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.

Mother and Infant Home Visiting Program Evaluation

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.

Mother and Infant Home Visiting Program Evaluation

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).

Mother and Infant Home Visiting Program Evaluation

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.

Mother and Infant Home Visiting Program Evaluation

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.

Mother and Infant Home Visiting Program Evaluation

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.

Mother and Infant Home Visiting Program Evaluation

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.

Mother and Infant Home Visiting Program Evaluation

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.

Mother and Infant Home Visiting Program Evaluation

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.

Mother and Infant Home Visiting Program Evaluation

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.

Mother and Infant Home Visiting Program Evaluation

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%.

Mother and Infant Home Visiting Program Evaluation

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

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The Mother and Infant Home Visiting Program Evaluation

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.

The Mother and Infant Home Visiting Program Evaluation

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.

The Mother and Infant Home Visiting Program Evaluation

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.