Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment

Building Infrastructure to Support Home Visiting to Prevent Child Maltreatment: Two-Year Findings from the Cross-Site Evaluation of the Supporting Evidence-Based Home Visiting Initiative

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Chapin Hall at the University of Chicago

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Evidence- Based Home Visiting Grantees

Grantee	Project Director as of fall 2010
County of Solano Department of Health and Social Services, California	Linda Orrante and Barbara Navolanic
Rady Children's Hospital, San Diego, California	Charles Wilson and Cambria Rose Walsh
Colorado Judicial Department	Lilas Rajaee-Moore
Children & Families First, Delaware	Leslie Newman
Hawaii Department of Health	Tod Robertson
Illinois Department of Human Services	Michael Holmes and Elizabeth Glassgow
Minnesota Department of Health	Laurel Briske
New Jersey Department of Children and Families	Sunday Gustin
Society for the Prevention and Care of Children, Rochester, New York	Laurie Valentine
Mercy St. Vincent Medical Center, Toledo, Ohio	Connie Cameron
The University of Oklahoma Health Sciences Center	Jane Silovsky
Rhode Island Kids Count	Leanne Barrett
The Children's Trust Fund of South Carolina	Ann Maletic
Child & Family Tennessee	Kathy Hatfield
Le Bonheur Community Health and Well-Being, Memphis, Tennessee	Ruth Hamblen
DePelchin Children's Center, Texas	Charity Eams and Stacey Clettenburg
Utah Department of Health	Robyn Lipkowitz

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EXECUTIVE SUMMARY

The Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment (EBHV) initiative is designed to build knowledge about how to build the infrastructure and service delivery systems necessary to implement, scale-up, and sustain evidence-based home visiting program models as a strategy to prevent child maltreatment.[1] The grantee cluster, funded by the Children's Bureau (CB) within the Administration for Children and Families (ACF) at the U.S. Department of Health and Human Services, includes 17 diverse grantees from 15 states. Each grantee selected one or more home visiting models it planned to implement for the first time in its state or community (new implementers) or to enhance, adapt for new target populations, or expand. To support the implementation of home visiting with fidelity to their evidence-based models and help ensure their long-term sustainability, the grantees are developing infrastructure such as identifying funding streams and establishing strategies for developing and supporting the home visiting workforce. The EBHV grantees must conduct local evaluations to assess implementation, outcomes, and costs associated with their selected home visiting models.

The national cross-site evaluation, conducted by Mathematica Policy Research and its partner, Chapin Hall at the University of Chicago, is designed to identify successful strategies for building infrastructure to implement or support the grantee-selected home visiting models (Koball et al. 2009). This report describes cross-site findings from the first two years of the initiative (fiscal years 2008–2010), including the planning period and early implementation of the grantee-selected home visiting models. The report primarily addresses four questions:

1. What was the state or local context with respect to home visiting as EBHV grantees planned and implemented their projects?
2. What partnerships did grantees form to support planning and early implementation of new home visiting programs?
3. What infrastructure was needed to implement home visiting program models in the early stages of the EBHV grant?
4. How did EBHV grantees and their associated home visiting implementing agencies (IAs) prepare for and implement new home visiting programs?

To answer these questions, the Mathematica-Chapin Hall team conducted site visits to ten grantees that could provide in-depth data on state-level implementation, the initiation of home visiting services, and/or infrastructure development to support home visiting. During site visits, researchers conducted interviews with grantee staff, partners contributing to infrastructure development, and a manager of a participating IA. For six of the site visits, researchers also conducted interviews with home visitors and their supervisors from IAs working with grantees providing new home visiting services. We also conducted a survey of representatives from partner organizations working with each of the 17 grantees. The survey used social network measures and

[1] Beyond preventing child maltreatment, home visiting programs target other short- and longer-term outcomes, such as (1) the quality of the parent-child relationship and attachment, (2) children's school readiness, (3) women's prenatal health, and/or (4) safety of the home environment (Bilukha et al. 2005; Gomby 2005; Olds et al. 2004; Olds et al. 2007; Sweet and Appelbaum 2004; Prinz et al. 2009).

measures of the quality of collaboration to examine the relationships among grantees' partners. It provided insight on how home visiting systems develop, the barriers to creating a system, and the patterns of communication and collaboration.

A. The Supporting Evidence- Based Home Visiting Grant Program

The EBHV initiative includes three unique features:

1. The EBHV grant was not intended to fund direct home visiting services. Rather, it was intended to help grantees build infrastructure to support evidence-based home visiting programs. To fund implementation of their selected home visiting models, grantees are to leverage their grants with other funding sources. To leverage funds, grantees partnered with ongoing home visiting programs or leveraged other sources to fund home visiting in cooperation with EBHV.
2. EBHV is a five-year initiative, with the first year devoted to planning and the remaining four years focused on implementation.
3. Each grantee is required to conduct process, outcome, and economic evaluations. Grantees identified local evaluators to conduct the evaluations.

In addition to these unique features, a number of external factors affected the EBHV grantees and the direction of the initiative. In December 2007, the United States entered a recession. The economic situation made it more challenging for the grantees to raise the funds needed for direct service and required many grantees to expend significantly more time and resources to raise those funds than originally anticipated. Then, in December 2009, CB/ACF announced to the grantees that funding for EBHV had been deleted from the federal budget after federal fiscal year (FY) 2009. Whether the funds might be replaced was unclear, leading to a period of uncertainty for the grantees.

The funding uncertainty affected two aspects of implementation and local and cross-site evaluations. First, although the EBHV funds were not meant to pay directly for home visiting services, most grantees had obtained support from their partners for implementation based on receiving EBHV grant funds. For many grantees, the potential funding changes disrupted their relationships with partners and hence threatened that leveraged financial support. Thus, some grantees revised their plans for implementing home visiting services. Depending on the grantee, these revisions might have included scaling back or delaying EBHV activities or home visiting operations to conserve resources for continued implementation in future years. Some grantees also found new partners willing to contribute funding to fill possible gaps. Second, grantees revised their evaluation plans to account for changes in planned home visiting operations and to further conserve resources. CB/ACF asked grantees to maintain their local evaluations, but allowed grantees flexibility in their scope and designs in light of decreased funding.

As the EBHV grantees addressed the funding cuts, health care reform was being debated. Proposed legislation included a national home visiting program that would provide federal funding to each state. Following passage of the Affordable Health Care Act of 2010 (P.L. 111-148) on March 23, 2010, the Health Resources and Services Administration (HRSA) and ACF, both at the U.S. Department of Health and Human Services, jointly announced the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, which began in FY 2010. The program aims to further the development of comprehensive statewide early childhood systems that emphasize the provision of health, development, early learning, child abuse and neglect prevention, and family

support services for at-risk children through the receipt of home visiting services. HRSA is the lead agency for the new national home visiting program and it is working collaboratively with ACF and other federal partners. HRSA and ACF announced that state funding would be determined through a formula that included supplemental funding if the state had received an EBHV grant in 2008. As long as their state applied for funding, EBHV grantees would have the resources to implement their original plans.[2]

B. The EBHV Grantees

The 17 EBHV grantees are geographically diverse, representing 15 states (Table 1). Of the grantees, most are private, nonprofit organizations or state agencies. Grantees are implementing five different models (Healthy Families America, Nurse-Family Partnership (NFP), Parents as Teachers, SafeCare, and Triple P); most grantees are implementing one model, but three grantees are implementing multiple models. The grantees work within diverse organizational settings to support the implementation of the home visiting models. Seven grantees are the IAs implementing their selected home visiting model; six grantees contract or partner with one or more IAs to deliver services; and four grantees are state agencies managing statewide home visiting initiatives. Ten EBHV grantees are newly implementing their selected home visiting models; the other seven grantees are building infrastructure to support existing programs or expanding implementation to new geographic areas or target populations.

C. The State and Local Context for Home Visiting

Nearly all grantees described rising levels of enthusiasm at the state and local levels for evidence-based home visiting. Clearly, the expectation of MIECHV in part drove this interest. Several grantees, however, reported that interest in evidence-based home visiting models preceded the new legislation and stemmed from recommendations to implement evidence-based models made by state-appointed committees and other state and local entities working to examine strategies to reduce child abuse and/or improve other child outcomes. Grantees and their partners attributed this swell of interest to two factors: (1) the need to decide which programs to fund during a period of diminishing state and local budgets, and (2) high expectations about the promise of evidence-based models to achieve outcomes. Officials preferred to use their limited resources to support programs that had shown effectiveness in achieving outcomes, rather than programs without existing evidence.

In all 15 states in which the EBHV grantees are located, grantee staff and their partners identified at least one home visiting model that was already in operation. Although at least 13 of the 15 states had implemented one or more national models before 2008, including some that were chosen for implementation by EBHV grantees, fidelity to program models may not have been assured. Several states with EBHV grantees had passed legislation that either mandated the

[2] Funding for MIECHV would be distributed to states using a formula determined by (1) an equal base allocation for each state; (2) an amount equal to the funds, if any, currently provided to a state or entity within that state under the EBHV program; and (3) an amount based on the number of children in families at or below 100 percent of the federal poverty level in the state as compared to the number of such children nationally. Thus 15 states with EBHV grantees would pass funds to those grantees (source: funding announcement [http://apply07.grants.gov/apply/opportunities/instructions/oppHRSA-10-275-cfda93.505-cid4513-instructions.doc] accessed June 11, 2010).

Table 1. EBHV Grantees' Characteristics and Implementation Status as of Spring 2010

State	Grantee	Grantee Type	Organizational Role of Grantee	Program Model	Implementation Status
CA	County of Solano Department of Health and Social Services	County agency	IA	NFP	New
CA	Rady Children's Hospital, San Diego	Hospital (research center)	Partners with IA	SC	New
CO	Colorado Judicial Department	State agency	Partners with IA	SC	New
DE	Children & Families First	Private, nonprofit	IA	NFP	New
HI	Hawaii Department of Health	State agency	Partners with IA	HFA	Continuing
IL	Illinois Department of Human Services	State agency	Statewide manager	NFP	Continuing
				HFA	Continuing
				PAT	Continuing
MN	Minnesota Department of Health	State agency	Statewide manager	NFP	Expanding
NJ	New Jersey Department of Children and Families	State agency	Statewide manager	NFP	Expanding
				HFA	Continuing
				PAT	Expanding
NY	Society for the Protection and Care of Children, Rochester	Private, nonprofit	IA	PAT	Continuing
OH	Mercy St. Vincent Medical Center	Hospital (safety net)	IA	HFA	New
OK	The University of Oklahoma Health Sciences Center	University research center	Partners with IA	SC	Expanding
RI	Rhode Island KIDS COUNT	Private, nonprofit	Partners with IA	NFP	New
SC	The Children's Trust Fund of South Carolina	Private, nonprofit	Partners with IA	NFP	New
TN	Child & Family Tennessee	Private, nonprofit	IA	NFP	New
TN	Le Bonheur Community Health and Well-Being	Private, nonprofit	IA	NFP	New
TX	DePelchin Children's Center	Private, nonprofit	IA	Triple P	New
UT	Utah Department of Health	State agency	Statewide manager	HFA	Continuing
				NFP	Continuing

Source: Mathematica site visits and telephone interviews, spring 2010.

HFA = Healthy Families America; NFP = Nurse-Family Partnership; PAT = Parents as Teachers; SC = SafeCare.

early childhood objectives as a method for achieving desired outcomes. In addition to plans, several of the EBHV grantee states had funding streams in place to support home visiting. States tended to support home visiting through a line item in the budget (given to departments of health or lead Community-Based Child Abuse Prevention agencies) or by using Temporary Assistance for Needy Families (TANF) dollars.

Often related to the nascent (or in some cases well-established) interest in evidence-based home visiting models at the state level were collaborative activities grantees had engaged in over the years to establish the groundwork for bringing evidence-based models to their states or local communities. Most grantees explained that their work stemming from the EBHV grant built upon previous efforts to collaborate and partner with other agencies, in some cases over the course of many years. Other grantees relied on more recent efforts as they applied for the EBHV grant. A few grantees reported that, before the current EBHV grant, there was little contact with or coordination between their implementation and evaluation of a child abuse and neglect prevention program or created statewide

home visiting programs. Others had included home visiting in their statewide plans for addressing agencies and relevant state agencies, despite the state's indicating support of the EBHV grant application.

D. Focus of the Planning Period

EBHV grantees engaged in intensive planning activities both during the grant application process and the initial planning year of the initiative. Grantees new to implementing their selected home visiting model reported focusing on three areas related to funding and operating home visiting services: (1) engaging funders and planning for sustainability, (2) selecting IAs to provide direct home visiting services, and (3) developing partnerships in the communities in which they were to implement services. In contrast, grantees that were enhancing or expanding an existing model focused on the following planning activities related to systems enhancements:

- Training to enhance the quality of existing home visiting programs and a statewide structure of collaboration
- Adapting selected program models to serve families in tribal communities, Latino families, and other groups
- Developing a central intake and referral system based on a common risk assessment tool
- Developing a data management system to support continuous improvement
- Developing a data system to support programs and track home visiting activities in the state

Grantees described three main types of collaboration activities they carried out (not all grantees used all three activities). First, they developed partnerships at both the community and state levels to build support for the EBHV initiative among a range of local and state service provider and advocacy organizations. Second, they formed partnerships with local foundations, state agencies, and other potential funders to support the sustainability of their selected home visiting model. Third, they built partnerships to facilitate referrals to home visiting programs, reinforce the use of common risk assessment and screening tools, and develop central intake and triage systems to support referrals to multiple home visiting programs within a single community. In addition to developing partnerships with individual organizations, most EBHV grantees also formed or participated in community or statewide collaborative groups.

E. Partnerships Formed by EBHV Grantees

During the first 18 months of the EBHV initiative, grantees tapped existing community- and state-level collaborative groups and partnerships and developed new partnerships and cross-agency steering committees, to help guide the planning process. All grantees partnered with at least one local or state agency, and most partnered with community-based service providers, national model purveyors, and universities.[3] Health care organizations were also common partners; eight grantees

[3] One development in the home visiting field is the transition from locally developed, mostly ad-hoc home visiting approaches to those developed by academic researchers and their program partners, some of whom have established implementation support for their models on a national level—hence the term "national models." The purveyor is the

partnered with a hospital, four with another type of health care organization, and one with a health plan. Community-based service providers, hospitals, other health care organizations, and other nonprofits worked in partnership with EBHV grantees. Local or state agencies, universities, and foundations also collaborated with grantees, along with national model purveyors.

F. Infrastructure to Support Evidence- Based Home Visiting Programs

Effective evidence-based programs depend on different kinds of infrastructure capacities, such as establishing lasting relationships between home visitors and families, having well-trained and culturally competent staff, providing high quality supervision, coordinating home visiting services and referral processes, and maintaining other external resources and supports (Daro 2006). Capacity is defined as "the skills, motivation, knowledge, and attitudes necessary to implement innovations" that exist at the individual, organizational, and community levels (Wandersman et al. 2006). Though their chosen area of emphasis differs, EBHV grantees are aiming to build infrastructure capacity in eight areas: (1) planning, (2) collaboration, (3) operations, (4) workforce development, (5) fiscal support, (6) community and political support, (7) communications, and (8) evaluation.

In addition to enhancing their planning and collaborations as described in Section E, each of the EBHV grantees and their partners reported working on most, if not all, of six other areas of infrastructure development, but their activities depended on their situations—which vary in the following important ways.

- Grantees starting new home visiting programs reported focusing on building organization-level operational and workforce development-related infrastructure. This included recruiting and hiring a qualified workforce, training and certifying staff and supervisors as home visitors and coaches, and obtaining approval from their national program model purveyors to start their operations.
- Grantees with existing home visiting programs tended to focus efforts on developing statewide assessment, referral, intake, training, or evaluation-related data systems. They are actively building infrastructure at both the organizational and state levels.
- Some grantees are state agencies in states with no direct management of home visiting programs. These grantees are building broad-based systems to provide training, coaching, operational technical assistance, evaluation, and ongoing funding streams to support local home visiting services.
- In a number of areas, particularly in communications and evaluation, grantees reported doing less infrastructure development than originally planned. These activities were reprioritized in part to align with changes in local, state, and federal economic circumstances, which affected public and private funding streams and sources.
- Due to uncertainty as to whether the EBHV initiative funding would continue after September 2010, during 2010 grantees focused considerably more attention than they

(continued)
person or organization that gives permission to use the model and provides training, materials, or infrastructure (such as data bases) required to implement it; may or may not be the same person or organization that developed the model.

had originally planned on building fiscal capacity to preserve their grant activities and continue their programs in both the short and long term.

- Based on their work so far, grantees described a number of barriers to their infrastructure-building work. They faced difficulties (1) building fiscal support given economic constraints, (2) building political support when many local and state governments were looking to cut support to social support programs, (3) justifying the need for a continuum of home visiting services, and (4) addressing concerns about local evaluation plans. To overcome these barriers, grantees devised various approaches, most of which relied on building strong partnerships with diverse stakeholders.

G. Beginning New Home Visiting Models

Home visiting operations for all grantees were affected by the economic downturn, the resulting fiscal stress on states, and the disruption in EBHV grant funding. These factors delayed implementation of home visiting services in some sites. Many grantees and implementing agencies—but not all—had to slow down their plans, found enrollment lagging behind their initial projections, or even saw home visiting services shrink due to funding cuts. Delays also occurred because planning and/or application processes for national model accreditation took longer than anticipated.

Despite these challenges, most grantees that planned to implement a model for the first time successfully launched program operations. They worked with program model purveyors, hired and trained staff, and began conducting home visiting with new enrollees. Their experiences provide useful insights about implementing evidence-based home visiting programs, especially hiring and supporting staff, and suggest lessons for EBHV grantees or others planning to operate similar programs.

1. Working with Model Purveyors

All five of the home visiting program models implemented under the EBHV initiative had requirements in place for new agencies wishing to implement their models, or for expanding models to new locations. Some grantees and IA managers described the accreditation process required by their model purveyors as time consuming. However, they also reported that aspects of the detailed process ultimately ensured fuller preparation for implementation, by making sure that they had addressed a range of issues well before implementation began.

In addition to working with model purveyors to meet accreditation requirements, organizations may need to work on their own and with purveyors to adapt or enhance models to new target populations. Two of the 17 EBHV grantees focused their grant activities on adapting or enhancing the home visiting models they selected for new target populations. Both were expanding their selected models: Minnesota was planning to expand NFP to tribal communities within the state, and Oklahoma aimed to implement a culturally competent model of SafeCare within Latino communities in Oklahoma City.

Along with establishing requirements, purveyors of home visiting models also provided important assistance and supports to grantees and IAs. In addition to the initial training they received on program models, staff reported during interviews that the purveyors offered additional training and support on a range of topics, assigned a consultant or regional representative to provide technical assistance, assisted with logistical issues, and helped resolve technology and infrastructure issues such as downloading materials from the program model's website.

2. Staffing Home Visiting Programs

The home visiting models selected by EBHV grantees vary in their educational requirements, for home visitors with some models' requiring home visitors with at least a bachelors' degree and others not specifying minimum educational requirements for staff. In addition to these requirements, EBHV grantees and IAs described going beyond model requirements and seeking candidates with prior experience and other professional characteristics and skills they deemed important. They reported seeking candidates who were comfortable working with families with many needs, hard working, passionate about the work, and could work independently while being comfortable receiving supervisory feedback. Finding home visitors who met all these criteria was not always a simple task. Three main challenges emerged:

- **Finding bilingual home visitors.** Several agencies were unable to locate bilingual candidates. In an effort to address this challenge, one agency worked closely with NFP's national service office. The agency hired a dedicated, full-time interpreter who accompanied the home visitors into homes where English was not the primary language spoken by the family. The interpreter completed all NFP required trainings and also received training designed to help the interpreter learn to facilitate rather than triangulate the relationship between the nurses and the families.
- **Identifying culturally competent home visitors.** In an effort to match home visitors with the populations the program served, IAs tried to identify racially or ethnically diverse candidates who were familiar with the cultural background of their target population. Agencies noted that, even when they could identify someone who spoke the language, it did not mean that the individual was culturally competent.
- **Salary competition.** Several agencies, particularly those implementing NFP, spoke about salary competition from other employers, such as hospitals that could offer nurses a higher salary than IAs could offer nurse home visitors.

3. Training Staff

In order to begin serving families, all of the models selected by EBHV grantees require that home visitors and supervisors complete initial training or a series of trainings provided by the model purveyor. Such staff training is a component of the accreditation process and typically involves one or more three- to five-day workshops. Supervisors must complete the training required of home visitors, plus additional training or post-training consultation specifically focused on supervision.

Participants we interviewed expressed satisfaction with training. That said, some supervisors and home visitors felt that the trainings focused too heavily on the theory of the model and less on the realities of conducting home visits and delivering the curriculum. In addition, the cost and time associated with required training need to be factored in when planning to implement models. Supervisors described the main challenges of the initial trainings as (1) the costs associated with sending staff to training, (2) the time needed to train new staff, and (3) resistance from some staff to structured training (and to supervision). Supervisors described the first two challenges as particularly difficult to address when dealing with staff turnover.

4. Conducting Home Visits

The rewards to the home visitor can be many. Those we interviewed described their joy in building strong relationships with families, and feeling encouraged when families made positive

changes. Home visitors enjoyed observing parents using behaviors with their children that home visitors had shown them in previous visits. They also reported increasing security in a home, increasing healthy birth outcomes for pregnant women, and elevating parenting skills as important successes of their work. Along with these rewards, the home visitors we interviewed also reported facing challenges in their work—some unique to home visiting or stemming from special requirements for program models. They cited the following challenges:

- Managing multiple responsibilities, including preparing for visits and completing paperwork
- Completing the number of home visits required by each program model
- Balancing the amount of time spent during home visits managing issues faced by the family and delivering the curriculum
- Addressing crises that families were experiencing, and dealing with distractions caused by other children in the home
- Overcoming client resistance to new ideas and changing behavior

5. The Role of Supervision

Supervision is an important support to help home visitors cope with the challenges that come with their jobs, along with a way to monitor fidelity to evidence-based models. Supervisors for some home visiting models reported providing one-on-one supervision as well as group meetings with home visitors, to help them meet the needs of families on their caseloads. Some used "reflective supervision" (exploring the home visitor's experiences with families and children, reflecting on their feelings and behaviors related to home visits, and discussing both personal and professional responses to families' situations) to support home visitors in building relationships with families.

To help ensure model fidelity, supervisors review documentation and case files and meet with home visitors to discuss whether they are able to meet with families at the frequency intended and cover the content as outlined in the model. Supervisors periodically conduct home visits with staff and/or review audio recordings of visits, in order to assess home visitors' adherence to dynamic aspects of the models such as whether home visitors are delivering services and interacting with families in the manner intended. Supervisors also used administrative data to assess fidelity and to better understand how home visitors worked with families. Program data (such as on the characteristics of families and the frequency of home visits), case notes, and their observations in the field enabled supervisors to identify families home visitors might be struggling to reach and ensure that home visitors were implementing the models as planned. Operational problems commonly identified by supervisors through these methods included (1) families who frequently canceled visits, (2) families who frequently received longer-than-expected visits, and (3) home visitors who did not complete required paperwork within specified timeframes or who completed documentation incorrectly.

Such intensive supervision can present logistical challenges, and may not be welcomed by all home visitors. Supervisors and home visitors were not always able to conduct supervision as frequently as planned, largely because either the home visitors needed to use the time to meet with a client or the supervisors had to work on other managerial tasks. Some staff members were unaccustomed to being shadowed and/or expected to participate in weekly supervision, so they were resistant to this level of oversight, at least initially. Nevertheless, the home visitors we interviewed

during site visits overwhelmingly reported feeling supported by their supervisors. Regardless of model, the home visitors said their supervisors were approachable and found it easy to talk with them.

H. Looking Forward

In June 2010, the Children's Bureau informed its EBHV grantees that, through a coordinated effort between CB/ACF and HRSA, funds from MIECHV would be used to restore funding to EBHV grantees.[4] By fall 2010, EBHV grantees were making necessary arrangements to obtain the funding and looking forward to continuing their grant-related operations through the original five-year timeline of the grant program, slated to end in September 2013. In October 2010, we had the opportunity to obtain updated information from the grantees on (1) how, if at all, they were working with their state MIECHV lead agency to integrate EBHV grant activities with emerging state home visiting agendas, (2) the status of implementation of home visiting services associated with EBHV grant activities, and (3) revisions they had made to their local evaluation plans, particularly their efforts to reinstate family and child outcome studies. Grantees reported the following:

- ***Coordination with MIECHV.*** In South Carolina, the EBHV grantee—The Children's Trust Fund—became the lead agency. In Hawaii, Illinois, Minnesota, and Utah, state agencies that had received the EBHV grant also became the MIECHV lead agency. Five other grantees had pre-existing relationships with their states' MIECHV lead agencies. As of October 2010, the other seven grantees had contacted and begun working with their states' lead agencies.
- ***Implementation status***. By October home visiting operations had begun or continued in all 15 sites where grantees had planned to implement home visiting or study outcomes in existing programs as part of their EBHV grant-related activities. Despite some delays in staffing programs and enrollment, families had been enrolled in home visiting.
- ***Local family and child outcome evaluations.*** Differences between the expected and actual pace of enrollment in home visiting reduced the number of families who could participate in local family and child outcome evaluations, so by October some grantees had to re-think their original plans. In some sites, enrollment in home visiting programs included in the evaluation proceeded more slowly than hoped, for a variety of reasons. Delays in staffing their home visiting programs required IAs to delay enrolling participants until home visiting and supervisor positions could be filled. Referral processes in some sites needed time to stabilize. These delays shrunk sample sizes or made it more difficult for evaluators to collect follow-up data over as long a time period as specified in their evaluation plans. In other sites, enrollment in the home visiting programs moved forward while the evaluation was delayed (often due to the disruptions in the EBHV funding). As a result, programs were reaching capacity, leaving few families eligible to participate in the evaluation.
- ***Other local evaluation components.*** As required by CB/ACF and specified in the original grant announcement, process and economic evaluations (cost, cost-effectiveness,

[4] Funding announcement [http://apply07.grants.gov/apply/opportunities/instructions/oppHRSA-10-275-cfda93.505-cid4513-instructions.doc] accessed June 11, 2010.

or cost-benefit studies) were also required as part of the EBHV initiative. By October 2010, local evaluators from nearly all grantees had begun or were about to begin these study components.

I. Next Steps for the Cross- Site Evaluation

A main focus for the cross-site evaluation team in year 3 of the EBHV grant (FY 2010) will be providing technical assistance to help grantees launch and conduct their outcome evaluations. In addition to providing one-on-one assistance as requested by individual grantees and/or local evaluators, we will also complete and disseminate training materials on core child and family outcome measures planned for collection and use in local outcome evaluations. Liaisons working with each grantee will also monitor study enrollment and provide advice as needed on retaining and locating study members for data collection or other operational issues important for completing planned local evaluations. The team will work with grantees and evaluators on developing local evaluation reports that contribute information on program impacts, implementation, model adaptations, or other relevant topics that can contribute to existing knowledge and literature on home visiting and maltreatment prevention.

Mathematica will collect updated information on the infrastructure-building goals and activities of each grantee in late spring 2011, as part of the system change dimension of the cross-site evaluation. Mathematica will issue a report based on this information in fall 2011. In addition, a second wave of the EBHV Grantee Partner Survey will be administered in FY 2011.

I. BACKGROUND AND STATE CONTEXT

The Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment (EBHV) initiative is designed to gather knowledge about how to build the infrastructure and service delivery systems necessary to implement, scale up, and sustain evidence-based home visiting program models as a strategy to prevent child maltreatment.[1] The grantee cluster, funded by the Children's Bureau (CB) within the Administration for Children and Families (ACF) at the U.S. Department of Health and Human Services, includes 17 diverse grantees from 15 states. Each grantee selected one or more home visiting models it planned to implement for the first time in its state or community (new implementers) or to enhance, adapt, or expand. To support the implementation of home visiting with fidelity to their models and help ensure their long-term sustainability, the grantees are developing infrastructure such as identifying funding streams and establishing strategies for developing and supporting the home visiting. The EBHV grantees must conduct local evaluations to assess implementation, outcomes, and costs associated with their selected home visiting models.

The national cross-site evaluation, conducted by Mathematica Policy Research and its partner, Chapin Hall at the University of Chicago, is designed to identify successful strategies for supporting the adoption, implementation, scale-up, and sustainability of grantee-selected home visiting models (Koball et al. 2009). This report describes cross-site findings from the first two years of the grant initiative (federal fiscal years [FY] 2008 and 2009), including the planning period and early implementation of the grantee-selected home visiting models. The report primarily addresses four questions:

- What was the state or local context with respect to home visiting as EBHV grantees planned and implemented their projects?
- What partnerships did grantees form to support planning and early implementation of new grantee-selected home visiting models?
- What infrastructure was needed to implement grantee-selected home visiting models in the early stages of the EBHV initiative?
- How did EBHV grantees and their associated home visiting implementing agencies (IAs) prepare for and implement new grantee-selected home visiting program models?

This chapter describes the EBHV initiative, its grantees, and their state contexts. It provides an overview of the evaluation design and identifies the data sources used to develop the report.

A. The EBHV Initiative

In an effort to prevent child maltreatment, nearly all states have adopted state-based home visiting programs (Johnson 2009). Many states and other stakeholders have expressed interest in or

[1] Beyond preventing child maltreatment, home visiting programs target other short- and longer-term outcomes, such as (1) the quality of the parent-child relationship and attachment, (2) children's school readiness, (3) women's prenatal health, and/or (4) safety of the home environment (Bilukha et al. 2005; Gomby 2005; Olds et al. 2004; Olds et al. 2007; Sweet and Appelbaum 2004; Prinz et al. 2009).

already begun replicating home visiting program models that have shown promise of improving short- and longer-term outcomes for families. With the increased emphasis by government and private funders on identifying evidence-based program models and practices, equal attention also must be paid to system-level mechanisms and supports needed for the successful dissemination of research-based program models and their adoption and implementation.

Interventions cannot be fully successful without taking into account the systems in which families are served (Foster-Fishman et al. 2007). Service delivery systems are important because they define who will be served and how they will receive services. Furthermore, systems define how services will be funded, monitored, and staffed. For home visiting interventions to have the greatest effects possible, the systems in which they operate must be integrated, supportive, and conducive to service delivery. Knowledge is needed about how to build the infrastructure and service systems necessary to implement and sustain evidence-based home visiting program models with fidelity to their models, and whether and how to scale up these program models and adapt them for new target populations. Over the past several years, state health and human services officials have demonstrated an interest in implementing evidence-based program models and practices, but limited resources have constrained their ability to develop the knowledge base of how such programs can fit within service delivery systems.

To support development of the infrastructure needed for the high quality implementation of grantee-selected home visiting models to prevent child maltreatment, CB/ACF funded 17 cooperative agreements in 2008.[2] The EBHV initiative includes three unique features:

1. The EBHV grant was not intended to fund direct home visiting services. Rather, grantees are to leverage their grants with other funding sources to operate their selected home visiting models. To leverage funds, grantees partnered with ongoing home visiting programs or leveraged other sources to fund home visiting in cooperation with EBHV.
2. EBHV is a five-year initiative with the first year devoted to planning and the remaining four years focused on implementation.
3. Each grantee is required to conduct process, outcome, and economic evaluations. Grantees identified local evaluators to conduct the evaluations.

In addition to these unique features, during the first year of the initiative (FY 2008) a number of external factors affected the EBHV grantees and the direction of the grant program. In December 2007, the United States entered a recession. The recession hit states hard. Revenues fell and the growth of state spending slowed in most states during FY 2008. By December 2009, a survey of state budget officers reported, "States are currently facing one of the worst, if not the worst, fiscal periods since the Great Depression" (National Governors Association and National Association of

[2] The summer 2008 federal grant announcement required applicants to select home visiting programs that met specified criteria so as to be considered an evidence-based model. For a summary of the specified criteria, see Appendix A. During the grant review process, an independent panel of peer reviewers evaluated applications based on the criteria listed in the announcement to determine if the program(s) proposed by the applicant met standards related to evidence-based models. The criteria used in the 2008 federal grant announcement were in no way related to the criteria for evidence of effectiveness for the *Maternal, Infant, and Early Childhood Home Visiting Program* included in the Affordable Health Care Act of 2010 (P.L. 111-148).

State Budget Officers 2009). The grantees faced state and local budget cuts and fewer funding opportunities through foundations (many of which had greatly diminished endowments) and private funders. The economic situation made it more challenging for the grantees to raise the funds needed for direct services and required many grantees to expend significantly more time and resources to raise those funds than originally anticipated.

Then, in December 2009, CB/ACF announced to the grantees that funding for the EBHV initiative had been deleted from the federal budget after FY 2009—perhaps due to error or to the expectation that other federal funds to support home visiting might become available. Whether the funds might be replaced was unclear, leading to a period of uncertainty for the grantees.

The funding uncertainty affected two aspects of implementation and local and cross-site evaluation. First, although the EBHV funds were not meant to pay directly for home visiting services, most grantees had leveraged support from their partners for implementation based on receiving EBHV grant funds. For many grantees, the potential funding changes disrupted their relationships with partners and hence threatened that leveraged financial support. Thus, some grantees revised their plans for implementing home visiting services. Depending on the grantee, these revisions might have included scaling back or delaying EBHV activities or home visiting operations to conserve resources for continued implementation in future years. Some grantees also found new partners to fill possible funding gaps. Second, grantees revised their evaluation plans to account for changes in planned home visiting operations to further conserve resources. CB/ACF asked grantees to maintain their local evaluations, but allowed grantees flexibility in their scope and designs in light of decreased funding.

As the EBHV grantees addressed the funding cuts in an already tight economy, health care reform was being debated. Proposed legislation included a national home visiting program that would provide federal funding to each state. Following passage of the Affordable Health Care Act of 2010 (P.L. 111-148), March 23, 2010, the Health Resources and Services Administration (HRSA) and ACF, both at the U.S. Department of Health and Human Services, jointly announced the *Maternal, Infant, and Early Childhood Home Visiting Program* (MIECHV)*,* which began in FY 2010. MEICHV aims to further the development of comprehensive statewide early childhood systems that emphasize the provision of health, development, early learning, child abuse and neglect prevention, and family support services for at-risk children through the receipt of home visiting services. HRSA, the lead agency for the new national home visiting program, is working collaboratively with ACF and other federal partners. HRSA and ACF announced that state funding would be determined through a formula that included supplemental funding if the state had received an EBHV grant in 2008. As long as their state applied for funding, EBHV grantees would have the resources to implement their original plans.[3]

[3] Funding for MIECHV would be distributed to states using a formula determined by (1) an equal base allocation for each state; (2) an amount equal to the funds, if any, currently provided to a state or entity within that state under the EBHV program; and (3) an amount based on the number of children in families at or below 100 percent of the federal poverty level in the state as compared to the number of such children nationally. Thus 15 states with EBHV grantees would pass funds to those grantees (source: funding announcement [http://apply07.grants.gov/apply/opportunities/instructions/oppHRSA-10-275-cfda93.505-cid4513-instructions.doc] accessed June 11, 2010).

B. The EBHV Grantees

The 17 EBHV grantees are geographically diverse, representing 15 states. Of the grantees, most are private, nonprofit organizations (7) or state agencies (6) (Table I.1). Grantees are implementing five different home visiting models; most are implementing one model, but three grantees are implementing multiple models (see Table I.1). The grantees work within diverse organizational settings to support the implementation of the home visiting models. Seven grantees are the IA implementing their selected home visiting model; six grantees contract or partner with one or more IAs to deliver services; and four grantees are state agencies managing statewide home visiting initiatives. Ten EBHV grantees are newly implementing their selected home visiting models; the other seven grantees are continuing to implement existing programs or expanding implementation to new geographic areas or target populations.

Table I.1. EBHV Grantees' Characteristics and Implementation Status as of Spring 2010

State	Grantee	Grantee Type	Organizational Role of Grantee	Program Model	Implementation Status
CA	County of Solano Department of Health and Social Services	County agency	IA	NFP	New
CA	Rady Children's Hospital, San Diego	Hospital (research center)	Partners with IA	SC	New
CO	Colorado Judicial Department	State agency	Partners with IA	SC	New
DE	Children & Families First	Private, nonprofit	IA	NFP	New
HI	Hawaii Department of Health	State agency	Partners with IA	HFA	Continuing
IL	Illinois Department of Human Services	State agency	Statewide manager	NFP	Continuing
				HFA	Continuing
				PAT	Continuing
MN	Minnesota Department of Health	State agency	Statewide manager	NFP	Expanding
NJ	New Jersey Department of Children and Families	State agency	Statewide manager	NFP	Expanding
				HFA	Continuing
				PAT	Expanding
NY	Society for the Protection and Care of Children, Rochester	Private, nonprofit	IA and partners with another IA	PAT	Continuing
				NFP	Continuing
OH	Mercy St. Vincent Medical Center	Hospital (safety net)	IA	HFA	New
OK	The University of Oklahoma Health Sciences Center	University research center	Partners with IA	SC	Expanding
RI	Rhode Island KIDS COUNT	Private, nonprofit	Partners with IA	NFP	New
SC	The Children's Trust Fund of South Carolina	Private, nonprofit	Partners with IA	NFP	New
TN	Child & Family Tennessee	Private, nonprofit	IA	NFP	New
TN	Le Bonheur Community Health and Well-Being	Private, nonprofit	IA	NFP	New
TX	DePelchin Children's Center	Private, nonprofit	IA	Triple P	New
UT	Utah Department of Health	State agency	Statewide manager	HFA	Continuing
				NFP	Continuing

Source: Mathematica site visits and telephone interviews, spring 2010.

HFA = Healthy Families America; NFP = Nurse-Family Partnership; PAT = Parents as Teachers; SC = SafeCare.

C. The Cross- Site Evaluation

The Mathematica-Chapin Hall team was contracted by CB/ACF to conduct a six-year national cross-site evaluation of the grantees' programs. The first year of the cross-site evaluation was a planning year and culminated in a report detailing the cross-site evaluation design (Koball et al. 2009). Just as the cross-site evaluation team was making plans to begin data collection, the funding cuts were announced by CB/ACF and the future of the EBHV initiative became uncertain. As a result, evaluation activities planned for FY 2009 were revised. Namely, the cross-site evaluation team revised its data collection plans for the baseline process and system domain studies by reducing the number of the site visits planned for spring 2010. Rather than visiting all 17 grantees, the cross-site evaluation team conducted site visits to 10 grantees.[4] With those grantees that did not participate in site visits, the cross-site evaluation team conducted telephone interviews with lead grantee staff. As planned, all 17 grantees participated in a partner survey.

The Mathematica-Chapin Hall team conducted site visits to grantees that could provide in-depth data on (1) state-level implementation, (2) the initiation of home visiting services, and/or (3) infrastructure development to support home visiting (Table I.2). During all site visits, researchers conducted interviews with grantee staff, partners contributing to infrastructure development, and a manager of an IA. During six site visits, researchers conducted interviews with home visitor supervisors and home visitors from IAs working with grantees providing new home visiting services.[5] For grantees working with more than one IA, we conducted interviews and discussions with only one agency per grantee.[6] The information provided by these IAs is not necessarily representative of all IAs, but rather provides a snapshot of the experiences of a selected group of agency managers, supervisors, and home visitors. (See Appendix B, Table B.2 for a summary of interview topics.)

We also conducted a survey of representatives from partner organizations working with each of the 17 grantees. The survey used social network analysis measures and measures of the quality of collaboration to examine the relationships among grantees' partners. It provides insight on the organizations that are part of child maltreatment home visiting systems, the barriers to creating a system, and the patterns of communication and collaboration. To identify the survey sample, each grantee identified up to 25 partners who had contributed to grant activities. Mathematica then sent surveys to each partner identified by the grantees. Partners typically included the grantee's relevant home visiting model purveyor, home visiting provider agencies, and key infrastructure building partners.[7]

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[4] In addition, Mathematica and Chapin Hall scheduled telephone interviews with a small number of grantees to obtain more in-depth information on certain of their experiences thought to be most pertinent to states and home visiting providers. Research briefs developed from these interviews discuss conducting state or community needs assessments (Paulsell and Coffee-Borden 2010), recruiting and training home visitors (Coffee-Borden and Paulsell 2010a), and supporting home visitors (Coffee-Borden and Paulsell 2010b).

[5] Of these six grantees, one had not yet hired home visitors or begun serving clients. During this site visit, we met with the home visitor supervisor only.

[6] To reduce the amount of travel required during site visits, Mathematica selected IAs located in closest proximity to the grantees.

[7] We plan to repeat the survey at least once during the remaining period of the grant, to examine changes over time.

Table I.2. EBHV Grantees' Participation in Spring 2010 Cross- Site Evaluation Activities

		Research Question(s) Addressed During Site Visits or Telephone Interviews			
Grantee	Site Visit	Question 1: State Context	Question 2: Infrastructure	Question 3: Implementing New Services	Telephone Interview
County of Solano Department of Health and Social Services, California					X
Rady Children's Hospital, San Diego, California	X	X	X	X	
Colorado Judicial Department	X	X	X	X	
Children & Families First, Delaware	X	X	X	X	
Hawaii Department of Health					X
Illinois Department of Human Services					X
Minnesota Department of Health	X	X	X		
New Jersey Department of Children and Families	X	X	X		
Society for the Protection and Care of Children, Rochester, New York					X
Mercy St. Vincent Medical Center, Toledo, Ohio					X
The University of Oklahoma Health Sciences Center	X		X		
Rhode Island KIDS COUNT	X	X	X	X	
The Children's Trust Fund of South Carolina	X	X	X	X	
Le Bonheur Community Health and Well-Being, Memphis, Tennessee	X		X	X	
Child & Family Tennessee					X
DePelchin Children's Center, Texas					X
Utah Department of Health	X	X	X		
	10	**8**	**10**	**6**	**7**

Source: Mathematica site visits and telephone interviews, spring 2010.

D. Organization of the Report

In the remainder of this report, we describe our findings from the site visits, telephone interviews, and partner survey. We begin below by describing the state or local context with respect to home visiting as EBHV grantees planned and implemented their projects. Chapter II then discusses the ways grantees planned and collaborated with other organizations to achieve common goals. In Chapter III, we describe how grantees used their planning and collaborative capacity to create new infrastructure and/or strengthen existing infrastructure. Chapter IV presents grantees' experiences hiring and training staff, recruiting and enrolling families, and conducting home visits. We conclude the report by summarizing where grantees stood at the close of the second year of the EBHV grant program including their next steps as EBHV grant funding was revived.

In each chapter, we highlight findings across all 17 EBHV grantees; however, given the way data collection was structured, some chapters of this report rely on different samples of grantees for more in-depth information and examples. Chapters II and III detail the experiences of the 10 grantees that participated in site visits. Chapter IV describes the experiences of the six grantees that participated in site visits and were implementing new home visiting services.

E. The State and Local Context for Home Visiting

Nearly all grantees described rising levels of enthusiasm at the state and local levels about evidence-based home visiting. Clearly, the expectation of MIECHV, authorized by Section 2951 of the Affordable Care Act of 2010 and signed into law in March 2010, in part drove this interest—but was not the only factor. Several grantees reported that growing interest in evidence-based home visiting models preceded the new legislation and stemmed from recommendations to implement evidence-based models made by state-appointed committees and other state and local entities working to examine strategies to reduce child abuse and/or improve other child outcomes.

Grantees and their partners attributed this swell of interest to two factors: (1) the need to decide which programs to fund during a period of diminishing state and local budgets, and (2) high expectations about the promise of evidence-based models to achieve outcomes. Officials preferred to use their limited resources to support programs that had shown effectiveness in achieving outcomes, rather than programs without existing evidence. As one grantee staff member said, "Policymakers and other funders have begun to ask 'Where's your evidence [of effectiveness]?'" Some interview participants reported that as *evidence-based* became a buzzword among state officials, they feared that legislators would expect a virtual guarantee of positive results without an understanding of the need to implement evidence-based models with fidelity.

1. Experience, Planning, and State Funding for Home Visiting

In all 15 states in which the EBHV grantees are located, grantee staff and their partners identified at least one national home visiting model that was already in operation. Although at least 13 of the 15 states had implemented one or more national models before 2008, including some that were chosen for implementation by EBHV grantees, fidelity to program models may not have been assured. Interviewees in three states remarked on changes their state had made to national models by expanding caseloads and/or compressing the length of intervention in order to serve more families.

Several states with EBHV grantees had passed legislation that either mandated the implementation and evaluation of a child abuse and neglect prevention program or created statewide

home visiting programs. Others had included home visiting in their statewide plans for addressing early childhood objectives as a method for achieving desired outcomes. Rhode Island's Early Childhood Comprehensive System plan calls for increasing effective, intensive, and comprehensive home visiting services for children and families with significant risk factors for poor developmental outcomes. The plan, published in 2005, had a goal of increasing home visiting services to Rhode Island families. Delaware also had an early childhood plan (2003) that established home visiting as a priority. The State Child Abuse Prevention Action Committee in Utah developed a plan in 2003–2004 for implementing evidence-based child abuse prevention services.

In addition to plans, several of the EBHV grantee states had funding streams in place to support home visiting. States tended to support home visiting through a line item in the budget (given to departments of health, or lead Community-Based Child Abuse Prevention [CBCAP] agencies) or by using Temporary Assistance for Needy Families (TANF) dollars. These existing funding streams benefited some grantees as they began their work:

- In 1998, voters in California passed Proposition 10, adding a 50-cent tax to each pack of cigarettes sold to create First 5 California, also known as the California Children and Families Commission. This statewide organization coordinates with First 5 commissions in all 58 counties in the state to improve the lives of children from prenatal care until the time they enter kindergarten. One of the ways First 5 has advanced its mission is through funding home visiting programs. One EBHV grantee, the County of Solano, Department of Health and Social Services, partners with and receives funding from the First 5 commission in Solano County. Additionally, the governor of California approved $98 million in FY 2007–2008 to support child abuse prevention and early intervention and treatment.

- Legislative partners working with the EBHV grantee in Oklahoma report that, for the past 10 years, the state has had a budget line item for home visiting, with SafeCare written into the Department of Human Services budget.

- Similarly, a line item in the Tennessee state budget provides funding to the Tennessee Department of Health for Nurse-Family Partnership (NFP) services in Shelby County. These funds support the EBHV grantees in Shelby County, through LeBonheur Community Health and Well-being.

- Minnesota funded its statewide home visiting program, Family Home Visiting, through TANF funds; the state passed legislation in 2007 to increase this funding.

2. Prior Collaborations Supporting Home Visiting

Often related to the nascent (or in some cases well-established) interest in evidence-based home visiting models at the state level were collaborative activities grantees had engaged in over the years to establish the groundwork for bringing evidence-based models to their states or local communities. Most grantees explained that their work stemming from the EBHV initiative built upon previous efforts to collaborate and partner with other agencies, in some cases over the course of many years. One grantee reported trying multiple times over the years to secure funding for the national home visiting model it is now implementing as part of the EBHV initiative, getting as far as gaining approval from the model purveyor as a new site before the funding fell through. Another grantee credited a state agency official with working for 10 years to bring their selected home visiting model to her state.

Other grantees relied on more recent efforts as they applied for the EBHV grant. One grantee wrote the grant application with the backing of a collaborative of local providers who in the past might have been competitors for the grant. About a year before publication of the EBHV grant announcement, these providers met to work on integrating services in their state. Through this process they developed a better understanding of the services each provided and the populations each targeted. When the announcement for the EBHV grant was released, the group decided to support the eventual grantee in the application. Grantees with prior collaboration efforts reported that the strength of those relationships was a real advantage to their work on the EBHV grant. They found they could build upon established partnerships, rather than starting from scratch. These relationships also helped serve as a buffer to inevitable disagreements among stakeholders and helped temper inclinations to protect one's own or an individual agency's interests.

Not all grantees began EBHV with this level of collaboration and support. A few grantees reported that, before the current EBHV initiative, there was little contact with or coordination between their agencies and relevant state agencies, despite the state indicating support for the EBHV application. The interview participants from these grantees credited the EBHV initiative as a catalyst for collaborative work and partnerships. The next chapter discusses planning and collaboration in more detail.

II. PLANNING AND COLLABORATION

The EBHV initiative is a system-building initiative with three main goals to: (1) implement, (2) scale-up, and/or (3) sustain grantee-selected home visiting models and maintain fidelity to the models, in order to reduce child maltreatment. To achieve these goals, grantees engaged in intensive planning activities during the grant application process and the initial planning year of the initiative. To support their planning and other system-building activities, they collaborated with existing community- and state-level groups and partnerships or developed new partnerships and cross-agency steering committees. Building capacity for such planning and collaboration—including by engaging partner organizations in the EBHV-related activities—was itself an important system-building goal for grantees.

Whether they were newly implementing or expanding their selected home visiting models, and whether they were operating within a community or statewide, EBHV grantees and their partners faced an ambitious agenda set by the EBHV initiative. This agenda required grantees to undertake activities at multiple levels of the home visiting infrastructure system, from supporting core program operations to engaging with national-level partners. Each level of the system is defined as follows (Hargreaves and Paulsell 2009).

Core Operations. This level includes provision of direct home visiting services, daily management of core home visiting services, and ground-level implementation.

Organizational Support. Core operations are carried out within organizations that establish administrative structures and processes to select, train, coach, and evaluate the performance of home visitors. The organizational support level includes administrative support for home visiting operations, external coordination with other local social service agencies, and organizational cultural elements such as leadership and staff commitment to the program.

Community. "Communities" may be cities, counties, or sub-regions of a state. Grant activities at the community level include developing local or county government partnerships, advocating for community resources, building community-level awareness and support for home visiting programs, and leveraging local funding sources.

State. At the state level, activities include developing regional or statewide awareness and support for home visiting programs; creating state-level political buy-in and support for expanding the program; leveraging funding for direct services; advocating for resources to preserve state fiscal support; and enacting legislative, regulatory, and policy changes.

National. National-level activities include participating in multistate learning collaboratives to support and spread evidence-based home visiting programs; supporting national research on effective service delivery; working with federal leaders, national model purveyors; building awareness and support for evidence-based home visiting programs among national-level policymakers and funders; and sharing information and disseminating findings.

For example, grantees must work at the core operations and organizational support levels to establish new programs and develop systems for hiring, training, supervising, and supporting home visitors. At the community and state levels, grantees must generate support for their selected home visiting models, establish referral sources, leverage public and private funding sources to support

direct services, and advocate for policies that support evidence-based models. At the national level, grantees work closely with CB/ACF, the national model purveyors, other EBHV grantees, and the cross-site evaluation team to share information and disseminate findings from the initiative.

This chapter describes the grantees' approaches to planning and collaboration during the grant application process and initial planning year. It explains the planning and collaboration goals established by grantees at the start of the planning year and activities undertaken. It also describes the range of partners grantees recruited to work with them on the EBHV initiative and the activities in which they engaged. Finally, it identifies challenges grantees and their partners experienced in their joint planning and collaboration activities, and ways they overcame them.

A. Planning and Collaboration Goals and Activities

1. Planning Goals

EBHV grantees developed a wide range of planning goals and engaged in intensive planning during the first year (Table II.1). At the core operations level, grantees had to develop plans for recruiting, hiring, and training staff; this was especially true for grantees implementing new home visiting programs. They also expected to plan for monitoring program performance and providing technical assistance to implementing agencies (IAs). At the organizational support level, grantees expected to plan for identifying funding sources and developing new local partnerships. Many grantees implementing a new home visiting program also anticipated planning for research and evaluation activities and developing contracts with IAs. At both the community and state levels, grantees aimed to plan for communication and advocacy activities. All grantees expected to plan for participating in the national cross-site evaluation, disseminating grant findings, and consulting with other grantees and national model purveyors.

Grantees' specific goals and development plans varied depending on whether they were working in local communities or statewide, and on the infrastructure already in place to support grantee-selected home visiting models. Of the 17 grantees, 10 were introducing new home visiting models in their states and communities (see Table I.2). For example, Rhode Island KIDS COUNT is bringing Nurse-Family Partnership (NFP) to Rhode Island, and Rady Children's Hospital-San Diego has developed a plan to establish and expand SafeCare in California. Although home visiting programs existed in some of their communities, they might not be evidence-based. The seven other grantees are located in states and communities that already had one or more of the grantee-selected home visiting models in operation when the initiative began. They are expanding service capacity by supporting program implementation in new IAs, introducing additional home visiting models, or enhancing or adapting existing home visiting models to new populations.

2. Primary Planning Activities

During the first 18 months of the EBHV initiative, grantees and their partners focused primarily on activities at the organizational support, community, and state levels. Grantees implementing new home visiting models commonly reported focusing on three areas related to funding and operating home visiting services:

- Engaging funders and planning for sustainability
- Selecting IAs to provide direct home visiting services

Table II.1. Planning and Collaboration Goals Identified by EBHV Grantees During the Planning Period, by Level

Goal Identified by Grantee	Planning Goals: Newly Implementing (N=10)	Planning Goals: Existing (N=7)	Collaboration Goals: Newly Implementing (N=10)	Collaboration Goals: Existing (N=7)
Core Operations Level				
Provide staff training	8	4	6	4
Develop or refine monitoring or continuous improvement system	5	4	3	1
Recruit and hire staff	7	1	4	1
Provide or arrange for TA for IAs	3	3	2	1
Develop or refine family recruitment and referral system	3	2	4	5
Implement or expand home visiting programs	0	0	3	1
Develop plans for staff supervision	2	2	2	2
Adapt or enhance a home visiting model	1	2	0	0
Submit application to national model purveyor	1	0	0	0
Organizational Support Level				
Identify potential sources of funding/create funding inventory	5	4	4	2
Plan research and evaluation activities	6	2	3	1
Develop local partnerships for infrastructure development	0	0	1	4
Develop local partnerships with other service providers	3	4	3	2
Develop public awareness strategies and communication tools	3	4	4	1
Develop or refine contracts with IAs	5	1	1	3
Plan for outreach, recruitment, and referral processes	2	2	0	0
Develop or refine monitoring or continuous improvement system	2	1	0	0
Assess readiness and capacity of potential IAs	2	1	0	0
Work with model purveyor on implementation plans	2	1	0	0

Goal Identified by Grantee	Planning Goals		Collaboration Goals	
	Newly Implementing (N=10)	Existing (N=7)	Newly Implementing (N=10)	Existing (N=7)
Community Level				
Develop community partnerships	6	3	0	0
Identify potential funders and plan for sustainability	6	2	2	1
Plan for communication and advocacy activities	4	2	2	3
Develop systems and tools for service coordination/integration	0	0	7	2
Conduct needs assessment to identify areas with many needs	1	2	0	0
Plan or arrange for TA to IAs	1	2	0	0
State Level				
Plan for communication and advocacy activities	7	6	2	4
Identify potential funders and plan for sustainability	4	6	5	4
Collaborate with programs and partners at the state level	5	2	7	2
Establish advisory or steering committee	2	4	2	4
Plan for building infrastructure to support implementation	3	3	1	2
Plan for research and evaluation activities	0	4	0	0
Plan or arrange for TA to IAs	2	2	0	0
National Level				
Participate in peer learning network and cross-site evaluation	10	7	10	7
Develop dissemination strategy	5	3	0	0
Meet EBHV grant reporting requirements	4	4	0	0
Consult with other grantees and national model purveyors	2	5	3	4

Sources: Grantees' applications for the EBHV grant and discussions with grantees about their goals conducted by the cross-site evaluation team in January 2009.

TA = technical assistance; IA = implementing agency.

Note: The information in the table is based on grantees' descriptions of their plans as of January 2009. Not all grantees included the same level of detail regarding their planned activities. As a result, if a grantee did not mention an activity this is not indication that the grantee did not plan to (or did not ultimately) carry out the activity.

- Developing partnerships in the communities in which they were to implement services

Some also cited selecting a home visiting model as a key planning activity, although for most grantees this occurred during the application process for the EBHV grant, rather than during the planning year.

In contrast, grantees focused on enhancing or expanding an existing home visiting model reported planning activities related to systems enhancements:

- Training to enhance the quality of existing home visiting programs and a statewide structure of collaboration (Illinois)
- Adding supplemental materials to the NFP model to enhance it for families in tribal communities (Minnesota)
- Developing a central intake and referral system based on a common risk assessment tool (New Jersey)
- Developing a data management system to support continuous improvement (Hawaii)
- Developing a data system to support programs and track home visiting activities in the state (Utah)

3. Collaboration Goals

There is substantial overlap between planning and collaboration goals identified by grantees at the start of the planning year, because many planning activities were carried out in collaboration with partners (Table II.1). For example, planning for staff training, establishing recruitment and referral systems, and technical assistance for IAs often involved collaboration with national model purveyors and other state and community agencies. At the organizational support level, grantees aimed to work with partners to identify potential sources of funding and develop public awareness campaigns. They expected to work with local research partners to plan for research and evaluation activities. At both the community and state levels, grantees worked with partners to plan communication and advocacy activities. They also worked with partners to form advisory and steering committees for their grant programs. At the national level, grantees expected to collaborate with other grantees, ACF, and the cross-site evaluation team on the peer learning network and the cross-site evaluation, and they consulted with national model purveyors.

4. Primary Collaboration Activities

During site visits and telephone interviews, grantees described three main types of collaboration activities they carried out during the planning year. First, they developed partnerships at both the community and state levels to build support for the EBHV initiative among a range of local and state service provider and advocacy organizations. Second, they developed partnerships with local foundations, state agencies, and other potential funders to support the sustainability of the EBHV programs. Third, they developed partnerships to facilitate referrals to the grantee-selected home visiting programs, reinforce the use of common risk assessment and screening tools, and develop central intake and triage systems to support referrals to multiple home visiting programs within a single community.

In addition to developing partnerships with individual organizations, most EBHV grantees also formed or participated in community or statewide collaborative groups. Most grantees, especially those newly implementing programs, reported participating in existing community or state collaborations to support the EBHV initiative or adapting existing committees to work on it. For example, in Solano County, California, the grantee has continued longstanding participation in the Baby First Collaborative, which aims to improve access to prenatal care. In Illinois, a home visiting subcommittee of the state's Early Learning Council served as the starting point for developing a 100-member state committee on home visiting; the 10-member executive committee of this group became the steering committee for the EBHV initiative. Others developed new collaborative groups to support grant implementation. In addition, almost all of the grantees formed or worked through existing steering committees to provide advice and input on the EBHV initiative.

B. Partnerships Formed by EBHV Grantees

Fixsen et al. (2005) note that system-level partnerships are a key driver of successful program implementation. Being able to coordinate and communicate with other agencies is considered an important organizational capacity to support implementation (Durlak and DuPre 2008). For the EBHV grantees, engaging other organizations as partners in their efforts was a necessary step. Because of the requirement to build infrastructure, and because some grantees were not themselves home visiting providers, none could "go it alone."

To understand the role of the partnerships and track their evolution over time, the cross-site evaluation includes baseline and follow-up surveys of grantees and their partners. The baseline survey, conducted in 2010, collected information about organizational characteristics, relationships, and joint activities among grantees and partners, and the quality of their collaboration. The total number of partner organizations identified by each grantee ranged from 10 to 25 (the maximum that could be included in the survey for each grantee), for an average number of 17 partners. In this section we describe who the partners working with the EBHV grantees are and what roles they play in the initiative.

The EBHV grantees worked with a wide range of partners at all systems levels (Table II.2). All grantees partnered with at least one local or state agency, and most partnered with community-based service providers, national model developers, and universities. Health care organizations were also common partners; eight grantees partnered with a hospital, four with another type of health care organization, and one with a health plan. Different types of partner organizations focused their grant-related activities at different levels. Community-based service providers, hospitals, other health care organizations, and other nonprofits worked in partnership with EBHV grantees most often at the core operations level. Local or state agencies, universities, and foundations collaborated with grantees most often at the state level, and collaborations with national model purveyors occurred most often at the national level.

Partner agencies were well established and most had 10 years or more of experience in home visiting and preventing child maltreatment. Two-thirds of organizations had been in operation for 20 years or more, with another 20 percent founded 10 to 19 years earlier. Over half had at least 20 years of experience in child abuse prevention (55 percent). Over a third reported 20 years of experience in home visiting (35 percent), with 27 percent citing 10 to 19 years of experience.

In surveys, partners reported a significant level of involvement in EBHV initiative activities. On average, about 70 percent of partners reported attending meetings with EBHV grantees regularly

and contributing to discussions during meetings (Table II.3). Nearly 60 percent served as members of committees or task forces, and half said they worked on EBHV-related projects outside of meetings. One-third of the grantees reported helping to organize initiative activities.

Even this early in the EBHV initiative, the quality of partner collaborations was relatively high, though partner's goals for the program sometimes diverged. The EBHV partner survey included measures of five different dimensions of collaboration from the Working Together survey (Chrislip and Larson 1994). A series of questions examined the context, structure, process, member relations, and results of collaboration. On a scale of 1 to 4, with 4 representing strong agreement with various statements characterizing positive collaborations and 1 strong disagreement, the mean scores of all survey respondents combined ranged from 3.17 to 3.62, meaning that they agreed or strongly agreed that these positive statements characterized their collaborations. Differences by grantee were statistically significant, indicating that in some cases collaborations still needed improvement. For instance, agreement on openness and shared goals among team members was lower than for other collaborative elements. An open-ended question asked respondents to describe their organization's three main goals for EBHV. For four grantees (in Rhode Island, New York, California [Rady Children's Hospital-San Diego], and Illinois), as many goals were identified as there were partner organizations responding (with 10, 10, 11, or 12 total respondents and separate goals, respectively). At the other end of the spectrum, the 21 survey respondents for Tennessee's Le Bonheur Community Health and Well-Being articulated a total of seven goals, and 19 respondents for Hawaii identified a total of nine goals. While goal divergence might indicate a lack of (or strong) alignment among partners, it could also simply reflect differences in the state or local contexts and more or less diverse capacity-building needs among EBHV grantees.

C. Overcoming Obstacles

EBHV grantees had to overcome several obstacles to planning and collaboration activities. First and foremost, grantees, like other social service programs, faced a loss of funds and funders due to the economic downturn. For example, many state agencies that provided funds for home visiting services—funding EBHV grantees were leveraging as part of the EBHV initiative—experienced budget cuts and had to reduce funding for these programs. Local foundations also reduced funding due to loss of investment income. Stemming from the downturn, grantees reported that staff turnover or layoffs at key partners, or loss of state staff, created challenges for developing and sustaining strong partnerships. Some grantees reported that, due to staff turnover in partner agencies, it was difficult at times to foster regular participation among partners in steering and advisory committee meetings. This uneven participation created challenges for moving planning activities forward.

Second, some grantees had to overcome turf issues and a lack of trust among other home visiting programs and stakeholders in their states and communities. In some cases, other home visiting programs feared that introduction of an evidence-based model in the community or state might result in a shift of resources away from their programs to the grantee-selected model. Some local programs were concerned that they might be described unfavorably (for example, as not evidence-based) in needs assessments and home visiting program inventories created through the grant, which they feared would lead to a loss of funding for their existing programs.

Table II.2. EBHV Grantees' Partners' Organization Type and System Level at Which They Reported Working

Partner Organization Type	Number of Grantees with at Least One Partner of this Type	Percentage of Partners that Reported Working Primarily at Each System Level[a]:				
		Core Operations	Organizational Support	Community	State	National
Local or state agency	17	17	19	17	47	1
Community-based service provider	14	56	24	16	0	4
National model developer or purveyor	10	18	12	0	12	59
University	10	11	16	5	63	5
Hospital	8	50	20	30	0	0
Health care organization other than a hospital	4	75	0	25	0	0
Foundation	3	0	0	33	67	0
Health care plan	1	0	0	100	0	0
Other nonprofit organization	15	33	21	13	31	3
Other	15	17	14	28	24	17

Source: EBHV Grantee Partner Survey, spring 2010.

Notes: N = 241. Partners that did not report an organization type (n = 1) or a system level (n = 9) are missing.

[a] All grantees are weighted equally to account for the number of partners that completed surveys at each grantee site.

Table II.3. Activities Reported by EBHV Partners

	Percentage of Partners[a]			
	Grantee Average	Grantee Minimum	Grantee Maximum	SD
Attend meetings regularly	71	14	100	24
Talk at meetings	69	0	95	26
Serve as member of committee or task force	59	11	95	27
Work on projects outside of meetings	50	0	92	25
Help organize activities (other than meetings)	32	0	60	16
Direct implementation of a program	24	0	60	17
Chair or lead a committee or subgroup	18	0	40	12
Chaired or cochaired the entire group	12	0	40	10
Served as an officer other than chair	3	0	20	6

Source: EBHV Grantee Partner Survey, spring 2010.

N = 241.

[a]All grantees are weighted equally to account for the number of partners that completed surveys at each grantee site.

SD = standard deviation.

Although funding challenges remained, grantees developed several strategies for overcoming these obstacles to planning and collaboration:

- Grantees built on existing partnerships in their states, including individual partnerships and collaborative groups that predated the EBHV initiative. Although staff turnover created difficulties, the strength of these longstanding collaborations and established working relationships helped to move the process forward.
- Grantees that were newly implementing their selected models took advantage of consensus among key stakeholders about which models to implement. In some cases, a key group of stakeholders had formed based on their common desire to bring a particular model to their state or community. The EBHV initiative presented an opportunity to fulfill this common goal, creating an environment for positive and productive collaborative working relationships.
- Grantees emphasized the need for a continuum of home visiting programs to meet the needs of families. To dispel the fears of some existing home visiting programs that the grantee-selected home visiting model would supplant their programs and to overcome the turf issues, grantees described consistently communicating the need for multiple home visiting models in the state or community to address the needs of families. Over time, consistent repetition of this message, in some cases by multiple state agencies, reduced tensions and fostered greater collaboration for working on shared goals.
- Some grantees had more than 20 partners, each with different perspectives and priorities, working together to achieve the goals of the EBHV initiative. Grantees emphasized the

importance of developing a shared vision of the goals of the grant among partners. For example, some grantee staff described starting all meetings with an overview of the outcomes for children and families the program aimed to achieve. Putting the needs of families at the forefront of activities encouraged partners to overcome their differences.

III. BUILDING INFRASTRUCTURE TO SUPPORT EVIDENCE- BASED HOME VISITING PROGRAMS

The structure of the EBHV initiative reflects the fact that social programs—in this case home visiting programs—do not operate in a vacuum. Their success depends on many factors outside the control of any single provider organization. Providers need funds to operate their programs, sources of qualified staff, access to eligible participants, and links to external services to help address family needs. Evidence-based programs, moreover, may need to build political or community understanding and support or obtain specialized training or technical assistance. Therefore, rather than offering grants to operate home visiting programs, CB/ACF designed EBHV to emphasize building infrastructure to support evidence-based home visiting models. That is, the program design recognizes that home visiting programs operate within a larger system that must evolve in its capacity to implement, expand, and sustain evidence-based home visiting programs that operate with fidelity to their chosen program models.

Capacity is defined as "the skills, motivation, knowledge, and attitudes necessary to implement innovations" that exist at the individual, organizational, and community levels (Wandersman et al. 2006). Effective evidence-based home visiting program models depend on different kinds of infrastructure capacities, such as establishing lasting relationships between home visitors and families, having well-trained and culturally competent staff, providing high quality supervision, coordinating home visiting services and referral processes, and maintaining other external resources and supports (Daro 2006).

Researchers have also identified the following capacities as being important to implementing evidence-based programs with fidelity: support and buy-in from community leaders; financial support through multiple funding streams; staff with expertise to address program planning, implementation, and evaluation issues; availability of onsite training, coaching, and consultation; and strong program leadership and staff commitment (Chinman et al. 2004; Durlak and DuPre 2008; and NIRN 2009). Other capacities for expanding and sustaining such programs include: real-time evaluation information on program benchmarks and outcomes that is used to guide continuous quality improvement (Olds et al. 2003; O'Brien 2005); early sustainability planning and clear strategies for developing financial self-sufficiency for programs; integration with other programs and compatibility with the mission of the host organization; and having respected program champions who can obtain program endorsements (Chinman et al. 2004). The need for these capacities can change over time as program environmental conditions change (Schreier 2005).

Though their chosen area of emphasis differs, EBHV grantees are aiming to build infrastructure capacity in eight areas: (1) planning, (2) collaboration, (3) operations, (4) workforce development, (5) fiscal support, (6) community and political support, (7) communications, and (8) evaluation (Table III.1). Moreover, grantees set goals and developed plans for work at multiple levels see (see Figure II.2). Chapter II focused on grantees' efforts to work collaboratively with a wide range of partners to plan their EBHV initiatives. This chapter summarizes grantees' efforts to develop or enhance the infrastructure capacity in the other six capacity areas. Section A highlights overall findings, followed by discussions of specific capacity areas: building funding and support (Section B), home visiting operations and workforce development (Section C), and evaluation (Section D). We indicate the number of grantees that pursued similar activities or strategies, and illustrate with selected examples. Section E concludes with information from EBHV grantees and partners about obstacles and facilitators to their capacity building work.

Table III.1. EBHV Infrastructure Capacity Categories

Infrastructure Categories	Types of Activities
Planning	Strategic planning, tactical planning, decision making
Collaboration	Leadership, alignment of goals and strategies, development of relationships, working through existing relationships
Operations	Outreach, intake, screening, assessment, home visiting, and referral services
Workforce Development	Training, coaching, supervision, technical assistance, and staff recruitment and retention
Fiscal Infrastructure	Fiscal partnering, planning, fundraising, researching funding sources, and leveraging funding to support direct services
Community and Political Support	Building community awareness or political support for EBHV programs and policies
Communications Capacity	Communication of EBHV information, lessons learned, and research findings, or policy advocacy to program partners, stakeholders, or the public
Evaluation Capacity	Data collection, storage, retrieval, and analysis for program evaluation, monitoring, or quality improvement

Sources: Flashpohler et. al 2008 and Coffman 2007.

A. Overall Findings

Each of the EBHV grantees and their partners reported working on most, if not all six, of the areas of infrastructure development, but their activities vary by factors such as grantee type, program model, and implementation status (see Table I.1).

- Grantees starting new home visiting programs reported focusing on building organization-level operational and workforce development-related infrastructure. This included recruiting and hiring a qualified workforce, training and certifying staff and supervisors as home visitors and coaches, and obtaining approval from their national model purveyors to start their operations.

- Grantees with existing home visiting programs tended to focus efforts on developing statewide assessment, referral, intake, training, or evaluation-related data systems. They are actively building infrastructure at both the organizational and state levels.

- Some grantees are state agencies in states with no direct management of home visiting programs. These grantees are building broad-based systems to provide training, coaching, operational technical assistance, evaluation, and ongoing funding streams to support local home visiting services.

- In a number of areas, particularly in communication and evaluation, grantees reported doing less infrastructure development than originally planned. These activities were reprioritized in part to align with changes in local, state, and federal economic circumstances, which affected public and private funding streams and sources.

- Due to uncertainty as to whether the EBHV initiative funding would continue after September 2010, during 2010 grantees focused considerably more attention than they had originally planned on building fiscal capacity in order to preserve their grant

activities and continue their selected home visiting programs in both the short and long term.

- Based on their work so far, grantees described a number of barriers to their infrastructure-building work. They faced difficulties in the following areas: (1) building fiscal support, given economic constraints; (2) building political support when many local and state governments were looking to cut funding for social support programs; (3) justifying the need for a continuum of home visiting services; and (4) addressing concerns about local evaluation plans. Grantees devised various approaches to overcome these barriers, most of which relied on building strong partnerships with diverse stakeholders.

B. Building Funding and Support

The EBHV initiative was designed to leverage sustainable resources by requiring grantees to fund direct home visiting services themselves rather than through the EBHV grant. This aspect of the initiative encouraged grantees to contribute other resources from within their own budgets and/or collaborate with other funders to secure resources for direct services. An unstable economy leading to severe cuts in state and local budgets, and a potential loss of federal grant funding, forced EBHV grantees to focus on building fiscal capacity immediately in order to rebuild their programs through a wide range of strategies (Table III.2). Twelve grantees reported developing and implementing sustainability plans or forming a funding- or sustainability-specific planning group. While some of these activities might have occurred early in the initiative even without added economic and fiscal pressure, grantees typically put off sustainability planning until the final years of their grants (Stevens and Hoag 2008).

1. Building Fiscal Capacity and Addressing Budget Shortfalls

To address budget shortfalls, grantees reached out to new partners for support (see Table II.2). These partners included private funders and local and national foundations. Several grantees tried to gain Medicaid reimbursement for home visiting services. These efforts did not succeed due to cuts being made in Medicaid at the state level. At the same time, however, close relationships between EBHV and Community-Based Child Abuse Prevention (CBCAP) grant lead agencies netted direct service funding for three EBHV grantees.[1] In anticipation of the Maternal, Infant, and Early Childhood Home Visiting Program (MECHV) scheduled to begin in FY 2011 and administered jointly by the HRSA Maternal and Child Health Bureau (MCHB) and by ACF, six EBHV grantees reached out to their states' MCHB Title V program administrators to secure a place for their selected home visiting models in their states' plans for the eventual funding.

Several grantees sought funding from a combination of state agencies, private funders, and foundations—a strategy that strengthened their financial viability. For example, the Colorado Judicial Department partnered with the Denver Juvenile and Family Justice Treatment Accountability for Safe Communities (TASC) to implement SafeCare. The grantee is targeting a

[1] The CBCAP grants program is funded through Title II of the Child Abuse Prevention and Treatment Act. CBCAP is a state grant program aimed at developing, operating, expanding, and enhancing community-based, prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect, through networks where appropriate (Child Welfare Information Gateway 2011).

Table III.2. Strategies Implemented by the EBHV Grantees to Build Fiscal Capacity, Community and Political Support, and Communication Capacity

	Number of EBHV Grantees
Fiscal Capacity	
Develop and implement a sustainability plan or form a funding- or sustainability-specific planning group	12
Leverage county and state support for the EBHV initiative	12
Reach out to new partners (including foundations and private businesses) for support	7
Cross-agency planning for MIECHV	6
Address reimbursement barriers and policies	5
Apply for grants to supplement EBHV grant	4
Provide funding to IAs for training and start-up	4
Secure CBCAP funding for grantee-selected evidence-based home visiting services	3
Write and win grants for grantee-selected evidence-based home visiting services	2
Conduct inventory of current funding streams for home visiting programs	2
Community and Political Support	
Work directly with state agencies, legislators, and the governor to share information, develop support, and/or leverage funding for the EBHV initiative	12
Work indirectly with partners, stakeholders, and program participants to reach out to state, local leaders, funders, and legislators for support	10
Conduct orientation trainings for partners and referral agencies to increase their understanding of the program	6
Conduct orientation sessions to inform county boards or state legislators of the EBHV initiative or grantee-selected model(s)	5
Support dissemination of partners' policy and advocacy briefs and reports	3
Provide advice, materials, and TA to help local IAs make presentations to create awareness and support for the grantee-selected evidence based home visiting model	3
Communication Capacity	
Share program information through website, electronic mailing lists, emails, newsletters, postcards, media stories, at association meetings, and agency-wide meetings	11
Host speakers, give presentations, and organize local, state, and other conferences to share information and findings	10
Give presentations at community meetings, forums, and trainings to market grantee-selected evidence based home visiting model(s)	8
Write, review, and disseminate research via journals, websites, and clearinghouses	5
Develop and implement communication plans	3
Support social marketing campaigns targeting child abuse prevention messages	2

Source: Mathematica site visit and telephone interviews, spring 2010.

Note: Sample size = 17 grantees. Grantees may be implementing one or more activity.

unique community served by many different funding streams—parents who are involved in the criminal justice system with children ages 5 or younger. TASC uses a blended funding approach in which the SafeCare project gets a portion of all grants sought by TASC, including grants from the Substance Abuse and Mental Health Services Administration, the Justice Department, the Colorado Trust, and the Colorado Department of Public Health. The Society for the Prevention of Cruelty to Children in Rochester, New York, provides home visiting services supplemented by mental health services to address depression, parent-child attachment issues, and trauma related to sexual abuse, physical abuse, and domestic violence. To support this approach, the grantee obtained financial support from a combination of the United Way, Monroe County Department of Human Services, and the state and also began approaching foundations. Children and Families First in Delaware also reached out to multiple funders, including state agencies, the state CBCAP lead agency, and private funders. To obtain needed support for the program after federal funding cuts were announced, Children and Families First worked closely with a local champion, an area businessman interested in bringing NFP to Delaware, to identify potential funders (including state agencies, foundations, and private funders) for the NFP program.

2. Seeking Community and Political Support

Because of the need to expand funding sources as well as to gain momentum for implementing new program models, EBHV grantees sought endorsement and credibility from state and local opinion leaders, including community organizations, academics, businesses, and political leaders. Two types of strategies emerged, with several grantees implementing both approaches. One strategy involved systematically making the case for their selected home visiting model's efficacy in presentations to local and state audiences (reported by 12 grantees) (see Table III.2). For example, grantees conducted orientation sessions for community organizations and referral agencies to increase their understanding and appreciation of the program model's value and policy-oriented information sessions about the models for county boards or state legislators. Some grantees wrote or circulated legislative reports or issue briefs about their selected home visiting model targeting those same audiences.

The second type of strategy used by grantees to build community and political support was working indirectly with others who supported their local initiative and goals (reported by 10 grantees). For example, some grantees created project advisory boards that included community, business, and academic partners that served as intermediaries advocating for the program. The Children's Trust Fund of South Carolina and its partner, South Carolina First Steps, helped the agencies implementing NFP in their state develop local community advisory boards to build awareness of the model, including understanding its benefits and effects. Sometimes local legislators sit on these community boards and participate in the efforts. Some grantees have advocacy organizations or lobbying groups as partners who can write and disseminate policy papers and issue briefs supporting home visiting services. In Memphis, Tennessee, Le Bonheur Community Health and Well-Being is working with local, state, and national leaders to implement the NFP program in Shelby County, with a focus on mental health. In Tennessee, the grantee credits the success of the program to the model's coalition of supporters, including a mayor, corporate leaders, the model developer, a university, and a local hospital—all of whom worked together for eight years to obtain support and funding for NFP.

3. Building Communication Capacity

Communication capacity is often needed to build community and political support through broadly targeted messages and media. Grantees reported that, although they included development

and implementation of communication messages among their original project goals and initial plans, this capacity was largely undeveloped during the initiative's first year of operations. Faced with funding cuts, grantees prioritized other infrastructure needs over communication activities. As a result, they primarily worked on adding messages about their selected home visiting models to existing websites and newsletters (reported by 11 grantees) and organizing or participating in conference presentations (reported by 10 grantees), but did not implement other new communication activities, such as social marketing campaigns (see Table III.2). For example, the County of Solano, Department of Health and Social Services included articles about its new NFP program, and evidence-based home visiting more broadly, in existing newsletters. The Minnesota Department of Health added information about NFP to its department website and agency newsletters. Children and Families First in Delaware planned to bring together and help support a panel of national home visiting model representatives at a statewide conference. The goals of the panel were to share information about multiple models with a broad audience and to discuss opportunities for collaboration across models both nationally and locally.

C. Operations and Workforce Development

EBHV grantees established groups to provide steering, oversight, or coordination for home visiting operations (Table III.3). A major focus of activities was identifying and recruiting targeted families, with several grantees working on developing state or local referral and intake processes (reported by seven and eight grantees, respectively). At the statewide level, the New Jersey Department of Children and Families worked with its state partners to expand an existing early identification, triaging, and point of entry database system for pregnant women and families in need of comprehensive home visiting services. DePelchin Children's Center, through its Community Resource Coordination Group, built relationships for exchanging referrals with a diverse group of community organizations, including three school districts.

Grantees that also served as IAs were responsible for getting their own home visiting programs up and running, while other grantees worked with selected IAs or a statewide system to support implementation of program models. This included identifying, recruiting, screening, and/or assessing IAs that could potentially implement grantee-selected models, along with developing agreements with the providers and in some cases helping them apply for accreditation by the national model purveyors. Some did both. For example in addition to starting its own NFP program, Children and Families First of Delaware worked with an advisory board to provide an integrated continuum of home visiting models in the state. The grantee conducted an inventory of existing home visiting models in Delaware and built working relationships with state partners. Based on the results of the inventory and agreement among the partners that no single home visiting model could adequately address the needs of all families, the partners are now working on the development of a centralized intake system for the state.

Seven grantees concentrated on expanding or integrating home visiting models statewide instead of, or, as with Delaware, in addition to, implementing new program models. Providing operational technical assistance was one strategy used by five of these grantees. These grantees developed statewide systems for training staff, offering technical assistance, and facilitating peer support among IAs.

Table III.3. Strategies Implemented by the EBHV Grantees to Build Operations Capacity and Workforce Capacity

	Number of EBHV Grantees
Operations Capacity	
Create project steering committee, advisory board, and/or a group for oversight, collaboration, service coordination, or planning	16
Develop local referral networks and service continuum across home visiting programs	8
Help IAs prepare and apply to model purveyors for certification as new home visiting programs	8
Plan statewide centralized triage, referral process, and single-point-of-entry database	7
Plan for statewide expansion of grantee-selected evidence based home visiting models	7
Plan for statewide continuum of home visiting services	6
Recruit IAs to implement new grantee-selected evidence based home visiting model services	6
Provide operational TA to existing or new IAs	5
Conduct inventory of home visiting programs	4
Select and sign MOUs with IAs for services	4
Help providers switch to grantee-selected evidence based home visiting models	4
Adapt grantee-selected evidence based home visiting models for new target populations	3
Conduct readiness assessments of IAs	2
Workforce Development Capacity	
Plan and conduct fidelity monitoring (including monitoring of structural and dynamic aspects of fidelity)	13
Develop and implement a training plan	11
Hire, train, and certify home visitors in grantee-selected evidence based home visiting model	10
Hire, fund, and train trainers, coaches, or supervisors	6
Plan and conduct supplemental training for home visitors	6
Provide workforce TA to existing or new IAs	5
Assist with hiring IA staff	4
Plan and conduct coaching or supervision (including reflective supervision) of home visitors	4
Create IA support network or "community of practice" for implementing grantee-selected evidence based home visiting models	2

Sources: Mathematica site visit and telephone interviews, spring 2010; EBHV Grantee Partner Survey, spring 2010.

Note: Sample size = 17 grantees. Grantees may be implementing one or more activity.

IAs = implementing agencies; MOUs = memoranda of understanding; TA = technical assistance.

1. Hiring Qualified Staff

Depending on their focus and content, the home visiting models selected by EBHV grantees came with specified qualifications for home visitors. Getting a qualified workforce in place was an important goal for all grantees that were newly implementing their selected program models. Grantees seeking to expand and sustain existing programs needed to prepare and sustain home visiting staff on an ongoing basis. Thus, EBHV grantees built workforce development capacity at the core operations and organizational support levels. At the core operations level, some grantees were responsible for getting their own staff of home visitors and supervisors or coaches hired or transferred from other units, trained, and certified by the national model purveyor. The experiences of grantees and their partner IAs in recruiting, hiring, training, and supporting qualified home visiting staff are described in detail in two cross-site research briefs published in 2010 (Coffee-Borden and Paulsell 2010a; Coffee-Borden and Paulsell 2010b). Chapter IV of this report also describes these and other experiences related to implementing home visiting operations. These experiences and the lessons learned from them contribute to the overall capacity of each state or local system to provide workforce development.

2. Developing Workforce Support

A second group of grantees worked at the organizational support level and focused on developing a permanent infrastructure of trainers, coaches, and technical consultants certified by national model purveyors to work directly with multiple IAs to help them implement home visiting models. Others developed supplemental or enhanced training materials and procedures to strengthen and support staff members at IAs throughout their states. For ongoing peer-level learning and support among new sites, two grantees (Rady Children's Hospital-San Diego, California and The Children's Trust Fund of South Carolina) also organized local "communities of practice" by facilitating regular conference calls among new sites. The following examples illustrate the types of goals and workforce development infrastructure capacities built by the latter group during the first two years of the EBHV initiative:

- In the case of the Chadwick Center at Rady Children's Hospital- San Diego, the grantee is implementing the Safe Kids California Project in collaboration with multiple local, state, and national partners. The project is seeking to transform California's current system of home visiting services into a more culturally robust and affordable service delivery system targeting child neglect, by implementing the SafeCare model in three cohorts of counties. In the project, the implementing counties fund the home visitors and supervisors, while the grantee staff work with the national SafeCare purveyor to provide a year of training, coaching, and technical assistance to each cohort of sites, certifying local home visitors as trainers and coaches to train local, within-cohort replacement and expansion staff. The grantee's original plan was to have locally trained trainers and coaches also train staff at sites in subsequent cohorts. When the first two cohorts selected were too far apart geographically to support cross-cohort training, the grantee revised its plans so that staff from the grantee and the national purveyor train and coach each new cohort. The cohorts train within their own county or region to assist in the spread and sustainability of SafeCare.

- The goal of the Minnesota Department of Health's grant is to strengthen the state's infrastructure for supporting national home visiting models, in part by offering state-level trainers, training sessions, coaches in reflective practice, and NFP technical consultants to provide training support for existing NFP and other programs. The

Department of Health is also offering support to sites interested in implementing evidence-based practices, and working with the NFP national purveyor and several tribal governments in the state to add supplemental materials to the NFP model to enhance it for tribal communities. That effort involves collaborating with the Health Department's Office of Minority and Multicultural Health (OMMH) tribal liaisons in the development and implementation of the materials, including training an OMMH tribal liaison as a reflective practice coach.

- Through its Strong Foundations program, the Illinois Department of Human Services is working with state agencies and other organizations to develop an integrated state infrastructure to support three home visiting models: NFP, Healthy Families America, and Parents as Teachers. Strong Foundations is organized into work groups, one of which is focused on providing special needs training to home visiting staff. By October 2010, they had provided training to more than 200 home visiting staff on domestic violence, working with people with disabilities, mental health, and other special needs.

A common challenge reported by grantees working to establish a permanent workforce development infrastructure was to make their workforce development resources (trainers, training sessions, coaches, and reflective practice consultants) available to all IAs requesting these services within the capacity of their grant budgets. A related challenge was to find ways to sustain this training infrastructure after the end of the EBHV initiative.

D. Developing Evaluation Infrastructure

Examining the effectiveness of home visiting models implemented in new settings, offered to different target populations or adapted for special needs, is an important follow-on to initial research on practices and models. Doing so was a stated goal of the EBHV initiative. Grantees were expected to evaluate their local implementation, outcomes for families and children (including possible reductions in maltreatment and risk and protective factors associated with maltreatment), and the costs and benefits of the model. For example, the University of Oklahoma Health Sciences Center (OUHSC) had been developing and testing SafeCare pilot programs for more than 10 years. The EBHV initiative provided an opportunity for the OUHSC to create and test an adaptation of the SafeCare program for Latino families. Staff from the OUHSC described the evaluation as one more step in building a strong evidence base for the expansion of SafeCare.

Through the EBHV initiative, grantees had to work with evaluators to develop an evaluation plan that met both local and national cross-site evaluation needs. Grantees participated in evaluation-related peer learning network conference calls hosted by the Mathematica-Chapin Hall team to discuss the cross-site evaluation design and data elements. The cross-site evaluation team also shared data collection templates, training manuals, and a fidelity data collection database.[13] On request, the cross-site evaluation team provided additional evaluation technical assistance to grantees and local evaluators.

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[2] The fidelity data collection database was developed by Mathematica and Chapin Hall for the national cross-site evaluation, to collect comparable data across grantee-selected program models. The database includes three primary areas of focus: (1) program-level characteristics (including caseload dynamics and service structure), (2) direct service staff characteristics, and (3) participant-level characteristics and experiences (Daro 2010; Barrett et al. 2010).

During the planning year, all grantees either hired or engaged their selected local evaluators. Most were university-based, though some grantees had evaluation staff and/or engaged consultants. Twelve grantees began collecting data for the cross-site evaluation or their process evaluations. Ten grantees created committees or worked with partners to design and direct their evaluations.

1. Designing Child and Family Outcome Evaluations

Many grantees initially formulated ambitious designs for evaluating child and family outcomes (Koball et al. 2009). By October 2009, nine grantees had submitted plans to conduct randomized controlled trials—experimental evaluations that estimate program impacts by randomly assigning eligible participants to treatment, comparison, or control groups. Four additional grantees proposed quasi-experimental designs, with the remainder aiming to conduct pre-post or descriptive outcome studies. Six grantees anticipated sample sizes of 400 or more, three grantees planned for between 300 and 400, and eight grantees planned to engage at least 200 participants in their outcome evaluations.

However, numerous challenges arose in executing these initial designs. Fiscal constraints and EBHV grant funding uncertainty delayed program operations, shrunk sample sizes due to lower program enrollment, or led grantees to delays finalizing designs or initiating their outcome studies.[3] While most model purveyors supported the EBHV initiative's evaluation goals, some had accreditation or research requirements that altered their planned studies (as described in Chapter V). One grantee experienced strong resistance to random assignment among local partner agencies. While these factors led some grantees to rethink their initial research designs, others held to their plans despite challenges and nearly all grantees began their local studies in 2010.

2. Improving Data and Its Use

In addition to planning evaluations, a few grantees reported using the EBHV initiative as an opportunity to build or expand existing data systems that could be sustained after the end of the initiative (Table III.4). For example, the Utah Department of Health's Office of Home Visiting developed a statewide web-based data system to collect required reporting information and to track home visiting trends. To make the system useful across multiple IAs and multiple home visiting program models, along with meeting both local and state data needs, the grantee's evaluation team worked collaboratively with IAs to create the system, which will support evaluation but also provide data IAs can use to monitor and refine operations. A developer hired through the grant created the data system, which became operational in the summer of 2010.

Two grantees worked with IAs to improve the quality of the data they collected and to interpret and use the data. For example, the Minnesota Department of Health's local evaluation team worked with local IAs to provide quality assurance for the data staff collect and enter into the Clinical Information System, the data system designed and maintained by NFP's national service office and used by all NFP IAs.[4] In addition, the team has been working with the state's NFP consultants and

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[3] Since CB/ACF itself was uncertain whether funding would be available for years 3 through 5, it suggested grantees focus their evaluation efforts on their process studies until the financial situation was resolved.

[4] In fall 2010, NFP's national service office replaced the Clinical Information System with a system called Efforts to Outcomes (ETO).

Table III.4. Strategies Implemented by the EBHV Grantees to Build Evaluation Capacity

	Number of EBHV Grantees
Evaluation Capacity	
Contract or partner with local evaluator	17
Collect evaluation data	12
Create committee or work with partners to design and implement local evaluation, select tools	10
Develop a common data system across home visiting programs	6
Develop common measures across programs	5
Have state and local agencies modify existing data system to track evaluation measures	3
Select and hire a data system developer	2
Work with IAs to improve quality of data collection; interpret and use findings	2
Inventory local data systems and needs	1
Seek and obtain additional grants to expand evaluation capacity	1

Sources: Mathematica site visit and telephone interviews, spring 2010; EBHV Grantee Partner Survey, Spring 2010.

Note: Sample size = 17 grantees. Grantees may be implementing one or more activity.

IAs = implementing agencies.

IAs to help them interpret the data by reviewing data and creating summary sheets with key lessons learned. The summary sheets are given to the state's NFP consultants who share them with each IA.

E. Obstacles and Facilitators to Infrastructure Development

In their efforts to develop the program infrastructure to support the implementation, scale-up, and sustainability of home visiting models, grantees encountered several factors that hindered or helped their infrastructure development process. Most of these factors reflected the constrained fiscal environment grantees encountered after the EBHV initiative began, as well as more common implementation obstacles and facilitators to maintaining collaborations and conducting evaluations. A challenge somewhat unique to evidence-based models was their perceived cost in comparison to traditional home visiting programs, while a countervailing strength was the growing awareness of the potential for evidence-based practices to enhance outcomes.

1. Overcoming Resource Constraints

Private donors and foundations faced constraints stemming from the economic downturn. Consequently, some grantees found it difficult to cover start-up (including staff training) and operating costs of their selected home visiting models and to carry out planned communication and evaluation activities. Grantees' infrastructure development activities were limited by staff reductions at their agencies and partner agencies, as well as by turnover among key staff.

Grantees cited the importance of having partners that were engaged, committed, focused, supportive, and accountable. They reached out to teach key partners more about their selected home visiting models and then use their influence to leverage support for the initiative. Grantees also

relied on existing studies about the effectiveness of evidence-based home visiting models to build support among partners, policymakers, and the public for their efforts.

2. Building Political Support for Home Visiting Program Models Despite Opposition

Some grantees encountered negative political stigma from state and/or local political leaders who were looking to cut funding for social support programs. Even when objections were not this pointed, some grantees and their partners felt they received little support from state and local legislative or executive branches. Some grantees' status as a state agency limited their ability to build political support or heightened the need to be selective about support-building activities.

Grantees searched for legislative champions to counter this opposition or tried to bide their time until office-holders turned over. Others collaborated with nonprofit organizations or advocates to develop and execute political and community support-building strategies for home visiting.

3. Justifying the Need for a Continuum of Home Visiting Services

Grantees and their partners had to help policymakers understand that a continuum of home visiting services would not result in duplication, but rather multiple programs were needed to serve different target populations and families with varying needs. Grantees also faced pushback from providers of other home visiting services who feared that the new home visiting model was going to eliminate their program, reduce their client base, or reallocate resources. Some said it was a challenge to ensure that all partners (including national model purveyors, funders, IAs, and others) understood their role in forming a continuum of home visiting services.

One way grantees addressed these concerns was to conduct inventories of the home visiting services operating in their states or local communities. Using the information from these inventories, grantees were able to help partners and funders more fully understand how each program could play a role in meeting the diverse needs of families.

4. Addressing Concerns about Local Evaluation Plans

Some partners (including IAs and providers of other home visiting programs) were resistant to grantees' local evaluation plans, fearing the studies would compare home visiting models and possibly undermine existing programs. These fears at times undermined collaboration efforts with partners. Grantees also reported working closely with funders and national model purveyors to get their buy-in and support for evaluation plans, and in some cases to resolve disagreements about the need for and/or efficacy of evaluation designs (particularly grantees planning randomized controlled trials). For some grantees, restrictions posed by national model purveyors regarding the timing of data collection and who could collect data from families, along with pushback from IA staff on the burden of data collection, affected their local evaluation plans and/or their ability to participate in the national cross-site evaluation. Grantees, IAs, CB/ACF, and the Mathematica-Chapin Hall team worked with national model purveyors to address these issues.

Some grantees and partners found that having an inclusive planning process for their local evaluations in which different views or perspectives were discussed helped ease concerns. Grantees educated funders, IAs, and other stakeholders about the role of evaluation in establishing the efficacy of grantee-selected home visiting models in their communities. Other grantees were unable to overcome the concerns raised by the funders, IAs, or model purveyors and ultimately altered their evaluation designs.

IV. BEGINNING HOME VISITING OPERATIONS

EBHV grant funds were mainly intended to support planning, infrastructure building, and evaluation, but could also be used to expand and enhance home visiting programs. Grantees either combined a portion of their EBHV grant funds with funds from other sources to implement home visiting, or focused mainly on providing infrastructure supports such as specialized training or centralized intake, assessment, and referral procedures and services to ongoing programs. Regardless of their chosen emphasis, grantees were required to examine how the approaches affected key outcomes of interest, meaning that even if grantees did not use their EBHV funds to support home visiting operations directly, they still needed to collaborate with providers or obtain program data to evaluate intended outcomes such as fidelity to program models, improvements in child and family characteristics, and reductions in child maltreatment.

Because of this variation in their approaches, grantees differed in the status of EBHV initiative-related home visiting operations when the grant began and the progress they made implementing home visiting during the first two years of the grant. Regardless of their specific situations, home visiting operations for all grantees were affected by the economic downturn and resulting fiscal stress on states, and by the disruption in EBHV initiative funding. These factors delayed implementation of home visiting services in some sites. Many grantees and IAs—but not all—had to slow down their plans, found enrollment lagging behind their initial projections, or even saw home visiting services shrink due to funding cuts. Delays also occurred because planning and/or application processes for national model accreditation took longer than anticipated.

Despite these challenges, most grantees that planned to implement or expand home visiting as part of the EBHV initiative successfully launched program operations. They worked with program model purveyors, hired and trained staff, and began conducting home visits with new enrollees. Their experiences provide useful insights about implementing evidence-based home visiting programs, especially hiring and supporting staff, and suggest lessons for EBHV grantees or others planning to operate similar programs.

This chapter describes the grantees' experiences operating their selected home visiting program models, especially initial activities staffing programs and serving clients. These experiences highlight the importance of readying organizations for implementing evidence-based practices, anticipating differences between evidence-based and traditional approaches and how these differences affect agency staff members and practices, and preparing for the initial challenges of operating programs and working with clients.[1]

A. Working with Program Model Purveyors

Selecting and implementing evidence-based program models is more involved than purchasing a curriculum or program model "off the shelf." Organizations may need to contact and work actively with model purveyors and their organizations to obtain necessary approvals or

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[1] Detailed information and "lessons" from selected grantees on recruiting, training, and supporting evidence-based home visiting staff are available in two research briefs published as part of the EBHV cross-site evaluation: Coffee-Borden and Paulsell (2010a) and Coffee-Borden and Paulsell (2010b).

accreditations, and take other steps toward implementation. These procedures take time and so may influence the pace of implementation, as well as plans for program operations and evaluation.

1. Receiving Accreditation

Program model purveyors may vet agencies interested in their models to ensure they meet model requirements. All five of the home visiting program models implemented under the EBHV initiative had requirements in place for new agencies wishing to implement their models, or for expanding programs to new locations (see Appendix C, Table C.1). Requirements usually included notifying the model purveyor and developing a plan of action designed to prepare an IA for implementation. Some models required a needs assessment, such as documentation of the annual number of low-income, first-time births in the program's planned catchment area; others required IAs to conduct self assessments or provide funding plans for review.

Model requirements sometimes challenged grantees and IAs. Under the grant structure and funding disruption facing the EBHV grantees, NFP requirements to develop a financing plan to include three years of demonstrated support and have first-year funding in hand in order to receive approval proved challenging. It was sometimes difficult to get funders to commit for more than one year for a program not yet in operation. The uncertainty about the future of the EBHV initiative also posed hurdles for grantees. Although EBHV funds were not designed to be used for service delivery, some grantees planned to use the funds to support staff training and supervision, key elements in program operations. The potential loss of those funds meant some grantees and IAs had to identify sources that could replace this funding if necessary before they could receive approval to implement NFP.

Some grantees and IA managers described the accreditation process required by their model purveyor as time consuming. However, they also reported that aspects of the detailed process ultimately ensured fuller preparation for implementation, by making sure that they had addressed a range of issues well before implementation began.

2. Adapting or Enhancing Models for New Populations

In addition to working with program model purveyors to meet accreditation requirements, organizations interested in evidence-based models may need to work on their own and with purveyors to adapt their models to new target populations. Even if national home visiting models have not been developed for narrowly targeted groups, they may only have been tested within a limited number of settings and/or with specific demographic or cultural groups, and with English-speaking populations. Translating materials from English into other languages, while important, is only one aspect of adapting home visiting program models to new groups.

Two of the 17 EBHV grantees focused their grant activities on adapting or enhancing the home visiting models they selected for new target populations. Both were expanding their selected home visiting models: Minnesota was planning to expand NFP to tribal communities within the state, and Oklahoma aimed to implement a culturally competent model of SafeCare within Latino communities in Oklahoma City. These grantees' plans addressed logistical or structural characteristics, program practices, and content.

The Minnesota Department of Health is working with NFP's national service office to add supplemental materials to the NFP model to make it well suited for serving tribal communities in the state. As of cross-site evaluation data collection in spring 2010, the grantee was still in the

planning phase of this work. Grantee staff members were exploring the possibility of translating NFP materials into Ojibwe, but planned supplemental materials were also being designed to address other cultural differences and the logistical needs and characteristics of Native American communities. Their plans include the following:

- To address differences in family roles and household structures among Native Americans, NFP home visitors will adapt their practices to encourage and support the presence of multigenerational family members during the home visits.
- Due to a nursing shortage in the tribal communities, it was decided that NFP home visitors working in the selected tribal communities may hold two-year nursing degrees rather than four-year degrees as is typically required.
- To reduce costs, training for home visitors will be held on location, not in Denver, Colorado, at the NFP national service office, where training is typically provided. Instead, NFP will send trainers to the three tribal communities.
- Because the circumstances and needs of tribal families, as well as their program outcomes, may differ from those of families that have traditionally participated in NFP, in its evaluation activities the Department of Health did not plan to compare data collected from the tribal communities with data from nontribal entities.

The University of Oklahoma Health Sciences Center is working with SafeCare to develop a culturally competent version of the model for Latino communities. Staff began the process of adapting the SafeCare model by forming a committee of program developers, university researchers, and service providers for the Latino community to examine the SafeCare model and propose adaptations. The committee proposed adaptations to language and the format for learning. The translation of curriculum materials and assessments involved adapting materials for families from multiple countries with different dialects and for families with lower literacy levels; this was achieved by relying on basic terms and incorporating pictures. The committee also recommended adaptations to SafeCare that would address the specific needs of the families they planned to serve. These adaptations included incorporating new topics including extended families and social networks, acculturation, traditional health beliefs and practices, storytelling and proverbs, racism and discrimination, spirituality and religion, immigration laws, and relationship development. In addition, the committee felt it was critical that home visitors speak Spanish if they were to deliver services to Latino families who might not speak English fluently. Therefore, they sought home visitors fluent in both English and Spanish.

Other EBHV grantees, while not planning to adapt their selected models, had proposed to enhance them for special needs or groups by providing access to substance abuse or mental health treatment or other services in conjunction with home visiting. In addition to the enhancements, they are now considering other adaptations to their chosen home visiting models. The Colorado Judicial Department is providing SafeCare to parents who have children age 5 or younger, are involved with the juvenile and criminal justice system, and have a known history of substance abuse and mental health issues. In Rochester, New York, the Society for the Prevention of Cruelty to Children is planning to implement the NFP and Parents as Teachers (PAT), along with providing additional services through the Interpersonal Psychotherapy, Child Parent Psychotherapy, and Incredible Years programs that focus on depression, attachment issues, and trauma-related issues such as sexual abuse, physical abuse, neglect, and domestic violence.

These grantees did not initially plan to adapt their selected program models but found through experience that some adaptations might be needed. The Colorado program found itself having to turn away Spanish-speaking families and by fall 2010 was considering the possibility of providing SafeCare in Spanish. The Rochester group, which serves teen mothers, found that the families it was serving had more needs and faced even higher risks than they had anticipated. They believe that, for some of these parents, the two-year program window of NFP (which serves families until the child's second birthday) was not long enough to fully address the risks. By fall 2010 they were considering referring families leaving NFP to PAT, which can serve families until their child enrolls in kindergarten. This approach had received initial support and encouragement from the NFP and PAT representatives working with the Society.

3. Planning Evaluations to Meet Grant and Model Purveyors' Goals

Program model purveyors in some cases influenced evaluation plans and timing, or even posed competing evaluation agendas that grantees and IAs had to navigate. A goal of the EBHV initiative was to build the knowledge base regarding best practices in the adoption, implementation, and sustaining of evidence-based home visiting programs and practices. Hence, a requirement of receiving the EBHV grant was conducting rigorous evaluations, including assessing home visiting program outcomes. While the purveyors of all models selected by EBHV grantees valued evaluation, a few expressed concerns. For example, one purveyor questioned whether IAs most likely to be evaluated would be those with sufficient budgets to cover evaluation costs, rather than those most competent in providing the model. Another that had longstanding relationships with IAs implementing their model in a state, but none with the EBHV grantee, noted the importance of ensuring that the grantee understood the model's criteria and expectations in designing its evaluation. Representatives from one program model questioned the need for evaluations of home visiting outcomes, since by definition the program models chosen by EBHV grantees had some evidence of effectiveness already. Despite these concerns, model purveyors were supportive of the evaluation requirements of the EBHV initiative and the efforts of grantees to develop and implement their evaluations.

Agencies evaluating NFP had to comply with research standards established by the national service office. The standards specified, for example, that all potential clients must be given the opportunity to receive services whether or not they agree to participate in research, and that research designs should not use nurse home visitors to collect research data as this might compromise program implementation. The standards also required that all research must be reviewed and approved by the national service office's Research and Publications Communications Committee (RAPComm) (Nurse-Family Partnership [website] 2009). RAPComm's function was to ensure that research conducted in NFP IAs was methodologically sound, coordinated, and complied with NFP research guidelines. This review was in addition to those of Institutional Review Boards to which grantees also needed to submit their research plans for review. These requirements complicated the efforts of some grantees and their evaluators to develop and implement rigorous research designs. A standard practice for NFP is to require that the model be implemented for an extended period prior to the start of research. For the EBHV initiative, CB/ACF and the NFP national service office agreed that grantees would wait at least six months to ensure smooth operations before approved evaluations could begin. For some grantees, this meant that evaluations could not be started and completed within the time frame of the EBHV initiative, or that the number of participants enrolled during the first six months and excluded from any evaluation reduced evaluation sample sizes below needed thresholds for achieving statistical power.

In practice, some of the discrepancies between the priorities and requirements for evaluations of the EBHV initiative and program model purveyors became moot once EBHV grant funding was disrupted in 2010. Because future funding was uncertain, the Children's Bureau advised its grantees to focus their efforts on their process and cost studies, and on participating in the system change and fidelity components of the national cross-site evaluation. If full funding could not be restored, it was hoped these aspects of the evaluation could still be implemented in creative and rigorous ways.

4. Support from Model Purveyors

Along with establishing requirements, model purveyors also provide important assistance and support to IAs. For example, despite the challenges of obtaining funding, interview participants reported receiving high levels of support and technical assistance from NFP regional and national office staff in identifying and soliciting new financial support. In addition to the initial training they received on program models, staff reported during interviews that the model purveyors offered additional training and support on a range of topics, assigned a consultant or regional representative to provide technical assistance, assisted with logistical issues, and helped resolve technology and infrastructure issues such as downloading materials from the program model's website. Staff implementing NFP reported that they completed web-based trainings and worked closely with a regional consultant who answered questions that arose during home visits and supported the supervision of home visitors. Staff from the two IAs that were delivering SafeCare reported that a representative from the model purveyor participated in monthly, and sometimes weekly, case management calls to support the supervisor and to field questions from the home visitors regarding any comments and/or concerns that arose during their work with families.

B. Staffing, Training, and Turnover

In their review of implementation literature, Fixen et al. (2005) emphasize that the selection of practitioners (in the case of the home visiting models, home visitors) is essential because it is at this level that evidence-based programs are actually carried out (or not). Although the home visiting models provided guidance on the staffing structure and the qualifications and experience of staff, grantee and IA staff often found it challenging to meet some requirements, and needed to go beyond others to find staff members who were passionate about the work. Hiring staff required becoming familiar with the model requirements and developing a vision for the type of staff the IAs sought to hire.

1. Hiring Staff with the Requisite Education and Experience

The home visiting models selected by EBHV grantees vary in their educational requirements for home visitors (see Appendix C, Table C.2). NFP requires agencies to hire registered professional nurses with a minimum of a baccalaureate degree in nursing, while Triple P requires that agencies hire professional practitioners with post-secondary qualifications in health, education, social services, mental health, or a closely allied field. PAT recommends that its parent educators have at least a bachelor's/four-year degree in early childhood or a related field. Neither Healthy Families America (HFA) nor SafeCare impose educational requirements, but they do recommend home visitors have prior experience in human services with families at risk for maltreatment (SafeCare) or experience working with or providing services to children and families along with knowledge of infant and child development and general abilities to establish trusting relationships and work with culturally diverse families (HFA). NFP recommends that home visitors should have experience in community, maternal, or child health; mental health; or behavioral health. PAT recommends previous supervised

work experience with young children and/or parents, while Triple P recommends such experience plus knowledge of child/adolescent development and parent-child interaction.

However, EBHV grantees and IAs described going beyond model requirements and seeking candidates with prior experience and other professional characteristics and skills they deemed important. They reported trying to hire candidates with prior experience delivering home visiting services even when their model did not require it. They explained that, in their experience, home visitors with prior experience were better equipped to work with families and address challenging situations that could arise from family needs or in the context of home visiting. In addition, they reported seeking candidates who were comfortable working with families with many needs, hard working, passionate about the work, and could work independently while being comfortable receiving supervisory feedback.

Finding home visitors meeting all these criteria was not always a simple task. Grantees and IAs reported that model purveyors' requirements plus their own high standards for home visitors intensified the challenges they commonly faced staffing social service programs, and had delayed hiring in two of the six sites where EBHV grantees were implementing new programs. Three main challenges emerged:

1. **Finding bilingual home visitors.** Several agencies were unable to locate bilingual candidates. In an effort to address this challenge, one agency worked closely with NFP's national service office. The hired a dedicated, full-time interpreter who accompanied the home visitors into homes where English was not the primary language spoken by the family. The interpreter completed all NFP required trainings and also received training designed to help the interpreter learn to facilitate rather than triangulate the relationship between the nurses and the families.
2. **Identifying culturally competent home visitors.** In an effort to match home visitors with the populations the program served, IAs tried to identify racially or ethnically diverse candidates who were familiar with the cultural background of their target population. Agencies noted that, even when they could identify someone who spoke the language, it did not mean that the individual was culturally competent. For example, one IA manager described hiring a home visitor fluent in Spanish; however, the home visitor was from Central America while most of the families the agency served came from Puerto Rico—an important difference within their community.
3. **Salary competition.** Several agencies, particularly those implementing NFP, spoke about salary competition from other employers, such as hospitals that could offer nurses a higher salary than IAs could offer nurse home visitors.

2. Training Home Visitors and Supervisors

In order to begin serving families, all of the models selected by EBHV grantees require that home visitors and supervisors complete initial training or a series of trainings provided by the model purveyor. Such staff training is an important component of the accreditation process and typically involves one or more three- to five-day workshops (see Appendix C, Table C.3). Three models—NFP, SafeCare, and Triple P—require continuing training and supervision as the home visitors begin serving families.

Despite differences in the home visiting model's structure, target populations, and content, the home visitors and supervisors we interviewed reported commonalities in the initial training topics

across models. These topics largely overlap with the functional components of staff training Fixen et al. (2005) identified: "knowledge of the program and practices, demonstrations of key skills, and practice to criterion of key skills." They included:

- The philosophy and history of the program model
- The curriculum and service delivery method used, with opportunities for home visitors and supervisors to practice delivering the curriculum
- The roles and responsibilities of both home visitors and supervisors
- The reporting requirements, including data collection forms and other paperwork
- Opportunities to role play and practice the skills introduced in training

Supervisors must complete the training required of home visitors, plus additional training or post-training consultation specifically focused on supervision. Additional training model purveyors provided for supervisors focused on topics such as professionalism, supporting staff, conducting assessment, and ongoing training requirements for home visitors. During our site visits, SafeCare supervisors reported that their training covered two additional topics: (1) supporting fidelity to the model and (2) providing constructive criticism and feedback to home visitors. NFP supervisors reported that the supervisor training in which they participated included training in reflective supervision, building up caseloads, and forming and working with a community advisory board.

Participants we interviewed expressed satisfaction with training. That said, some supervisors and home visitors felt that the trainings focused too heavily on the theory of the model and less on the realities of conducting home visits and delivering the curriculum. To help home visitors address the needs of their clients, four IAs provided supplemental training to their home visitors. The topics were varied and included mandatory reporting requirements (such as for suspected maltreatment), blood-borne pathogens, handling issues of substance and drug abuse and domestic violence, infant assessment skills, and conflict resolution.

The cost and time associated with required training need to be factored in when planning to implement the grantee-selected models. Supervisors described the main challenges of the initial trainings as (1) the costs associated with sending staff to training, (2) the time needed to train new staff, and (3) resistance from some staff to structured training (and to supervision). Supervisors described the first two challenges as particularly difficult to address when dealing with staff turnover. One supervisor who had recently had a home visitor leave her agency explained that, even if she could have hired a replacement home visitor immediately, it would be several weeks before the new home visitor could receive training and begin serving families. The families, therefore, experienced a gap of several weeks in services.

C. Conducting Home Visits

The five home visiting models selected by EBHV grantees differ from one another in their target populations, expected dosage, and duration of service delivery (Appendix C, Tables C.4 and C.5). All these differences are factors organizations and communities need to consider carefully in selecting potential models to best meet their needs. For example, NFP serves families up to the focal child's second birthday, so programs desiring to include older children may not find it a suitable match for their target populations. The duration of other models, such as SafeCare (18 to 20 weeks)

may be short for serving some high-risk families; organizations that want to both follow their families longer and serve older children may find models such as HFA more appropriate.

EBHV grantees and IAs varied in their stages of planning and implementation of home visiting at the start of the EBHV initiative and when we conducted site visits in 2010. The site visits included six grantees where new home visiting operations had gotten underway; these all happened to involve either NFP or SafeCare. Future reports will provide more detailed descriptions of home visiting operations, including similarities and contrasts across the five models selected by EBHV grantees and all aspects of the program, from referrals and recruiting to providing services and ending services. In the meantime, the early implementation experiences described in this chapter serve as snapshots of a selected group of staff as they began delivering services to families and children.

1. Contacts with Families

The first contact with a family that has been referred to the home visiting model is typically a telephone call rather than a visit. The initial telephone call is an opportunity for home visitors to provide the client with basic information about the model and its requirements and expectations, and to schedule the first home visit. Home visitors then prepare for their initial visits by reviewing information about the client, including any information gathered during the referral process, and gathering materials and documentation needed for the first visit, such as needs of health assessments, consent forms, and program background or promotional materials. In the first visit, home visitors typically focus on describing the service and what enrollment will mean for the client, gathering information about the client, and signing consent forms. Some home visitors also spend time during the initial visit setting goals and building a relationship with the client. The home visitors reported that frequently this first visit includes not just the client, but also other family members, such as the client's mother, boyfriend, or husband.

After completing the initial meeting, home visitors continue to meet with their families at the intervals recommended by the models they are delivering. The families' needs, age of the child, and the home visiting model content and curriculum together drive the focus of these visits. For NFP, during early pregnancy home visit content focused on healthy eating during pregnancy and prenatal care; during infancy the visits focused on bonding between mother and child and caring for an infant. SafeCare home visitors described delivering three modules to families: (1) a health module designed to train parents to use health reference materials, prevent illness, identify symptoms of childhood illnesses or injuries, and provide or seek appropriate treatment by following the steps of a task analysis; (2) a home safety module that involves the identification and elimination of safety and health hazards by making them inaccessible to children; and (3) a training module on parent-infant interactions (birth to 8–10 months) and parent-child interactions (8–10 months to 5 years) that aims to teach parents to provide engaging and stimulating activities, increase positive interactions, and prevent troublesome child behavior (Georgia State University, National SafeCare® Training and Research Center 2009).

Regardless of the model, relationship building between the parent and home visitor is an important aspect of these early visits. Unlike many social service programs delivered at a central location by an agency and its employees, home visiting is a service delivery mechanism that depends to some degree on the ability of a home visitor to develop trust and rapport with her clients in the intimate setting of their homes, while still maintaining respect for one another on a professional level (Gomby 2005; Korfmacher et al. 2008). Home visitors reported that the comfort level between the home visitor and the family builds during each visit. However, it usually takes four to five visits before families became comfortable sharing personal information with their home visitor.

The rewards to the home visitor can be many. Those we interviewed described their joy in building strong relationships with families, and feeling encouraged when families made positive changes. Home visitors enjoyed observing parents modeling behaviors with their children that home visitors had shown them in previous visits. Home visitors also reported increasing security in a home, increasing healthy birth outcomes for pregnant women, and elevating parenting skills as important successes of their work.

Along with these rewards, the NFP and SafeCare home visitors we interviewed also reported facing challenges in their work—some unique to home visiting or stemming from special requirements for evidence-based program models. They cited the following challenges:

- Managing multiple responsibilities, including preparing for visits and completing paperwork. Preparing for home visits often required substantial time, especially when delivering content for the first time. Although home visitors anticipated that preparation time would decrease as they became more familiar with the material, they still anticipated needing to individualize content to the needs of each family. Home visitors also reported being burdened by required paperwork following visits.
- Completing the required number of home visits. Home visitors reported finding it difficult to complete the required number of visits per model specifications because families often canceled visits. Rescheduling visits was not always feasible, even when home visitors tried to adjust their schedules to make time available.
- Balancing the amount of time spent during home visits managing issues faced by the family and delivering the curriculum. Home visitors must cover a significant amount of planned material with a family during each visit. Yet families often had urgent or competing issues that they wanted to discuss such as relationship issues, housing concerns, or food shortages. Rather than avoiding these issues, some home visitors ask families what is new and what has transpired since the last visit. After acknowledging any issues, they then try to redirect the visit back to the content they planned to cover.
- In addition to addressing crises, home visitors described distractions caused by other children in the home. Sometimes other family members or friends' children are present during the visit. To allow them time to work with the client, home visitors sometimes brought toys or other activities to keep other children occupied. Other distractions include mothers engaging in cell phone conversations and texting during visits.
- Overcoming client resistance to new ideas and changing behavior. Home visitors described frustration they experienced when some families were not receptive to the information they provided.

2. The Role of Supervision in Home Visiting

Supervision is an important support to help home visitors cope with the challenges that come with their jobs, along with a way to monitor fidelity to evidence-based models. Aspects of the supervisory systems established by the models selected by EBHV grantees are thus more structured and intensive than many traditional social service programs (Coffee-Borden and Paulsell 2010). While they differ by model, supervisory systems take on many forms and involve multiple levels of an organization (see Appendix C, Table C.6).

To help ensure model fidelity, supervisors review documentation and case files and meet with home visitors to discuss whether they are able to meet with families at the frequency intended and

cover the content as outlined in the model. Supervisors conduct home visits with staff and/or review audio recordings of visits, in order to assess home visitors' adherence to dynamic aspects of the models such as whether home visitors are delivering services and interacting with families in the manner intended.

Supervisors also used administrative data (largely data required by the EBHV models; see Appendix C, Table C.7) to assess fidelity. Supervisors used these data to better understand how home visitors worked with families. Program data (such as on the characteristics of families and the frequency of home visits), case notes, and their observations in the field enabled supervisors to identify families home visitors might be struggling to reach and ensure that home visitors were implementing the models as planned. Operational problems commonly identified by supervisors through these methods included (1) families who frequently canceled visits, (2) families who frequently received longer-than-expected visits, and (3) home visitors who did not complete required paperwork within specified time frames or who completed documentation incorrectly.

Supervision is also intended to help ensure home visitors can meet the needs of families on their caseloads. Supervisors implementing both NFP and SafeCare said they aimed to provide one-on-one supervision, as well as team meetings, on a weekly basis. Weekly one-on-one sessions held between supervisors and home visitors in both models aim to address any questions, concerns, or challenges that might surface as the result of visiting families. During one-one-one meetings, supervisors discuss each family on the home visitors' caseloads to review progress and address any challenges. Weekly group meetings provide an opportunity for staff to come together and report back on their progress with the families. If one case is particularly challenging, the staff discuss the specifics of that family as a group. Group meetings are also a time to review model procedures and components of the curriculum, or provide additional training. Some supervisors used "reflective supervision" (exploring the home visitor's experiences with families and children, reflecting on their feelings and behaviors related to home visits, and discussing both personal and professional responses to families' situations) to support home visitors in building relationships with families.

Supervisors for both models also conduct home visits with staff; NFP recommends doing so quarterly and SafeCare recommends monthly visits. NFP supervisors use these visits as an opportunity to observe the home visitors and provide feedback on their practice. For SafeCare, an additional goal of the visits is to ensure that the visitor is making progress with a family. In addition to on-site visits, SafeCare supervisors review audio-taped sessions between home visitors and their families. The supervisors review the tapes and assess whether home visitors are delivering services and interacting with families in the manner intended; if any questions come up, the coach then discusses those concerns at the weekly one-on-one sessions with staff.

Such intensive supervision can present logistical challenges, and may not be welcomed by all home visitors. Supervisors and home visitors were not always able to conduct supervision as frequently as planned, largely because either the home visitors needed to use the time to meet with a client or the supervisors had to work on other managerial tasks. Some staff members were unaccustomed to being shadowed and/or expected to participate in weekly supervision, so they were resistant to this level of oversight, at least initially. Nevertheless, the home visitors we interviewed during site visits overwhelmingly reported feeling supported by their supervisors. Regardless of model, the home visitors said their supervisors were approachable and felt comfortable talking to them. One group described themselves as a close-knit family that can call meetings at any time to talk about challenging situations that arise in their work with families. Over time, supervisors expect home visitors will view the training and supervision as a useful support rather than a burden.

V. LOOKING AHEAD

For the EBHV grantees and the field of home visiting, 2010 was an eventful year. After a year of planning during 2009, grantees had expected to focus in 2010 on implementing their infrastructure building efforts and home visiting operations along with initiating evaluations. With future EBHV grant funding suddenly uncertain, many had to refocus their attention on acquiring other funding sources to supplement future home visiting operations. Tightening fiscal constraints in the states exacerbated the funding challenge. With permission from the Children's Bureau, some grantees set aside planned outcome evaluation activities, and all grantees worked with the Mathematica-Chapin Hall team to help collect and provide data for the cross-site evaluation. Adding to the uncertainty, but on a more positive note, proposed health reform legislation supported by President Obama's administration included provisions to fund home visiting programs.

In June 2010, the Children's Bureau informed its EBHV grantees that, through a coordinated effort between CB/ACF and HRSA, funds from the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program would be used to restore funding to EBHV grantees.[1] By fall 2010, EBHV grantees were making necessary arrangements to obtain the funding and looking forward to continuing their grant-related operations through the original five-year timeline of the EBHV initiative, slated to end in September 2013.

Data for this report were collected in spring 2010, when grantees were in a very uncertain phase of their work. This chapter describes where grantees stood by the end of the second year of the EBHV program when funding issues had been resolved, and their plans for going forward. Grantees, their partners, and the IAs working with them were considering two primary issues: (1) how to best integrate their efforts with plans and goals for MEICHV emerging within their states; and (2) where home visiting implementation stood, and how to restore or revise plans for family and child outcome evaluations, given the status of home visiting enrollment and time remaining in the EBHV program. Other local evaluation components were also proceeding, and plans for cross-site evaluation data collection for the third year of the EBHV initiative were under way.

A. Integrating Grant Activities with Emerging State Home Visiting Agendas

To receive funding to support their EBHV activities, as well as to integrate and/or align their efforts with emerging state MIECHV goals, EBHV grantees had to make contact and develop relationships with their states' MIECHV lead agencies. State lead agencies were announced in August 2010. Lead agencies varied across states and included state departments of health, public health, or social services; governors' offices for children and families; and state bureaus or departments of family health, child services, or early learning.

[1] Funding for MIECHV would be distributed to states using a formula determined by (1) an equal base allocation for each state; (2) an amount equal to the funds, if any, currently provided to a state or entity within that state under the EBHV program; and (3) an amount based on the number of children in families at or below 100 percent of the federal poverty level in the state as compared to the number of such children nationally. Thus 15 states with EBHV grantees would pass funds to those grantees (source: funding announcement [http://apply07.grants.gov/apply/opportunities/instructions/oppHRSA-10-275-cfda93.505-cid4513-instructions.doc] accessed June 11, 2010).

In South Carolina, the EBHV grantee—The Children's Trust Fund—became the lead agency. In Hawaii, Illinois, Minnesota, and Utah, state agencies that had received the EBHV grant also became the MIECHV lead agencies. Five other grantees had pre-existing relationships with their state's MIECHV lead agencies. The remaining seven grantees had, as of October 2010, contacted and begun working with their states' lead agencies.

Grantees with pre-existing or new relationships with the lead agencies were generally optimistic that obtaining their EBHV grant funds would be a smooth process, although timing was uncertain and in a few cases there were some issues to overcome. For example, some lead agencies told the grantee that state legislative approval would be required, which could delay the transfer of funds. In a few cases, lead agencies were barred by state requirements from dispensing lump sums, so grantees anticipated receiving their funds incrementally. As part of the process, some lead agencies planned to impose accountability procedures that might add to the existing federal reporting requirements for EBHV grantees, which remain in place.

However, states could not pass on the funds until their plans for MIECHV were submitted to HRSA and approved. This involved the following three steps:

1. States had to formally apply for the funds. Their applications had to include plans for (1) completing a required statewide needs assessment, and (2) developing the program to meet criteria specified in the Affordable Care Act. Applications were due July 9, 2010.
2. States had to provide the required statewide needs assessments. A supplemental information request (SIR) released in August described requirements for the needs assessments and established a due date of September 20, 2010.
3. States applying for MIECHV funds—including funds intended for EBHV grantees—had to submit an updated state plan based on a second SIR expected to be released in September, which had yet not been released by the end of October 2010.[2]

By October 2010 some states were also considering ways of integrating EBHV-related activities with their goals and activities for MIECHV. A few states were considering how to refocus their local evaluations to obtain information helpful for implementing evidence-based home visiting under the new MIECHV program. Others were exploring overlaps between outcome data being collected for EBHV and reports on eight specific benchmarks required to be tracked under MIECHV, to see whether they could use or adapt EBHV measures, instruments, or data collection tools or approaches.

Under MIECHV states have to determine which programs meeting evidence criteria they will fund in their states. Program models being supported as part of EBHV might be more likely to be selected if they were (1) among the first evidence-based models implemented in their states, or (2) known to policymakers because of their prominence in the EBHV initiative. Alternatively, the long-term viability of grantee-selected home visiting models might suffer if (1) they were not among the

[2] On February 8, 2011, the second SIR was released. States were expected to submit their plans 90 to 120 days after this final SIR.

models specified by the state and thus not eligible for MIECHV dollars, or (2) other funders influenced by the state's choices reduce funding for non-selected models.

B. The Status of Implementation and Evaluation

1. Implementation of Home Visiting

By October, home visiting operations had begun or continued in all 15 sites where grantees had planned to implement home visiting or study outcomes in existing programs as part of their EBHV grant-related activities (Table V.1). Despite some delays in staffing programs and enrollment, families had been enrolled in home visiting. In a few cases, IAs had no difficulty enrolling families and were already approaching capacity.

As they gained experience operating home visiting, grantees described some difficulty with staff turnover. In some cases, turnover was related to uncertain EBHV funding. Although the grant funds covered only a portion of home visiting program costs, some staff members were wary that their positions could not be continued without such funding and so sought other employment. IAs also experienced turnover due to high competition for qualified nurses, in the case of NFP programs, or simply being unable to match salary and benefit levels available to qualified staff if they worked in other occupations or agencies.

Grantees implementing multiple evidence-based models reported progress toward better-coordinating services, or had established improved communication across program models. In Rochester, New York, the Society for the Prevention of Cruelty to Children said they had already seen a major improvement in communication and coordination across several home visiting program models in their community. In New Jersey, representatives of NFP, PAT, and HFA had met together several times. Among other results of the meeting, they had identified a core set of data elements commonly collected across models that could serve as a basis for a coordinated, statewide database to be developed in the future.

Two state-level grantees not operating home visiting programs under EBHV had delivered planned supplemental support and training to existing IAs. In Illinois, the Strong Foundations workgroup established to provide training to IAs and their staff members in meeting special family needs had been active. By October 2010 they had provided training to 200 home visiting staff members on addressing domestic violence, working with people with disabilities, and dealing with mental health and other special needs. In Minnesota, the Department of Health had provided subgrants to five IAs to support operations. They also increased by hiring state-level staff to consult with IAs on reflective supervision.

2. Local Outcome Evaluations

Differences between the actual and expected pace of enrollment in home visiting reduced the number of families who could participate in local family and child outcome evaluations, so by October some grantees had to re-think their original plans. In some sites, enrollment in home visiting programs included in the evaluation proceeded more slowly than hoped, for a variety of reasons. Delays in staffing their home visiting programs required IAs to hold off enrolling participants until home visiting and supervisor positions could be filled. Referral processes in some sites needed time to stabilize. For example, the Colorado Judicial Department found it took some time for judges to become aware of the program and develop a solid understanding of potential benefits it offered to individuals in the criminal justice system. As their buy-in to the program

Table V.1. EBHV- Related Home Visiting Enrollment and Capacity as of October 2010

Grantee	Program Model	Enrollment in Home Visiting Programs as of October 2010	Planned Capacity of Home Visiting Programs Involved in the EBHV Grant Program
County of Solano Department of Health and Social Services, California	NFP	80 families	The grantee anticipated reaching full enrollment of 100 in December 2010
Rady Children's Hospital, San Diego, California	SC	43 families across 3 IAs	The grantee was planning implementation in a second cohort of counties beginning in fall 2010; ultimately 3 cohorts of counties are expected to participate
Colorado Judicial Department	SC	62 families	The grantee intended to enroll an additional 90 participants
Children & Families First, Delaware	NFP	39 families	Capacity was 100 families; grantee also planned to expand to 200 clients in additional counties in 2011
Hawaii Department of Health	HFA	120 families across 2 IAs	The combined enrollment goal is 240 families
Illinois Department of Human Services	NFP HFA PAT	Implementation of home visiting is not part of the EBHV grant; existing HFA, PAT, and NFP programs in the state were ongoing	n.a.
Minnesota Department of Health	NFP	Three tribes have received state funds to plan supplemental materials to the NFP model to make it appropriate for tribal populations, and state may add 6 other new NFP sites	n.a.
New Jersey Department of Children and Families	NFP HFA PAT	2 new NFP IAs had enrolled 61 and 31 families, respectively; a new PAT site was at capacity with 55 families	Both NFP IAs seek additional staff in order to serve a total of 75 families each
Society for the Protection and Care of Children, Rochester, New York	PAT	300 families in PAT or an enhanced PAT program	Capacity for PAT is 350; enrollment in NFP by a second IA had not yet started, but planned capacity was 300
Mercy St. Vincent Medical Center, Toledo, Ohio	HFA	117 families in HFA and enhanced HFA programs	Expected capacity is 538 enrollees
The University of Oklahoma Health Sciences Center	SafeCare	35 families	When implementation trials begin, expected capacity is 180 at IA 1 and between 75 and 100 per year for 4 years at IA 2
Rhode Island KIDS COUNT	NFP	30 families	IA anticipated reaching full capacity of 100 families in June 2011; the grantee was exploring possibilities for expanding NFP to more families in 2011

Table V.1 *(continued)*

Grantee	Program Model	Enrollment in Home Visiting Programs as of October 2010	Planned Capacity of Home Visiting Programs Involved in the EBHV Grant Program
The Children's Trust Fund of South Carolina	NFP	2 IAs were at full enrollment of 100 families each; 4 IAs were serving between 80 and 90 families each	There are 6 IAs implementing NFP with a capacity of 100 families each, for combined capacity of 600 families
Le Bonheur Community Health and Well-Being, Memphis, Tennessee	NFP	30 families	Planned capacity was 200 families
Child & Family Tennessee	NFP	91 families	Planned capacity was 100 families
DePelchin Children's Center, Texas	Triple P	55 families	Capacity is approximately 300 families
Utah Department of Health	NFP HFA	2 IAs had enrolled a total of 170 families in either NFP or HFA	Anticipated total capacity was 240 families

Source: CB/ACF phone conferences with EBHV grantees and local evaluators, October, 2010.

HFA = Healthy Families America; NFP = Nurse-Family Partnership; PAT = Parents as Teachers; IA = implementing agency.

n.a. = not applicable.

increased, judges began making more referrals to the program. The DePelchin Children's Center in Texas found that some referral sources, troubled by plans to place a portion of families into a control group that would receive community services but not home visiting, were hesitant to refer potential participants. These delays shrunk sample sizes or made it more difficult for evaluators to collect follow-up data over as long a time period as specified in their evaluation plans.

On the other hand, fast enrollment also reduced sample sizes in some cases. By October, Le Bonheur Community Health and Well-Being in Tennessee had already enrolled 91 of their anticipated sample of 100 families, yet their outcome evaluation had not yet begun. Delays in launching evaluation enrollment and data collection resulted from the disruption in EBHV funding for some grantees. Others, such as Le Bonheur, that were newly implementing NFP programs, had to delay their evaluations until programs had operated for at least six months. This delay, required in order to obtain research approval from NFP's RAPComm, was intended to ensure that new programs were not evaluated until their compliance with the program model could be well established. This was an understandable goal, but did affect initial evaluation plans. Table V.2 lists each grantee's planned design and sample size for the local family and child outcome evaluations.

3. Other Local Evaluation Components

As required by CB/ACF and specified in the original grant announcement, process and economic evaluations (cost, cost-effectiveness, or cost-benefit studies) were also required as part of the EBHV initiative. By October, grantees were working closely with their local evaluators to flesh out plans for or begin process evaluations of their state and infrastructure-building efforts. In Illinois, evaluators from Chapin Hall at the University of Chicago had completed their draft "early findings" implementation report. The University of Oklahoma Health Sciences Center was developing a report describing the process of adapting SafeCare for Latino families. Delaware's evaluator was developing a detailed report on the costs of home visiting program start-up, and planning a subsequent study of implementation costs.

Some grantees had planned to conduct impact evaluations, which could support cost-benefit analyses, while others were exploring alternative methods to estimate potential program benefits or otherwise supplement cost analyses being conducted in conjunction with the cross-site evaluation. (For example, grantees may consider conducting sensitivity analyses to estimate what type and level of benefits would need to be achieved to offset the costs of home visiting programs, along with examining whether existing impact evaluations could provide evidence that such benefits were achievable.) Finally, though not required by CB/ACF, nearly all EBHV grantees were considering adding a local evaluation component to examine program fidelity, often by using fidelity data being collected as part of the cross-site evaluation. Grantees planned to use such data to provide feedback to home visiting program managers and staff to support program monitoring and improvement, or to provide a core set of data that could be collected across program models as part of an eventual statewide home visiting database.

C. Next Steps for the Cross- Site Evaluation

A main focus for the cross-site evaluation team in year 3 of the EBHV grant (FY 2010) will be providing technical assistance to help grantees launch and conduct their outcome evaluations. In addition to providing one-on-one assistance as requested by individual grantees and/or local evaluators, the Mathematica-Chapin Hall team will also complete and disseminate training materials on core child and family outcome measures planned for collection and use in local outcome evaluations. Liaisons working with each grantee will also monitor study enrollment and provide

Table V.2. Grantees' Family and Child Outcome Evaluation Designs and Estimated Sample Sizes

	Study Design			Estimated Sample Size				
Grantee	RCT	QED	Descriptive	Less than 200	200-299	300-399	400-499	500 or more
County of Solano Department of Health and Social Services, California		X		X				
Rady Children's Hospital, San Diego, California			X					X
Colorado Judicial Department	X						X	
Children & Families First, Delaware			X	X				
Hawaii Department of Health [c]								
Illinois Department of Human Services[a]								
Minnesota Department of Health			X	X				
New Jersey Department of Children and Families			X		X			
The Society for the Protection and Care of Children, Rochester, New York[b]	X	X						X
Mercy St. Vincent Medical Center, Toledo, Ohio	X							X
University of Oklahoma Health Sciences Center[b]	X							X
Rhode Island KIDS COUNT		X		X				
Children's Trust Fund of South Carolina		X				X		
Child & Family Tennessee			X	X				
Le Bonheur Community Health and Well-Being, Memphis, Tennessee			X	X				
DePelchin Children's Center, Texas[c]	X							
Utah Department of Health		X					X	
Total	**5**	**5**	**6**	**3**	**4**	**1**	**2**	**4**

Source: Grantee local evaluation plans, March 2011.

QED = Quasi-experimental design; RCT = Randomized controlled trial.

[a]Grantee is not conducting a family and child outcome study.

[b]Grantee is conducting two studies. The Society for the Protection and Care of Children, Rochester has an estimated combined sample size of 650 (350 in the RCT and 300 in the QED). The University of Oklahoma, Health Sciences Center[b] has an estimated combined sample size of between 640 and 760 (240-360 in study 1 and 400 in study 2).

[c]As of March 2011, grantee was still revising the evaluation design for the local family and child outcome study.

advice as needed on retaining and locating study members for data collection or other operational issues important for completing planned local evaluations. The team will work with grantees and evaluators on developing local evaluation reports that contribute information on program impacts, implementation, model adaptations, or other relevant topics that can contribute to existing knowledge and literature on home visiting and maltreatment prevention.

During the year, two types of cross-site data collection will take place. First, Mathematica will continue to obtain fidelity data from local IAs and via a data system used by NFP IAs to collect and report participant-level data.[3] Fidelity data were first obtained in October 2010. Data analysis and reporting by the Mathematica-Chapin Hall team are planned following a second round of collection in March 2011. (Collection of fidelity data will then continue at quarterly intervals until December 2014.) In addition, Mathematica will conduct telephone interviews with grantees in spring 2011 to gather information needed to create an updated logic model for each grantee and to learn about how planning for MIECHV and other key events have affected grant activities, grantees' key successes and challenges over the past year, and grantees' self-assessments of their infrastructure capacities.

As grantees move from the planning year into a phase of fully implementing their grant activities, planning and collaboration goals and activities are likely to change and partners might take on different roles. For example, grantees implementing new EBHV programs in their communities or states are likely to focus on the goals and activities in the core operations and organizational support levels related to implementing services, working with local partners, and supporting home visitors. Partners that have been heavily involved in planning activities could shift their focus to supporting implementation and helping grantees assess their activities and develop plans for continuous improvement. Grantees expanding or enhancing existing programs are likely to focus on infrastructure development activities at the community and state levels, such as building data systems, implementing common needs assessment tools, and operating triage and referral systems. In addition, many grantees are likely to be involved in planning and collaboration activities related to MIECHV to help their states plan for implementation. To capture these and other potential changes, Mathematica will collect updated information on the infrastructure-building goals and activities of each grantee in late spring 2011, as part of the system change dimension of the cross-site evaluation. Mathematica will issue a report based on this data by fall 2011. In addition, a second wave of the EBHV Grantee Partner Survey will be administered in FY 2011.

[3] In fall 2010, NFP's National Service Office replaced its Clinical Information System with a new system called Efforts to Outcomes (ETO).

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APPENDIX A

FEDERAL GRANT ANNOUNCEMENT CRITERIA FOR SELECTION OF HOME VISITING MODELS

The summer 2008 federal grant announcement for EBHV required applicants to select home visiting program models that met specified criteria. These criteria were

- No clinical or empirical evidence has been found suggesting the practice constitutes a risk of harm to families receiving services.
- An articulated theory of change is documented through a logic model or conceptual framework, and a manual or training program describes how to implement the model.
- At least two randomized control trials, or comparable methodology, have been conducted and found the practice to be superior to a comparison practice with published results in the peer-reviewed literature.
- The program model has been tested and replicated in multiple sites and settings.
- The program model must have demonstrated sustained effects, lasting at least one year beyond program end.
- Outcome measures used in studies are reliable and valid and administered consistently across subjects.
- The overall weight of evidence must support the program's efficacy.
- Program models must be working to build stronger evidence through ongoing evaluation and quality improvement.

During the grant review process, an independent panel of peer reviewers evaluated applications based on the criteria listed in the announcement to determine if the program model(s) proposed by the applicant met standards. The funded applications included six different models grantees planned to implement: Family Connections; Healthy Families America; Nurse-Family Partnership; Parents as Teachers; SafeCare; and Triple P.[1,2] The grantee-selected models have established performance standards that not only address issues such as service dosage and duration, but also provide guidelines on who can best serve as a home visitor, the initial and ongoing training levels for home visitors and supervisors, supervisory standards, and core characteristics of a high quality participant-provider relationship. The models also specify requirements an applicant organization must meet with respect to its management capacity and financial stability.

[1] The only grantee that planned to implement Family Connections decided to focus on supporting one instead of two home visiting programs. Family Connections is no longer being implemented as part of the EBHV initiative and thus is not discussed in this report.

[2] Triple P is not by definition a home visiting program. It is a practice reform designed to alter the manner in which all providers working with families approach their program participants regarding child management and parent-child interactions. Triple P is based on a multifaceted program model that includes five levels of increasingly intensive and targeted services that can be delivered in different formats (Prinz et al. 2009). The EBHV grantee implementing Triple P is using home visitors to provide the most intensive services (levels 4 and 5) in the Triple P model.

APPENDIX B

TECHNICAL APPENDIX

As discussed in Chapter I, Mathematica used three primary data sources for this report: (1) site visits, (2) telephone interviews, and (3) a partner survey. In the remainder of this section, we provide information about our data collection activities and analysis of these data sources.

Site Visits and Telephone Interviews

The cross-site evaluation team worked with the Administration for Children and Families (ACF) to identify which grantees would participate in site visits and which would be invited to participate in brief telephone interviews. Selection was driven by whether grantees were in a position to contribute to addressing the revised cross-site research questions that would benefit from in-depth data collection and analysis.

Site Visits. Teams of two Mathematica staff conducted site visits to each of 10 selected EBHV grantees during April and May 2010. Visitors included the Mathematica researcher who served as the grantee liaison and a second visitor (either another researcher, a research assistant, or a research analyst). The purpose of the site visits was to gather detailed information from the grantees about the research questions related to state context, infrastructure development, and implementation of services (described in Chapter I). Site visit participants included grantee staff; partners contributing to infrastructure development; and managers, supervisors, and home visitors from agencies providing services to families. Table B.1 displays the overall number of site visit participants. The topics discussed during each interview are included in Table B.2.

Telephone Interviews. For each grantee not visited, the Mathematica grantee liaison conducted a telephone interview with grantee lead staff. The interview's purpose was to gather updated information for the process study and systems analysis from each grantee, though the level of detail from telephone interviews was less than grantees participating in site visits. The number of staff participating in a telephone interview ranged from one to five. Each telephone interview lasted between 60 and 90 minutes.

Analysis Approach. Qualitative analysis of the site visit and telephone interview data was an iterative process using thematic analysis and triangulation of data sources (Patton 2002; Ritchie and Spencer 2002). First, we developed a coding scheme for the study, organized according to key research questions. Within each question, we defined codes for key themes and subtopics we expected to cover in the interviews. Then, we wrote up the interview and focus group notes. To facilitate consistent note writing and ensure that the site visitors' information would be comparable, prior to the visits we developed write-up templates tailored for each interview type. Because of the large number of interviews and focus groups conducted, we used a qualitative analysis software package, Atlas.ti (Scientific Software Development 1997), to facilitate organizing and synthesizing the qualitative data. Using the software, we coded the notes and retrieved data from all respondents that were linked to our research questions. We retrieved data on particular questions across all participants, from individual participants, and for different categories of participants (such as grantee staff, partners, or home visitors). We also used the software to retrieve all the relevant data on specific topics and assess the consistency and quality of information across respondents. This process of triangulation facilitated confirmation of patterns or findings and identifying important discrepancies (Patton 2002). We triangulated at two levels: (1) among the multiple interview participants from a grantee and (2) among individual respondents participating in small-

Table B.1. Site Visit Participants, by Participant Type

	Number of Participants
Grantee Staff (90 minutes)[a]	45
Partners Contributing to Infrastructure Development (60 minutes)	75
Implementing Agency Managers (75 minutes)	25
Home Visitor Supervisors (60 minutes)	8
Home Visitors (75 minutes)	21
Total Participants	**174**

Source: Mathematica site visits, spring 2010.

[a]Some grantees chose to include additional participants in the interview with grantee staff, such as local evaluators.

Table B.2. Site Visit Interview Topics, by Participant Type

Interview Topics	Grantee Staff[a]	Partners	IA Managers	Supervisors	Home Visitors
EBHV Initiative Characteristics and Context					
Grantee characteristics	X				
Context	X	X	X		
EBHV Initiative Planning	X	X	X		
Home Visiting Operations and Workforce Development					
National model accreditation	X		X		
Staffing			X	X	
Workforce training			X	X	X
Supervision			X	X	X
Staff turnover			X	X	X
Caseloads			X	X	X
Target population			X	X	X
Conducting home visits					X
Monitoring service delivery	X		X	X	X
Partnerships and Collaborations	X	X			
Building Community and Political Support	X	X			
Communication	X	X			
Evaluation Capacity	X	X			
Building Fiscal Capacity	X	X			
Successes, Challenges, and Lessons Learned	X	X	X	X	X

Source: Mathematica site visits, spring 2010.

[a]Some grantees chose to include additional participants in the interview with grantee staff, such as local evaluators.

IA = implementing agency

group interviews. When responses conflicted, we verified the information, if possible (for example, if discrepancies existed among responses to a question about the date an agency began serving clients we verified the information with the grantee). If it was not possible to verify the information, we noted the discrepancy as a difference of opinion among respondents (for example, if partners disagreed about the frequency of communication we concluded that not all partners received and/or read ongoing communication from the grantee).

Partner Survey

Communication and collaboration among partners involved in EBHV initiatives is central to developing infrastructure to support the adoption and implementation of home visiting programs to prevent child maltreatment and then sustaining these programs. Observing the broader system in which the infrastructure supports are developed and maintained and documenting the relationships among partners and how they change over time is important for understanding how the system works, the barriers to creating a system, and the patterns of communication.

To gather useful information about partnerships, communication, and collaboration, we attempted to collect data from up to 25 partners in each grantee's network using a web-based partner survey. We designed this first partner survey to observe the relationships among grantees' partners and through subsequent surveys we will be able to assess how partnerships develop and change over time. The survey documents how the home visiting system develops, the barriers to creating a system, and the patterns of communication and collaboration. We asked grantees to identify the most knowledgeable individual within each organization to serve as the potential respondent for that organization unit. When grantees identified multiple individuals representing distinct units within the same organizations as potential respondents, each unit or department within a larger organization served as a separate unit of analysis. On April 12, 2010, we sent all sample members (grantees and their identified partners) an invitation email to participate in the EBHV Partner Survey. This invitation email described the purpose of the survey, explained the selection of respondents, and stressed the confidential nature of the survey. The letter included was a hyperlink to the web survey, as well as contact information if questions or technical issues arose. At approximately 7- to 10-day intervals, we sent reminder emails to nonresponders and to those who began the survey but did not finish. Telephone reminders began on May 24, 2010. Data collection ended on June 4, 2010.

At the end of data collection, within-grantee response rates ranged from a low of 56 percent to a high of 93 percent (Table B.3). The overall response rate across all grantees was 80 percent.

For the purposes of this report, we used descriptive analyses to quantify survey responses across the 17 grantees. Descriptive statistics, including the frequencies of response categories endorsed by survey respondents were calculated based on all observed data. We did not include observations with missing response data on the questions of interest in any tables. In certain circumstances, we averaged response category frequencies within a grantee and then compared across grantees (that is, the unit of analysis was the 17 grantees).

Table B.3. Response Rates, by Grantees and Overall

Grantee	Total Partners	Completed Surveys	Response Rates (percentage)
County of Solano Department of Health and Social Services, California	24	19	79
Rady Children's Hospital, San Diego, California	16	11	69
Colorado Judicial Department	16	9	56
Children & Families First, Delaware	22	17	77
Hawaii Department of Health	22	19	86
Illinois Department of Human Services	14	12	86
Minnesota Department of Health	14	13	93
New Jersey Department of Children and Families	25	21	84
Society for the Protection and Care of Children, Rochester, New York	11	10	91
Mercy St. Vincent Medical Center, Toledo, Ohio	14	11	79
The University of Oklahoma Health Sciences Center	18	16	89
Rhode Island KIDS COUNT	12	10	83
The Children's Trust Fund of South Carolina	21	15	71
Child & Family Tennessee	10	7	70
Le Bonheur Community Health and Well-Being, Memphis, Tennessee	25	21	84
DePelchin Children's Center, Texas	15	9	60
Utah Department of Health	24	22	92
TOTAL	**303**	**242**	**80**

Source: Mathematica Partner Survey, spring 2010.

APPENDIX C

CHARACTERISTICS OF THE GRANTEE- SELECTED HOME VISITING PROGRAM MODELS

Table C.1. Summary of National Model Accreditation Requirements for Grantee- Selected Models

Model	Requirements for Accreditation
HFA	The accreditation process has three steps: 1. Site development of a self study based on the HFA best practice standards 2. External review performed by a team of at least two HFA certified reviewers 3. Accreditation decision made by the HFA Accreditation Panel
NFP	The process for becoming an NFP implementing agency involves submitting an implementation plan for review by NFP's national service office. In the implementation plan, agencies are asked to: 1. Demonstrate a need for NFP services and document the presence of other home visiting programs in the community. 2. Provide the NFP national service office with the number of low-income first time births in the catchment area per year 3. Identify a plan for the sound financing of the program (three years demonstrated support and first year in hand) 4. Articulate their experience with innovative programs 5. Demonstrate community support for NFP 6. Identify ability to coordinate with existing health and human service programs 7. Demonstrate the ability to establish effective referral procedures 8. Outline a plan to recruit and retain qualified registered nurses Agencies are considered official NFP implementing agencies only after a formal contract has been signed by local agency and the NFP national service office.
PAT[a]	To become a certified PAT program site, all applicants must complete four steps: 1. Submit a program plan to the national or state office that covers program design and service, funding sources, service population, leadership, recruitment and retention, public awareness efforts and evaluation 2. Receive approval of the program plan 3. Register individuals for training 4. Attend and successfully complete the Born to Learn Institute training
SafeCare	The national office works with interested implementation sites to determine the fit between the SafeCare model and the potential site and the readiness of a site to implement SafeCare. The national office requires site to review readiness information and complete an application for training. The office suggests that sites have: 1. Identified the target population and referral sources 2. Appropriate staffing 3. A commitment of staff and management to SafeCare 4. Infrastructure, support and materials needed to implement SafeCare with fidelity 5. Considered systemic level issues that can affect implementation
Triple P	All professionals trained to deliver Triple P are required to become accredited. The accreditation process, built into every Triple P professional training course, includes full mastery of the model and demonstrated competencies assessed by the trainer.

Sources: Georgia State University, National SafeCare® Training and Research Center 2009; Healthy Families America [website] 2010; Nurse-Family Partnership [website] 2009; Parents as Teachers 2005; Triple P Positive Parenting Program 2010. Information was reviewed by program model purveyors for accuracy in September 2010.

HFA = Healthy Families America; NFP = Nurse-Family Partnership; PAT = Parents as Teachers.

[a]Beginning January 1, 2011, all PAT affiliates must meet the 2011 Essential Requirements; existing affiliates will have until July 2014 to come into compliance with the essential requirements.

Table C.2. Summary of Home Visitor Education and Experience Requirements for Grantee- Selected Models

Model	Education	Experience
HFA	No requirements specified	Experience in working with or providing services to children and families; an ability to establish trusting relationships; acceptance of individual differences; experience and willingness to work with the culturally diverse populations that are present among the program's target population; and knowledge of infant and child development.
NFP	Registered professional nurses with a minimum of a Baccalaureate degree in nursing	Experience in community, maternal or child health, mental/behavioral health
PAT	Recommend that parent educators have at least a Bachelor's/4-year degree in early childhood or a related field; the minimum education and experience level for parent educators is a high school diploma or GED	For staff with the minimum education level, a minimum of 2 years previous supervised work experience with young children and/or parents. For other staff, supervised experience working with young children and/or parents is recommended.
SafeCare	No requirements specified	No requirements specified but some experience in human services with families at risk for maltreatment is recommended.
Triple P	Professional practitioners with post-secondary qualifications in health, education, social services, mental health, or a closely allied field.	Knowledge of child/ adolescent development and parent-child interaction, plus experience working with families

Sources: Georgia State University, National SafeCare® Training and Research Center 2009; Healthy Families America [website] 2010; Nurse-Family Partnership [website] 2009; Parents as Teachers 2005; Triple P Positive Parenting Program 2010. Information was reviewed by program model purveyors for accuracy in September 2010.

HFA = Healthy Families America; NFP = Nurse-Family Partnership; PAT = Parents as Teachers.

Table C.3. Summary of Training Requirements for Home Visitors and Supervisors for Grantee-Selected Models

Model	Training Requirements for Home Visitors	Training Requirements for Supervisors
HFA	Home visitors must complete a four-day workshop called Integrated Strategies for Home Visitors delivered by HFA certified trainers. HFA also offers training on supporting families during the prenatal period. This training lasts three to four days depending on staff experience.	In addition to completing the Integrated Strategies for Home Visitors workshop, supervisors must attend a fifth day of training specific to their work. The training an introduction to administrative, clinical and reflective supervisory practices.
NFP	Home visitors complete three core education sessions in both distance and face to face training formats over a nine month timeframe; this includes a four day long in person training in Denver, CO. Home visitors can begin serving families after completing the training in Denver.	In addition to completing the three core education sessions required for home visitors, nurse supervisors complete four supervisor core education session (two of these sessions are conducted in person).
PAT[a]	Parent educators must attend a five day training called the Born to Learn Institute Prenatal to 3 years. If programs serve preschool-aged children, parent educators must attend two additional days of training. Additional training is required for staff that administers developmental, vision, and hearing screenings.	In addition to the training for parent educators, supervisors must complete a training for supervisors called the Introductory PAT Supervision Training.
SafeCare[b]	Home visitors must complete a five day workshop delivered by a SafeCare trainer. Home visitors are provisionally certified after the workshop training; home visitors then get feedback on their implementation of SafeCare in the field with families from a SafeCare coach. When home visitors demonstrate mastery of SafeCare skills in the field, they are granted certification as SafeCare providers.	Supervisors (known as coaches) must meet all training requirements for home visitors and achieve certification. They must also complete a one day workshop delivered by a SafeCare trainer. After the workshop, they must demonstrate skills in assessing fidelity and providing feedback to home visitors via recorded (or live) sessions with home visitors.
Triple P	Triple P offers a series of accredited training courses for professionals. The courses offer training in various levels of the intervention for practitioners delivering brief through more intensive services. Two to three months after training, practitioners must complete a competency-based accreditation process.	Triple P recommends that supervisors participate in a manager's briefing before going through professional Triple P training, and then engage in post-training consultation with Triple P consultation staff.

Sources: Georgia State University, National SafeCare® Training and Research Center 2009; Healthy Families America [website] 2010; Nurse-Family Partnership [website] 2009; Parents as Teachers 2005; Triple P Positive Parenting Program 2010. Information was reviewed by program model purveyors for accuracy in September 2010.

HFA = Healthy Families America; NFP = Nurse-Family Partnership; PAT = Parents as Teachers.

[a]As of January 1, 2011, the training requirement for newly implementing PAT affiliates will be the 3 day Parents as Teachers Foundational Training plus the 2 day Model Implementation Training. In addition, the requirement for supervisors will be attendance at a 2 day Model Implementation Training.

[b]As of fall 2010, SafeCare is implementing new training requirements that will require newly trained home visitors demonstrate skills in each of the three SafeCare modules before being certified.

Table C.4. Summary of Target Populations for Grantee- Selected Models

Model	Age at Enrollment	Characteristics
HFA	Mothers must be enrolled prenatally or within the first three months after a child's birth	Overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences (typically determined by the Parent Survey Assessment – formerly known as the Kempe Family Stress Checklist).
NFP	A woman must be enrolled early in her pregnancy and receive a first home visit no later than the end of her 28th week of pregnancy	First-time, low-income mothers and their children
PAT	Families with children up to kindergarten entry	Implementing agencies select the specific characteristics of the target population they plan to serve
SafeCare	Families with children birth to age 5	Families with a history of child maltreatment or risk factors for child maltreatment, including young parents; parents with multiple children; parents with a history of mental health problems, substance abuse, or intellectual disabilities; foster parents; parents being reunified with their children; parents recently released from incarceration; parents with a history of domestic violence; and parents of children with developmental or physical disabilities
Triple P	Families with children birth to age 12	Varies by intensity of model being implemented and by families' preferences; typically higher intensity models target families with children with behavior problems, families facing challenges (such as parental depression), families with a child with a disability, and/or families at risk for child maltreatment

Sources: Georgia State University, National SafeCare® Training and Research Center 2009; Healthy Families America [website] 2010; Nurse-Family Partnership [website] 2009; Parents as Teachers 2005; Triple P Positive Parenting Program 2010. Information was reviewed by program model purveyors for accuracy in September 2010.

HFA = Healthy Families America; NFP = Nurse-Family Partnership; PAT = Parents as Teachers.

Table C.5. Summary of Expected Dosage and Duration of Grantee- Selected Models

Program Model	Expected Dosage	Expected Duration
HFA	Offered a minimum of weekly visits the first six months after the birth, then scaled (from weekly to quarterly) depending on family needs & the child's age; visits last 60 to 90 minutes	Until child is at least 3 and up to 5 years of age
NFP	Scaled (from weekly to quarterly) depending on the child's age; visits last 60 to 90 minutes	Until child's 2nd birthday
PAT	At least monthly; visits last 60 to 90 minutes	Until enrollment in kindergarten
SafeCare	Weekly; visits last 60 to 90 minutes	18 to 20 weeks
Triple P	The frequency and length of visits vary by the intensity level of the Triple P model being delivered.	Consistent with intensity level, the duration of services can vary from a few weeks up to four months depending on the family's needs. In addition, the Triple P multi-level system lends itself to either starting with a brief duration followed by a longer duration program, or starting with a longer duration program followed by a briefer booster program as needed.

Sources: Georgia State University, National SafeCare® Training and Research Center 2009; Healthy Families America [website] 2010; Nurse-Family Partnership [website] 2009; Parents as Teachers 2005; Triple P Positive Parenting Program 2010. Information was reviewed by program model purveyors for accuracy in September 2010.

HFA = Healthy Families America; NFP = Nurse-Family Partnership; PAT = Parents as Teachers.

Table C.6. Summary of Supervision Requirements Specified by the Grantee- Selected Models

Model	Supervisors to Staff Ratio	Supervision Requirements
HFA	HFA recommends one supervisor for every five or six home visitors	HFA recommends program managers/supervisors provide formal supervision and shadowing of home visitors weekly for a minimum of 1.5 hours to monitor and assess their performance and provide constructive feedback and development.
NFP	NFP requires that a full-time nursing supervisor provides supervision to no more than 8 individual nurse home visitors	Nurse supervisors provide home visitors weekly clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role. Supervisory activities include weekly one-on-one clinical supervision, weekly case conferences and/or team meetings, and field supervision conducted three times a year.
PAT	A maximum of 10-12 parent educators can be assigned to each supervisor.	PAT requires that supervisors meet individually with parent educators for reflective supervision at least once per month.
SafeCare [a]	SafeCare does not specify a maximum ratio of supervisors to home visitors	SafeCare requires that certified supervisors (known as coaches) conduct weekly team meetings to discuss cases and SafeCare implementation. Coaches are required to monitor the quality of home visits either via live observation or via recordings of sessions. SafeCare requires at a minimum that coaches monitor the first four sessions of each home visitor's SafeCare sessions and then monitor sessions monthly thereafter.
Triple P	Triple P does not specify supervision requirements but rather encourages each agency to follow their established supervisory guidelines.	Triple P recommends that every staff person implementing the model receive sufficient quality supervision (including peer supervision to facilitate professional development and increase fidelity to the model). Triple P does not specify requirements because it aims not to intrude on an agency's established supervisory guidelines.

Sources: Georgia State University, National SafeCare® Training and Research Center 2009; Healthy Families America [website] 2010; Nurse-Family Partnership [website] 2009; Parents as Teachers 2005; Triple P Positive Parenting Program 2010. Information was reviewed by program model purveyors for accuracy in September 2010.

HFA = Healthy Families America; NFP = Nurse-Family Partnership; PAT = Parents as Teachers.

[a] As of Sept 2010, all new SafeCare sites will be required to conduct coaching twice monthly at a minimum until a new home visitor is certified and monthly thereafter.

Table C.7. Summary of Model Specifications for Reporting on Service Delivery

Program Model	Whether Reporting is Mandatory or Voluntary	Frequency of Reporting	Reporting System	Type of Information Collected
HFA	Voluntary	Annual	Program Information Management Systems (PIMS)	PIMS can be used by IAs to track information about site infrastructure (including site resources, staff characteristics, staff training, target community characteristics, and funding resources) and family characteristics (including demographics; information on screenings and assessments; and activities including home visits, medical visits, and immunization records).
NFP [a]	Mandatory	Daily	Clinical Information System (CIS)	CIS is used to record participant level data including family characteristics, family and child outcomes, and information about home visits (including the number of completed visits and content covered during visits)
PAT	Mandatory	Annual	Annual Program Report web-based system	Aggregate level data on program operations.
SafeCare	Mandatory	Minimum of twice monthly until staff are certified, and then monthly thereafter	Audio files of sessions and coach's scoring of those sessions are uploaded to a web site. In addition, basic information about home visitors is recorded by certified SafeCare trainers in a database.	Agencies implementing SafeCare are required to provide NSTRC ongoing information about home visitors' fidelity to the model. This is accomplished by submitting recordings of home visiting sessions and scoring sheets of those sessions completed by supervisors (coaches). In addition, SafeCare trainers provide basic demographic and contact information on new home visitors, along with performance data during training, and fidelity data once they begin working with families.
Triple P	Triple P America does not collect service monitoring data from implementing agencies but does provide consultation for implementing service monitoring procedures internally within IAs.			

Sources: Georgia State University, National SafeCare® Training and Research Center 2009; Healthy Families America [website] 2010; Nurse-Family Partnership [website] 2009; Parents as Teachers 2005; Triple P Positive Parenting Program 2010. Information was reviewed by program model purveyors for accuracy in September 2010.

HFA = Healthy Families America; NFP = Nurse-Family Partnership; PAT = Parents as Teachers.

[a] In fall 2010, NFP is launching a new system known as Efforts to Outcomes (ETO™).