were deemed evidence-based by the original HomVEE review were considered promising approaches rather than evidence-based approaches when used within Tribal communities (Lyon et al., 2015). In response to this lack of evidence of

Implementation Plan Guidance: Evidence-Based Home Visiting Model

"Grantees under the Tribal MIECHV program may choose to implement both models that meet the HHS criteria for evidence of effectiveness in AIAN communities and promising approaches. HHS uses Home Visiting Evidence of Effectiveness (HomVEE, http://homvee.acf.hhs.gov/) to conduct a thorough and transparent review of the home visiting research literature and provide an assessment of the evidence of effectiveness for home visiting models that target families with pregnant [persons] and children from birth to kindergarten entry. There is currently one model [Family Spirit] that meets the HHS criteria for evidence of effectiveness in AIAN communities. All other home visiting models, including those that have been designated by HHS as meeting criteria for evidence of effectiveness for the general population through the HomVEE review, are currently considered promising approaches for use with AIAN populations." (Implementation Plan Guidance, p. 43)

[4] Beginning in 2023, the Tribal set-aside increased to 6 percent.

[5] As of March 2023, that number has increased to 22 models (Avellar & Paulsell, 2011).

[6] In a 2014 update to the systematic review, Family Spirit met the criteria for evidence of effectiveness with AI/AN populations (Mraz Esposito et al., 2014).

effectiveness in Tribal communities, ACF determined that all Tribal MIECHV grant recipients initially funded in 2010 would be required to conduct a rigorous evaluation of their program (Tribal Evaluation Institute, 2020) to further develop the evidence base for home visiting in Native communities.

Referencing lessons learned about infrastructure development from the Children's Bureau's experience with early childhood home visiting research (e.g., Brodowski et al., 2007; Filene et al., 2012) and from implementation science (Fixsen et al., 2005), ACF elected to support rigorous evaluation and to invest in supporting high-quality implementation. For example, informed by implementation science principles, ACF introduced grant activities in stages that aligned with drivers of high-quality implementation and identified phases of program planning, implementation, scale-up, and sustainability (Lyon et al., 2015). ACF used two primary strategies to support high-quality program implementation. First, it instituted an implementation planning requirement (i.e., the reason for the implementation plans analyzed in this report). The requirement was based on the guidance template designed for building infrastructure to implement, scale up, and sustain evidence-based early childhood home visiting programs with fidelity (Boller et al., 2014). Second, they contracted technical assistance (Programmatic Assistance for Tribal Home Visiting) for program implementation composed of universal and targeted features (separate from technical assistant models).

As a result, Tribal MIECHV grants began with a planning year that entailed conducting a community needs and readiness assessment that would inform the selection of a home visiting model and the development of a comprehensive implementation plan designed to guide all aspects of program delivery, monitoring, and evaluation.

ACF staff provided detailed Implementation Plan Guidance (appendix A) for developing the implementation plans and worked closely with programs as they wrote their plans. The guidance was 80 pages and included the following five sections:

- **Section 1**—Needs & Readiness Assessment, Home Visiting Program Vision, Goals and Objectives, and Home Visiting Program Design
- **Section 2**—Action Plan for Effective Implementation of Home Visiting Program
- **Section 3**—Plan for Data Collection and Management, Continuous Quality Improvement, and Performance Measurement
- **Section 4**—Plan for Rigorous Evaluation of Home Visiting Program
- **Section 5**—Integrated Years 2–5 Timeline

Implementation Plan Guidance

"Grantees are expected to respond to every section of the guidance and each element listed under each section, with the goal that by responding to each section and area, grantees will have developed a comprehensive plan that will outline critical activities that are required to successfully execute their Tribal MIECHV grants. ACF will work closely with and provide ongoing technical assistance (TA) to grantees as they develop implementation plans. ACF and TA providers will provide TA tools throughout the development of implementation plans to assist in organizing and presenting requested information. Approval of the plan will be an iterative process between the grantee and ACF as part of the cooperative agreement." (Implementation Plan Guidance, p. 2)

Programs received initial and ongoing TA from ACF and TA contractors on a range of implementation planning topics, including needs assessment; model selection; program design; developing policies and procedures; and plans for recruiting, retaining, and supporting staff.

To support Tribal MIECHV's goal of providing culturally relevant evidence-based home visiting, ACF and TA contractors provided guidance to programs on the development of local adaptations or enhancements to home visiting models. The Implementation Plan Guidance identified and defined various approaches to tailoring home visiting models to local contexts (i.e., adaptations, enhancements, and supplements) and provided guidance for planning and implementing these approaches while also maintaining fidelity to the model.

Because a coordinated referral network is critical for the success of home visiting, Tribal MIECHV also emphasized systems-building activities to improve cooperation and coordination among early childhood and other service providers. To track and monitor critical components of evidence-based service delivery, including service linkages, ACF identified performance measures and supported programs to develop plans for collecting, tracking, and reporting performance measurement data that were tailored to program context. Implementation Plan Guidance also outlined how to develop and implement a rigorous evaluation that would add to the knowledge base on home visiting in Indigenous communities. ACF established contracts with TA providers to support programs with systems building, performance measurement, rigorous evaluation, and other grant requirements. In summary, within Tribal MIECHV, there was a purposeful effort to embed practices supported by implementation science into program planning and implementation through strategic grant requirements, including (1) conducting a local needs and readiness assessment, (2) selecting an evidence-based home visiting model to

implement, (3) articulating a detailed implementation plan, and (4) establishing and implementing a comprehensive performance measurement system.

Report Organization

This report will be one of a suite of resources developed through the MUSE study. The report describes how Tribal MIECHV programs are planned and what influenced the planning process, including but not limited to the MIECHV legislation described previously. It will present and discuss findings generated through a qualitative analysis of Tribal MIECHV program implementation plans that were used as a secondary data source. In addition to describing Tribal MIECHV program planning and its influences, this report offers key findings, lessons learned, and considerations that pertain more generally to the impact of evidence-based policy on Tribal MIECHV program implementation.

Report Chapters

Chapter 3. Ripples in a Pond: Planning Home Visiting as an Investment in Community by Community shows how Tribal MIECHV programs root home visiting in community wellness. Placing children at the center of generational connections that sustain community, the chapter focuses on home visiting as critical to connecting children and families to community resources and (re)invigorating Indigenous knowledge and practice.

Chapter 4. Rigorous Indigenous Frameworks: Incorporating Equity Into Tribal MIECHV Program Planning focuses on programs' attention to inequity and injustice in both historical and contemporary forms. Highlighting inequity as a significant external influence on Tribal MIECHV implementation, the chapter discusses strategies programs use to further equity for enrolled families and staff.

Chapter 5. Supporting Cultural Values and Fit: Applying Flexibility and Using Multiple Sources of Evidence in Tribal MIECHV Program Planning investigates planning related to program design and implementation systems, specifically implementation requirements of model developers and funders. The chapter shows how Tribal MIECHV programs modify home visiting model delivery to better ensure fit (e.g., family engagement and model efficacy) for families in Native communities.

Chapter 6. Strengthening Ties: Serving Families, Engaging Community, and Building Trust describes how programs envision whom they will serve through their home visiting programs.

Chapter 7. Findings, Recommendations, and Implications covers primary lessons learned from systematically analyzing implementation plans and related recommendations to support home visiting implementation.

Chapter 2 | Research Methods for Identifying and Describing Influences on Planning Tribal MIECHV Programs: Introduction

MUSE Overview

MUSE examined how Tribal MIECHV programs operate across diverse community contexts. The 17 Tribal MIECHV programs that participated serve rural and urban communities across diverse regions of the United States.

MUSE used a mixed-methods research design to describe interventions, services, programs, and policies implemented across Tribal MIECHV programs; identify influential conceptual frameworks and local theories of change; and characterize program participants and their experience with services. Additionally, the study conducted preliminary examinations of relationships between core constructs drawn from human services and implementation science and sought to understand what supports and hinders successful implementation.

MUSE had three study aims:

- **Aim 1**: Identify and describe primary influences shaping Tribal MIECHV program planning.
- **Aim 2**: Identify and describe how Tribal MIECHV programs are implemented.
- **Aim 3**: Explore supports and challenges to home visiting implementation in Tribal communities.

MUSE Is a Community-Engaged Study

MUSE used a community-engaged approach, detailed in Salvador et al. (in press), across 17 Tribal MIECHV programs that elected to partner on the study. Community engagement is widely recognized as a strategy for enhancing the ethics, rigor, and impact of research. It is also widely acknowledged as a way to integrate Indigenous and non-Indigenous research approaches.

Guided by the *Roadmap for Collaborative and Effective Evaluation in Tribal Communities*, the MUSE team established a shared vision for the study's community-engaged approach, including a set of principles for partnership. Simultaneous to this process, the study team established a structure for engaging study partner groups, including Tribal MIECHV programs and federal funding partners from the Office of Planning, Research, and Evaluation. Other contributor groups supported MUSE as members of the Technical Workgroup (TWG). They are federal partners from Tribal MIECHV; Technical Assistance (TA) providers, including those from Programmatic Assistance for Tribal Home Visiting and the Tribal Evaluation Institute,

respectively; and evaluation consultants who specialize in Tribal sovereignty and data governance and/or implementation of evidence-based models.

The MUSE team engaged partners in designing a study with aims, questions, and hypotheses that were relevant and important for Tribal MIECHV; developing and refining instruments and measures that could provide accurate data for Tribal communities; creating practicable and effective data collection methods; forming an analytic plan; and disseminating study findings. This report is a result of this community-engaged process.

MUSE's community-engaged approach is reflected in the conceptual model (exhibit 2) that guided the study. Tribal MIECHV programs partnering on MUSE collaboratively developed this model. MUSE study partners used an embedded circular model as opposed to a linear logic model more typical of mainstream home visiting implementation (e.g., Mother and Infant Home Visiting Program Evaluation study). Study partners then added bidirectional arrows to account for relationality between domains, thus highlighting the dynamic and interactive way parenting affects and is affected by community as well as by external factors. This vision attends to community as not only a context for home visiting intervention but also a primary source and beneficiary of home visiting services. In doing so, it expands the role of Tribal MIECHV programs and desired outcomes in significant ways. For example, child and parenting outcomes are commonly envisioned as interwoven with community building and wellness. The MUSE team and Tribal MIECHV programs plan to collaboratively continue to refine this model throughout the study based on study findings and programs' insights. The final chapter includes considerations for refinements based on Aim 1 findings.

The MUSE conceptual model features five embedded mutually influencing domains. The **Parent and Child Health and Well-Being** domain highlights the overarching commitment of MUSE partners toward increasing parent and child health and well-being. Within this domain is **Community and Cultural Context**, which is a broad Indigenous community-level context that influences how home visiting services are designed and implemented to support parent and child well-being. Within this contextual domain is the **Service and Policy Environment**, which includes the Tribal MIECHV program service agency, the MIECHV legislation and federal program office, home visiting model options and designs, referral networks, and more. The **Program Design and Implementation System** domain refers to unique program-level Tribal MIECHV design elements, including the home visiting model selected for implementation, any supplements or enhancements, adaptations, and other features described in the implementation plans. It also refers to the administrative features, resources, supports, and

priorities of the service agency operating the program, including training and supervision of home visitors and clinical and administrative supports. The **Families and Home Visitors** domain refers to the home visitor–family dyads at the heart of home visiting, including the families that participate in Tribal MIECHV programs and the Tribal MIECHV program staff who provide home visiting services, including curricula, child development, and family support. Home visitors are staff with diverse backgrounds and credentials. They include parent educators, parent advocates, and nurses. Finally, at the center of the MUSE Conceptual Model is **Quality Implementation of Services,** which includes the home visiting services delivered (amount and content) as well as the relational work that contributes to home visiting services being efficacious and valued.

Exhibit 2. MUSE Conceptual Model

Study Aim and Questions Addressed by the Report

This report presents findings on Aim 1 of MUSE. Aim 1 seeks to *identify and describe primary influences shaping Tribal MIECHV program planning*. Aim 1 includes the following five research questions:

1. What is the local context that informs planning?
2. How are implementation science principles reflected in local program planning?
3. What is the degree of alignment between local context and implementation science principles? How are differences addressed in planning?
4. How do model requirements inform program planning?
5. What adaptations, enhancements, and supplements are planned? Why?

The study addressed these research questions through a step-by-step evaluation of the implementation plans written by the 17 Tribal MIECHV programs participating in MUSE.[7] Analysis of Tribal MIECHV grant recipients' implementation plans offered a unique opportunity to examine the role federal planning requirements (Implementation Plan Guidance) played in Tribal MIECHV program planning (implementation plans).

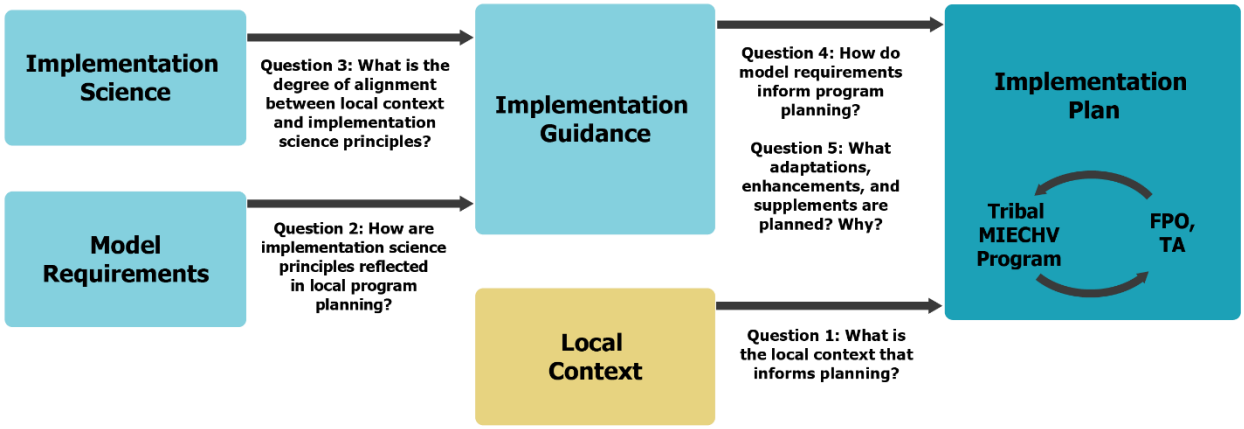
Analytic Approach, Data Source, and Methods

Analytic Approach

With guidance from the MUSE TWG, the MUSE Team developed an analytic approach for Aim 1 analysis (exhibit 3) linking Aim 1 research questions to several interrelated influencing domains, including (1) implementation science, (2) model requirements (3) local context, and (4) the Implementation Plan Guidance provided by ACF.

[7] To maintain study confidentiality, MUSE partnering programs are not identified.

Exhibit 3. Aim 1 Analytic Approach



FPO = federal project officer; **TA** = technical assistance, **MIECHV**= Maternal, Infant, and Early Childhood Home Visiting.

As visualized in exhibit 3, Aim 1 analysis traced the influences of implementation science and model requirements as they were integrated into Tribal MIECHV Implementation Plan Guidance. We asked two research questions focused on this level of influence: (1) *What is the degree of alignment between local context and implementation science principles?* and (2) *How are implementation science principles reflected in local program planning?* Analysis then followed the influences of the Implementation Plan Guidance and the local context on Tribal MIECHV program planning by ascertaining how related contexts appeared in implementation plans that were written by Tribal MIECHV programs with support from federal program officers and TA providers. We asked three research questions focused on this level of influence: (1) *How do model requirements inform program planning?* (2) *What adaptations, enhancements, and supplements are planned? Why?* and (3) *What is the local context that informs planning?* This analysis also generated several considerations for subsequent analysis of MUSE aims 1 and 2.

Data Source

MUSE study partners identified secondary analysis of Tribal MIECHV program implementation plans as an optimal way to ask key questions about Tribal MIECHV implementation planning. MUSE researchers generated Aim 1 findings through qualitative analysis of secondary data (implementation plans of all 17 Tribal MIECHV programs participating in MUSE). The MUSE team systematically coded (i.e., assigned conceptual categories to excerpts of text) Tribal MIECHV programs' local implementation plans to identify major concepts and themes used in the program planning stage that were required of all Tribal MIECHV programs. These programs dedicated substantial effort to developing implementation plans. They are the result of

intentional, reflective, sustained, and proactive work. Rigorously analyzing implementation plans as a secondary data source allowed the study to amplify this work while minimizing the burden that would be imposed on programs with interviews, focus groups, or surveys to gather similar information.

Several special considerations are related to using implementation plans as secondary data. First, the following evidence presented was not generated as part of the research study and therefore is not directly tied to study aims or research questions. Plans were written to facilitate approval of an individual program planning process and *not* to address questions about planning more generally. Second, programs wrote implementation plans during a designated period that varied in length, after program funding in September 2016. Therefore, these data do not represent subsequent or ongoing planning done by Tribal MIECHV programs, nor do they integrate changes to plans that have undoubtedly been made. These plans were written before the COVID-19 pandemic and thus do not address emergent implementation concerns or strategies such as virtual home visiting. As possible, findings will be used in concert with forthcoming interview data to address change over time. Third, plans varied significantly across programs. The plans all followed the overall required structure, but plans ranged in length from just over 100 pages to well over 300 pages. For some programs, this was their first plan. For others, these plans were revisions of previously approved plans submitted under a prior funding period. As such, data used for Aim 1 were not consistent across programs. Finally, as described previously, federal staff provided implementation plan authors with detailed Implementation Plan Guidance with instructions on what to address in each section. Therefore, the plans represented a combination of Tribal agency priorities and ACF guidance and requirements.

Methods and Procedures

Data Reduction

Data used in this analysis required significant reduction to make implementation plans a viable secondary data source. To focus analysis on the most relevant data, the study team extracted three sections, removing all other material from the plans before upload into qualitative analysis software. These are the three sections featured:

1. Needs and Readiness Assessment, Home Visiting Program Vision, Goals, and Objectives and Home Visiting Program Design
2. Action Plan for Effective Implementation of Home Visiting Program

3. Plan for Data Collection and Management, Continuous Quality Improvement, and Performance Measurement

Sections not analyzed include Plan for Rigorous Evaluation of Home Visiting Program (no programs selected this option) and Timeline. We also removed the following components of Sections 1–3 before uploading plans into the qualitative coding software: Program Logic Models and Plan for the Reporting of Required Demographic, Service Utilization, Implementation, and Performance Measurement Data.

We also removed all visual material in the implementation plans because at the time of analysis, the qualitative analysis software we used (Dedoose) was only able to render text and not visual materials or unique formatting. Removed visual material included photographs, other artwork, diagrams, and other visual presentations.

The study team maintained a complete digital copy of each original implementation plan so that we could access material we removed when necessary for clarification or to provide context during analysis and interpretation.

Data Cleaning

Data used in this report are direct quotes (i.e., verbatim copy of statements from Tribal MIECHV program implementation plans of MUSE partners). Because implementation plans were not written to be used as data, the study team cleaned the data to ensure that they do not identify any given program and to enhance readability. Modifications removed identifying information, including references to programs, places, events, and communities. These modifications adhere to research ethics guidelines, help protect the privacy of participating programs, and follow agreements with our study partners. Additionally, we made minor revisions to quotes to enhance readability.

We also replaced job titles used by programs to further obscure program and participant identity. For example, although programs used a variety of titles for staff who perform home visits (e.g., home visitor, nurse, parent educator, advocate), we refer to these staff as home visitors. This choice means that findings and data presented do not provide differential analysis across staff with widely diverse backgrounds, training, and roles (e.g., home visitors with nursing licenses and training, social workers, those with other credentials).

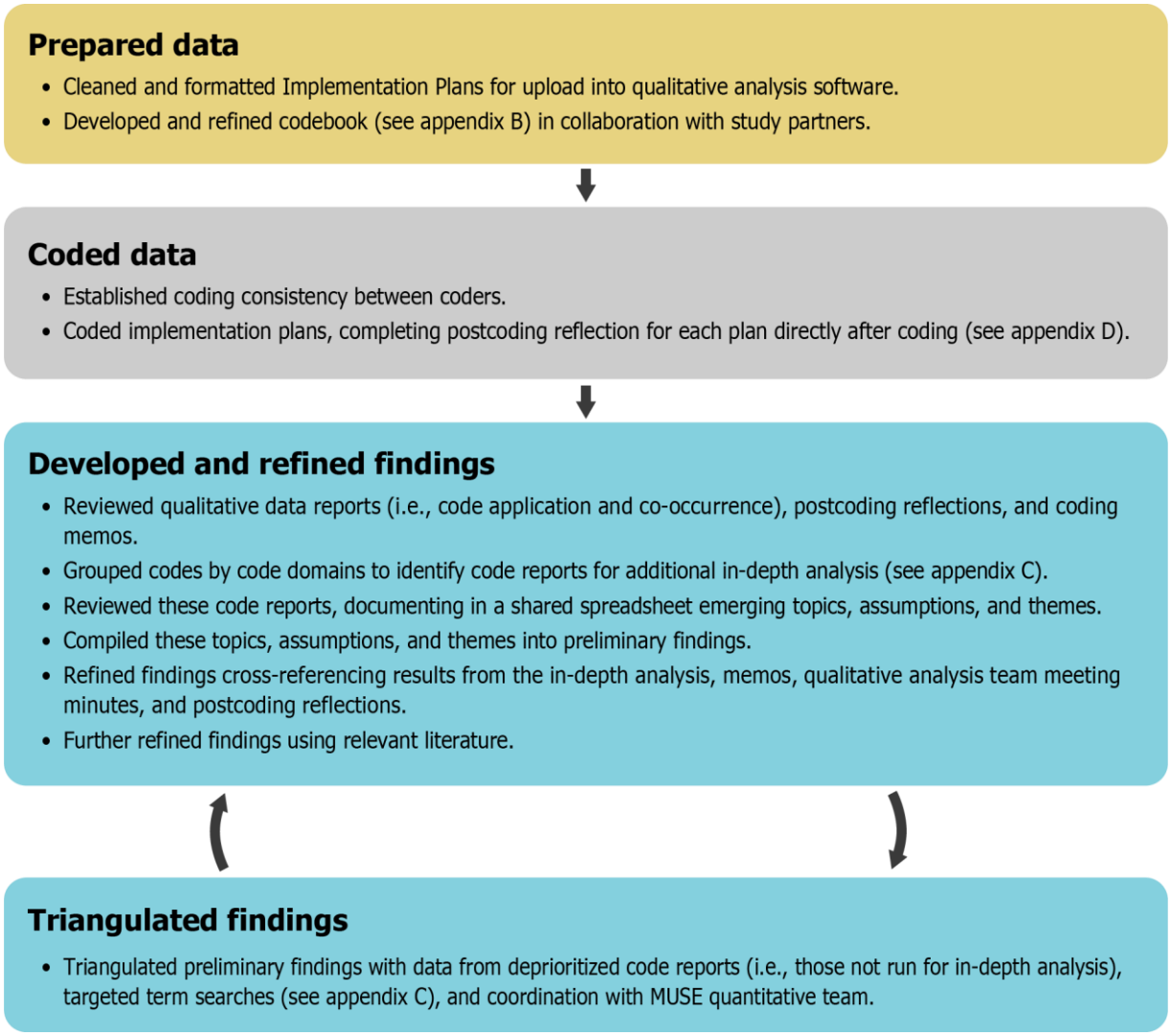
Although data cleaning considerations help provide program and participant anonymity, they conceal meaningful connections to place, land, and people that shape the practices and

language conveyed in program plans. It is important to acknowledge that these omissions present a paradox. As they strive to respect Tribal nations' data sovereignty, they also risk generalizing the very relations and forms of governance that constitute it.

Systematic Coding of Implementation Plans

Aim 1 analysis used a systematic, iterative, and reflective process (exhibit 4).

Exhibit 4. Data Analysis Process



The MUSE team used systematic, iterative, and reflective processes to enhance the transferability of findings. Following Carminati (2018) and others, we have chosen to use transferability—the degree to which data and findings can be shown to apply to new or different contexts or populations from where they were gathered—instead of generalizability in

part to distinguish from probabilistic generalizability used in quantitative analysis. Ultimately, transferability of findings is a question of the trustworthiness of the data and analysis, which, as Carminati (2018, p. 2099) argued, is "built through the transparency, reflexivity, and accuracy of the research practice itself." To help readers assess transferability of findings, we have detailed, in the report and in the appendices, the analysis practices we undertook to generate report findings, including several instances of iterative reflexivity.

Implementation plan text was analyzed through open (i.e., categorize material by type) coding (Adu, 2019; Patton, 2002; Saldaña, 2016). Open coding organized data according to two types of codes—item and free. Analysts used a total of 73 codes, including 53 codes that corresponded directly to specific prompts in the Implementation Plan Guidance and 20 codes that corresponded to a concept operationalized by the study team. The final codebook is provided in appendix B.

MUSE study team members worked in partnership with federal staff from the Office of Planning, Research, and Evaluation to identify, prioritize, and select the codes used for analysis. Such collaboration is an example of how MUSE functions as a contracted study, including ongoing investments by federal staff. Additionally, the MUSE TWG reviewed and provided feedback on proposed codes and on the Aim 1 analysis plan. The qualitative evaluation expert from the TWG helped refine the final list of codes. The team then developed and refined a codebook that provided operational definitions of codes. We tested the code book through two rounds of simultaneous coding across four team members. Once we established intercoder consistency, we proceeded with independent coding of implementation plans.

The team then pulled coded excerpts into individual files by code and conducted data synthesis on these files. Analysis did not proceed through discrete interrogation of material by research question because codes were not unique to any one research question. Rather, through the coding process described, material was organized by concepts and prompts for the Implementation Plan Guidance (i.e., items).

The team then conducted more in-depth analysis on just over 25 of the files. We prioritized files for in-depth analysis that addressed emergent research priorities, had content that was evenly distributed across domains, and included material that contained robust data with the potential to impact the field (appendix C). The team used memos, meeting minutes, and postcoding reflections (template available in appendix D) to identify, guide, and facilitate generation of findings.

Finally, once preliminary findings were developed, we refined and triangulated our findings with data from deprioritized files and targeted term searches (e.g., for fidelity, trust, equity).

Selecting Quotes for This Report

In most cases, the analysis team identified quotes to be included in this report that were clear examples of similar reflections or sentiments expressed across multiple programs' plans. In other instances, a quote may represent a finding particular to one plan, selected for its salience. It is important to note that although analysis systematically relates quoted material across sites to establish commonality across the programs (i.e., themes), each quote is unique to the authoring program.

Such uniqueness makes the use of counts of instances where specific ideas were expressed less scientifically reliable. As such, we have chosen to not use counts for this analysis. Quantifying qualitative data in the form of counts (e.g., how many programs mentioned a sentiment) can provide readers with referents that can help with generalizability, but they also run the risk of both overrepresentation (criteria for count was too broad) and underrepresentation (criteria for count was too narrow) as researchers impose criteria for counting. Because of the uniqueness of each implementation plan, it is more transparent and rigorous to not provide counts. We recognize, however, that it is important for readers to have a sense not only of the salience of findings but also their scope and scale. Therefore, we offer minor and purposefully vague qualifiers (e.g., program or programs, few, some, many, most) to give readers a sense of a conceptual scale for findings. These qualifiers do not cohere to any objective numerical value. Rather, the qualifier reflects a recognition, triangulated across multiple analysts, of a generalized number of programs represented by a specified finding.

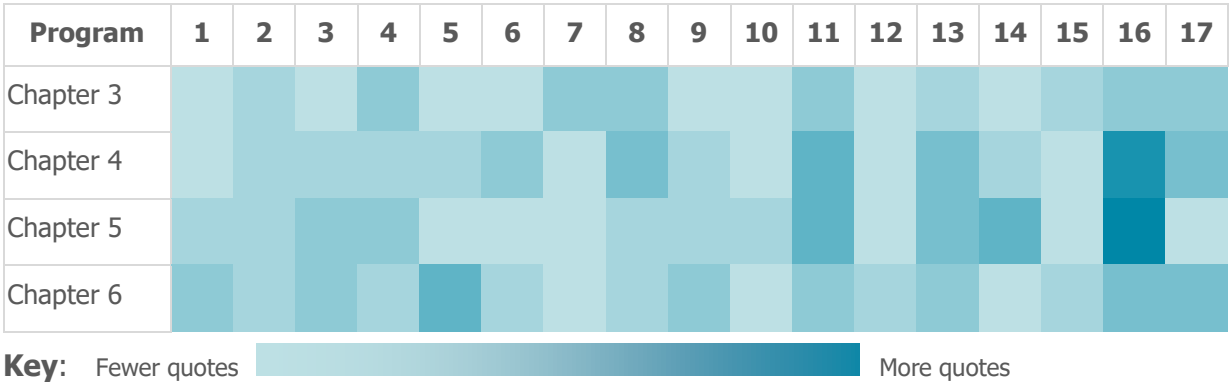
Quotes from the implementation plans of all 17 Tribal MIECHV programs that partnered on MUSE are included in this report. Exhibit 5 gives a sense of the diversity of programs quoted within the report. MUSE qualitative researchers systematically selected quotes for this report that were demonstrative of the finding, salient, clearly stated, and comprehensive. As such, in the majority of cases, **most** of the programs that provided evidence to support any given finding are **not** directly quoted within discussion of that finding.

This report presents data provided by the full sample of MUSE partners or all 17 implementation plans. All 17 plans are quoted at some point in the report. Most Tribal MIECHV program

implementation plans are quoted in all of the findings chapters. Findings chapters include quotations from as few as 12 programs and as many as 17.

Attributing quotes to specific programs was not possible because the MUSE study chose to not identify partnering sites. This makes it more difficult for the reader to assess the diversity of programs featured throughout the report. Exhibit 5 provides a visual heatmap depicting the intensity of quotes featured by Tribal MIECHV program across chapters.

Exhibit 5. Quotes by Program and Chapter



The map shows the number of unique quotes used by programs for each chapter, with the most even distribution in Chapters 3 and 6, the largest range in Chapters 4 and 5, and programs 11 and 16 being the most quoted.

Limitations

The Aim 1 findings have significant limitations, the primary one being the structure of the data source. Implementation plans were existing data. Therefore, no input from researchers was included in the preparation or content of these plans. The plans were not structured to facilitate coding and required significant cleaning. Additionally, the plans were not developed for the purpose of answering study questions. Therefore, analysis was limited to inferential findings. Qualitative interviews will supplement this inquiry and may be able to offset some limitations, described further in the conclusion of this report.

Other limitations include the following:

- The presence or absence of concepts in a plan does not necessarily indicate salience for the program because plans were written for the explicit purpose of attaining federal approval. Rather, implementation plans were structured by the Implementation Plan Guidance provided by ACF and were influenced by feedback from federal staff and TA providers.

- We do not know the extent to which implementation plans were used during implementation. Therefore, findings cannot address the application or utility of what was proposed in plans. Data from interviews may address this topic in future MUSE reports.
- Plans were developed at a specific time, and some were subsequently updated to reflect evolving program planning. For consistency, we chose to analyze the plan that was first approved during the specified funding period. This decision means that any changes made to implementation plans after this point are not represented in the data. Findings, therefore, may not represent current approaches.
- MUSE is designed to analyze the influence of home visiting models but not the models themselves. Therefore, findings may have varied relevance to implementation planning across models.

Chapter 3 | Ripples in a Pond: Planning Home Visiting as an Investment in Community by Community

"The ultimate goal is to coordinate and strategically align activities that support a comprehensive, holistic approach, one that thrives with diverse opportunities yet is focused on growing quality.... Ultimately, the Tribe envisions interlocking efforts to serve as a catalyst for an early childhood system of care, which, like 'ripples in a pond,' will reach out to all families."

Chapter 3 at a Glance

Tribal MIECHV programs partnering on MUSE envisioned their programs making a community-wide impact, like *ripples in a pond*. In these visions, Tribal MIECHV was a way to support child, family, and community well-being through the provision of home visiting services along with opportunities for cultural (re)engagement.

It was common for Tribal MIECHV implementation plans to approach home visiting as an investment in community by community. Plans provided visions of programs where the focus was on children and families, but the goal was to make long-term impacts for the community. For example, the aforementioned quote illustrates how the program strategically planned for the home visiting program to have impacts that would radiate from the family enrolled in home visiting to *all* community families—like *ripples in a pond.*

Programs envisioned home visiting as contributing to a reciprocal system of wellness flowing among children, caregivers, and community. They described their role as, at least in part, actively (re)establishing[8] families' connections to community, including facilitating access to community resources as well as supporting (re)engagement in cultural practice.

Key Findings

- Program vision statements were committed to furthering child, family, and community well-being through home visiting.
- Programs planned to make lasting impacts on community by centering children.
- Programs planned to be a primary connector between community members and community agencies that support children and families.
- Programs identified connection to cultural practice and knowledge as a source of well-being for children and families in communities served.
- Programs envisioned home visiting programs as a site for (re)engagement in cultural practices and knowledge.
- Some programs identified incorporating Indigenous language into home visiting as critical to achieving program visions.
- Programs supported family engagement by offering access to cultural learning and practice, especially in a communal environment.

[8] We use "(re)establishing" here to show that these actions are designed to support families in engaging with cultural practices across a continuum where some families have no experience or knowledge, others have disengaged, and yet others are active participants. Such support requires a nuanced approach that is at once cognizant of the families' relationship to cultural practices and also to Tribal norms around who holds cultural knowledge and under what terms.

Influencing Community Through Tribal MIECHV

Programs planned for home visiting to have a resonating positive impact on community well-being. Tribal MIECHV program plans were typically framed in relation to visions of healthy Native communities. In the following example, a program envisioned the community it serves as deeply rooted in generational history, Indigenous knowledge, and a commitment to active engagement in cultural practice:

> We envision a community that is united in spirit and practice, trusting and compassionate in our relationships, and fully embracing the ancient wisdom and healing that will sustain us for generations. We envision healthy, safe, self-reliant Native families actively engaged in the community, celebrating our vibrant, diverse, and unique cultures.

Building and sustaining a reciprocal system of child and community well-being were the overall vision for many Tribal MIECHV programs.

Program vision statements were committed to furthering child, family, and community well-being through home visiting. For Tribal MIECHV, ACF advanced an overall goal of "supporting the development of happy, healthy, and successful American Indian and Alaska Native (AI/AN) children and families." During planning, Tribal MIECHV grant recipients developed their own program visions, which were committed to providing supportive, nurturing home visiting services that enhance child, family, and community well-being. Exhibit 6 presents program vision statements from each of the 17 programs that participated in MUSE and identifies key priorities communicated. As the figure shows, the most frequently mentioned priorities within program visions included Tribe and community, children, family, and health and wellness. This frequency is depicted in the larger petals. Inversely, the concepts mentioned least frequently across Tribal MIECHV plans are shown with smaller petals. Additionally, programs envisioned home visiting services to be supportive and nurturing, empowerment oriented, and strengths focused. Program visions also highlighted commitments to fostering success and happiness by positively affecting child development and providing evidence-based services.

Exhibit 6. Tribal MIECHV Program Vision Statement Themes

To support the development of happy, healthy, and successful AI/AN families and communities through the provision of home visiting services that seek to break the chain of toxic stress exposures.

Families nurture their child in ways that honor their traditions and values and incorporate practices for optimal child and family development, healthy lifestyles, and strong community connections.

Motivated, healthy, strong Native families.

The community's children are healthy. Our families thrive. Our community prospers. Cycles are broken.

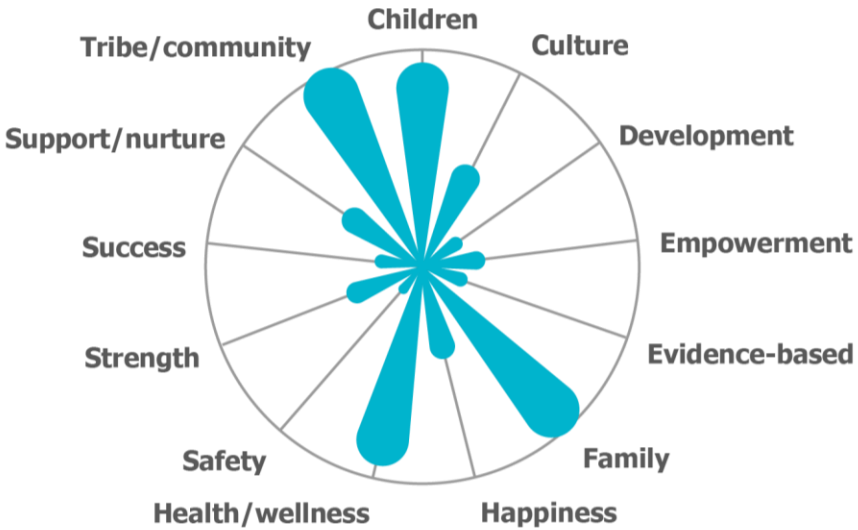
The Tribe's parents and children will learn, develop, and grow to realize their full potential and thrive together in a culturally connected community.

A Native Community that enjoys physical, mental, emotional and spiritual wellness.

To build healthy families and strong communities for Native American children and families in the State.

Empowering families to realize their vision of raising capable, holistic, culturally strong, and happy children through services that promote healthy family–child relationships, healthy life choices, and the community's cultural values and language.

A tribal community where families and children are empowered, culturally informed, and personally connected to one another in a way that supports good health, strong social-emotional skills, and a positive sense of self-identity.



We will build on the strengths of our community through connection, nurturance, education, and empowerment to facilitate healing, growth, and holistic wellness of loving and strong Native children and families.

Native families are empowered to strengthen their emotional, mental, physical, social, and spiritual wellness and to increase connections to their culture and community so that parents and children are safer, healthier, happier, and more resilient.

To provide holistic, culturally sensitive home visiting services to AI/AN children and families living in the county to support their health, happiness, and success using a high-quality, evidence-based program.

Expectant families and parenting families with children 0–5 on the reservation are healthy and safe and thrive in their communities and cultural traditions.

Our vision is that the community knows the program as a trusted, safe, and supportive resource for families with children under 2 years of age.

It is the vision of our program for all of the Tribe's children to grow into beautiful individuals who are happy and healthy.

Dedicated to equity, health, education, and wellness for American Indian, Alaska Native, Native Hawaiian, and Pacific Islander families and cultures in the county.

Healthy, happy, successful children and families supported by a coordinated, high-quality, evidence-based home visiting program.

Programs planned to make lasting impacts on community by centering children. Plan statements, such as the one that follows, reinforced the important role children play in the well-being of Native communities:

> Healthy children are the future of the tribes. Keeping children safe and healthy, away from negative paths in life, and toward resilience and learning is essential. …Supporting parents to be resilient; have healthy social connections; know where to access concrete resources and supports in times of need; and know how to help their children develop, grow, and learn is essential to the AIAN communities.

In such descriptions, the relationship among children, parents, and community is reciprocal and tied to a shared future. Although most, if not all, evidence-based home visiting models advance non-Indigenous conceptions of child development (such as those that privilege the nuclear family and biological kinship), implementation plans suggest that programs are also influenced by Indigenous understandings of children and family. Consider the following conceptualization of youth in one implementation plan:

> Youth are the community's most precious resource, for in their being holds the hope and future of the Tribe. Their health and well-being is a reflection and leading indicator of the health and well-being of our people, families, and community. Elders hold an important position as an intergenerational link, enabling the circle of knowledge to be completed. They have a responsibility to share their wisdom by passing on their knowledge to the youth and those who will carry it forward to future generations.

The statement emphasizes multigenerational relationality. The child and the community's well-being are tied to one another and mediated through the knowledge and generosity of Elders. Nurturing children nurtures community. This orientation highlights a moral imperative for investing in community programs that meet the needs of children and families. It also establishes shared stakes in the effort, demonstrating practically how programs that help children thrive, such as Tribal MIECHV programs, will benefit everyone.

At least one program directly related their commitments to furthering community-wide wellness directly to a Tribal health initiative:

> The program understands its purpose is to work on behalf of Tribal leadership to implement programming that will work towards positive and healthy outcomes on individual, family, and community levels.

Making Connections to Community Resources

Programs planned to be a primary connector between community members and community agencies that support children and families. Programs framed this connecting work in various ways, including as outreach and as services encompassing health, mental health, and substance misuse treatment. One program explained that in their community:

> Home visiting is seen as an effective outreach method to bring community members into the clinic and to utilize other services, especially with a focus on maternal health and pediatrics.

Although many programs called attention to a lack of available services in their communities, others acknowledged availability of services but showed how access can be limited for families. In the following example, the program identified how access to community resources can be established and reinforced through home visiting:

> Residents have the potential to access an extensive system of support, care, and assistance; however, many AI/AN families are not aware of what is available to them and how to access these resources. The Home Visiting Program is well positioned to help coordinate resources and educate families on what is available.

Variably referred to as coordination, navigation, education, and outreach, implementation plans made clear that Tribal MIECHV programs purposefully plan not only for the delivery of home visiting services but also for the extension of access to other community resources for enrolled families.

(Re)connecting to Cultural Practice

Programs identified connection to cultural practice and knowledge as a source of well-being for children and families in communities served. Many Tribal MIECHV programs identified connection to culture as a primary component of well-being. As such, many Tribal MIECHV programs identified (re)establishing connection to culture as a major program goal. Connections cited in implementation plans ranged across many practices and concepts. Connections to places of origin and ancestral land and connections, via community Elders, to traditional parenting and childbirth practices emerged as common relational practices.

In some plan statements, cultural practice was identified as a protective factor for children and families. Consider the following example:

> Cultural factors include an ever-growing awareness of how connection to culture can be a protective factor and that culture matters. Our strength as a people is embedded in our culture and traditions and these teachings show through each day via gatherings and culturally related events.

In another section of this same implementation plan, the program provided more clarity on how cultural factors operate:

> Families acquiring cultural knowledge, skills, abilities, and experiences are becoming more grounded in understanding how they can use their culture to make changes in their lives. Being culturally informed enables families to become more connected with their tribal culture and to rely on it as a resource during stressful times.

In such statements, culture is a grounding practice that can facilitate change and simultaneously a mode of connection that can mitigate harmful impacts of stress. Other implementation plans linked the concept to resilience. For example,

> The primary strength of the communities is resiliency. Residents in the target area are continually described as individuals/families with resilience by being grounded in tradition and culture expressed through daily activities, being independent, having meaningful relationships in family and the community, having the ability to continuously problem solve, and having the ability to live with and push through uncertainty and adversity…. These tremendous factors of resilience should be celebrated, highlighted, and built upon by the Tribal MIECHV home visitors.

Resilience, in this statement, is founded in connection and less as an individual's ability to recover from difficulties. Grounding in communal practices of tradition and culture is the source of resilience, and home visiting is identified as potentially being able to further such grounding.

Programs envisioned home visiting programs as a site for (re)engagement in cultural practices and knowledge. Consider the following reflection from one implementation plan:

> The needs and readiness assessment also highlighted the desire within the community to be more connected to the Native culture and the importance of language and Native traditions being taught to their child/children…the Home Visiting program can take a larger and more directed role for the community by

> offering more robust and comprehensive services within the home that incorporate cultural practices, traditions, or language.

Authors shaped Tribal MIECHV implementation plans with deeply valued cultural practices. Many Tribal MIECHV programs planned for home visiting to be an opportunity to (re)invigorate cultural practices that nurture children and families.

Implementation Plan Guidance stated a goal for Tribal MIECHV programs to provide "culturally relevant" services and provided discrete prompts for grant recipients to reflect on community strengths. Attention to the importance of cultural connection was emphasized throughout the plans, including in multiple sections where, without explicit prompting, Tribal MIECHV programs resoundingly identified culture (broadly and diversely defined) as a community strength. In some plans, the program's commitment to (re)connecting enrolled families to cultural practice was framed as part of a larger governmental priority, as in the following example:

> Tribal leadership has also made it clear, both formally and informally, that tribal programs should take realistic steps to include cultural learning within their services as appropriate.

In many Tribal MIECHV program plans, establishing and maintaining cultural connection were integral to program implementation. This added a complex dimension to program planning that required significant community knowledge and investments of resources.

Some programs identified incorporating Indigenous language into home visiting as critical to achieving program visions. Consider the importance of language in the following example:

> The Indigenous language is an essential element of the life, culture, and identity and its revitalization is a primary focus of the education department and of critical concern to the people.… In the community, language and thought guide the way natives make sense of events in their lives and thus can be observed in the beliefs and practices revolving around sickness and health in their society.

In this plan, language was at once an essential element, a primary focus, and a critical concern during program planning. Programs acknowledged that many community members reported speaking their Indigenous languages in the home. They also noted that language was not only a means of communication but also a mode of understanding critical to experience and well-being.

In the following example, the program referred to results from the rigorous evaluation they completed during the previous grant cycle to highlight the concrete and compounding benefits of adding Indigenous language into home visits:

> The rigorous evaluation study revealed that parents and extended family members greatly appreciate the emphasis the program puts on culture and language. The community has also recognized the important role home visiting can play in restoring the Native language among community households. Language maintenance and revitalization will require a deep commitment and constant vigilance from tribal leaders, tribal partners, elders, parents, and other community members.

Tribal MIECHV implementation plans identified many potential benefits to incorporating Tribal language into home visiting service delivery, including to further community and program values, engage families into home visiting services, and meet the desires and priorities of enrolled families.

Programs supported family engagement by offering access to cultural learning and practice, especially in a communal environment. Referencing needs assessment findings and/or implementation experience, many programs understood that providing access to cultural practice and learning was a major factor for program recruitment and retention. One program explained:

> Parents express high satisfaction with the cultural content, and we expect prospective families to see this content as relevant and as a potential hook to bring them into the program.

The following program used data from community focus groups conducted during their needs assessment to highlight the community-wide commitment to home visiting as a mode for cultural (re)connection. Reflecting on the importance of providing a neutral environment for people to come together, the program explained:

> Not all Tribal people know traditional values; but there are Elders and others who can teach how to parent traditionally. This is an important cultural and multigenerational aspect to consider in the home visiting program design going forward.

Such planning efforts aimed to foster social support within community members by building multigenerational and culture-rich programming. The program recognized the need to provide such resources in neutral environments where families unfamiliar with cultural parenting

practices can learn from community Elders. This approach builds on the demonstrated success of family group connections in home visiting and extends the reach of cultural connection to involve community members with treasured knowledge.

Conclusion

Tribal MIECHV programs envisioned home visiting as contributing to the community's overall well-being. Programs recognized the importance of incorporating cultural programming, and, in some cases, access to Indigenous language, into Tribal MIECHV service delivery in realizing this vision. The next chapter discusses how such investments in community well-being benefited from approaches that centered equity and considered the harmful impacts of colonialism on Indigenous people in the United States.

Chapter 4 | Rigorous Indigenous Frameworks: Incorporating Equity Into Tribal MIECHV Program Planning

"Our vision of achieving equity, health, education, and wellness for Indigenous families and children will require a multipronged approach to truly realize. Centuries of colonial practices, failed federal policies, systemic injustices perpetuated across multiple generations, and the epistemicide—near to total destruction or 'death' of cultures, languages, ways of life, and Indigenous philosophies—will not be undone and remedied in the immediate future. Healing will require hard work and intense focus over many generations.

"With this in mind, our communities require an extensive, rigorous Indigenous framework to successfully address the needs and priorities we have identified, as well as to make full use of and build upon our existing strengths that have seen us through the generations of loss.... We require a flexible, tested, and culturally grounded home visiting program to achieve our vision."

Chapter 4 at a Glance

Programs centered equity to emphasize the impact of colonization and structural inequity while reinforcing Indigenous thriving and well-being. This approach, deeply rooted in experience, data, and rigorous Indigenous knowledge, enables Tribal MIECHV programs to creatively plan home visiting services that address or repair harm while also preventing future harm for families and home visiting staff.

Although the prominence of equity discourse has skyrocketed in recent years (Taggart et al., 2023, p. S98), communities facing inequity have a demonstrated history of centering equity and social justice as primary factors of health promotion (e.g., Baciu et al., 2017). When writing their implementation plans in 2016–2017, years before the 2020 increase in attention to racial and health equity in health and social service sectors, Tribal MIECHV programs carefully framed home visiting programs within contexts that include land dispossession, child removal, and the violent suppression of Indigenous science and knowledge systems as well as continued structural inequities such as racism, gender discrimination, and poverty.

In implementation plans, Tribal MIECHV programs envisioned home visiting as part of larger efforts toward addressing these inequities and supporting healing across multiple generations. As the program demonstrates in the opening quote of this chapter, such visions require rigorous Indigenous frameworks. Following Nêhiyaw and Saulteaux scholar Margaret Kovach (2021), we understand such frameworks to be those rooted in Indigenous ethics, community, personal experience, and beliefs about knowledge creation (i.e., epistemology). Within such frameworks, rigor may emphasize evaluation practices beyond those that privilege certain designs (e.g., randomized controlled trials). For example, rigor may depend on "using (as appropriate to the situation) local cultural protocols that promote a fundamental respect for knowledge of cultural leaders who can provide meaningful insight/explanations to important questions" (Tribal Evaluation Workgroup, 2013, p. 11).

U.S. Policies and Actions Related to Indigenous People

"U.S. history, as well as inherited Indigenous trauma, cannot be understood without dealing with the genocide that the United States committed against Indigenous peoples. From the colonial period through the founding of the United States and continuing in the twenty-first century, this has entailed torture, terror, sexual abuse, massacres, systematic military occupations, removals of Indigenous peoples from their ancestral territories, and removals of Indigenous children to military-like boarding schools." (Dunbar-Ortiz, 2014, p. 9)

During home visit program planning, programs reflected on the need for such comprehensive healing efforts and how interventions that help parents address their experience with inequity can cultivate a changed future:

> Through the needs assessment process, it was revealed that during their life, those in the target population, either from overt racism, self-imposed alienation, or societal constructs, have been told that they are not smart, not capable, and not worthy. That must change for these parents to be confident enough to pass on a new message to their own children that can change the future dynamics within the community.

Key Findings

- Programs contextualized home visiting implementation with histories of colonial violence that continue to this day.
- Programs identified experience with inequity as a primary risk factor for children and families.
- Programs envisioned a role for home visiting in repairing harms from historical and contemporary conditions of structural inequity and injustice.
- Programs used trust building to address harmful effects of systems of injustice that continue to negatively affect Indigenous families.
- Programs planned to take part in community efforts to confront ongoing inequity affecting children and families across related systems such as healthcare and education.
- Programs planned to address historical harms to cultural vitality and to prevent future ones by educating staff and community partners to engender cultural responsivity.
- Some programs associated home visiting's focus on supporting children and families in their homes with longstanding and enduring practices of care.
- Programs recognized that inequities facing the community also affect staff.
- Programs used reflective supervision as one key tool to support staff well-being in the context of trauma and inequity.

Structural Inequity Rooted in Colonialism

Programs contextualized home visiting implementation with histories of colonial violence that continue to this day. Programs described the context of implementation that shapes program planning as multifaceted and intersecting. They spoke to the persistence of community strengths that reinforce family well-being alongside ongoing colonial efforts to

undermine these strengths and do harm to Indigenous children and families. Under the colonial system, the U.S. government attempted (often in partnership with private and religious institutions) the genocide (deliberate destruction), land dispossession, and forced assimilation of Indigenous Peoples through practices such as war, missionization, and child removal. Assimilation policies are legislated impositions of language and cultural practices by those in power. These colonial tactics transformed into more recent child service programs that continue to disrupt Tribal families' and communities' abilities to determine for themselves what is best for their children.

Revitalization

U.S. Secretary of the Interior Deb Haaland: "I believe that our obligations to Native communities mean that federal policies should fully support and revitalize Native healthcare, education, Native languages, and cultural practices that prior federal Indian policies, like those supporting Indian boarding schools, sought to destroy. We can heal from the harm and violence caused by Indian assimilation by effecting government-wide policies of revitalization for the Indigenous people of our country." (U.S. Department of the Interior, 2022)

In most plans, the lack of adequate child and family structural supports was attributed to the detrimental effects of colonization and related structural inequity rather than to deficits of parents:

> Historically, Native American Tribes had strong social systems with cohesive family and community structures. Tribes had well developed protective systems that acted in the rare occurrence of family breakdown. Unfortunately, these protective systems eroded under the weight of colonization, boarding schools and cultural assimilation policies imposed by the U.S. federal government.

Another program went to great lengths to describe the embodied and profound impacts of ongoing colonial practices:

> During the times of termination, many Indigenous children were taken away from their communities and placed in non-Indigenous schools. They were dressed as white children and forced to give up their native language. Many had an aversion to speaking the native language even as adults because of the beatings they received when they were caught. One elder said that his hands hurt when he tried to speak his language because as a child in school his hands were severely beaten with a ruler if he was caught.

> During that time, many aspects of our culture were lost to most people—our language, our ceremonies, our spirituality, our way of life, our Native diet—almost everything that made our community distinct. Some people took on the duty of saving our life ways by taking them underground until the day they could be rekindled. And that day is now.

The work of dismantling the underlying assimilationist and destructive aspects of family services programs is ongoing in the present day. Implementing present-day evolutions of such initiatives—for example, home visiting—without critical analysis would negatively affect programming quality in Indigenous contexts and would undermine community trust in the services in question.

These harmful impacts can be mediated through practices of state surveillance of Indigenous people, including through policing Indigenous caregivers, primarily mothers, through child welfare and educational systems. Such forms of surveillance have led to extensive child removal and to Indigenous caregivers avoiding social services. Tribal MIECHV programs are acutely aware of how such impacts of this system of surveillance of Indigenous families continue to affect attitudes toward home visiting in Tribal communities. Several implementation plans argued that such histories taint the reputation of parental interventions generally, and home visiting specifically, thus compromising the likelihood that families will seek out home visiting services. The following implementation plan segment carefully demonstrated this effect:

Surveillance of Indigenous Caregivers

Scholars explain how "...the scrutiny placed on Indigenous women continues to perpetuate situations in which women and families are set up for failure. The state's unforgiving and often merciless gaze often forces Indigenous women to conceal their problems. Instead of seeking help, they fear further intervention from the state, including having their children removed" (Shahram, 2017, pp. 23-24).

> Up to a few years ago, home visiting was perceived as a form of punishment or a consequence for families who had gotten into trouble with some branch of social services. Even though people have started to appreciate that home visiting can be a positive and supportive intervention, it is still not fully understood by many in the community.

Tribal MIECHV programs purposefully attended to this complex element of implementation and were intentional in shaping their service approaches accordingly. Plans highlighted how rooting home vising programs in cultural strengths and Indigenous science, such as the rigorous

Indigenous frameworks mentioned previously, was a foundational aspect of delivering equitable early childhood services in Tribal communities.

Home visiting models developed outside of a community's specific context generally lack content informed by Indigenous science. By not being rooted in a community's highly specified conditions, such home visiting models are not, on their own, able to promote cultural strengths, the very things that have nurtured and protected Indigenous family well-being before colonial contact. When Tribal MIECHV programs infuse their program designs with culturally grounded and culturally aligned approaches, they strive to support ongoing Indigenous *survivance* and thriving at the individual, family, and community levels.

Survivance

Survivance is a concept developed by Anishinaabe writer Gerald Vizenor. Lumbee scholar Bryan Brayboy (2005) described survivance as the "uniqueness of the American Indian experience with persevering in hostile contexts. Survivance, which combines survival and resistance, calls for adaptation and strategic accommodation in order to survive and develop the processes that contribute to community growth" (p. 435).

Programs identified experience with inequity as a primary risk factor for children and families. As one program wrote:

> Native children and families in general are more at risk due to the overwhelming trends and inequities the population faces.

Plans detailed ongoing issues of inequity and racism within their health, education, and social service systems. They referenced direct experiences of their program families and other communities as well as current population-level data on AI/AN health and social well-being. Plans demonstrated impacts across many domains, including the following:

Historical Trauma

Maria Yellow Horse Brave Heart defines historical trauma as "cumulative emotional and psychological wounding across generations, including one's own lifespan, because everything up to a moment ago is history" (Smith College, 2015).

- How inequity affects program engagement:

  > Because of the impact of historical trauma, adverse childhood experiences, and poverty, the ability to and resources for families to engage in supportive services are sometimes limited. Some of these individuals have difficulty engaging and maintaining progress in services. Staff

turnover in programs also creates difficulties for families who have difficulty trusting and connecting with service providers.

- How inequity contributes to toxic stress, a form of stress that adversely affects a person's cognitive development and functioning (Harvard University Center on the Developing Child, n.d.):

  Given the history experienced by Tribal families and the extended stress with colonization and the displacement that resulted from it, Tribal members have been responding to toxic stress for generations.

- How inequity compounds with other risk factors to further poor pregnancy outcomes, specifically infant mortality:

  The infant mortality rate provides a proxy for overall population health, and for AI/AN infants in the state, the mortality rate is more than twice that for the general population.… The high infant mortality rate coincides with numerous additional heightened risk factors for poor pregnancy outcomes among Natives in this state: mental health problems, alcohol and/or substance abuse, smoking, threatened preterm labor, history of prior low birth weight, preterm delivery or fetal death, and nutrition and weight.

- How inequity results in a staggering number of children residing in Native nations living in poverty:

  Overall, roughly two in five residents of the Native nation live below the 185 percent Federal Poverty Line. In the state, 31.5 percent of children under age 5 live in poverty compared to 23.9 percent nationally. The county has a staggering 45.4 percent of children living in poverty.

Home Visiting as a Means for Repairing Harms

Programs envisioned a role for home visiting in repairing harms from historical and contemporary conditions of structural inequity and injustice. An extensive sustained history of structural inequity and injustice has been imposed on Indigenous communities since the colonial and settler colonial periods in North America. The impacts of these systems have been, and continue to be, incredibly traumatizing and detrimental to the intergenerational health and well-being of many Indigenous families. The following home visiting program described the harmful histories of boarding school removals, violence, and forced assimilation and identified the need for programs to work toward repair for Tribal communities:

> Research indicates that ensuring families and children have access to programs designed to repair the damage of colonization, war, and the boarding school system is of great importance to the future of Tribal communities.

In implementation plans, Tribal MIECHV programs addressed the need to account for these sociohistoric contextual influences in home visiting implementation. For example, implementation plans described dedicating much time and effort to (re)building trusting relationships with families through practices rooted in strengths-based approaches and Indigenous notions of parenting support. The following implementation plan passage highlighted the essential connection between trust building efforts that address the reputation of home visiting and successful implementation:

> Elders emphasized that extended relationships support parents best.… They recognize that stigma of home visiting still exists and that building in meaningful relationships that support the development of trust between the family and the program is key to implementing the program.

Programs argued that the results of such repair work have been, or will be, reflected in community buy-in and engagement over time.

Programs used trust building to address harmful effects of systems of injustice that continue to negatively affect Indigenous families.

In one primary example of addressing such harm, programs described the need to disentangle home visiting services from the sphere of punitive child welfare, both reputationally and in practice. Consider how the following program attended to concerns around privacy in the delivery of home-based services:

> During development of the program, there was some initial resistance to the initiation of the tribal home visiting programs and other in-home outreach efforts to tribal families. There were privacy concerns and issues around who would be visiting with what types of community connections (i.e., influence of fears of child welfare and trauma around removal of children from the home, etc.).

Although Tribal MIECHV programs are voluntary and often strengths-based, mandatory reporting elements of home visiting can directly link it to the child welfare system. This situation means that connection to child welfare is simultaneously problematic and necessary within current structures of authority. Tribal MIECHV programs described navigating such paradoxes by planning for practices of mutual trust building across individual, organizational, and community levels.

Such trust building strategies are used to enhance parent–program connection generally and seemed to be particularly important at this juncture between home visiting and child welfare. Programs wrote about important elements of culturally rooted relationship building that addressed many of the issues presented. These relationship building efforts were often presented within an ecological framework that considers the family–home visitor relationship within the family–program relationship and the program–community relationship. Strategies for enhancing parent–program connection include the following:

- Establishing and maintaining strong parent–home visitor relationships:

  > Parents and home visitors felt the relationships between home visitors and families accounted for the strong program connection.

- Retaining staff:

  > Our program has benefited from the presence of consistent home visitors who have been active with the program since the onset and have developed great connections with families.

- Ensuring staff–family cultural alignment within their mutual community context:

  > The program will hire Native staff to ensure that families are working with individuals that know and understand their communities and cultural practices and have an understanding of the community's needs and strengths.

- Receiving support from Tribal Elders and Tribal government and/or community leaders:

  > Tribal leaders have been at every site visit that has been conducted in the previous grant years.…When new tribal leadership is appointed every year, our program has been able to inform them on home visiting and how they could support programming.… We plan to continue to accept guidance and advisement from tribal elders on implementation. One of the members of the [program leadership council] is a community member and a respected elder. Her continuous promotion and support of the program is invaluable.

- Building a program with longevity and substantial community support:

  > Since selecting the model and implementing the program, we served hundreds of women and families. The program has become well known in the community and has a very positive reputation. When community members value this as much as providers, Tribal council and executive teams also have buy-in.

Programs advanced such multilevel mutual trust building—between caregivers and home visitors, between home visitors and community, and between community and program—not only as foundational to service delivery but also as a means for addressing the harmful effects of systems of injustice that continue to negatively affect Indigenous families.

Cultural Responsiveness

The child welfare gateway describes cultural responsiveness as enabling "individuals and organizations to respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations, and other diversity factors in a manner that recognizes, affirms, and values their worth." (Child Welfare Information Gateway, n.d.)

Programs planned to take part in community efforts to confront ongoing inequity affecting children and families across related systems such as healthcare and education. Programs presented information on inequity in a way that bolstered the early childhood and family support systems in their local communities and demonstrated the central role they play in that effort. As such, it is clear the Tribal MIECHV programs can play a vital role in overall community health equity, and Tribal MIECHV program activities, such as the needs assessment, can serve as catalysts for initiatives and collaboration across early childhood systems.

Consider how the following program described the development of its advisory board as deeply rooted in the community efforts of its early childhood collaborative system:

> The Collaborative is a work group comprised of individuals who provide services in the community to children and families from prenatal to age 8.… Collaborative members have organized joint trainings that focused on important community topics such as historical trauma and mental health.… The program's community needs assessment activities with the Collaborative, in early 2016, was a catalyst for the group to set sights on revitalizing its mission, vision, goals, and objectives.… The relationship is seen as symbiotic, in that strengthening the home visiting program should strengthen the early childhood system, and because the program could devote resources to strengthen the capacity of the Collaborative to build an effective early childhood system.

Programs planned to address historical harms to cultural vitality and to prevent future ones by educating staff and community partners to engender cultural responsivity. Previous negative experience with health service providers and other referral partners who were not culturally connected or attuned to the service community or

communities has resulted in a lack of trust and willingness to seek services on the part of Indigenous families. As a result, Tribal MIECHV programs planned to work hard to identify trusted community referral partners and to enhance capacity within their own teams and in their referral networks to better serve Native families. This work with partnering agencies is another example of Tribal MIECHV programs going well beyond providing home visiting services. Through their rigorous Indigenous frameworks, where equity is often centered, programs work to prevent harm and to enrich the support networks surrounding families.

One program identified cultural competence as necessary in its own right and also as a means for addressing structural inequity:

> Our commitment to cultural competence with families is due to several factors: (1) AI/AN clients seek out culturally specific services and providers, offering an opportunity to expand our reach across the AI/AN community; (2) culturally competent services, including referrals, offer our families trusted providers to help overcome systemic inequities and harms such as discrimination, and work toward our mission as a service provider and Tribal MIECHV goals and objectives; and (3) our culturally infused programming is appreciated by the families we serve.

In another implementation plan, the program advanced cultural responsivity as a requirement for home visitors:

> Home visitors need to be able to be culturally responsive to the diverse backgrounds, heritages, and practices of families in urban and rural tribal communities they serve and be equipped to adapt knowledge and training to fit individualized needs of Native American families.

As with multiple programs, this program paid special attention to various forms of cultural diversity within the service population in their implementation plan.

Some Tribal MIECHV programs associated home visiting's focus on supporting children and families in their homes with longstanding practices of care. Some programs shared that home visiting itself is connected to long-term traditional practices of supporting families in their home environments. In the following plan, the availability of federal funding facilitated the community to (re)build home visiting services, not from scratch or as an innovation, but in reference to a long history of such practice.

> For generations, people of the Native nation have utilized the lessons and innate protective factors available in their environments to care for and attend to the

> needs of families in their communities. The natural and informal approach of "visiting" with each other provided healing factors that created a promising practice for maintaining community wellness. While home visits were recognized as a traditional cultural practice, ingrained as an everyday practice, the community also recognized the potential of a more structured approach to home visits that supports improvements in child and family outcomes.

The statement recognizes the value of both traditional and more structured approaches to home visiting, supporting program planning that was uniquely capable of weaving the two modes together.

Enhancing Equity for Staff

Programs recognized that inequities facing the community also affect staff. Programs were deliberate about supporting staff well-being through a variety of mechanisms, with awareness that many staff have dual roles as program professionals and community members. Many staff, especially home visitors, have backgrounds and experiences similar to those of enrolled program families. Some Tribal MIECHV programs reflected on how often their home visitors either have received home visiting services themselves or have been a close relative of someone who has. For example:

> Many Tribal employees live on the Reservation, have received home visiting services, know someone who has received home visiting services, and/or have made referrals for their clients, family, or friends.

Such close relationality between home visitors and caregivers is a strength of Tribal MIECHV programs, and in the context of equity, a necessary factor to consider when building a supportive infrastructure for staff. This close relationality also means that inequities facing the community—such as fewer opportunities for educational attainment and historical and lived trauma—implicitly affect staff team members. Tribal MIECHV programs directly addressed this issue by building in staff supports that intentionally support growth in holistic well-being and professional stability over time.

Supporting educational attainment and professional growth of home visitors was one prominent theme throughout implementation plans. Implementation plans highlighted program staff as well educated and well trained. Although ample evidence showed the high caliber of Tribal MIECHV programs teams' qualifications, some programs emphasized how program staff can be affected by disparities related to opportunities for educational attainment and professional development. Many plans identified hiring and retaining staff as a challenge to implementation.

Tribal MIECHV programs addressed this challenge in various ways, including reconsidering home visitor qualifications required by models and/or selecting new home visiting models with different qualification requirements.

Most commonly, programs planned to provide professional development and prioritized staff retention as primary approaches to address staffing challenges.

As one program described:

> Staff professional development is a key component of our program success so far, and we believe it is also tied directly to staff retention.

The following program described their commitment to supporting educational attainment for staff in the context of continued disparities:

> There are still disparities in regard to education attainment, and because of this, program leadership strongly advocates for supporting educational attainment among staff.

The following implementation plan proposed scaffolding their educational development for staff with a supportive supervisory structure:

> Professional development remains important throughout each staff's career.… The program will support approved professional development plans through accredited colleges courses, continuing education or professional development conferences, online workshops provided by credible organizations, workshops and seminars sponsored by ours and other agency organizations. At least every 6 months, the home visitor and supervisor will review the professional development status to date, along with professional development for the rest of the year, to ensure that home visitors are on track.

One implementation plan recognized that in addition to providing a working environment that supports staff retention, the program needed to ensure that it could provide a wage for home visitors that reflects their value to the organization:

> We work hard to bring in extra funding and find dollars wherever we can to provide pay increases to our staff on a semi-regular basis. The reality is that we live in a very expensive place, and, organizationally, we are somewhat limited in funding opportunities, but the staff know that this is a priority, and it helps them feel valued.

For this program, ensuring adequate resources for staff retention required leveraging funding and resources beyond grant funds from the larger service environment.

Implementation Plan Guidance: Reflective Supervision

"For the purposes of the Tribal MIECHV program, reflective supervision is a distinctive form of competency-based professional development that is provided to multidisciplinary early childhood home visitors who are working to support very young children's primary caregiving relationships. Reflective supervision is a practice that acknowledges that infants and toddlers have unique developmental and relational needs and that all early learning occurs in the context of relationships. Reflective supervision is distinct from administrative supervision and clinical supervision due to the shared exploration of the parallel process, that is, attention to all of the relationships is important, including the relationships between home visitor and supervisor, between home visitor and parent, and between parent and infant/toddler. Reflective supervision supports professional and personal development of home visitors by attending to the emotional content of their work and how reactions to the content affect their work. In reflective supervision, there is often greater emphasis on the supervisor's ability to listen and wait, allowing the supervisee to discover solutions, concepts and perceptions on his/her own without interruption from the supervisor." (Implementation Plan Guidance, p. 45)

Programs used reflective supervision as one key tool to support staff well-being in the context of trauma and inequity. Programs identified reflective supervision as a method for supporting staff well-being and to debrief challenging aspects of their jobs. Identified topics included addressing the potential for secondary trauma that can be directly tied to home visitors' own historical and/or intergenerational trauma. About one-quarter of implementation plans mentioned historical trauma training as a specific category of introductory and ongoing staff support for home visitors.

Programs recognized that providing home visiting services can be challenging and isolating, and they followed Tribal MIECHV guidance and planned to use reflective supervision, clinical supervision, and administrative supervision to support staff through those experiences.

> Reflective supervision as an in-house resource would build capacity and sustain services into the future.… The supervisor, who has insight into cultural norms, the community, enrolled cases, and each staff member, can effectively respond to the culturally specific needs and priorities of home visitors. Staff also have access to clinical staff, who are available to provide guidance and consultation for any issues that arise.

Programs planned to support staff by intentionally addressing inequity and enhancing professional opportunities for staff and the community more generally. Program plans recognized that quality of staff support is directly related to the care staff provide to families:

> Home visiting work is dependent on a strong parallel process; when home visitors feel cared for and supported, only then can they provide care and support to the families they work with.

Conclusion

For Tribal MIECHV programs, equity takes on rich and nuanced meaning within the contexts of Indigenous community strengths and resilience, colonialism, and historical trauma. Across implementation plans, Tribal MIECHV programs engaged deeply with these sociohistoric factors. Drawing on Indigenous-based equity considerations and frameworks, program planning laid a foundation for Tribal MIECHV programs to use multiple ways of knowing that incorporate Indigenous cultures when tailoring program curricula (or models). This theme is the focus of the next chapter.

Chapter 5 | Supporting Cultural Values and Fit: Applying Flexibility and Using Multiple Sources of Evidence in Tribal MIECHV Program Planning

"The use of a home visiting model that had been proven effective at improving development outcomes for children and improving the skills of the parents—combined with cultural adaptations that create mutual trust and acceptance of this resource—has far-reaching implications for strengthening families."

Chapter 5 at a Glance

Programs recognized that most home visiting models are not developed with Indigenous communities in mind. Therefore, they would not, in and of themselves, be able to adequately address more holistic and expansive visions for home visiting necessary for successful and efficacious service delivery in Native communities. Planning processes emphasized the importance of prioritizing cultural values and fit. Programs planned to achieve fit to community not only by identifying and adhering to the "right" model but by leveraging model flexibility and treating the model as one highly valued component of a larger set of practices informed by prior experience and Indigenous knowledge.

Central to the MIECHV program is the idea that implementing evidence-based home visiting programs with fidelity improves the likelihood that families will experience desired outcomes. As described in the introduction, Tribal MIECHV also placed similar emphasis on fidelity to evidence-based models, yet only one home visiting model had data demonstrating effectiveness within Native communities (Avellar & Paulsell, 2011). Therefore, home visiting models with demonstrated effectiveness in non-Tribal settings were considered promising approach models for Tribal MIECHV. The lack of evidence specific to the service population in Tribal MIECHV programs introduced challenges and opportunities in program planning. Programs addressed these challenges and opportunities by acknowledging the dilemma of selecting a home visiting model without evidence of effectiveness in Native communities and by expanding how they incorporate implementation principles such as adaptation, fidelity, staff support, and data use into program design. In the plans, flexibility, more than adherence, emerged as a primary means for achieving program fit, model fidelity, and successful implementation.

Key Findings

- Most programs decided to modify a home visiting model rather than implement it without any modifications.
- Programs elected to supplement and enhance selected home visiting models more often than they chose to adapt them.
- Programs drew on many sources of evidence to plan for home visiting services, including Indigenous knowledge and prior experience.
- Programs committed to contributing to the evidence base for selected models and for home visiting more generally.
- Programs planned to balance model fidelity with meeting cultural and community needs and values.
- Programs anticipated a wide range of challenges to implementing home visiting models with fidelity.
- Programs observed that flexibility of home visiting models helped program staff deliver services to fit with community context and priorities.
- Programs benefited from trusting relationships with model developers throughout planning and implementation.
- Programs planned flexibility into the home visit.

Modifying Models to Fit Communities

During the 2016 implementation planning period captured in this report, Tribal MIECHV programs had to evaluate and select from a set of home visiting models that lacked a strong evidence base in Indigenous communities. The Tribal MIECHV programs featured in this report began planning implementation in 2010. At the time, no models had demonstrated evidence of effectiveness specifically with Indigenous populations. In 2014, Family Spirit was identified by HomeVEE as one of 20 home visiting models to meet HHS criteria for an evidence-based early childhood home visiting service delivery model (Mraz Esposito et al., 2014). Critically for Tribal MIECHV, Family Spirit had been designed and tested in a Tribal community, meaning the evidence of effectiveness met HHS criteria and was demonstrated within a Native population. As of 2022, Family Spirit was still the one early childhood home visiting model to meet HHS criteria as an evidence-based model for Tribal populations (Bleiweiss-Sande et al., 2022).

In the following implementation plan, a program described model selection as a dilemma or "Catch-22," a term that refers to a situation where a person is positioned between two conflicting conditions:

> There is limited availability of training in AI/AN culturally relevant and proven programs. This is a bit of a Catch-22, since grant funding will often require that a proven approach be implemented, but there are limited options available from which AI/AN communities can choose.

Not only was there a lack of evidence supporting the efficacy of home visiting models in Native communities, but many programs reported having difficulty acquiring more general data for Native populations to inform more foundational aspects of program planning. Programs particularly highlighted the lack of available census and other secondary data for Indigenous populations. Data specific to Native communities were particularly challenging to obtain:

> Common throughout this document is the challenge to get meaningful Tribal community data. There are a variety of reasons these data are challenging to obtain at the Tribal level, but the issues are larger than just the program.

Recognizing that there were limited evidence-based home visiting models to select, ACF guided grant recipients to select a promising practice. Tribal MIECHV programs could choose to implement a home visiting model deemed evidence-based for the state MIECHV program, implement a model with evidence of effectiveness with a Tribal population, or implement a model without evidence of effectiveness. They could also develop their own model in partnership with a national organization or institution of higher education. Additionally, programs could modify home visiting models to meet community needs or implement the existing models as is.

Implementation Plan Guidance: Definitions of Key Terms

- **"Enhancements** are changes or additions to the model that have not been tested with rigorous impact research but are determined by the model developer not to alter the core components related to program impacts.…
- **"Supplements** are the addition of a supportive or complementary curriculum or strategy to an evidence-based home visiting model. The supplement may or may not have been tested with rigorous impact research, but must be determined by the model developer not to alter the core components related to program impacts.…
- **"Adaptations** include changes to the model that have not been tested with rigorous impact research and are determined by the model developer to alter core components related to program impacts.…" (Implementation Plan Guidance, pp. 40–46)

Exhibit 7 shows the home visiting models selected, enhancements, supplements, and adaptations identified across implementation plans.

Exhibit 7. Models, Supplements, Enhancements, and Adaptations Planned by Tribal MIECHV Programs

	Examples from implementation plans
Home visiting models selected	Parent Child Assistance Program is used by 1 program; Family Spirit, 2 programs; Nurse Family Partnership, 3 programs; and Parents as Teachers, 12 programs[9]
Enhancements	Imagery, examples, and other content incorporated into selected model materials, activities, and lessons to reflect unique cultures and populations served; Native language use and learning; community events that include individuals not enrolled in home visiting program
Supplements	Conscious Discipline; additional caregiver screening and referral tools; Circle of Security; Fatherhood Is Sacred; financial literacy components; Positive Indian Parenting; Promoting First Relationships (currently included on HomVEE list)
Adaptations	Expanded enrollment criteria; expanded length of services beyond model prescribed dosage; locally developed curriculum; or additional curriculum content (e.g., birthing) via adapting model lessons

When selecting a home visiting model, programs reported many considerations, such as these:

- Support for the selected model by agencies within the program service environment:

  > The presentation [on selected model and supplement] was met with excitement and support for the design.… The support from partner agencies positively reinforced staff decision making.

- Correspondence with the state home visiting initiative:

  > Not only did the model meet our needs at the time, but it was originally selected as one of the two evidence-based models for the state.… This did mean that we were able to rely on the state to build some of the infrastructure needed to support the program and coordinate measures.

- Resources in the community

  > The constant challenge for the development of any new program within the organization is funding to hire staff to do the work. With a small population and workforce, it is difficult to restructure current positions to do new duties without creating gaps in current service delivery. More specifically, the use of Nurse-

[9] Tribal MIECHV programs were not limited to selecting just one home visiting model. Thus, Tribal MIECHV programs can implement more than one model as well as enhancements and supplements.

> Family Partnership would present challenges for sustainability as it might be difficult to hire nurses to fill the home visiting role.

- Existence of strong peer networks to support implementation:

> The program belongs to a strong peer network of statewide model implementers and implements the program with fidelity.… The programs have a good working relationship. They regularly consult one another and travel to trainings and meetings together.

Most programs decided to modify a home visiting model rather than implement it without any modifications. According to Tribal MIECHV requirements, all modifications had to be agreed upon by model developers and ACF. Tribal MIECHV programs used three types of modifications: enhancements, supplements, and adaptations. Two of these, enhancements and supplements, were determined by the model developers not to alter the core components related to program impacts.

Programs described planning modifications for various reasons, including to improve program efficacy, attend better to individual family and community values and needs, and increase program engagement. Consider the following example:

> Available research shows that culturally enhanced services can increase program efficacy. Our enhancements ensure that we are able to rely on the strengths of the model while simultaneously making certain that our program is the right fit for the community.

Programs identified cultural modification specifically as essential for meeting program goals and for meeting broader community commitments. One plan explained:

> With the model, the team has found that cultural enhancements and additions are easy to include. These cultural enhancements not only support the program goals but also represent the overall vision for tribal services as directed by Tribal Council.

Programs elected to supplement and enhance selected home visiting models more often than they chose to adapt them. Most programs did not adapt selected home visiting models, citing the burden of attaining model approval for adaptations and concerns that adaptations might alter the effectiveness of core components. Quotes from two plans demonstrate such considerations. One program wrote the following:

> We will make sure that these additional components do not rise to the level of adaptations, which would then require approval from the curriculum model developers.

Another program described planning:

> [The] cultural enhancements have been carefully developed so they enhance but do not change core components of each model. The model developers have endorsed the enhancements and confirmed that integrity to the model will be maintained.

A few Tribal MIECHV programs planned modifications to home visiting models that met the definition of adaptation from the Implementation Plan Guidance. Some programs had previously worked with model developers to approve adaptations to model components and curricula, including eligibility criteria, which programs planned to continue in the current grant period. Tribal MIECHV programs also planned for additional new adaptations that continued to focus on changes to models' eligibility criteria, as aligned with Tribal MIECHV programs' commitment to serving their broader communities.

Given the lack of demonstrated effectiveness of home visiting models in Indigenous populations, many Tribal MIECHV programs supplemented or made cultural enhancements to facilitate community fit without sacrificing the benefits of implementing a proven intervention. Programs often supplemented home visiting with interventions specifically developed for Native communities and supported by knowledge development and practice outside of evidence-based medicine (Braithwaite et al., 2018). Positive Indian Parenting (PIP) and Fatherhood Is Sacred are two examples. Programs described these supplements as supporting responsiveness to community needs, as enhancing fit and effectiveness of home visiting services, and as linked to asserting Indigenous knowledge throughout service delivery and evaluation.

The following plan described the ways PIP aligns home visiting implementation with Indigenous science and knowledge systems and thereby helps affirm Indigenous parenting.

> PIP relies on Indigenous epistemologies [i.e., knowledge] and methodologies, with the intention of promoting parenting behavior change through a culturally relevant, strengths-based approach. Worldwide, Indigenous communities have asserted their right to reclaim and incorporate their own science and produce their own knowledge, essential components of their communities and cultures. … PIP provides an important support for parents navigating a non-Indian world. Valuing Indigenous parenting serves to confirm and affirm Indigenous parents.

Other programs planned supplemental interventions to enhance the pursuit of community visions and goals. The following plan described how supplementing the selected model would extend services to fathers, beyond the maternal and infant focus of many home visiting models.

> The Fatherhood Is Sacred training will allow the provision of a 12-week program that is designed to assist fathers in gaining a deeper understanding of the importance of responsible fatherhood as reflected in Native American values and beliefs.

Additionally, many programs planned to enhance their selected models through practices that were planned in advance and through those that would emerge more organically during home visits (Stark, 2021).

When modifying their home visiting models, not all programs relied solely on the terms provided in the Implementation Plan Guidance (e.g., supplementation, adaptation). One program referred to their modification as cultural attunement*,* a process of cultural synchronization that decenters mainstream culture (Falicov, 2009). This program used cultural attunement to help synchronize services with cultural surroundings and social contexts. Although the proposed modifications meet definitional criteria for enhancements, the program's use of this term decenters settler colonial frameworks in the home visiting evidence base. Rather than a sense that cultural modifications augment a primary model, which is evidence-based, cultural attunement offers instead a balanced notion of synchronization—a weaving together of multiple, evenly weighted practices rooted in various knowledge systems and prior experience.

Relying on Indigenous Knowledge and Prior Experience

Programs drew on many sources of evidence to plan for home visiting services, including Indigenous knowledge and prior experience. Although Tribal MIECHV programs drew heavily on existing research literature on home visiting and related topics throughout planning, Indigenous knowledge and prior experience were also vital knowledge sources for how Tribal MIECHV programs were planned. One program explained:

> The curriculum was developed to supplement the chosen evidence-based model as a way to coincide research-based parenting theories with our parenting techniques that have shown to be effective among our people since our inception.

Across the plans, programs rooted explanations of how and why their home visiting services will "work" in the evidence of Indigenous and community knowledge of what has worked for parents in communities throughout time.

Applying Indigenous Knowledge

Indigenous knowledge informed program philosophies, modifications to selected models, and implementation practices, especially those supporting family and community engagement. One program addressed the lack of available research supporting Indigenous home visiting by turning to Indigenous knowledge and other forms of evidence:

> It is possible that the research literature on the topics identified by community members is limited or nonexistent. We plan to address this by consulting with expert review panels on how to access other best practices or additional resources, such as gray literature and/or indigenous knowledges, to inform content development.

Another program looked to tailoring as a way of incorporating Indigenous knowledge and experience-based teaching into home visiting service delivery to complement more non-Indigenous models of education:

> The needs assessment identified…priorities for tailoring parenting education and support to include traditional AI/AN ways of knowing and utilize different strategies for experiential teaching and modeling of support versus strictly using a didactic Western [i.e., non-Indigenous] model for education.

Reflecting on findings from their prior evaluation, one program described the value of incorporating cultural healing and Indigenous knowledge within their program:

> Also salient are findings from the rigorous evaluation study indicating that cultural enhancements were widely embraced, highly valued, and perceived as beneficial.… Evaluation findings offer support for the program's strategy of addressing cultural healing and indigenous ways of knowing in explicit ways, both by offering a stand-alone cultural curriculum as well as by enhancing the evidence-based model.

Using Prior Experience

Programs used knowledge gained through years of prior home visiting implementation to inform planning. Many of the MUSE participating sites had been implementing home visiting programs through Tribal MIECHV for several years before writing these implementation plans. These programs drew heavily on such experience, which is especially valuable given the lack of available research on home visiting in Indigenous communities. For example, one plan explained:

> The program has six years of experience implementing the model and the supplemental curriculum. This experience will allow the program to build on previous successes to improve the program and address the organizational needs identified in the needs and readiness assessment.

Another program remarked on a longstanding and community-wide familiarity with home visiting generally and the model more specifically:

> Our targeted communities are familiar with home visiting, and in particular with the selected model.… Home visiting has been in our communities for over 26 years. Families moving into new communities from across the reservation find consistency in the delivery of home visitation knowing the expectations and also the resources provided, which is critical to sustainability and family engagement and retention.

Expanding the Knowledge Base

Programs committed to contributing to the evidence base for selected models and for home visiting more generally. One program highlighted such commitment, clearly stating this:

> The program hopes to expand the knowledge base around the model curriculum by providing a study sample of Native American families.

The following plan highlighted the need for more evidence on home visiting in Native communities generally but, more specifically, for evidence to be generated that emerges from and contributes to Indigenous knowledge systems:

> We see the program as an opportunity to contribute to this important legacy and renew, with current research specific to Indigenous communities, this longstanding effort to revitalize Indigenous ways of knowing and ensuring families have a meaningful opportunity to pass these knowledge systems and content down to their children.

Implementing With Fidelity

Programs planned to balance model fidelity with meeting cultural and community needs and values. Implementation plan guidance asked programs to describe how they would monitor fidelity and the challenges they anticipated.

Implementation Plan Guidance: Implementation of a High-Quality Program

"Monitoring of fidelity of program implementation to ensure services are delivered according to the requirements of the selected program components.

"i. Describe how you will monitor, assess, and support implementation with fidelity to the chosen program components and maintain implementation quality assurance.

"ii. Discuss anticipated challenges to maintaining quality and implementation fidelity and how you will address them." (Implementation Plan Guidance, p. 18)

Implementation plans conveyed a commitment to implementing with fidelity and acknowledged the role fidelity plays in delivering effective home visiting services. One plan attributed the program quality to both model fidelity and addressing community priorities:

> The program has developed into a high-quality program that both implements the model with fidelity while meeting cultural and community needs. … In addition, we have developed program services based on past experience and identified client and community needs to ensure that urban Indian priorities are met.

Programs anticipated a wide range of challenges to implementing home visiting models with fidelity. Implementation Plan Guidance prompted Tribal MIECHV programs to identify anticipated challenges to implementation fidelity (exhibit 8).

Using experience from prior years of home visiting implementation, programs identified challenges related primarily to data collection and use, staffing, and service delivery. Programs also recognized that meeting fidelity requires coordination with the model and identified challenges to that coordination. Written before the onset of COVID-19, the challenges identified in these implementation plans do not reflect those introduced by the pandemic. It is also possible that some of the strategies used in response to the pandemic (e.g., virtual service delivery) have mitigated the following challenges to some extent. Future MUSE briefs will

address the impact of COVID-19 on Tribal MIECHV implementation using data collected during the pandemic.

Exhibit 8. Challenges to Implementing With Fidelity

Challenge category	Examples of challenges named in plans
Data collection and use	• Double data entry (e.g., multiple models and curricula, multiple data systems) • Meeting data collection standards and practices • Overcoming negative perceptions of data collection and entry • Keeping up with fidelity tracking • Transferring data between data management systems • Data collection tools not being available in Indigenous languages • Data collection being administered in written format only • Community families experiencing overassessment • Families' reluctance to participate in data collection because of prior experience with or knowledge of traumatic research practice • Data having limited perceived value for home visitors relative to other aspects of home visiting • Numerical data having limited value relative to other forms of evidence (e.g., community experience) • Tracking and documenting enrolled families' progress
Staffing	• Staff changes and turnover • Finding staff who meet model qualifications (e.g., registered nurses) • Making the "right" hire (fit) • Not enough time for staff to complete activities • Competing deadlines for staff • Ensuring coverage during staff leave • Meeting staff training needs • Maintaining model standards
Working with models	• Keeping up with updates from models • Model database function and updating • Using tools for monitoring service delivery when services are delivered in Indigenous language

Challenge category	Examples of challenges named in plans
Service delivery	• Remoteness of service areas (e.g., home visitor drive time) • Recruitment and retention • Participant family crisis • Drops in enrollment • Completing screenings and assessments • Scheduling and missed visits

Many programs anticipated challenges in meeting minimum visit and data collection requirements. Programs planned to address these challenges in multiple ways. To enhance the chance of meeting minimum visit requirements, some programs proposed strategies centered on increasing the feasibility of service delivery by adjusting caseload sizes, hiring staff who live in the geographic area of families served, or making clear expectations during hiring about travel across rural areas to meet with families. Another program planned to improve on the program's completion of missed or canceled visits by implementing a new scheduling system and revised procedures.

Programs planned to address data collection and reporting requirement challenges through extended staff training, providing incentives for successful data collection and data entry, providing staff with multiple media options for data collection, and ongoing data collection oversight and management.

Enhancing Implementation Through Flexibility and Trust

Programs observed that flexibility of home visiting models helped program staff deliver services to fit with community context and priorities. Many Tribal MIECHV programs identified model flexibility as a primary consideration for ensuring program fit to community context. As one plan clearly stated:

> Our community has prioritized supporting cultural values and fit. The model's flexibility remains a key factor in our continued use.

Programs explained that home visiting models, along with modifications, make up the interdependent components of high-quality comprehensive and culturally attuned Tribal MIECHV programs. Together, these components enable Tribal MIECHV programs to fit

community context in ways that no single component could alone. Programs prioritized selecting models with flexibility for incorporating additional components. Consider the following:

> No single curriculum can meet the multilevel, systemic needs our communities experience. We therefore chose a home visiting curriculum that best aligns with community needs and Indigenous philosophies and that has the flexibility to include additional components that further tailor our program to best fit our community.

Programs identified several descriptions of instances where model flexibility allowed for important innovations or modifications.

One program worked with model developers to address a conflict between the model's inclusion criteria and the program's intention to serve the broader community. Model flexibility allowed for a strategy that would meet fidelity standards without compromising the community's commitment to a universal service delivery approach.

In another example, after not meeting the required number of visits for their selected model, one program used a strategy from a fellow Tribal MIECHV program and expanded the maximum number of visits delivered to all enrolled families regardless of risk status. The plan explained:

> A fellow grantee implementing the same model recommended aiming to provide 24 visits per year for all families. Changing the required number of visits improved communication between home visitors and clients, as they were meeting regularly, and compliance with number of required visits improved dramatically. The program will consult further with this fellow grantee to transition to providing 24 visits per year for all families.

Programs benefited from trusting relationships with model developers throughout planning and implementation. Plans showed how selecting, planning, and implementing home visiting models benefit from trusting relationships between programs and model developers and with other agencies and programs within the service environment. Throughout the plans, programs elevated the importance of trusting relationships in all aspects of planning and implementing home visiting. Some programs identified how trust between programs and model developers enhanced model fit:

> The program has developed a high level of trust with model staff. They have been available and accessible and have invested time, technical assistance, and training into the program's growth. Perhaps most importantly, model staff have

> been extremely supportive of the program's efforts to fit the model to the priorities and needs of community children and families. Model developers helped the program adapt, augment, and refine the model in ways that preserve fidelity while also meeting Tribal MIECHV grant requirements and community cultural protocols and needs.

Programs planned flexibility into the home visit. In addition to planning for flexibility of home visiting model developers, programs planned for flexibility in delivering home visits, including where and when home visits take place and what content is covered. Such flexibility was described as supporting home visitors to better meet the needs and interests of families and to support continued family investment in services. These strategies supported programs' commitments to delivering successful and efficacious home visiting services that center trust, relationships and community, and family contexts. Flexibility was articulated as an asset to implementation. Consider, for example, how one program adjusted to delivering home visiting services in locations other than the home:

> We found in the past grant period that many clients wanted to have their "home visits" in office settings where the home visitors work.… While it might be ideal to have these visits in the home and the program staff will continue to encourage participation in home settings, the current program is well situated to work with families where they feel most comfortable.

For another program, home visitors were described as following model guidance in a flexible way that holds time for personal connection with family:

> Our home visitors have been very good about creating a relationship-based environment for their families, and while they follow the model guidance on a home visit structure, they also allow time for "check-ins," emotional intelligence activities, and any other social support the family may need. That "extra," along with the education delivered, is what our families value and what they enjoy about our home visiting model.

In the following plan, the program identified meeting model requirements around home visit frequency as a potential challenge. In the passage, flexibility is important in addressing this challenge. First, the program described scheduling flexibility on the part of home visitors as enhancing the autonomy of families participating in home visiting. Second, flexibility on the part of the model would support program staff in implementing with fidelity in a way that preserves relationships with families.

> Flexibility is also important for our program. If clients can't meet every two weeks, it's important to allow some autonomy for meeting schedules. The model stresses the importance of balancing program fidelity with local adaptation.

Conclusion

Tribal MIECHV programs relied on multiple knowledge systems and sources of evidence to decide on what home visiting model to select and how to implement it. These systems included the home visiting evidence base, Indigenous knowledge, and prior experience implementing home visiting services. Programs followed Implementation Plan Guidance to consider how they would implement with fidelity. Programs identified flexibility and trust as ways to deliver effective home visiting services in Native communities even amid anticipated challenges. Programs strategically planned implementation in a way that balanced fidelity to the model with fit to the community context to best engage and serve community families. The next chapter focuses on how programs focused on family strengths, program engagement, and community connection.

Chapter 6 | Strengthening Ties: Serving Families, Engaging Community, and Building Trust

"Information on identified needs was presented to stakeholders, and various evidence-based home visiting models were discussed. The Tribal leaders expressed the belief that using home visiting with a proven model would improve the lives of entire families while strengthening ties of families to their culture, their communities, and to each other."

Chapter 6 at a Glance

Tribal MIECHV programs balanced familial need for services with a strengths-based and empowered orientation. Therefore, home visiting services addressed individual family needs through direct service and by helping families strengthen the ties they have to other community families, to the program and associated resources, and to the community itself.

Programs used results from their community needs assessments to identify and describe prioritized service populations. Many programs also used strength-based approaches to build service delivery around familial attributes other than or in addition to need. Programs planned home visiting to augment or enhance the strengths of families in the community.

One program described how, during their needs assessment, community members acknowledged unmet need, risks, and disparities for families while simultaneously recognizing families' resourcefulness, resilience, and genuine love for children and community:

> While each stakeholder and focus group participant was intimately familiar with the needs, risks, and disparities that the AI/AN community faces on a daily basis, they also eagerly shared the ways in which the community strives to take care of one another and work towards a healthier future. Several themes arose, including the resiliency and resourcefulness of community members. Many people discussed families' advocacy skills, resilience, and genuine love for their children. While there were many stories of struggle, challenge, and heartbreak, there were just as many examples of how families used different tools and agencies to overcome.

Such strength-based orientations to home visiting were common across implementation plans. Programs planned home visiting services to support families in strategically building on their strengths by strengthening community ties.

Key Findings

- Programs followed Implementation Plan Guidance to establish and describe communities to be served.
- Some programs used alternative conceptualizations in addition to or other than *need* and *risk* to define and describe the families they planned to serve.
- Many programs planned specifically to support families experiencing challenges related to mental health or substance use through coordination and by anticipating gaps in service availability.
- Some programs planned to expand their service populations beyond the population the home visiting model was developed to serve or beyond those prioritized in previous years, especially to engage fathers.
- Programs planned to use coordination across programs to provide access to home visiting services for families with children ages 0–5.
- Programs understood that building and maintaining trust was a key component of engaging and retaining families.
- Programs recognized that earning a family's trust can take time.
- Programs understood that supporting a family in meeting basic needs helps establish trust in home visiting.
- Programs acknowledged that having established trust in the program at the community level helps build trust with families.
- Programs recognized the importance of employing and retaining staff who are members of the Native community served or who identify as Indigenous in helping establish and maintain trust in the program.
- Programs recognized that retaining staff is critical to maintaining and strengthening families' ties to Tribal MIECHV programs.

Defining Populations to Be Served

Delivering services that meet the needs of service recipients is a widely accepted tenet of implementation science. It is featured, for example, as step 1 in *Getting to Outcomes* (Chinman et al., 2008; Wandersman, 2014), a widely used implementation science framework. The *Getting to Outcomes* framework heavily influenced the shift toward evidence-based policy at

ACF. Informed by such frameworks and this legislation, Implementation Plan Guidance led programs through a process of using results from the required community needs assessments to determine and describe the "at-risk Native community or communities that will be served." The process linked community, familial, and individual needs to various risk factors.

Programs followed Implementation Plan Guidance to establish and describe communities to be served. Programs identified and prioritized communities to be served based on the needs assessment having demonstrated a need for home visiting services or related services (e.g., treatment for substance use). These demonstrations of need were generally evidenced by statistical data citing poor health outcomes, high rates of poverty, limited access to education, and qualitative findings from needs assessments where community members reinforced need for services in the community. Identifying needs in the community also informed model selection by facilitating deliberation by program leaders to identify which specific home visiting model had been demonstrated to meet an identified need or set of identified needs. Programs also anticipated serving families with unmet basic needs, including unmet economic and educational needs.

Implementation Plan Guidance: Identify and Assess At-Risk Tribal Community or Communities

1. "A tribe or tribes within a discrete geographic region
2. "Subgroups or communities of a tribe or tribes within a discrete geographic region
3. "Members of a tribe(s) scattered throughout a larger, non-Tribal geographic area interspersed with non-Tribal members" (Implementation Plan Guidance, p. 10).

Generally, programs followed the Implementation Plan Guidance to define service populations using some combination of Tribal nation membership, affiliation, or Indigenous identity along with geographic markers designating areas for service delivery.

For example, one program planned to serve any family identifying as AI/AN in the area:

> The "at-risk tribal community" that will be served will be AI/AN families with children ages 0–5 living in the community.

In another example, a program was careful to also extend services to any family caring for a child who is American Indian, Alaska Native, Native Hawaiian, and/or Pacific Islander.

> We define the at-risk community to include self-identified American Indians, Alaska Natives, Native Hawaiians, and Pacific Islanders and caregivers raising American Indian, Alaska Native, Native Hawaiian, and Pacific Islander children living within the geographic boundaries of the County.

As programs reflected on their defined communities, they planned to serve families experiencing a wide range of risk factors, including entrenched structural inequity, generational trauma related to colonization and land displacement, poverty, domestic violence, substance abuse, and a history of being underserved by social systems, including education and health and mental healthcare. Programs also referenced established lists of risk factors provided by selected home visiting models and those determined by their larger service agencies.

A few programs identified and described certain families as being "high needs." Because most Tribal MIECHV programs planned to implement Parents as Teachers, this attribution was likely a reference to Parents as Teachers' description of their intended population, featured on their HomVEE model profile. The profile highlights the following high-needs characteristics: "children with special needs, families at risk for child abuse, low-income families, teen parents, first-time parents, immigrant families, low-literate families, parents with mental health or substance use issues, or families experiencing homelessness or unstable housing" (U.S. Department of Health and Human Services, 2019). The model recommends that these characteristics be used to refine the intended population for service delivery and to determine the intensity and length of home visits for families.

Programs described using the "high-needs" characterization to better manage home visitor caseloads and to ensure strong and responsive relationships with clients who meet these criteria. One program explained:

> Developing and strengthening our relationships with families continues to be our priority. This includes a strong commitment to addressing high-risk issues as they arise. Taking into consideration the travel time, data collection, and high needs of the majority of our clients, ensuring consistent visits necessitates increasing our focus on each family and ensuring that home visitors are able to provide high-quality services. This has led us to reduce the caseload size of our home visitors.

Some programs used alternative conceptualizations in addition to or other than *need* and *risk* to define and describe the families they planned to serve. Consider how this program's reflection addressed risks and needs but centered on serving families who would *most benefit* from home visiting:

> Native children and families in general are more at risk due to the overwhelming trends and inequities the population faces. However, the families who would receive the most benefits are those that are low-income, unemployed, have received low education attainment, have had babies with low birth weight or having or recently had their first child, have been identified by child protection services or tribal courts, or another behavioral health program for domestic violence, substance abuse, or have multiple needs and challenges, living in rural and/or urban settings.

Another program planned to offer home visiting services to all families that want them, prioritizing families' interests over that of service providers:

> We may be more interested in "at-risk" families with younger children, single-parent situations, or younger parents, but frankly, we are in a position to serve all in this population who desire these services.

At least two programs pursued universal service delivery as an alternative approach to prioritizing families based on need or risk or other model requirements (e.g., first-time mother or early gestational age). One program explained this approach as stemming from cultural values:

> It is important to understand our program philosophy: all families should have access to high-quality home visiting services.… We have always offered the programming and services to all families enrolling at any point between pregnancy and children through age 2. The universal service delivery approach honors traditional and cultural values.

Many programs planned specifically to support families experiencing challenges related to mental health or substance use through coordination and by anticipating gaps in service availability. Programs also recognized that they struggle with engaging and retaining individuals experiencing mental health challenges and substance use in home visiting services.

One program described this program priority as integral to meeting community needs and to create positive social change:

> It was obvious that the community wants to reach, engage, and retain young mothers with addictions.… Members/participants of the advisory board and the focus group meetings felt that there first needed to be a public relations campaign in educating the community on addiction. By doing this, the intent would be to change social stigma around addiction in the community.

As part of planning to serve this population, programs acknowledged the importance of having accessible, high-quality, and culturally informed mental health services and substance use treatment available for home visiting service users. Plans showed that access to referral networks for mental health and substance use services varied across Tribal MIECHV programs. Some programs described robust service infrastructure with ready access to services, and others reported mental health and substance use services as lacking in their communities.

Highlighting the benefits of embedding the home visiting program within a network of programs, including behavioral health initiatives, one program described:

> Group sessions include a weekly psychoeducational group and weekly support groups. There are plans to re-initiate the Alcoholics Anonymous group as well as cultural art group sessions. When higher-level services such as detox and/or inpatient treatment are needed, referrals are made to outside agencies, and Medicaid funds are used to support these services. Counselors provide continued care coordination after referrals are made.… Aftercare services for support and sobriety are provided.… Substance abuse counselors also provide family education, preparing family members to support the individual returning from treatment.

For implementing programs not embedded in or connected to robust behavioral health systems, planning focused on identifying service gaps. Consider the following example:

> Providers confirm that there simply are not enough resources available to provide the level of service they would like… there is a serious dearth of attorneys for survivors of domestic violence, housing for trafficked women and children, domestic violence defenders, and housing with cultural programming.

Data show how identified gaps in the behavioral health system extended beyond availability of treatment into other related services such as legal supports, housing, and transportation. These reflections for planning highlighted the interrelatedness of these services and how they can become necessary to the wellness of families enrolled in home visiting, especially those attempting to maintain sobriety.

Expanding Service Populations

Tribal MIECHV programs planned to serve a caseload of 30 to 225 families per year. Programs addressed various considerations in anticipating these estimates, including home visitor service capacity (most often operationalized by model guidance for minimum and maximum home

visitor caseloads), distance traveled to home visits, and social trends (birth rates and increases in drug use in community).

Some programs planned to expand their service populations beyond the population the home visiting model was developed to serve or beyond those prioritized in previous years, especially to engage fathers. Many Tribal MIECHV programs built their plans for recruiting and engaging families on years of experience implementing home visiting services in the community. Reflecting on this experience, a few programs used their implementation plans to establish plans for broadening their priority populations. Specific examples did not limit participation to first-time mothers and included fathers and extended family.

> The program has learned that a broader population within the community needs its services, including non-teen mothers, multiparous mothers, fathers acting as primary caregivers, fathers acting as secondary caregivers, and extended family members. Fathers who are not currently involved in parenting are another important population to target for engagement.

A few Tribal MIECHV programs planned to enhance engagement of fathers in home visiting services. Referencing findings from their needs assessment, one program identified disengagement of fathers as a problem for the community. Connecting this disengagement to various risk factors and difficult outcomes for families, the program explained:

> This disconnection (of fathers from their children) is likely reflected in the unfortunate statistics, lack of educational attainment, and rising numbers of early drug use and other risky behaviors.

Other programs also emphasized making sure fathers were involved in home visiting services and developed plans to enhance engagement of fathers in program activities. One program highlighted home visitor flexibility as a strategy to enhance inclusion of fathers:

> Home visitors have set up alternating visit topics, so that if the child's father works out of town, when he is home, the topics are relevant to both parents, and when he is out at work, they are focused on the conversations mom wants to have privately with the home visitor.

After having difficulty recruiting fathers into home visiting services, one program worked closely with model developers and consulted with another Tribal MIECHV program to develop a group intervention specifically for men. The group, led by a male staff member, succeeded in introducing community fathers to home visiting services and increasing enrollment of fathers in

the program. As fathers' engagement increased, the program observed that fathers were interested in new topics and adjusted the focus of home visits:

> Although we have been able to engage men in the three-year program, their utilization of services has been different than the mothers with less frequency in home visits and more focused on attaining goals that contribute to providing for family, such as increasing education and vocational skills, finding employment, and resolving legal issues.

Multiple programs recognized both the importance of father engagement in services and a lack of service engagement with fathers. They addressed this dilemma in various ways that all went beyond adjusting recruitment strategies. Some created specific spaces for fathers to come together. Others encouraged home visitors to be flexible in the timing and content of home visits to create home visits that were more inclusive of fathers. Programs recognized that engagement of fathers meant not only getting more fathers to participate but also purposefully adjusting services to ensure meaningful and resonant service delivery for fathers specifically.

Programs planned to use coordination across programs to provide access to home visiting services for families with children ages 0–5. Evidence-based home visiting programs are designed and marketed as interventions for families of a child within specific age ranges. For example, Family Spirit supports young parents throughout pregnancy and up to 3 years postpartum. Nurse Family Partnership provides support to families beginning early in pregnancy and continuing until the child's second birthday, and Parents as Teachers serves families from pregnancy through kindergarten. Most programs used the established age ranges for their selected model, yet several programs noted gaps in home visiting services.

In one plan, the program identified that even with a significant network of home visiting programs in the area, there was a risk of families not being able to receive home visiting services once their child turns 3. They explained that enrollment criteria (e.g., focus on young or first-time parents) meant that home visiting services that extend beyond when the child turns 3 are difficult to access for parents in this community. The program advocated for collaboration across programs to ensure coverage of services:

> Coordination and collaboration with this program are essential for families who already have a firstborn child over the [cutoff age] or who have aged out of the program.

Another program planned specifically to focus outreach on families with children 0–2 after noticing reduced interest in services for families with children older than 2:

> There are a few reasons why we chose to focus on children ages 0–2 rather than the more expansive population of children ages 0–5.… We found over time little interest in the home visitation services among those with older children. The program didn't suit their needs, it did not pique their interest, and for many, their family needs were being addressed by other programs in the community.

In addition to adhering to the demonstrated age ranges of identified home visiting models, programs sought ways to ensure that families had access to services during pregnancy and to age 5. Sometimes, as with the previous example, programs used the needs assessment or prior implementation experience to identify and fill a gap in community services for a specific age range. Other times, programs sought to establish networks of coordinated programming for community families.

Building Trust, Engaging Families

Programs understood that building and maintaining trust was a key component of engaging and retaining families. As one plan stated plainly:

> Clients need to be able to build trust to effectively engage in the program.

Many plans echoed this sentiment, depicting trust as an ongoing process occurring within the context of complex and interrelated relationships among individuals, families, programs, agencies, and communities.

Throughout the implementation plans, the stakes of trust building were obvious as it was described again and again as a foundational component of community and family engagement, staff support, and home visiting service delivery. One program highlighted the critical role trust plays in relationship-based home visiting:

> Our approach is based on relationship building. Our clients need to gain trust early and know that we are there to support their goals and dreams. We focus on building a quality home visitor–client relationship. Often considered the "heart" of home visiting, quality home visitor–family relationships are critical for sustaining family engagement.

This quote demonstrates how "quality" home visiting relationships are seen as built through authentic and deep investments in families and in their dreams. Such engagement means

taking the time to track and acknowledge special moments. It means being with families for life events. This effort, considerable when done across an entire caseload, fortifies the heart of home visiting.

Programs recognized that earning a family's trust can take time. In the following example, the program planned for prolonged periods of trust building while acknowledging how the experience of historical trauma compromises relationship and trust building.

> Trust is necessary to be able to provide effective services. Establishing trust is key to sustaining relationships or partnering with Native American families. When we consider historical trauma, it may take a while to build trust and meaningful relationships.

Programs understood that supporting a family in meeting basic needs helps establish trust in home visiting. Building on prior implementation experience and the results from needs assessments, many programs recognized the importance of supporting families in meeting their basic needs. Programs identified the crucial and trusted role home visitors play in this work:

> As the needs assessment highlighted, many families in this community are looking for basic need support (housing, food, etc.). The agency is working to address this and understands that home visiting staff hold a unique place of trust and support for the most vulnerable families.

Programs acknowledged that having established trust in the program at the community level helps build trust with families. Many Tribal MIECHV programs benefit from being situated within or related to agencies or organizations that are trusted by the community. When a Tribal MIECHV program is situated within a trusted community organization, especially one known for providing culturally resonant services, trust building does not start from scratch. In these situations, home visiting programs, such as the following one, can reach prioritized families from the outset:

> The home visiting program is situated within a unique and trusted community organization, which prides itself on making culturally appropriate services the cornerstone of its service approach. Culturally competent and relevant services are seen as essential to being able to continue to reach a population and community that for some, often the most needy or vulnerable, won't typically access these types of supportive services from other service providers.

When embedded in a trusted community organization, the program is better positioned to serve the families who might be least likely to access services.

For programs not embedded in this way, programs planned to build or expand on collaborations with community organizations. Consider the following implementation plan description of a carefully constructed and reinforced service array:

> The program continues to be very successful in building collaborative relationships with key stakeholders. These stakeholders consist of direct services providers who have a wealth of experience working with Tribal members. Each program plays an integral part in enhancing the lives of our mothers and children, and by joining forces, we have established a more complete array of services to meet our clients and their children's needs. This has made a tremendous difference in Tribal members accepting the services that are being provided in the home setting.

Programs recognized the importance of employing and retaining staff who are members of the Native community served or who identify as Indigenous to help establish and maintain trust in the program. Throughout the implementation plans, program leaders recognized many ways that hiring and retaining Native staff benefits home visiting programs and the families they serve. In the following passage, one program acknowledged how having trusted and established citizens of Native nations on staff affirms the trustworthiness of the program and facilitates open conversations about sensitive topics.

> Because staff are Native and have worked a great deal with this population, they have earned the trust of their audience and are able to navigate this topic extremely well.… This experience, combined with their personal life experience, makes it possible to build trust and rapport, especially around sensitive subjects.

Another program described:

> Participating Tribes have been very clear about the need for the home visitors to be drawn from the Tribal communities that they are to serve.… It is a key to building trust between parents and home visitors and for the successful implementation of culturally appropriate information and activities.

Cultivating parental engagement in home visiting services is widely recognized as a challenge (Guastaferro et al., 2020). As such, hiring staff with established community trust and rapport is of real consequence. Programs framed the benefits of hiring Tribal nation members to be home visitors in multiple ways, highlighting specifically how it helps home visitors provide culturally resonant services.

Programs recognized that retaining staff is critical to maintaining and strengthening families' ties to Tribal MIECHV programs. Plans acknowledged that losing staff is detrimental to program engagement and costly to programs in terms of staff morale and resources. Programs planned to mitigate the negative effects of staff turnover on peers and enrolled families:

> It can be very disheartening to lose a colleague.… A systematic process is applied when a home visitor leaves. The family is notified at the earliest time possible, and a transition plan is developed with the family and, when possible, with the involvement of a newly assigned home visitor. Program administrators are aware of the significant cost that occurs when a staff turns over and have made budgetary provisions to cover the additional cost.

Many plans connected families' trust in the program directly to their relationships with home visitors, further reinforcing the importance of home visitor retention. In the following example, the program recognized how job instability for home visitors can affect enrolled families. They took a proactive approach and advocated for extended contracts:

> Those being served value the relationship they have with the home visitor, and when the home visitor leaves, the families become disenfranchised, and, in many cases, simply leave the program. In consideration of these issues, the Tribal Council approved 5-year contracts for the duration of the MIECHV program for all staff.

Conclusion

Building on previous chapters, this chapter shows how programs followed their visions for supporting long-term community wellness by using home visiting to strengthen ties within families and between families and the community. Programs used strengths-based strategies to define their service population in ways that extended beyond "need" while simultaneously focusing service delivery on caregivers experiencing hardship (e.g., mental health issues). They planned to extend services to caregivers not generally prioritized in home visiting (e.g., extended family members and fathers) and to families with children from birth to age 5. They also invested deeply in cultivating and maintaining trust with families and throughout the community. Tribal MIECHV programs recognized the relationship between family and community engagement and planned strategies to reinforce trusting connections within families, between families and the program, and across the community. The next and final chapter of this report continues the discussion of Tribal MIECHV programs' commitments to community wellness and other selected cross-cutting themes.

Chapter 7 | Findings, Recommendations, and Implications

Tribal MIECHV programs envisioned home visiting as an intervention that centers child wellness as part of an aim to cultivate long-term community wellness. Tribal MIECHV programs planned home visiting services not only to support families in building on their strengths but also to strengthen the community ties that support families. Tribal MIECHV program planning was heavily influenced by prior experience and Indigenous knowledge and advanced with a focus on equity. Viewed through Indigenous frameworks, such as Jessica Saniġaq Ullrich's Indigenous Connectedness Framework (2019), Tribal MIECHV program visions presented in this report could come together in a theory of change for home visiting that understands child and community well-being as reciprocal ties among families, community, and land, across generations. Such understandings might diverge from mainstream behavior change approaches that envision home visiting as an intervention focused primarily on individual children and families.

Analysis of Tribal MIECHV program implementation plans generated lessons learned and considerations related to implementation support, implementation research, and home visiting.

Findings and Recommendations

Tribal MIECHV programs planned to use equity-focused Indigenous practices to support child and community well-being through home visiting.

Program implementation plans called attention to impacts of historical and contemporary inequity—including colonialism, land dispossession, child removal, and punitive child welfare action—as a primary context to inform program planning. Many programs directly addressed the detrimental effects of colonialism and inequity on the community and on child, family, and home visitor well-being.

Programs strategically planned to advance equity for families and staff by (re)building trusting relationships between community members and agencies; supporting staff in trauma-informed ways, including reflective supervision; and weaving cultural (re)engagement throughout program implementation. Programs envisioned home visiting to have wide and lasting impacts not only on individual families but also on the broader community, recognizing the connection between child and community well-being. Given this finding, we recommend the following.

Tribal MIECHV implementation support staff might consider—

- Adding experience with inequity to the list of family and community at-risk designations in Implementation Plan Guidance. Such action could highlight the structural components that sustain risk and need.
- Incorporating strengths-based perspectives into designations of priority service populations (e.g., young mothers interested in their child's development) rather than emphasizing need and risk.
- Focusing on connectedness and community goals and outcomes along with individual behavior change throughout service delivery supports and evaluation.
- Learning from Native staff what supports recruitment and retention of Native staff and applying those supports.
- Strengthening trauma-informed approaches for families and staff, especially approaches developed by and for Indigenous communities.

Implementation researchers might consider—

- Incorporating social theories, especially Indigenous theories and frameworks and those pertinent to understanding (in)equity, throughout implementation science. Such effort could enhance the applicability of implementation frameworks in Indigenous communities and beyond and contribute to anti-racist frameworks and equity within implementation science (e.g., Shelton et al., 2021).
- Studying trust, and the repair of trust, as a primary driver or foundational influence for implementation.

Home visiting researchers, practitioners, and policymakers might consider—

- Studying how child–family–community relationships influence home visiting implementation.
- Evaluating the feasibility and effectiveness of home visiting service delivery strategies used to broaden service populations and caregiver participation (e.g., fathers, grandparents).

Programs built on implementation plan guidance and model guidance to plan their home visiting programs.

Program implementation plans reflected implementation science principles prioritized in the guidance, which suggests meaningful impact of the guidance on planning. For example, plans emphasized needs assessment results and a preference for evidence-based models. Guided by prompts in the guidance, programs also demonstrated their commitment to implementing proven models with fidelity by identifying potential challenges and solutions to successful

implementation (e.g., mitigating data collection issues through ongoing training and supervision).

Programs based much of their program planning on model requirements, with some adjustments to fit community contexts and program goals. For example, programs aimed to define their service populations based on model criteria, demonstrated efficacy (e.g., first-time mothers), and caseloads. However, several broadened their population to fit community priorities and gaps identified through the needs assessment (e.g., fathers, people experiencing substance use or mental health issues). For example, although our analysis could not specify intention unless it was stated in the plan, universal service delivery seemed to support strengths-based approaches by alleviating the need to frame families as in need or at risk or opting instead to focus on those who would most benefit. Universal service delivery also enhanced community support and fit community ethics by not denying services to families.

Finally, programs recognized and valued flexibility in model guidance to increase implementation feasibility and success. Flexibility emerged as a pragmatic strategy, especially given the lack of demonstrated efficacy of home visiting in Native communities, and also as a sign of models' respect for local program knowledge. Some implementation scientists have called for models to develop empirically validated components that could be implemented flexibly across different contexts and populations (Harn et al., 2013), which supports these findings. Given this finding, we recommend the following.

Tribal MIECHV implementation support staff might consider—

- Enhancing the relevance of future implementation guidance by incorporating Indigenous concepts (e.g., about children, family, community). Participatory processes could help ensure that guidance addresses Indigenous concepts and implementation science principles that are most meaningful to Tribal MIECHV programs. Such integration could lead to the development of new tools, strategies, and approaches.
- Expanding opportunities to amplify Tribal MIECHV programs' innovations and implementation strategies to support cross-site learning. Several plans mentioned using implementation strategies learned through peer-learning program planning opportunities.
- Supporting Tribal MIECHV programs to rebuild the trust necessary to (re)invigorate home visiting in Native communities.

Additional and augmented implementation approaches and concepts may be required to adequately support evidence-based program implementation in Native communities.

Implementation science argues that effective program implementation requires the use of theories, models (i.e., steps or stages of implementation), and/or frameworks (Nilsen, 2015). Analysis of Tribal MIECHV implementation plans showed significant influence of Indigenous and experience-based knowledge throughout program planning, including visioning, needs assessment, modifying home visiting models, and defining key concepts such as child or family. Few implementation theories, models, and frameworks have emerged from or incorporated Indigenous knowledge. This fact is especially problematic because assumptions in the early childhood field about best practices or developmental appropriateness "may represent Eurocentric and middle-class views and life experiences and not speak for all cultures" (Soto & Swadener, 2002, p. 40). Analysis of implementation plans supports the need to develop or integrate Indigenous theories, models, and frameworks into Tribal MIECHV.

Tribal MIECHV programs rooted their program visions in Indigenous frameworks, inspiring commitments to enhancing child, family, and community well-being. They planned to foster community connection by facilitating access to community resources and nurturing cultural (re)engagement, including connection to cultural practices, place, land, education, and language.

Findings suggest that certain concepts used in home visiting implementation may need to be broadened or refined to adequately support Tribal MIECHV programs' visions and work. For example, many programs advanced a nuanced understanding of children and families through Indigenous and strengths-based orientations. Scholars have shown how assumptions about family may not resonate with Indigenous frameworks and may also produce or reinforce models of authority by federal and state governments into Indigenous home life that can compromise self-determination (e.g., Simpson, 2007).

Another example is how programs identified trusting relationships as a critical component of program implementation. Implementation plans built on prior home visiting program experience to demonstrate that trust is critical to family engagement and retention and that building trust can take time. Supporting families during crises or meeting their basic needs was discussed as both a challenge to service delivery and a vital way to establish and reinforce trust. Plans also highlighted how trust with individual families benefited from trust among programs, home agencies, and the community. Trusting relationships between program staff and model

developers was also identified as a core consideration for model selection and continued use. Given this finding, we recommend the following.

Implementation researchers might consider—

- Recognizing how implementation frameworks that emphasize the present and future at the expense of the past may not adequately account for the ways historical harms and enduring Indigenous practices shape planning. Findings suggest that successful implementation may mean returning strategically to organizational and/or community histories to address both harms from the past and longstanding practices that sustain community well-being.

Home visiting researchers, practitioners, and policymakers might consider—

- Continuing to learn more about Indigenous home visiting programs and how they work.
- Developing and testing strategies for incorporating flexibility into the design of models to make implementation more practical, effective, and sustainable in diverse settings. It may be particularly important to clarify core components of models that are best implemented with fidelity and define thresholds for modifications.
- Assessing how screeners used in home visiting could be modified or augmented to advance more strengths-based and trauma-informed assessments of caregivers and children.
- Following White House guidance (White House, 2022) to apply Indigenous knowledge to better understand maternal and infant health, and home visiting in Tribal communities.

Findings also offer unique implications for MUSE and related studies. Analysis of implementation plans offered a unique opportunity to trace the effects of planning requirements (Implementation Plan Guidance) on actual planning (implementation plans). Analysis for Aim 1 used local implementation plans as existing data on the planning process, thereby eliminating the burden of asking people to describe in a survey or interview what they had already taken significant effort to describe in the plans. This analysis generated several considerations for the MUSE study specifically.

Implications

This report describes the planning process, undertaken between 2016 and 2017, of a specific cohort of Tribal MIECHV grant recipients. It highlights fundamental commitments of Tribal MIECHV programs, including enhancing community wellness, advancing equity, repairing harms from inequity and colonial violence, fostering cultural engagement, and building on a vast foundation of Indigenous knowledge. Analysis of original implementation plans gives rich

historical context to the complex and iterative work of implementation. It helps establish a baseline from which the Tribal MIECHV implementation community, including implementing programs, policymakers, TA providers, and researchers (e.g., MUSE study team), can assess emergent program concerns, implementation strategies, and plan modifications. Therefore, findings have continued relevance for practitioners, policymakers, and researchers concerned with home visiting, especially in Indigenous communities, and with evidence-based policymaking more generally.

It is important to note that the implementation plans analyzed in this report were written before the onset of COVID-19, but much of the implementation itself occurred during the pandemic. Rather than make implementation planning obsolete, the crisis highlighted strengths and challenges that may otherwise have been overlooked. For example, research shows that the pandemic revealed and reinforced existing inequities, specifically within Native communities where "inequities established the architecture for COVID-19" (Yellow Horse et al., 2022). Historical and contemporary inequities—including land dispossession, underlying health disparities, high rates of poverty, and barriers to resource access—shaped the gap in COVID-19 incidence and mortality rates between American Indians and Alaska Natives and between other racial and ethnic groups (Brodt & Empey, 2021). The unequal impact of the pandemic on Indigenous people underscores the importance of the equity approach highlighted in the implementation plans and further demonstrates the prescient resonance of the commitments expressed in the plans.[10]

Documenting these commitments reinforces ongoing shifts in home visiting implementation and implementation generally. Report findings push the field toward more equity-focused approaches. They advance expansive and Indigenous science–informed ideas about what counts as evidence. They also highlight the importance of setting visions for home visiting that extend beyond an individual child, caregiver, or family to effect change at the community level.

[10] Future study reports will directly address the impact of COVID-19 on Tribal MIECHV program implementation.

References

American Public Health Association. (2022). *Social justice and health: Why should I care?* Retrieved July 13, 2023, from https://www.apha.org/what-is-public-health/generation-public-health/our-work/social-justice#:~:text=These%20inequities%20are%20the%20result,gender%2C%20place%20and%20other%20factors

Administration for Children and Families. (2021). *ACF evaluation policy.* https://www.acf.hhs.gov/opre/report/acf-evaluation-policy

Adirim, T., & Supplee, L. (2013). Overview of the federal home visiting program. *Pediatrics*, *132*(Supplement 2), S59–S64.

Adu, P. (2019). *A step-by-step guide to qualitative data coding.* Routledge.

Avellar, S., & Paulsell, D. (2011). *Lessons learned from the Home Visiting Evidence of Effectiveness Review*. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (Eds.). (2017). *Communities in action: Pathways to health equity*. National Academies Press.

Baron, J. (2018). A brief history of evidence-based policy. *The Annals of the American Academy of Political and Social Science, 678*(1), 40–50.

Bauer, M. S., Damschroder, L., Hagedorn, H., Smith, J., & Kilbourne, A. M. (2015). An introduction to implementation science for the non-specialist. *BMC Psychology*, *3*(1), 32.

Bleiweiss-Sande, R., Sama-Miller, E., Chavez, C., Coughlin, R., & Mraz Esposito, A. (2022). *Assessing effectiveness of early childhood home visiting models implemented with tribal populations.* Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Boller, K., Daro, D., Del Grosso, P., Cole, R., Paulsell, D., Hart, B., Coffee-Borden, B., Strong, D., Zaveri, H., & Hargreaves, M. (2014). *Making replication work: Building infrastructure to implement, scale-up, and sustain evidence-based early childhood home visiting programs with fidelity*. Children's Bureau, Administration for Child and Families, U.S. Department of Health and Human Services. Contract No.: GS-10F-0050L/HHSP233201200516G. Mathematica Policy Research.

Braithwaite, J., Churruca, K., Long, J. C., Ellis, L. A., & Herkes, J. (2018). When complexity science meets implementation science: A theoretical and empirical analysis of systems change. *BMC Medicine*, *16*(1), 63.

Brayboy, B. (2005). Toward a Tribal critical race theory in education*. Urban Review*, *37*(5), 425–446.

Brodowski, M. L., Flanzer, S. Nolan, C.M., Shafer, J., & Kaye, E. (2007). Children's Bureau discretionary grants: Knowledge development through our research and demonstration projects. *Journal of Evidence-Based Social Work*, *4*(3/4), 3–20.

Brodt, E., & Empey, A. (2021). American Indians and Alaska Natives in the COVID-19 pandemic: The grave burden we stand to bear. *Health Equity, 5*(1), 394–397.

Carminati, L. (2018). Generalizability in Qualitative Research: A Tale of Two Traditions. *Qualitative Health Research, 28*(13), 2094–2101.

Child Welfare Information Gateway. (n.d.). *Cultural Responsiveness.* Retrieved August 3, 2023, from https://www.childwelfare.gov/topics/systemwide/cultural/#:~:text=Cultural%20responsiveness%20enables%20individuals%20and,affirms%2C%20and%20values%20their%20worth

Chinman, M., Hunter, S., Ebener, P., Paddock, S., Stillman, L., Imm, P., & Wandersman, A. (2008). The Getting To Outcomes demonstration and evaluation: An illustration of the Prevention Support System*. American Journal of Community Psychology, 41*(3–4), 206–224.

Cobb, A. J. (2005). Understanding Tribal sovereignty: Definitions, conceptualizations, and interpretations. *American Studies*, *46*(3/4), 115–132.

Del Grosso, P., Kleinman, R., Esposito, A. M., Sama Martin, E., & Paulsell, D. (2011). Assessing the evidence of effectiveness of home visiting program models implemented in tribal communities. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Dunbar-Ortiz, R. (2014). *An Indigenous peoples' history of the United States.* Beacon Press.

Eakins, D., Gaffney, A., Marum, C., Wangmo, T., Parker, M., & Magarati, M. (2023). *Indigenous evaluation toolkit for tribal public health programs: An actionable guide for organizations serving American Indian/Alaska Native communities through opioid prevention programming*. Seven Directions: A Center for Indigenous Public Health at University of Washington.

Eccles, M. P., & Mittman, B. S. (2006). Welcome to *Implementation Science*. *Implementation Science*, *1*, 1.

Falicov C. J. (2009). Commentary: On the wisdom and challenges of culturally attuned treatments for Latinos. *Family Process*, *48*(2), 292–309.

Fernandes-Alcantara, A. L. (2018). *Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program: Background and funding.* (CRS Report No. R43930). Congressional Research Service.

Filene, J. H., Bell, J., Smith, E. G., & McDonnell, C. J. (2012). National cross-site evaluation of the replication of Family Connections: Final evaluation report. Submitted to the Office on Child Abuse and Neglect, Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families.

Fixsen, D., Naoom, S., Blase, K., Friedman, R., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. University of South Florida, Louis de la Parte Florida Mental Health Institute, National Implementation Research Network.

Guastaferro, K., Self-Brown, S., Shanley, J. R., Whitaker, D. J., Lutzer, J. R. (2020). Engagement in home visiting: An overview of the problem and how a coalition of researchers worked to address this cross-model concern. *Journal of Child and Family Studies, 29*(8), 4–10.

Harn, B., Parisi, D., & Stoolmiller, M. (2013). Balancing fidelity with flexibility and fit: What do we really know about fidelity of implementation in schools? *Exceptional Children*, *79*(3), 181–193.

Harvard University Center on the Developing Child. (n.d.). *Toxic stress.* Retrieved March 24, 2023, from https://developingchild.harvard.edu/science/key-concepts/toxic-stress/

Health Resources and Services Administration. (2016). *Demonstrating improvement in the Maternal, Infant, and Early Childhood Home Visiting Program: A report to Congress*.

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homeless services settings. *The Open Health Services and Policy Journal*, *3*, 80–100.

Kovach, M. (2021). *Indigenous methodologies: Characteristics, conversations, and contexts.* University of Toronto Press.

LaFromboise, T. D., Hoyt, D. R, Oliver, L., & Whitbeck, L. B. (2006). Family, community, and school influences on resilience among Native American adolescents in the upper Midwest. *Journal of Community Psychology, 34*(2), 193–209.

Lyon, K., Geary, E., Sparr, M., Buckless, B., Salvador, M., & Morales, M. (2015). *Tribal maternal, infant, and early childhood home visiting: A report to Congress.* (OPRE Report #2015-88). Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

McGregor, D. (2004). Coming full circle: Indigenous knowledge, environment, and our future. *American Indian Quarterly*, *28*(3/4), 385–410.

Mraz Esposito, A., Del Grosso, P., Kleinman, R., Sama-Miller, E., & Paulsell, D. (2014). Assessing the evidence of effectiveness of home visiting program models implemented in tribal communities. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Native Governance Center. (n.d.). *Terminology style guide.* Retrieved March 29, 2023, from https://nativegov.org/resources/terminology-style-guide/

Nilsen, P. (2015). Making sense of implementation theories, models and frameworks. *Implementation Science, 10*, 53.

Norris, T., Vines, P. L., & Hoeffel, E. M. (2012). The American Indian and Alaska Native population: 2010 (2010 Census Briefs). U.S. Census Bureau.

Patton, M. (2002). *Qualitative research & evaluation methods*. Sage.

Powell, B. J., Waltz, T. J., Chinman, M. J., Damschroder, L. J., Smith, J. L., Matthieu, M. M., Proctor, E. K., & Kirchner, J. E. (2015). A refined compilation of implementation strategies: Results from the Expert Recommendations for Implementing Change (ERIC) project. *Implementation Science, 10*(21).

Saldaña, J. (2016). *The coding manual for qualitative researchers.* Sage.

Salvador, M., Abrahamson-Richards, T., Lyon, K., & Whitesell, N. R. (in press). *Engaging Indigenous communities in research to inform practice: The Multi-Site Implementation Evaluation of Tribal Home Visiting* [Manuscript submitted for publication].

Sarche, M., & Spicer, P. (2008). Poverty and health disparities for American Indian and Alaska Native children. *Annals of the New York Academy of Sciences, 1136*, 126–136.

Shahram, S. Z. (2017). Indigenous pregnancy, birthing, and mothering in colonial Canada. In HT Neufeld and J Cidro (Eds.), *Indigenous experiences of pregnancy and birth* (pp. 13–29). Demeter.

Shelton, R., Adsul, P., Oh, A., Moise, N., & Griffith, M. (2021). Application of an antiracism lens in the field of implementation science (IS): Recommendations for reframing implementation research with a focus on justice and racial equity. *Implementation Research and Practice, 2,* 1-19.

Simpson, A. (2007). On ethnographic refusal: Indigeneity, "voice," and colonial citizenship. *Junctures, 9*, 67–80.

Singleton, M., Atukpawu-Tipton, G., & Joraanstad, A. (2022, March). Advancing equity in home visiting. National Home Visiting Resource Center Innovation Roundup Brief. James Bell Associates.

Smith College. (2015, November 4). My social work journey and beyond: Historical trauma and resolved grief. An interview with Maria Yellow Horse Brave Heart, Ph.D., MSW [Video]. YouTube. https://youtu.be/RZtCS1362UI

Soto, L., & Swadener, B. (2002). Toward liberatory early childhood theory, research and praxis: Decolonizing a field. *Contemporary Issues in Early Childhood, 3*(1), 38–66.

Spicer, P., BigFoot, D. S., Funderburk, B. W., & Novins, D. K. (2012). Evidence-based practice and early childhood intervention in American Indian and Alaska Native communities. *Zero to Three*, *32*(4), 19–24.

Stark, D. R. (2021). Cultural enrichments, enhancements, and adaptations of tribal home visiting programs. Administration for Children and Families.

Substance Abuse and Mental Health Services Administration. (2014). Trauma-informed care in behavioral health services. Treatment Improvement Protocol (TIP) Series 57. U.S. Department of Health and Human Services Publication No. (SMA) 13-4801. Substance Abuse and Mental Health Services Administration.

Taggart, T., Smiley, S. L., & Ritchwood, T. D. (2023). Advancing public health and social equity through research, training, and action. *American Journal of Public Health, 113*(S2), S98–S101.

The Milken Institute School of Public Health at The George Washington University. (2020, November 5). *Equity vs. equality: What's the difference?* https://onlinepublichealth.gwu.edu/resources/equity-vs-equality/

Tribal Evaluation Institute (2020, June). *Rigorous evaluation in Tribal maternal, infant and early childhood home visiting: A series of briefs.* https://www.tribaleval.org/good-news/tei-publishes-five-briefs-on-tribal-evaluation/

Tribal Evaluation Workgroup. (2013, September). *A roadmap for collaborative and effective evaluation in Tribal communities.* Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

Ullrich, J. S. (2019). For the love of our children: An Indigenous connectedness framework. *AlterNative: An International Journal of Indigenous Peoples*, *15*(2), 121–130.

U.S. Department of Health and Human Services. (n.d.-a). *HHS criteria for evidence-based models.* https://homvee.acf.hhs.gov/about-us/hhs-criteria#:~:text=To%20meet%20HHS%20%E2%80%99%20criteria%20for%20an%20%E2%80%9Cevidence-based,favorable%20%28statistically%20significant%29%20impacts%20in%20the%20same%20domain

U.S. Department of Health and Human Services. (n.d.-b). *Outcomes*. https://homvee.acf.hhs.gov/outcomes

U.S. Department of Health and Human Services. (2019). *Implementing Parents as Teachers (PAT).* https://homvee.acf.hhs.gov/implementation/Parents%20as%20Teachers%20(PAT)%C2%AE/Model%20Overview

U.S. Department of the Interior. (n.d.). *Bureau of Indian Affairs (BIA).* Retrieved October 25, 2023, from https://www.bia.gov/bia

U.S. Department of the Interior. (2022, June). *Statement of Deb Haaland Secretary of the United States Department of the Interior before the Senate Committee on Indian Affairs, June 22, 2022.* https://www.doi.gov/ocl/boarding-school-initiative

Vizenor, G. (1998). *Fugitive poses: Native American Indian scenes of absence and presence.* University of Nebraska Press.

Wandersman, A. (2014). Getting to outcomes: An evaluation capacity building example of rationale, science, and practice. *American Journal of Evaluation, 35*(1), 100–106.

Weiss, H. B. (1993). Home visits: Necessary but not sufficient. *The Future of Children, 3,* 113–128.

White House. (2022, December 1). *White House releases first-of-a-kind Indigenous knowledge guidance for federal agencies* [Press release]. https://www.whitehouse.gov/ostp/news-updates/2022/12/01/white-house-releases-first-of-a-kind-indigenous-knowledge-guidance-for-federal-agencies/

Wolfe, P. (2006). Settler colonialism and the elimination of the native. *Journal of Genocide Research, 8*(4), 387–409.

Yellow Horse, A. J., Yang, T-C., & Huyser, K. R. (2022). Structural inequalities established the architecture for COVID-19 pandemic among American Indians in Arizona: a geographically weighted regression perspective. *Journal of Racial and Ethnic Health Disparities*, *9*, 165–175.

Younging, G. (2018). *Elements of Indigenous style: A guide for writing by and about Indigenous Peoples.* Brush Education.

Appendices

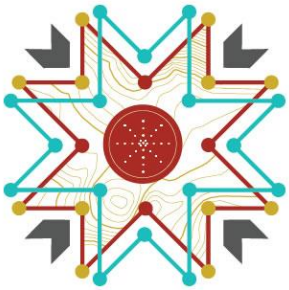
A. *Implementation Plan Guidance Provided to Tribal MIECHV Programs by the Administration for Children and Families*

B. *MUSE Aim 1 Codebook*

C. *In-Depth Analysis of Coded Reports by Aim 1 Domain*

D. *Post-Coding Reflections Template*

Appendix A | Implementation Plan Guidance Provided to Tribal MIECHV Programs by the Administration for Children and Families



TRIBAL
HOME
VISITING

Tribal Maternal, Infant, and Early Childhood Home Visiting Program

Implementation Plan Guidance & Form 1

OMB No.: 0970-0389
Expiration: 08/31/2019

Tribal Maternal, Infant, and Early Childhood Home Visiting Program

Implementation Plan Guidance & Form 1: Demographic and Service Utilization Data

As stated in the funding opportunity announcements for the Tribal Maternal, Infant, and Early Childhood Home Visiting (Tribal MIECHV) Program, the Administration for Children and Families (ACF) must provide grantees with detailed guidance for submitting a needs and readiness assessment and an implementation plan that describes how the grantee will carry out required grant activities in Years 2-5, including implementing home visiting services, conducting performance measurement and continuous quality improvement activities, and engaging in rigorous evaluation. Grantees are expected to submit the implementation plan by the end of Year 1 of the grant, with draft submission milestones throughout the first year.

This document provides guidance for submission of the implementation plan for both **Tribal MIECHV Development and Implementation** grantees and **Tribal MIECHV Implementation and Expansion** grantees. The document also includes Appendices containing supplementary information and resources, including key definitions.

It is important to note that many of the core requirements for both Tribal MIECHV grant programs are the same. Where there are differences in the guidance related to each grant program, the guidance includes specific instructions. Grantees are expected to respond to every section of the guidance and each element listed under each section, with the goal that by responding to each section and area, grantees will have developed a comprehensive plan that will outline critical activities that are required to successfully execute their Tribal MIECHV grants in Years 2-5. ACF will work closely with and provide ongoing technical assistance to grantees as they develop their implementation plans and approval of the plan will be an iterative process between the grantee and ACF as part of the cooperative agreement. As part of the non-competing continuation application for Years 3-5 of the grant, Tribal MIECHV grantees will update their implementation plans as necessary to ensure that the plan accurately reflects activities to be completed throughout the remainder of the grant.

This document also includes Tribal MIECHV Form 1: Demographic and Service Utilization Data, which grantees will submit annually.

Any questions and comments regarding this guidance may be addressed to:

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TRIBAL MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM

IMPLEMENTATION PLAN GUIDANCE

Background and Implementation Plan Guidance Overview

Background

Section 511 of Title V of the Social Security Act, as amended by the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (Public Law 114-10), authorizes the Secretary of the U.S. Department of Health and Human Services (HHS) to award grants to Indian tribes (or a consortium of Indian tribes), tribal organizations, or urban Indian organizations to conduct an early childhood home visiting program.

The Maternal, Infant, and Early Childhood Home Visiting program (MIECHV, the Federal Home Visiting Program), administered by HRSA in collaboration with ACF, responds to the diverse needs of children and families in communities at risk and provides an opportunity for significant collaboration and partnership at the Federal, state, tribal, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs. The goals of the MIECHV program are to: (1) strengthen and improve the programs and activities carried out under Title V of the Social Security Act; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for eligible families who reside in at-risk communities.

The legislation sets aside 3 percent of the total MIECHV appropriation for grants to tribal entities and requires that the tribal grants, to the greatest extent practicable, be consistent with the requirements of the MIECHV grants to states and territories, and includes conducting a needs assessment and establishing benchmarks.

Tribal Maternal, Infant, and Early Childhood Home Visiting Program

Along with the goals of the overall MIECHV program, the Tribal MIECHV Program has the specific goals of:

- Supporting 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;
- Implementing high-quality, culturally relevant evidence-based home visiting programs in AIAN communities;
- Expanding the evidence base around home visiting interventions with Native populations; and
- Supporting and strengthening cooperation and coordination and promoting linkages among various programs that serve pregnant women, expectant fathers, young

children, and families, resulting in coordinated, comprehensive early childhood systems in grantee communities.

The Tribal MIECHV program includes two grant programs, both of which are designed to meet the overall goals of Tribal MIECHV. First, through Tribal MIECHV Development and Implementation grants, funds support grantees to develop infrastructure needed for planning, implementing, and sustaining home visiting programs in tribal communities. Second, through Tribal MIECHV Implementation and Expansion grants, funds support grantees to sustain and/or expand their established infrastructure for home visiting services in tribal communities.

During the 5-year project periods of the cooperative agreements, funds support:

- Conducting a coordinated needs and readiness assessment of at-risk tribal communities through a collaborative process that engages all relevant stakeholders;
- Collaborative planning efforts to address identified needs by developing capacity and infrastructure to fully plan for, adopt, implement, and sustain high-quality home visiting programs in AIAN communities;
- Implementing high-quality, culturally relevant, evidence-based home visiting programs that meet the needs of at-risk tribal communities;
- Engaging with tribal, local, and state early childhood program partners and other stakeholders to maximize the success of home visiting programs and support the comprehensive needs of pregnant women, parents and caregivers, and children from birth to kindergarten entry living in at-risk tribal communities;
- Conducting performance measurement and continuous quality improvement activities; and
- Conduct rigorous evaluation activities using quality research methods that answer questions of interest to grantee communities and the broader field.

The activities that grantees carry out throughout this grant will support tribally and locally driven decision-making, development, implementation, and evaluation of grant-funded projects that are high-quality, evidence-based, and culturally responsive to the community. Throughout the cooperative agreement, ACF and contractors will provide technical assistance and support to carry out required activities while respecting tribal sovereignty and self-determination.

Tribal MIECHV Development and Implementation Grants

The Tribal MIECHV Development and Implementation Grants funds support 5-year grants (cooperative agreements) between ACF and federally-recognized Indian tribes (or a consortium of Indian tribes), tribal organizations, or urban Indian organizations to: conduct community needs assessments; develop the infrastructure needed for widespread planning, adopting, implementing, and sustaining of evidence-based maternal, infant, and early childhood home visiting programs; provide high-quality evidence-based home visiting services to pregnant women and families with young children aged birth to kindergarten entry; implement performance measurement systems and engage in continuous quality improvement activities;

engage in activities to strengthen early childhood systems of support for families with young children; and conduct rigorous program evaluation activities.

Year 1 grant activities are designed to support grantees in understanding the needs and capacities of their communities and designing and building capacity to implement and evaluate programs that meet these needs and fulfill grant requirements. In Year 1 of the cooperative agreement, grantees must therefore: (A) conduct a comprehensive community needs and readiness assessment; (B) build organizational and community infrastructure and capacity to implement high-quality evidence-based home visiting services, conduct performance measurement and continuous quality improvement activities, and conduct rigorous program evaluation; and (C) develop an implementation plan that describes how the grantee will carry out these activities during Years 2-5.

Grantees must engage in needs and readiness assessment, planning, and capacity-building activities during Year 1, but will not fully implement their plan. Grantees are expected to submit the Implementation Plan by the end of Year 1 of the grant, with draft submission milestones throughout Year 1.

Tribal MIECHV Implementation and Expansion Grants

The Tribal MIECHV Implementation and Expansion grantees support 5-year grants (cooperative agreements) between ACF and federally-recognized Indian tribes (or a consortium of Indian tribes), tribal organizations, or urban Indian organizations that are currently operating an evidence-based home visiting program and propose to conduct or update a needs and readiness assessment, sustain and/or expand their established infrastructure for home visiting services in tribal communities, implement performance measurement systems and engage in continuous quality improvement activities; engage in activities to strengthen early childhood systems of supports for families with young children; and conduct or participate in rigorous evaluation activities.

Year 1 grant activities are designed to support grantees in refining their understanding of community needs and adjusting, modifying, sustaining, and/or expanding their programs to meet these needs and fulfill grant requirements, without disrupting critical ongoing home visiting services to eligible families. In Year 1 of the cooperative agreement, grantees must therefore: (A) conduct or update a comprehensive community needs and readiness assessment; (B) improve and enhance organizational and community infrastructure and capacity to sustain and/or expand high-quality evidence-based home visiting services, conduct performance measurement and continuous quality improvement activities, and engage in rigorous program evaluation; (C) develop an implementation plan that describes how the grantee will carry out these activities during Years 2-5; and (D) maintain existing home visiting services to expectant families and families with young children.

Grantees must engage in needs and readiness assessment, planning, and capacity-building activities during Year 1, and are expected to continue serving children and families under their

existing home visiting program, but will not fully implement their plan. Grantees are expected to submit the Needs Assessment and Implementation Plan by the end of Year 1 of the grant, with draft submission milestones throughout Year 1.

Guidance Overview

This document provides guidance for submission of the needs assessment and implementation plan for both Tribal MIECHV Development and Implementation grantees and Tribal MIECHV Implementation and Expansion grantees.

There are five main sections to the guidance: Section 1 provides instructions for submitting the needs and readiness assessment, program goals and objectives, and program design and logic model; Section 2 provides instructions for submitting an "action plan" that outlines how the grantee will implement its program as designed; Section 3 provides instructions for submitting a data collection and management plan, plan for continuous quality improvement, and plan for performance measurement; Section 4 provides instructions for submitting a plan for rigorous evaluation, and Section 5 provides instructions for submitting an integrated timeline of activities for Years 2-5. The document also includes Appendices containing supplementary information and resources, including key definitions, Tribal MIECHV Performance Measures Numerators and Denominators; and MIECHV Form 4: Quarterly Data.

It is important to note that many of the core requirements for both Tribal MIECHV Program grant programs are the same. Where there are differences in the guidance related to each grant program, the guidance includes specific instructions.

Grantees are expected to respond to every section of the guidance and each element listed under each section, with the goal that by responding to each section and area, grantees will have developed a comprehensive plan that will outline critical activities that are required to successfully execute their Tribal MIECHV grants. ACF will work closely with and provide ongoing technical assistance (TA) to grantees as they develop implementation plans. ACF and TA providers will provide TA tools throughout the development of implementation plans to assist in organizing and presenting requested information. Approval of the plan will be an iterative process between the grantee and ACF as part of the cooperative agreement.

Grantees will be permitted to implement program services upon approval of Sections 1, 2, 3, and 5. Grantees will be permitted to implement their rigorous evaluation activities upon approval of Section 4. As part of the non-competing continuation application for Years 3-5 of the grant, Tribal MIECHV grantees will update their implementation plans as necessary to ensure that the plan accurately reflects activities to be completed throughout the remainder of the grant.

Section 1: Needs & Readiness Assessment, Home Visiting Program Vision, Goals, and Objectives, and Home Visiting Program Design

Overview

This section will help you to describe community and organizational strengths, needs, capacity, and priorities and, based on what you discover, outline your home visiting program vision, goals and objectives, design, and logic model. The section is divided into five parts: 1) identify and assess your at-risk tribal community or communities; 2) assess your organizational capacity and readiness; 3) assess home visiting, substance abuse, and early childhood programs and systems in your at-risk tribal community; 4) program design; and 5) program logic model.

In each of the first three parts, you will be asked to reflect on the needs, strengths, and priorities that stand out and how these are likely to influence your program vision, goals, objectives, and design. In part four, you will articulate program vision, goals, objectives, and design based on the most critical identified needs, strengths, and priorities (including the program components such as evidence-based home visiting model, adaptations, enhancements, and supplements). Finally, you will present an integrated visual logic model that captures the direct relationship between identified needs, strengths, and priorities; goals and objectives; and program design.

For every numbered section below, respond to each lettered item accordingly (for example: Use numbered items as headings, lettered items as sub-headings, etc.).

1. Identify and Assess At-Risk Tribal Community or Communities

A. Describe the process used to conduct your needs and readiness assessment for the community (or communities) including:

i. *Stakeholder Participation and Coordination with Other Needs Assessments.* Describe who participated in planning and carrying out the community needs and readiness assessment and how stakeholders were engaged and diverse perspectives ensured.

ii. *Needs Assessment Methodology.* Describe the methods used for gathering data (e.g., quantitative data, focus groups, surveys, etc.) including how these methods were selected and implemented, and how they complement each other.

iii. *Successes, Challenges, and Lessons Learned.* Please discuss the successes, challenges, and lessons learned that arose through conducting the needs and readiness assessment. What were some of the factors that facilitated the assessment process? What were some of the challenges faced, and how were they addressed? What lessons did you learn that might be relevant to future assessments that your community or organization might undertake?

B. Describe the targeted community or communities that you studied in your needs and readiness assessment

   i. Overview of targeted community or communities
      a. Provide a general description of your service area.
      b. Define the targeted community that was assessed for risk.
      c. Describe the targeted community, including demographics, geography, historical and cultural factors.
      d. Identify the "comparison" population or community against which relative needs and strengths of the targeted community were assessed (e.g., city, county, state, overall AIAN population in the U.S., U.S. as a whole)
   ii. Describe the targeted community's established goals, visions, and priorities related to young children and families and how home visiting could fit in to these goals, vision, and priorities.
   iii. Characterize the needs and strengths of the targeted community or communities by providing data on the health and well-being of the community, as compared to the comparison population or community. If multiple targeted communities were assessed, provide information on each of these. For each targeted community, list indicators, sources of information (quantitative and qualitative), and key findings.
      a. Premature births
      b. Low birth weight
      c. Infant mortality
      d. Other risky prenatal, maternal, newborn, or child health and mental health conditions
      e. Child maltreatment
      f. Poverty and use of public assistance
      g. Unemployment and underemployment
      h. Crime, including juvenile delinquency and incarceration
      i. Domestic or intimate partner violence
      j. High school dropout and graduation rates
      k. Substance use/abuse, including alcohol, tobacco, prescription drugs, illicit drugs
      l. Other risk factors
      m. Community strengths

C. Reflections and implications

   i. Based on the information in the table above, identify the "at-risk tribal community" or communities that will be served as part of your program. **Please note: your at-risk tribal community (or communities) could be the same as the targeted community (or communities) that**

was assessed. You may define an at-risk tribal community in the following ways:

a) A tribe or tribes within a discrete geographic region (e.g., on a reservation, Tribal Jurisdictional Service Area, Alaska Native village)
b) Subgroups or communities of a tribe or tribes within a discrete geographic region
c) Members of a tribe(s) scattered throughout a larger, non-tribal geographic area interspersed with non-tribal members (e.g., AIAN living in an urban environment)

ii. For the identified at-risk tribal community or communities, discuss the needs, strengths, and priorities that stand out and how these are likely to influence your program vision, goals, objectives, and design

2. Organizational Capacity and Readiness Assessment

A. Assess your organization's capacity to respond to the identified needs of the at-risk community through a high quality, culturally appropriate, evidence-based home visiting program. Assess your organization's readiness and identify any administrative and organizational concerns that must be addressed prior to program implementation. Areas within your organization to consider include (but are not limited to) the following.

i. Leadership and Governance
   a. Describe the leadership or governance structure in place in your tribe or organization
   b. Describe how home visiting programs would or do fit into the broader structure, including a current organizational chart
   c. Describe how this structure receives input from key stakeholders

ii. Management Practices
   a. Discuss current management practices within your tribe or organization that are or would be applicable to your home visiting program

iii. Human Resources
   a. Describe organizational hiring practices and the extent to which they would or do support the ability to respond quickly and effectively to home visiting program staffing needs

iv. Financial Resources
   a. Describe how the organization ensures sound fiscal management practices
   b. Describe the existing resources that are available to support home visiting program implementation (e.g., office space, IT, GSA or agency vehicles)

c. Describe how organizational funding streams are coordinated or leveraged to streamline administrative functions

v. Service Delivery
   a. Describe any organizational experience implementing evidence-based programs or practices
   b. Describe any organizational experience implementing a home visiting program
   c. Describe existing organizational capacity and experience to deliver reflective practice and supervision

vi. Data management infrastructure
   a. Describe existing organizational capacity for data collection, analysis and management, as well as quality assurance and continuous quality improvement

vii. Capacity for conducting rigorous evaluation
   a. Describe existing organizational capacity and experience with evaluation projects using rigorous research methods. This could include capacity through subcontractors

B. Reflections and implications

   i. Based on the information above, discuss organizational needs, strengths, and priorities that stand out and how these are likely to influence your program vision, goals, objectives, and design

3. Services and Systems Quality and Capacity Assessment. Assess the quality and service capacity of existing programs or initiatives for maternal, infant, and early childhood home visiting and substance abuse treatment and mental health services in the at-risk tribal community, and assess the community's capacity to implement and integrate home visiting services to be provided by your program into an early childhood system.

A. Describe the capacity for home visiting services and systems in your community. For **Tribal MIECHV Implementation and Expansion grantees**, this includes the existing home visiting program you are currently implementing, as well as other existing home visiting programs in your at-risk tribal community. For **Tribal MIECHV Development and Implementation grantees**, this includes any existing home visiting programs in your at-risk tribal community.

   i. Describe the home visiting programs or initiatives that currently serve your at-risk tribal community or communities
   ii. Describe the funding sources for these programs and who administers them
   iii. Discuss how many families are currently receiving services through these programs

iv. Describe the characteristics of individuals and families who are receiving services
v. Discuss which home visiting models, adaptations, enhancements, and supplements are being implemented
vi. Discuss the extent to which existing programs or initiatives are high-quality (i.e., are evidence-based or based on strong theory, and are implemented with fidelity)
vii. Describe the extent to which existing programs meet the needs of eligible families and are culturally relevant for AIAN families in the at-risk tribal community
viii. Describe some of the factors that limit additional investment and capacity for providing home visiting services in the at-risk tribal community
ix. Discuss the existing mechanisms for screening, identifying, and referring families and children to home visiting programs serving the at-risk tribal community (e.g., coordinated intake procedures)
x. Discuss the existing availability of qualified staff, including supervisors and home visitors, in the at-risk tribal community
xi. Describe the extent to which there is buy-in from community members, including Tribal Leaders and Elders, for home visiting programs in the at-risk tribal community
xii. Discuss the referral resources currently available to support families enrolled in home visiting programs residing in the at-risk tribal community

B. Assess the at-risk tribal community's capacity for providing substance abuse treatment and mental health services to individuals and families in need of treatment or services and who are eligible for home visiting programs.

i. List the existing investments in providing substance abuse treatment and mental health services through various funding streams
ii. Identify the numbers and characteristics of individuals and families who are receiving substance abuse treatment and mental health services in the at-risk tribal community(s)
iii. Discuss to what extent are the services high-quality and meet the needs of individuals and families who are eligible for home visiting services (e.g., are accessible and culturally relevant)
iv. Discuss what factors limit additional investment and capacity for providing needed services to individuals and families who are eligible for home visiting programs

C. Assess the at-risk tribal community’s capacity to implement and integrate home visiting services to be provided by your program into an early childhood system.

i. Describe the existing programs, services, supports, and other resources in the at-risk tribal community or communities that serve pregnant women, expectant fathers, and children from birth to kindergarten entry and their families (including Head Start/Early Head Start, child care, health, mental health, early learning, child welfare, child abuse prevention, nutrition, housing, and other types of supportive services provided through federal, state, tribal, local, public, and private programs)
ii. Discuss to what extent the services described above are linked in an early childhood system
iii. Describe to what extent the community has a sustainable governance structure (e.g., early childhood advisory council) or coordinated way to plan for services for pregnant women, young children, and their families
iv. Describe to what extent the community has, or is able to collect, accurate and current data on an ongoing basis on the status and well-being of pregnant women, young children, and their families and the services available to them, and use these data for planning purposes
v. Describe to what extent the community is able to measure the quality of services being delivered to pregnant women, young children, and families and provide information, incentives, and support for continuous improvement (e.g., professional development and training opportunities, data systems, dedicated financing)
vi. Describe to what extent the community has a school system that is ready for children and has a strong connection to early childhood programs to facilitate a seamless transition to school and ensure continuity

D. Reflections and implications

i. Based on the information above related to the services and systems in your at-risk community, discuss the needs, strengths, and priorities that stand out and how these are likely to influence your program vision, goals, objectives, and design

4. Program Design

A. Summarize the most critical **needs, strengths, and community priorities** that emerged from your community needs and readiness assessment, organizational capacity and readiness assessment, and services and systems quality and capacity assessment

B. Based on these, define the **vision, goals, and objectives** of your proposed program. These should reflect a direct relationship to the needs, strengths, and priorities of the at-risk tribal community or communities identified through the needs and readiness assessment laid out above

i. Vision – a one-sentence statement describing the clear and inspirational long-term desired change resulting from your program's work
ii. Goals – the intended specific results of your program, should it be effective
iii. Objectives – the specific and measurable steps for reaching your goals

C. Describe the **design of your proposed home visiting program**, including its key components (i.e., evidence-based home visiting model(s), proposed adaptations to home visiting models, proposed enhancements to home visiting models, and other proposed supplemental components to the program).

i. For each proposed program component (model, adaptation, enhancement, supplement) already in existence:
    1. Identify and provide a basic description of the component
    2. Describe how the component meets the identified needs, strengths, and priorities of the at-risk community and aligns with your organizational capacity
    3. Describe how the component meets your identified programmatic vision, goals, and objectives
    4. Describe the component's theory of change
    5. Describe the component's evidence of effectiveness. If no evidence of effectiveness, what is its empirical basis (from research, theory, practice, culture, and/or context)?
    6. Describe how the component aligns with ACF's definition of an "evidence-based home visiting model", "adaptation", "enhancement", or "supplement"
    7. Describe how the community was involved in the identification and selection of the component. Discuss which stakeholders (e.g., Tribal Leaders, model developers, Elders, families) were involved and how
ii. For each proposed program component that you plan to develop as part of Years 2-5 activities under this grant, provide a general description and overview of the component's intended purpose (i.e., how it will meet identified needs and strengths and your programmatic vision, goals, and objectives). In Section 2, you will describe the process you plan to take to develop these program components
iii. Provide a rationale for how all of the proposed components will work in concert to meet the needs, strengths, and priorities of the at-risk tribal community or communities identified through the needs and readiness assessment and organizational capacity assessment. Discuss how their theories of change align with or enhance one another, and how they collectively meet your proposed vision, goals, and objectives

5. Program Logic Model

A. Provide a logic model summarizing what you have articulated above. A TA tool will be provided to you to help organize this information and present it as part of Section 1 of your implementation plan.

i. At-risk tribal community context, culture, needs, and strengths you have prioritized to address with your program
ii. Vision, goals, and objectives of your program
iii. Underlying assumptions
iv. Program inputs
v. Program design (key components)
vi. Program activities and outputs
vii. Short- and long-term outcomes

Section 2: Action Plan for Effective Implementation of Home Visiting Program

Overview

This section will assist you to articulate your action plan for effectively implementing your vision, goals, objectives, and program design as laid out in Section 1. Each of the sections below, including leadership and governance; community engagement; creating and maintaining a quality workforce; recruitment enrollment and engagement of families in home visiting services; implementation of a high-quality home visiting program; development, improvement, and implementation of an early childhood system; sustainability; and dissemination, will assist you in developing an action plan for successfully implementing your program in Years 2-5 of your grant.

For every numbered section below, respond to each lettered item accordingly (for example: Use numbered items as headings, lettered items as sub-headings, etc.).

1. **Leadership, Governance, and Administration**

    A. Identify the lead agency for your program
    B. Describe the administrative management and structure that your program operates within, and who will be responsible for ensuring successful implementation and oversight of your program
    C. Describe who will be responsible for ensuring fiscal planning and oversight of your program is in place
    D. Provide a list of lead collaborative partners, including subcontractors, and their roles and responsibilities in the development and implementation of your program
    E. Describe the composition and use of a local advisory committee to support planning and oversight of your program, including:
        i. Role of advisory committee and tasks it will perform
        ii. Composition of advisory committee and how members will potentially advise and inform your program
        iii. How often the advisory committee will meet
    F. Identify the governing body(ies) that has legal oversight, including tribal governance, tribal standing committee(s), or board of directors to which your program will report
    G. Provide an organizational chart for your program

2. **Community Engagement**

    A. Identify community stakeholders that will be engaged throughout the development and implementation of your program, including tribal and organizational leadership, parents, Elders, and community leaders

B. Identify partner organizations, departments, or programs not identified in Section 1 and that your program plans to engage
C. Identify strategies for engagement with the entire community
    i. Describe methods for engagement and outreach
    ii. Identify existing tribal, community, and organizational resources that can be utilized and leveraged to increase community engagement

3. Creating and Maintaining a Quality Workforce

A. Describe the staff positions that are necessary for the implementation of your program, and the key competencies and activities that are required for each position. Include job descriptions for these positions and resumes of staff or proposed staff as an appendix
B. Describe how new staff will be recruited and provide an overview and general timeline of the hiring process
C. Describe how new employee orientation and training will be provided, including training in your program components
D. Describe how you will provide high quality reflective, clinical, and administrative supervision
    a. How frequently it will be provided
    b. The format it will take (e.g., group, individual)
    c. Who will provide it
E. Describe how reflective practice will be supported in your program
F. Describe how the program will support access to infant and early childhood mental health consultation and other supports
G. Describe how you will support staff professional development
H. Describe strategies to prepare for and address potential staff turnover

4. Recruitment, Enrollment and Engagement of Families

A. Describe strategies for identifying and recruiting families who will most benefit from your program
B. Describe the process for enrolling families into your program
C. Estimate the number of families to be served, including your total proposed caseload
D. Describe your approach to engaging and retaining families, including ensuring appropriate dosage of services

5. Implementation of a High-Quality Program

A. For each existing program component (model, adaptation, enhancement, supplement) proposed as part of your program design, provide a plan for working with model developer(s) and/or developers of other program components, including:

i. The approach to ongoing communication and working relationship with the developers to address challenges that may arise and share best practices
ii. How component curriculum and materials will be accessed, as well as any necessary pre-service or recurring training, licensing, affiliation, and/or certification
iii. What technical assistance and supports will be provided

B. If you proposed in Section 1 to develop a program component as part of Year 2-5 activities, please describe the process through which it will be developed
   i. Which stakeholders will be involved and how
   ii. How you will ensure that the component meets ACF requirements and definitions
   iii. Anticipated challenges and how they will be addressed

C. Monitoring of fidelity of program implementation to ensure services are delivered according to the requirements of the selected program components
   i. Describe how you will monitor, assess, and support implementation with fidelity to the chosen program components and maintain implementation quality assurance[1]
   ii. Discuss anticipated challenges to maintaining quality and implementation fidelity and how you will address them

6. Early Childhood Systems Building

A. Describe how your program will accomplish the goal of meeting the needs of families from pregnancy through kindergarten entry through the development, improvement, and implementation of an early childhood system of support for families that includes your home visiting program. Discuss how your program will meet the needs of families served through collaboration with tribal and community stakeholders and partners providing services and supports such as, but not limited to:
   i. Early care and education (Head Start/Early Head Start, child care, pre-kindergarten)
   ii. Home visiting (including State MIECHV)
   iii. Maternal, child, and family health
   iv. Mental and behavioral health
   v. Substance abuse prevention and treatment
   vi. Domestic violence

[1]The quality assurance plan you articulate in Section 3 may be one piece of this overall implementation quality assurance plan.

vii. Child welfare, child maltreatment and injury prevention
viii. Economic self-sufficiency
ix. Elementary and secondary education
x. Early intervention for developmental delays
xi. Housing and homelessness
xii. Other social and health services for pregnant women, expectant fathers, young children, and families

7. Developing Policies and Procedures

A. Identify topic areas of existing policies at the tribal or organizational level, such as human resources/personnel, confidentiality and privacy, etc.
B. Identify topic areas of policies and/or procedures that will need to be revised, refined, or developed for your program
C. Describe strategies for engaging program staff and other stakeholders in the development of your program policies and procedures manual, including administrative leadership, advisory groups, and service recipients
D. Describe activities that will ensure the regular utilization and review of your program policies and procedures manual

8. Engaging in Dissemination – Telling Your Program Story

A. Describe your program's main goals for dissemination
B. Describe the audiences you plan to prioritize for dissemination
C. Discuss the types of information you think these audiences will be most interested in and how you will gather this information
D. Provide an overview of the types of dissemination materials and products you will develop or have already developed to reach these audiences
E. Describe your plans to disseminate the materials and products you develop
F. Describe your plans to evaluate the successes of your dissemination efforts

9. Promoting Sustainability

A. Describe how your program will build and ensure sustainability after the grant has ended. Discuss how your program will engage with tribal or other organizational leaders, and how your program fits into and is important within the historical and cultural contexts of the community; including:
    i. How your program's purpose aligns within and is critical to the larger tribal or organizational strategic vision for the future
    ii. How your program demonstrates to stakeholders that it provides a vital and critical service and is important to the families and to the community

iii. Identify the strategic linkages between your community engagement strategy and sustainability, including how will you leverage relationships and engage with advisory groups and other stakeholders

B. Assess the current infrastructure and resources for retaining and extending home visiting services beyond the federal funding period.

C. Identify resources that potentially may be leveraged to sustain home visiting, including collaborations with service partners, various funding streams, both public and private.

Section 3: Plan for Data Collection and Management, Continuous Quality Improvement, and Performance Measurement

Overview

The broad aim of this section is to support you in monitoring and improving the program design and implementation action plan you developed in Sections 1 and 2. All grantees will engage in ongoing planning, collection, and monitoring of data on program activities. The purpose of this section is for you to: 1) develop a data collection and management plan; 2) develop a plan for using data to inform program management and improvement; and 3) develop a plan for the reporting of demographic, implementation, and performance measures required by the Tribal MIECHV Program.

For every numbered section below, respond to each lettered item accordingly (for example: Use numbered items as headings, lettered items as sub-headings, etc.).

1. **Data Collection and Management Plan**

   A. Plan for data collection and entry

      i. Describe your data collection process for Tribal MIECHV Form 1, MIECHV Form 4, and performance measurement data
         a. Identify the persons responsible for data collection (i.e., home visitors, intake specialist, data collector, coordinator, etc.)
         b. Identify mode of data collection (i.e., paper forms, tablet, combination of the two, etc.)
         c. Describe whether participants will complete forms themselves, whether the data will be collected via interview or with computer assisted interviewing technology
         d. Identify the persons responsible for data entry
         e. Describe data entry procedures and timeframes

   B. Plan to ensure the quality of data collection and analysis

      i. Describe procedures for training and staffing around data
         a. The minimum qualifications or training requirements for those administering measures
         b. The qualifications of personnel responsible for data management at the grantee and program level
         c. The qualifications of personnel responsible for data analysis at the grantee and program level
         d. The time estimated for the data collection-related activities for different staff positions

e. Strategies you have for minimizing the impact of any staff turnover on data collection and analysis

ii. Describe your approach to promoting a culture of quality within the organization and program

iii. Discuss your policies and procedures around data collection and management
   a. Describe your plans for documenting procedures or policies related to data collection, data entry, data management and/or data analysis
   b. If you have developed policies and procedures already, please describe them
      Describe your plan for using, monitoring, or updating these procedures or policies

iv. Provide a plan for data quality checks
   a. Describe your process for verifying the validity, accuracy, completeness, consistency and uniformity of data collected in the field, including frequency of data quality checks
   b. Describe your process for verifying the validity, accuracy, completeness, consistency and uniformity of data entry, including frequency of data quality checks
   c. Describe process for providing feedback and improving data quality issues if they arise

C. Plan for Data Management Information System (MIS)

i. Describe your data management information system(s)
ii. Describe the contractor responsible for the data system (if applicable), what services are provided, and what training and TA are provided
iii. Describe your plan for data entry/upload
iv. Describe whether and how your data system will link with other systems
v. Discuss the functions your system will provide (e.g., auto-calculations, reports)
vi. Describe which staff will have access to the system, including whether different staff will have different levels of access
vii. Identify which staff will run reports
viii. Identify the staff responsible for making changes to the system, and describe how those changes will be made (e.g., is there a period where system locks and all changes are made? Or do changes occur on an ongoing basis?)
ix. Discuss how data system policies will be manualized
x. Describe how staff will be trained to use the system in an ongoing way
xi. If applicable, identify goals for improving your existing data system

D. Plan for Data Security

i. Describe plan for data security including privacy of data, administration procedures that do not place individuals at risk of harm (e.g., questions related to domestic violence and child maltreatment reporting), and compliance with applicable regulations related to Tribal oversight and approval of strategies for protection of human subjects, data safety and monitoring, and compliance with applicable regulations, other Institutional Review Board/human subject protections, Health Insurance Portability and Accountability Act *(*HIPAA), and Family Educational Rights and Privacy Act *(*FERPA)
ii. Discuss how staff will be trained on these topics

2. Plan For Using Data to Inform Program Management And Improvement

A. Quality Assurance Plan

i. Identify data elements that you will use on an ongoing basis for quality assurance,
    a. Describe what model-specific data you will review, such as fidelity measures
    b. Discuss which core and flex performance measures you will review
    c. Discuss which demographic, service utilization, and implementation data you will review
    d. Identify other sources of data you may use for quality assurance
ii. Describe the data analytic methods you will use to monitor program performance, such as data visualization, run charts, etc.
iii. Discuss how often you will review these data, and who will be involved in sharing, reviewing, and acting upon the data within your program, organization, and community

B. Continuous Quality Improvement Plan

i. Discuss your program's readiness to engage in CQI, including your past experiences with CQI and the steps your program might need to take to be ready to integrate CQI into regular practice
ii. Provide a plan to support CQI
    a. Identify members of your CQI team
    b. Describe members' roles and responsibilities
    c. Describe a plan for meetings, including if CQI will be incorporated into regular staff meetings or occur in separate CQI meetings
    d. Discuss how often your CQI team will meet

e. Describe how the CQI team will work in an ongoing way to identify CQI opportunities and topics, including which data you will use and how you will use data

3. Plan for the Reporting of Required Demographic, Service Utilization, Implementation, and Performance Measurement Data

Grantees under the Tribal MIECHV program must collect, analyze, use, and report data on program implementation and improvements for eligible families participating in the program in the legislatively-mandated benchmark areas of: I) improved maternal, newborn, and child health; II) prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency room visits; III) improvements in school readiness and child academic achievement; IV) reductions in crime or domestic violence; V) improvements in family economic self-sufficiency; and VI) improvements in the coordination and referrals for other community resources and supports. Grantees will also collect and report on demographic and service utilization and service capacity, place-based services, family engagement, and staffing data.

The data that you will collect and report include the following.

- 15 Performance Measures (will be submitted annually starting in Year 2 of the grant; definitions are provided in Appendix C)
    - 12 Core Measures
        - Implementation Measures
            1. Receipt of Home Visits
            2. Home Visit Implementation Observation
            3. Reflective Supervision
        - Benchmark Measures
            4. Depression Screening (I)
            5. Substance Abuse Screening (I)
            6. Well-child Visit (I)
            7. Child Injury Prevention (II)
            8. Parent-Child Interaction (III)
            9. Developmental and Behavioral Screening (III)
            10. Screening for Intimate Partner Violence (IV)
            11. Screening for Economic Strain (V)
            12. Developmental and Behavioral Referrals (VI)
    - 3 Flex Measures
        - Grantees must select 3 measures, two from items 1-7 and one from items 8-11.
            1. Breastfeeding (I)
            2. Postpartum Health (I)
            3. Immunizations (I)
            4. Screening for Parenting Stress
            5. Safe Sleep Education (II)

6. Child Injury Prevention (II)
7. Early Language and Literacy Activities (III)
8. Intimate Partner Violence Referrals (VI)
9. Depression and Parenting Stress Referrals (VI)
10. Substance Abuse Referrals (VI)
11. Economic Strain Referrals (VI)

- Demographic and service utilization data (Tribal MIECHV Form 1) (will be submitted annually starting in Year 2 of the grant for Development and Implementation grantees and Year 1 of the grant for Implementation and Expansion grantees)
- Service capacity, place-based services, family engagement, and staffing data (MIECHV Form 4) (will be submitted quarterly starting in Year 2 of the grant for Development and Implementation grantees and Year 1 of the grant for Implementation and Expansion grantees)

A. For each required element, you will be required to address the following in your plan. A TA tool will be provided to you to help organize this information and present it as part of Section 3 of your implementation plan.

i. Target population to be assessed
ii. Data sources, forms, and tools
iii. Data time points
iv. Data elements to be used for computing data value
v. Data systems modifications needed
vi. Data reporting fields to be used for calculation
vii. Unique data reporting elements

Section 4: Plan for Rigorous Evaluation of Home Visiting Program

The evaluation activities of the Tribal MIECHV grantees occur as part of a continuous program of rigorous research within the broader MIECHV Strategic Learning Agenda. It is expected that collectively these program evaluation activities will contribute to the empirical evidence base on implementation, efficacy, effectiveness, and/or adaptation of home visiting programs in AIAN communities. Tribal MIECHV Development and Implementation grantees will propose and put into action a plan for iterative formative evaluation of home visiting in their tribal community. Tribal MIECHV Implementation and Expansion grantees will either participate in a multi-site implementation evaluation (MUSE) OR plan and conduct a local efficacy study of home visiting in their tribal community. All Implementation and Expansion grantees that choose to conduct a local efficacy study will be encouraged to participate in the multi-site implementation evaluation to the extent feasible and relevant. In the following section, the implementation plan guidance for evaluation for each set of grantees is presented separately (i.e., Development and Implementation grantees pages 27-31; Implementation and Expansion grantees pages 32-38).

EVALUATION GUIDANCE FOR TRIBAL MIECHV DEVELOPMENT AND IMPLEMENTATION GRANTS

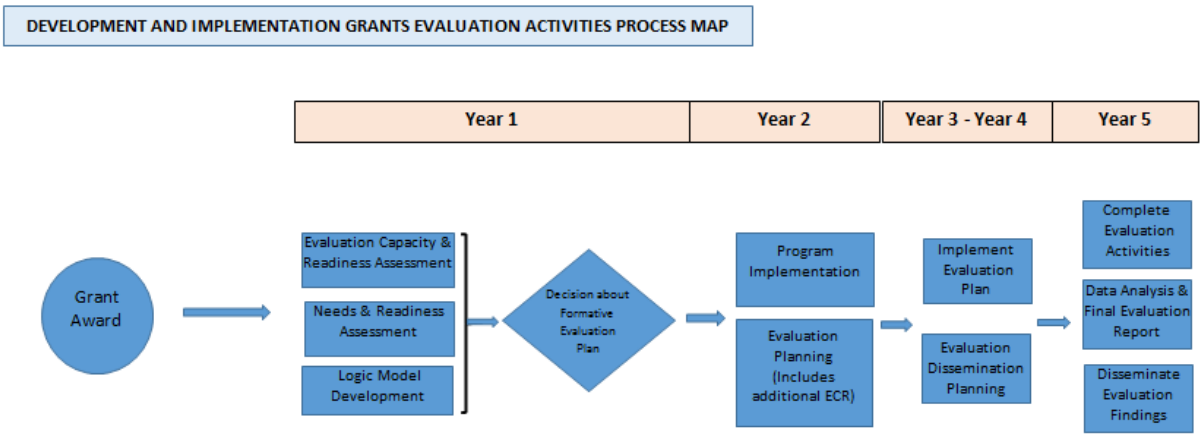
Overview

Grantees will propose a plan for participating in ongoing program evaluation activities that addresses locally relevant questions that emerge from their needs and readiness for home visiting assessment. It is expected that these evaluations will contribute to building the knowledge base around successful strategies for implementing, adopting, providing, and sustaining high-quality, evidence-based home visiting services to AIAN populations. The grantee's evaluation plan will be grounded in the grantee's logic model for home visiting and an Evaluation Capacity and Readiness (ECR) assessment. Upon review of the logic model and ECR, grantees will consider evaluation approaches that clarify and/or test the relationships between elements within the logic model. For example, design and development studies help answer questions about how activity components influence outputs and how outputs influence immediate outcomes. Efficacy studies help answer questions about, how a particular intervention when implemented in a particular context effects specific immediate and proximal outcomes for a particular group of participants. ACF will provide technical assistance to support grantees in developing and implementing an evaluation plan, design and measurement strategy that is grounded in their ECR and that best fits their local question(s). For more information on types of research and evaluation, see The Administration for Children and Families Common Framework for Research and Evaluation, available at http://www.acf.hhs.gov/programs/opre/resource/the-administration-for-children-families-common-framework-for-research-and-evaluation.

Timeline of Evaluation Activities

The Development and Implementation grants process map (below) provides a visual representation of the evaluation activities for the Development and Implementation grants for the five year grant cycle. Some of the included activities are not exclusively evaluation-related activities, such as logic model development and needs and readiness assessment. A stage-like progression of iterative planning and technical assistance that includes reflection and revision based on local experience will be followed. In Year 1, you will describe your plan for engaging the community, tribal, and organizational leadership in the development and oversight of the evaluation. You will also develop a logic model that represents your expectations regarding home visiting in their community, conduct a needs and readiness assessment, and participate in an evaluation capacity and readiness (ECR) assessment. You will then make a decision about your formative evaluation priorities. In Year 2, you will plan your formative evaluations, with continued ECR assessment. You will choose a focus for your evaluation and describe planned evaluation activities, including a specification of evaluation question(s) and design, measurement plans, the plan for data collection and management, the data analysis plan, the planned strategy for tribal oversight, the plan for protection of human subjects, and a timeline of evaluation activities to occur during Years 3-4. In Years 3 and 4, you will implement you evaluation, adjust as needed, and begin planning for the dissemination of your evaluation.

Early in Year 5, you will complete evaluation activities. You will then conduct data analysis, complete their final evaluation report, and disseminate evaluation findings.



Developing the Evaluation Plan. You will develop the following information regarding your evaluation plan. For every numbered section below, respond to each lettered item accordingly (for example: Use numbered items as headings, lettered items as sub-headings, etc.).

<u>Years 1- 2</u>

1. Plan for Collaboratively Building a Knowledge Base for Home Visiting and its Impact with AIAN Populations (2-3 paragraphs)
   a. Strategy for community participation in and Tribal oversight of evaluation plans and activities

2. Logic Model – visual and verbal description (1 page graphic and 5 paragraphs)

3. Summary of and reflection on ECR (3-5 paragraphs)

4. Summary of potential evaluation questions that have been considered, including the advantages and challenges for each. If you considered expanding a piece or pieces of the logic model to examine components more closely, describe this here. () (5-7 paragraphs)

5. Choice of evaluation focus and rationale for it being the priority with clear links to logic model, needs and readiness assessment, ECR assessment. The evaluation focus may involve one 'big' question with data collection over years or staged questions that are modified over time based on plan/decisions . (3-5 paragraphs)

6. Evaluation Design

    a. Evaluation question(s) to be addressed

Clearly state your evaluation question(s) as a REP question:

Evaluation Question(s):	
R	*The relationship(s) in logic model that will be studied*
E	*The elements you plan to measure to understand the relationship(s)*
P	*The prediction for how you think the relationship(s) will work*

    b. Based upon the evaluation question(s) above, clearly state the hypothesis (hypotheses) that you mean to explore.

    c. Evaluation approach and method(s)
        i. Rationale and considerations for proposed evaluation approach to address evaluation questions
        ii. Evaluation Diagram: Please briefly diagram in a visual form how your evaluation approach will help clarify and/or explain aspects of your logic model.
        iii. Describe your expected sample.

.

    d. Planned quantitative and/or qualitative measures and instruments (please provide in a table format)

Measure/Instrument & Source Information	**Logic Model element to be measured (e.g., input, activity, output, outcome)**

    e. Data collection process
        i. Description of current and/or planned system(s) for collecting program management and evaluation data (basic design, software, potential access for evaluation, challenges or barriers to accessing data)

    f. Data collection schedule (provide detailed timeline) Analysis plan
        i. Describe your analysis plan for answering each of your research questions/hypotheses.
        ii. If using quantitative analysis, include information on your selected statistical method for each planned comparison (i.e., descriptive and

inferential statistics), and how each of the variables in 2.g above will be analyzed.

iii. If using primarily qualitative data analysis, include discussion of plans for data reduction (i.e., coding, defining themes and patterns), testing validity (i.e., triangulation, validation procedures), and qualitative data analysis software to be utilized.

iv. If you will be utilizing a consultant for your data analysis, please describe your plan for the data analysis consultation process.

7. Tribal Oversight and Institutional Review Board Requirements and Plan

   a. Documentation of Office of Human Subjects Protection approved Federal-wide Assurance (see http://www.hhs.gov/ohrp/assurances/forms/domesticfwainstructions.html).The Federal-wide Assurance (FWA) is an assurance of compliance with the Federal regulations for the protection of human subjects in research. It is approved by the Office for Human Research Protections (OHRP) for all human subjects research conducted or supported by the Department of Health and Human Services (HHS).
   b. Plan for human subjects protection and Tribal oversight (if applicable)
   c. Confidentiality procedures
   d. Plans for submission of proposed evaluation design to IRB(s)
   e. Plan for staff training related to human subjects protection

8. Data Collection Management Plan

   a. Organization(s) Responsible for Collecting and/or Reporting Evaluation Data
      i. Organization name, qualifications, location, and role in the project
      ii. Contact name and information
   b. Plans for data safety and monitoring (storage, access, disposal, relevant staff training)

9. Evaluation Staffing, Timeline, and Budget

   a. Evaluation organization chart/staffing
   b. Timeline (e.g., evaluation planning, Tribal oversight and IRB approval, instrument development, staff recruitment and training, data collection schedule, administration of instruments, analysis, reporting)

Please indicate the month and year that each of the following evaluation tasks will begin and end (modify table as needed):

Evaluation Task	Month/ Year	Month/ Year	Month/ Year	Month/ Year	Month/ Year	Month/ Year	Month/ Year	Month/ Year

Evaluation planning								
Tribal oversight and IRB approval								
Instrument development								
Staff recruitment and training								
Data collection								
Administration of instruments								
Data analysis								
Reporting								

c. Budget for evaluation activities described in above table

Years 3-4

10. Planned Evaluation Dissemination Activities. This will be submitted early in Year 3, then reviewed and revised early in Year 4, and then reviewed and revised at the beginning of Year 5.

Please indicate which of the following evaluation dissemination activities are planned and then elaborate on each as needed:

✓	**Dissemination Activity**
	Internal newsletter/publication
	External newsletter/publication
	Conference presentations/posters
	Tribal Organization Publication
	Website publication
	Peer reviewed evaluation journal

11. Review and Revision of Evaluation Plan. During implementation of the evaluation, reflection and review of plans will occur. Revision will occur on an ad hoc basis as needed.

Year 5

12. Submit Final Report

Overview

Implementation and Expansion grantees will either participate in a multi-site implementation evaluation (MUSE) OR plan and conduct a local efficacy study of home visiting in their tribal community that involves a comparison (e.g., the receipt of home visiting to not receiving home visiting; the provision of intensive coaching for implementation compared to implementation without coaching), either through a quasi-experimental design such as a matched comparison, a wait-list control, or multiple-baseline design (e.g., single-case design), or a randomized control design (EFFICACY). All Implementation and Expansion grantees that choose to conduct a local efficacy study will be encouraged to participate in the multi-site implementation evaluation to the extent feasible and relevant as well (EFFICACY+MUSE). ACF will provide technical assistance to support grantees as appropriate across these three options.

Timeline of Evaluation Activities

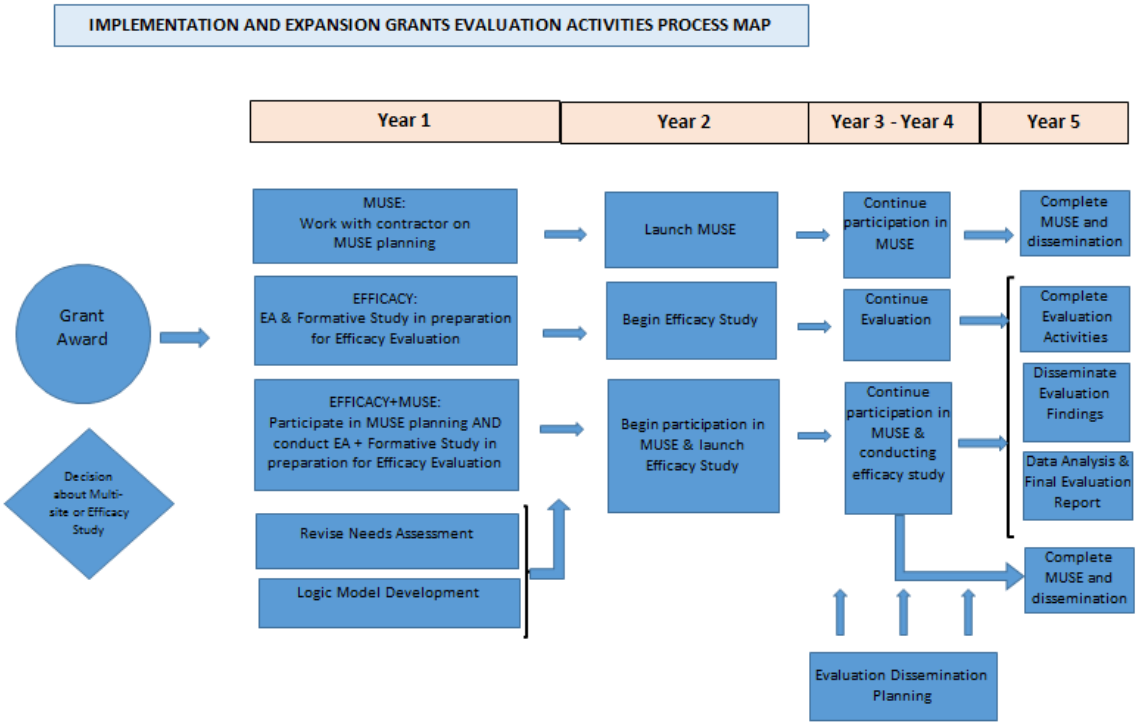
The Implementation and Expansion grants process map (below) provides a visual representation of the evaluation activities for the Implementation and Expansion grants for the five year grant cycle. Some items in the map represent activities that are not exclusively evaluation-related activities, such as logic model development and needs assessment.

In Year 1, all grantees will describe their plan for engaging the community, tribal, and organizational leadership in the development and oversight of the evaluation. You will also develop a logic model that represents your expectations regarding home visiting in your community and revise your needs assessment. Evaluation timeline activities for Implementation and Expansion grantees are described below.

In Year 1, MUSE and EFFICACY+MUSE grantees will work with the ACF contractor on the multi-site implementation evaluation. In Year 2, these grantees will launch the multi-site evaluation. In Years 3 and 4, MUSE and EFFICACY+MUSE grantees will continue participation in the multi-site evaluation. Early in Year 5, all grantees will complete evaluation activities.

In Year 1, EFFICACY and EFFICACY+MUSE grantees will participate in an evaluability assessment (EA) to determine formative evaluation steps appropriate to prepare for and refine their proposed efficacy study. In Year 2, EFFICACY and EFFICACY+MUSE grantees will refine plans for their efficacy study and initiate implementation of their study. During Year 2, EFFICACY and EFFICACY+MUSE grantees will refine and describe planned evaluation activities, including a re-specification of evaluation question(s) and design, measurement plans, the plan for data collection and management, the data analysis plan, the planned strategy for tribal oversight, the plan for protection of human subjects, and a timeline of evaluation activities to occur. In Years 3 and 4, EFFICACY and EFFICACY+MUSE grantees will continue implementing their efficacy study and begin planning for the dissemination of their evaluation. Early in Year 5, all grantees will complete evaluation activities. During Year 5, EFFICACY and EFFICACY+MUSE

grantees will conduct data analysis, complete their final evaluation report, and disseminate evaluation findings.



MUSE and EFFICACY+MUSE Participation. The details for the multi-site implementation evaluation will not be addressed in this guidance, as grantees will work with the contractor for this study to develop any necessary plans.

EFFICACY and EFFICACY+MUSE: Re-fining the Evaluation Plan. Grantees choosing this option will plan and conduct a local efficacy study of home visiting in your tribal community that involves a comparison (e.g., the receipt of home visiting to not receiving home visiting; the provision of intensive coaching for implementation compared to implementation without coaching), either through a quasi-experimental design such as a matched comparison, a wait-list control, or multiple-baseline design (e.g., single-case design), or a randomized control design.

You will develop the following information regarding your evaluation plan. *Efficacy study grantees will need to write a rationale for your study based in the literature, will use the PICO model for your evaluation question, as well as include information on additional research questions and data plans (e.g., qualitative component).*

Developing the Evaluation Plan. You will develop the following information regarding your evaluation plan. For every numbered section below, respond to each lettered item accordingly (for example: Use numbered items as headings, lettered items as sub-headings, etc.).

1. Plan for Collaboratively Building a Knowledge Base for Home Visiting and its Impact with AIAN Populations (2-3 paragraphs)

    a. Strategy for community participation in and Tribal oversight of evaluation plans and activities

2. Logic Model – visual and verbal description of overall home visiting logic model as well as components to be studied in evaluation (1 page graphic and 5 paragraphs)

3. Summary of and Reflection on Evaluability Assessment (3-5 paragraphs)

4. Rationale for efficacy study (with clear links to a specific review of home visiting literature (as well as other empirical and theoretical justification), logic model, needs and readiness assessment, EA assessment). (3-5 pages)

5. Efficacy Study Design

    a. Evaluation question(s) to be addressed

Clearly state your evaluation question(s) as a PICO question:

Evaluation Question(s):	
P	*The target population and their prioritized needs.*
I	*The intervention, program, or program component to be evaluated.*
C	*The comparison that will be made to understand the impact of the program.*
O	*The intended outcomes you want to see achieved.*

    b. Based upon the evaluation question(s) above, clearly state the hypothesis (hypotheses) that you mean to test.

    c. Research design and method(s)
        i. Rationale and considerations for proposed research design and methods to address evaluation questions

        ii. Research design

Please briefly diagram your evaluation design in the box provided below. In this diagram: 0's will represent observations/points of measurement, and X's will represent

the introduction of the intervention/component. An example of a comparison group design is provided below.

Example Evaluation Question:
Does the HV intervention decrease substance abuse, more than existing services?
In this example, the X represents the HV intervention, and the O's represent the observations/administration of measures of the targeted outcome; and the T's represent each data collection time point (time 1 to time 4).

Quasi-Experimental Design

	T_1		T_2	T_3	T_4
HV Program	O	X	O	O	O
Services as Usual	O		O	O	O

iii. Sample size(s)

d. Planned measures and instruments (please provide in a table format)

Measure/Instrument & Source Information	**Evaluation Plan element to be measured (e.g., input, activity, output, outcome)**

e. Data sources (see table below for 5 l., m. & n.)
f. Data collection process (see table below for 5 l., m. & n.)
   v. Description of current and/or planned system(s) for collecting program management and evaluation data (basic design, software, potential access for evaluation, challenges or barriers to accessing data)
g. Data collection schedule (see table below for 5 l., m. & n.)

Input, Activity, Output, or Outcome	**Measure/ Indicator**	**Data Source**	**Measurement Interval**	**Data Collection Method**	**Person Responsible**
	What is the operational definition of the variable? How will it be systematically measured (percent of recommended home visits received, number of books in the home, etc.)?	What tool or method will be used to collect the data on a given measure (e.g., attendance logs, client self-report, etc.)?	How frequently will the data be collected (e.g., every 6 months, at intake and 1 year post-enrollment, etc.)?	What format or method will you use (e.g., electronic data system, ACASI, hard copy, etc.)?	Who will record the data (e.g., home visitor, evaluator, etc.)?
1.					
2.					
3.					
4.					
5.					
6.					

h. Analysis plan

vi. Describe your analysis plan for answering each of your research questions/hypotheses.

vii. If using quantitative analysis, include information on your selected statistical method for each planned comparison (i.e., descriptive and inferential statistics), and how each of the variables in 2.g above will be analyzed.

viii. If using primarily qualitative data analysis, include discussion of plans for data reduction (i.e., coding, defining themes and patterns), testing validity (i.e., triangulation, validation procedures), and qualitative data analysis software to be utilized.

ix. If you will be utilizing a consultant for your data analysis, please describe your plan for the data analysis consultation process.

6. Tribal Oversight and Institutional Review Board Requirements and Plan

    a. Documentation of Office of Human Subjects Protection approved Federal-wide Assurance (see http://www.hhs.gov/ohrp/assurances/forms/domesticfwainstructions.html).The Federal-wide Assurance (FWA) is an assurance of compliance with the Federal regulations for the protection of human subjects in research. It is approved by the Office for Human Research Protections (OHRP) for all human subjects research conducted or supported by the Department of Health and Human Services (HHS).
    b. Plan for human subjects protection and Tribal oversight (if applicable)
    c. Confidentiality procedures
    d. Plans for submission of proposed evaluation design to IRB(s)
    e. Plan for staff training related to human subjects protection

7. Data Collection and Management Plan

    a. Organization(s) Responsible for Collecting and/or Reporting Evaluation Data
        i. Organization name, qualifications, location, and role in the project
        ii. Contact name and information
    b. Plans for data safety and monitoring (storage, access, disposal, relevant staff training)

8. Evaluation Staffing, Timeline, and Budget

    a. Evaluation organization chart/staffing
    b. Timeline (e.g., evaluation planning, Tribal oversight and IRB approval, instrument development, staff recruitment and training, data collection schedule, administration of instruments, analysis, reporting)

Please indicate the month and year that each of the following evaluation tasks will begin and end:

Evaluation Task	Month/ Year	Month/ Year	Month/ Year	Month/ Year	Month/ Year	Month/ Year	Month/ Year	Month/ Year
Evaluation planning								
Tribal oversight and IRB approval								
Instrument development								
Staff								

recruitment and training								
Data collection								
Administration of instruments								
Data analysis								
Reporting								

c. Budget for evaluation activities described in above table

Years 3-5

9. Planned Evaluation Dissemination Activities. This will be submitted early in Year 3, then reviewed and revised early in Year 4, and then reviewed and revised at the beginning of Year 5.

Please indicate which of the following evaluation dissemination activities are planned and then elaborate on each as needed:

✓	**Dissemination Activity**
	Internal newsletter/publication
	External newsletter/publication
	Conference presentations/posters
	Tribal Organization Publication
	Website publication
	Peer reviewed evaluation journal

10. Review and Revision of Evaluation Plan. During implementation of the evaluation, reflection and review of plans will occur. Revision will occur on an ad hoc basis as needed.

Year 5

12. Submit Final Report

Section 5: Integrated Years 2-5 Timeline

Overview

In this section, you will provide a comprehensive timeline that reflects the major milestones that have been identified in each of Sections 2-4 and that will be executed in years 2-5 of the grant. Technical assistance tools will be provided to you to help develop and organize the timeline and submit it as part of your implementation plan.

1. Program component development
2. Leadership, governance, and administration plans
3. Community engagement activities
4. Recruitment, enrollment and engagement of families in home visiting services
5. Implementation of a high-quality home visiting program
6. Meeting the needs of families from pregnancy through kindergarten entry through the development, improvement, and implementation of an early childhood system
7. Developing, refining, or updating policies and procedures for your home visiting program, including the development of a policies and procedures manual
8. Development and implementation of dissemination activities into your program
9. Sustainability planning
10. Development of a data collection and management infrastructure
11. Data system development and management
12. Quality assurance activities
13. Continuous quality improvement activities
14. Collection, analysis, and reporting of required data
15. Rigorous evaluation planning and implementation activities

Appendix A – Definitions of Key Terms in Implementation Plan Guidance

- Adaptation
    - For the purposes of the Tribal MIECHV program, an acceptable adaptation of an evidence-based model or promising approach includes changes to the model that have not been tested with rigorous impact research and are determined by the model developer to alter core components related to program impacts, are aligned with Tribal MIECHV program requirements, and are agreed to by the model developer and ACF in partnership with the grantee.

- Administrative supervision
    - For the purposes of the Tribal MIECHV program, administrative supervision is the oversight of tribal, federal, state, and agency regulations, program policies and procedures, quality assurance and safety. Administrative supervision is aimed at monitoring an employee's productivity and performance.

- Advisory committee
    - For the purposes of the Tribal MIECHV program, a local advisory committee is comprised of community members from the program's service area and provides input on a variety of program and evaluation activities. Advisory committees are created to ensure that the program is in touch with the community's needs and incorporates the community's perspective in program operations and evaluation activities. Advisory committees should meet on a regular basis and perform a number of valuable functions, including providing input on needs assessment, performance measurement, continuous quality improvement, evaluation, and dissemination activities; defining program vision, goals, objectives, and design; and helping shape many core functions and activities of the program.

- At-risk tribal community
    - For the purposes of the Tribal MIECHV program, in order to reflect the diverse circumstances of tribal populations, ACF takes a broad and inclusive view of what constitutes an at-risk tribal community. Grantees may define an at-risk tribal community in the following ways:
        - A tribe or tribes within a discrete geographic region (e.g., on a reservation, Tribal Jurisdictional Service Area, Alaska Native village) could be considered an at-risk tribal community;
        - Subgroups or communities of a tribe or tribes within a discrete geographic region could be considered an at-risk tribal community; or
        - Members of a tribe(s) could live scattered throughout a larger, non-tribal geographic area interspersed with non-tribal members (e.g., AIAN living in an urban environment) and be considered an at-risk tribal community.

- Clinical supervision or Consultation

- For the purposes of the Tribal MIECHV program, clinical supervision is case-focused and supports a practitioner in reviewing, discussing and evaluating cases, including treatment planning, implementation of intervention strategies and progress of clients. Clinical supervision may or may not be reflective.

- Continuous quality improvement
  - For the purposes of the Tribal MIECHV program, an effectively implemented system of continuous quality improvement (CQI) within a home visiting program supports the ongoing use of performance and implementation data to optimize program outcomes, facilitate cultural and contextual adaptations of evidence-based models to meet community and program needs, identify and disseminate best practices, and test new approaches in home visiting that can increase efficiency and enhance effectiveness of programs. To maximize the utility of data for decision-making and learning, grantees under this FOA will build capacity for rapid-cycle continuous quality improvement and testing of improvement strategies through use of run charts and other tools.

- Culture of quality
  - For the purposes of the Tribal MIECHV program, culture of quality is defined as an organization that has the systems and structure in place to support continuous quality improvement and actively engages in continuous quality improvement processes and data-driven decision making. Continuous quality improvement drives the organization's culture of quality and must be aligned with the organization's mission, vision, and strategic plan and linked to organizational and individual performance.

- Data source characteristics
  - Grantees under this FOA should consider the following in planning for and conducting needs and readiness assessments:
    - *Recency or timeliness of data:* Data sources are updated on different schedules, some annually and others much less frequently. The most recently updated data sources may be preferred to more outdated sources, even if the estimates may be less precise.
    - *Geographic boundaries of data:* Grantees have discretion in how they geographically define 'community(ies).' However, whenever possible, needs assessment data should be aggregated at the same or similar geographic level (e.g., tribal reservations, counties, cities, neighborhoods, zip codes, census tracts, etc.) as the communities being described. Thus, when choosing between data sources, grantees should make careful note of the geographic units for which the data are available.
    - *Stability of data:* While it may be possible to disaggregate some national, tribal, and state data into community level data, this does not mean that the data indicators will be stable or reliable at that level. For many assessments, the sub-sample of residents from a specific community will

be too small to be a trustworthy representation of the characteristic of that community and its residents.

- Dissemination
  - Dissemination is an intentional process to move new information relevant to policy, practice, and research from your home visiting program to well-defined multiple early childhood and tribal audiences for a particular purpose. The dissemination cycle includes planning, identifying content, materials development, and dissemination and evaluation.

- Early childhood system
  - For the purposes of the Tribal MIECHV program, an early childhood system brings together health, early care and education, and family support program partners, as well as tribal and community leaders, families, and other stakeholders to achieve agreed-upon goals for thriving children and families. An early childhood system aims to: reach all children and families as early as possible with needed services and supports; reflect and respect the strengths, needs, values, languages, cultures, and communities of children and families; ensure stability and continuity of services along a continuum from pregnancy to kindergarten entry; genuinely include and effectively accommodate children with special needs; support continuity of services, eliminate duplicative services, ease transitions, and improve the overall service experience for families and children; value parents and community members as decision makers and leaders; and catalyze and maximize investment and foster innovation.

- Eligible family
  - The MIECHV legislation (Section 511(k)(2) of the Social Security Act) states that an eligible family in MIECHV means a woman who is pregnant, and the father of the child if the father is available; or a parent or primary caregiver of a child aged birth through kindergarten entry, including grandparents or other relatives of the child, foster parents who are serving as the child's primary caregiver, and non-custodial parents who have an ongoing relationship with, and at times provide physical care for, the child. Section 511(d)(4) of the Act further requires that MIECHV grantees give priority to serving high-risk groups including: eligible families who reside in at-risk tribal communities in need of such services, as identified in the needs assessment; low-income eligible families; eligible families who are pregnant women who have not attained age 21; eligible families that have a history of child abuse or neglect or have had interactions with child welfare services; eligible families that have a history of substance abuse or need substance abuse treatment; eligible families that have users of tobacco products in the home; eligible families that are or have children with low student achievement; eligible families with children with developmental delays or disabilities; and eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have

members of the Armed Forces who have had multiple deployments outside of the United States.

- Enhancement
  - For the purposes of the Tribal MIECHV program, an acceptable enhancement of an evidence-based model or promising approach includes changes or additions to the model that have not been tested with rigorous impact research but are determined by the model developer not to alter the core components related to program impacts, are aligned with Tribal MIECHV program requirements, and are agreed to by the model developer and ACF in partnership with the grantee.

- Evaluation
  - Program evaluation is the use of quantitative and qualitative research methods to systematically study, appraise, and help improve social programs, including their conceptualization and design, their implementation and administration, their outcomes, their effectiveness, and their efficiency. For more information on types of research and evaluation, see The Administration for Children and Families Common Framework for Research and Evaluation available at http://www.acf.hhs.gov/programs/opre/resource/the-administration-for-children-families-common-framework-for-research-and-evaluation.

- Evidence-based home visiting model
  - For the purposes of the Tribal MIECHV program, the term evidence-based home visiting model is used to describe both models that meet the HHS criteria for evidence of effectiveness in tribal communities and models that are considered promising approaches. Grantees under the Tribal MIECHV program may choose to implement both models that meet the HHS criteria for evidence of effectiveness in AIAN communities and promising approaches. HHS uses Home Visiting Evidence of Effectiveness (HomVEE, http://homvee.acf.hhs.gov/) to conduct a thorough and transparent review of the home visiting research literature and provide an assessment of the evidence of effectiveness for home visiting models that target families with pregnant women and children from birth to kindergarten entry. There is currently one model that meets the HHS criteria for evidence of effectiveness in AIAN communities. All other home visiting models, including those that have been designated by HHS as meeting criteria for evidence of effectiveness for the general population through the HomVEE review, are currently considered promising approaches for use with AIAN populations.
  - The home visiting models that Tribal MIECHV grantees select must be research-based and grounded in relevant empirically based knowledge, target outcomes specified in the authorizing legislation, be associated with (or developed by or in partnership with) a national organization or institution of higher education, and have comprehensive home visiting program standards that ensure high quality service delivery and continuous program quality improvement. Grantees may

incorporate cultural and contextual adaptations or enhancements to their selected models, and must ensure fidelity of implementation of selected home visiting models, adaptations, and enhancements.

- Fidelity
    - For the purposes of the Tribal MIECHV program, fidelity constitutes a grantee's adherence to model developer requirements for high-quality implementation as well as any affiliation, certification, or accreditation required by the model developer, if applicable. These requirements include all aspects of initiating and implementing a home visiting model, including, but not limited to, recruiting and retaining clients, providing initial and ongoing training, supervision, and professional development for staff, establishing a management information system to track data related to service delivery and model fidelity, and developing an integrated resource and referral network to support client needs. Changes to a model that alter the core components related to program outcomes (otherwise known as drift) could impair fidelity and undermine the program's effectiveness. Tribal MIECHV grantees will therefore work in close partnership with communities, model developers and ACF to identify, develop, and implement the cultural and contextual enhancements and adaptations that will support optimal fit between the model and the community without compromising the potential impact of the services.

- Infant and early childhood mental health consultation
    - IECMHC is a multi-level preventive intervention that teams mental health professionals with people who work with young children and their families. The model builds the capacity of early childhood teachers, home visitors, and families to promote social-emotional and behavioral development and has demonstrated impacts for improving children's social skills and adult-child relationships; reducing challenging behaviors, expulsions and suspensions; increasing family-school collaboration; increasing classroom quality; and reducing teacher stress, burnout, and turnover. In contrast to direct therapeutic services, IECMHC offers an indirect approach to promoting positive social and emotional development among children and families.

- Home visiting program
    - For purposes of the Tribal MIECHV program, a home visiting program:
        - Includes home visiting as the primary service delivery strategy (excluding programs with infrequent or supplemental home visiting);
        - Is offered on a voluntary basis to eligible families in at-risk tribal communities; and
        - Targets outcomes specified in the MIECHV legislation, including: improved maternal and child health; prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or

domestic violence; improvements in family economic self-sufficiency; and improvements in the coordination and referrals for other community resources and supports.

- Needs and readiness assessment
    - For the purposes of the Tribal MIECHV program, a thorough needs and readiness assessment has two major components: an assessment of community needs and an analysis of community readiness and capacity of organizations and programs to meet these needs.

- Professional development
    - For the purposes of the Tribal MIECHV program professional development is any learning experience delivered to develop and strengthen staff knowledge and skills that are needed to perform job duties.

- Quality Assurance
    - For the purposes of the Tribal MIECHV program, Quality Assurance (QI) is defined as a way to warrant that predefined standards are met. QA is the first step toward quality improvement.

- Reflective practice
    - For the purposes of the Tribal MIECHV program, reflective practice refers to work approaches that are characterized by trust, support and growth. Reflective practice includes self-awareness, careful and continual observation, and respectful, flexible responses among colleagues and with clients.

- Reflective supervision
    - For the purposes of the Tribal MIECHV program, reflective supervision is a distinctive form of competency-based professional development that is provided to multidisciplinary early childhood home visitors who are working to support very young children's primary caregiving relationships. Reflective supervision is a practice that acknowledges that infants and toddlers have unique developmental and relational needs and that all early learning occurs in the context of relationships. Reflective supervision is distinct from administrative supervision and clinical supervision due to the shared exploration of the parallel process, that is, attention to all of the relationships is important, including the relationships between home visitor and supervisor, between home visitor and parent, and between parent and infant/toddler. Reflective supervision supports professional and personal development of home visitors by attending to the emotional content of their work and how reactions to the content affect their work. In reflective supervision, there is often greater emphasis on the supervisor's ability to listen and wait, allowing the supervisee to discover solutions, concepts and perceptions on his/her own without interruption from the supervisor.

- Rigorous program evaluation
    - For the purposes of the Tribal MIECHV program, rigorous program evaluation is the use of quality research methods to systematically study, appraise, and help improve social programs, including their conceptualization and design, their implementation and administration, their outcomes, their effectiveness, and their efficiency (Rossi, P.H., Freeman, H.E., and Lipsey, M.W. (2004)). The most appropriate research methods to use for evaluation depend on the question being addressed. It is important to note that no specific evaluation type is more rigorous than another. Descriptive studies, quasi-experimental studies, and experimental studies can all be rigorous. Rigorous program evaluation incorporates the following features:
        - *Credibility/Internal Validity:* Ensuring what is intended to be evaluated is actually what is being evaluated; making sure that descriptions of phenomena or experience being studied are accurate and recognizable to others; ensuring that the method(s) used is the most definitive and compelling approach that is available and feasible for the question being addressed. If conclusions about program efficacy are being examined, the limitations of non-experimental designs are carefully considered.
        - *Applicability/External Validity:* Generalizability of findings beyond the current project (i.e., when findings fitinto contexts outside the study situation). Ensuring the population being studied represents one or more of the populations being served by the program.
        - *Consistency/Reliability:* When processes and methods are consistently followed and clearly described so that someone else could replicate the approach and other studies can confirm what is found.
        - *Neutrality:* Producing results that are as objective as possible and acknowledge the bias and limitations brought to the collection, analysis, and interpretation of results.

- Supplement
    - For the purposes of the Tribal MIECHV program, an acceptable supplement to an evidence-based model or promising approach is the addition of a supportive or complementary curriculum or strategy to an evidence-based home visiting model. The supplement may or may not have been tested with rigorous impact research, but must be determined by the model developer not to alter the core components related to program impacts, aligned with Tribal MIECHV program requirements, and agreed to by the model developer and ACF in partnership with the grantee.

- Tribal MIECHV Performance Measurement System
    - This redesigned system, developed by ACF following consultation with existing Tribal MIECHV grantees and other stakeholders, will support grantees to collect, analyze, and use data on program implementation and improvements for the

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

Appendix B: MIECHV Form 4: Quarterly Data

OMB Control Number 0906-0016
Expiration data 03/31/2019

Service Utilization Instructions and Forms

U.S. Department of Health and Human Services
Health Resources and Services Administration
Administration for Children and Families

DGIS-HV FORM: MIECHV Quarterly Data

Maternal, Infant, and Early Childhood Home Visiting (MIECHV) and Tribal MIECHV grantees are required to submit the information outlined below on a quarterly basis.

Quarterly reporting periods are defined as follows. Reports are due 60 days after the end of each reporting period:

- Q1 - October 1-December 31;
- Q2 - January 1-March 31;
- Q3 – April 1-June 30;
- Q4 – July 1-September 30

Definitions for key terms are included in Appendix A. Please carefully consult key term definitions before completing this form.

Grant Number(s): _____

Section A:

Table A.1: Program Capacity

Column A	Column B	Column C	Column D	Column E
Number of New Households Enrolled	**Number of Continuing Households**	**Current Caseload (A+B) (Auto-Calculate)**	**Maximum Service Capacity**	**Capacity Percentage (C÷D) (Auto-Calculate)**

Table A.2: Place-Based Services

Add a row for each additional community served during the reporting period.

Column A	Column B	Column C
Community	**Zip Codes within Community**	**Number of Households Served**
Total		**Sum of Column C (all rows)**

Table A.3: Family Engagement

Column A[2]	Column B	Column C	Column D	Column E[3]	Column F
Number of Households Currently Receiving Services	Number of Households who Completed Program	Number of Households who Stopped Services Before Completion	Other	Total (A+B+C+D) (Auto-Calculate)	Attrition Rate (C÷E) (Auto-Calculate)

Table A.4.1: Staff Recruitment and Retention

Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
Number of New FTE MIECHV Home Visitors	Number of Continuing FTE MIECHV Home Visitors	Number of FTE MIECHV Home Visitors (A+B) (Auto-Calculate)	Number of New FTE MIECHV Supervisors	Number of Continuing FTE MIECHV Supervisors	Number of FTE MIECHV Supervisors (D+E) (Auto-Calculate)	Number of New FTE MIECHV Other Staff	Number of Continuing FTE MIECHV Other Staff	Number of FTE MIECHV Other Staff (G+H) (Auto-Calculate)

Table A.4.2: Staff Vacancies

Column A	Column B	Column C	Column D
Number of Vacant FTE MIECHV Home Visitors	Number of Vacant FTE MIECHV Supervisors	Number of Vacant FTE MIECHV Other Staff	Number of FTE MIECHV Staff Vacancies (A+B+C) (Auto-Calculate)

[2] Validation: Column A should equal Table A.1. columns A and B
[3] Validation: Column E should equal Table A.2 sum of all rows in Column C

Form 4: Definitions of Key Terms

Capacity Percentage: Capacity percentage is a calculated indicator that results from dividing the current caseload by the maximum service capacity and multiplying by 100.

Community: A community is a geographically distinct area that is defined by the MIECHV grantee. Communities should be areas that hold local salience and can be defined as a neighborhood, town, city, or other geographic area. Services provided within a particular community should be distinguishable from other communities.

Completed Program: The number of households who completed the program refers to families who have completed the program or transitioned to another program according to home visiting model-specific definitions and criteria during the quarterly reporting period.

Continuing Household: A household, including a pregnant woman, female caregiver, and/or male caregiver who were signed up and actively enrolled in the home visiting program prior to the beginning of the quarterly reporting period and continues enrollment through the reporting period. The household may include multiple caregivers depending on model-specific definitions.

Continuing FTE Home Visitor/Supervisor/Other Staff: A full time equivalent home visitor(s)/supervisor(s)/other staff who was employed by a contracted local implementing agency in the previous quarterly reporting period. Grantees should only report the proportion of the FTE is that is supported by MIECHV grant funds.

Current Caseload: The number of households actively enrolled at the end of the quarterly reporting period. All members of one household represent a single caseload slot.

Currently Receiving Services: The number of households currently receiving services refers to households that are participating in services at the end of the quarterly reporting period.

Maximum Service Capacity: The highest number of households that could potentially be enrolled at the end of the quarterly reporting period if the program were operating with a full complement of hired and trained home visitors.

Note: The maximum service capacity is equivalent to the caseload of family slots indicated in your Notice of Award.

Caseload of Family Slots: The highest number of families (or households) that could potentially be enrolled at any given time if the program were operating with a full complement of hired and trained home visitors. Family slots are those enrollment slots served by a trained home visitor implementing services with fidelity to the model for whom at least 25% of his/her personnel costs (salary/wages including benefits) are paid for with MIECHV funding. All members of one family or household represent a single caseload slot. The count of slots should be distinguished from the cumulative number of enrolled families during the grant period. It is known that the caseload of family slots may vary by federal fiscal year pending variation in available funding in each fiscal year. Applicants should remember that inability to meet proposed caseloads may result in deobligated funds, which may impact future funding.

New Household: A household, including a pregnant woman, female caregiver, and/or male caregiver who signs up to participate in the home visiting program at any time during the quarterly reporting period and continues enrollment through the reporting period. The household may include multiple caregivers depending on model-specific definitions.

New FTE Home Visitors/Supervisors/Other Staff: A full time equivalent home visitor(s)/supervisor(s)/other staff who begins employment with a contracted local implementing agency during the quarterly reporting period. Grantees should only report the proportion of the FTE that is supported by MIECHV grant funds.

Stopped Services before Completion: The number of households who stopped services before completion refers to households who left the program or were lost to follow-up for any reason prior to completion.

Appendix C - Tribal MIECHV Performance Measures Numerators and Denominators					
	Area	**Construct**	**Indicator**	**Numerator**	**Denominator**
			Core Measures		
1	***Implementation***	Receipt of Home Visits	Percentage of recommended home visits received by families enrolled in the home visiting program during the reporting period	Number of home visits received by families during the reporting period	Number of home visits families should receive according to model developer fidelity requirements during the reporting period
2	***Implementation***	Home Visit Implementation Observation	Percentage of recommended home visits where home visitors are observed for implementation quality and receive feedback from their supervisors during the reporting period	Number of home visits where home visitors are observed for implementation quality and receive feedback from their supervisors during the reporting period	Number of home visits where home visitors should receive an observation according to model developer guidelines during the reporting period
3	***Implementation***	Reflective Supervision	Percentage of recommended individual and/or group reflective supervision sessions received by home visitors during the reporting period	Number of individual and/or group reflective supervision sessions received by home visitors during the reporting period	Number of individual and/or group reflective supervision sessions that home visitors should receive during the reporting period
4	***I - Maternal and Newborn Health***	Depression Screening	Percent of primary caregivers enrolled in HV who are screened for depression using a validated tool within 3 months of enrollment (for those not enrolled prenatally) by 3 months post- delivery (for those enrolled prenatally) and at least annually thereafter	For those not enrolled prenatally, number of primary caregivers enrolled in HV who are screened for depression within the first three months since enrollment; for those enrolled prenatally, the number of primary caregivers screened for depression by three months post- delivery; or annually after the first year of enrollment	Number of primary caregivers not enrolled prenatally who are enrolled in HV for at least three months; the number of mothers enrolled prenatally who have reached 3 months post-delivery
5	***I - Maternal and Newborn Health***	Substance Abuse Screening	Percent of primary caregivers enrolled in HV who are screened for substance abuse using a validated tool within 3 months of enrollment and at least annually thereafter	Number of primary caregivers enrolled in HV who are screened for substance abuse using a validated tool within 3 months of enrollment and annually after the first year of enrollment	Number of primary caregivers enrolled in HV for at least three months
6	***I - Maternal and Newborn Health***	Well Child Visit	Percent of the AAP-recommended number of well-child visits received by children enrolled in home visiting during the reporting period	Number of AAP-recommended well-child visits received by children (index child) enrolled in home visiting during the reporting period	Number of AAP-recommended well-child visits children (index child) enrolled in home visiting should receive during the reporting period
7	***II - Child Maltreatment, Injuries and ED Visits***	Child Injury Prevention	Percentage of primary caregivers enrolled in home visiting who are provided with training on prevention of child injuries	Number of primary caregivers enrolled in home visiting who are provided with training on prevention of infant and child injuries during the reporting period	Number of primary caregivers enrolled in home visiting
8	***III – School***	Parent-Child	Percent of primary caregivers enrolled in HV who receive an	Number of primary caregivers enrolled	Number of primary caregivers

Appendix C - Tribal MIECHV Performance Measures Numerators and Denominators					
	Area	**Construct**	**Indicator**	**Numerator**	**Denominator**
	Readiness and Achievement	Interaction	observation of caregiver-child interaction by the home visitor using a validated tool.	in HV who receive an observation of caregiver-child interaction by the home visitor using a validated tool	enrolled in HV with children reaching the end of the desired age range specified by the tool or HV model
9	***III – School Readiness and Achievement***	Developmental Screening	Percentage of children enrolled in HV screened at least annually for developmental delays using a validated* parent-completed tool	Number of children (index child) enrolled in HV with at least one documented developmental screening during the reporting period.	Number of children (index child) enrolled in HV during the reporting period that required a screening
10	***IV - Crime or Domestic Violence***	IPV Screening	Percentage of primary caregivers enrolled in HV who are screened for intimate partner violence using a validated* tool within 6 months of enrollment and at least annually thereafter	Number of primary caregivers enrolled in HV who are screened for IPV using a validated tool within 6 months of enrollment and annually after the first year of enrollment	Number of primary caregivers enrolled in HV for at least 6 months
11	***V - Family Economic Self-Sufficiency***	Screening for Economic Strain	Percentage of primary caregivers who are screened for unmet basic needs (poverty, food insecurity, housing insecurity, etc.) within 3 months of enrollment and at least annually thereafter	Number of primary caregivers who are screened for unmet basic needs within 3 months of enrollment and annually after the first year of enrollment	Number of primary caregivers enrolled in home visiting for at least 3 months
12	***VI- Coordination and Referrals***	Completed Developmental Referrals	Percentage of children enrolled in home visiting with positive screens for developmental delays (measured using a validated* tool) who receive a timely referral for services and a follow up	Number of children (index child) enrolled in HV who received referral information to early intervention services (and met the conditions specified in the denominator) and for whom the HV program followed up on the referral within 45 days	Number of children (index child) enrolled in HV during the reporting period with positive screens for developmental delays (measured using a validated tool)
Flex Measures (select 2 from 1-7 and 1 from 8-11)					
1	***I - Maternal and Newborn Health***	Breastfeeding	Percentage of women enrolled prior to child's birth who initiate breastfeeding	Number of women enrolled prenatally who initiate breastfeeding	Number of women enrolled prenatally who gave birth within the reporting period
2	***I - Maternal and Newborn Health***	Postpartum Care	Percent of mothers enrolled in HV prenatally or within 30 days after delivery who received a postpartum visit with a health care provider within 8 weeks (56 days) of delivery.	Number of mothers enrolled in HV prenatally or within 30 days after delivery who received a postpartum visit with a health care provider within 8 weeks (56 days) of delivery	Number of mothers who enrolled in HV prenatally or within 30 days after delivery and remained enrolled for at least 8 weeks (56 days) after delivery
3	***I - Maternal and Newborn Health***	Immunizations	Percent of children enrolled in home visiting who receive all AAP-recommended immunizations during the reporting period	Number of children (index child) enrolled in HV who receive all AAP-recommended immunizations during the reporting period	Number of children (index child) enrolled in HV during the reporting period
4	***II - Child Maltreatment,***	Screening for Parenting Stress	Percentage of primary caregivers who are screened for parenting stress using a validated* tool within 3 months of enrollment and at	For those not enrolled prenatally, number of primary caregivers enrolled	Number of primary caregivers not enrolled prenatally who are enrolled

Appendix C - Tribal MIECHV Performance Measures Numerators and Denominators					
	Area	**Construct**	**Indicator**	**Numerator**	**Denominator**
	Injuries and ED Visits		least annually thereafter	in HV who are screened for parenting stress within the first three months since enrollment; for those enrolled prenatally, the number of primary caregivers screened for parenting stress by three months post- delivery; or annually after the first year of enrollment	in HV for at least three months; the number of mothers enrolled prenatally who have reached 3 months post-delivery
5	***II - Child Maltreatment, Injuries and ED Visits***	Safe Sleep	Percentage of primary caregivers educated about the importance of putting infants to sleep on their backs, without bed-sharing and soft-bedding	Number of primary caregivers educated about the importance of putting infants to sleep on their backs, and without bed-sharing and soft-bedding during the reporting period	Number of primary caregivers enrolled in home visiting during the reporting period who are either pregnant or have a child under 12 months of age
6	***II - Child Maltreatment, Injuries and ED Visits***	Child Injury	Rate of injury-related visits to the Emergency Department (ED) or urgent care since enrollment among children enrolled in HV	Number of parent-reported nonfatal injury-related visits to the Emergency Department (ED) or urgent care since enrollment among children (index child) enrolled in HV	Number of children (index child) enrolled in HV during the reporting period
7	***III – School Readiness and Achievement***	Early Language and Literacy Activities	Percent of children enrolled in HV with a caregiver who reported that during a typical week the caregiver or a family member read, told stories, and/or sang songs with their child every day	Number of children (index child) enrolled in HV with a caregiver who reported that during a typical week the caregiver or a family member read, told stories, and/or sang songs with their child every day.	Number of children (index child) enrolled in HV during the reporting period
8	***VI- Coordination and Referrals***	Completed IPV referrals	Percentage of primary caregivers screening positive for intimate partner violence who receive a timely referral for services and a follow up	Number of primary caregivers enrolled in HV who received referral information to appropriate services (and met the conditions specified in the denominator) and for whom the HV program followed up on the referral within 45 days	Number of primary caregivers enrolled in HV with positive screens for IPV (measured using a validated tool)
9	***VI- Coordination and Referrals***	Completed Depression and Parenting Stress Referrals	Percent of primary caregivers screening positive for depression or parenting stress using a validated* tool who receive a timely referral for services and a follow up	Number of primary caregivers enrolled in HV who received referral information to appropriate services (and met the conditions specified in the denominator) and for whom the HV program followed up on the referral within 45 days	Number of primary caregivers enrolled in HV who had a positive screen for depression or parenting stress (measured using a validated tool)
10	***VI- Coordination***	Completed	Percent of primary caregivers screening positive for substance	Number of primary caregivers enrolled	Number of primary caregivers

Appendix C - Tribal MIECHV Performance Measures Numerators and Denominators					
	Area	**Construct**	**Indicator**	**Numerator**	**Denominator**
	and Referrals	Substance Abuse Referrals	abuse using a validated* tool who receive a timely referral for services and a follow up	in HV who received referral information to appropriate services (and met the conditions specified in the denominator) and for whom the HV program followed up on the referral within 45 days	enrolled in HV who had a positive screen for substance abuse (measured using a validated tool)
11	***VI- Coordination and Referrals***	Completed Economic Strain Referrals	Percent of primary caregivers with unmet basic needs who receive a timely referral for services and a follow up	Number of primary caregivers enrolled in HV who received referral information to appropriate services (and met the conditions specified in the denominator) and for whom the HV program followed up on the referral within 45 days	Number of primary caregivers enrolled in HV who had a positive screen for unmet basic needs

TRIBAL MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM

FORM 1

DEMOGRAPHIC AND SERVICE UTILIZATION DATA

SECTION A: PARTICIPANT DEMOGRAPHICS AND SERVICE UTILIZATION

A.1: Participant Demographics during Reporting Period (Newly Enrolled and Continuing)

Table 1. Unduplicated Count of Adult Participants and Index Children Served by Tribal MIECHV Home Visitors during Reporting Period (Newly Enrolled and Continuing)

	Number Newly Enrolled	Number Continuing	Total
Adult Participants			
Pregnant Women			
Female Caregivers			
Male Caregivers			
All Adult Participants (Auto Calculate)			
Index Children			
Female Index Children			
Male Index Children			
All Index Children (Auto Calculate)			

Table 1(a). Female Caregivers in the Current Reporting Period who Were Counted as Pregnant Women in the Prior Reporting Period

Adult Participants	Number
Number of Female Caregivers in the Current Reporting Period who Were Counted as Pregnant Women in the Prior Reporting Period	

Table 2. Unduplicated Count of Households Served by Tribal MIECHV Home Visitors (Newly Enrolled and Continuing)

Households	Number Newly Enrolled	Number Continuing	Total
Number of Households			

Table 3. Adult Participants by Current Educational Status (Newly Enrolled and Continuing)

Adult Participants	Student/trainee	Not a student/trainee	Unknown/Did not Report	Total
Newly Enrolled Pregnant Women				
Newly Enrolled Female Caregivers				
Newly Enrolled Male Caregivers				
All Newly Enrolled Adults (Auto Calculate)				
Continuing Pregnant Women				
Continuing Female Caregivers				
Continuing Male Caregivers				
All Continuing Adults (Auto Calculate)				
All Adult Participants (Auto Calculate)				

Table 4. Adult Participants by Employment Status (Newly Enrolled and Continuing)

Adult Participants	Employed Full Time	Employed Part-Time	Not employed	Unknown/Did not Report	Total
Newly Enrolled Pregnant Women					
Newly Enrolled Female Caregivers					
Newly Enrolled Male Caregivers					
All Newly Enrolled Adults (Auto Calculate)					
Continuing Pregnant Women					
Continuing Female Caregivers					
Continuing Male Caregivers					
All Continuing Adults (Auto Calculate)					
All Adult Participants (Auto Calculate)					

Table 5. Household Income in Relation to Federal Poverty Guidelines (Newly Enrolled and Continuing)

Households	Newly Enrolled Households	Percent	Continuing Households	Percent	Total Households	Percent
50% and under						
51-100%						
101-133%						
134-200%						
201-300%						
>300%						
Unknown/Did not Report						
All Households (Auto Calculate)		**100**		**100**		**100**

Table 6. Index Children by Age (Newly Enrolled and Continuing)

Index Children	Under 12 months	12-24 months	25-36 months	37-60 months	60-72 months	Unknown /Did not Report	Total
Newly Enrolled Female Index Children							
Newly Enrolled Male							

Index Children							
All Newly Enrolled Index Children (Auto Calculate)							
Continuing Female Index Children							
Continuing Male Index Children							
All Continuing Index Children (Auto Calculate)							
All Index Children (Auto Calculate)							

Table 7. Adult Participants by Housing Status (Newly Enrolled and Continuing)

Adult Participants	**Not Homeless**	**Homeless**				**Unknown/ Did not Report**	**Total**
	Not Homeless	**Homeless and sharing housing**	**Homeless and living in an emergency or transitional shelter**	**Homeless with some other arrangement**	**Total Homeless (Auto Calculate)**		
Newly Enrolled Pregnant Women							
Newly Enrolled Female Caregivers							
Newly Enrolled Male Caregivers							
All Newly Enrolled Adult Participants (Auto Calculate)							

Continuing Pregnant Women							
Continuing Female Caregivers							
Continuing Male Caregivers							
All Continuing Adult Participants (Auto Calculate)							
All Adult Participants (Auto Calculate)							

Table 8. Adult Participants and Index Children by Type of Health Insurance Coverage (Newly Enrolled and Continuing)

	Not Insured			**Insured**					
	Has access to IHS, CHS, or UIHP facility	**Does not have access to IHS, CHS, or UIHP facility**	**Total Not Insured (Auto Calculate)**	**Medicaid or CHIP**	**TriCare**	**Private Insurance**	**Unknown/ Did not Report**	**Total Insured (Auto Calculate)**	**Total**
Adult Participants									
Newly Enrolled Pregnant Women									
Newly Enrolled Female Caregivers									
Newly Enrolled Male Caregivers									
All Newly Enrolled Adult Participants (Auto Calculate)									
Continuing Pregnant Women									
Continuing									

Female Caregivers									
Continuing Male Caregivers									
All Continuing Adult Participants (Auto Calculate)									
All Adult Participants (Auto Calculate)									
Index Children									
	Has access to IHS, CHS, or UIHP facility	**Does not have access to IHS, CHS, or UIHP facility**	**Total Not Insured (Auto Calculate)**	**Medicaid or CHIP**	**TriCare**	**Private Insurance**	**Unknown/ Did not Report**	**Total Insured (Auto Calculate)**	**Total**
Newly Enrolled Female Index Children									
Newly Enrolled Male Index Children									
All Newly Enrolled Index Children (Auto Calculate)									
Continuing Female Index Children									
Continuing Male Index Children									
All Continuing Index Children (Auto Calculate)									
All Index Children (Auto									

Calculate)									

A.1 NOTES:

A.2: Participant Demographics during Reporting Period (Newly Enrolled Only)

Table 9. Adult Participants by Age (Newly Enrolled)

Adult Participants	≤17	18-19	20-21	22-24	25-29	30-34	35-44	45-54	55-64	≥65	Unknown /Did not Report	Total
Pregnant Women												
Female Caregivers												
Male Caregivers												
All Adults (Auto Calculate)												

Table 10. Participants by Ethnicity (Newly Enrolled)

Participants	Hispanic or Latino	Not Hispanic or Latino	Unknown/Did not Report	Total
Pregnant Women				
Female Caregivers				
Male Caregivers				
All Adults (Auto Calculate)				
Female Index Children				
Male Index Children				
All Index Children (Auto Calculate)				

Table 11. Participants by Race (Newly Enrolled)

Participants	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	More than one race including AI/AN	More than one race not including AI/AN	Unknown/Did not Report	Total
Pregnant Women									
Female Caregivers									
Male Caregivers									
All Adults (Auto Calculate)									
Female Index Children									
Male Index Children									
All Index									

Children (Auto Calculate)									

Table 12. Adult Participants by Marital Status (Newly Enrolled)

Adult Participants	**Single**	**Legally Married**	**Not married but living together with partner**	**Separated/Divorced/ Widowed**	**Unknown/Did not Report**	**Total**
Pregnant Women						
Female Caregivers						
Male Caregivers						
All Adults (Auto Calculate)						

Table 13. Adult Participants by Educational Attainment (Newly Enrolled)

Adult Participants	**Less than HS diploma**	**HS Diploma/ GED**	**Some college/ training**	**Technical training or certification**	**Associate's Degree**	**Bachelor's Degree or higher**	**Other**	**Unknown /Did not Report**	**Total**
Pregnant Women									
Female Caregivers									
Male Caregivers									
All Adults (Auto Calculate)									

Table 14. Primary Language Spoken at Home of Index Children (Newly Enrolled)

Index Children	**Number Newly Enrolled**	**Percent**
English		
Spanish		
Any Native American Language		
Other		
Unknown/Did Not Report		
All Index Children (Auto Calculate)		**100**

Table 15. Secondary Language Spoken at Home of Index Children (Newly Enrolled)

Index Children	**Number Newly Enrolled**	**Percent**
English		
Spanish		

Any Native American Language		
Other		
None		
Unknown/Did Not Report		
All Index Children (Auto Calculate)		**100**

Table 16. Priority Population Household Characteristics (Newly Enrolled)

Households	**Yes**	**No**	**Unknown/Did not Report**	**Total**
1. Low income household				
2. Household contains an enrollee who is pregnant and under age 21				
3. Household has a history of child abuse or neglect or has had interactions with child welfare services				
4. Household has a history of substance abuse or needs substance abuse treatment				
5. Someone in the household uses tobacco products in the home				
6. Someone in the household has attained low student achievement or has a child with low student achievement				
7. Household has a child with developmental delays or disabilities				
8. Household includes individuals who are serving or formerly served in the US armed forces				

A.2 NOTES:

A.3: Participant Service Utilization during Reporting Period

Table 17. Number of Home Visits

Home Visits	Number
Total Number of Home Visits Completed	

Table 18. Family Engagement by Household (Newly Enrolled and Continuing)

Households	Number of Newly Enrolled Households	Number of Continuing Households	All Households (Auto Calculate)
Currently receiving services			
Completed program			
Stopped services before completion			
Enrolled but not currently receiving services/Other			
Unknown/Did not Report			
All Categories (Auto Calculate)			

Table 19: Unduplicated Count of Households by Evidence-Based Home Visiting Model

Home Visiting Model (Select One per Row – Add Rows for Additional Models)	Households
All Models (Auto Calculate)	

A.3 NOTES:

SECTION B: PROGRAM STAFF DEMOGRAPHICS

Table 20. Program Staff by Age

Program Staff	≤29	30-39	40-49	50-64	≥65	Unknown/ Did not Report	Total
Home Visitors							
Project Directors/ Managers/Coordinators							
All Staff (Auto Calculate)							

Table 21. Program Staff by Gender

Program Staff	Female	Male	Unknown/Did not Report	Total
Home Visitors				
Project Directors/ Managers/Coordinators				
All Staff (Auto Calculate)				

Table 22. Program Staff by Ethnicity

Program Staff	Hispanic or Latino	Not Hispanic or Latino	Unknown/Did not Report	Total
Home Visitors				
Project Directors/ Managers/Coordinators				
All Staff (Auto Calculate)				

Table 23. Program Staff by Race

Program Staff	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	More than one race including AI/AN	More than one race not including AI/AN	Unknown/ Did not Report	Total
Home Visitors									
Project Directors/ Managers/ Coordinators									
All Staff (Auto Calculate)									

Table 24. Program Staff by Educational Attainment

Program Staff	Less than HS Diploma	HS Diploma /GED	Some college/ training	Technical training or certification	Associate's Degree	Bachelor's Degree	Master's Degree or Higher	Other	Unknown/ Did Not Report	Total
Home Visitors										
Project Directors/ Managers /Coordinators										
All Staff (Auto Calculate)										

Table 25. Unduplicated Count of Home Visiting Staff Full Time Equivalents

Home Visiting Program Staff	Number
Number of FTE Home Visitors	
Number of FTE Project Directors /Managers/Coordinators	
All Tribal MIECHV Staff FTE (Auto Calculate)	

SECTION B NOTES:

INSTRUCTIONS AND DEFINITIONS OF KEY TERMS

Tribal MIECHV Form 1 Instructions

Data for Tribal MIECHV Form 1: Demographic and Service Utilization Data should be collected at enrollment (as defined by grantee or per model developer guidelines) for newly enrolled participants/households and once during the reporting period (as determined by grantee) for continuing participants/households. Grantees may determine the method of and individuals responsible for data collection based on their own policies and procedures, and as guided by model developers and in consultation with ACF. Technical assistance is available to grantees to determine the method and timing of data collection and to ensure high quality data collection and reporting.

The form is organized into two sections. Section A includes Participant Demographics and Service Utilization and contains three sub-sections (A.1: Participant Demographics during Reporting Period (Newly Enrolled and Continuing); A.2: Participant Demographics during Reporting Period (Newly Enrolled Only); and A.3 Participant Service Utilization during Reporting Period (Newly Enrolled and Continuing)) and requests demographic and service utilization data for program participants and households, which will be used to help ACF better understand the population receiving services from Tribal MIECHV grantees and the degree to which they are using services. Section B includes Program Staff Demographics and requests information on demographics of program staff, which will be used by ACF to better understand the Tribal MIECHV workforce. All information is collected to support improved knowledge of Tribal MIECHV grantee programs and guide technical assistance provided through the cooperative agreement.

After each sub-section, the form includes a “Notes” field. Grantees should use this field to explain the reasons for missing data if more than 10 percent of data are missing (i.e., Unknown/Did Not Report) for a particular data element, and to provide any other contextual information that may be helpful to ACF in understanding the data reported. For each explanation of missing data, include the Table number for ease of reference.

Definitions: The following table includes definitions for key terms listed in Tribal MIECHV Form 1 Tables.

Table Number	Field or Item	Definitions
General Definitions		
N/A	**Reporting Period**	The most recent 12-month budget period during which a Tribal MIECHV grantee provided home visiting services.
N/A	**Tribal MIECHV Home Visitor**	A home visitor for whom at least 25 percent of his/her personnel costs (salary, wages, and benefits) are paid for with Tribal MIECHV funding.
N/A	**Adult Participant**	An adult (pregnant woman, female caregiver, male caregiver) who participates in the home visiting program during the reporting period and was served by a Tribal MIECHV home visitor. This could include teenage participants who have not yet reached age 18 but who meet the definition of either a pregnant woman, female caregiver, or male caregiver.
N/A	**Household**	Adult(s) who are caregivers for the same index child(ren) who participate in the home visiting program during the reporting period and were served by a Tribal MIECHV home visitor. A household may include one or multiple adult participants depending on model-specific definitions.
N/A	**Newly Enrolled (Adult Participant or Household)**	A participant or household who participates in the home visiting program for the first time at any time during the reporting period.
N/A	**Continuing (Adult Participant or Household)**	A participant or household who participated in the home visiting program prior to the beginning of the reporting period and continues enrollment during the reporting period. This includes any participants who had been enrolled in any prior reporting period, became inactive, and then enrolled again in the reporting period.
N/A	**Pregnant Woman (Adult Participant)**	A female participant who participated in the program while pregnant at any time during the reporting period.
N/A	**Female Caregiver (Adult Participant)**	A female participant who participated in the program during the reporting period and is considered a primary caregiver of the index child (e.g., biological mother, adoptive mother, foster mother, grandmother). If a woman has been pregnant at any time during the reporting period, she should be considered a Pregnant Woman (not Female Caregiver).
N/A	**Male Caregiver (Adult Participant)**	A male participant who participated in the program during the reporting period and is considered a primary caregiver of the index child (e.g., expectant father, biological father, step-father, foster parent, partner).
N/A	**Index Child**	The target child (male or female) in an individual household who is under the care of the participant. More than one index child can be identified (e.g., in the case of twins, triplets, or per model developer

		guidelines). Thus, there could be more than one female or male index child in a given household. A single child could have multiple primary caregivers reported in Tribal MIECHV Form 1.
A.1 Participant Demographics During Reporting Period (Newly Enrolled and Continuing)		
1 (a)	**Female Caregivers in the Current Reporting Period who Were Counted as Pregnant Women in the Prior Reporting Period**	Those continuing participants who are counted as female caregivers in the reporting period who were counted as pregnant women in the most recent prior reporting period.
3	**Adult Participants by Educational Status (Newly Enrolled and Continuing)**	**Student/trainee:** a participant who is considered a full- or part-time student or trainee by the educational institution or training program he/she is attending during the reporting period. **Not a student/trainee:** a participant who is not enrolled in any type of educational or training programs during the reporting period.
4	**Adult Participants by Employment Status (Newly Enrolled and Continuing)**	**Employed:** a participant who works for pay during the reporting period. **Employed Full Time:** an employee who works an average of at least 30 hours per week, as per https://www.healthcare.gov/glossary/full-time-employee/ **Employed Part Time:** an employee who works an average of less than 30 hours per week **Not Employed:** a participant who is not working for pay (e.g. students, stay-at-home parents, and those actively seeking work but currently not employed)
5	**Household Income in Relation to Federal Poverty Guidelines (Newly Enrolled and Continuing)**	The appropriate category for a given household will depend both on household income and on the number of household members (*both home visiting participants and non-participants*). Household income refers to the annual gross income for the household as defined in programmatic guidance, recorded at enrollment and annually thereafter. **Federal Poverty Guidelines:** Annual income data can be estimated from monthly data (monthly income x 12). The Federal Poverty Guidelines are updated each year. See https://aspe.hhs.gov/poverty-guidelines for the guidelines (updated every year).

7	**Adult Participants by Housing Status (Newly Enrolled and Continuing)**	**Homeless:** participants who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the McKinney-Vento Homeless Assistance Act). Report the participant as homeless if they were homeless for one or more days during the month prior to data collection. **Fixed nighttime residence:** stationary, permanent, and not subject to change. **Regular nighttime residence:** used on a predictable, routine, or consistent basis. **Adequate nighttime residence:** sufficient for meeting both the physical and psychological needs typically met in home environments. **Homeless and sharing housing:** individuals who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason **Homeless and living in an emergency or transitional shelter:** individuals who are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement **Homeless with some other arrangement:** individuals who are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; individuals who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); individuals who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings. For more: http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/family/family/Homelessness/hmls/definition/definition-legal.html
8	**Adult Participants and Index Children by Type of Health Insurance Coverage (Newly Enrolled and Continuing)**	**Not Insured: "**Not insured" indicates that the individual is currently not covered by any source of insurance. This table is intended to capture insurance status, and for those not insured: access to Indian Health Services, UIHP or CHS health services. For example, receipt of care provided by the Indian Health Service or another safety net health care provider such as a Federally Qualified Health Center does not constitute insurance coverage. The not insured categories are mutually exclusive. **Not insured but has access to Indian Health Services, Contract Health Services, or Urban Indian Health Program facility:** The Indian Health Service is funded each year through appropriations by the U.S.

		Congress. The Indian Health Service is not an entitlement program, such as Medicare or Medicaid. The Indian Health Service is not an insurance program. The Indian Health Service is not an established benefits package. Two types of services are provided by the Indian Health Service: (1) Direct health care services, which are provided by an IHS facility, or (2) contract health services (CHS), which are provided by a non-IHS facility or provider through contracts with the IHS. CHS are provided principally for members of federally recognized tribes who reside on or near the reservation established for the local tribe(s) in geographic areas called contract health service delivery areas (CHSDAs). The eligibility requirements are stricter for CHS than they are for direct care. In addition, the IHS Urban Indian Health Program (UIHP) supports contracts and grants to 34 urban health programs funded under Title V of the Indian Health Care Improvement Act. Approximately 100,000 American Indians use 23 Title V Urban Indian health programs and are not able to access hospitals, health clinics, or contract health services administered by IHS and tribal health programs because they either do not meet IHS eligibility criteria or reside outside of IHS and tribal service areas. A member of a Federally recognized tribe may obtain care at any IHS hospital or clinic if the facility has the staff and capability to provide the medical care. One of the additional requirements for CHS is that the patient must reside in certain areas. One way to meet the residency requirement is to live on the reservation of any Federally recognized tribe. Another way to meet the residency requirement is to reside within the contract health service delivery area (CHSDA) for the patient's tribe. Many, or even most, people who move away from their home reservations are not eligible for CHS since they would be moving away from the CHSDA in which they have eligibility. Some programs or portions of programs are tribally operated instead of being operated by the Federal Government through the IHS. Some tribally operated hospitals or clinics restrict services to members of their own tribe. Consequently, although a patient may be a member of a Federally recognized tribe they may not be provided medical care at a tribally operated hospital or clinic. For more: https://www.ihs.gov/forpatients/faq **Insured:** The health insurance coverage categories are mutually exclusive. **Medicaid or CHIP: "**Medicaid" is a joint federal and state program that helps with medical costs for some people with limited income and resources. (https://www.medicare.gov/your-medicare-costs/help-paying-

		costs/medicaid/medicaid.html) "CHIP", the Children's Health Insurance Program is a joint federal and state program that provides health coverage to eligible children. (https://www.medicaid.gov/chip/chip-program-information.html) **TriCare** is the health care program for uniformed service members (includes active duty and retired members of the U.S. Army, U.S. Air Force, U.S. Coast Guard, U.S. Marine Corps, U.S. Navy, Commissioned Corps of the U.S. Public Health Service, Commissioned Corps of the National Oceanic and Atmospheric Association), and their families. (http://tricare.mil/About.aspx?utm_source=footer&utm_medium=organic&utm_campaign=about-us) **Private Insurance** includes supplemental insurance that is provided to an individual by a private insurer (whether purchased by an individual for him/herself and family, a Tribe for tribal members, or an employer for employees).
A.2: Participant Demographics during Reporting Period (Newly Enrolled Only)		
10	**Participants by Ethnicity (Newly Enrolled)**	**Hispanic or Latino**: individuals of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. The responses regarding ethnicity should reflect what the individual considers herself/himself to be and are not based on percentages of ancestry.
11	**Participants by Race (Newly Enrolled)**	**White:** individuals having origins in any of the original peoples of Europe, the Middle East, or North Africa. **Black or African American:** individuals having origins in any of the Black racial groups of Africa. **American Indian and Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment. **Asian:** individuals having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. **Native Hawaiian and Other Pacific Islander:** individuals having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

		More than one race: individuals who considers himself/herself to be of more than one race as defined above. The responses regarding race should reflect what the individual considers herself/himself to be and are not based on percentages of ancestry. If ethnicity and race are unknown or not reported for some participants, enter that count in the respective "Unknown/Did not Report" columns.
12	**Adult Participants by Marital Status (Newly Enrolled)**	If more than one adult participant is enrolled in the program in a single household, proide the status for all adult participants. For example, if a pregnant woman is enrolled with her spouse in the program, both participants would be counted under the married category. **Single:** individuals who have never married. **Legally Married:** individuals that have wed in manner legally recognized by their jurisdiction. **Not Married but living together with partner:** individuals living with a partner but not considered legally married. **Separated/Divorced/Widowed: "**Separated" refers to married individuals who are not living with their spouse due to marital discord. "Divorced" indicates individuals who reported being divorced and have not remarried. "Widowed" indicates individuals whose last marriage ended with the death of their spouse and they have not remarried. https://www.census.gov/prod/2003pubs/c2kbr-30.pdf
13	**Adult Participants by Educational Attainment (Newly Enrolled)**	**Less than high school diploma:** includes individuals who are older than high school age and who did not complete their high school education. For example, a 23 year old mother who did not finish high school would be included in this category because she is not of high school age and did not finish her high school education. **High school diploma/GED:** includes individuals who completed their high school education or received a GED. **Some college/training:** includes individuals who are currently enrolled in an undergraduate degree or taking undergraduate coursework, or participate in a training program, and those who attended in the past

		but did not obtain a degree or certification. **Technical training or certification:** includes individuals who received technical training or certification in the past. **Associate's Degree:** includes individuals who obtained an Associate's Degree. **Bachelor's Degree or higher:** includes individuals who obtained a Bachelor's Degree or higher (e.g. Master's Degree, graduate-level courses). **Other:** includes those individuals who did not fall into the other specified categories.
14	**Primary Language Spoken at Home of Index Children (Newly Enrolled)**	**Primary language:** the language spoken in the home the majority of the time. **Any Native American language:** includes any language indigenous to an American Indian or Alaska Native tribe or community.
15	**Secondary Language Spoken at Home of Index Children (Newly Enrolled)**	**Secondary language:** a language spoken in the home the minority of the time. **Any Native American language:** includes any language indigenous to an American Indian or Alaska Native tribe or community..
16	**Priority Population Household Characteristics (Newly Enrolled)**	Categories are not mutually exclusive. A household can be counted in more than one category. **Low-Income household:** A household with an income determined to be below the official poverty line defined by the Census Bureau. This is updated every year online: https://aspe.hhs.gov/poverty-guidelines **Household contains an enrollee who is pregnant and under age 21:** A household where a primary caregiver is a pregnant woman under 21 years old at time of enrollment. **Household has a history of child abuse or neglect or has had interactions with child welfare services:** Based on participant self-report, a household where an adult participant or index child has a history of abuse or neglect and has had involvement with child welfare services either as a child or as an adult.

		Household has a history of substance abuse or needs substance abuse treatment: Based on self-report, a household with at least one adult participant who has a history of substance abuse or who has been identified as needing substance abuse services through a substance abuse screening administered upon enrollment. **Someone in the household uses tobacco products in the home:** Based on self-report, a household with at least one adult participant who uses tobacco products in the home or who has been identified as using tobacco through a substance abuse screening administered during intake. Tobacco use is defined as combustibles (cigarettes, cigars, pipes, hookahs, bidis), non-combustibles (chew, dip, snuff, snus, and dissolvables), and electronic nicotine delivery systems (ENDS). **Someone in the household has attained low student achievement or has a child with low student achievement:** Based on participant self-report, a household where an adult participant has perceived themselves or their child(ren) (index child or another child in the household) as having low student achievement. **Household has a child with developmental delays or disabilities:** Based on participant self-report or home visitor/staff observation, a household with a child or children (index child or another child in the household) suspected of having a developmental delay or disability. **Household includes individuals who are serving or formerly served in the US armed forces:** Based on participant self-report, a household that includes individuals who are serving or formerly served in the U.S. Armed Forces (Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard and Reserve), including such families that have members of the Armed Forces who have had multiple deployments outside of the United States. For this criterion, the definition includes a military member's dependent acquired through marriage, adoption, or other action during the course of a member's current tour of assigned duty.
A.3: Participant Service Utilization during Reporting Period (Newly Enrolled and Continuing)		
18	**Family Engagement by Household (Newly Enrolled and Continuing)**	**Currently receiving services:** refers to a household that is participating in services at the end of the reporting period. **Completed program:** refers to a household that completed the program according to model-specific definitions and criteria, or grantee-defined criteria if the model does not provide guidance, during the reporting period.

		Stopped services before completion: refers to a household that left the program for any reason prior to completion. **Enrolled but not currently receiving services/Other:** refers to those households that do not fall into the previous categories and may include unreachable participants (i.e. the family is not regularly participating but did not actively sever ties, etc.) Please provide additional information about household reason for stopping services before completion, or for being enrolled but not currently receiving services/other in the A.3 Notes section.
SECTION B: PROGRAM STAFF DEMOGRAPHICS		
All Tables in Section B		**Home Visitors:** A home visitor employed by the Tribal MIECHV program, regardless of the percentage of his/her personnel costs paid for with Tribal MIECHV funding. **Project Directors/Managers/Coordinators:** Staff that play a key oversight role for the Tribal MIECHV grant, regardless of the percentage of his/her personnel costs paid for with Tribal MIECHV funding.
22	**Program Staff by Ethnicity**	**Hispanic or Latino**: individuals of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. The responses regarding ethnicity should reflect what the individual considers herself/himself to be and are not based on percentages of ancestry.
23	**Program Staff by Race**	**White:** individuals having origins in any of the original peoples of Europe, the Middle East, or North Africa. **Black or African American:** individuals having origins in any of the Black racial groups of Africa. **American Indian and Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment. **Asian:** individuals having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. **Native Hawaiian and Other Pacific Islander:** individuals having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

		More than one race: individuals who considers himself/herself to be of more than one race as defined above. The responses regarding race should reflect what the individual considers herself/himself to be and are not based on percentages of ancestry. If ethnicity and race are unknown or not reported for some participants, enter that count in the respective "Unknown/Did not Report" columns.
24	**Program Staff by Educational Attainment**	**Less than high school diploma:** includes individuals who are older than high school age and who did not complete their high school education. **High school diploma/GED:** includes individuals who completed their high school education or received a GED. **Some college/training:** includes individuals who are currently enrolled in an undergraduate degree or taking undergraduate coursework, or participate in a training program, and those who attended in the past but did not obtain a degree or certification. **Technical training or certification:** includes individuals who received technical training or certification in the past. **Associate's Degree:** includes individuals who obtained an Associate's Degree. **Bachelor's Degree:** includes individuals who obtained a Bachelor's Degree. **Master's Degree or Higher:** includes individuals who obtained a Master's Degree or higher (e.g., PhD, MD, JD). **Other:** includes those individuals who did not fall into the other specified categories.

Appendix B | MUSE Aim 1 Codebook

Analysts used the following codebook to operationalize codes during analysis of Tribal Maternal, Infant, and Early Childhood Home Visiting (Tribal MIECHV) implementation plans. Column 1 provides a list of all codes used for the Aim 1 analysis, including item codes (listed first) and free codes (listed second). The operational definitions used during coding are provided in column 2. For item codes, these definitions correspond to specific prompts from the Implementation Plan Guidance and include the section numbers. For free codes, the operational definition was established and refined throughout the coding process.

Item codes are applied to responses within plans to specific sections of the Implementation Plan Guidance. Section number and verbatim guidance are provided as (Section Number: Guidance).

Code	Code definition
Number of families served	II. 4.C: Estimate the number of families to be served, including your total proposed caseload.
Aligns with Administration for Children and Families (ACF (design)	I.4.C.i.7: Describe how the component aligns with ACF's definition of an "evidence-based home visiting model," "adaptation," "enhancement," or "supplement."
At-risk Tribal community defined	I.1.C.i: Identify the "at-risk Tribal community" or communities that will be served as part of your program.
Basic (design)	I. 4.C.i.2: Identify and provide a basic description of the component.
Capacity to collect data	I.3.C.iv: Describe to what extent the community has, or can collect, accurate and current data on an ongoing basis on the status and well-being of pregnant women, young children, and their families and the services available to them and uses these data for planning purposes.
Collaborative partners	II.1.D: Provide a list of lead collaborative partners, including subcontractors, and their roles and responsibilities in the development and implementation of your program.
Community buy-in for current models	I.3.A.xi: Describe the extent to which there is buy-in from community members, including Tribal Leaders and Elders, for home visiting programs in the at-risk Tribal community.
Community engagement	II.2.A-C: Entire section includes stakeholders, partner organizations, and strategies.

Code	Code definition
Community involved (design)	I.4.C.i.8: Describe how the community was involved in the identification and selection of the component. Discuss which stakeholders (e.g., Tribal Leaders, model developers, Elders, families) were involved and how.
Community strengths	I.1.B.iii.m: Characterize the needs and strengths of the targeted community or communities by providing data on the health and well-being of the community, as compared to the comparison population or community. If multiple targeted communities were assessed, provide information on each of these. For each targeted community, list indicators, sources of information (quantitative and qualitative), and key findings for community strengths.
Components working in concert to meet needs	I.4.C.iii: Provide a rationale for how all proposed components will work in concert to meet the needs, strengths, and priorities of the at-risk Tribal community or communities identified through the needs and readiness assessment and organizational capacity assessment. Discuss how their theories of change align with or enhance one another and how they collectively meet your proposed vision, goals, and objectives.
Continuous quality improvement	III.2.B: Continuous quality improvement plan.
Culture of quality	III. 1.B.ii: Describe your approach to promoting a culture of quality within the organization and program.
Data quality checks	III. 1.B.iv: Provide a plan for data quality checks.
Design	I.4.C.i.1-7: Describe the design of your proposed home visiting program, including its key components.
Employee orientation and training	II.3.C: Describe how new employee orientation and training will be provided, including training in your program components.
Engaging and retaining families	II.4.D: Describe your approach to engaging and retaining families, including ensuring appropriate dosage of services.
Evidence of effectiveness (design)	I.4.C.i.6: Describe the component's evidence of effectiveness. If no evidence of effectiveness exists, what is its empirical basis (from research, theory, practice, culture, and/or context)?
Fidelity	II.5.C: Monitoring of fidelity of program implementation to ensure services are delivered according to the requirements of the selected program components.

Code	Code definition
Focus population—at-risk determination	I.1.B.i.b: Define the targeted community that was assessed for risk.
General population—needs assessment	I.1.B.i.a: Provide a general description of your service area.
Goals, visions, and priorities	I.1.B.ii: Describe the targeted community's established goals, visions, and priorities related to young children and families and how home visiting could fit into these goals, vision, and priorities.
Governing bodies	II. 1.F: Identify the governing body(ies) that has legal oversight (including Tribal governance), Tribal standing committee(s), or board of directors to which your program will report.
Likely influence	I.1.C.ii: For the identified at-risk Tribal community or communities, discuss the needs, strengths, and priorities that stand out and how these are likely to influence your program vision, goals, objectives, and design.
Limitation in substance abuse and mental health services	I.3.B.iv: Discuss what factors limit additional investment and capacity for providing needed services to individuals and families who are eligible for home visiting programs.
Local advisory committee	II.1.E: Describe the composition and use of a local advisory committee to support planning and oversight of your program, including prompts i–iii.
Measure quality	I.3.C.v: Describe to what extent the community can measure the quality of services delivered to pregnant women, young children, and families and provide information, incentives, and support for continuous improvement (e.g., professional development and training opportunities, data systems, dedicated financing).
Meets goals, vision, and objectives (design)	I.4.C.i.4: Describe how the component meets your identified programmatic vision, goals, and objectives.
Meets needs (design)	I.4.C.i.3: Describe how the component meets the identified needs, strengths, and priorities of the at-risk community and aligns with your organizational capacity.
Models implemented	I.3.A.v: Discuss which home visiting models, adaptations, enhancements, and supplements are implemented.

Code	Code definition
Needs assessment	I.1.A.iii: Successes, challenges, and lessons learned. Discuss the successes, challenges, and lessons learned that arose in conducting the needs and readiness assessment. What were some of the factors that facilitated the assessment process? What were some of the challenges faced, and how were they addressed? What lessons did you learn that might be relevant to future assessments that your community or organization might undertake?
Needs, strengths, and community priorities summarized	I.4.A: Summarize the most critical needs, strengths, and community priorities that emerged from your community needs and readiness assessment, organizational capacity and readiness assessment, and services and systems quality and capacity assessment.
Needs, strengths, and priorities	I.3.D: Based on the information related to the services and systems in your at-risk community, discuss the needs, strengths, and priorities that stand out and how these are likely to influence your program vision, goals, objectives, and design.
Organizational readiness reflection	I.2.B: Based on the previous information, discuss organizational needs, strengths, and priorities that stand out and how these are likely to influence your program vision, goals, objectives, and design.
Organizational needs, strengths, and priorities	I.2.A: Assess your organization's capacity to respond to the identified needs of the at-risk community through a high-quality, culturally appropriate, evidence-based home visiting program. Assess your organization's readiness and identify any administrative and organizational concerns that must be addressed prior to program implementation.
Policies and procedures for data	3.1.B.iii.a: Describe your plans for documenting procedures or policies related to data collection, data entry, data management, and/or data analysis.
Persons responsible for data collection	3.1.A.a: Identify the persons responsible for data collection.
Policies and procedures that need refinement	II.7.B: Identify topic areas of policies and/or procedures that will need to be revised, refined, or developed for your program.
Professional development	II.3.G: Describe how you will support staff's professional development.
Quality assurance plan	III.2.A: Quality assurance plan.

Code	Code definition
Quality of current model implementation	I.3.A.vi: Discuss the extent to which existing programs or initiatives are high quality (i.e., are evidence based or based on strong theory and are implemented with fidelity).
Recruitment	II.4.A: Describe strategies for identifying and recruiting families that will benefit most from your program.
Staff turnover strategies	II. 3.H: Describe strategies to prepare for and address potential staff turnover.
Substance abuse and mental health quality	I.3.B.iii: Discuss to what extent the services are high quality and meet the needs of individuals and families who are eligible for home visiting services (e.g., are accessible and culturally relevant).
Supervision	II.3.D: Describe how you will provide high-quality, reflective, clinical, and administrative supervision.
Sustainability—build	II.9.A: Describe how your program will build and ensure sustainability after the grant has ended. Discuss how your program will engage with Tribal or other organizational leaders and how your program fits into and is important within the historical and cultural contexts of the community.
Sustainability—extend	II.9.B: Assess the current infrastructure and resources for retaining and extending home visiting services beyond the federal funding period.
Sustainability—resources	II.9.C: Identify resources that potentially may be leveraged to sustain home visiting, including collaborations with service partners and various funding streams, both public and private.
Sustainable governance	I.3.C.iii: Describe to what extent the community has a sustainable governance structure (e.g., early childhood advisory council) or coordinated way to plan for services for pregnant women, young children, and their families.
Technical assistance and supports	II.4.A.iii: Describe what technical assistance and supports will be provided.
Theory of change (design)	I. 4.C.i.5: Describe the component's theory of change.
Use of policies and procedures	II.7.D: Describe activities that will ensure the regular use and review of your program policies and procedures manual.

Code	Code definition
Vision, goals, and objectives	I.4.B: Based on these, define your proposed program's vision, goals, and objectives. These should reflect a direct relationship to the needs, strengths, and priorities of the at-risk Tribal community or communities identified through the needs and readiness assessment laid out previously.
Free codes are applied based on the analyst's understanding of content regardless of plan section.	
Adaptation, enhancement, and supplements	Discussion of adaptations, enhancements, or supplements beyond those discussed in section 1.4.C, Design. Includes both those motivated by culture and those motivated by needs, barriers, or facilitators established either informally or through data collection (i.e., needs assessment).
Application of local needs assessment	Mention of any practice, strategy, or program activity informed by the needs assessment.
Assess for readiness	Assess various aspects of an organization to determine its degree of readiness to implement, barriers that may impede implementation, and strengths that can be used in the implementation effort.
Barriers to implementation	References to things (e.g., policies, procedures, rules, regulations) of the institution housing the home visiting program or partner organizations and institutions that create barriers to implementation.
Capture and share local knowledge	Reflections on the sharing of local knowledge of program learning without the expressed purpose of improving the local service environment to include the use and cultivation of program champions.
Facilitators for implementation	References to things (e.g., policies, procedures, rules, regulations) of the institution housing the home visiting program or partner organizations and institutions that facilitate implementation.
Fit to implementation strategy	Discussion of alignment and fit between local context and a concept defined as an implementation strategy (Powell et al., 2015).
Home visitor innovations	Discussions of home visitor innovations and their integration into program activities. Program innovations are distinguished among adaptation, enhancement, and supplements in that they are more informal and do not necessarily require advanced planning. They can include conversations about how the program will promote, share, and institutionalize innovation from home visitors.
Learning from other sites	Reflections on learning from other sites (virtual or in person) either in the past or future.

Code	Code definition
Local, cultural, and historical context	References to context surrounding the institution, including norms, values, or practices, as they inform or impact implementation, including recommendations for incorporation into programming.
Model fit	Any reference to how the model was assessed as fitting, not fitting, or modified to fit the implementation context.
Quality programming	Definition(s)or descriptions of what characterizes "quality" or "good" programming within the local site. What makes services of value to this particular community? Includes discussion of what cultivates or prevents quality programming.
Recruit, designate, and train for leadership	Reflections on recruiting, designating, and training leaders for the change effort (i.e., building local leaders).
Service environment	Reflections on how the service environment will be or has been built, including collaboration, coalition building, etc. (e.g., recruiting and cultivating relationships with partners in the implementation effort and including local providers and other stakeholders in discussions that address whether the chosen problem is important and whether the clinic innovation to address it is appropriate or best).
Tailor strategies	Use to capture any discussions of implementation strategies to address needs, barriers, or facilitators that do not qualify as an adaptation, enhancement, or supplement but are shared as desired program activities across home visitors.
Tribal bureaucracy	References to policies, procedures, rules, and regulations of the Tribal government as they inform or affect implementation.
Why it matters	"Grand" statements that make claims for why the program or home visiting services matter. Includes statements that attach the program or grant activities or practices to a broader vision, commitment, or purpose (i.e., mention of any practice, strategy, or program activity related to program or local goals, visions, and priorities). Includes local frames of reference and terms.

Appendix C | In-Depth Analysis of Coded Reports by Aim 1 Domain

This document shows the primary phase of the iterative analysis process used to generate findings for this report (exhibit C1). First, the study team identified and prioritized major implementation domains during Aim 1 analysis planning (column 1). Next, the study team traced Code Reports (documents that compile all the excerpts coded under a specific code) to these domains, refined and reprioritized domains, and identified missing and cross-cutting themes based on data. Finally, the study team used term searches (column 3) to generate Term Reports based on emergent data to triangulate preliminary findings, repeating steps as necessary for further clarification.

Exhibit C1. Primary phase of iterative analysis

Domain	Code reports prioritized during in-depth analysis and identification of findings	Search term reports used in data triangulation
Adapt/innovation	Components working in concert to meet needs; model fit	Child welfare; culture/cultural; dignity; equity/fair; fidelity; flexibility; justice; quality; reflective practice; repair; strengths-based; trust
Adopt	Evidence of effectiveness (design); models implemented	
Community partnerships	Community buy-in for current models; community engagement	
Evaluate/quality	Fidelity; quality programming	
Focus	Likely influence; needs assessment	
Organizational staffing processes	Staff turnover strategies; supervision	
Plan	Number of families served; engaging and retaining families; recruitment; theory of change (design)	
Resources/organizational characteristics	Culture of quality; (design) meets needs	
Service environment	(Design) aligns with Administration for Children and Families; needs, strengths, and community priorities	
Sustain	Sustainability—build; sustainability—extend; sustainability—resources	
Target	At-risk Tribal community defined; community strengths; vision, goals, and objectives; why it matters	

Appendix D | Postcoding Reflections Template

Post Coding Reflection

Item Coded:

Date:

Name:

How long did it take you approximately to code this plan:

Was there anything noticeable about the process of coding (e.g. harder than usual, lots of missing codes—which ones; long or short):

Reflection:

1) **Briefly summarize the transcript content**:

2) **Did anything surprise you or stick out:**

3) **Thinking with the Aims below, does this transcript address any of these questions in a unique or noticeable way?**
   1. Aim 1: Identify and describe primary influences shaping tribal home visiting program planning
   2. Aim 2: Identify and describe how tribal home visiting programs are being implemented.
   3. Explore supports and challenges to home visiting implementation in tribal communities.

4) **Any further reflections:**

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