[Slide 1] >> CAROL: Hi, everybody. How are you?

This is Carol here in ACF. I'm really excited to be bringing you, along with others, this first in a series of webinars. This one is entitled, "Tribal Home Visiting Evidence of Effectiveness Review: Process and Results." Here with me today are Moushumi [Slide 2] Beltangady; Aleta Meyer, Diane Paulsell, Patricia Del Grosso, and Doug Bigelow. We're really excited to have all these folks on the call with us today, and we'll give you some...[Slide 3] thank you...obviously, I can't read and talk and push a button at the same time.

One of the reasons that we wanted to do today's call with you is that this is actually the very first time that we're going to have a conversation with you regarding the implementation plan and the requirements that will be in the implementation plan. As you know, we're scheduling follow-up conversations with each of you that we're doing on a one-on-one basis; and we have all but four of those scheduled. For the tribal grantees, you should have received e-mails from me this morning about those calls.

As the operator said, during this webinar you'll be able to submit questions. You can either look on your screen and there's a place where it says, "Chat," and "Message Item." You can type in a question there. We'll also open it up for questions at different points, and you can actually voice in a message; and the operator will then forward us that message.

This webinar is also being recorded as most of our webinars are, and they'll be available on the HomVEE website for later use; so you'll be able to share this with other partners and refer to it later. It will be important webinar information for you to have as we get near to putting together your implementation plan.

The outline of this presentation is as follows:

[Slide 4] Implications of the review for home visiting program selection, and that's how we want you to be able to use the review that we're going to talk about and what it means for you when it comes time for you to select your home visiting model or models.

Again, how to use the systematic reviews. The process of how to review this with them will be explained to you.

The overview of the process and results of the review, which is in Chapter 1, will be discussed; and an overview of the lessons learned and the implications will also be provided in that in Chapter 2.

Then the last part of the webinar will be provided by Doug Bigelow, and that's strategies for using the tribal review and its real practical strategies.

We really are glad that she's able to join us today. With that, I'm going to turn it over to Moushumi.

>> MOUSHUMI: Thank you, Carol.

[Slide 5] I just wanted to give a quick kind of context for this review. The purpose of the evidence review that was done by Mathematica Policy Research under our contract with Planning, Research, and Evaluation and ACF is to help grantees make evidence-informed decisions about home visiting program implementation and research and evaluation activities in your communities for the purpose of the Tribal Home Visiting program.

As you'll see today, and also if you read the report, no home vising models previously implemented in tribal communities were found to be criteria for evidence effectiveness; and there was legislative language for the Tribal Home Visiting Program that stated that requirements for this program shall, to the greatest practicable, be consistent with the requirements for the State Home Visiting Program. So it doesn't have to meet the exact requirements of this program, but it's supposed to be consistent to the greatest extent practicable.

Tribal Home Visiting grantees may therefore propose a home visiting model that is a promising approach as part [Slide 6] of their implementation plan, and a promising approach is basically a model in which there is little to no evidence of effectiveness or a modified version of an evidence-based model. You will be getting more information about this in your implementation and guidance as well. The approach or the model that you choose should be grounded in relevant empirical work and have an articulated theory of change and must have been developed by, or identified with, or developed in consultation with a national institution of higher education; and it must be evaluated through a well-defined and rigorous process. As I mentioned, more details will be provided in the guidance coming.

So now I'm going to turn it over to Aleta, who will give a little bit more context before the review.

[Slide 7] >> ALETA: The systematic review of home visiting is that two of them were done. What a systematic review is, is a thorough and transparent review of any kind of program regarding the (inaudible) on that program and the review assesses the evidence to determine its level of effectiveness. This is done for home visiting.

The first report was for the state program, and very little information was found when they did that report on home visiting with American Indians and Alaska natives. So we had an additional call for a study that would be relevant to tribal communities and American Indians and Alaska natives. The report that you're hearing about today is from that call, and we'll be focusing on that in the webinar. The same standards of evidence were used for both of the reports, and you can go to the HomVEE website to find more information about those standards.

[Slide 8] The information from both of these reports can really be helpful to you as you make decisions about your home visiting program through the community and the way you want to evaluate it. The tribal report includes a lot of valuable lessons on ways for building programs that are culturally valid, ways for implementing programs in tribal communities, and then strategies for building knowledge and learning about home visiting for American Indian and Alaska native children and families.

Our hope is that this webinar will help to bring the Tribal report to life in a way that will be a really useful tool for your own decision-making. That's why it's in two parts...first, going over the report and then, second, we'll have Doug providing us with his reflections on how ways that we could use this.

Now I'll turn it over to Diane Paulsell of Mathematica.

>> DIANE: Thank you, Aleta.

Let me just get my [Slide 9] slides up here.

I'm going to give you a brief overview of how we conducted the review and the results; but I want to let you know, as other presenters have said, you can find more detailed information about the review on the HomVEE website.

[Slide 10] To inform the field and also prepare for the potential for an evidence-based home visiting initiative, in fall 2009, OPRE contracted with Mathematica Policy Research to conduct the Home Visiting Evidence Effectiveness Review or HomVEE. The review was carried out under the guidance of an HHS working group that included staff from OPRE; the Children's Bureau; the Centers for Disease Control, particularly the Division of Violence Prevention and the National Center on Birth Defects and Developmental Disabilities; the Health Resources and Services Administration; and the Office of the Assistance Secretary for Planning and Evaluation.

[Slide 11] In addition to the review that we conducted for the state program, we also conducted a review of tribal home visiting programs. For the purposes of this review, we defined tribal early childhood home visiting programs very specifically; and I want to mention that our definition closely aligns with how HRSA has designed home visiting for the state program. So the two definitions are very similar.

First, models must be implemented in tribal communities or include substantial proportions of American Indian/Alaska native families in the study samples. I want to mention that we included program models implemented and evaluated outside of the United States. While there's tremendous variation between native and indigenous communities both within the United States and across the globe, they do share similarities such as traditional culture, historical trauma from colonization, and health disparities. For those reasons, we included programs implemented in other parts of the world; and we think that lessons learned from these models can potentially provide some useful information to American Indian/Alaska native communities as they make decisions about home visiting models for their own communities.

The next part of the definition is that models' target populations must include pregnant women or families with children from birth to age five. Home visiting must be used as the primary service delivery strategy and be provided to most or all families enrolled in the program. Home visits had to be voluntary for pregnant women, expectant fathers, and parents and caregivers of children birth to kindergarten entry. Models that provided services primarily in center-based settings with supplemental home visits were excluded because home visiting was not the primary service delivery strategy.

Finally, home visiting services had to be targeted to at least one of the eligible participant outcomes. [Slide 12] Eligible participant outcomes include outcomes in these eight domains, which align with the legislation. They are child health; maternal health; child development and school readiness; family economic self-sufficiency; linkages and referrals to other community services; positive parenting practices; reductions in child maltreatment; and reductions in juvenile delinquency, family violence, and crime.

[Slide 13] Now I'm going to very briefly describe the five steps that we followed to conduct the review. In Step 1, we thought to identify all potentially relevant studies. Next, we screened all of the identified studies to determine whether they were appropriate for this review. In Step 3, we rated the quality of the studies; and in Step 4, we assessed the evidence of effectiveness for each model according to criteria established by HHS. Then in the final step, we reviewed implementation information about each of the models that we had identified.

[Slide 14] To identify all of the potentially relevant studies, we conducted keyword searches in a wide range of research databases. In addition to the keywords that we used for the main home visiting review, which are listed on the website, we added some additional terms for the tribal review...including tribe, tribal, Indian, Native American, indigenous, and nation.

We also created a custom Google search engine to search over 50 government, research, and nonprofit websites for unpublished reports and papers sometimes referred to as "grey literature." A list of the websites we searched is also available on the HomVEE website.

Then finally, in November 2010, we issued a call for studies for research on home visiting models implemented in tribal communities or evaluated with American Indian/Alaska native families and children. We sent this callout to six relevant Listservs in five additional groups for dissemination. Through all of these different searching strategies, we identified 213 unduplicated studies including 5 articles that were submitted through the call.

[Slide 15] Our second step was to screen the studies for relevance to the review. We screened out studies of program models in which home visiting was not a substantial program element. For example, home visiting might have been a supplemental service or might not have been provided to most of the families. We also screened out studies that did not use an eligible study design; as specified in the legislation, these were randomized controlled trials and quasi-experimental designs. But we retained implementation studies so that we could collect information about how the program models were implemented.

We also eliminated studies in which the target populations did not include either pregnant women or families with children ages birth to five. We eliminated some studies because they did not examine any of the child and family outcomes from the eight eligible outcome domains I reviewed earlier. We also eliminated studies of programs that were not named program models. These were often generic home visiting interventions; and because there would be no way for tribes to replicate them, they weren't useful to the review.

Then finally, we did not review studies published in a language other than English or published before 1979.

[Slide 16] After we completed the screening, we had citations on 14 home visiting models implemented in tribal communities; and they're listed here in alphabetical order. I'm not going to go through each one of them now because Patricia is going to provide more information about them in just a few minutes.

[Slide 17] Now I want to very briefly review our study rating system and some of the criteria we considered when reviewing studies. The underlying interest here is identifying effective program models, those that achieve favorable outcomes for families. Assessing whether a program model is effective requires that a study establish that a program caused the observed outcome. This can be quite challenging because it means we need to rule out all the other reasons for why the outcomes might have occurred.

To link a program model with outcomes, a study attempts to establish what would have happened in the absence of program services. This is known as the counterfactual. So we only reviewed studies with comparison groups or conditions because the comparison condition is designed to represent that counterfactual...what would have happened to the treatment group if they had not received program services. Then the difference between the treatment and the comparison outcomes are the study's effects, also called impacts.

Following the legislation, we included two types of study designs...randomized controlled trials and quasi-experimental designs. In randomized controlled trials, families are assigned by chance to treatment and comparison groups. The main advantage of this design is that the groups are similar on average, both for characteristics that are known...such as ethnicity or education levels of parents...and for those which might be unknown, for example parents' motivation to seek services for their children.

In terms of quasi-experimental designs, the thee designs were eligible for review...matched comparison studies, single case designs, and regression discontinuity designs. Matched comparison designs also have a treatment and a comparison group; but the assignment process is not random, potentially compromising the quality of the study. Single case and regression discontinuity designs also were eligible for the review; however, these designs were not used in any of the literature we identified. So across all the programs models, we reviewed nine impact studies.

[Slide 18] Within the HomVEE rating system, we assigned all eligible studies a rating of either high, moderate, or low. The rating indicates the study's ability to produce unbiased estimates of a program model's effects. Our rating system helps to distinguish between studies in which we have more confidence that the observed findings were caused by the program compared to those in which the observed findings might be the result of other unobserved differences between the program and comparison conditions...such as the motivation of parents to seek services, as I mentioned earlier.

In short, the high rating was assigned to randomized controlled trials that were well-implemented. The moderate rating was assigned to randomized controlled trials that had some problems and matched comparison studies that established that the treatment and comparison groups were the same on important characteristics at the beginning of the study. A low rating was assigned to all other studies that did not meet the criteria for either the high or moderate rating.

As mentioned earlier, all of the studies in the tribal review received a lower rating in the HomVEE system. I want to emphasize that the study ratings do not tell us anything about the findings themselves or whether the program model is effective. For example, it's perfectly valid to have a high-quality study that shows the program model had no effect. A program model with a low-rated study may very well be effective, but we just don't have the evidence to make that determination.

Now I'm going to turn the presentation over to Patricia Del Grosso, who will tell you about findings from our review of implementation studies and share some lessons learned.

>> PATRICIA: Thank you, Diane.

[Slide 19] As Diane mentioned, the HomVEE systematic review identified a limited body of research and few rigorous studies of tribal home visiting programs. Although limited information was available about program impact, nearly all studies included some information about the home visiting models being evaluated or documented lessons learned about implementation. To gain what knowledge we could from the existing body of research, we extracted these experiences and lessons learned.

We gathered descriptive information about each of the models. With the understanding that additional research is needed on these models, we hope that you may find this information useful in determining whether these programs could be a good fit for your community.

Next, we summarized lessons learned across studies on three topics...the adaptation of existing models in the development of new models culturally relevant to American Indian and Alaska native families and children; the implementation challenges faced and their strategies for overcoming them; and, third, the challenges evaluators faced conducted studies. I want to note that the lessons learned we discussed reflect the experiences of the program, but we do not know whether or not these strategies are evidence-based.

We extracted information from nine causal studies, seven standalone implementation studies, and three studies that were otherwise relevant but did not have eligible designs included in the HomVEE review of evidence. From this group of studies, we identified 14 models, which Diane mentioned earlier. For the remainder of the presentation, I'm going to summarize what we learned from this process.

[Slide 20] I'm going to begin by providing a brief overview of the 14 models. Additional details about each of these models is included in the report. Most programs targeted outcomes in three domains...child health, child development and school readiness, and positive parenting practices. Some were focused

broadly on improving maternal and child health outcomes across a number of domains. For example, the Baby, Family, and Child Education Program known as Baby FACE, which used the Parents and Teachers Born to Learn curriculum, was designed to promote free literacy experiences for children and to increase parenting skills and knowledge of child development.

Others were more narrowly focused on improving outcomes in a specific domain. For example, the Perinatal Intervention Program aimed to encourage earlier entry to prenatal care and improve health outcomes among American Indian women.

All the visiting program models used home visits as the primary mode of service delivery. Eight programs also included other types of services such as parent group meetings, access to referral networks, and center-based services.

[Slide 21] The home visiting models targeted participants based on the age of their children. Six of the models began offering services to families at birth or in early infancy and continued to serve families until children were between 2 and 5 years old, with one program offering services up to age 8. Five program models specifically targeted pregnant women, and one targeted women postnatally. Two programs targeted families with 2- to 4-year-old children. Some program models were available to any family meeting the target age and living in specific geographic locations or from a specific community.

Other models targeted families with specific risk factors. For example, Family Spirit targeted adolescents or young women who were 19 years old or younger at the time of conception. In another study of the same program, they expanded that up to age 22.

[Slide 22] Twelve models specifically targeted families and children living in tribal communities. Of the two models that did not specifically target this population, one gave priority to implementing agencies with service areas that included Indian reservations. The Healthy Families Arizona program was a statewide program that served American Indian families and children but did not specifically target tribal communities.

As Diane mentioned earlier, we did include some models that were evaluated outside the United States. Three program models were evaluated in Canada; and one program, the Filani Child Health and Nutrition Program, was implemented in South Africa.

[Slide 23] Most program models employed paraprofessionals and did not set minimum education requirements for home visitors. Rather, they sought home visitors who were from the community being served, had strong interpersonal and communication skills, and had experience working with families targeted by the program. Although few home visiting programs set guidelines for minimum education or experience, nearly all mandated that home visitors complete preservice and ongoing training.

[Slide 24] Next, I'm going to turn to lessons learned related to adapting existing models or developing new models that are culturally competent. Castro and colleagues described the continuum among cultural

adaptations. At one end of the spectrum lie programs that maintained the basic content of a standard program model but made some minor adjustments to peripheral components...such as changes to the program materials to reflect the target population, culture, language, food, and music. In contrast, programs on the opposite end of the continuum reject standard models in favor of developing, in conjunction with the target population, services that build upon the cultural traditions and knowledge of the community.

The approaches used by programs described in this review mirror this continuum of adaptation. They included both national home visiting models that were adapted for American Indian and Alaska native participants, as well as local programs developed specifically for, and often in partnership with, the tribal populations that were targeted.

Among programs along this continuum, we found many similarities in how program developers planned for and implemented services. Three trends that emerged included involving tribal leaders in program development and implementation, employing culturally competent staff, and building on cultural strengths and traditions.

[Slide 25] Programs engaged tribal leaders throughout the development process to provide input on designing culturally appropriate and relevant programs, developing program content, recruiting families, and training staff. Studies described the instrumental role tribal elders played in nurturing and promoting programs. For example, one program designed to strengthen parenting practices formed collaborative relationships with the communities targeted by the intervention. In each community, the tribal council was involved in all stages of the project, from conceptualization and drafting the grant proposal to the evaluation design. One tribe appointed a Cultural Oversight Committee to oversee development of the intervention.

Program planners also sought the verbal support of the tribal communities and asked them to refer families to the program. In one program, the tribe's involvement and promotion of the program continued throughout the project, from participation in a dedication ceremony at the beginning to attendance at a celebration of participants' achievements at the end of the program. One study described how a parenting consultant from the local tribe cofacilitated the preservice training for program staff.

[Slide 26] Some program planners felt that families would be better able to connect with staff from their tribes than with an outside professional, six hired staff members from the target community. A stated goal of one of these programs was to use the home visitors to create an extended family support system. In other programs, the home visitors included those tribal members and professionals from outside the community. When programs employed staff from outside their communities, program planners placed importance on cultural sensitivity training for staff to help them understand the history of the tribes and its cultural traditions and strengths.

One study that employed staff from both within the tribal community...in this case, the Navajo nation in Arizona and New Mexico...and outside the community explored the relationship between the racial ethnic match of the family and provider and the family satisfaction with the program. The authors found that most families did not have preference as to the racial ethnic background of the provider. Families did

note, however, the importance of having culturally competent home visitors who could speak their native language.

[Slide 27] A number of studies described building on the cultural strengths and customs of the target populations and incorporating traditional practices. For example, the Indian Wellness Prevention Project developed a curriculum based on tribal legends and delivered it with a traditional storytelling approach. One of the articles discussed how a community health center went about designing a logo for the program. They commissioned an American Indian artist to create the logo and sought feedback from the tribal elders on various drafts.

Programs also integrated traditional arts and crafts, food, and music into the curriculum. Several programs emphasized the value of traditional child rearing practices and the wisdom of tribal elders. For example, one program had a medicine woman assist with a series of Lamaze classes. Another program invited tribal elders to speak at program events.

[Slide 28] Several studies described lessons learned about delivering home visiting services...including the challenges they faced reaching the intended target population, maintaining enrollment, and providing adequate levels of services. Studies reported the programs were generally able to recruit from their target population, but almost all programs faced attrition. Three studies reported that between 10% and roughly half of participants withdrew from the program early or elected not to enroll in subsequent years of the program.

The best test of the effectiveness of an intervention occurs when the program model is implemented with a high degree of fidelity to the original design. This ensures that the model being evaluated was actually implemented as intended by the developer. Only 4 of the 19 studies included in this review provided information about a program's fidelity standards or systems for monitoring fidelity.

We also learned that for program staff in rural communities, traveling long distances to visit participants was a barrier to service delivery. Furthermore, a lack of coordination among service providers created obstacles to service delivery. Studies also reported that families' day-to-day needs often made it difficult for home visitors to deliver the content as intended.

To over challenges, staff modified program models to better align them with the needs of participants. To modify services, programs collected from participants and staff mid-course consistent with a process of continuous quality improvement. For example, staff from different agencies delivering the Perinatal Intervention Program adapted to the specific needs of the group. Based on ongoing input from home visitors, program planners determined that home visitors should attend medical appointments with participants who were finding the appointments to be somewhat threatening. They also held one-on-one make-up classes after participants began to frequently miss scheduled group classes.

While these modifications may have allowed program staff to overcome implementation challenges, these changes may have changed core elements of the model. When considering modifications, program staff working in partnership with model developers was likely to best assure program integrity. The developers

can help programs ensure that the changes are acceptable and do not interfere with core elements of the model.

[Slide 29][Slide 30] From the studies reviewed, we identified three key challenges evaluators face. Although these challenges are not unique to research in tribal communities, they may serve as consideration for future evaluation. The ability of any evaluation to detect real improvements (inaudible) on the ability of researchers to collect solid data. Obtaining high response rates was a challenge across studies. One recent study states low response rate was because when participants dropped out of a program, they often dropped out of the evaluation as well and did not want to participate in follow-up data collection.

The cultural relevance of measures was also an issue. One study noted that cultural differences might have influenced interview responses. Navajo caregivers were asked to rate services, a behavior considered in conflict with cultural norms. The study concluded that their responses possibly meant to satisfy the interviewer rather than to reflect their genuine impressions.

Some said studies described conflicts between community preferences and research design elements. In one study, the evaluation was developed by a committee-appointed working group, which decided on a pre/post design rather than a randomized controlled trial because the latter had potential to raise concerns in the community. One study addressed this issue by randomizing participants to a treatment or an active control condition. In other words, the comparison group received a highly-valued level of services rather than usual care. While this approach may have increased community buy-in, the study authors reported that it reduced the contrast between the treatment and control conditions.

[Slide 31] Collaboration between tribes and model developers to plan for, adopt, implement, and sustain home visiting programs, along with rigorous local evaluations, will provide opportunities to build the evidence base on tribal home visiting programs. We recommend that these efforts include research to support the model development and implementation of culturally relevant home visiting models as well as examine how well the models work for American Indian and Alaska native children and families.

[Slide 32] Detailed information about program models should be documented. This information will increase the feasibility that models can be sustained and replicated over time. Most studies in our review included information about some model components, such as staff training requirements and program materials; but few studies provided detailed information about all aspects of implementation. To replicate models, programs need operations manuals, training manuals, information about qualified trainers, documentation of curriculum or program content, and formed an assessment for service delivery. In addition, developers should identify core elements of the program models...meaning those elements in the models that programs *must* implement with integrity to achieve outcomes.

[Slide 33] Model developers should create fidelity standards for core elements. Measurers of implementation fidelity assess the degree to which the initiative is implemented as planned. Such standards should include measures of those structural components of the model...such as proper frequency of service delivery, minimum staff qualifications and training, and the manner in which content should be delivered including interactions between home visitors and families.

In addition, more research is needed to understand the challenges of implementation and whether and how they can be met. Specifically, information is needed about challenges programs face funding and sustaining models, recruiting and retaining staff, recruiting and enrolling families, and delivering model content as well as how programs attempted to overcome these challenges. This information can help inform future efforts to implement these models.

[Slide 34] Finally, when programs choose to adapt national home visiting models, detailed information is needed about the process that programs use for making these adaptations including how they engage with developers to design, implement, and test adaptation. The studies we examined provided some lessons; however, additional information is needed, as well as information from program participants about their preferences.

It is also important to note the inherent tension between maintaining fidelity to core elements of the program model, yet making culturally-relevant adaptations. Information on how communities and developers work together to address this tension will contribute to the research literature on this topic.

[Slide 35] As we mentioned previously, we identified few studies with designs that had the capacity to provide unbiased estimates of program impact. Using a utilization-focused participatory evaluation approach, evaluators and stakeholders may be able to work jointly to overcome these issues by defining and evaluation that is useful to both groups. This approach is intended to create joint ownership of the evaluation and to maximize the usefulness of evaluation data for both evaluation and program services.

[Slide 36] The main reason the randomized controlled trials included in the HomVEE review were rated low was their high level of sample attrition, which weakened the validity of the study findings. From the onset, evaluators should pay particular attention to the needs maintaining the study sample. In addition, researchers should design and implement research designs that achieve strong internal validity; that is, studies with the potential to establish causality and rule out other reasons for the observed outcomes.

As Diane mentioned earlier, these designs include well-implemented randomized controlled trials with single-case and regression discontinuity design. Although single-case and regression discontinuity design has not been widely used in home visiting research, they may be less expensive and more feasible to implement and should be considered in the future. For example, in a single-case design, each case receives the treatment; and thus, treatment is not withheld from any sample member as must be done in randomized controlled trials.

Researchers should use their highest quality measures when feasible...including direct observation, stress assessments, and administrative data. They may need to use secondary measures, such as self-report. For example, some evaluators may rely on parent reports when collecting information on child outcomes because direct observation measures are too costly. Similarly, researchers may encounter limitations in the availability of culturally-relevant measures which may require them develop or use new measures that are not yet standardized.

Finally, we suggest that researchers consider the HomVEE study rating criteria in planning and implementing future studies. Information about the criteria is included on the HomVEE website.

I want to thank you for your time. I'm now going to turn it over to Carol for a question and answer session.

[Slide 37] >> CAROL: Hi, this is Carol. We want to try to stay on schedule, but we have time for maybe one question now. Does anybody have an immediate question?

>> WEBINAR PRODUCER: If anyone would like to ask a question at this time, please press “star 1”. Once again, if anyone has a question at this time, please press “star 1”.

[Pause for audience response]

[No response]

>> CAROL: Okay, well, we'll let you save your questions for the end. Thank you to Diane and [Slide 1] Patricia for their presentations. Now I'd like to turn it over to Dr. Doug Bigelow from One Sky Center.

Are you there, Doug?

>> DOUG: Good day, everybody. It's an honor to be asked to speak with you. I will offer some thoughts on the report that you've just heard described. [Slide 2] I'm going to talk a little bit about all of the information that's published in that report about programs similar to your own that have been previously studied in tribal communities.

Now, this webinar business is new to me; so forgive me if I stumble a bit.

Thanks...you've gone ahead to my next slide, I think.

One Sky Center is a national resort for American Indian and Alaska native behavioral health programs. Dr. Walker on the right there is the director, and she's also president this year of the Association of American Indian Physicians. Dr. Silk Walker is in the blue, and both those Walkers are Cherokee. Michelle Singer, who is next to Pat, is Navajo; and Executive Secretary Susan Halada is on the left in red. And that's me in the striped shirt talking to you. You can see my jaws wiggling. I'm wearing that same striped shirt right now, and Dr. Walker here is sitting right beside me to make sure I don't tell any lies.

Next slide, [Slide 3] please. Thank you.

Now, this OPRE report...let me tell you what I think is useful in this report. First, it affirms the value of community-driven, culture-based planning and programming. That is a very important contribution coming out of this report. Second, it provides program descriptions including some programmatic activities as well as outcomes and measures. This descriptive material can be used, cut-and-paste style, to help you design and describe your own local programming.

For example, the report mentions a curriculum for parents based on six tribal stories and legends and the reintroduction of storytelling. Fisher and Ball, whom you see in the Appendix, it describes that stuff; and you can cut and paste it.

Another example is elder prayers for new program families, and you can imagine how influential that is getting those families recruited and committed to the program...cut and paste it.

Staff sensitivity to historical exploitation and trauma are described by Crater and Davis. You'll also find that in the appendices.

The third value in this report is that it gives you ten specific lessons. Now, you've already heard those lessons described; and I'm going to talk about them some more. But maybe the background music will have a different sound and feel to it. These lessons are drawn from research on previous tribal home visiting programs, so you can use what we call "evidence-informed local program design."

Next slide, please. [Slide 4] Thank you.

First, let me make this sound like religion. Every home visiting program, even if it's adapted from a model program, is embedded in and powerfully shaped by local context and culture. Therefore, every program is a local innovation.

Second, I want to emphasize that detailed program descriptions, program manuals, program research and evaluation are vitally important for certain reasons. First, describing your program to funders, regulators, and other tribes; second, training your staff; third, monitoring and managing your program; fourth, designing your evaluation plan and for sharing lessons learned with other tribes.

Third, local innovations are much more likely to succeed if they incorporate lessons learned from research. It doesn't have to be randomized controlled research to provide you with useful lessons.

Fourth, there are lessons to be learned from previous home visiting programs that are studied in Indian communities, including (inaudible).

Next slide, please. [Slide 5] Thank you.

Here is graphic to illustrate how and why every program, including replications of model programs and indeed the original model program itself, are local innovations. Program interventions...for example, parent training...produce their outcomes by acting through what we researchers call "intervening, moderating, and mediating variables." See them in the blue box in the middle there? These variables are what we call "local context and culture." When we're researchers we call them intervening, moderating, and mediating variables. When we're out there in the street, we call them local context and culture; and these affect...indeed, they completely change...the outcomes of an intervention like, say, parent training.

Some of the obvious local context and culture variables include what other problems clients have...like substance abuse, depression, fragile families. Different kinds of clients respond differently to the intervention. What other service is the client receiving; for example, subsidizing housing or not subsidizing housing, whether the client is rich or poor, literate or not, older or younger, whether staff are highly trained and motivated or just average people or are themselves dispirited and impaired.

The physical settings of the program...urban, rural, remote...highly different. With electricity or not affects child welfare. The social setting, a neighborhood with lots of social capital or a neighborhood that's fragmented. And, very importantly, the cultural setting...whether it's Navajo or Apache, whether it's traditional or modern or bicultural. All of those moderating and mediating variables, also known as local context and culture, have a tremendous impact on how the program works.

These intervening variables are certain to be substantially different in every locale and cultural setting. Even the local context and cultural setting of model programs is unique and may not at all be like your local and cultural setting. Although every community program can and should learn from others, significant differences must also be taken into account.

Next slide, please. [Slide 6]

In this graphic, we illustrate how you can begin with either, one, adapting a model program to a local context...see that on the left there...or by innovating a local program. Incorporating what has been learned from research on the models and other programs, this is what we call evidence-informed innovation. So you can start either way; and what the OPRE report notes is whichever way you start, you're likely to wind up in the same place with the same program design.

Whether you approach the design of the program by choosing a model program or adapting it or starting with a local planning process, whichever approach you use, I want to emphasize the importance of your community owning the planning process.

Next slide, please. [Slide 7]

Community-driven planning is (inaudible) the planning process. Whether you adapt a model program or do what we call evidence-based local innovation, a community-driven tribally-owned planning process is very important. Here's what I see as the tribe's interest in actively owning the planning process. When a tribe owns the planning process, one, the tribe satisfies tribal plains of sovereignty and a government-to-government relationship; that is, under executive orders, treaties, and legal precedents, nobody can tell you what you have to do. You have to decide yourself.

The tribe experience is a higher degree of tribal self-efficacy, community competency, and more extensive control over community institutions and assets. The tribe can optimize synergy among its community institutions...the ones that it lives with, the ones that it drinks coffee with. The tribe can design home visiting programs with optimal levels of local content. If you start by choosing a model program to adapt, just remember...you, the tribe, are in the driver's seat.

Just a little footnote...tribal ownership has important health consequences. Tribal ownership and control have been proven to reduce the risk of suicide among younger tribal members. For you researchers out there, the reference is a Michael Chandler and Chris Lalonde article entitled *"Cultural Continuity as a Protective Factor."* Google it.

Next slide, please.

Where am I? Am I on the next...? Give me the next one if you would, please. [Slide 8] There we go...Why Research is Useful.

Now, I'm a researcher. I've got to tell you, research is very, very useful. This is a call to arms for researchers and evaluators. The OPRE study illustrates why research on tribal home visiting programs is useful. Research and evaluation on tribal home visiting programs provides culturally-appropriate knowledge that can be incorporated into local program design an operation by other tribes...I'll get to some of that in a minute...and can produce improvements in your own program.

For example, the OPRE study reports the fact that storytelling and legends are effective content for the process of parental reading to a child...an importance piece of fact for that research. The study reports the principle that outcome depends on intensity of home visiting contact...that is, one per week...and duration...that is, three months to two years. The study supports the theory that cultural *is* prevention and treatment, specifically parenting performance is increased by personal identity, which is increased by cultural identity; and parenting performance yields school readiness, which is one of the goals of the HP Program.

Research evaluation of your unique community-driven programs will yield more lessons to share with all tribal communities; and listen up, and this demonstrates the power of culture-based interventions and demonstrates the effectiveness of tribal programs, *and* earns some overdue, long overdue, understanding and respect in the non-tribal world.\

Next slide, please. [Slide 9] There we go.

The ten lessons, which have already been reviewed but I'm going to say them again, can be classified as content and system-design lessons. First, the content lessons:

One...content, the things unique tribal communities includes home visitors acting in the cultural role of extended family; fulfilling cultural expectations for caregiving, support, and encouragement; and, consequently being accorded familial influence with those families. This is compared with home visitors acting as external agents with expertise and agent authority.

Two...great acceptance and likely effectiveness are yielded by using tribal approaches to child rearing rather than approaches based on structures and norms of Western families. For example, some tribes prohibit punitive child rearing practices and use other means for eliciting compliance.

Three...use of traditional storytelling as a tool for developing reading readiness. Synergistically incorporating culture-based printed materials to supplement oral telling is likely to be readily accepted and effective. This would also further community goals of developing a cultural identity in the new generation of tribal members.

Four...arts, crafts, music, food, and fun are traditional cultural and community assets. That is, program content that can be used to strengthen parents' morale, commitment to parenting, and capabilities; for example, getting an isolated parent to participate in a powwow can be uplifting and instructive. Build that into your program.

Fifth...community celebration of life's milestones is a cultural asset that can be used to reinforce parent participation and effort...again, something you can build right into your programs. Honor your culture. Then there are some system lessons in this report.

One, in Indian communities, it is important to get guidance and endorsement from elders; and creating roles for elders in planning and oversight of operations is important to community acceptance, client/parent compliance, as well as to cultural appropriate programming design.

Lessons two and three include the necessity of replacing structural, policy, and territorial conflict and inconsistency with teamwork and services coordination. There *are* major coordination and cooperation

issues around Indian child welfare and development that can, and should be, resolved with a good spirit in the Indian communities.

Four, parents cannot be effective parents if their own basic needs are not met. This requires planning access to local services and resources.

Five, furthermore system resources require completed referral. Home visiting personnel must walk through the process with parents to ensure successful referral.

Next slide, please. [Slide 10]

Here I'm going to drive down a bit into system lessons four and five. We're talking about the big purple circle on the left there. This whole diagram here is a chunk of a larger logic diagram I have prepared to cover the entire community home visiting program, which you may have seen in D.C. back in January when I got snowed in. I don't have time to go through the whole diagram today; this is just a piece of it, and then I'll do one more piece in a minute.

Home visiting program is targeted on high-need, at-risk parents. Therefore, we cannot expect good parenting without ensuring that their basic needs are met. The services resources in this component, the big circle, are supplementary; that is, they're designed to assist persons not able to independently fulfill their needs from the normal demands at particular times in their lives. High-need, at-risk parents need these services as a perquisite to being able to perform well as parents. The children themselves also need these services.

So this becomes an important part of your local design. You've got to figure out how to meet these needs very thoroughly and very early in your services. Ideally, these services would be readily acceptable to anybody needing them. however, navigating the service system and actually accessing the services and resources can be challenging. For persons with disabilities, the challenges can be insurmountable without assistance.

One of the functions of a home visiting program is linking the parents to these services; but note, linking means assessing the need for service, making referrals, and assisting the process of navigation and access...what I call "completed referral."

Next slide, please. [Slide 11]

Here, I'm going into content lessons three and four. Again, this is just a piece of a larger logic diagram. Cultural content, in the yellow circle there, can be used in a number of important ways. Culture affects the parental morale, knowledge, skills, and ultimately performance by inputting vision, aspiration, morale,

values, principles, stories, and images. That's based on the theory that culture *is* prevention and treatment. You can put that theory in your plan. Culture *is* prevention and treatment.

The home visiting program can facilitate cultural input by getting the parent and child to attend cultural events, for example. There's an activity for you. Improving the tribal of culturalization, socialization, integration of parents serves to make the better members of the tribe, which is also a tribally-valued goal in addition to parenting performance itself.

Cultural content provides assets for the process of facilitating child development. The home visiting program can use the cultural process, storytelling...really center to most cultures, and the cultural content of traditional stories to develop early reading skills. I'm really just very excited about that principle. I think there's a lot of power in that. I have myself served in a program to help non-tribal, at-risk kids become better readers. I am much aware of the importance of the content of the written material one uses to entrain the child's interest. Popular movies like cars, animals like dinosaurs, monster stories...all of these things seemed to work for the kids I was working with. Tribal legends and stories provide the same motivating content; and if you use them right, you're going to have kids that are school-ready.

Also, the home visiting program can enhance cultural vision through child reading as part of a larger tribal initiative that's what we call "cultural renaissance."

Necessity and last slide. [Slide 12]

Now, this is directed especially to the attention of the researchers and evaluators in the crowd. Whether you are adapting a model program or starting with a local innovation planning process, it is essential to add some technical assistance to your local planning process. No matter how unique your local context and culture, there is a great deal of value in building upon the lessons of previously-implemented programs. Of course, if you're working a model program, the developer can be a valuable source of technical assistance in design, implementation, evaluation, and ultimately in sharing your experience with others...like we're doing here today.

But if you are beginning with a local innovation planning process, you really, really need to get advice and assistance...perhaps directly from those tribes who are identified in this OPRE report. Tribe-to-tribe technical assistance is a good way to go in our experience. You might also get valuable assistance from the researchers and evaluators. Maybe there are some of you guys on this call right now who should be sources of technical assistance to the tribes that are inventing programs.

One Sky Center wishes you every success on this journey. Thank you. That's it.

>> CAROL: Thank you, Doug.

At this time, we'll take any questions that people have for Doug or for us.

>> WEBINAR PRODUCER: Thank you. Once again, if anyone would like to ask a question at this time, please press “star 1”. You will be prompted to record your name. Your name is required to introduce your question. Once again, if you'd like to ask a question at this time, please press “star 1”.

One moment, please.

[Pause for audience response]

We do have a couple of questions today. Your first question is from Maria Brock.

>> MARIA: Hi, good afternoon, everyone. This is Maria Brock from Albuquerque, New Mexico. I had a question. I was looking on the HomVEE website at the outcomes. One thing that I know we're curious about with our project that I didn't see anywhere was around attachments. I was wondering if any attachment outcomes were looked at or if that was part of the criteria, and where was it placed. Was it part of, like, Child Health or part of Positive Parenting Practices?

>> ALETA: Diane, do you want to take that one?

>> DIANE: Sure.

Hi, this is Diane Paulsell. I think those attachment outcomes, if they're there, would be in Positive Parenting Practices. I don't remember myself seeing any attachment outcomes; but there are so many studies that we reviewed, it could be that I'm just not remembering. I'm just going to take a look while the webinar is going on and see if I find any as well.

>>DOUG: This is Doug Bigelow. There's the Barlow study, which is in the reference list there, included bonding, which is an attachment, as one of its three outcomes. It was marginal, but it was an outcome.

>> DIANE: Okay, yeah, so that would be one of the studies that's specifically in the tribal review.

>> MARIA: Okay, thank you.

>> WEBINAR PRODUCER: Our next question is from Ann Dahl.

Your line is open.

>> ANN: This is Ann Dahl, Spokane Tribe of Indians, Wellpinit, Washington. I am wondering about the slides that we have seen today. Are those going to be available to us before this over, or how do we get copies of those?

>> ALETA: Yes, this webinar will be recorded and posted on the HomVEE website. So we will definitely let participants know when those slides have been posted.

>> ANN: Thank you.

>> WEBINAR PRODUCER: We have no other questions at this time.

>> ALETA: Okay, well, thank you so much, everybody. As Carol mentioned, we will be having individual calls with the grantees; and you're, of course, always welcome to contact Carol or me or Aleta with any questions. We look forward to working with you all moving forward. Thanks.

>> WEBINAR PRODUCER: Thank you for participating in today's conference. You may disconnect at this time.