Maternal, Infant, and Early Childhood Home Visiting Program Evaluation:

Plans for the 2015 Report to Congress

September 12, 2013

SUMMARY

The Patient Protection and Affordable Care Act of 2010 (ACA) authorized the creation of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program and required a national evaluation of the program in its early years of operation. That evaluation is the Mother and Infant Home Visiting Program Evaluation (MIHOPE). The ACA also required that the national evaluation present a Report to Congress in 2015, which will lay the foundation and framework for understanding future findings from the national evaluation. This document summarizes plans for the Report to Congress.

The report will have five sections, as described below.

- The report will begin with a brief overview of the potential importance of home visiting programs for improving outcomes for families. This section will also highlight funding provided under the ACA for states to operate the MIECHV program, and the tools put in place to support states and local programs (such as technical assistance to states and setting benchmarks). Finally, it will summarize the MIHOPE design, which called for 5,100 families to be randomized across 85 sites in 12 states, and which is collecting information on program implementation and family outcomes from a variety of sources.

- The report will then explain the process by which states and sites were chosen to be in the study, and describe the states and sites that were chosen. In short, the study sought to include states that were using MIECHV funds for more than one national model, that had the potential to add more rural areas to the study, and that ensured that states would be chosen from each of four broad geographic regions. Within states, MIHOPE sites had to have been operating for at least two years, had to have enough demand for services to allow the ethical creation of a control group, and had to have relatively few other services for families who would be in the study to ensure a "treatment differential" between the home visiting program and control groups.The 12 MIHOPE states include California, Georgia, Illinois, Iowa, Kansas, Michigan, Nevada, New Jersey, Pennsylvania, South Carolina, Washington, and Wisconsin.

- An analysis of needs assessments completed by states, territories, and Washington, D.C. to obtain MIECHV funds will summarize the types of communities and families in need of home visiting. As requested by the Advisory Committee on the Maternal, Infant and Early Childhood Home Visiting Program Evaluation (the Committee), MIHOPE is also asking MIECHV administrators how the assessments were used in making decisions about the allocation of MIECHV funds. The report will include a narrative synthesis of those interviews.

- The report will describe the families enrolled in MIHOPE using data from surveys completed by study participants and observations of the home environment. In addition to describing families' demographic characteristics, the report will describe families in terms of the outcome domains of interest identified in the ACA. In particular, the report will provide information on (1) prenatal, maternal

and newborn health; (2) domestic violence; (3) family economic self-sufficiency, and (4) parenting. To illustrate differences in who the national home visiting models serve, a select set of characterisics will be shown for each national model. In addition, because services for pregnant women may differ from those for women with young children, and services for women with children may differ from those for first-time mothers, selected characteristics will be shown by parity and pregnancy status.

- The report will provide information on how the local home visiting programs participating in MIHOPE are implementing the MIECHV program. Tables will present basic features of participating local sites and their staff, such as the national model implemented, program size, and staff demographic characteristics. The report will also describe the home visiting service models and implementation systems being used in MIHOPE sites. Finally, the report will describe the influence of the MIECHV program on local sites by noting where and how it has motivated changes in their intended service models. Data will come from several sources: interviews with national model developers, interviews with state MIECHV administrators, and baseline surveys of local sites' program managers, supervisors and home visitors.

Based on the report's descriptive results, the report will summarize how the MIECHV program has thus far influenced what states are doing to support the implementation in communities, and how local program sites are defining their intended services and supporting staff to improve outcomes for targeted families. This discussion will be further informed by a preliminary examination of the health, socio-economic, and demographic profiles of families that are enrolled in the national evaluation.The findings will serve as the first glimpse into how evidence-based policymaking as embodied by MIECHV is being implemented and interpreted by states, and by home visiting program models at both the national and local levels across a wide range of targeted domains.

The Patient Protection and Affordable Care Act of 2010 (ACA) authorized the creation of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program and required a national evaluation of the program in its early years of operation. That evaluation is the Mother and Infant Home Visiting Program Evaluation (MIHOPE). MIHOPE was launched in 2011 by the Administration for Children and Families (ACF) and the Health Resources and Services Administration (HRSA) within the U.S. Department of Health and Human Services (HHS). The evaluation is being conducted by MDRC with Mathematica Policy Research, James Bell Associates, Johns Hopkins University, the University of Georgia, and Columbia University.The ACA also required that the national evaluation present a Report to Congress in 2015.

MIHOPE uses a rigorous study design and includes four components: (1) an analysis of the needs assessments that states, territories, and Washington, D.C. completed when they were making decisions about how to allocate MIECHV funds (hereafter referred to as state needs assessments); (2) an implementation study, which will examine how the program models operate in their local and state contexts; (3) an effectiveness study, which uses random assignment to estimate the effects of home visiting programs on family outcomes; and (4) an economic analysis that will examine the financial costs of operating the programs. Because families are being recruited for the study through 2014, information on the effectiveness and costs of home visiting programs will not be available for the Report to Congress due on March 23, 2015. However, the study team will have reviewed the state needs assessments and collected a considerable amount of information on program implementation and on the families who are in the study.

Given these considerations, the Report to Congress has five primary objectives:

(1) **To provide research and policy context for the national evaluation**. An introductory section of the report will review the promise of home visiting programs, the requirements

of the part of the Affordable Care Act (ACA) that authorized the MIECHV program, and the goals and design of MIHOPE.

(2) **To provide information on states and sites included in the evaluation**. MIHOPE is nearing the end of the process of enrolling sites in the study. This section of the report will describe the process for choosing states and sites and some characteristics of the study sites.

(3) **To provide information on state needs assessments**. The needs assessments were used by states in deciding which communities should receive MIECHV funds and which families should be targeted for MIECHV-funded services. They therefore contain considerable information on the extent to which home visiting existed prior to the MIECHV program, the types of home visiting services that were being provided, and the types of families who were being served. This section of the report will discuss differences in the types of information that states collected in order to make these funding decisions, as well as illustrate how selected states from the evaluation of program effectiveness used this information to inform their selection of evidence-based programs and their targeting of communities and families.

(4) **To describe the families who are served by the home visiting programs in MIHOPE**. Information used in the report will come from surveys conducted with families when they entered the study, as well as observations of the families' homes. Knowing who is in the evaluation will shed light on whether states and local programs are successfully targeting some of the groups highlighted in the ACA, such as pregnant women under age 21. It will also indicate the types of needs families have, providing context for interpreting information on how programs were implemented. Finally, it may indicate the

opportunities for MIECHV to achieve impacts on key domains. For example, home visiting may be less likely to make a difference in areas where families are already doing well but may be more beneficial in areas where families need help.

(5) **To describe the local programs that are in the evaluation and the staff who provide services at those programs**. Since home visiting programs are influenced by national model developers, state MIECHV administrators, and individuals at the organizations providing home visiting services, the report will trace the development of program features through those three levels. For example, it will describe the extent to which national model developers and local programs report having adapted to respond to the requirements of MIECHV. It will present local programs' reports of how well-aligned they are with the expectations of their national models. It will also provide an initial indication of how home visiting programs are training staff to help families with the challenges they face and providing them with administrative supports such as MIS systems and continuous quality improvement processes.

The Report to Congress will thus provide an early look at the implementation of MIECHV and will lay the foundation and framework for understanding future findings from the national evaluation. To accomplish the objectives identified above, data will be drawn from the following sources: 51 state-wide needs assessments (including the District of Columbia) and 5 needs assessments of U.S. territories; completed surveys of home visitors, supervisors, and program managers in all of the approximately 85 MIHOPE sites and the 12 MIHOPE states; and completed baseline surveys and home observations of a sub-sample of families (approximately 60 percent) who have been enrolled in MIHOPE.

Below is an outline of the report, followed by detail on the purpose and proposed content of each section. Proposed table shells are provided in a separate document.

Outline for MIHOPE 2015 Report to Congress

1. **Introduction**
    a. Policy context: Home visiting, the ACA, and MIECHV.
    b. Home visiting background and rationale for potential importance of MIECHV (prevention of health and developmental disparities; long-term cost-benefits; early education and child development benefits; improvement of health over the life course through early intervention) drawing from existing knowledge and research
    c. Overview of the national evaluation: Discuss what MIHOPE is studying, including (1) an analysis of state needs assessments; (2) an effectiveness study, which incorporates an implementation study and an analysis of impacts on family outcomes; and (3) an economic analysis, and what the national evaluation does not include (e.g., tribal populations, competitive funding grants).
    d. Design elements of MIHOPE study of program implementation and effectiveness.
    e. Overview of the remainder of the report.

2. **Overview of MIHOPE States and Sites**
    a. Discuss how states were selected (e.g., all have a history and experience with home visiting programs). Discuss home visiting services (including use of different models) available in the states.
    b. Discuss how sites were selected within states.

c. Highlight geographic and program model diversity (e.g., urban and rural differences, representation of the four models).

3. State needs assessments

a. Summarize initial state needs assessments and state plans used in implementation decision-making (data from 2010).

b. Describe how select states (i.e., the state MIECHV administrators who have been interviewed as part of the MIHOPE study on program effectiveness) developed and used their needs assessments, how they planned to target communities chosen for MIECHV funding, and how states planned to use MIECHV funding.

4. **Family Baseline Characteristics**

a. Recruitment of MIHOPE families: How it was done.

b. Describe sample characteristics, including information from baseline surveys and observations of home environment. (*Note:* This information will not be available for all families in time for inclusion in the Report to Congress.)

5. Service Models and Implementation Systems

a. The ACA outlines key attributes that implementing agencies should possess to promote the delivery of high-quality home visiting services, including: competent staff, ongoing and specific training, high quality supervision to establish competencies, organizational capacity, linkages and referral networks, and fidelity. These components are examined in MIHOPE through assessing core

elements of sites' service models and implementation systems (national and local), staff characteristics, and the role of influential organizations (refer back to conceptual framework). Descriptive information on these implementation components, using data collected thus far, will be presented in this section of the report.

b. Describe the organizations, as identified and discussed by program managers, that influence local sites' service models and implementation systems.

c. Present basic characteristics of local sites at entry into MIHOPE.

d. Describe characteristics of service models. The defining features of the service model to be presented are (1) intended goals and outcomes, (2) intended recipients, (3) intended service delivery, and (4) intended staffing.

e. Describe implementation systems. The defining features of the implementation system to be presented are categorized as policies, procedures and resources for: (1) staff development; (2) facilitative clinical supports; (3) facilitative administrative supports; and (4) systems interventions.

6. Implications

a. Summarize grantees' perceptions of how MIECHV has influenced what states are doing, what national models are doing, and what local sites are doing to impact health and well-being for families.

b. Contextualize how implementation analysis and findings thus far informs the impact analysis to come.

7. **List of potential appendix tables**

Appendix A: At-risk Indicators Reported in State needs assessments

Appendix B: Quality and Capacity of Existing, Pre-MIECHV Home Visiting Programs, as Reported in State needs assessments

Appendix C: How States Planned to Use Their MIECHV Funding

Appendix D: Maps or tables showing geographic distribution of states/sites

The remainder of this document summarizes the information to be presented in the Report to Congress, focusing on the proposed content and purpose of each section.

I. INTRODUCTION

The first section of the report will provide a brief overview of the role and potential importance of home visiting programs in improving outcomes for families. This section will also highlight funding provided under the ACA for states to operate the MIECHV program, which places clear emphasis on federal-state-local partnerships, as well as on supporting rigorous research on the implementation and effectiveness of home visiting programs. It will thus briefly summarize the various tools put in place to support states and local programs (e.g., providing technical assistance to states, setting benchmarks), and the importance of the Home Visiting Evidence of Effectiveness (HomVEE) review in identifying evidence-based program models for states to use in their MIECHV programs. [1]

After presenting this context, the motivation for the national evaluation and an overview of its core components will be highlighted. A brief discussion of these issues is provided below to remind the Advisory Committee on the Maternal, Infant and Early Childhood Home Visiting Program Evaluation (the Committee) of the evaluation's goals and design. More details on these issues can be found in the MIHOPE design report, which is being provided along with this document.[2]

Background on the Evaluation

[1] USDHHS (2011)
[2] Michalopoulos et al. (2013)

Legislative requirement. The ACA included $1.5 billion in funding for home visiting programs over five years and mandated an evaluation of the MIECHV program in its early years, which became MIHOPE. The ACA specified four main components of the national evaluation:

- **Analysis of the needs assessments.** An analysis, on a state-by-state basis, of the results of assessments of state needs that are required by the legislation and state actions in response to the assessments.
- **Effectiveness study.** An assessment of the effects of early childhood home visiting programs on child and parent outcomes, with respect to each of the benchmark areas and participant outcomes specified in the legislation. Specifically, these outcome areas are: (1) prenatal, maternal, and newborn health; (2) child health and development; (3) parenting skills; (4) school readiness and academic achievement; (5) crime and domestic violence; (6) family economic self-sufficiency; and (7) referrals and service coordination.
- **Subgroup analysis.** An assessment of the effectiveness of such programs on different populations, including the extent to which effects on participant outcomes vary across programs and populations.
- **Study of effects on the health care system.** An assessment of the potential for the activities conducted under such programs, if scaled broadly, to improve health care practices, eliminate health disparities, improve health care system quality, and reduce costs.

To meet legislative requirements and additional goals set forth by HHS, MIHOPE is doing the following:

- **Using a rigorous design for assessing the effectiveness of home visiting services overall, and variations across programs and populations.** The evaluation is seeking to

obtain credible evidence of the effects of home visiting services and to address questions about key subgroups of programs and families.

- **Studying the effectiveness of home visiting programs across all domains specified in the Affordable Care Act (ACA).** Prior studies of home visiting have varied in the domains they analyzed and the outcomes examined within each domain. The national evaluation is improving what is known about home visiting by measuring outcomes consistently across all sites included in the evaluation.
- **Reflecting the national diversity of communities and populations.** Home visiting currently takes place in thousands of communities involving many thousands of families. Under the Maternal Infant and Early Childhood Home Visiting (MIECHV) program, home visiting may be extended to even more places and serve even more families with particular needs. The national evaluation is seeking to represent this diversity.
- **Systematically studying program implementation.** Prior studies of home visiting programs have often included little information on the actual services provided to families and on the community, organizational, and family characteristics that influence service delivery. The national evaluation includes a variety of information on each of these areas.
- **Linking information on communities, organizations, services, and families to program impacts in order to deepen understanding of program features associated with greater benefits.** This can be used to expand the range of outcomes, strengthen impacts and broaden populations in which home visiting improves child and family well-being and eliminates health disparities.

Research questions. The national evaluation is addressing the following research questions:

State Needs Assessments:

- What were the results of the state-wide needs assessment process?
    - How did states identify at-risk communities?
    - How did they identify the quality and capacity of existing programs?
- How did states respond to the development of the needs assessments?

Program Effectiveness:

- What are the effects of home visiting programs across the range of outcomes specified in the ACA?
    - Do the effects of home visiting programs vary across subgroups of families?
- What is the relationship between the features of home visiting programs and their effects on family outcomes?
- What are the effects of home visiting programs on health disparities, health care quality, and health care practices?

Program Implementation:

- How do the funded home visiting programs actually operate?
- How are the different types of inputs of home visiting programs – such as community context, influential organizations, service models, staff characteristics, family characteristics and implementation systems -- related to one another?
- How is the full set of inputs related to the services provided to families through home visiting and through referrals to other services?

Economic Analysis:

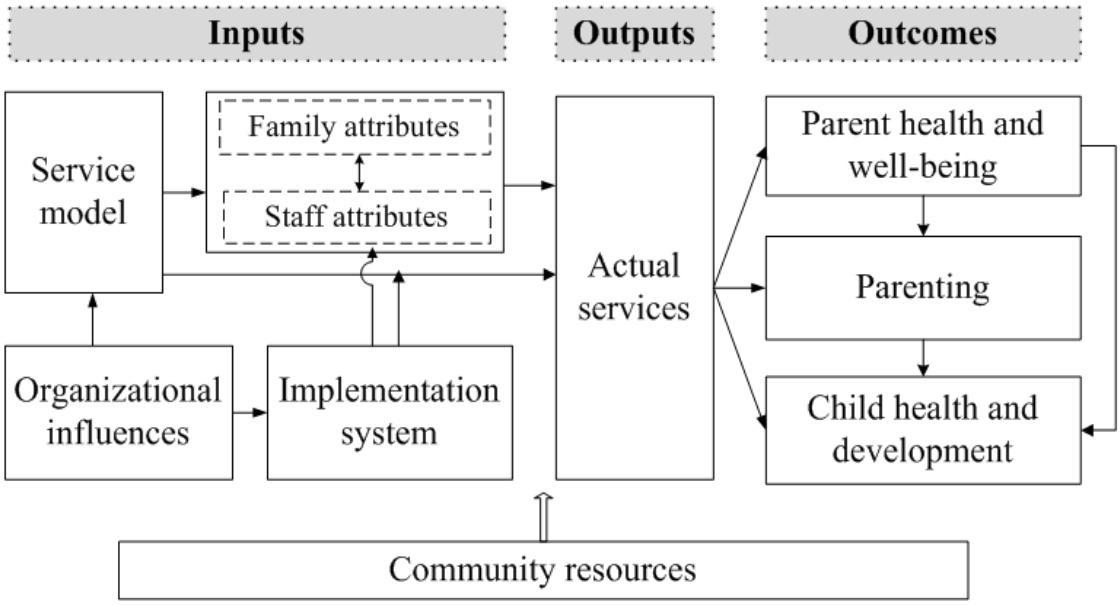
- What is the cost to deliver home visiting services, and how do these costs vary across groups of families and local programs?
- What is the cost to achieve key impacts for families and children, and how do these costs vary across groups of famlies and local programs?
- What are the returns on investment for home visiting programs in terms of Medicaid savings and other health care use?

Conceptual framework. MIHOPE is based on a conceptual framework of how home visiting programs work and achieve their effects, as shown in Exhibit 1. The Report to Congress will contain greater detail on the theoretical and empirical context for this framework. This framework is organized into three broad aspects: (1) factors that influence service delivery, (2) actual service delivery, and (3) outcomes. The framework postulates that a number of considerations may influence how services are provided to families. For example, resource availability and needs are thought to be situated within community contexts, and multiple organizations are thought to influence how a program adapts a service model and defines its implementation systems.

Local implementing sites in the evaluation will use one of four national evidence-based service models. The resources used by a site to implement this model are referred to collectively as the implementation system. A site's service model and implementation system, in turn, are thought to influence the skills and characteristics of staff that deliver home visiting services and the types of families that enroll. Characteristics of the community, service model, implementation system, home visitors, and families all have the potential to affect the actual services that families receive directly from the home visiting program and indirectly as a result

of referrals to other services. According to the framework, the actual services received should ultimately influence outcomes of interest, including parenting behavior, parent and child health and well-being, and child development.

Exhibit 1. Conceptual framework



The evaluation design. To provide unbiased estimates of the effects of home visiting programs, families who are recruited into the study are being randomly assigned either to a MIECHV program or to a control group that can use other services available in the community. The study will include approximately 5,100 families spread across about 85 sites (that is, 85 local programs). This number of families will provide enough statistical power to examine differences in impacts of home visiting across key subgroups of families. The large number of sites in part reflects the small capacity of most local home visiting programs but also is creating

an opportunity to learn about the relationship between local program features and the impacts of home visiting.

Model selection. The evaluation is focused on four evidence-based models of home visting that were chosen by 10 or more states: Early Head Start—Home Visiting Option (EHS), Healthy Families America (HFA), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT). All four of these evidence-based models work with pregnant mothers or mothers of infants, but only two of the models enroll children 2 and older.

Site selection. The 85 sites are being selected to include a diversity of program models, families, and geographic locations across the country. For example, the evaluation has sought to include a similar number of local programs for each of the four evidence-based program models included in the evaluation to ensure that the results do not primarily reflect one or two program models. Likewise, the evaluation has sought to include a diverse set of families to provide fairly precise estimates of the effects for subgroups of families.

Sites chosen for the evaluation are meeting several other criteria. Since new programs might take time to evolve to their full level of effectiveness, the evaluation has chosen only sites operating programs that had existed for at least two years. In addition, sites must have had enough demand for services to allow for the ethical creation of a control group. To reduce recruitment costs, sites are concentrated in 12 states.Family eligibility. Since it can be difficult to compare many outcomes across a broad range of children's ages, and because the majority of families in MIECHV are likely to enroll during pregnancy or infancy, the evaluation is including only families in which the mother is pregnant or the child is less than six months old at enrollment. The evaluation is including families in which the mother is at least 15 years old,

given concerns about randomly assigning younger women. Follow-up data will be collected around the time the child is fifteen months old.

Data sources. Data for the impact and implementation studies are being collected from a variety of sources to provide the most reliable evidence possible about home visiting services and their effects on families and children. Data sources include: surveys with parents; observations of the home environment; observed interactions of parents and children; direct assessments of children's receptive language skills; observations of home visitors in their work with families during home visits; logs completed by home visitors and supervisors; observations of home visitors during home visits; surveys and interviews with home visitors, supervisors, and program administrators; program model documentation from program developers, grantees, and local sites; and administrative data on child maltreatment, health care use, maternal health, birth outcomes, and employment and earnings. Many of the findings presented in the Report to Congress will rely on information from surveys of national model developers; state MIECHV administrator interviews; web-based surveys of home visitors, supervisors and program managers across local sites; as well as on the baseline survey of families and interviewers' observations of the home environment at baseline.

After reviewing this background and context, the first chapter of the report will identify the objectives of the Report to Congress, which is to provide a rich description of state needs assessment processes and of MIHOPE families and programs, as well as expectations for future reports (findings from a detailed implementation study; findings of impacts on targeted outcomes and results of the cost analysis; and an assessment of how various components of implementation processes affect outcomes).

II. OVERVIEW OF MIHOPE STATES AND SITES

This section of the report will review the process by which states and sites were chosen to participate in MIHOPE, and to discuss which states and sites were chosen for the study. MIHOPE sought to include states that would promote several study goals: to provide enough sites for the evaluation, to provide a similar number of programs for each of the four national models, to ensure geographic diversity, and to include states using MIECHV funds for two or more of the four national models. In the end, MIHOPE included all 12 states that had study-eligible home visiting programs (described below) for more than one of the national models. These states are California, Georgia, Illinois, Kansas, Michigan, Nevada, Pennsylvania, Washington, and Wisconsin – where MIHOPE has already begun recruiting families – and Iowa, New Jersey, and South Carolina – where sample recruitment will begin in the near future. These states met the goal of geographic diversity, as they represent each of four broad geographic regions (Northeast, Midwest, South, and West). A map that illustrates the geographic reach of the MIHOPE study across states and sites is attached.

Within states, MIECHV funds were awarded to local implementing agencies to support home visiting programs. Individual MIHOPE sites were selected from these MIECHV-funded home visiting programs, but not all MIECHV-funded programs in the study states were selected to participate. Chosen sites offer one of the four models and have at least two years experience implementing the model; they have more than one home visitor; and they are located in communities with greater need for the services than they can fulfill. In states that had more sites than needed for the study, the evaluation sought to include both metropolitan and non-metropolitan areas. However, the number of rural areas in the study is limited because many did not meet the study's sample requirements.

III. STATE NEEDS ASSESSMENTS

The analysis of state needs assessments will include information from two different sources. As required by the ACA, the chapter will provide a state-by-state analysisof the results of assessments of state needs and an analysis of state actions in response to the assessments.[3] This analysis will summarize the information collected by the states, territories, and Washington, D.C. on the types of communities and families in need of home visiting in these areas. As requested by the Committee, MIHOPE also asked MIECHV administrators in the 12 MIHOPE states how the assessments were used in making decisions about the allocation of MIECHV funds. The second part of the chapter will summarize the information gleaned from those interviews.

State-by-state charts

The central component of this part of the evaluation will be a set of tables that show key information from each state's needs assessment and state MIECHV plan. This information will be provided in three appendix tables for each state, while the body of the report will provide a summary of patterns that emerge across states. The text and summary exhibits[4] will focus on questions such as:

- How many communities were funded? (average and range across states)
- How are the counties that are receiving funding similar and dissimilar across states, in terms of the at-risk indicators identified in the state needs assessments?
- How do at-risk indicators in funded counties compare to national averages?

[3]All states and Washington, D.C., Guam, Puerto Rico, Northern Mariana Islands, U.S. Virgin Islands and American Samoa completed needs assessments and are included in the analysis.
[4]Note: The summary exhibits are not yet created.

- Before MIECHV, what kind of home visiting services were available?
- How many models were used in states? (average and range across states)
- Before MIECHV funding, which models were used across states?
- What program models did states pick for MIECHV funding? (totals by model, average number of models per state); and,
- Did states plan to use funds mostly to expand existing programs or to start new programs?

To illustrate the three tables that will be provided for each state, the materials provided with this document include completed tables for two states. In their needs assessments, states were asked to provide several specific indicators meant to help identify at-risk communities (such as number of live births before 37 weeks as a percentage of the total number of live births). The first table for each state – **Appendix Tables A.1** and **A.2** for the two example states – will show the at-risk indicators that states reported for their targeted counties as well as showing the average state values of these indicators. When states did not provide a requested indicator, a dash is shown next to the requested indicator in the table. When states provided a close substitute for a requested indicator, that new indicator was included in place of the requested indicator and a footnote explains the difference from what was requested. When states provided additional indicators that were not specifically requested, those were also included in the table, generally at the end. For these tables, there will be at least two pages per state (and more for states with a large number of targeted communities).

In their needs assessments, states were required to report several indicators of the quality and capacity of existing (pre-MIECHV) home visiting programs, such as the home visiting models or approaches in use and the specific services provided. The second table for each state –

Appendix Tables B.1 and **B.2** for the two example states– will show select information about the quality and capacity of programs or initiatives for early childhood home visiting that existed in 2010 when states did their needs assessments. For each program the state listed, the tables will include the information the state reported on home visiting model, target population, demographic characteristics of families served, and number of families and counties served. In cases where the state listed more than ten home visiting programs, these tables will be limited to the ten programs serving the most families in the state. (The remainder of programs will be listed in a footnote.) Only about half of states reported demographic characteristics for at least one of their models, and very few reported demographic characteristics for all of their models. In addition, the reported characteristics vary widely in level of detail. For this set of tables, there will be at least one page per state (and more for states with a large number of home visiting programs).

Appendix Table C.1 will show select information about how states reported that they were planning to use their MIECHV funding in their FY10 and FY11 state plans and competitive grant applications. These tables will include information on how many sites states proposed to fund, how many sites were proposed in metropolitan and non-metropolitan areas, and what models states were proposing to use the MIECHV funding for. This table will show information for several states on each page.

Narrative description from state administrator interviews

In addition to summarizing the collective needs assessment data gathered for all states, this section of the report will include a narrative synthesis of how selected states developed and used their needs assessments to identify targeted populations and communities, as well as choice

of national models. This information will be drawn from the state MIECHV administrator interviews, which are conducted as part of the evaluation of program implementation and effectiveness for the 12 MIHOPE states. Most of these interviews should be completed by the end of 2013. Key similarities and differences will be highlighted across several topics of interest including: involvement of stakeholder groups and decision-making processes in developing the needs assessment, identification and ranking of communities and specific population sub-groups, and changes in prioritizations since the initial need assessments were developed. This summary is intended to qualitatively describe the process of decision-making for MIECHV funding allocations from the state administrators' perspectives.

IV. FAMILY BASELINE CHARACTERISTICS

Having discussed the MIHOPE states and sites, this section of the report will describe the families enrolled in MIHOPE using data from the family baseline survey and from an observational measure of the home environment at baseline. Before introducing the family characteristics, the report will briefly overview the key population sub-groups and communities emphasized by the MIECHV program and operationalized by states as priority groups for home visiting services. It will also discuss how the four national models define eligible families. Certain characteristics, such as poverty or low-income status, are common to both MIECHV goals and the models. At the same time, local sites vary in how much discretion they have in further refining the types of families to target for services, depending on community need. Thus, there may be variation in some of the characteristics of families across sites in the study.

Table 4.1 will describe key socio-demographic characteristics of the study sample at baseline. The ACA specifies that pregnant women under 21 years of age and households with

members who have served or are currently serving in the Armed Forces are priority groups for home visiting. Other characteristics are relevant to understanding the diversity and risk profiles of families served by local sites in MIHOPE, including maternal age, maternal race and ethnicity, pregnancy status, whether the mother has any other children, maternal acculturation, household composition, and a measure of housing mobility. For example, housing mobility may affect the ability of home visiting programs to achieve their goals both directly, by influencing service delivery and coordination, and indirectly, by influencing parenting and child development. Young maternal age is associated with low educational attainment, poorer birth and child well-being outcomes, and is often tied to economic disadvantage.[5] Through provision of direct services and referrals to community resources, home visiting programs aim to improve these outcomes.

The following tables describe families at baseline in terms of characteristics included in the outcome domains that many established programs target and that are identified in the legislation. As noted earlier, the domains specified in the ACA are (1) prenatal, maternal and newborn health; (2) child health; (3) family economic self-sufficiency, parenting skills; (4) crime and domestic violence; (5) school readiness and academic achievement; and (6) referrals and service coordination.

Table 4.2 will describe the health and well-being of women at the time of their enrollment in MIHOPE. The table will report mothers' self-rated health, health-related quality of life, prenatal health care, health behaviors, mental health and well-being, and experience of intimate partner violence. Describing these characteristics will help understand the risks posed to mothers and children in the study, across a wide range of outcome domains. For example, mothers' self-reported health may represent assessments of physical health, but also functional

[5]Bissell (2000); Fletcher and Wolfe (2008); Fraser, Brockert, and Ward (1995); Gilbert et al. (2004)

and mobility limitations, which may affect their work patterns, educational achievement, personal and child care needs, daily activities, and ability to interact with their child.[6] Likewise, maternal health-related behaviors such as tobacco, alcohol, and drug use may affect birth outcomes. These behaviors are also associated with risk factors after the child's birth, including children's increased exposure to second-hand smoke, and in the case of alcoholism and illegal drug use, greater risk of child abuse and neglect and intimate partner violence.[7] Home visiting may help families with such risk factors avoid these adverse outcomes; consequentially, families with histories of substance use and household tobacco use are identified as priority groups in the ACA.

These maternal risk factors may be used to identify important subgroups of interest to be examined through analyses. These subgroups could include families identified as priority groups in the ACA, such as users of tobacco products in the home. They could also include subgroups of women who may respond differentially to home visiting. As noted in the MIHOPE design report, families vary in their cognitive and emotional capacity to engage with the services offered.[8] For example, prior research has shown that depressive symptoms can be predictive of how mothers respond to home visiting programs.[9]

The proposed table also shows measures of prior service receipt for alcohol or substance use, mental health help or treatment, domestic violence services, and counseling for domestic violence or anger management. Service receipt is important to report for several reasons. First, it provides us with some comparison between the proportion of parents who report particular needs

[6] http://www.healthmeasurement.org/Measures.html (2008)
[7] USDHHS and Office of Disease Prevention and Health Promotion (2010); Centers for Disease Control and Prevention (2010); Roberts and Pies (2011); Lemon, Verhoek-Oftedahl, and Donnelly (2002); Magura and Laudet (1996)
[8] Michalopoulos et al. (2013)
[9] Duggan et al. (2009); Love et al. (2002)

and the services they are already receiving when they first enroll in home visiting. Second, according to the conceptual model of home visiting programs proposed in the MIOHPE design report, community resources provide the foundation from which home visiting programs operate by determining what resources are available to program sites and what opportunities are available to families.[10] Past use of services may be indicative of the availability of these types of community resources.

Table 4.3 will describe maternal health care coverage, whether the mother has a usual source of care, and whether the child (if born) has insurance coverage and a usual source of care as well. These indicators are frequently reported in population health data (e.g. Behavioral Risk Factor Surveillance System, National Health Interview Survey), and will establish a baseline portrait of health care coverage and access. They may also be important predictors of the family's future health care use. Future reports can provide information on whether MIECHV home visiting increase mothers' access to health care coverage and care, and whether impacts on health care vary with insurance status at baseline.

Table 4.4 will describe the following measures of family economic self-sufficiency: maternal employment history, maternal earned income, household receipt of public benefits, and maternal education. Family economic characteristics and maternal education may be used to identify important subgroups highlighted in the ACA, such as eligible low-income families. Furthermore, the negative consequences of poverty and low-socioeconomic status affect multiple outcomes, including birth outcomes and child health, cognitive development, academic achievement later in life, and socio-emotional development.[11] Finally, family economic self-sufficiency was identified by the ACA as a key area for improvement. Many home visiting

[10] Michalopoulos and colleagues (2013)
[11]Duncan and Brooks-Gunn (2000); Aber, Bennett, Conley, and Li (1997); Eamon (2001); McLoyd (1998)

programs aim to help families reach economic self-sufficiency and to connect families to services that may help them reach this goal.

Table 4.5 will describe the quality of the home environment, as well as self-reported and observed parenting behaviors. Because some of the MIHOPE participants will be pregnant, first-time mothers, the table will show these characteristics by pregnancy status and parity at baseline. The proposed observational measures of the home environment are useful indicators of parents' baseline capacity to promote child development. For example, in addition to showing an overall assessment of the quality of the home environment, the table would show the percentage of households with at least 10 books. This measure was chosen because the presence of books in the home is correlated with family literacy practices and child language and cognitive development.[12] Although observational measures of parenting behaviors will only be available at baseline for parents who had children prior to random assignment, this information will help characterize the sample and the potential for home visiting programs to achieve their intended impacts. In meeting their goal of improving child health and development, some home visiting programs place particular emphasis on promoting positive parenting skills. By presenting information on baseline parenting behaviors, the report will be able to provide a portrait of parents' responsiveness to their children's distress and harshness prior to receiving home visiting services.

In addition to reporting information on parenting that might affect child development, the report will present an indicator of the child's adverse experiences (based on the mother's reports of current adverse experiences in the family).[13] The Adverse Childhood Experiences (ACE)

[12]Linver, Martin, and Brooks-Gunn (2004)

[13]Since the original Adverse Childhood Experiences (ACE) study, researchers have used various categories to create a cumulative measure of adverse childhood experiences. For example, the National Survey of Children's Health (NSCH) developed a modified list based on their survey, which included the following: (1) perceived of

study demonstrated that as the number of negative experiences increases, the risk for numerous health problems (such as alcoholism and alcohol abuse, depression, health-related quality of life, illicit drug use, risk for intimate partner violence, smoking, and unintended pregnancies) also increases.[14] Furthermore, some research has found that certain risks may be intergenerational in nature; that is, depressed youth are more likely to have a parent who also struggled with depression in youth, and child abuse and neglect can be cyclical in nature.[15]

Table 4.6 will describe birth outcomes for children born prior to random assignment. Birth weight, gestational age, and infant size are well-recognized indicators of birth outcomes and infant health, tracked and monitored by the CDC, and internationally by the WHO. These newborn health indicators are associated with long-term health and development and, therefore, serve as key baseline covariates and variables to identify subgroups of children who are at particular risk of poor longer-term outcomes.

Table 4.7 will describe selected family baseline characteristics by program model. Until this point, tables will have displayed characteristics for the entire sample or by pregnancy and parity status. Because each of the four models defines its eligible populations somewhat differently, this table will highlight differences in risk factors that might be present in the MIHOPE sample, including in age, prior births, parental empathy (a risk factor for child maltreatment), and in primary reasons for enrolling in home visiting. The reasons for enrolling in home visiting will come from open-ended responses to a question on the family baseline survey,

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socioeconomic hardship, (2) divorce/separation of parent, (3) death of parent, (4) parent served time in jail, (5) witnessed domestic violence, (6) victim of neighborhood violence, (7) lived with someone who was mentally ill, suicidal, or severely depressed, (8) lived with someone with an alcohol/drug problem, or (9) perceived to be treated or judged unfairly due to race/ethnicity. For the purpose of MIHOPE, the ACE score will reflect information available from the family baseline survey and administrative records: (1) child abuse (emotional, physical, sexual), (2) neglect (emotional, physical), (3) intimate partner violence; (4) maternal substance abuse; (5) maternal mental illness (clinical levels of anxiety or depressive symptoms); (6) parental separation or divorce; and (7) prior maternal arrests.

[14]Centers for Disease Control and Prevention (2013)

[15]Anda et al. (2009)

which the team will recode into broad categories reflective of the targeted outcome domains in the ACA.

The table will show these characteristics by program model because women who enroll in one program may be demographically different (for example, some programs only enroll first-time mothers) and, as a result, may have different motivations and expectations than women who enroll in another program. The table will report on mothers' reasons for enrolling in home visiting and their social networks' attitudes toward their receipt of home visiting services. In keeping with the aforementioned conceptual model, these characteristics (like maternal depression or psychological resources) are thought to influence how engaged mothers are in the home visiting program and may also affect the actual services provided.[16]

V. SERVICE MODELS AND IMPLEMENTATION SYSTEMS

This chapter will focus on how the local home visiting programs participating in MIHOPE are implementing the MIECHV program. The chapter will begin with tables that present the most basic features of participating local sites and their staff, such as the national model implemented, program size, and staff demographic characteristics. It will then move to descriptive tables and text that provide information about the home visiting service models and implementation systems being used in MIHOPE sites. Data will come from several sources: interviews with national model developers, interviews with state MIECHV administrators, and baseline surveys of local sites' program managers, supervisors and home visitors.

MIHOPE's conceptual framework emphasizes how local sites' service models and implementation systems are influenced by forces at the national, state and local levels. The chapter will highlight the role of three such forces – the MIECHV program, national home

[16]Michalopoulos et al. (2013)

visiting models, and the state agencies that are implementing MIECHV. For selected features of service models and implementation systems, it will highlight local sites' alignment with their national models.

The chapter will also describe the influence of the MIECHV program on local sites participating in MIHOPE by noting where and how it has motivated changes in their service models and implementation systems. The main mechanisms for this are the MIECHV program's benchmarking process, focus on quality improvement initiatives, provision of training and technical assistance, and financial support to states to strengthen their implementation systems. Much of the MIECHV program's influence on local sites is mediated by state-level actions, a process that will be illustrated, where possible, using information from qualitative interviews with state MIECHV administrators. For example, it is states, not local sites, that decide how to define benchmarks, how to collect performance data, and whether and how to augment features of the implementation system, such as infrastructure for staff development.

Basic Characteristics of Local Sites and Staff

Table 5.1 will describe local sites' basic characteristics, including type of implementing agency, years of program operation, enrollment capacity, type of community served, and proportion of funding from the MIECHV program. These characteristics are thought to influence both the service model and implementation system which in turn influence program effectiveness. Prior studies of human service programs have produced some evidence that program effects are associated with factors such as program maturity.[17]

Table 5.2 will describe staff demographic and employment characteristics, including age, race and ethnicity, educational attainment, and prior experience in home visiting. These

[17]Fixsen et al. (2005)

characteristics are important to understanding the background of home visiting staff. Education and prior experience, for example, may have implications for staff's skills in working with families. The table will also describe staff members' psychosocial well-being, as indicated by relationship style and depressive symptoms. Home visitor psychosocial well-being has been shown to influence home visitor burnout and turnover, how services are delivered and how well families engage in home visiting.[18]

Service Model

The defining features of the service model are (1) intended goals and outcomes, (2) intended recipients, (3) intended service delivery, and (4) intended staffing. MIHOPE's implementation study focuses on understanding how local programs define their service models, the reasons for variation in this, and the effects of variation on service delivery and impacts. The report to Congress will provide cross-sectional information on local sites' definitions of service models, as well as national models. The report will also discuss these aspects of service models in relation to the MIECHV program and state-level actions, which may potentially explain some variation at the local level.

An important framework for understanding the service model is the program's theory of behavioral change – that is, the articulation and specification of how their model of intended services will lead to intended outcomes. The theory of change cited by the national models will therefore be discussed in the report as relevant context for understanding how local sites and national model developers define different aspects of their intended service model. In fact, service model features may vary not only across local sites, but across local sites implementing the same national model. Moreover, local variation may be greater among sites that are

[18]Burrell et al. (2009);Sharp, Ispa, Thornburg, and Lane (2003); McFarlane et al. (2010)

implementing less prescriptive national models, as well as in states that are less prescriptive about the implementation of MIECHV.

Intended Goals and Outcomes.

The MIECHV program is ambitious in the range of outcome domains in which it expects states to show evidence of change. One important goal of the study will be to examine the outcome domains in which programs demonstrate the greatest impacts, and ultimately, how local implementation decisions are related to those patterns of impacts.

Implementation research shows that program impacts are greater for outcomes that are given a high priority.[19] Therefore, as a first step in the investigation of outcomes, **Table 5.3** will describe how national model developers, state MIECHV administrators, and local program managers prioritize outcomes designated as important outcomes for MIHOPE that are set out in the MIECHV program legislation. The national models, states, and local sites are likely to differ in the priorities they assign to these outcomes. Table 5.3 will allow us to identify the outcomes with universal versus selective endorsement as a high priority from the perspectives of the national models, states, and local sites, respectively.

Table 5.3 gives an indirect look at alignment of priorities from national models to states to local sites. **Table 5.4** goes beyond this by presenting local sites' reports of how the MIECHV program has influenced their outcome priorities. This is important because changes in priorities often imply adding priorities to existing ones, and therefore imply increasing complexity of the service model. Increased complexity of the service model increases the challenges of successful implementation by staff.

National and state-level priorities should be predictive of local site priorities. The degree of alignment of outcome priorities across the MIECHV program, national models, states, and

[19]Fixsen et al. (2005); Filene, Kaminski, and Cachat (2012)

local sites is also important. How well the prioritization of outcomes is aligned may determine how clearly local programs communicate expectations to staff, how well they prepare and support staff to fulfill these expectations, and how services are actually delivered. National-state-local agreement in priorities is therefore expected to be positively associated with other inputs, such as front line staff's own understanding of outcome priorities. Agreement in priorities is also expected to be positively associated with actual service delivery and with impacts on outcomes. While these hypotheses will not be formally tested in this report (although they will be in future reports), the discussion will highlight whether the outcomes that show a high degree of alignment as high priority across stakeholders are also reported by home visitors to be a high priority for service delivery.

Intended Recipients.

Implementation science suggests that program impacts are strongest for those individuals who are defined as the primary beneficiaries. The MIECHV program clearly focuses on mothers and children, though some of its intended outcomes, such as family economic self-sufficiency and domestic violence, imply benefits for other family members as well.

As discussed above, Chapter IV will have described the families enrolled in MIHOPE. **Table 5.5** will focus on how national models and local sites define the individuals for whom they assume responsibility for improving intended outcomes. Home visiting programs are often referred to as 'family support' programs, not just mother and child programs. Yet, research has shown that other family members rarely take part in visits, and very little research has examined program impacts on family members other than mothers and children.[20]

All national models and local sites will likely see themselves as having a primary responsibility to improve outcomes for mothers and the focal children. However, some national

[20]Duggan et al. (2004)

models and local sites are likely to see their responsibility as extending to other family members. The scope of responsibility is important because it is positively associated with the complexity of home visiting – the greater the number of family members for whom staff feel responsible, the more complex their task. The alignment of national models and local sites in defining intended beneficiaries is also important because it is an indicator of the clarity of the service model. Alignment is also likely to be associated with the adequacy of the implementation system, such as the availability of professional development and clinical supports, to improve outcomes for the individuals who are the intended beneficiaries.

Intended Service Delivery.

Intended service delivery includes intended dosage, content, and approach. It is the foundation for defining staff roles and competencies and for constructing the implementation system. Intended service delivery is an important factor for actual service delivery and is the standard against which to compare actual service delivery to measure service fidelity. This section will describe and compare the national models in terms of intended dosage, content and approach. It will also describe variation among local sites and their alignment with the national models they have adopted.

The tables in this section will focus on national models' and local sites' policies, rather than on MIECHV program policy and state policy. The MIECHV program does not specify intended service delivery per se, beyond requiring that states devote at least 75 percent of MIECHV funds for evidence-based models. Where relevant, information from state administrator interviews on any state adaptations to national service models will be discussed.

Table 5.6 will describe intended dosage as indicated by service initiation, duration of enrollment, and visit length and frequency. It will summarize the definitions for each national

model and report the percent of local program sites who report that their policies are aligned with those of their national model. The national models vary in how they specify intended services and in how much flexibility they allow local sites in defining intended services, but most sites will likely report aligning with their national models in defining intended dosage. Where applicable, information gathered from the state administrator interviews on whether states intentionally narrowed or broadened intended dosage and duration recommendations among their MIECHV programs will be included, which may also help explain variation in alignment.

MIHOPE conceptualizes home visit content as comprising three types of tasks: information gathering, education and support, and referral. **Table 5.7** will use this rubric to describe intended visit content for five domains that are common subjects of formal assessment, education, and referral protocols in home visiting programs -- maternal mental health, substance use, healthy relationships, parenting, and child development. For each domain, the table will report the percentage of local sites that have explicit policies for when information gathering is to be carried out, how decisions are made about when to provide education and support, and the role of the home visitor in making and following up on referrals. A description of how the MIECHV program, the national models, and the states have influenced local sites in developing policies around visit content will be provided.

Approach refers to the strategies and techniques used by home visitors. **Table 5.8** will focus on specific supportive strategies and parent training techniques that may play a role in achieving the goals of the program. It will indicate which national models encourage each technique, the percent of local sites encouraging each technique, and the alignment of local sites with the national model they have adopted. National and local encouragement of specific strategies and techniques will likely be positively associated with actual service delivery, and it

is also likely that the influence of encouragement at each level will be stronger when there is national-local alignment. In future analyses, it will be important to provide information on how home visiting service models are linked to how services are actually provided. For example, the effects of parent training programs on parenting behavior and children's externalizing behavior have been linked to specific program components and service delivery strategies.[21]

Intended Staffing.

Another fundamental way in which service models may vary is in their intended staffing, which has both quantitative and qualitative dimensions. In quantitative terms, staffing refers to caseload size, as indicated by the intended number of home visitors per supervisor, and by the number of families per home visitor. In qualitative terms, staffing refers to the expected roles of each staff member, how staff members are to collaborate, and the competencies they need to fulfill their roles.

Table 5.9 will compare the national models' policies for supervisor and home visitor caseloads. It will also report how well local sites are aligned with their national models. Caseloads are important because they have been shown to be related to staff burnout and service quality which, in turn, have been shown to moderate impacts on outcomes.[22] This could occur either because well-trained home visitors will deliver services that have greater fidelity to the national or local service model, or because more highly skilled and supported service providers are likely to deliver higher quality services, even in areas that may not be well-specified in the service model.[23]

Nearly all local sites are expected to have written job descriptions that specify staff members' roles and responsibilities. As part of the MIECHV program, national models are now

[21]Filene, Kaminski, and Cachat (2012)
[22]Fixsen et al. (2005); Durlak and DuPre (2008)
[23]Fixsen et al. (2005); Durlak and DuPre (2008)

working together to share their approaches to defining core competencies. They may differ, however, in their current approach to this and local sites may vary considerably in whether and how they define core competencies for home visitors and supervisors. Although this information will not be presented in table format, local site variation in definitions of roles of responsibilities will be discussed in the text of the report.

Theories of behavior posit that individuals are more likely to engage in particular behaviors if they believe they are expected to do so.[24] Thus, home visitors' actual behavior in home visits may be influenced by their understanding of what is expected of them. For example, home visitors who believe strongly that they are expected to help mothers reduce their tobacco use may carry out more activities to address smoking cessation than will home visitors who do not believe this is expected of them. **Table 5.10** will present home visitors' perceptions of their sites' expectations of them. The table gives the percentage of respondents who believe that their site expects home visitors to help mothers have positive maternal health and well-being, parenting and family economic self-sufficiency outcomes. The percent of home visitors endorsing specific actions may vary in the same way that states and sites varied in the priority they assign to specific outcomes.

Implementation System

The implementation system includes the policies, procedures, and resources needed to implement the service model and is thus a critical link between the intended service model and the services that are actually delivered to families. The defining features of the implementation system can be categorized as policies, procedures and resources for: (1) staff development; (2) facilitative clinical supports; (3) facilitative administrative supports; and (4) systems

[24]Glanz, Rimer, and Viswanath (2008)

interventions. Staff development includes recruitment and hiring, training, supervision and evaluation. Facilitative clinical supports include screening and assessment tools, protocols, and curricula, the availability of peer support, and the availability of professional consultation for situations that require expertise beyond that of the home visitor. Facilitative administrative supports include the availability and use of a management information system, and continuous quality improvement procedures to monitor and promote adherence to the service model. Systems interventions include formal agreements and shared information systems that make it easier for staff to link families with needed services and to coordinate services.

Staff Development.

Theories of behavior posit that individuals are more likely to engage in behaviors they believe they can carry out competently. Implementation science posits that the adequacy of training is positively associated with staff competence. National models' and local sites' resources for staff development will be described, with an emphasis on training.

First, a description of the national models' approach to initial and ongoing training will be discussed. All of the **national models** have training requirements for home visitors and supervisors. Their requirements differ in terms of timing, intensity, and content. Most local sites build on the training provided by the national models, likely motivated to do so by different forces. These include how they prioritize outcomes and how they assess the adequacy of existing and new staff training opportunities for each outcome.

It is important to understand not only if sites provide training, but to get a sense of the adequacy of that training as perceived by trainees. Thus, **Table 5.10** will describe home visitors' ratings of the adequacy of the training they have received to help mothers achieve positive maternal health and well-being, parenting and family economic self-sufficiency outcomes .

Facilitative Clinical Supports.

Implementation science shows that clinical supports promote fidelity in carrying out desired behaviors. This section will focus on four aspects of clinical support: the availability of screening and assessment tools to facilitate information gathering, the availability of curricula to facilitate parenting education and support, the availability of consultants for situations that require special expertise, and home visitor ratings of the usefulness of available strategies and tools. It is important to understand not only whether supports are available, but to get a sense of their value as perceived by users. The last column of **Table 5.10** will describe home visitors' perceptions of the usefulness of the strategies and tools available at their local site to assist them in helping mothers achieve positive maternal health and well-being, parenting and family economic self-sufficiency outcomes.

Table 5.11 will describe the availability of consultants or consultation across major MIHOPE outcome areas, including prenatal health, maternal physical health, substance use, stress and mental health, healthy adult relationships, family economic self-sufficiency, and parenting to support child development and parenting to support child health. Prior work has found that consultative expertise in content areas is related to higher fidelity of implementation.[25]

Facilitative Administrative Supports.

Implementation science shows that administrative supports promote fidelity in carrying out desired behaviors, and MIECHV at the national level emphasizes the importance of states' building the supports local staff need to deliver the intended services. Sites that monitor aspects of service delivery may be more likely to make changes in service delivery when problems are identified. Program impacts are expected to be greater when these types of administrative supports are adequate to assist leadership with program management and operations.

[25]Fixsen et al. (2005); Durlak and DuPre (2008)

This section will focus on two types of administrative support: the availability of management information systems (MIS) and electronic records, and the use of program monitoring and continuous quality improvement (CQI) to promote service fidelity and quality.

Table 5.12 will describe local sites' availability and use of these supports. MIS indicators include: whether the site has assigned staff to assist with service delivery data entry; whether the site has an MIS; how the site uses its MIS; and whether the sites uses electronic records. Monitoring and quality improvement indicators include: whether the site routinely reports on performance; whether it monitors referrals into the program, family enrollment, visits, and screening of enrolled families; whether there are staff with dedicated time for CQI; and whether the site has carried out CQI in the past year. As noted earlier, the MIECHV program may have influenced local sites' monitoring and CQI activities. The report will discuss this influence.

Systems Interventions.

The national MIECHV program emphasizes the importance of building strong referral and coordination systems in local communities, since home visiting is reliant on relationships with other organizations for both referrals of families into home visiting and linkage of enrolled families with needed community services. Local sites with strong ties to other early childhood services are more likely to be able to operate at capacity and to enroll families that are truly interested in and likely to benefit from home visiting. Local sites with strong ties to needed community resources are more likely to be able to link families to these services and, in so doing, improve outcomes.

This section will focus on formal agreements with referral sources and with resources to which to refer enrolled families. **Table 5.13** will present the percentage of local sites that have

formal agreements with a range of referral sources. Referral sources may vary by national model and community.

Table 5.14 will describe the local sites' availability of needed resources as indicated by the percentage of local sites that can identify at least one community resource to which to refer families for each of twelve services relevant for MIECHV Program outcomes.

VI. IMPLICATIONS

Based on the report's descriptive results of states' needs assessments, family characteristics, staff characteristics, and features of local home visiting sites, the final section will summarize how the MIECHV program has thus far influenced what states are doing to support the implementation in communities, as well as how local program sites, with the guidance of the national models and state agencies, are defining their intended services and supporting staff to improve outcomes for targeted families. This discussion will be further informed by a preliminary examination of the health, socio-economic, and demographic profiles of families that are enrolled in the national evaluation.

The collective findings will serve as the first glimpse into how evidence-based policymaking as embodied by MIECHV is being implemented and interpreted by states, and by home visiting program models at both the national and local levels across a wide range of targeted domains. This report will also describe the types of families being served in MIHOPE sites participating in MIECHV home visiting programs, and will highlight the diverse range and prevalence of needs among the targeted communities.

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Mother and Infant Home Visiting Program Evaluation

Table 4.1

Selected Demographic and Household Characteristics of Sample Members at Baseline

Characteristic	For Families Average	Across Sites Minimum	Across Sites Maximum
Maternal Demographic Characteristics			
Average age (years)			
Age 15-21 (%)			
Pregnancy status at baseline (%)			
Pregnant			
Less than 28 weeks			
More than 28 weeks			
Given birth			
Pregnant under 21 years old (%)			
Any other living children (%)			
Race/ethnicity (%)			
Hispanic			
White, non-Hispanic			
African-American, non-Hispanic			
Asian			
Other/Multiracial			
Language other than English spoken in the home (%)			
Ability to speak English self-rated as "not very well" or "not at all" (%)			
Household and Family Characteristics (%)			
Mothers' spouse/partner lives in the home			
Other adult relative lives in the home			
Moved more than once in the past year			
Family member has served or is serving in the Armed Forces			
Sample size			

SOURCE: Calculations based on data from the MIHOPE Family Baseline Survey

NOTES: Means are reported for families, and minimum and maximum values are reported by site.

Mother and Infant Home Visiting Program Evaluation

Table 4.2

Selected Health and Well-Being Characteristics of Sample Members at Baseline

Characteristic	For Families Average	Across Sites Minimum	Across Sites Maximum
Maternal health (%)			
Health self-rated "poor" or "fair"			
Health problems self-rated as limiting activities "a lot"			
Health problems during most recent pregnancy			
Prenatal health care (%)			
Initiated prenatal care (PNC) in first trimester			
Health-related behaviors and service receipt (%)			
Tobacco use			
Any tobacco use			
Smoking is permitted in the home			
Alcohol and substance abuse			
Ever binged[a] alcoholic drinks			
Any use of illegal drugs			
Alcohol and substance abuse services received in the past year			
Maternal mental health and well-being (%)			
Depression (CES-D-10) score above cut-off			
Anxiety (GAD-7) score above cut-off			
Mental health services received in the past year			
Verbal comprehension below average[b]			
Intimate partner violence (IPV) (%)			
Physical IPV towards mother			
Psychological IPV towards mother			
Physical IPV perpetrated by mother			
Domestic violence services received in the past year			
Counseling for domestic violence or anger management			
Sample size			

SOURCE: Calculations based on data from the MIHOPE Family Baseline Survey

NOTES: Means are reported for families, and minimum and maximum values are reported for sites. Box 1 describes how characteristics of maternal mental health and well-being and how intimate partner violence are defined.

[a]Binged is defined as drinking 4 or more drinks on one occassion.

[b]Verbal comprehension is based on mothers' scores on the Similarities subtest of the WAIS-III.

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Table 4.3

Health Insurance Coverage and Health Care Access by Sample Members at Baseline

Characteristic	For Families Average	Across Sites Minimum	Across Sites Maximum
Maternal health care insurance coverage and health care access (%)			
Insurance type			
Uninsured			
Public insurance			
Private insurance			
Has usual source of care			
Child health care access (%)[a]			
Insurance type			
Uninsured			
Public insurance			
Private insurance			
Has usual source of primary care			
Sample size			

SOURCE: Calculations based on data from the MIHOPE Family Baseline Survey

NOTES: Means are reported for families, and minimum and maximum values are reported for sites

[a]Data is only available for women who gave birth prior to random assignment.

Mother and Infant Home Visiting Program Evaluation

Table 4.4

Selected Economic Self-Sufficiency Characteristics of Sample Members at Baseline

Characteristic	For Families Average	Across Sites Minimum	Across Sites Maximum
Maternal employment during the past three years (%)			
None			
1-12 months			
13 months or more			
Household income in the last month			
Maternal monthly earnings ($)			
0			
1-1,249			
1,250-2,080			
2,080 or more			
Sources of household income or benefits (%)			
TANF			
Food stamp			
Disability insurance			
Earnings from other household members			
WIC			
Maternal education (%)			
Currently taking education or training classes			
Currently planning to take education or training classes			
Highest level of education			
No high school diploma			
High school diploma			
Some college but no degree			
Sample size			

SOURCE: Calculations based on data from the MIHOPE Family Baseline Survey

NOTES: Means are reported for families, and minimum and maximum values are reported for sites.

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Table 4.5

Selected Home Environment and Parenting Characteristics at Baseline, by Pregnancy Status and Parity at Enrollment

Characteristic	Prenatal Enrollment, First-Time Mother	Prenatal Enrollment, Multiparous	Postnatal Enrollment
Environment for learning (%)			
Mother has low verbal skills			
Low-quality home environment[a]			
Household has at least 10 books			
Father involvement (%)			
Biological father is present in the home			
Father helped with pregnancy expenses[b]			
Parenting (%)			
Mother has high empathy skills			
Mother[c] shows low responsivity			
Mother[c] shows low acceptance			
Ever breastfed			
Number of Adverse Childhood Experiences[d]			
None			
1			
2 or more			
Sample size			

SOURCE: Calculations based on data from the MIHOPE Family Baseline Survey and baseline HOME assessment

NOTES: Box 1 describes how maternal empathy is defined. A two-tailed t-test was applied to differences between the characteristics for the home visiting program groups. Statistical significance levels are indicated as follows: *** = 1 percent, ** = 5 percent, * = 10 percent.

[a]Low quality home environment is based on observations of the home interior. This data is available for all families.

[b]Father helped with pregnancy expenses a few times a month or more.

[c]Observational baseline data on parenting is only available for mothers with children.

[d]Number of adverse childhood experiences is based on child's exposure to the following risk factors: child abuse (emotional, physical, sexual), neglect (emotional, physical), and household dysfunction (intimate partner violence, maternal substance abuse, maternal mental illness, parental separation or divorce, prior maternal arrests).

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Table 4.6

Newborn Health at Baseline, for Focal Children Born Prior to Random Assignment

Characteristic	For Families	Across Sites	
	Average	Minimum	Maximum
Birth Outcomes			
Gestational age (weeks)			
Pre-term birth (<37 weeks) (%)			
Child was low birth-weight, <2500 grams or 5.5 lbs (%)			
Small-for-gestational age[a] (%)			
Large-for-gestational age[b] (%)			
Sample size			

SOURCE: Calculations based on data from the MIHOPE Family Baseline Survey

NOTES: Means are reported for families, and minimum and maximum values are reported for sites.

[a]Small-for-gestational age is defined as under the 10th percentile for gender-specific distributions of weight.

[b]Large-for-gestational age is defined as above the 90th percentile for gender-specific distributions of weight.

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Table 4.7

Selected Family Characteristics at Baseline, by Program Model

Characteristic	EHS	HFA	NFP	PAT
Maternal Demographic Characteristics				
Average age (years)				
Pregnancy status at baseline (%)				
Pregnant				
Less than 28 weeks				
More than 28 weeks				
Pregnant under age 21				
First-time mother				
Given birth				
Any other living children (%)				
Risk factors (%)				
Maternal age 15-21				
Moved more than once in the past year				
Mother is uninsured				
Maternal depression (CES-D) score above cut-off				
Maternal anxiety (GAD) score above cut-off				
IPV towards mother				
Mother has low empathy skills				
2 or more adverse childhood experiences[a]				
Primary reasons for enrolling in home visiting services (%)[b]				
Prenatal, maternal and newborn health				
Child health and development				
Parenting skills				
Crime and domestic violence				
Family economic self-sufficiency				
Referrals and service coordination				
Attitudes toward enrollment (%)				
Mother was encouraged to enroll in home visiting program				
Mother was discouraged from enrolling in home visiting program				
Sample size				

SOURCE: Calculations based on data from the MIHOPE Family Baseline Survey

NOTES: Box 1 describes how maternal risk factors are defined. A one-way ANOVA was applied to differences between the characteristics for the home visiting program groups. Statistical significance levels are indicated as follows: *** = 1 percent, ** = 5 percent, * = 10 percent.

[a]Number of adverse childhood experiences is based on child's exposure to the following risk factors: child abuse (emotional, physical, sexual), neglect (emotional, physical), and household dysfunction (intimate partner violence, maternal substance abuse, maternal mental illness, parental separation or divorce, prior maternal arrests).

[b]Mothers were asked to provide up to three reasons for enrolling in home visiting. Percents may not add up to 100 as a result.

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Table 5.1

Basic Characteristics of Local Sites at Entry into Study

Characteristic	Local Sites
Type of local implementing agency (LIA) (%)	
Community-based non-profit	
Local health department	
School district	
Health care organization	
Other [a]	
Community served (%)	
Urban	
Suburban	
Rural	
Years of program operation (%)	
Two to Three	
Four to Five	
Six or more	
Enrollment capacity (%)	
≤ 50 families	
51-100 families	
> 100 families	
Proportion of funding from MIECHV (%)	
Less than 20%	
20-49%	
50-74%	
75% or more	
Sample Size	

SOURCES: Calculations based on data from the MIHOPE Program Manager Baseline Survey and the MIHOPE site selection team.

NOTES: Rounding may cause slight discrepancies in sums.

[a] Other types of organizations include: [LIST OF RESPONSES GIVEN]

Mother and Infant Home Visiting Program Evaluation

Table 5.2

Characteristics of Home Visitors and Supervisors

Characteristic	Home Visitors	Supervisors
Demographic Characteristics (%)		
Age		
29 or under		
30-39		
40-49		
50 or older		
Race/ethnicity (%)		
Hispanic		
White, non-Hispanic		
African-American, non-Hispanic		
Asian		
Other/Multiracial		
Education and Employment Background (%)		
Highest education level		
High school/GED or less		
Vocational/technical training or some college		
Associate's degree or training program degree		
Bachelor's degree		
Master's degree or higher		
Prior experience providing home visiting services		
None		
Less than 1 year		
1-2 years		
3-5 years		
More than 5 years		
Psychosocial Characteristics (%)		
Relationship Security type		
High on anxiety		
High on avoidance		
High on both		
Low on both		
Depression (CES-D) score above cut-off [a]		
Sample Size		

SOURCES: Calculations based on data from the MIHOPE Baseline Home Visitor Survey and the MIHOPE Baseline Supervisor Survey.

NOTES: Numbers may not sum to 100 percent because of rounding.

[a]Based on the 10 item Center for Epidemiological Study Depression Scale (CES-D 10). A score of 8 or higher is indicative of mild depresssive symptoms.

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Table 5.3

Priority Ratings by National Models, States, and Local Sites for Intended Outcomes

	National Model Developer				State Admininstrators		Local Sites	
	EHS	HFA	NFP	PAT				
Outcome	Average				Range	Average	Range	Average
Maternal health and well-being								
Prenatal health								
Maternal physical health								
Family planning and birth spacing								
Tobacco use								
Mental health and substance abuse								
Intimate partner violence								
Parenting								
Breastfeeding								
Positive parenting behavior								
Child abuse and neglect								
Family economic self-sufficiency								
Child health and development								
Birth outcomes								
Child preventive care								
Child development								
Sample size								

SOURCES: Calculations based on data from the MIHOPE National Model Developer Survey, the MIHOPE State Administrator Interview, and the MIHOPE Program Manager Baseline Survey.

NOTES: Outcomes were rated from 0 to 10, with 0 indicating that the outcome was not a priority at all, 5 indicating that the outcome was a moderate priority, and 10 indicating that the outcome was the highest priority.

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Table 5.4

Local Sites' Perceptions of Whether MIECHV Raised Their Prioritization, Lowered Their Prioritization, or Did Not Change Their Prioritization of Intended Outcomes

Outcome	Local Site Has Raised the Priority Since MIECHV	No Change Since MIECHV	Local Site Has Lowered the Priority Since MIECHV
Maternal health and well-being (%)			
Prenatal health			
Maternal physical health			
Family planning and birth spacing			
Tobacco use			
Mental health and substance abuse			
Intimate partner violence			
Parenting (%)			
Breastfeeding			
Positive parenting behavior			
Child abuse and neglect			
Family economic self-sufficiency (%)			
Child health and development (%)			
Birth outcomes			
Child preventive care			
Child development			
Sample size			

SOURCE: Calculations based on data from the MIHOPE Program Manager Baseline Survey.

NOTES: Numbers may not sum to 100 percent because of rounding.

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Table 5.5

Individuals for Whom Programs Assume Major Responsibility for Improving Outcomes, According to National Models and Local Sites

Responsibility Assumed for Individuals	According to the National Model Developer (Yes/No)				According to the Local Sites (%)	
	EHS	HFA	NFP	PAT	Percent of All Sites	Percent of Sites Aligned With National Model
Child						
Mother						
Biological father						
Other father figure						
Child's other familial caregivers						
Mother's children other than focal child						
Pregnancies and children subsequent to the focal child						
Sample Size						

SOURCES: Calculations based on data from the MIHOPE National Model Developer Survey and the MIHOPE Program Manager Baseline Survey.

NOTES: Percentage of sites aligned with the national model reflect the share of local sites whose program manager's report is aligned or in agreement with the parameters of their respective national model developer.

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Table 5.6

Intended Service Initiation, Duration and Visit Length Preference of National Models and Local Sites

	National Model Developer				Local Sites
					Percent Of Sites Aligned
	EHS	HFA	NFP	PAT	With National Model
Service Initiation					
Duration of intended enrollment					
Preference for visit length					
Visit Frequency					
Sample Size					

SOURCES: Calculations based on data from the MIHOPE National Model Developer Survey and the MIHOPE Program Manager Baseline Survey.
NOTES: Percentages reflect the share of local sites whose program manager's report is aligned or in agreement with the parameters of their respective national model developer.

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Table 5.7

Local Sites' Policies for Information Gathering, Education and Support, and Referrals in Selected Domains

	Domain				
	Maternal Mental Health	Maternal Substance Use	Intimate Partner Violence	Parenting Behavior	Developmental Delay
Information Gathering (%)					
Formal screening to be carried out [a, b]					
By time to/since child's birth or enrollment					
When home visitor or parent has concern					
Education and Support (%)					
Family education and support regarding positive screen [b]					
Specified in written protocol					
Determined in consultation with supervisor					
Referral (%)					
Role of home visitor in making referral					
Provide information only					
Help family access the resource					
No policy					
Role of home visitor in following up on referral					
Home visitor expected to monitor follow-up					
Not expected to monitor					
No policy					
Sample Size					

SOURCE: Calculations based on data from the MIHOPE Policies and Procedures Inventory.

NOTES:

[a]Only asked of those who reported that a specific tool is required

[b]Response categories are not mutually exclusive, so percentages can total more than 100%.

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Table 5.8

Parent Training Techniques and Supportive Strategies Encouraged by Local Sites

	Encouraged, Discouraged, Or Neither By National Model[a]				Local Sites	
	EHS	HFA	NFP	PAT	Percent of All Sites That Encouraged Technique	Percent of All Sites Aligned With National Model
Parent training technique						
Role modeling of positive parenting practices						
Directing parent-child activities						
Observing and giving positive feedback on parent-child interaction						
Observing and giving constructive feedback on parent-child interaction (noting ways parent could improve his/her behavior)						
Playing with child/ direct interaction with child						
Supportive strategies encouraged by agency						
Caregiver goal setting						
Caregiver problem solving						
Crisis intervention						
Emotional support						
Sample Size						

SOURCES: Calculations based on data from the MIHOPE National Model Developer Survey and the MIHOPE Program Manager Baseline Survey.

NOTES: Percentage of sites aligned with the national model reflects the share of local sites whose program manager's report is aligned or in agreement with the parameters of their respective national model developer.
[a]E = Encouraged; D = Discouraged; N = Neither Encouraged or Discouraged

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Table 5.9

Supervisor and Home Visitor Caseload Size Policies of National Models and Local Sites

	National Model Developer				Local Sites		
	EHS	HFA	NFP	PAT	Percent That Exceed the National Model	Percent That Are About the Same	Percent That Are Lower Than National Model
Policy on the maximum number of home visitors per supervisor							
Policy on maximum caseload size							
Sample Size							

SOURCES: Calculations based on data from the MIHOPE National Model Developer Survey, the MIHOPE Program Manager Baseline Survey, and information from the MIHOPE Site Selection Team.

NOTES: Percentages that exceed the national model, that are the same, and that are lower than the national model reflect the share of local sites whose program manager's report is higher than, in agreement with, or lower than the maximum specified by their respective national model developer.

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Table 5.10

Home Visitors' Perceptions of Their Role, Adequacy of Training, and Usefulness of Strategies and Tools

Activity	Home Visitors are Expected to Help Mothers…	Home Vistiors are Adequately Trained to Help Mothers…	Home Visitors Perceive that Local Program Has Useful Strategies and Tools to Help Mothers…
Maternal health and well-being (%)[a]			
Have a healthy lifestyle prenatally			
Develop a healthy lifestyle outside of pregnancy			
Space their births			
Reduce their tobacco use			
Recognize and deal with problem alcohol/other drug use			
Recognize and deal with mental health issues			
Recognize and address intimate partner violence			
Have health care coverage or access to a free or low cost clinic for themselves			
Parenting (%)[a]			
Start and continue breastfeeding			
Use positive child behavior management techniques			
Baby proof their homes			
Secure high quality child care			
Support their children's cognitive and language development			
Support their children's social-emotional development			
Make sure children up to date on shots and well child care			
Have health care coverage or access to a free or low cost clinic for their children			
Family economic self-sufficiency (%)[a]			
Get the public benefits for which they qualify			
Become economically self-sufficient			
Sample Size			

SOURCE: Calculations based on data from the MIHOPE Baseline Home Visitor Survey.

NOTES: [a]Percentages reflect respondents who report that they "Strongly Agree."

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Table 5.11

Availability of Consultants by Service Area in Local Sites

Availability of Consultant Type	Local Sites
Prenatal Health (%)	
Maternal Physical Health (%)	
Substance Use (%)	
Stress and Mental Health (%)	
Healthy Adult Relationships (%)	
Family Economic Self-Sufficiency (%)	
Parenting to Support Child Development (%)	
Parenting to Support Child Health (%)	
Sample Size	

SOURCE: Calculations based on data from the MIHOPE Program Manager Baseline Survey.

NOTES:

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Table 5.12

Data Management and Program Monitoring Characteristics at Local Sites

	Local Sites
Data Management (%)	
Site has staff to assist with service delivery data entry	
Site has management information system	
None	
One system	
More than one system	
Use of management information system[a]	
For own program monitoring and quality improvement	
For note entering	
Use of electronic records	
Program Monitoring (%)	
Annual or bi-annual reporting for program site performance	
Monitoring of selected aspects of operations[a]	
Referrals into program	
Family enrollment	
Visits	
Screening of enrolled families	
Staff with dedicated time for CQI[b]	
One or more CQI activities in the past 12 months	
Sample Size	

SOURCES: Calculations based on data from the MIHOPE Program Manager Baseline Survey and MIHOPE Baseline Home Visitor Survey.

NOTES: [a] Response categories are not mutually exclusive so percentages might exceed 100%.

[b] Continuous Quality Improvement

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Table 5.13

Formal Agreements with Referral Sources for Recruitment of Families across Local Sites

	Local Sites
Presence of Formal Referral Agreements (%)[a]	
No written agreement with any organization	
Centralized intake	
Hospitals	
Health Departments	
Prenatal Clinics	
Pediatric Clinics	
Child Welfare Services	
WIC	
Schools	
Other[b]	
Sample Size	

SOURCE: Calculations based on data from the MIHOPE Program Manager Baseline Survey.

NOTES: [a] Response categories are not mutually exclusive so percentages might exceed 100%.

[b] Includes [List the types of organizations named by 1 or more local agencies].

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Table 5.14

Availability of Community Resources to Which Local Sites Can Refer Families for Needed Services

Type of Community Resource	Local Sites
Prenatal Care (%)	
Maternal Preventive Care (%)	
Family Planning and Reproductive Health Care (%)	
Substance Use (Alcohol and other drugs) treatment (%)	
Mental Health Treatment (%)	
Shelter for Intimate Partner Violence (%)	
Intimate Partner Violence Counseling (%)	
Adult Education Services (%)	
Job Training and Employment (%)	
Pediatric Primary Care (%)	
Childcare (%)	
Early Intervention Services (%)	
Sample Size	

SOURCE: Calculations based on data from the MIHOPE Community Services Inventory.

NOTES:

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Appendix Table A.1

Indicators of At-risk Communities for Counties Targeted by MIECHV Funding, based on the 2010 State Needs Assessment, State A

	1	2	3			4		State
At-risk indicators	County 1	County 2	County 3	County 4	County 5	County 6	County 7	Average
Live births that occur before 37 weeks of gestation (%)	9.2	9.8	14.7	10.2	8.7	11.3	12.8	9.7
Total live births that are less than 2500 grams (%)	9.4	9.1	14.9	9.4	10.2	9.4	10.6	9.0
Infant deaths ages 0 – 1[a]	6.3	6.8	-	17.8	3.9	8.2	0.0	6.2
Child deaths ages 1-14[b]	24.2	13.8	0.0	0.0	32.5	15.4	0.0	17.7
Residents living below 100% FPL (%)	16.8	12.0	24.8	29.9	21.4	22.2	46.2	11.2
Children living in poverty (%)[c]	23.9	16.6	37.4	43.9	27.8	31.5	34.4	14.4
Reported crimes[d]	45.8	74.7	0.0	12.2	51.6	35.3	1.9	34.6
Crime arrests ages 0 – 17[e]	9.8	212.6	0.0	37.8	77.9	63.0	6.1	75.0
Drop-out rates grades 9 - 12	6.3	8.0	0.6	5.5	3.7	1.8	3.1	5.0
Other school drop-out rates as per State/local calculation (%)	-	-	-	-	-	-	-	-
Prevalence of activities in the past month								
Binge alcohol use (%)	20.3	20.6	20.3	20.3	20.3	20.3	20.3	21.1
Marijuana use (%)	5.0	7.9	5.0	5.0	5.0	5.0	5.0	7.3
Nonmedical use of prescription drugs (%)	6.4	5.5	6.4	6.4	6.4	6.4	6.4	5.6
Other illicit drug use (%)	3.9	4.2	3.9	3.9	3.9	3.9	3.9	4.3

(continued)

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Appendix Table A.1 (continued)

Indicators of At-risk Communities for Counties Targeted by MIECHV Funding, based on the 2010 State Needs Assessment, State A

	1	2	3			4		State
At-risk indicators	County 1	County 2	County 3	County 4	County 5	County 6	County 7	Average
Residents unemployed and seeking work (%)	9.8	9.1	12.4	11.6	7.2	8.1	9.9	8.0
Substantiated maltreatment[f]	7.7	13.2	0.0	15.2	22.8	7.9	15.2	8.6
Substantiated maltreatment by type								
Child abuse by neglect[b]	6.3	10.0	0.0	9.9	15.4	4.9	14.2	6.0
Child abuse by physical abuse[f]	0.8	1.8	0.0	4.1	3.1	1.6	0.0	1.3
Child abuse by sexual abuse[f]	0.3	0.6	0.0	0.6	3.1	0.4	1.0	0.7
Child abuse by emotional abuse[f]	0.1	0.1	0.0	0.6	0.7	0.0	0.0	0.2
Child abuse by medical neglect	0.1	0.0	0.0	0.0	0.0	0.2	0.0	0.1
Infant death due to maltreatment[b]	33.5	18.9	0.0	0.0	0.0	15.4	0.0	10.6
Domestic violence	-	-	-	-	-	-	-	-
Three maternal risk factors (%)[g]	13.0	8.5	12.9	13.8	8.9	9.2	10.0	6.7

SOURCES: State A's MIECHV Needs Assessment and FY11 State Plan.

NOTES: Numbers (1-4) represent the target communities identified by the state. Target communities often included area from more than one county.

[a]Per 1,000 live births.
[b]Per 100,000.
[c]Children age 18 and under.
[d]Per 1,000 residents.
[e]Per 1,000 juveniles age 0-17.
[f]Overall maltreatment rate, per 1,000 children ages 0-17.
[g]Maternal risk factors are: unmarried, under age 25, and less than high school graduate.

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Appendix Table A.2

Indicators of At-risk Communities for Counties Targeted by MIECHV Funding, based on the 2010 State Needs Assessment, State B

At-risk indicators	County 1	County 2	County 3	County 4	County 5	County 6	County 7	**State Average**
Live births that occur before 37 weeks of gestation (%)	12.3	19.2	13.4	14.5	11.7	18.1	11.7	13.3
Total live births that are less than 2500 grams (%)	8.7	16.0	10.4	9.4	9.5	10.9	7.8	9.6
Infant deaths ages 0 – 1[a]	7.2	8.9	7.9	10.0	9.4	12.9	7.2	8.0
Residents living below 100% FPL (%)	28.4	27.0	15.3	16.8	11.1	17.6	13.9	14.3
Reported crimes[b]	56.9	67.4	53.4	62.4	40.5	85.3	34.3	39.8
Crime arrests ages 0 – 19[c]	1,521	1,262	1,128	574.1	2,514	2,679	858.6	847.7
Drop-out rates grades 9 - 12 (%)	4.7	6.1	5.1	3.8	2.6	3.3	5.8	3.5
Other school drop-out rates as per State/local calculation (%)[d]	28.8	31.2	18.9	26.6	16.1	17.6	54.4	2.6
Prevalence of activities in the past month								
Binge alcohol use (%)	15.8	6.4	13.6	13.3	10.3	15.9	6.6	19.7
Marijuana use[e]	-	-	-	-	-	-	-	6.2
Nonmedical use of prescription drugs	-	-	-	-	-	-	-	4.7
Other illicit drug use	-	-	-	-	-	-	-	3.4
Residents unemployed and seeking work (%)	7.3	11.7	9.6	8.2	6.9	8.8	12.4	9.6
Substantiated maltreatment[b]	5.9	11.0	4.5	9.7	8.1	9.4	10.3	13.2
Substantiated maltreatment by type								
Child abuse by neglect[b]	5.1	9.2	3.2	6.5	5.5	6.9	7.4	6.6
Child abuse by physical abuse[f]	65.6	98.3	105.1	212.8	175.0	185.4	67.5	115.6
Child abuse by sexual abuse[f]	23.4	98.3	20.1	36.3	65.6	39.9	32.0	40.3
Child abuse by emotional abuse[f]	0.0	0.0	20.1	109.0	65.6	97.7	266.6	136.7

(continued)

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.2 (continued)

Indicators of At-risk Communities for Counties Targeted by MIECHV Funding, based on the 2010 State Needs Assessment, State B

At-risk indicators	County 1	County 2	County 3	County 4	County 5	County 6	County 7	**State Average**
Domestic violence[g]	26.7	113.9	69.9	108.4	68.4	58.4	122.9	59.9
Other indicators								
Mothers unmarried at delivery (%)	48.2	67.2	50.7	53.5	41.3	55.1	45.3	-
Poor birth interval (%)	27.6	28.9	25.0	27.6	19.5	24.8	23.1	-
Repeat adolescent pregnancy (%)	26.0	41.5	30.5	30.5	17.9	29.4	28.8	-
Children receiving free or reduced lunch (%)	77.6	74.0	68.5	54.4	49.9	61.5	96.1	-
Single parent households (%)	10.5	17.6	12.2	11.2	12.1	16.8	10.8	-
Liquor store density[h]	0.2	0.0	1.1	0.0	0.2	0.0	1.6	-
Inpatient hospitalization for substance abuse[f]	3.6	19.0	6.1	4.9	8.4	6.9	2.2	-
Emergency room encounters for substance abuse[f]	69.1	65.2	35.2	133.8	91.8	52.0	76.0	-

SOURCE: State B's MIECHV Needs Assessment, , FY11 State Plan, and FY11 Competitive Grant Application.

NOTES:

[a]Per 1,000 live births.

[b]Per 1,000.

[c]Per 100,000 juveniles age 0-19.

[d]Mothers with less than 12 years of education.

[e]HHS requested prevelance rate of marijuana use in the past month. State B provided the state average, and included county rates for inpatient hospitalization and emergency room encounters for substance abuse.

[f]Per 100,000.

[g]Per 10,000 households.

[h]Per 10,000 people.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table B.1

Pre-MIECHV Quality and Capacity of Programs and Initiatives for Early Childhood Home Visiting, based on the 2010 State Needs Assessment, State A

Characteristic	Parents as Teachers	Home Instruction for Parents of Preschool Youngsters	Home Intervention Program	Nurse-Family Partnership	Early Head Start
Model	Parents as Teachers	Home Instruction for Parents of Preschool Youngsters	Not available.	Nurse-Family Partnership	Early Head Start, Parents as Teachers, Creative Curriculum, Partners for a Healthy Baby[a]
Target population	Families from prenatal to age 5	Parents of preschool children, ages 3 to 5 and children through kindergarten	Children who are deaf or hard of hearing and their families, from birth to age 3	Low-income, first-time mothers and their children	Low-income, pregnant women, and families with infants and toddlers
Demographic characteristics of families served	20% of children served were prenatal to 12 months old, 28% were 2 years old, 22% were 3 years old, 15% were 4 years old, 13% were 5 years old. The majority of participants were Hispanic/Latino, and 37% were white. 72% of families participating in PAT were low-income[b]	54% of children served were male. 50% of children served were age 3, 35% were age 4, 15% were age 5. 77% were Hispanic/Latino, 11.8% were Caucasian, 6.5% identified as more than one racial/ethnic group, 2.7% were African American, 1.1% were Native American, 0.3% were Asian/Pacific Islander, 0.1% did not track race/ethnicity. 54.4% received the curriculum in Spanish, 45.6% received it in English.[b] 90% of families were low-income, and 54% of children resided in families with one or more parents having no high school diploma or equivalency[f]	Demographic characteristics mirror that of the state. Approximately 40% of children served have multiple disabilities, and all are considered to be at-risk for developmental delays due to hearing loss	The majority of mothers served range in age from 15-24 years, with an average age of 19. The majority of mothers are Hispanic (47%), followed by White/non-Hispanic (41%)[h]	Not available

(continued)

The Mother and Infant Home Visiting Program Evaluation
Appendix Table B.1 (continued)

Pre-MIECHV Quality and Capacity of Programs and Initiatives for Early Childhood Home Visiting, based on the 2010 State Needs Assessment, State A

Characteristic	Parents as Teachers	Home Instruction for Parents of Preschool Youngsters	Home Intervention Program	Nurse-Family Partnership	Early Head Start
Number served	2,700[c]	898[c]	>350[g]	2,640[c]	738[j]
Counties served	35[d]	8[e]	64[d]	52[i]	16[k]

SOURCE: State A's MIECHV Needs Assessment.

NOTES:

[a]Curricula use varies by program.

[b]These data are from FY 2009-2010. Only key demographic data are included in this table. The Needs Assessment provides more demographic characteristics of participants. Low-income defined as: families eligible for Free and Reduced Lunches, Public Housing, Child Care Subsidy, WIC, Food Stamps, TANF, Head Start/Early Head Start, and/or Medicaid.

[c]These data are from FY 2009-2010.

[d]Counties served include the following target communities: County 1, County 2, County 3, County 4, County 5, County 6, County 7.

[e]Counties served include the following target communities: County 1, County 2, County 3, County 6.

[f]These data are from 2008.

[g]These data are from 2010.

[h]These data are from January 2000 through June 2009. Only key demographic data are included in this table. The Needs Assessment provides more demographic characteristics of participants.

[i]Counties served include the following target communities: County 1, County 2, County 3, County 6, County 7.

[j]In FY 2009, State A had funded enrollment for 738 EHS children.

[k]Counties served include the following target communities: County 1, County 3, County 6.

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Appendix Table B.2

Pre-MIECHV Quality and Capacity of Programs and Initiatives for Early Childhood Home Visiting, based on the 2010 State Needs Assessment, State B

Characteristic	Concerted Services, Inc. Head Start/EHS/Pre-K	Healthy Start 1	Community-Based Doula Program	Healthy Start 2	Healthy Families
Model	Head Start/ Early Head Start/Pre-K	Healthy Start 1 Initiative	G-CAPP's community-based home visiting model	Healthy Start 2	Healthy Families America
Target population	Early Head Start: pregnant moms to 2 years 11 months Head Start: children 3 to 5 years of age	Residents of counties served with children less than 2 years of age	First time African-American and Latina teen mothers age 10-19 in a metropolitan area	Teenage pregnancy, preexisting medical diagnosis, high risk pregnancy, short interpregnancy interval, severe social situation or NICU-admitted infant	Pregnant women and children prenatal to 5 years
Demographic characteristics of families served	Early Head Start: All pregnant women to 2 years and 11 months in named counties; Head Start: Ages 3-5 and Pre-K: age 4 who meet income guidelines for these programs	Primarily African American women, no age restriction	First time African-American and Latina teen mothers ages 10 to 19 years	Maternal age <17 years and <12 years of education and/or > 2 pregnancies during teenage years. Infant: low birth weight infants, premature delivery, IUGR, infant with >4 days NICU stay, genetic condition, newborn through 2 years of age	Not available
Number served[a]	1,079 children and 1,079 families	166 children and 200 families	70-100 children	249 children and 293 families	1,300 children and 1,300 families
Counties served	12	1	2[b]	2	13[c]

(continued)

Appendix Table B.2 (continued)

Pre-MIECHV Quality and Capacity of Programs and Initiatives for Early Childhood Home Visiting, based on the 2010 State Needs Assessment, State B

Characteristic	Healthy Start 3	McIntosh Trail ECDC	Nurturing Parenting Program	Heart of [State] Healthy Start America	Parents as Teachers
Model	Healthy Start 3	Head Start/ Early Head Start/Pre-K	Nuturing [State]'s Families	Healthy Start	Parents as Teachers
Target population	Pregnant women and at-risk infants	Families below federal poverty guidelines	Children ages 0-18 with an emphasis on children ages 0-5, any family/ individual not currently receiving or have been identified to receive substance abuse treatment services	Infants 0-2 and pregnant or parenting adolescent women 10-20 years of age with personal history of a previous preterm birth, previous history of stillbirth or infant death, presence of a health condition associated with an increased risk of poor perinatal outcomes	Families with children prenatal through to kindergarten entry
Demographic characteristics of families served	Not available	Not available	Families with children 0 to 5 years of age and teen parents. 75% of participants are female, 58% are white. Majority are single parents with an average of 2 children, with less than a high school education, and live in poverty	Not available	Children ages 0-5, teen families under the age of 20, low income families as determined by federal poverty guidelines, parents with low educational attainment, and all races
Number served[a]	249 children and 300 families	749 children and 749 families	220 children and 195 parents	353 children and 402 families	1,962 children and 1,635 families
Counties served	1	7	13[d]	10	44[e]

(continued)

SOURCE: State B's MIECHV Needs Assessment.

NOTES: Three additional home visiting progarms were named in the Needs Assessment: SafeCare, Children 1st, and Project Healthy Grandparents. The number of families served was not reported for these programs.

[a]These numbers come from 2009-2010.

[b]Counties served include the target county of County 3.

[c]Counties served include the target counties of County 1, County 2, County 3, County 4, County 7.

[d]Counties served include the target county of County 5.

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Appendix Table C.1

State Plans for MIECHV Funding[a]

Characteristic	State A	State B
Sites funded	13	10
Programs in metro counties[b]	7	9
Programs in nonmetro counties[c]	6	1
Program sites funded for		
Early Head Start - Home Visiting (EHS)	3	1
Healthy Families America (HFA)	0	5
Nurse Family Partnership (NFP)	4	2
Parents As Teacher (PAT)	4	2
Family Check-Up (FCU)	0	0
Healthy Steps (HS)	0	0
Home Instruction for Parents of Preschool Youngsters (HIPPY)	2	0

SOURCES: FY10 and FY11 State Plans and first round of competitive grant applications for all states.

NOTES: [a]This table only includes information for the first seven models that were designated as evidence-based models. Child FIRST and the Early Intervention Programs for Adolescent Mothers (EIP) were designated as evidence-based too late to be included in the FY10 and FY11 state plans.

[b]Beale codes 1-3 represent counties in metropolitan areas.

[c] Beale codes 4-9 are counties in nonmetropolitan areas.