ABSTRACT: Early childhood home-visiting has been shown to yield the greatest impact for the lowest income, highest disparity families. Yet, poor communities generally experience fractured systems of care, a paucity of providers, and limited resources to deliver intensive home-visiting models to families who stand to benefit most. This article explores lessons emerging from the recent Tribal Maternal and Infant Early Childhood Home Visiting (MIECHV) legislation supporting delivery of home-visiting interventions in low-income, hard-to-reach American Indian and Alaska Native communities. We draw experience from four diverse tribal communities that participated in the Tribal MIECHV Program and overcame socioeconomic, geographic, and structural challenges that called for both early childhood home-visiting services and increased the difficulty of delivery. Key innovations are described, including unique community engagement, recruitment and retention strategies, expanded case management roles of home visitors to overcome fragmented care systems, contextual demands for employing paraprofessional home visitors, and practical advances toward streamlined evaluation approaches. We draw on the concept of “frugal innovation” to explain how the experience of Tribal MIECHV participation has led to...
more efficient, effective, and culturally informed early childhood home-visiting service delivery, with lessons for future dissemination to underserved communities in the United States and abroad.

**Keywords:** home-visiting implementation, early childhood, tribal innovations, low income, health disparities

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Research has indicated that the impact of early childhood home-visiting interventions is highest among the most vulnerable low-income mothers and their children (Minkovitz, O’Neill, & Duggan, 2016; Olds, 2002; Peacock, Konrad, Watson, Nickel, & Muhajarine, 2013). Ironically, families living in the deepest poverty are often out of reach of effective home-visiting interventions due to isolation, lack of resources, and limited community and organizational capacity to implement and sustain intensive home-visiting interventions (McDaniel, Heller, Adams, & Popkin, 2014). American Indian and Alaska Native (AI/AN) communities, who experience more health and economic disparities than does any other racial or ethnic group in the United States, have been among those historically underserved by home-visiting implementation and evaluation efforts (Avellar, Paulsell, Sama-Miller, & Del Grosso, 2012).

Fortunately, the recent Tribal Maternal and Infant Early Childhood Home Visiting (MIECHV) legislation set aside 3% of funds to improve knowledge on how to best deliver evidence-based and promising home-visiting interventions in low-income and hard-to-reach AI/AN communities.

This article describes the ecological challenges experienced and solutions derived by tribal communities participating in the MIECHV opportunity (either as a Tribal MIECHV grantee or a part of state-funded MIECHV grantees). We represent and draw examples from our work in four diverse tribal settings: (a) a tribal jurisdictional area (Choctaw Nation of Oklahoma; “Choctaw”), (b) a rural reservation-based tribe (White Mountain Apache Tribe in Arizona; “Apache”), (c) six remote AN villages (Kodiak Area Native Association; “Kodiak,” and (d) an urban Indian center (Native American Health Center in Oakland, California; “Oakland”). These sites reflect the diversity of lands, languages, cultures, population densities, governance, and societal structures that distinguish the more than 560 North American tribal populations (see Table 1). They also battle dire poverty and economic and human resource challenges that strain home-visiting implementation, from a lack of reliable vehicles to drive to homes to more complex issues of historical oppression and trauma that burden families and demand more from home-visiting programs, and, in the case of the representative urban site, homelessness was a serious challenge for clients and their “home” visitors. Yet, the will to succeed among the represented communities has outpaced setbacks, as these tribes have exhibited resilience and creativity to forge solutions.

Thus, the aim of the article is to provide real-world examples of how low-income, culturally distinct, and historically disenfranchised communities have seized the benefits of home visiting through frugal innovations attuned to local needs and available resources. We review a broad set of home-visiting implementation challenges from start-up through model selection, service delivery, and evaluation, and provide case examples of local innovations that could benefit home-visiting efforts in other settings.

### START-UP CHALLENGES AND INNOVATIONS

#### Distrust

The most pervasive start-up challenge experienced by the sites was distrust. In tribal communities with low resources, a common concern about any new grant-funded program is: “It won’t last.” In addition, federal grant programs requiring extensive data collection and reporting can elicit historical fears that something is being done “to us” and not “for us or by us.”

Thus, all sites prioritized relationship- and trust-building. The rural sites—Choctaw, Apache, and the Kodiak—all employed indigenous home visitors from their respective communities to overcome distrust and reinforce local ownership. They hired home visitors fluent in their Native language to ensure that traditional homes could be served. Even before implementation, Kodiak home visitors led weekly play groups to build community trust and provide families with information on the program and other helpful resources. In the meantime, the Native American Health Center, located in a diverse urban community in Oakland, hired home visitors who reflected the diversity of their service population, generally with mixed Native and other ethnic or racial ancestry. Several had worked previously at the health center in other roles and had gained community trust.

#### Fractured Service Networks

All communities at start-up were challenged by fractured service networks. Barriers to care included overburdened health clinics with long wait times, closed waitlists in everything from public housing to domestic violence shelters, and geographic isolation, the most extreme in Kodiak, Alaska—where most primary and tertiary care are accessible to village communities only by boat or plane. However, there also was an extreme sense of isolation among families in urban Oakland, as participants were isolated from the social support of families, tribes, and reservations due to relocation policies that were compounded by a lack of transportation and experience in navigating urban services. Thus, home visitors in these settings found themselves in the immediate role of case managers. At all sites, home visitors facilitated contact with difficult-to-reach providers and offered patient support for difficult visits. Over time,
### TABLE 1. Characteristics of Participating Tribal Sites

<table>
<thead>
<tr>
<th>Tribal Community</th>
<th>Population</th>
<th>Geography</th>
<th>Unique Community Characteristics</th>
<th>Primary Risk Factors</th>
<th>Key Aim of Home-Visiting Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kodiak Area Native Association, Kodiak, AK</td>
<td>The five village communities, including Akhiok, The City of Kodiak, Old Harbor, Ouzinkie, and Port Lions, range in population size from 74 (Ouzinkie village) to 226 residents (Old Harbor).</td>
<td>Rural (Frontier) nonreservation; 5 communities located on Kodiak Island, the largest island on Alaska’s Southwestern coast; 5 communities are included: Akhiok, The City of Kodiak, Old Harbor, Ouzinkie, and Port Lions</td>
<td>At the time of first European contact, total Native population on Kodiak was &gt;6,500. Russian colonization had a devastating effect on the Native population and culture. Alutiiq (Russian-Aleut) is the present-day Native language. Housing is a problem that limits the ability to recruit and retain staff. Traveling to communities to provide services is difficult because the only way of travel to the villages on the island is by boat or plane, and weather often interferes with transportation. Villages are largely dependent on a subsistence lifestyle during the summer into fall; fishing and hunting are key activities, and produce food for the winter months.</td>
<td>Lack of access to high-quality childcare programs, lack of parent training and resources, lack of indoor play facilities and programs for young children, lack of developmentally appropriate outside play for toddlers and preschoolers, lack of child-abuse prevention strategies across projects</td>
<td>Positive parenting; prevention of child abuse, neglect, and maltreatment; improved family traditional foraging activities and cultural values; and improved family wellness.</td>
</tr>
<tr>
<td>Native American Health Center, Oakland, CA</td>
<td>The Bay Area hosts one of the largest and most diverse urban AI/AN populations in the United States, with over 200 tribes represented. The community is multicultural, multiracial, and multiracial. Health Center in Oakland served more than 7,200 patients in 2011 (most recent data).</td>
<td>Urban nonreservation; located in California’s San Francisco Bay Area; services provided primarily in Oakland, California</td>
<td>AI/ANs from various tribes began migrating in significant numbers from reservations to major urban areas during the 1950s under the Bureau of Indian Affairs Relocation Program. This has created a unique identity and acculturation experiences for urban AI/ANs, such as those served by Native American Health Center, Inc. These experiences include increased intertribal or interracial marriages and offspring, isolation from tribal-specific practices, and invisibility to non-Indians. With the interconnectedness of the AI/AN community within the Bay Area as well a high concentration of AI/AN and AI/AN-serving organizations across the Bay Area, there is a strong platform for informal community-support opportunities to maintain AI/AN cultural connection.</td>
<td>Crime, community violence, illegal drug trade, human exploitation, unemployment, poverty, and homelessness. The public health, education, and social service systems are characterized as underfunded and overly bureaucratic.</td>
<td>Culturally appropriate prenatal and early childhood education; integrated care coordination; support for mother, caregiver, and child wellness; referrals for medical and substance-abuse services; and support for community events</td>
</tr>
</tbody>
</table>
TABLE 1. Continued

<table>
<thead>
<tr>
<th>Tribal Community</th>
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</thead>
<tbody>
<tr>
<td>Choctaw Nation, OK</td>
<td>The Choctaw Nation is an integrated tribe, meaning it is not reservation-based, with over 220,000 enrolled members.</td>
<td>Rural nonreservation/ Oklahoma Tribal Jurisdiction Area (TJA); The Choctaw Nation serves more than 80,000 tribal members on its 11,784 square miles of rugged hills and valleys, an area larger than Delaware, Massachusetts, Rhode Island, and the District of Columbia combined. The Nation is bordered by Arkansas to the east and Texas to the south. The Choctaw service area has no major metropolitan city; the nearest city is over a 3-hr drive outside the area. The program serves 5 of the 10 1/2 counties within the TJA: Atoka, Haskell, Latimer, McCurtain, and Pushmataha.</td>
<td>The Choctaw Nation offers more than 90 support services to its tribal members, but due to the large geographic area, tribal members may need to drive several hours to utilize these services. The overall economy of the Choctaw Nation TJA leaves many of the families facing challenges finding jobs due to a lack of education and the scarcity of employers. There are too few service providers to serve a nation spanning the geographic area equivalent of four states and fragmentation between existing services.</td>
<td>Very limited economic opportunities, poverty, unemployment and underemployment, poor adult literacy, high rates of low birth weight and premature birth, high percentage of school dropouts, high rates of teen pregnancy, alcohol or substance abuse, delinquency, child maltreatment, and domestic violence; low knowledge and capacity of residents to access available services; lack of community readiness to overcome substance abuse and other sensitive problems affecting families</td>
<td>Development of healthy, happy, successful Choctaw/Native American children; integration of traditional cultural strengths as a way to overcome young family and early childhood disparities</td>
</tr>
</tbody>
</table>

White Mountain Apache Tribe, AZ | The White Mountain Apache Tribe has approximately 17,000 enrolled members who live on the Fort Apache Indian Reservation. | The Fort Apache Indian Reservation in Northeastern Arizona is rural and isolated, and spans a 1.5-million acre rural land mass the size of Delaware. Geographic features include elevations that range from 2,000–11,000+ ft, mountains, lakes. The closest cities, Phoenix and Tucson, are more than 3 hours by car. | Residents of the reservation endure notable socioeconomic challenges: 61% of the population >16 years old are either “Not in Labor Force” or unemployed; 47% aged ≥25 years have not received a high-school diploma; Median household income is $14,496; and the majority live below the federal poverty line. Over half (53%) of homes are led by single mothers, and 75% of children are born to unwed mothers. | The White Mountain Apache Tribe battles significant behavioral health disparities, including high rates of suicide and substance abuse, particularly among adolescents and young adults of childbearing age. However, the tribe has partnered in a long line of health research and is intent on defining sustainable, community-driven solutions while continuing to renew its language and valued traditions. | Increase parenting knowledge and skills; address maternal psychosocial risks, including substance use and depression; promote optimal physical, cognitive, socioemotional development for children from 0 to 3 years |

all sites moved toward increasing their networks of community partners and making referrals aided by warm handoffs. These examples illustrate that in low-resource communities, home visitors can become key connectors in fragmented service systems.

MODEL-SELECTION CHALLENGES AND INNOVATIONS

The Tribal MIECHV Program required that all communities choose an evidence-based or promising home-visiting intervention. While model selection was intended to be based on a year-long community needs assessment, in the end, the following contextual realities were primary drivers of both model selection and enhancements.

Home-Visitor Background and Training

Each community prioritized hiring local home visitors who would be trusted with sensitive issues and could naturally navigate cultural and social mores required by home-based outreach. Nurse home-visiting models were ultimately rejected (although some other Tribal MIECHV grantees did choose nurse-run models) due to a shortage of local Native nurses and because the expense of employing outside nurses was not feasible or sustainable. Respecting the intensity and responsibility of the role, each community strove to pay their paraprofessional home visitors a livable wage. The sites also provided supplemental work skills education (e.g., reflective supervision, boundary setting, human ethics and confidentiality, computer skills and data management, and
continuing education and professional development) beyond the training specified by home-visiting models selected by the sites.

**Need for Flexibility in Model Implementation and Delivery**

All sites identified the need for “flexibility” in model implementation and delivery, which was conceptualized in two ways: (a) flexibility for cultural enhancement and (b) flexibility to meet families “where they were.” Regarding the second model implementation and delivery conceptualization, because of the small sizes of the communities, it was not viewed as a good use of resources to limit recruitment to first-time or expectant mothers—an original requirement of some evidence-based home-visiting models. However, small population size was generally not the dominant decision driver—many indigenous cultural value systems prioritize inclusivity and democracy, which in this case translated as a desire to share available resources with all who can benefit. Further, all sites discovered the importance of responding to families’ immediate needs after recruitment. Some sites prioritized case management in the early months of service while others first offered the most relevant home-visiting lessons. Meanwhile, the sites introduced administrative innovations to secure ample time for home visitors to deliver the selected model. The Apache site taught visitors boundary-setting skills. Oakland supplemented their home-visiting curriculum with family training on service navigation, including scripts to help participants make appointments, instruction on problem-solving to keep appointments, and guidance to empower families to know their service rights and ask questions during appointments. Oakland’s placement in an urban setting afforded more potential resources to families, but there still were formidable transportation and access barriers in connecting home-visiting clients to services.

**SERVICE-DELIVERY CHALLENGES AND INNOVATIONS**

**Meeting Families Where They Were**

In addition to meeting stressed families where they were emotionally, tribal home visitors learned to meet families where they were physically. The idea of “home” visiting became elastic. For example, due to lack of transportation, Choctaw and Apache families often needed transport to their children’s pediatric appointments or to a referral agency. Home visitors adapted by providing lessons during the drive or wait times at their destination. Sometimes, highly stressful or crowded home environments were not conducive to lessons, so lessons took place in vehicles or other private settings. Clients were sometimes homeless; Oakland staff met families at libraries, parks, cafés, recreation sites, other family members’ houses, or medical offices. They also created walk-in hours for clients to be seen at the Center (a service provision that would be more difficult in rural communities), and provided warm handoffs to “Counselor of the Day” services as part of the Center’s behavioral health department. The Apache site supported flexible work hours for home visitors to ensure that lessons could be taught when most convenient for families. Often, home visitors could best connect with younger mothers who were still in school in the late afternoon and early evening; some families preferred weekend visits. Flexible work schedules can challenge some organizations’ human resource management, particularly within publically supported agencies that have stricter institutional policies but whose populations may have the greatest need for visits outside of routine work hours. A common concern is that nighttime or weekend hours may draw overtime compensation and exceed available resources. The Apache site solved this problem by allowing flexible hours and the use of texts and telephone calls for home visitors to check in and out with supervisors. When workers were given flexible hours, there were no observed abuses in the system; on the contrary, home visitors appeared to work harder and more efficiently because their time was respected and well spent.

**Multigenerational Child-Rearing**

No nationally endorsed, evidence-based home-visiting program has been specifically designed for multigenerational families or households (U.S. Department of Health & Human Services, 2015). In all participating sites, multigenerational households were the norm. Shared child-rearing responsibilities among multiple family members are driven by historical traditions and modern necessity. Choctaw and Apache sites observed that younger parents often relegate child-rearing to the baby’s grandparents while parents sought to finish education or gainful employment. The Oakland site observed that fathers are often drawn into home-visiting sessions by their interest in care-coordination services, including advocacy and navigation within the court system for custody and other legal issues. All sites welcomed the participation of grandparents, aunts, uncles, cousins, older children, and other caregivers because the communities embraced the importance of supporting the holistic wellness of the family to optimally serve the child. Whether rural or urban, communities valued the important role that elders held in transmitting knowledge and wisdom to children during formative development, and the traditional roles played by aunts and uncles in child-rearing. These communities’ improvisations to serve extended-family networks is an exemplar for building out existing home-visiting models to engage caregivers from multiple generations, which is important to serving other low-income and ethnically diverse, multigenerational households in the United States and abroad.

**Recruitment/Retention Challenges**

Isolated and stressed tribal families have many responsibilities and competing priorities, and therefore can be difficult to reach, recruit, and retain. In addition to community-wide trust-building, the ubiquitous solution for successful recruitment was persistence; it was standard across programs to visit some families multiple times before participants felt adequately informed and inspired to enroll. The next step after recruitment was laying groundwork for retention. Oakland and Apache sites ensured that families knew at
enrollment that if they ever felt overwhelmed and needed a break, they could let their home visitors know, and could resume services when they were ready. Oakland and Choctaw sites formalized a 90-day “persistence” period, where the home visitor tried consistent, repeated contacts and sent a letter letting them know that they would be listed as inactive after 90 days but that they were welcome to return to the program. When a client was considered inactive, another client could be recruited. Alternatively, the Apaches did not drop clients unless the client proactively requested to be dropped. This site found that over the 39-month service period (pregnancy–3 years’ postpartum) of the home-visiting model they used, some mothers and families could take a 3- to 6-month break and then re-engage as an active participant. A common reason for a break was when families moved into a new household—and the presence of home visitors had to be renegotiated within the new family networks. Many of the programs made adjustments to stay in touch with families by telephone or text through long breaks or chaotic periods, and did not require new intake forms when families restarted regular visits. The communities also learned to obtain at recruitment, with participants’ consent, a comprehensive list of secondary contacts (mother, sister, grandmother) who could provide information about where participants had moved. Prior home-visiting programs, particularly in low-income communities, have battled high attrition rates—largely due to stricter, but perhaps unnecessary, protocols about dropping clients after a certain number of missed visits. The innovations derived by representative tribal home-visiting programs may help improve retention within communities comprised of severely stressed and hard-to-reach families.

Transportation and Weather Challenges

Some of the rural communities found it necessary to budget for four-wheel drive vehicles due to severe weather and poor roads while others were able to recruit home visitors who could use their own vehicles if reimbursed for mileage. Kodiak’s seasonal and environmental challenges were most extreme. Home visitors had to fly to five different villages and relied on Village Safety Officers, Behavioral Health Aides, and the Tribal Council for rides to and from the airstrip. When home visitors got to villages in inclement weather, they were prepared to stay for several days and do as many lessons as possible. Sometimes, weather prevented visits for days or weeks. When this happened, Kodiak’s home visitors called families and mailed out activity packets. They also used videoconferencing to do visits when families had an Internet connection and a computer with a webcam.

Home-Visitor and Participant Safety

Serving stressed families in poor communities can present safety issues for home visitors, such as encountering domestic violence or family members who were intoxicated, witnessing active crime, navigating hazardous roads, or fending off unfriendly dogs. Each community developed comprehensive safety protocols. Home visitors were supplied with telephones, traveled in pairs when necessary, and checked in with supervisors before and after traveling to a worrisome home visit. In Kodiak, the Village Safety Public Officers were frequently engaged to transport home visitors to visits to monitor safety. All home visitors also were trained in local protocols to address threats of clients’ danger to themselves or others. Due to high rates of suicide among youth and young adults in their community, Apache home visitors received additional “Applied Suicide Intervention Skills Training” (LivingWorks Education, 2014) to recognize signs and symptoms of suicide among family members and triage to appropriate emergency care.

Overcoming High Turnover at all Levels

Home visiting is an occupation that takes its toll on staff emotionally, especially in communities that suffer a heavy burden of historical and modern trauma. High stress levels combined with the necessity of working alone can lead to home visitors feeling isolated and burned out—with risk for high attrition among them and their supervisors, who may be unprepared to manage workers’ stress. Each community developed staff support plans to reduce risk of home-visitor turnover. Oakland provided home visitors with individual reflective supervision and group support by a licensed clinical supervisor from the Clinic’s Behavioral Health Department. Kodiak provided twice-monthly, one-on-one reflective supervision with a clinical psychologist who was not their direct supervisor. The use of outside support reduced supervisors’ stress and allowed home visitors an opportunity to disclose work-setting concerns with greater freedom. Several communities used regular “retreats” in which home visitors learned relaxation and stress-management skills to assist them and to pass on as tools to families. Choctaw engaged home visitors in traditional activities to confer relaxation and rejuvenation—including dancing and drumming. Successful retention and support for home visitors also included engaging them in quality-improvement discussions and promoting their role as central to the community’s pursuit of wellness rather than as a frontline worker distant from the hub of leadership.

DATA AND EVALUATION CHALLENGES AND INNOVATIONS

Challenges of Data Management and Evaluation

The Tribal MIECHV Program required tribal grantees to conduct rigorous benchmark and outcome evaluations. Common to low-income communities, participating tribes were constrained by inadequate resources and capacity to collect and manage large amounts of data. It also proved difficult to identify a local evaluator with adequate technical experience. Instead, all participating communities hired external evaluators with appropriate skills and capacity for strong trust relationships with tribes. The most successful outside evaluators relied on local Native teams for measurement and design input, and cultural and contextual understanding. However, the teams all struggled with choosing culturally relevant and reliable measures, with Oakland having the additional challenge of...
modifying measures to be relevant to a multtribal community. For example, in adapting the Multi-Ethnic Identity Measure (MEIM) to the community, they selected general terms (e.g., “Native community” and “Urban Native community”) to measure cultural connection. For future efforts, we advocate for a user-friendly compendium of measures, downloadable tools, and “how-to” manuals that can be accessed through a common database by all grantees.

Overcoming Assessment Burden

Another challenge was the widespread perception that assessments were a burden and a barrier to meeting the significant needs of tribal families. The Apaches’ solution was to ensure that home visitors were trained and could communicate the “big picture” of how evaluation ultimately benefited families and the community. All sites strove to demonstrate that aspects of the data collection were beneficial. For example, Oakland trained home visitors to conduct strength-based discussions of the Ages & Stages Questionnaires (a standardized screening tool of young children’s physical, social, and emotional developmental milestones; as cited in McKnight, 2014). Families appreciated learning more about the healthy development of their child and received assistance when they had concerns. In addition, Choctaw and Oakland reported that emphasis was placed on the use of assessments as a means “to make sure we are doing our job and serving you well.”

In addition, the sheer volume of data proved very burdensome to staff, and when exacerbated by high family demands, sites experienced a frustrating backlog of data. All communities resorted to streamlining and shifting the burden of data management to the evaluator and data assistants and not to the home visitors. Choctaw and Oakland’s evaluators sent reminders and assessment forms to home visitors when assessments were due for particular participants to minimize home-visitors’ time and focus on organizing assessments. The Apache team worked with their evaluator to implement an Automated Computer Assisted Self-Interview (ACASI) tool. (The participant uses headphones and both sees and hears items on a laptop computer, and answers with a single key stroke.) The ACASI tool combined both benchmark and local evaluation measures and replaced paper-and-pencil self-reports and face-to-face interviews. ACASI data were automatically uploaded from the laptop the client used to a web-based data management system. Previous research in the Apache setting identified that ACASI was less burdensome and collected sensitive data more confidentially and reliably (Mullany et al., 2013).

TOWARD SUSTAINABILITY

The participating communities universally agreed that the Tribal MIECHV-supported, locally run early childhood home-visiting programs were a powerful and culturally competent tool to address a myriad of health, economic, and education disparities. Seeking strategies to sustain the programs, the authors would prioritize demonstrating the cost—benefits to relevant policy makers. While at face value the cost per child may appear high—due to the added expense of building needed infrastructure (i.e., trained workforce, vehicles to travel long distances to homes)—net savings in terms of medical dollars, human suffering, and the capacity for reversing centuries-old, multigenerational decline may far outweigh costs (see Olds et al., 2010; Karoly, Kilburn, & Canon, 2005) It will be important to the cost analysis model to factor in the benefits of workforce development for tribal home visitors, the closing of health system gaps, and the long-term potential to improve outcomes for two, three, or four generations who share households and childcare responsibilities. In addition, we advocate for exploring potential avenues for medical reimbursement for home visitation. Finally, there may be avenues to tap into federally funded workforces such as the Indian Health Service’s community health representatives or public health nurses, or Early Head Start tribal home visitors, who could be trained to deliver proven home-visiting programs in tribal communities.

DISCUSSION

The ecological contexts of many tribal communities, including the ones represented in this article, are defined by socioeconomic, geographic, and structural challenges that both call for early childhood home-visiting approaches and increase the difficulty of delivery. There is a burgeoning business concept called “frugal innovation” (Radjou & Prabhu, 2015), which observes that the most resourceful entrepreneurs can be found in the most economically constrained environments and that their inventions are generally more efficient and sustainable than are products designed by engineers in businesses with a largesse of resources. The experiences and innovations of the Tribal MIECHV Programs may be a key example of frugal innovation in the home-visiting context. Key lessons have been learned in terms of preparing communities for the introduction of home-visiting intervention; expanding home visitors’ roles as case managers and connectors in otherwise fragmented care systems; recruiting and retaining hard-to-reach families through trust-building, flexibility, expanding the meaning of “home-visiting” to other private and convenient settings, and long-distance retention; and special care in supporting home visitors through adequate wages and transportation, reflective supervision, and cultural activities that rejuvenate motivation and inspiration. Practical advances also were made to coordinate linkages to care and address health-system gaps and to streamline evaluation and data management—with recommendations for using a common compendium of accepted measures and automated data-collection technologies (i.e., ACASI) to further reduce evaluation burden (for a summary of key challenges and innovations across the five community contexts represented in this article, see Table 2).

The structure of the Tribal MIECHV Program—including the required successive stages of community needs assessment, model selection and adaptation, and evaluation—is providing time and opportunity for tribes to overcome deficiencies at every stage of home-visiting implementation in economically constrained, high-need communities. These lessons are essential to the field, given past evidence that home-visiting programs could provide the
<table>
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<tr>
<th>Challenges</th>
<th>Solutions</th>
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<tr>
<td><strong>START-UP CHALLENGES &amp; SOLUTIONS</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Distrust | • Community trust-building activities prior to implementation X
| | • Hiring indigenous, bilingual home visitors X
| | • Hiring multiethnic/racial (mixed Native American and racial ancestry) home visitors who are representative of urban service community X
| Fragmented Service Networks | • Home visitors had responsibility for developing relationships with area providers and community stakeholders. X
| | • Home visitors facilitated client contact with difficult-to-reach providers, providing “warm handoffs.” X
| | • Home visitors offered patient support/advocacy for difficult visits. X
| | • Home visitors became key connectors. X
| **MODEL SELECTION CHALLENGES & SOLUTIONS** | |
| Not Feasible to Recruit, Afford, and Train Nurse Home Visitors | • Chose home-visiting models proven with paraprofessional Home Visitors X
| | • Provided additional work skills training to paraprofessionals (e.g., reflective supervision, boundary setting, computer/data-management skills, continuing education and professional development X
| Needed Models With Flexibility for Cultural and Contextually Informed Enhancement and Meeting Families “Where They Were” Emotionally | • Chose models with flexibility to enhance content to reflecting local cultural and contextual understanding X
| | • Served all mothers (not just first-time mothers) based on value systems that preferred inclusivity rather than narrow eligibility criterion X
| | • Early in-service delivery, responded to families’ immediate needs (as opposed to rigid attention to lesson order) X
| | • Home visitors spent significant time on case management and service navigation. X
| **SERVICE-DELIVERY CHALLENGES & SOLUTIONS** | |
| Meeting Families Where They Were Physically | • Drove clients without transportation to pediatric visits and referral resources and did lessons in concert with these trips X
| | • Flexible schedules, evening, weekend hours X
| | • Met homeless clients in libraries, parks, other family members’ homes, local cafés, etc. X
| | • Provided “office hours” for client drop-ins X
| Clients Embedded in Multigenerational Households | • Invited all family members to participate, including alternative caregivers and other siblings, cousins, etc. X
| | • Honored and encouraged input of elder grandparents, aunts, uncles as part of traditional respect for elders’ positive influence on children’s formative development X
| | • Responsive to fathers’ particular interests in advocacy and navigation within the court system for custody and other legal issues X
| **RECRUITMENT/RETENTION CHALLENGES & SOLUTIONS** | |
| Stressed Tribal Families Difficult To Reach and Retain | • Allowed breaks in service X
| | • Provided either 90-day persistence period or did not drop families unless families requested X
| | • Stayed in touch with families by telephone/text during chaotic periods X
| | • Collected comprehensive list of secondary contacts (i.e., mother, siblings, grandmother) X
| Transportation and Weather Challenges | • Budgeted for four-wheel-drive vehicles X
| | • Doubled up lessons, mailed out activity packets, or did video-conferencing when possible X
| Home-Visitor and Participant Safety | • Developed comprehensive safety protocols: home visitors supplied with telephones, traveled in pairs when necessary, checking in/out with supervisors X
| | • Suicide intervention training for home visitors X
| | • Accompanied by or in contact with local Safety Officer X

(Continued)
TABLE 2. Continued

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<thead>
<tr>
<th>Challenges</th>
<th>Solutions</th>
<th>Rural Site</th>
<th>Urban Site</th>
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<tbody>
<tr>
<td>Threat of High Turnover of Home Visitors and Supervisors</td>
<td>• Incorporated stress-management activities</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>• Instituted reflective supervision activities</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>• Onsite licensed counselor available for debriefings</td>
<td>X</td>
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<td></td>
<td>• Engaged in traditional activities to confer relaxation and rejuvenation</td>
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<td>DATA AND EVALUATION CHALLENGES &amp; SOLUTIONS</td>
<td>X</td>
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<tr>
<td>Lack of Locally Trained Evaluators</td>
<td>• Hired evaluators with strong trust/respect capacity who would engage local staff and community stakeholders in data-instrument adaptation and interpretation</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Distrust in Assessments</td>
<td>• Comprehensive community-level efforts to explain purpose and potential benefits of research</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Placed emphasis on strengths of assessments and showing if “home visitors” were doing job well vs. measuring clients’ characteristics</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Assessment Burden</td>
<td>• Concerted efforts at data reduction</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>• Used different staff than home visitors to collect outcomes data</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Used Automated Computer Assisted Self-Interview (ASCAI) technology</td>
<td>X</td>
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</tbody>
</table>

greatest benefit in low-income, high-disparity populations. Further, the resulting innovations may prove more culturally appropriate, cost-effective, and efficient than are the original home-visiting models and delivery structures. Finally, given the promise of frugal innovation, opportunities for ground-up development of new home-visiting models by and for tribal communities may prove a wise investment for funders and policy makers.

REFERENCES


