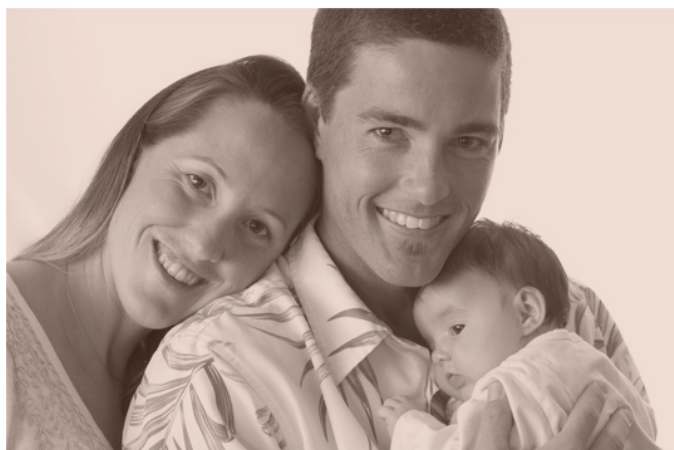**SRI International**

RISE Home Visiting Evaluation: Final Evaluation Report

Selected Findings from Years 1 and 4 of the Evaluation

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Executive Summary

This executive summary includes selected findings from the Researching Implementation Support Experiences (RISE) Home Visiting Evaluation follow-up study. The RISE Home Visiting Evaluation was a three-year study that ran from fall of 2013 to fall of 2016 and concluded with a final report. During fall of 2016 to fall of 2017, a follow-up evaluation occurred to collect an additional year of outcome data, four years after the initial implementation of the intervention, the Implementation HUB (HUB). The follow-up evaluation explored factors related to longer-term outcomes as well as unique factors necessary to support rural home visiting programs in implementing evidence-based home visiting.

Introduction

Washington State Department of Early Learning (DEL), in partnership with Thrive Washington (Thrive), is using MIECHV funds to support an Implementation HUB that works to:

♦ broaden **the availability of home visiting** services,
♦ develop **community capacity** for implementing home visiting services, and
♦ support the **quality and accountability** of home visiting program implementation.

The Implementation HUB is a centralized support system for home visiting programs to improve **organizational capacity, model fidelity**, and **quality of service delivery**. Supports include continuous quality improvement (CQI), program monitoring, model-specific supports, coaching, training, and technical assistance (TA) using Implementation Science frameworks. The follow-up evaluation included both an outcome evaluation and rural case study. The **outcome evaluation** measured the impact of the HUB on three major outcomes: use of training and TA; model fidelity and implementation quality; and program staff competency and self-efficacy. The primary research question was:

> *How do the identified programs in Washington that receive support from the Implementation HUB differ from comparison programs in other states with regard to the three major outcomes?*

The **rural substudy** used mixed methods to learn more about the experiences of rural programs to answer the primary research question:

> *What are the unique features of implementing evidence-based home visiting in rural communities?*

Although the HUB is part of a system that supports home visiting using both evidence-based programs and promising practices, the **evaluation** focused on programs in Washington state that are implementing two evidence-based programs—Parents as Teachers (PAT) and Nurse-Family Partnership (NFP) which are the target of the state's MIECHV expansion funding. Comparison programs for the outcome evaluation were also PAT or NFP programs. Most comparison programs received MIECHV funding, and were similar on key program characteristics (e.g., capacity, geography, length of time providing services).

Outcome Evaluation

In the outcome evaluation, SRI used a quasi-experimental design to understand differences between the home visiting programs that received TA and support from Washington's Implementation HUB and comparison programs in other states. The primary research question for the outcome evaluation was: *How do the participating programs that receive support from Washington State's centralized support system (Implementation HUB) differ compared with similar programs in other states on the outcomes of interest*:

- ♦ use of and satisfaction with training, TA, and coaching;
- ♦ model fidelity and implementation quality; and
- ♦ staff competency and self-efficacy.

Data were collected about programs and staff at the beginning, referred to as Time 1, of implementation and then again at the end of the project, referred to as Time 3 for all data sources except the Home Visiting Snapshots, which were collected twice, fall 2015 for Time 1 and then again in the add-on year in Fall 2016 for Time 2. Data for the outcome evaluation were collected through a number of sources, including

- ♦ **TA logs (2014–15 and 2016–17)**: documented amount, format, content, and source of TA.
- ♦ **Home Visiting Snapshot Form (Fall of 2015 and 2016)**: collected data on home visit content and activities, assessment of family needs and strengths, referrals and outreach, and use of progress monitoring and assessments.
- ♦ **National Service Office (NSO) Data Exports (2012–13 and 2015–16)**: included data routinely submitted by programs to the PAT or NFP national office on model fidelity and implementation quality.
- ♦ **Program Practices Survey (2014 and 2017)**: collected data on perception of TA and support, supervision practices, self-efficacy, and best practices.

Selected Findings from the Outcome Evaluation

Using multiple methods in a longitudinal design, we compared findings from 18 programs and staff in Washington receiving support from the HUB (intervention programs) with 32 programs and staff in other states (comparison programs).[1]

> *What impact did the HUB have on TA? How did the amount, content, format, source and quality of TA compare to TA for programs in other states?*

Evidence from the final year of the evaluation indicates that the HUB actively provided TA and support across many different formats and topics to program staff.

- ♦ Data showed that staff members across the states in the sample and in **both groups were receiving TA throughout the project period** although the intervention programs

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[1] At the start of the add-on year in Fall 2016, comparison programs were asked to continue participating in data collection activities. At that time, 8 of the 32 comparison programs (5 NFP programs, 3 PAT programs) declined to continue.

reported an increase in TA (average hours per staff per month) from Time 1 to Time 3 and the comparison programs reported a decline in the amount of TA from Time 1 to Time 3.

♦ Intervention programs received much of their TA from the HUB at Thrive, including state model leads, whereas staff at comparison programs received TA from a broader range of sources. At Time 3, intervention programs reported a decrease in TA from state model leads and a corresponding increase in TA from the NSOs and government agencies likely due to changes in staffing and interim vacancy for one of the state model lead positions.

♦ Staff members from intervention programs were much more likely than staff from comparison programs to report having support from someone in their state/region that minimized their need for NSO TA or helped them coordinate with the NSO for TA.

♦ Most of the TA continued to be provided to program supervisors and sometimes to administrators.

♦ Similar to previous time points, only about one-third of staff in both the intervention and comparison groups described the TA they received as **relationship-based** or **tailored to their individual needs**. However, the percentage of staff in intervention programs who endorsed their TA as "mostly" or "always" relationship-based did increase about 5% while staff in the comparison programs decreased by the same amount.

♦ In terms of **content** of TA, **building home visitor and supervisor competencies** and **meeting model requirements** were key topics for TA at both Time 1 and Time 3 and in both groups. There was an increased focus on contract requirements for intervention supervisors from Time 1 to Time 3. For home visitors in the intervention group, there was a decreased focus on program administration and connections/referrals from Time 1 to Time 3.

The HUB is providing centralized support to home visiting programs in the state of Washington, but the nature of the support is still developing. The increase in TA from Time 1 to Time 3 is promising and suggests the HUB continues to evolve and develop to serve the needs of program staff. The increase in TA in the Washington programs and decrease in TA over time in the comparison programs suggests that the HUB may allow for more sustainability of needed TA.

Were intervention programs with access to the HUB's TA different from comparison programs in model fidelity and implementation quality?

The evaluation also considered **model fidelity and implementation quality**. Data suggest that **most programs in both groups met the targets set forth by NFP and PAT**. While there are some limitations in interpretation given the ways in which NSOs gathered these data and in how much we know about the stage of the family being visited, these data are consistent with common challenges observed in maximizing participation from families in home visiting programs.

♦ Both intervention and comparison programs generally had fidelity that was consistent with their home visiting model guidelines at Time 1 and Time 3.

♦ Most programs met model-specific guidelines when it came to staff and/or cross-team meetings and staff qualifications.

♦ Most program staff also reported that they had a clear, systematic approach for training new staff.

♦ Information from home visits showed that home visitors were reporting consistently assessing family strengths and needs, building strong participant-provider relationships, and covering content during visits that was consistent with model expectations.

♦ Both intervention and comparison programs were implementing home visiting practices as expected by their home visiting models and in keeping with quality practices.

♦ The main area for improvement for both intervention and comparison programs continued to be enrollment, and maintaining and engaging families.

Were intervention programs with access to the HUB's TA different from comparison programs in staff competency and self-efficacy?

With regard to **staff competency and self-efficacy**, we found that staff report **confidence** and **comfort implementing evidence-based practices**. Data about staff competency and self-efficacy suggest staff in both intervention and comparison programs have a high level of **self-efficacy** about their work and there is evidence that staff believe in implementing evidence based practices, and personally feel that it is important to use interventions in the same way they were done in the studies in their own home visits.

♦ Results showed that programs receiving HUB TA and support have staff members who feel relatively confident in their own abilities to implement the model and work with families.

♦ Staff in both intervention and comparison programs reported having a fairly high level of understanding about model goals and requirements.

♦ Most home visitors reported using quality practices in their work with families and an even greater understanding of how their specific practices relate to the goals of the NFP/PAT models.

♦ Supervisors confirmed these ideas as well, indicating that their staff showed competence implementing the model effectively with children and their families.

♦ Most program staff in both groups support use of evidence-based practices. In particular, intervention home visitors were more likely to report families engaging in new activities both at Time 3 compared to Time 1 and compared to the comparison group at Time 3. Also, the data indicate that over time there were increases in endorsement of evidence-based practices in both groups(?).

♦ Most staff reported that they both schedule and actually participate in supervision meetings at least a couple times a month, consistent with model guidance. However, there was a slight decrease in regular supervision (both scheduled and actual) at Time 3 in the intervention group as reported on the Program Practices Survey.

Taken together, the current evidence does not suggest that staff with support from the HUB differ in major ways from staff at comparison programs. However, the data do suggest intervention and comparison programs are implementing a number of key model indicators with fidelity.

Rural Substudy

In the rural substudy, SRI used qualitative case study methodology to obtain perspectives of home visiting program, HUB and state staff. Quantitative analyses were also conducted by disaggregating the outcome evaluation data by rural and non-rural programs.

For the rural case study, data were collected in two phases. The first was a planning phase that consisted of interviews with key informants at DEL and the HUB, accompanied by a review of relevant written documents, to learn about the history of the rural development work and community planning process. The second phase consisted of site visits to four rural sites selected to represent four different categories, or types, of programs in Washington: 1) expansion site, rural only, 2) expansion site, mixed rural and urban, 3) start-up site, participated in community planning process, and 4) start-up site, did not participate in community planning process.

In what ways were the rural case study sites different from one another?

Our four profiled evidence-based home visiting (EBHV) programs were both similar to and very different from each other due to a number of factors that were as defining of their character as the rural status that united them. In order to paint a broader picture of rural programs' MIECHV implementation experiences, we purposely selected sites that represented a combination of start-up and expansion programs, NFP and PAT models, those serving a mainly rural community versus a mixed rural and urban community, and programs that did or did not participate in the community planning process. The four sites[2] and their primary characteristics were as follows:

- Alder Community Health Center (ACHC): PAT start-up program that served a mainly rural community and participated in the community planning process
- Cedar County Health Department: NFP start-up program that served a mainly rural community that did not participate in the community planning process
- Pine County Health Department: NFP expansion site that served a mixed rural/urban community
- Spruce Family Services: PAT expansion site that served a mainly rural community

Additionally, the specific community context of each of the four programs varied greatly; for example, ACHC served a predominantly Hispanic migrant population in an agricultural community, while Spruce had a significant number of migrant clients but still served mostly White families living in an area that was rural but very popular with tourists. Despite the differences, we did see some commonalities across the four programs:

- Staff at all four programs cited seeing positive change in the behavior and circumstances of their clients as their primary and most important success.
- Some challenges common to all sites were the data collection and documentation burden, and the stress inherent to working with high-needs clients experienced by home visitors.
- Common challenges related to being a rural program included having fewer available resources in the community, needing to refer clients outside of the community especially for specialty services, transportation challenges for both clients and home visitors, and a restricted labor pool which affected the ability to hire and retain qualified EBHV program staff.

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[2] Pseudonyms are used for confidentiality.

What are important factors to consider for leadership and administration to facilitate implementation of evidence based home visiting (EBHV) in rural communities?

♦ Successful hiring and retention of the appropriate staff is important for a program's long-term success. Using nurses, who have high levels of formal education, as staff compounds hiring difficulties in rural communities that already have a restricted labor pool. The PAT model allows for more flexibility in hiring.

♦ Once hired, staff who feel supported are more likely to stay. Pay and quality of life (e.g., hours worked, travel burden, paperwork burden, feeling supported by leaders and peers) have an impact on staff mental health and morale.

♦ Staff dissatisfaction leads to turnover, which then contributes to client attrition (i.e., many clients of departing home visitors exit the program due to loss of the relationship) and lower program capacity (i.e., new home visitors need training and carry lower caseloads.

♦ The travel time involved in providing home visiting services in rural area is a feature that can present a barrier to quality implementation.[3] Travel time and dispersion of clients was a common cross-cutting challenge identified in the rural case study site visits. The added travel time may reduce the time available for important activities outside of home visits, such as supervision. In the outcome analysis, home visitors at rural sites were significantly less likely to report actually meeting with their supervisors a couple times a month or more frequently that home visitors in non-rural programs.

What are important factors to consider and address at an organizational level facilitate implementation of evidence based home visiting (EBHV) in rural communities?

♦ A growing proportion of home visitor staff time is now spent on documentation and data collection, although thus far, programs have had limited success in using these data to inform their practice.

♦ The ability to maintain full caseloads and operate at maximum capacity is important for a program's long-term success, and a strong referral network is necessary for maintaining full caseloads. Referrals are a product of trust built between two agencies; this relationship-building requires time and energy and is often disrupted when key staff turn over.

♦ Rural communities often have more success implementing NFP using a "regional" or "mentoring" approach, in which a higher capacity county supports a neighboring lower capacity county via contracting of staff or supervisors.

What are important considerations for supporting the start-up of EBHV in rural communities?

♦ The community planning process created many of the "conditions of success" described above, such as successful hiring and retention of staff, and ability to maintain full caseloads and operate at maximum capacity, and positioned the agency to more efficiently and effectively start up and sustain their EBHV program. HUB staff observed there were benefits to participating in the community planning process even for communities that went

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[3] While all of the case study sites serviced rural areas, one of the sites, Spruce Family Services, also services a predominantly frontier and remote area as designated by the United States Department of Agriculture Economic Research Service.

through the process but were not awarded MIECHV funding, because their level of preparation left them well-positioned to seek other sources of support.

♦ A challenge of the community planning process was that, with only two models, it was difficult for the facilitators to avoid giving the impression that the PAT and NFP models were in competition with one another.

Were rural program outcomes different from non-rural programs?

Overall, there were few differences between rural and non-rural programs in Washington, which suggests that by enlarge the implementation drivers of successful implementation of evidence based home visiting are not unique to rural areas.

♦ While providing evidence based home visiting services in a rural setting may present additional or unique implementation challenges, the lack of significant differences on model fidelity and implementation quality items suggest that rural programs are just as capable of reaching fidelity and quality implementation.

♦ There were several notable differences found on outcome items related to use and satisfaction with training, TA and coaching. Rural program staff were found to receive more TA hours than non-rural staff, but more of their TA is received in remote formats. On average, rural staff receive a fair amount of in-person workshops and trainings, but receive noticeably less in-person individualized TA. Although most of their TA is provided remotely, rural program staff were more likely to be satisfied with in-person workshops than non-rural staff.

♦ By enlarge, rural and non-rural staff were not significantly different on outcome items relating to staff competency and self-efficacy. Rural home visiting staff were found to be lower on two items but higher on another. Rural home visitors were less likely to report actually meeting with their supervisors as planned and may not be doing as much facilitation of effective parent-child interactions during home visits as their non-rural counterparts. Yet, a strength found was that rural program staff were more likely to report positive attitudes toward implementing evidence-based home visiting than non-rural staff.

What are the Key Implications or Recommendations?

Based upon the information from the additional year of the outcome evaluation from a wide variety of sources at both the individual- and program-level, and the findings from the rural substudy, we developed a set of key implications and recommendations for the HUB and state to consider as it continues to build its home visiting system and supports.

♦ Support transmission of skills and knowledge from **supervisors to home visitors** by developing a consistent message about expected indirect benefits from TA and provide HUB TA staff with strategies to use with supervisors to encourage further transmission of ideas and changes.

♦ To support change in both program and system level outcomes, **clarify how HUB work** is connected to program and systems level outcomes and specify the amount of time HUB staff are expected to focus on program-focused vs. systems-focused activities.

♦ To support change in practice around a specific topic, generate an **annual TA plan** with emphasis on specific topics; include planned activities that supplement individualized TA work.

♦ **Use the community planning process whenever time and resources permit.** Dedicating time and energy to Exploration, as a stage leading up to and distinct from Installation, is worth the upfront investment, because it creates conditions that enable the agency to implement its chosen EBHV model more efficiently and effectively. Additionally, using the community planning process to prepare multiple communities to apply for competitive grant funding gives the granting entity latitude to fund only those communities that have demonstrated readiness to implement.

♦ **Get true buy-in, in the form of a deep commitment to facilitating a program's success, from the agency's key decision-makers, as this can be critical for the program's longevity.** Without a willingness from leaders to find creative solutions to problems that may arise, and at times, to challenge the status quo, some roadblocks to implementation may prove insurmountable.

♦ **Communities should choose an EBHV model keeping both client needs and program staffing needs in mind.** They must be able to meet the needs of the families, and the requirements of the model, with the applicants available to them in their particular community in balance in program planning.

♦ **Support home visiting staff with a robust system of supervisory and peer supports to reduce burnout and turnover.** Opportunities for skill development, collective problem solving, and emotional "unloading" are important, as are policies demonstrating respect for home visitors' overall quality of life. The HUB and local program leaders can create a supportive environment for staff through both formal and informal means. The formal supports include reflective supervision and opportunities for professional development, while the latter includes instituting policies that value home visitors' daily experience and setting a warm and caring tone in the workplace.

♦ **Employ home visitors with varied backgrounds and a deep skill set to serve clients well, and support their continued professional growth and self-care.** Strategies can include holding meetings to address specific topics such as how to set boundaries with clients, and providing regular opportunities for home visitors to lighten their emotional burden through effective supervision and conferencing with peers.

♦ **Programs need a strong referral network to sustain their caseloads.** Relationship building with external partners is particularly important if there is no internal source of referrals.

♦ **If possible, co-locate an EBHV program with other maternal or child services within an agency.** Advantages include a ready source of referrals and a single point of entry into a network of services that may represent a more holistic approach toward serving families.

♦ **Open communication channels among local agencies to dispel the tendency to compete with one another for clients, and build referral relationships instead.** This may be best accomplished via third-party facilitation by a common funder, such as the Thrive HUB, or through existing community coalitions. Guidelines for matching clients to

programs should be mutually agreed upon, so that slots at all agencies are filled, and families receive services that are the best fit for their needs.

♦ **Rural home visiting can be isolating work; programs value and are eager for more opportunities to stay connected and share across-programs.** Rural programs received more remote TA than non-rural programs but report the highest satisfaction with in-person workshops. Thus, it may be worth increasing opportunities for in-person TA when possible as the results suggest it may have a greater impact.

Introduction

Home visiting programs buffer the effects of risk factors and stress in the family and support positive health and development for children and families who participate (Avellar & Supplee, 2013). A strong return on investment from implementing prevention-based early learning supports with underserved populations has prompted expansion of home-based support services in many states and throughout the nation (Karoly, Kilburn, & Cannon, 2005; Washington State Institute for Public Policy, 2014). The Affordable Care Act created the first nationwide Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, which allocated federal grants to support evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry.

Washington State, in partnership with Thrive Washington (Thrive), is using MIECHV funds to support an Implementation HUB (HUB) that works to broaden the availability of home visiting services, develop community capacity for implementing home visiting services, and support the quality and accountability of home visiting program implementation. The HUB was established to serve as a centralized support system for home visiting programs to improve model fidelity, community and organizational capacity, and the quality of service delivery.

The HUB was envisioned as a system of program supports that include continuous quality improvement (CQI), program monitoring, model-specific supports, coaching, training, and technical assistance (TA) using Implementation Science frameworks as the foundation. The HUB is an innovative feature of Washington's MIECHV expansion grant that aims to achieve rapid, high-quality scale-up of evidence-based home visiting models. It also fits with one of the MIECHV program goals to change from decentralized local home visiting programs to home visiting that is incorporated into more sustainable systems of care (Stark, Gebhard, & DiLauro, 2014).

In fall 2013, SRI International (SRI) was awarded the contract to conduct the Washington State Competitive Federal MIECHV Program Evaluation Research Project (RFP # 14-102) for the Department of Early Learning (DEL). SRI's evaluation is referred to as the RISE (Researching Implementation Support Experiences) Home Visiting Evaluation. RISE was designed to learn more about the development of the HUB, the processes through which the Implementation HUB may influence home visiting programs, and the impact of the HUB's centralized support on those programs and staff. The design of the RISE Home Visiting Evaluation was developed in collaboration with DEL and Thrive staff to ensure that it meets high-quality evaluation standards and the MIECHV-recommended standards of credibility, applicability, consistency, and neutrality. Thus, the evaluation had two purposes: (1) measure the progress and impacts of the Implementation HUB's centralized support system on participating programs and staff and (2) meet the federal funding requirement associated with the competitive MIECHV expansion grant to conduct a rigorous evaluation that will contribute to the national body of research and knowledge on implementing evidence-based home visiting programs on a large scale.

This is the final report for Phase 2 of the RISE Home Visiting Evaluation. After receipt of an additional year of competitive funding, a second phase was added that extended the outcome evaluation data collection by a year and added a rural substudy to better understand the experiences of rural programs providing evidence-based home visiting (EBHV) services in

Washington. This report describes the design of specific evaluation activities and presents key findings from the nearly 4 years that the evaluation has been conducted.[4]

The outcome evaluation section describes the design, methods, sample, and findings for the three outcomes of interest: use of and satisfaction with TA and training opportunities, model fidelity and implementation quality, and staff competency and self-efficacy. The outcome evaluation section covers two time points of data near the beginning (Time 1) and near the end (Time 2) of the study and includes data from home visiting programs in Washington and from comparison programs in other states.

The rural experience section seeks to describe and better understand the unique features of programs' experiences implementing EBHV within the context of rural communities, including expanding or starting up services using MIECHV funds. The findings were gathered on the basis of document reviews, semistructured planning interviews with HUB and state staff, and case studies with four rural programs in Washington. The report describes findings across these multiple methods and synthesizes additional subgroup analyses of the outcome evaluation data comparing outcomes for rural and non-rural programs in Washington.

Background

Home Visiting Services in Washington

Over time, Washington has shown a strong commitment to home visiting services. State legislative efforts have helped establish a unique financing strategy to administer and support effective implementation of home visiting services. Many partners from both the private and public sectors have been extensively involved in this work, leading to what is now the Implementation HUB that is the topic of this evaluation.

Statewide support to make quality home visiting services available in Washington has been an important backdrop for the HUB's work. The Washington State legislature created the Home Visiting Services Account (HVSA) in 2010 as a way to leverage public and private dollars. Early champions of home visiting set the course for a blended financing strategy that is implemented through a state HVSA housed within Thrive Washington.[5] The HVSA provided a structure of innovative financing for a comprehensive portfolio of home visiting programs serving priority populations in some of the state's most at-risk communities. The HVSA statute allows pooled funds[6] to be directed toward building statewide systems to support home visiting in the long term, as well as distributing funds to the community programs that provide home visiting services. These private-public funds are the basis for home visiting service contracts that support infrastructure and help build capacity to expand services more uniformly. Through the contracts, the state also

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[4] Refer to the *RISE Home Visiting Evaluation Annual Report 2016* for findings from the process evaluation conducted in the first 3 years.

[5] After the conclusion of data collection, the HVSA statue was revised on July 1, 2017. In this revision, DEL administers the HVSA account and Thrive supports implementation through training and technical assistance to grantees.

[6] The Bill & Melinda Gates Foundation provided many of the initial private funds for the HVSA. The establishment of this HVSA structure with a combination of private and public funding helped make Washington competitive for subsequent MIECHV-funding competitions.

gathers aggregate data to provide evidence about the impact of home visiting programs on families and communities. The private-public funds of the HVSA, including considerable MIECHV-funding resources, enabled Thrive to develop the infrastructure of the Implementation HUB that provides centralized support to contracted home visiting programs. For more information about the HVSA, see Appendix A.

Historically, home visiting in Washington was provided by a variety of state departments (e.g., Council for Children and Families, Department of Health [DOH]). During the data collection period, the HVSA statute required co-administration between DEL and Thrive.[7] When MIECHV proposals were announced, the governor recommended a unified approach to home visiting to coordinate the efforts of the DOH, DEL, and Department of Social and Health Services (DSHS). To that end, the HUB's partners include Thrive, DOH, DEL, and DSHS. During the first year of MIECHV funding, the DOH completed a needs assessment to guide planning. After that, in 2011, planning and implementation moved to DEL, and quarterly meetings were held for leaders from all organizations. Exhibit 1 shows a timeline of key activities in building capacity and expanding home visiting services in the state of Washington before receipt of MIECHV competitive expansion funding.

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[7] After the conclusion of data collection, the HVSA statue was revised on July 1, 2017. In this revision, DEL administers the HVSA account and Thrive supports implementation through training and technical assistance to grantees.

Exhibit 1. **Timeline of Key Activities in Washington State Before Initial MIECHV Innovation-Expansion Funding[8]**

2012: DEL received MIECHV competitive expansion funds

2010: Home Visiting Services Account (HVSA) established

2007: Washington State legislature allocated general fund dollars for home visiting

2010: Governor appointed DEL as the lead agency for home visiting

2011: MIECHV state plan submitted and approved by the Health Resources and Services Administration (HRSA)

| 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |

2007-09: Home visiting resources allocated in the state's biennial budget

2010: Needs assessment conducted by DOH[a]

2010: MIECHV funds awarded to Washington State

2011 and beyond: Continued state funding contributions allocated to HVSA for home visiting

At the outset of the RISE evaluation, the HVSA was funded with a mix of MIECHV, state, and matching private dollars that were used to establish the HUB; the HUB had begun distributing contracts to grantees for home visiting services and had begun providing TA and support to those grantees. DEL oversaw public investment in the HVSA, and Thrive staffed and managed the Implementation HUB. The HUB was charged with subcontracting, monitoring, and providing training, TA, and support to all programs funded through the HVSA, including those funded with federal MIECHV, state, and private funding. This overarching structure and division of activities across organizations is depicted in Exhibit 2 remained consistent throughout the 4 years of the RISE evaluation.

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[8] The MIECHV program has two kinds of grants – formula and competitive grants. The formula-funded grants are for expansion and the competitive funds are for innovation. Washington state received both kinds of grants.

Exhibit 2.   Overview of Relationships Between DEL and Thrive in Co-Administration of the HVSA and Implementation HUB
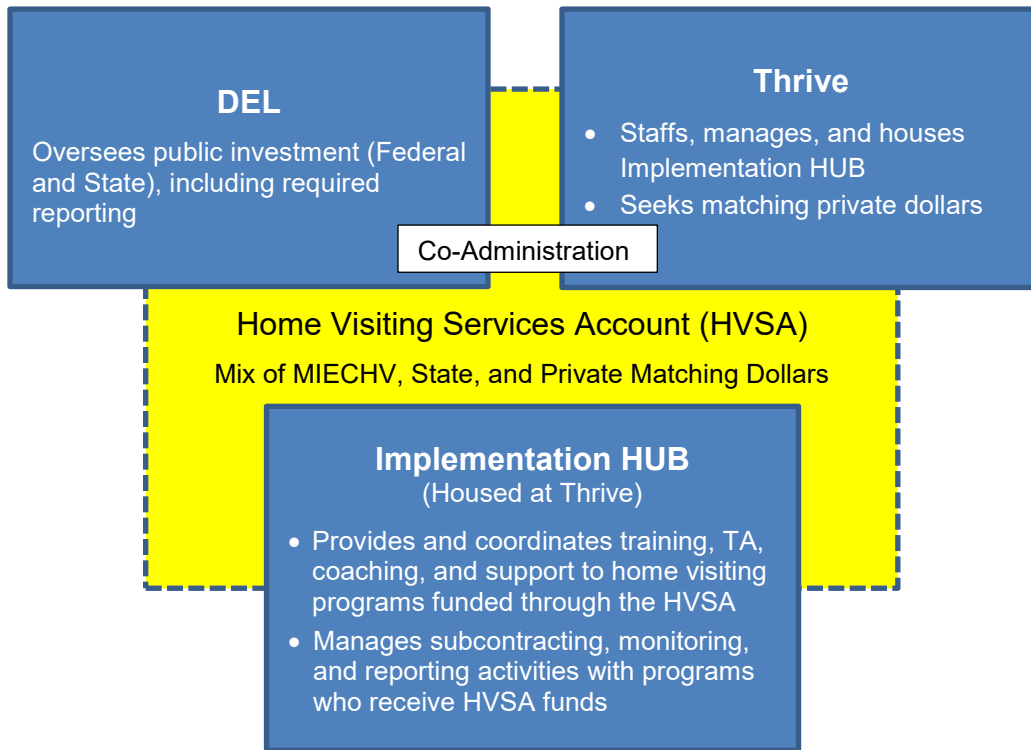
Changes in the HUB Throughout the Evaluation

Although the structure remained fairly consistent, during the RISE evaluation both the HUB and Thrive underwent many changes. Exhibit 3 is a timeline of events related to the HUB's development. It includes events that affected the HUB and major milestones in HUB activities, as well as when the RISE Home Visiting Evaluation was initiated. For instance, the National Implementation Research Network (NIRN) has provided the HUB with consultation and support to help shape its conceptualization and development.[9]

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[9] NIRN played an important role especially in expanding staff understanding about Implementation Science. NIRN worked with the HUB to be sure its infrastructure, its TA and support activities, and the overall work plan for its internal activities were articulated clearly and were well grounded in an Implementation Science framework.

Exhibit 3.   Key Events Throughout the Implementation HUB's Development

Staffing related event

Partner/Contractual event

HUB activity

Thrive begins systematic tracking of TA and coaching
Mid 2014

All state model leads now Thrive staff; turnover in PAT lead, gap in position
July 2015

Senior HV manager at Thrive leaves
Dec. 2015

All program models have quarterly TA mtgs with supervisors
Fall 2014

Contract with NIRN ends
July 2015

Additional year of evaluation work funded
Oct. 2015

DEL begins transition to oversee LIA contracts
June 2017

HUB hires core staff and begins TA
Jan.-Feb. 2013

Thrive begins newsletter to programs
Nov. 2014

HUB hires staff to focus on CQI
Apr. 2015

First WA state home visitor summit
Sept. 2015

Thrive Deputy Director leaves
Dec. 2017

DEL receives competitive expansion funds
Early 2012

SRI hired as evaluator
Oct. 2013

Thrive re-organization
Fall 2014

DOH begins data warehouse and data related work
Apr. 2015

Thrive HUB and DOH staff begin CQI visits
Summer/Fall 2015

HUB practice model completed
Aug. 2015

Director over HV work at Thrive leaves, gap in position
Jan. 2016

New Thrive CEO comes on board
Nov. 2017

New PAT & additional NFP state model lead hired
June-July 2017

Initial community capacity building with rural sites
Fall 2013

Turnover in core data/ evaluation Thrive staff
Feb. 2015

CEO at Thrive leaves
May 2016

Initial HVSA contracts
2011

Thrive contracts to work with NIRN
Spring 2012

3 programs funded and included in evaluation
Jan. 2014

2011   2012   2013   2014   2015   2016   2017

The timeline shows when the contracts with NIRN began and ended. The timeline also depicts a number of key staffing changes in organizational leadership, HUB leadership, and HUB staff. These shifts are critical for interpreting the findings from the outcome evaluation and rural case study.

The Implementation HUB has undergone considerable development since its inception.[10] In fact, the HUB was working through stages of implementation while the study was occurring.

- ♦ Near the beginning of the RISE evaluation, the HUB was midway through its own tasks of the exploration stage.[11] Some work had been done to articulate desired changes and results and to compare approaches, but further refinement and consolidation of thinking were occurring. HUB leadership also was exploring what implementation would look like and raising awareness with the public, programs, and partner organizations about the HUB and its role in the home visiting and community systems.

- ♦ Early in the study, the HUB shifted into the installation phase. The HUB secured leadership support, hired staff to form an implementation team, expanded staff training and TA capacity, and began developing a communication approach to emphasize key messages. The HUB also developed plans for implementing TA and support, including outlining expected activities for each person in different roles at the HUB.

- ♦ As the HUB moved quickly into the initial implementation stage, the staff began offering TA and support to programs. There were intentional efforts to create opportunities for reflection, and HUB leadership encouraged open communication and feedback loops about how to improve internal processes and TA approach. The HUB also adjusted its infrastructure repeatedly to better support quality practices. For example, the HUB implemented and refined key systems for internal functioning, clarified specific, intentional activities for TA and support with programs, and established processes for gathering and using data. Some efforts also were undertaken to think about what fidelity means within HUB practices, to identify the extent to which quality practices were being implemented, and to begin to make further refinements.

- ♦ By the end of the 3-year RISE evaluation, the HUB was continuing with tasks of initial implementation; its approach was not solidified enough yet to focus on sustainability and full implementation of one consistent TA and support approach.[12] For instance, further work remained to articulate how to match the type and extent of TA and support to the

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[10] It is difficult to pinpoint a precise date for the inception of the HUB. The HVSA reviewed the needs assessment results in 2011 and provided its first contracts to programs shortly thereafter. See Exhibit 3 for more information about the subsequent progression of activities as staff for the HUB were hired and the HUB began providing TA and support to programs.

[11] According to Implementation Science, organizations move through four stages of organizational implementation when incorporating a new practice or approach into an established one. Those are: exploration, installation, initial implementation, and full implementation. For more information about Implementation Science and the four stages, see http://implementation.fpg.unc.edu/modules-and-lessons

[12] The HUB was not striving to implement a standard one-size-fits-all approach to TA and support. The expectation is that some of the TA always will be individualized to the unique needs of each program. However, as the HUB continues to develop, the HUB will more clearly articulate its approach, and, for instance, show more consistency in the types and intensity of TA and support that is offered for programs who are at distinct stages of implementation, are using similar models, and are confronting similar challenges.

specific strengths, needs, and implementation stage of particular grantees and their home visiting programs.

Exhibit 3 reveals both milestones associated with different steps in this journey (e.g., all models have quarterly supervisor meetings as an adjustment that was an outcome from feedback loops) and key events that influenced progress and required the HUB to revisit steps from earlier stages (e.g., the Thrive reorganization required revisiting leadership support and adjustments to the infrastructure and staff roles). More details about the HUB's development are provided in the findings from the process evaluation. However, across the 4 years of the RISE evaluation, it is important to note that the HUB:

♦ Navigated changes at the same time that it continued to scale up services. During the RISE evaluation, the number of programs the HUB contracted with and supported increased rapidly. By the end of the project, the HUB provided support to 38 grantees in 23 counties, with a number of the grantees managing multiple contracts for services to different populations, service areas, or covering different programs that the grantee administers.

♦ Experienced considerable staff turnover among HUB leadership, HUB staff, and staff at key partner organizations (e.g., DEL, DOH, DSHS, including DEL leadership). Indeed, only three out of the original 10 HUB staff members at the RISE kickoff meeting remained involved as the final report was being developed.

♦ Was affected by organizational restructuring at Thrive and multiple major shifts in leadership at both Thrive and DEL.

♦ Adjusted in response to major shifts in involvement with and responsibilities of key partner organizations (e.g., transition of data responsibilities to DOH, increased partnership and collaborative implementation with DSHS).

This surrounding context and the rapid development and change within the HUB were perceived and experienced by people at many different levels of the system and are described in the process evaluation. This also is important to consider in interpreting findings from the outcome evaluation because findings are based on information from programs and staff who did not receive one "uniform intervention" and may have had different experiences with TA and support with the HUB at any given point in time and also across the 4 years of the study.

Implementation HUB: Intended Functions and Approaches

The Implementation HUB was developed as a centralized support system for home visiting programs to improve model fidelity, organizational capacity, and quality of service delivery. It was envisioned as a system of supports for programs to replicate national home visiting models and effectively implement home visiting programs, including those categorized as "evidence-based" or as "promising practices." Supports include CQI, program monitoring, model-specific supports, coaching, training, and TA using Implementation Science frameworks. Supports were expected to be provided in many different formats, for example as general resources, as a response or resource developed for a group with a specific need, or individualized to respond to particular needs or questions of a staff member. Throughout this report, we refer to this package of many different kinds of supports more generically as TA and supports.

Implementation HUB team members support local program staff in many different activities that bolster staff and program functioning. The HUB supports local programs[13] as they hire, train, and coach home visitors and supervisors. HUB staff also support programs with professional development opportunities, coordinated evaluation and data supports, CQI-focused activities, and planning supports. The state model leads for Parents as Teachers (PAT), Nurse-Family Partnership (NFP), and Parent-Child Home Program (PCHP) provide programs with TA and supports related to model fidelity and implementation quality in a variety of formats. It is worth noting, however, that there was a 1.5 year vacancy in the PAT model lead at the HUB that reduced the model-specific supports available to PAT programs for a substantial portion of the evaluation. HUB TA staff are managers with significant years of experience with home visiting implementation and community capacity building; they make phone calls, conduct site visits, and provide virtual and in-person support on a wide range of contractual, organizational, leadership, professional development, and model-specific topics. Many of the HUB supports are provided at the supervisor level, with some support also provided directly to administrators and home visitors in programs. The specific content and format of support are tailored to program and staff needs. Because programs may face similar challenges, the Implementation HUB also is able to connect programs to one another to solve problems and share solutions. The TA is planned to be stage based. That is, the HUB would support the program and its staff in different ways depending on a program's stage of implementation of its home visiting model. So, for newer programs still in the installation stage, the HUB's TA was more on building organizational, administrative and leadership supports and establishing what systems might be needed to move forward with initial implementation, whereas programs already involved in initial implementation might receive more support on how to gather feedback about initial implementation efforts and refine practices or professional development activities based on the feedback they hear.

The Washington State MIECHV logic model[14] in the proposal for the initial competitive expansion funds is shown in [Appendix B](#) as is an earlier logic model developed in the planning phase at Thrive. The Washington State MIECHV logic model provides detail about the many resources, activities, outputs, and outcomes that are expected of the MIECHV competitive expansion funds. The Implementation HUB plays a major role in these efforts. The goals of the HUB are the following: "upholding fidelity to home-visiting models; providing ongoing monitoring and technical assistance; facilitating comprehensive program evaluation; and creating opportunities to learn and improve based on data" (personal communication, Jim Ott, October 23, 2014).

Since the establishment of the HUB, there has been considerable effort to identify and further refine a systematic and intentional approach to work with programs and provide TA and supports most effectively. Core elements of these HUB supports were in place beginning in 2013. However, given the relatively recent establishment of the HUB and what is known about where the HUB has been in its own implementation process, specific strategies and activities that the HUB incorporates into its

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[13] Throughout this report we use the terms local programs, home visiting programs, and local implementing agencies interchangeably.

[14] Neither of the logic models in [Appendix B](#) map exactly on to the precise research questions for the RISE Home Visiting Evaluation. The Implementation HUB, DEL, DOH, and other partners came together to jointly determine priority areas for evaluation and identified the research questions described later for each study.

work with programs have been evolving and are expected to continue to evolve as it uses CQI activities internally to refine its approach.

Overview of Evaluation Design and Research Questions

The Phase I of the RISE Home Visiting Evaluation was designed to include both a process and an outcome evaluation. The process evaluation was conducted for the first three years of the evaluation. Details and results for the process evaluation can be found in the *RISE Home Visiting Evaluation Annual Report 2016*.[15] In Phase II, with the extension of the evaluation by an additional year, a rural substudy to better understand of the experience of rural evidence-based home visiting programs was conducted. Information about the evaluation research questions and the Washington programs involved in the evaluation are below.

Research Questions for the RISE Home Visiting Evaluation

The **outcome evaluation** measured the impact of the Implementation HUB on three major outcomes: use of training and TA; model fidelity and implementation quality; and program staff competency and self-efficacy. The primary research question was: *How do the identified programs in Washington that receive support from the Implementation HUB differ from comparison programs in other states with regard to the three major outcomes?* Details about the designs and methods of the process and outcome evaluations are presented at the beginning of the sections of the report describing those findings. All data were collected, analyzed, and reported by SRI staff on the RISE Home Visiting Evaluation Team consistent with expectations for conducting an independent evaluation.

The **rural substudy** answered the primary research question: *What are the unique features of implementing evidence-based home visiting in rural communities?* It addressed this question from the perspectives of program staff with additional contextual information gathered from HUB and state staff. Data were collected through semistructured interviews, focus groups, and through disaggregating the outcome evaluation data by rural and non-rural programs.

Programs From Washington in the RISE Evaluation

Although the HUB is part of a system that supports home visiting using both evidence-based programs and promising practices, the evaluation focused on programs in Washington that are implementing two evidence-based programs—PAT and NFP. PAT and NFP were selected because they are the target of the state's MIECHV expansion funding.[16] The specific programs included in the evaluation were drawn from two cohorts of that received funding in 2012 and 2014. Through a community needs assessment[17] conducted by the DOH in 2010 and updated in 2011, communities that were serving the highest-risk populations either because of geography or race/ethnicity, or both, were ranked using a set of 15 indicators (e.g., percentage of preterm births, infant mortality

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[15] (Gaylor, Schachner, Barton, Hudson, & Chen, 2016)

[16] The HUB also provides TA and support to programs implementing promising practices like PCHP. However, because the MIECHV funding in Washington only supported programs implementing NFP and PAT, the evaluation focused only on programs implementing the NFP or PAT model.

[17] For more information about the community needs assessment undertaken by the DOH, see http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/Funding/HomeVisitingNeedsAssessment

rates, rates of domestic violence.). Twenty-three programs serving communities with the highest-risk characteristics worked with Thrive to conduct a community-capacity assessment that considered the community's readiness to implement either the PAT or NFP model. Programs that believed they had the community capacity to implement PAT or NFP submitted an application, and 15 expansion programs were funded in 2012 and eventually included in the evaluation.

Building on this work, in October 2013 Thrive engaged in a more intensive process with five rural communities with significant risk characteristics to help them consider their unique needs and resources, the perspectives of various organizations and stakeholders, the capacity for implementing an evidence-based home visiting model, and what is required for implementing the PAT or NFP models effectively.[18] Each community considered its readiness to implement PAT or NFP and began establishing the commitment, support, and basic infrastructure to build evidence-based home visiting. Three of these communities were selected to submit a capacity assessment or application for funding to Thrive for evidence-based home visiting and were funded early in 2014 to implement services. These three additional programs were added to both the process and outcome evaluations early in 2014. Thus, the 18 Washington programs listed in Exhibit 4 were included in the evaluation of the Implementation HUB. In the next two sections, we describe the outcome evaluation questions, methods, and key findings across the 4 years of the project and findings from the rural case study.

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[18] For more information about work undertaken with rural communities by Thrive and HUB staff, see https://thrivewa.org/work/expanding-hv/.

Exhibit 4.   Programs in Washington State Participating in the RISE Evaluation

Program Name	Evidence-Based Home Visiting Model		County
	PAT	NFP	
Catholic Charities of the Diocese of Yakima	X		Yakima
Children's Home Society of Washington	X		Pierce,[b] Cowlitz, Spokane, South King[c]
Columbia Basin Health Association[a]	X		Adams
First Step Family Support Center	X		Clallam
Friends of Youth	X		Snohomish
Grays Harbor County Public Health and Social Services Department[a]	X		Grays Harbor
Okanogan County Child Development Association[a]	X		Okanogan
United Indians of All Tribes Foundation	X		King
Yakima Valley Farm Workers Clinic	X		Yakima
Little Red School House/ChildStrive[a]	X		Snohomish
Little Red School House/ChildStrive		X	Snohomish
Benton-Franklin Health District		X	Franklin
Cowlitz County Health Department		X	Cowlitz[d]
Mason County Public Health and Human Services		X	Mason
Seattle-King County Public Health		X	King
Skagit County Public Health		X	Skagit
Spokane Regional Health District		X	Spokane
Yakima Valley Memorial Hospital Association		X	Yakima

[a] These programs represent the additional rural expansion sites described above.

[b] Children's Home Society of Washington, Pierce County discontinued PAT services on September 30, 2014. It participated in the RISE Evaluation until that time.

[c] Children's Home Society of Washington, South King County discontinued PAT services on December 31, 2016. It participated in the RISE Evaluation until that time.

[d] Cowlitz County Health Department transitioned to have NFP services for Cowlitz County provide by Clark County on January 1, 2017. It participated in the RISE evaluation until that time.

Outcome Evaluation

In the outcome evaluation, SRI used a quasi-experimental design to understand differences between the home visiting programs that received TA[19] and support from Washington's Implementation HUB and comparison programs in other states without this specific TA structure. This report describes the methods used to answer the research questions, the timeline of data collection, the baseline characteristics of participating programs in Washington State (intervention) and the matched comparison group (comparison), and the final outcomes in both groups. Previous reports include information about the interim outcomes in years 2 and 3 (Gaylor et al., 2016; Gaylor, Winer, Barton, Chen, & Hudson, 2014, 2015).

Outcome Evaluation Questions and Design

The primary research question for the outcome evaluation was: *How do the participating programs that receive support from Washington State's centralized support system (Implementation HUB) differ compared with similar programs in other states on the outcomes of interest*. The outcome evaluation examined whether the home visiting programs that received support from Washington State's centralized Implementation HUB differed relative to similar programs in other states on

- ♦ use of and satisfaction with training, TA, and coaching;
- ♦ model fidelity and implementation quality; and
- ♦ staff competency and self-efficacy.

The TA question is a descriptive one. We were interested in examining how much TA each group received, how it was delivered, who delivered it, and what the perceptions of home visitors and supervisors/administrators were about the TA, training, and coaching received during the project. Given that the HUB delivers TA, we expected provision of TA to be a short-term outcome of program and staff member participation. However, we also expected TA to be an intermediate outcome that could influence differences between groups over time in implementation and model fidelity and staff competence and self-efficacy. We included TA in both the outcome evaluation and the process evaluation in the hope it would provide greater understanding for program and systems improvement as well as interpretation of the outcomes.

Given the objective of examining whether this TA structure produced better outcomes in program- or staff-level outcomes, SRI designed a quasi-experimental study in which the intervention programs were identified initially and then a matched set of programs were identified to serve as the comparison group. A randomized control trial design was not feasible because only Washington programs were eligible to participate in the intervention, and it was not appropriate to withhold the centralized supports from half the programs receiving MIECHV funding in the state of Washington. However, it was determined to be feasible to identify programs with similar characteristics in other states and compare the outcomes between the two groups.

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[19] As used here, TA broadly references training, technical assistance, support, and coaching received by programs from the HUB, coordinated through the HUB, and/or obtained from any other sources. The TA may be individualized or a standard group offering.

Evaluation Sample and Data Sources

To identify a group of programs similar to the group of Washington programs, we used propensity score matching techniques, as described below. We collected data about programs and staff at the beginning (or close to the beginning) of implementation, which we refer to as Time 1, and then again at the end of the project, which we refer to as outcome or Time 3 for all data sources except the Home Visiting Snapshots, which were collected twice, fall 2015 for Time 1 and then again in the add-on year in Fall 2016 for Time 2. Details on the time frames of data collection are provided in the descriptions of each data collection source.

Outcome Evaluation Program Sample

This section describes the process of selecting and recruiting the matched comparison programs. Because Washington State home visiting programs were not randomly assigned to participate in the HUB, we needed to try and ensure in the evaluation design that differences between those programs and comparison programs on the outcomes of interest (use of and satisfaction with training, TA, and coaching; model fidelity and implementation quality; and staff competency and self-efficacy) were not likely to be attributable to preexisting characteristics rather than to the impact of the HUB. A credible evaluation of the impact of the HUB should be based on the difference between the Washington programs that participated in the HUB and programs in other states that are similar to them but did not participate in the HUB or a similar centralized system of support (Michalopoulos, Bloom, & Hill, 2004).

Process for selecting comparison programs

To identify a matched comparison group, SRI used propensity score matching to pair Washington (intervention) programs with non-Washington (comparison) programs on the basis of the conditional probability of participation in the HUB given observable characteristics such as agency type, enrollment capacity, and number of years implementing NFP or PAT. The logic of the propensity score method is to select comparison programs that would have had a similar chance of participating in the HUB given selected program characteristics (Rosenbaum & Rubin, 1983, 1984, 1985). In essence, the method identified comparison programs that differ from the Washington programs only in that they did not participate in the HUB (presumably because it was not offered in their state). A logistic regression uses data on observable characteristics of each program and the population served by the program to model the probability that the program was an intervention program. We planned to recruit comparison programs that had the nearest probability scores to the scores that actual intervention programs obtained in the model. In short, propensity score matching should create two comparable groups of programs like those that would have been created using random assignment in a randomized control trial.

SRI's propensity score matching process was conducted separately for PAT programs and NFP programs primarily because different variables were available for each set of programs. Details about the steps and variables involved in identifying comparison programs for each model are outlined in Appendix C Briefly, we followed these steps:

1. Identify programs that meet minimal selection criteria.[20]
2. Conduct propensity score matching using a set of predictor variables and nearest neighbor matching to identify a large set of potentially suitable programs.
3. Confirm whether preliminary matches had any extenuating state or program issues that might interfere with their use as a comparison program.
4. Review characteristics of remaining comparison sites for balance and to cluster selections in as few states as possible.
5. Recruit programs for study participation.

More than half the comparison programs (n = 21, 66%) were identified through propensity score matching. Some new home visiting programs were in their first year of data collection and had not submitted data in reports to the national office (or the program was being reorganized into a consolidated agency), so no data were available for the propensity score matching process. In those instances, the characteristics of the intervention programs were identified with the help of Thrive and MIECHV Data Warehouse and used in hand-matching with data provided by NSO staff. SRI worked with the PAT and NFP NSOs to review forms or plans developed at program enrollment and start-up as well as notes about new programs. The process also built on the knowledge of TA providers from the NSO working within states to identify appropriate programs that had characteristics similar to the intervention programs' but were located in other states. This process was used to identify 11 comparison programs.

SRI conducted a power analysis to examine the appropriate sample size for the outcome study and ensure that the final sample size would be sufficient to detect the expected effects of the Implementation HUB on staff and program outcomes. Power calculations were conducted using 17 programs in the intervention group. Power was examined based on recruiting two to three comparison programs for each intervention program; thus, the number of comparison programs was expected to range from 28 to 51.

Because home visitors are nested within programs, it was appropriate to estimate power using a hierarchical linear model. Under the above assumptions, if baseline measures were not available for both intervention and comparison programs, then the minimum detectable effect size (MDES) at a power of 80% and 5% two-sided alpha level would be quite large. If the data from pre-intervention or baseline were reliable measures of the outcome variables and these baseline measures reduced the variance components by 50% at both the program and home visitor level, we could detect more

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[20] SRI contacted TA providers, evaluators, and NSO staff working with states to identify states that might have TA support systems that seem centralized or that might be involved in initiatives that might greatly increase available TA support. On the basis of recommendations from various sources, a number of states were excluded from each program. States excluded for NFP matching were Colorado, Georgia, Hawaii, Kentucky, Louisiana, New Hampshire, and New York. States excluded for PAT matching were Colorado, Delaware, Georgia, Hawaii, Kentucky, New Hampshire, New Jersey, New York, Texas, Virginia, and Wyoming. In addition, we excluded Missouri for PAT because it is proximal to the NSO national headquarters, possibly increasing access to NSO support. Further, programs in Missouri have a long history of implementing PAT that has influenced their adoption of recent curriculum updates. We also excluded PAT programs located outside the United States, as well as school-based PAT programs because none of the PAT sites in the intervention group were in a school-based setting and implementation of school-based PAT programs differs in important ways from implementation of community-based or health organization-based PAT programs.

moderate effect sizes in the range of .3 to .4 for individual staff outcomes. Based on some of our initial assumptions, we determined that a minimum of 28 programs in the comparison group would enable us to detect a .40 effect size for individual staff outcomes and a .64 effect size for program-level outcomes. This means that the power analysis indicated that fairly large effects are necessary to achieve statistical significance. Effect sizes are typically used when the outcome measures have strong reliability and validity. In this evaluation, we were limited to available measures of the outcomes of interest. We also were limited by the fixed number of programs and staff (i.e., sample sizes). That is, because the sample of programs is small, the evaluation is powered to discern only very large effect sizes (i.e., differences between the two groups of programs). Given these limitations, we decided to analyze the data multiple ways, ranging from descriptive statistics to conducting multi-level models nesting outcome observations within staff and staff within programs.

The intervention group for the outcome evaluation consisted of 18 participating programs that received MIECHV funds, provided either NFP or PAT home visiting services in the state of Washington, and that were identified through a needs assessment process to be serving the highest risk populations in the state. Eight of these programs provided NFP services, and 10 provided PAT services (Exhibit 4).

The evaluation team began recruitment in summer 2014 with the goal of seeking 28 to 45 matched comparison sites to agree to participate. We attempted to recruit 70 programs across NFP and PAT. About half the programs (46%) agreed to participate (n = 32) and 47% declined. An additional 7% were dropped because of extenuating circumstances or the program became ineligible after agreeing to participate. Thus, following the recruitment steps described above yielded 32 comparison programs agreeing to participate. Participating programs were from 17 states overall, with 15 NFP comparison programs from 8 states and 17 PAT programs from 10 states. One state had both NFP and PAT programs participating. At the start of the add-on year in fall 2016, comparison programs were asked to continue participating in data collection activities. At that time, 8 programs (5 NFP programs, 3 PAT programs) declined to participate resulting in 84% retention.

Exhibit 5 presents the variables used in the matching for each home visiting model. The information on capacity was not defined in the same way for the models. NFP and PAT provided the data for number of families served in different ways. NFP provided information on total capacity, and PAT provided information on number of families actually served. The number for NFP may be an overestimate of the number of families served. Also, if data were missing, we estimated the capacity based on the number of parent educators/home visitors.

Exhibit 5.   Program Characteristics Used for Selecting Comparison Programs for the Outcome Evaluation

Characteristics	PAT	NFP
Agency type	X	X
Enrollment capacity or number of families served	X	X
Geographic location (rural, urban)	X	X
Percentage of families served who are African American	X	
Percentage of families served who are Spanish speaking	X	
Receives MIECHV funding or not	X	X
Length of time conducting PAT/NFP services	X	X
Percentage of families served with two or more high-risk characteristics	X	

Baseline equivalence of intervention and comparison groups

Once the matched comparison group had been identified and recruited, we examined the equivalence between it and the intervention group on key program characteristics (Exhibit 6). The groups were equivalent on some key characteristics but not on others. They were not equivalent on the characteristics of rural, urban, or MIECHV funding. More programs in the intervention group served a rural population, and more programs in the comparison group served an urban population. About one-fourth of the comparison programs serve both rural and urban, while only 11% of the intervention programs serve both. Also, by definition 100% of the programs in the intervention group received MIECHV funds, whereas 78% of the comparison programs received them. The intervention and comparison groups were comparable at baseline on enrollment capacity (defined as number of families currently served or capacity to serve if the actual number of families served was not available), agency type, and the percentage of programs operating as new programs (defined as providing services for less than 3 years). The average number of families served or capacity to serve was 146 families (standard deviation = 144) for the intervention programs (range: 20–675) and 148 families (standard deviation = 98) for the comparison programs (range: 45–429).

Exhibit 6.   Equivalence of Key Program Characteristics in Intervention and Comparison Groups

Program characteristics[21]	Intervention (%) n = 18	Comparison (%) n = 32
Rural	83	69[a]
Urban	28	56[a]
Health department agency	56	50
Community-based organization (CBO)	39	41
MIECHV funding	100	78[a]
New program (defined as operating for < 3 years)	44	37

Source: NSO data export.

[a] Hedges' g calculated differences ≥ 0.25.

We considered weighting data to account for the differences and did identify a weighting algorithm whereby intervention and comparison groups would have been comparable on these key characteristics. However, the Technical Work Group (TWG)[22] advising the project encouraged the use of unweighted analysis of findings (personal communication with Technical Work Group, October 16, 2015). Although these key characteristics/covariates are believed to be important features that could influence program participation and evaluation outcomes, the TWG believed that there was insufficient empirical evidence that establishes the specific ways rural/urban service area or MIECHV funding influence program participation or key outcomes of interest. Propensity score weighting generally has been used to estimate the impact of a policy, intervention, or program when random assignment is not feasible and the researcher cannot establish baseline equivalence. By accounting for the covariates that are highly predictive of the outcomes and intervention participation in the estimation of propensity score weights, this approach assures that differences in outcomes are not the result of differences in mean values on those covariates (Caliendo & Kopeinig, 2008; Heckman, Ichimura, Smith, & Todd, 1998; Lechner, 2002; Ravallion, 2001). This approach also works best when there are a smaller number of variables being examined, which is not the case in this evaluation. Given these considerations, the TWG believed it was better to compare the groups using unweighted data and to conduct supplemental analyses that considered how additional factors might be related to any differences in outcomes. Indeed, more extensive analysis of rural/urban influences were conducted and are included in this report.

Outcome Evaluation Data Sources

Before presenting the outcome findings for the intervention and comparison groups, we describe the data sources used in the evaluation. Some data were available at the program level

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[21] Baseline equivalency was established using the characteristics of the programs participating at the start of the study. During the course of the study, one PAT comparison program discontinued their participation. At the start of the add-on year in fall 2016, comparison programs were asked to continue participating in data collection activities. At that time, 8 additional comparison programs (5 NFP programs, 3 PAT programs, 4 rural) declined to participate.

[22] TWG members were Deanna Gomby, Jon Korfmacher, Diane Paulsell, Judy Pfannenstiel, and Lori Roggman.

(e.g., program data exports from NFP and PAT NSOs), and some were available at the individual staff member level (e.g., surveys). Some data were self-report (e.g., survey) and other data were analogous to a time-sampling approach (e.g., the Home Visiting Snapshot form). In addition, we asked programs to document on a monthly log the TA that staff received which we collected on a quarterly basis. These TA logs were a rich source of information on one of the intermediate outcomes the HUB was trying to influence.

Exhibit 7 lists the data sources used and their timing. Note that although we refer to Time 1 and Time 3, there was variation in the timing of Time 1 and Time 3 data collection. Note that because the Home Visiting Snapshot was only collected twice, the additional time point is referred to as Time 2 even though it was collected in the add-on year.

Exhibit 7 provides a more detailed timeline showing when data were collected. In general, the timing of information captured for Time 1 and Time 3 is pretty similar across all of the data collection methods with the exception of the data export information; because programs report data on earlier time periods, Time 1 for the data export was from prior to the beginning of the RISE evaluation study timeline and export data represented in Time 3 are from an earlier time point than the Time 3 data reported for other methods of data collection.

Exhibit 7.   Outcome Evaluation Data Sources and Timing

Measure	Timing
Data export from NSO	July 2012 through June 2013 (Time 1) July 2013 through June 2014 (Time 2) July 2014 through June 2015 (Time 3)
Online Program Practices Survey	September to December 2014[a] (Time 1) February to March 2016 (Time 2) February to March 2017 (Time 3)
Technical assistance logs	July 2014 through May 2015 (Time 1) June 2015 through February 2016 (Time 2) March 2016 through February 2017 (Time 3)
Home Visiting Snapshot form	September 2015 to November 2015[b] (Time 1) October 2016 to November 2016 (Time 2)

[a] A few additional comparison programs were recruited into the study late. They completed the Program Practices Survey in January and early February 2015 for Time 1. Questions in the survey asked about experiences in the year prior to the survey.

[b] Timing reflects data collection dates for most programs. Two comparison programs completed their Home Visiting Snapshot forms for Time 1 later because of transitions and program changes influencing staff in fall 2015. These programs submitted the completed forms in December 2015 and January 2016.

TA Logs (2014–15 and 2016–17)

Intervention and comparison programs documented the amount, format, content, and source of TA that administrators, supervisors, and home visiting staff received throughout the project. In this report, we present analyses comparing the first and last years of data. Capturing these basic characteristics of TA provided a broad measure of the ways that the support intervention programs in Washington State received may have differed from the support programs in other states

received. Documenting TA received also helped identify the extent to which differences in TA between programs may have been due to the presence of the centralized system of support that is the Implementation HUB.

TA log content and data collection methods

To collect data on the TA, support, and coaching programs received, the evaluation team developed the TA log template. The template was a blank log with separate columns for the categories of information (date, TA content, format, source, duration, and staff attendance), instructions for filling out the log (e.g., what types of TA events to include and not include), and additional information, such as definitions of terminology used and an example of a completed log (see Appendix D).

Each home visiting program was asked to keep an ongoing record of TA in the template and then complete and return a log every 3 months. In general, programs were asked to record instances of TA provided to home visitors, supervisors, and administrators to support professional development, improve program practices, and address questions and concerns. TA provided from a distance (e.g., webinar, phone call, extended series of emails), in addition to in-person TA, was expected to be logged. Programs were asked *not* to log what we considered to be regular program practices, such as new hire orientations, staff meetings,[23] and supervision, as well as brief emails and texts answering quick questions (e.g., when the date of a training is, where to find the written policy on a specific topic). The evaluation team attempted to standardize data collection to the extent possible by communicating the same set of instructions and expectations to all liaisons and reviewing records to provide a standard set of feedback to those involved. However, there is natural variation in how different individuals completed their logs. For instance, we do not know whether participants kept an ongoing record of TA as the months progressed or completed the log based on record review at the end of the quarter.

The TA logs were released to programs participating in the study beginning July 1, 2014, and the four subsequent quarters[24] of data are reported here as Time 1.[25] Programs submitted an additional four quarters of data from March 2016 to February 2017 that are reported here as Time 3.[26] Upon receiving the completed logs, a team of coders cleaned and prepared them for analysis. This included removing TA events that were mistakenly recorded (e.g., those considered regular program practices), recoding staff roles and TA sponsors into meaningfully distinct categories, and to the extent possible ensuring the sequence of logs from a program accurately reflected staff

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[23] If staff meetings included outside speakers or time set aside specifically for TA or support on a certain topic, it would be logged; routine staff meetings were not logged.

[24] Time 1 quarters were as follows: July 1 to September 30, 2014; October 1 to December 31, 2014; January 1 to March 31, 2015; April 1 to May 31, 2015. The last quarter consisted of only 2 months because home visiting programs requested a change in the log submission schedule. Thus, Time 1 included 11 months of data.

[25] Not all programs submitted a log for each quarter; several programs joined the study later in the year so were missing the earlier logs, one program stopped participating in the log component of the study so was missing the later logs, and one program submitted largely incomplete logs for two quarters because of supervisor turnover.

[26] Eight programs did not participate in the add-on year of the study and thus did not submit Time 3 logs. All remaining participating programs submitted a log for each of the four quarters of Time 3.

changes over time (i.e., removing staff who left in a previous quarter and adding new staff). Coders followed established guidelines and met regularly to discuss any challenges in order to facilitate reliability. The cleaned TA logs were then read into a single dataset in SAS. The dataset was organized by TA event, meaning that each event that was attended by at least one staff member was a record in the dataset.[27] Each event had an associated list of staff in attendance. Staff members were then linked across events using a name match, so the total amount of TA received by an individual over the course of the year could be known.

Sample for TA log data

At Time 1, 18 intervention and 32 comparison programs submitted 187 quarterly TA logs that captured the TA that staff received over an 11-month period (July 1, 2014–May 31, 2015). After cleaning, the resulting TA log dataset comprised 2,815 records; each individual TA event marked as attended by at least a single staff member constituted one record. Of these records, 206 (7%) were missing data on one or more fields (i.e., TA format, content, source, duration, staff attendance) but all available data were utilized to the extent possible. Intervention and comparison programs had similar amounts of missing data (8% and 7%, respectively).

At Time 3, the same 18 intervention programs and only 23 comparison programs (four PAT and five NFP comparison programs declined to participate) submitted 164 quarterly TA logs that captured TA that staff received over a 12-month period (March 1, 2016–February 28, 2017). After cleaning, the resulting TA log dataset comprised 2,692 records, with 195 records (7%) missing data on one or more fields. Comparison programs had slightly more missing data than intervention programs (9% and 5%, respectively).

Records captured TA and support received by 450 staff members at Time 1 and 435 staff members at Time 3 (Exhibit 8).

Exhibit 8.   Sample of Individuals Represented in TA Logs

	Intervention Time 1 *n* = 18	Comparison Time 1 *n* = 32	Intervention Time 3 *n* = 18	Comparison Time 3 *n* = 23
Number of staff in TA logs	161	289	167	268
Supervisors (%)	19	16	14	16
Home visitors (%)	71	75	72	74
Administrators/directors (%)	11	9	13	10

Note: The category of supervisors includes individuals who were dual supervisor/home visitors, dual administrator/supervisors, and supervisors only. Changes between Time 1 and Time 3 in percentages of staff in the different roles were not statistically significant at $p < .05$.

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[27] Events themselves were not necessarily discrete, meaning that staff from two different home visiting programs could have attended the same event (for example, a community resource sharing event) and then recorded it on their two separate logs so this event would appear twice in the dataset (once for each program).

Home Visiting Snapshot Form

From approximately September to November 2015 (referred to as "Time 1") and October to November 2016 (referred to as "Time 2"), data were collected using the brief Home Visiting Snapshot form designed to address model fidelity and implementation quality constructs that were not available in program exports. These included home visit content, provider-participant relationship quality, assessment of family needs and strengths, referrals and outreach, and use of progress monitoring and assessment to guide visit content and approach. Home visitors collected data immediately after individual home visits with the first 10 families served during a 4-week period (a snapshot sampling strategy).[28] Home Visiting Snapshot forms did not collect identifying information on the families themselves because the data collection focused on what was happening during home visits rather than the characteristics or outcomes of families receiving services.

Home Visiting Snapshot form content and data collection methods

The content of the snapshot form was influenced by the Home Visiting Encounter form developed and used by the Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment evaluation (Daro, Hart, Boller, & Bradley, 2012) and the Enhanced First Steps Home Visit Observation form from the Better Beginnings study (Hallgren, Boller, & Paulsell, 2010). In addition, we adapted questions that were used in an Early Head Start evaluation to measure provider-participant relationship quality (Roggman, Cook, & Jump Norman, 2008; Roggman, Cook, Jump Norman, et al., 2008). The RISE TWG reviewed the form and provided feedback on how best to tailor the content to address topics of interest and how to ensure reliability and validity of items. The final content of the Home Visiting Snapshot form was selected to match categories and content of the models, using language that PAT and NFP NSO staff indicated would be easy to understand and interpret for those implementing the models.

Prior to the initial 2015 data collection, we sent the form to PAT and NFP programs for piloting. Pilot programs were selected and recruited with assistance from the NSOs. Each program was sent printed snapshot materials to complete and return, along with supplemental guidance explaining how the materials were to be distributed and completed. In addition, each participant was asked to complete a one-page feedback form to gather information about any directions or item language that was not clear, assess how long it took to complete the forms, and identify any questions that made the pilot testers uncomfortable. Three PAT programs participated in a full pilot effort over 4 weeks in June and July 2015, with a total of eight parent educators and supervisors participating in completing and collecting the forms. Two NFP programs assisted in a modified pilot effort in July and August 2015. One of the programs reviewed materials and sent feedback but did not complete forms for any visits. A second program completed forms after visits but only for a period of 2 weeks. A total of nine nurse home visitors from NFP programs participated. Feedback from all pilot programs was reviewed and incorporated into the final snapshot form. See [Appendix E](#) for the final version of the form.

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[28] A small number of home visitors completed fewer than 10 forms if they worked part time, had a small caseload, or were unable to complete the full amount of forms during the data collection period.

Sample from Home Visiting Snapshot form

At Time 1 (September to November 2015), the snapshot forms were mailed to programs for distribution to 95 staff at 18 intervention programs and 189 staff at 31 comparison programs. As indicated in records from the time period that snapshot forms were collected, there was an average of 5.4 home visitors per program at intervention sites and 5.9 at comparison sites. Rates of data collection participation were high across both groups, with 96% of intervention staff ($n = 91$) and 97% of comparison staff ($n = 183$) completing forms. This high participation rate indicates that data collected on the forms were most likely representative of home visits conducted by the programs during this time period. In addition, forms were obtained for a high percentage of the expected number of visits. If all identified staff ($n = 284$) completed 10 forms during the 4-week window, we would expect 2,840[29] completed forms. SRI received forms for 2,647 home visits (or 93% of the expected visits): 876 visits in intervention and 1,771 visits in comparison sites.

At Time 2 (October to November 2016), the forms were mailed to 104 staff at 18 intervention programs and 151 staff at 23 comparison programs. As indicated in records from the time the forms were collected, there was an average of 5.8 home visitors per program at intervention sites and 6.6 at comparison sites. Rates of data collection remained high at Time 2, with 89% of intervention staff ($n = 93$) and 89% of comparison staff ($n = 135$) completing forms. If all identified staff ($n = 255$) completed 10 forms during the 4-week window, we would expect 2,550 completed forms representing the same number of home visits. SRI received forms for 2,172 home visits (or 85% of the expected visits): 885 visits in intervention and 1,287 in comparison sites. Given that forms were completed for so many of the expected visits, we have confidence that these data are a good representation of the visits that occurred in programs during that time period. Also, note that the number of snapshot forms received from NFP and PAT programs was consistent with the percentage of programs in the outcome study sample that were participating in the evaluation indicating participation rates were similar across NFP and PAT programs.

Home visitors completed basic information about the family served during each home visit. No identifying information was gathered about families, but home visitors did record when the family had enrolled in the program and the age of the youngest child in the family. The families represented in home visits where snapshot forms were collected were similar between intervention and comparison programs in length of time enrolled and age of youngest child (Exhibit 9) at both Time 1 and Time 2 (see Exhibit 9 for Time 2 data).

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[29] This is only an estimate; it was not based on specific information about the model's caseload and visit frequency, staff full-time equivalence, or the stage of family (e.g., pregnancy, infancy) that affected the actual number of home visits, and therefore forms, completed by home visitors during the 4-week data collection period.

Exhibit 9.   Family Program Enrollment Length and Child Age in Home Visiting Snapshot Forms at Time 2

	Intervention *n* = 876	Comparison *n* = 1,205
Length of time enrolled in program (months) Mean (*SD*), range	12.3 (10.0), 0–49	12.6 (11.3), 0–67
12 months or less (%)	55	56
13 months to 2 years (%)	29	27
More than 2 years (%)	16	17
Age of youngest child		
Pregnancy	19	17
Birth to 12 months (%)	39	36
13 months to 24 months (%)	28	25
25 months to 36 months (%)	10	13
More than 36 months (%)	4	8

Source: Home Visiting Snapshot Form (Fall 2016).

Note: There were no statistically significant differences between the two groups on any of these variables.

NSO Data Exports

All programs in NFP and PAT have standard reporting requirements and routinely summarize and submit program and staff information to the PAT or NFP national office. SRI received data exports from both models' national offices for 2012–13, 2013–14, 2014–15, and 2015-16. For the purposes of the evaluation, we report data from only 2012–13 (Time 1) and 2015–16 (Time 3). Appendix F includes guidelines from the NSOs to help interpret the export data.

Data export content and data collection methods

SRI worked with the national offices to obtain export data that programs already routinely submitted. This approach was used to minimize burden to programs using diverse database systems and capitalized on the processes that were in place to ensure reporting of quality data to the national office. SRI exported the data about programs participating in RISE directly from the national office. In 2015, the national NFP and PAT program offices provided us with data on participating intervention and comparison programs from 2012–13. Data were exported if they were related to the three overarching outcomes in the outcomes evaluation.

Sample of programs for NSO data exports

At Time 1 (2012–13), 13 of 18 (72%) intervention programs (6 PAT, 7 NFP) and 31 of 32 (97%) comparison programs (16 PAT, 15 NFP) had complete export data for analysis. A few programs were new affiliates, both in the Washington State program intervention group and the matched comparison group. These new programs did not have complete export data because they were not yet fully established in 2012–13. Specifically, two intervention programs and one comparison program did not have complete data to export for 2012–13 because they completed only the short

form of the Affiliate Performance Report, which did not have all fields we requested. Two intervention programs were too new and did not have any data for the 2012–13 export. In addition, two programs (one intervention and one comparison) were structured with multiple sites. Some of these individual sites did not have data. We tried to estimate data for the programs based on data for the sites that did have data.

At Time 2 (2014-2015), all 18 intervention programs (10 PAT, 8 NFP) and all 32 comparison programs (17 PAT, 15 NFP) provided some export data. All programs except two intervention NFP programs had complete export data for Time 2. The only data missing from the two programs was information about the duration of client participation; otherwise, these programs provided complete data.

At Time 3 (2015-2016), 17 of 18 (94%) intervention programs (10 PAT, 7 NFP) provided complete export data. One intervention NFP program transitioned its services to a neighboring county and did not provide export data. All 25 comparison programs (14 PAT, 11 NFP) that agreed to participate in the add-on year provided complete export data. Seven comparison programs did not continue participation for the add-on year.

Program Practices Survey

Online surveys were used to gather additional data for the outcomes evaluation from administrators, supervisors, and home visitors at intervention and comparison programs. These surveys were administered in September to December 2014, February to March 2016, and February to March 2017 and asked questions about perception of TA and support, supervision practices, self-efficacy, and best practices. For the purposes of this report, we focused on the survey responses at Time 1 and Time 3 to explore how responses changed with an additional year of implementation of the HUB.

Survey content and data collection methods

Program staff members received an invitation email with an individualized survey link using SRI's secure online interface. They could complete the survey at any time during the multi-week data collection period. Embedded in the survey was a consent form for participants. Survey questions were individualized with content appropriate to the participant's role in the program and language appropriate to the home visiting model implemented in that program (e.g., language in questions referenced "essential requirements" for PAT programs and "model fidelity" for NFP programs). See Appendix F for the Time 3 Program Practices Survey. SRI used common survey questions, existing scales or subscales/short forms with established psychometric properties, and measures validated in other home visiting studies whenever possible, based on the tool's appropriateness for this population.

Characteristics of program practices survey respondents

At Time 1, a total of 333 individuals completed the survey (111 respondents from intervention programs and 222 from comparison programs). The overall response rate for the survey was 87%,

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[30] The PAT NSO allows affiliated programs to submit a short form during their first year because they are not yet expected to have complete information to report on all fields.

with 83% of staff at intervention sites responding and 89% at comparison sites. At Time 3, a total of 271 individuals completed the survey (113 respondents from intervention programs and 158 from comparison programs), with an overall response rate of 85%; 87% of staff at intervention sites and 83% of staff at comparison sites completed the survey. About 60% (61%; *n* = 167) of the Time 3 respondents also completed the survey at Time 1. See p. 62 for the section on staff turnover.

- ♦ At Time 1, more than half (56%) of the respondents were from PAT programs, and the remainder (44%) were from NFP programs. Within NFP and PAT, about two-thirds of respondents were from comparison programs and one-third were from intervention programs. This proportion was very similar to the overall sample. Approximately the same distribution by model was found at Time 3 (57% from PAT programs and 43% from NFP programs; 42% from intervention sites, 58% from comparison sites).

- ♦ At Time 1, most respondents were home visitors (75%), with the remaining 25% describing their roles as supervisors and/or administrators. At Time 3, 71% of the respondents were home visitors and the remaining 29% of respondents were either supervisors or administrators. Approximately 5% at both time points identified themselves as both a supervisor and home visitor who carried a caseload. Often, this latter group was asked both the questions for supervisors and the questions for home visitors.

- ♦ At both time points, about two-thirds of the respondents identified as White, non-Hispanic, with about 13 to 18% identifying as Latino/Hispanic and 3 to 10% identifying as African American, non-Hispanic. Almost all (98–99%) respondents were female.

- ♦ At both time points, the ages of respondents were somewhat evenly spread over several categories: about one-quarter between 26 and 35 years (29% at Time 1; 31% at Time 3), one-quarter between 36 and 45 years (24% at Time 1; 24% at Time 3), one-quarter between 46 and 55 years (21% at Time 1; 23% at Time 3), and 17–18% between 56 and 65 years.

- ♦ The majority (84–88%) of the respondents at both time points had a bachelor's degree or higher.

Exhibit 10 shows the survey respondents' average years of experience in their role and in the home visiting field. Information is provided for both supervisors and home visitors, by condition (intervention vs. comparison) at Time 1 and Time 3. These data show the variation in experience across the groups of respondents participating in the evaluation. Some staff members were new to their role, whether as a home visitor or supervisor, and some staff had decades of experience in their role and/or in the field of home visiting. Although, on average home visitors and supervisors in the intervention group have worked in the field of home visiting longer than comparison staff, this difference was not statistically significant.

Exhibit 10. **Average Years of Experience in Role and in Home Visiting Field, by Condition**

	Intervention Min-max Mean (*SD*) Time 1	Comparison Min-max Mean (*SD*) Time 1	Intervention Min-max Mean (*SD*) Time 2	Comparison Min-max Mean (*SD*) Time 2
Supervisors' length of time in role (months)[a]	48.6 (47.9) 2-159 *n* = 27	50.9 (49.9) 1-228 *n* = 42	56.8 (51.5) 1-183 *n* = 24	62.5 (57.9) 0-204 *n* = 29
Home visitors' length of time in role (months)	50.2 (46.2) 2-184 *n* = 81	47.3 (45.4) 0-269 *n* = 167	58.5 (57.0) 1-300 *n* = 88	61.0 (49.4) 1-192 *n* = 120
Supervisors' length of time in home visiting field (months)	187.7 (129.4) 12-444 *n* = 30	153.8 (117.7) 0-480 *n* = 55	181.7 (127.8) 10-411 *n* = 25	160.3 (121.0) 0-480 *n* = 38
Home visitors' length of time in home visiting field (months)	115.7 (102.6) 0-348 *n* = 81	99.9 (92.2) 0-427 *n* = 167	114.7 (105.2) 2-420 *n* = 88	110.4 (92.6) 0-444 *n* = 120

Source: Program Practices Survey 2014 and 2017

[a]Supervisor category includes all respondents who identified as a supervisor. This includes supervisors who also acted as a home visitor as well as dual supervisors/administrators.

Note: No between-group differences reached statistical significance.

Analytic Approach and Presentation of Findings

♦ **Program practices survey data:** Survey data were analyzed for differences between intervention and comparison groups at Time 3. We conducted basic descriptive analysis as well as comparative analyses using chi-square for categorical and ordinal outcomes and independent samples *t* tests of significance for continuous variables. In addition, differences between the intervention group at Time 1 and Time 3 were tested for significance using chi-square and *t* tests.

♦ **Home Visiting Snapshot form data:** These data were analyzed by nesting individual visits within staff members and then testing whether there were differences between intervention and comparison groups on the indicators of interest at Time 2. Because home visiting snapshot forms collected from individual home visitors over time are correlated, it is necessary to account for this dependency in the data (Hedeker & Gibbons, 2006). For example, home visitors probably tended to complete their individual forms in a similar manner, making each home visitor's forms more similar to each other than to another home visitor's forms. Hierarchical linear modeling v (HLM; Raudenbush & Bryk, 2002) is appropriate for this purpose because it takes into account the nesting of snapshot forms within each individual. We used 2-level HLM to nest each form within the home visitor to estimate the difference between the intervention and comparison groups. Level 1 is the data for the two time points for each home visitor and predicts responses between the two time

points. Level 2 accounts for differences across home visitors in the two different conditions (intervention and comparison). We modeled intercept and time as random effects, and group membership as a fixed effect. Restricted maximum likelihood estimation with an unstructured covariance was specified.

♦ **TA log data:** The TA log data were unique because TA support was both an outcome of the HUB's work and the mechanism through which the HUB was expected to influence other program- and staff-level outcomes. Therefore, we examined differences in groups at Time 3 (outcomes) as well as changes from Time 1 to Time 3 for the intervention group. Change from Time 1 to Time 3 would be expected from the activities of the Implementation HUB as it reached full implementation. We conducted basic descriptive analyses as well as comparative analyses using independent samples t-tests of significance for continuous variables, and a z-score calculator to test for significant differences in population proportions.

Outcome Evaluation Findings

Presented in this section are the outcome findings in three areas that the Implementation HUB is trying to influence—training, TA, and coaching; model fidelity and implementation quality; and staff competency and self-efficacy. As described in the methods, we primarily present data for Time 3 for staff and programs in the intervention and comparison groups when we present findings for model fidelity and implementation quality, and staff competency and self-efficacy. We present data from the TA logs at both Time 1 and Time 3 to examine changes in the primary services of the HUB, providing technical assistance, coaching, and connecting programs to resources online and in their community.

Findings About Use of and Satisfaction with Training, TA, and Coaching

As a centralized system of supports, the HUB was expected to provide a significant amount of training, TA, coaching, and support to enhance supervisors' work with home visiting staff and home visitors' work with families. The HUB TA was expected to be easy to access, relationship based, individualized to programs' needs, and coordinated with other sources of TA and support. Given that the HUB was a new system that continued to develop, we expected to see an increase in the amount and quality of TA over time in the intervention group as the HUB became more established in Washington State. Further, given that intervention programs had access to a centralized system of support and comparison programs did not, we expected that the intervention group would receive a greater amount and higher quality of TA than the comparison group.

The findings about the amount, source, content, and format of TA were drawn from the intervention and comparison programs' TA log data. The TA log data reflected TA that programs received from *all* sources; for intervention programs, the data were not limited to HUB TA and support.[31] These data were supplemented by findings from the Program Practices Survey about staff satisfaction with TA. We also included findings from the Program Practices Survey relating to the presence of

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[31] This is an important distinction. Whereas in the process evaluation, TA questions focus on program and staff experiences specifically with TA and support provided by or coordinated through the HUB. The outcomes evaluation focuses on TA and support from all sources.

CQI activities in programs. See Exhibit 11 for key constructs being examined and the corresponding source of those data.

Exhibit 11.   Training, TA, Coaching, and Support: Key Constructs and Data Sources for the Outcome Evaluation

Construct	NSO Data Export	Program Practices Survey	Home Visitor Snapshot Form	TA Log
Amount of training, TA, and coaching				X
Source of training, TA, and coaching		X		X
Content and format of training, TA, and coaching				X
Satisfaction and perception of training, TA, and coaching experience		X		
Changes made as a result of CQI activities		X		

Here, we describe the TA experiences reported by staff in intervention and comparison groups at the two time points. We begin by providing information from the TA log data collection Time 1 and Time 3 on the amount, source, content, and format of TA received and examine the TA by staff member roles and by intervention versus comparison group. We also examine perceptions of the TA from responses on the Program Practices Survey. Survey respondents shared additional information about the amount, satisfaction with, and quality of TA they had received.

Amount of training, TA, and coaching

The literature has not defined an optimal amount of TA support for home visiting program staff, nor was a specific amount of TA articulated as a goal for either group at the outset of this evaluation. Rather, the amount of HUB-provided TA was expected to be individualized to the needs of each program to best support its staff and address its needs. Below we present the average number of hours of TA received and the average number of TA events staff participated in during the two time points.

Average hours of TA for staff, by role and condition

First, we calculated the average number of hours of TA that a typical staff member received in a typical month, by role, for each program and time point.[32] See Exhibit 12. In other words, we calculated the number of hours of TA that a typical staff member received in a typical month for each program.[33] We found the following:

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[32] Although we describe TA as "received," technical assistance does not just flow in one direction. TA logs captured the total amount of time that individuals were involved in some TA activity. No data were collected about the level of engagement, active participation, or how much individuals benefited from any hour of TA received.

[33] The calculation involved summing the hours of TA received by all staff in a particular role (e.g., home visitors) in a particular program across all months included in the time point (e.g., July 2014 through May

♦ For intervention programs, the average number of TA hours per month across staff overall[34] did not change significantly between Time 1 and Time 3 (3.5 hours vs. 3.8 hours, respectively). Home visitors received slightly more TA hours per month at Time 3 than at Time 1 (3.1 hours vs. 2.8 hours), as did supervisors (6.9 hours vs. 6.3 hours), but the increases did not reach statistical significance.

♦ The average number of TA hours per month for comparison program staff decreased significantly between Time 1 and Time 3 (5.8 hours vs. 4.5 hours, $p < .01$). Comparison home visitors received significantly fewer TA hours per month at Time 3 than at Time 1 (4.1 hours vs. 5.1 hours, $p < .01$), and supervisors also received fewer hours at Time 3 than at Time 1 (7.1 hours vs. 9.3 hours), but the decrease was not statistically significant.[35]

♦ At Time 3, comparison staff overall continued to receive more TA hours per month than intervention staff overall (4.5 hours vs. 3.8 hours, $p < .05$), but the gap was narrower than it was at Time 1 (5.8 hours vs 3.5 hours, $p < .01$). The narrowing of the gap was especially apparent for supervisors. However, at Time 3, comparison home visitors continued to receive significantly more TA hours per month than intervention home visitors (4.1 hours vs. 3.1 hours, $p < .01$).

♦ Across both intervention and comparison programs, supervisors received more TA per month than home visitors at both time points.

2015 for Time 1) and then dividing that number by the number of months represented (i.e., 11 months for Time 1) and again by the number of staff in that role in that program. The result is the average number of TA hours that a "typical" home visitor received in that program per month.

[34] "Staff overall" refers to staff in all roles—supervisors, home visitors, and administrators/directors.

[35] Changes between Time 1 and Time 3 for the comparison group should be interpreted within the context of the loss of 9 out of 32 comparison programs at Time 3; non-random program attrition could be a contributor to differences between time points.

Exhibit 12.   Average Number of TA Hours Received by Each Staff Member per Month
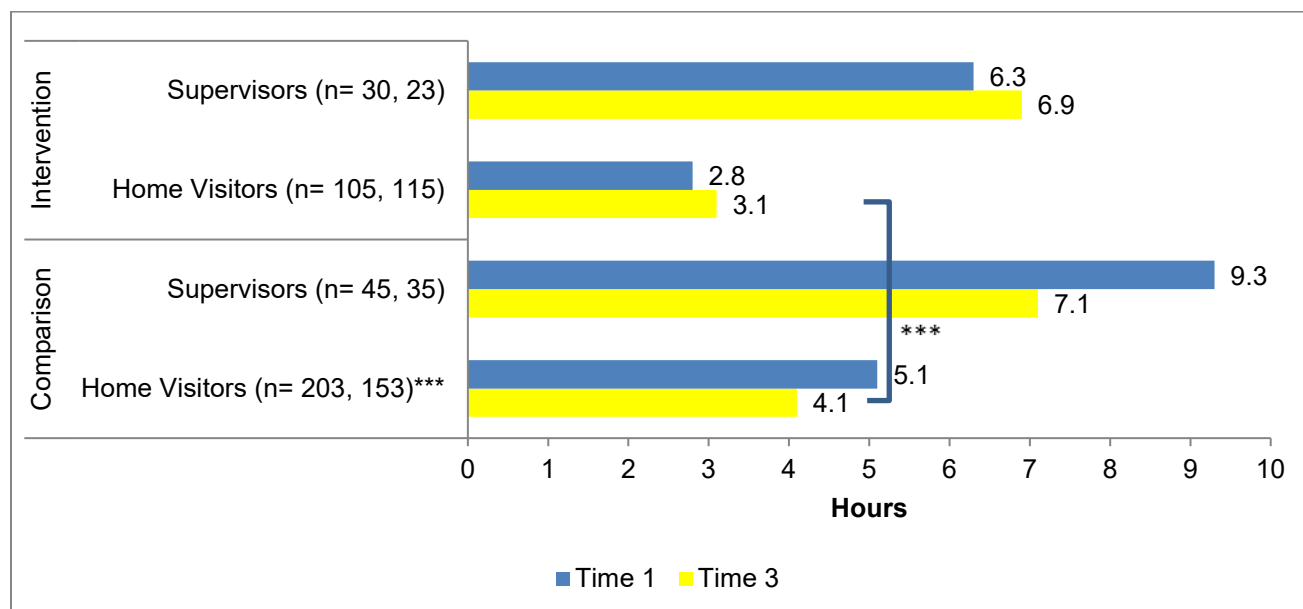
Source: TA log data (2014–17).

Note: *N*'s reflect the number of individuals in that role at Time1 and Time 3. For example, (*n* = 30, 23) indicates there were 30 supervisors at Time 1 and 23 at Time 3.

Differences tested for statistical significance were those between intervention staff at Time 1 and Time 3 and between intervention staff at Time 3 and comparison staff at Time 3.

*p < .10; **p < .05; ***p < .01.

These data are consistent with previous years' qualitative data suggesting that the Implementation HUB viewed supervisors and administrators as the target audience for TA. It is interesting to note that supervisors also received more TA than home visitors in comparison programs and this TA was from a variety of other states.

Average hours of TA for staff by program, by condition

Looking at program-level information about TA may help interpret the differences between intervention and comparison programs, as well as the changes between Time 1 and Time 3. Exhibits 13 and 14 show the average number of hours of TA for staff in each program. For instance, each staff person in Washington Program 6 (WA-6, Exhibit 13) averaged 3.6 hours of TA for each of the 11 months during Time 1 and 4.2 hours per month for each of the 12 months during Time 3.

- ♦ At Time 1, intervention programs averaged 3.8 hours of TA per month for each staff member, and this average-of-program averages remained exactly the same at Time 3.

- ♦ Comparison programs averaged 6.0 hours of TA per month for each staff member at Time 1, and this decreased to 4.9 hours of TA per month at Time 3.

Exhibit 13.   Average Number of TA Hours Received by Each Staff Member per Month in Intervention Programs
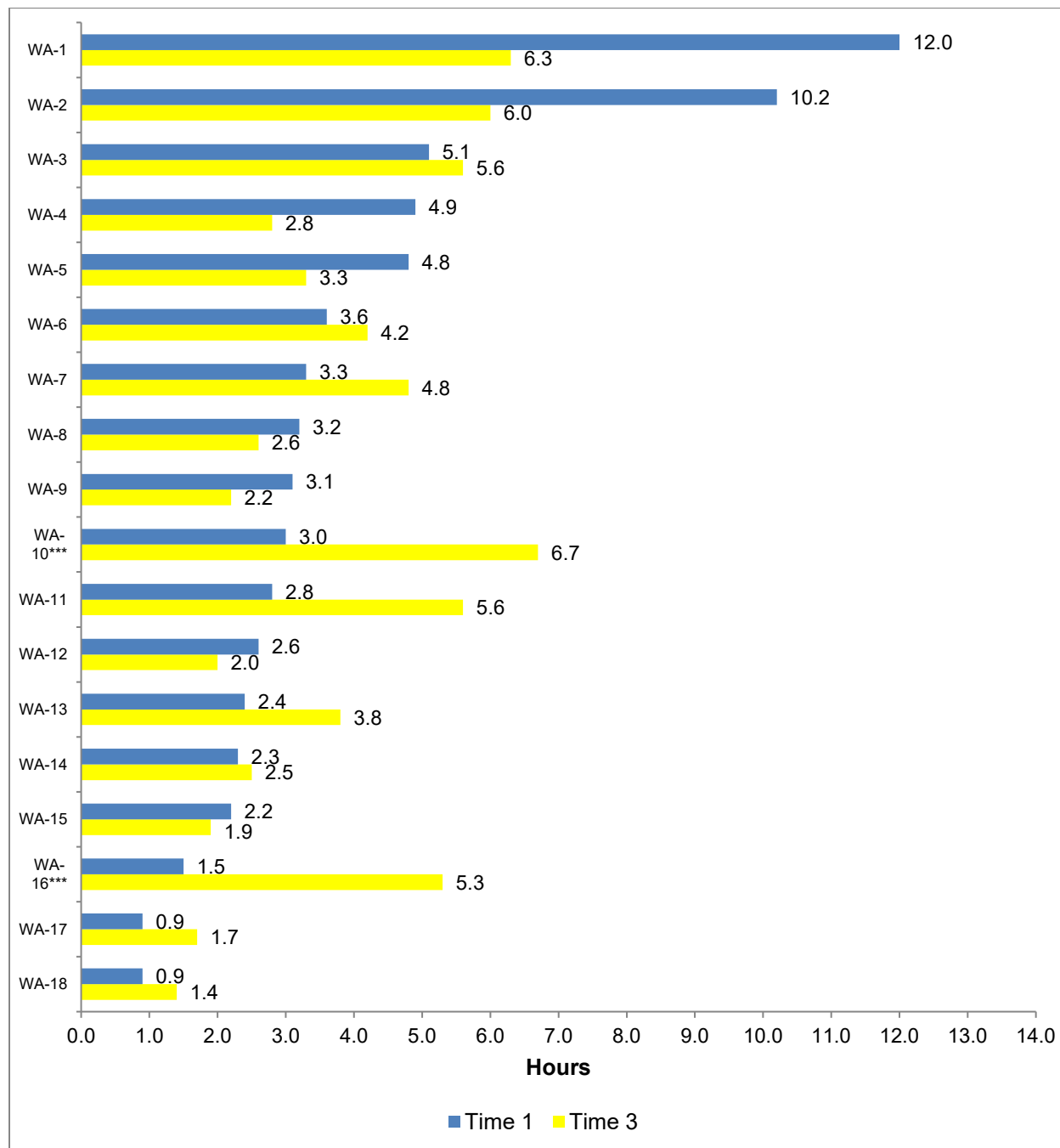
Source: TA log data (2014–17).

Note: Includes all staff roles (supervisors, home visitors, and administrator/directors). Program numbers were assigned randomly based on the rank order of programs on the variable of interest. Program numbers are *not* associated with a given program and are not held constant on various program-level charts throughout the report.

*$p < .10$; **$p < .05$; ***$p < .01$. Differences between Time 1 and Time 3 are more likely to reach statistical significance when the program *n,* or size of staff, is larger because the differences are less likely to be due to chance. For WA programs at Time 3, *n* ranged from 4 to 16, with a mean of 8.6. Eight of 18 programs had *n* ≥ 9. The two programs that showed significant differences both had *n* ≥ 9.

Exhibit 14.   **Average Number of TA Hours Received by Each Staff Member per Month in Comparison Programs**
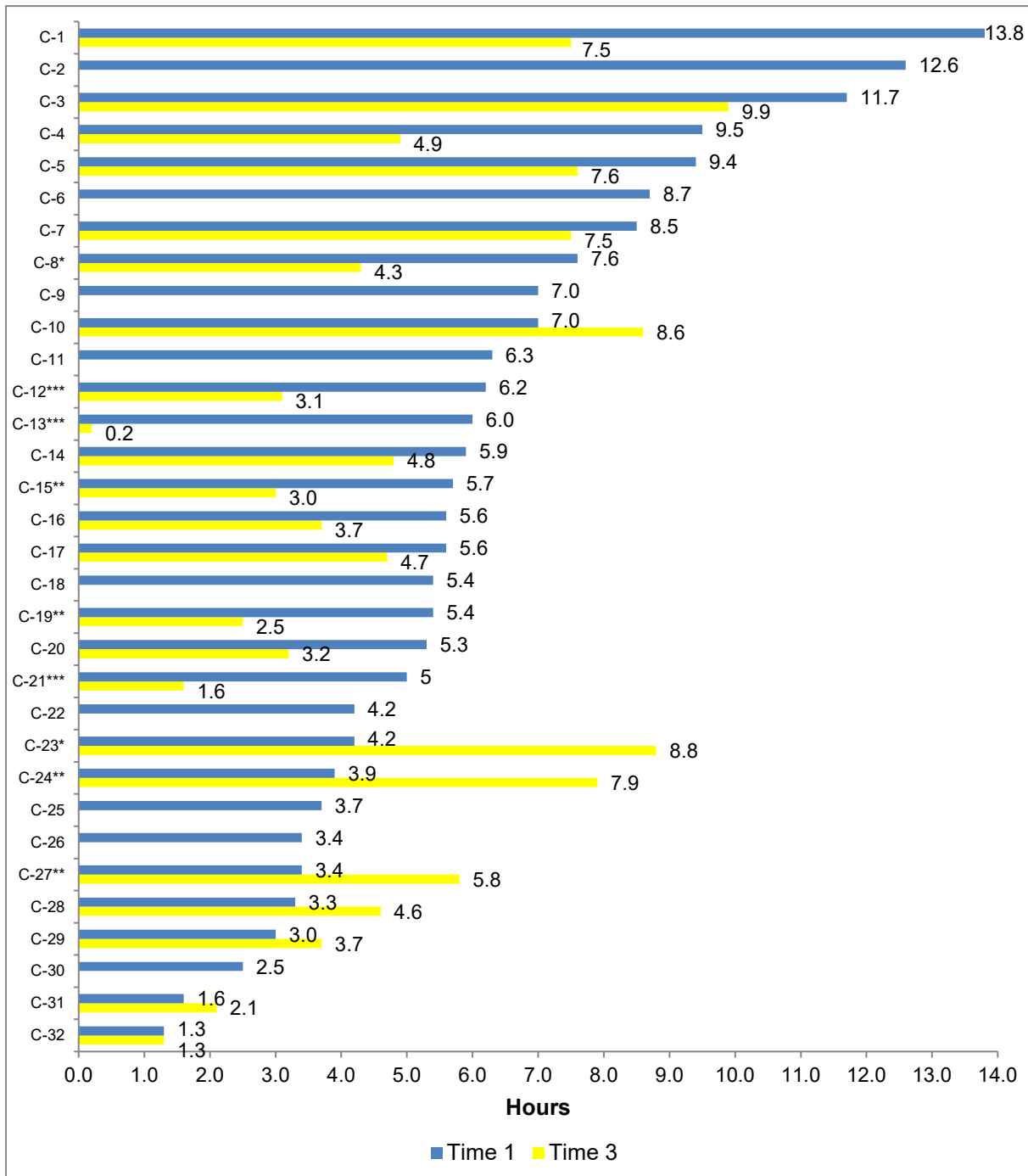
Source: TA log data (2014–17).

Note: Includes all staff roles (supervisors, home visitors, and administrator/directors). Program numbers were assigned randomly based on the rank order of programs on the variable of interest. Program numbers are *not* associated with a given program and are not held constant on various program-level charts throughout the report.

*$p < .10$; **$p < .05$; ***$p < .01$. Differences between Time 1 and Time 3 are more likely to reach statistical significance when the program *n,* or size of staff, is larger because the differences are less likely to be due to chance. For comparison programs at Time 3, *n* ranged from 2 to 24, with a mean of 9.0. Thirteen of 23 programs had $n \geq 9$. Five of nine comparison programs that showed significant differences had $n \geq 9$.

Between Time 1 and Time 3, the average number of TA hours per month increased significantly for two intervention programs, and no intervention program experienced a significant decrease. At the same time, the average number of TA hours per month increased significantly for three comparison programs, while decreasing significantly for six. Numerous programs in both intervention and comparison groups had very small staff sizes, however, so even seemingly large changes did not necessarily reach statistical significance.

In an alternative look at the data, we found the following:

♦ At Time 1, intervention programs received between 0.9 and 12.0 TA hours per month. During that time, comparison programs received between 1.3 and 13.8 hours per month.

♦ At Time 3, intervention programs received between 1.4 to 6.7 hours per month of TA; comparison programs received between 0.2 to 9.9 hours at the same time. Both groups had a narrower range and lower maximum number of hours at Time 3.

♦ There was a modest increase in the number of intervention programs that averaged 5 or more hours of TA per month at Time 3 compared with Time 1. That is, compared to Time 1, at Time 3 there was a small increase in the number of intervention programs where each staff person overall in the program received an average of 5 hours of TA per month or more. Whereas only 3 of the 18 (17%) intervention programs averaged 5 or more hours at Time 1, at Time 3, 6 of 18 (33%) did. For comparison programs, 21 of 32 (66%) averaged 5 or more hours of TA at Time 1, and this decreased to 9 of 23 (39%) at Time 3.

Taken together, results show that staff in comparison programs received more TA than staff in intervention programs at both time points, but the intervention programs made small gains between Time 1 and Time 3 whereas the comparison programs largely experienced decreases.

Average number of TA events for staff, by role and condition at Time 1 and Time 3

Next, we examined the average number of TA events that staff participated in each month. Looking at the number of events may help explain more about the pattern of TA activity observed in programs. Exhibit 15 shows some key findings from analysis of the number of TA events:

♦ Similar to what we found using hours as the unit of analysis, intervention program staff participated in more TA and support events at Time 3 than at Time 1. Both supervisors and home visitors experienced small increases between time points (2.4 events at Time 1 vs. 2.6 events at Time 3 for supervisors; 0.6 events at Time 1 vs. 0.8 events at Time 3 for home visitors), but the increases did not reach statistical significance.

♦ Staff at comparison programs attended fewer events at Time 3 than at Time 1, with the decreases for staff overall and for home visitors reaching statistical significance (1.4 events at Time 3 vs. 2.0 events at Time 1 for staff overall, $p < .01$; 1.2 events at Time 3 vs. 1.7 at Time 1 for home visitors, $p < .01$).

♦ At Time 3, comparison home visitors continued to attend more TA events per month than intervention home visitors (1.2 events vs. 0.8 events, $p < .01$), but the gap was much narrower than at Time 1 (1.7 events vs. 0.6 events, $p < .01$). For supervisors, the gap between comparison and intervention groups closed completely at Time 3 (2.5 events for the former vs. 2.6 events for the latter).

Exhibit 15.   Average Number of TA Events Attended per Month by Each Staff Member
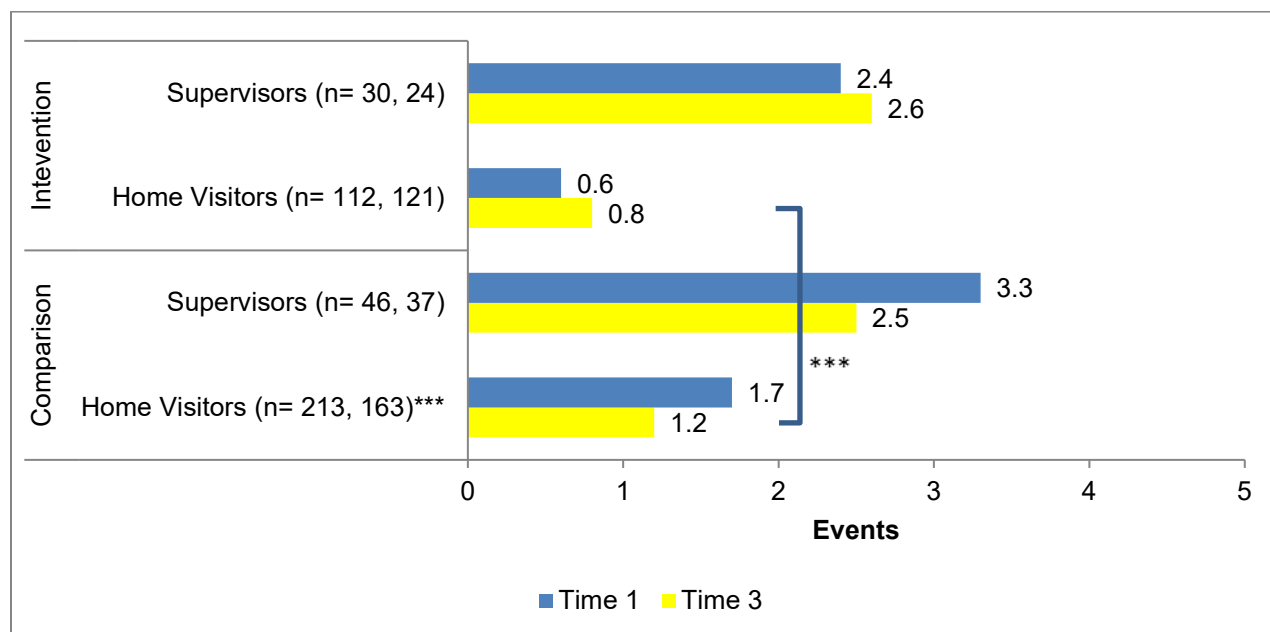
Source: TA log data (2014–17).

Differences tested for statistical significance were between intervention staff at Time 1 and Time 3 and between intervention staff at Time 3 and comparison staff at Time 3.

*$p < .10$; **$p < .05$; ***$p < .01$.

- o   At Time 3, on average each staff member overall in intervention programs participated in 1.1 TA events per month compared with staff in comparison programs who participated in an average of 1.4 TA events per month ($p < .05$).
- o   Consistent with findings based on average hours of TA, supervisors attended more TA events per month than home visitors at both time points. This difference in TA by role was observed in both intervention and comparison groups. The differences between supervisors' and home visitors' TA event participation were greater in intervention programs than in comparison programs at both time points as well.

Source of training, TA, and coaching

Below we describe what staff reported about receiving TA and support from someone in their state or region. The Program Practices Survey asked respondents to share information about the TA and support they had received. Both supervisors/administrators and home visitors were asked how much TA they had received in the last 6 months from someone in the state or region. Findings from Time 3 revealed that across states, program staff generally did receive "quite a bit" of TA from someone at the state/regional level including the following findings (Exhibit 16):

- ♦   Supervisors/administrators were more likely to receive "quite a bit" or "very much" support from someone in their state or region than home visitors at both time points.
- ♦   Intervention supervisors/administrators were more likely to report receiving TA from someone at the state/regional level at Time 3 (66%) than supervisors/administrators in the

comparison group (47%) (Time 1: 70% intervention, 59% comparison). This is consistent with the HUB's centralized system of support at the state level that focuses TA and support on supervisors/administrators.

♦ However, among home visitors, the reverse trend was found; home visitors in intervention programs were slightly less likely to report receiving TA from someone at the state/regional level (33% intervention vs. 37% comparison) than home visitors at comparison programs. This was in line with findings from Time 1 (34% intervention, 34% comparison).

Exhibit 16.   State/Regional TA Support Received by Program Supervisors/Administrators at Time 3
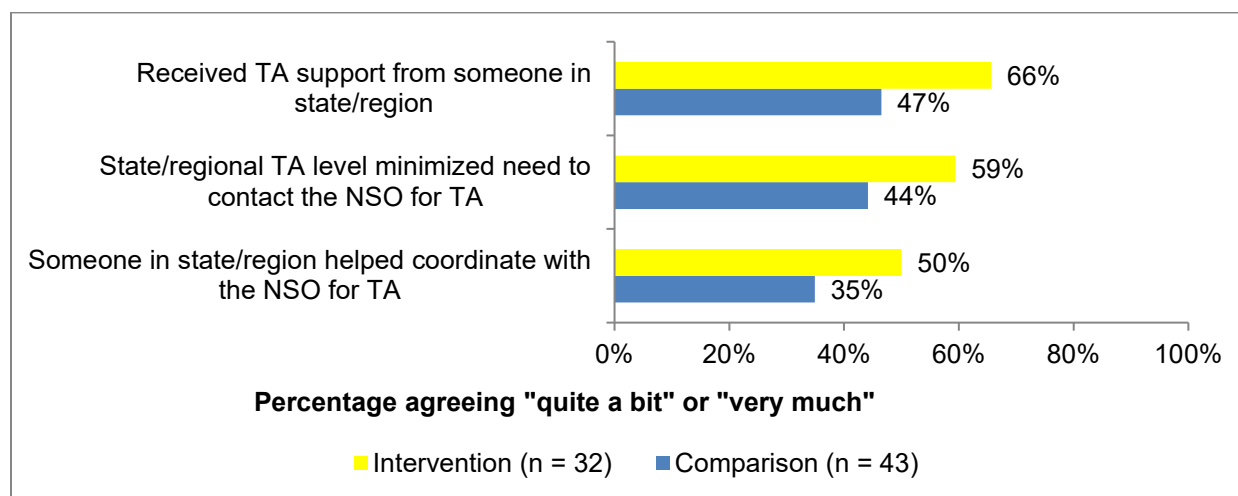
Percentage agreeing "quite a bit" or "very much"

■ Intervention (n = 32)   ■ Comparison (n = 43)

Source: Program Practices Survey, Spring 2017

Note: No between-group differences reached statistical significance.

Supervisors/administrators and home visitors also provided information about how much the TA and support from someone in their state/region had minimized their need to receive TA from their model's NSO.

♦ About 59% of intervention and 44% of comparison supervisors/administrators agreed "quite a bit" or "very much" that state or regional TA support minimized their need for support directly from the NSO. This was in line with findings from Time 1.

♦ About 40% of home visitors from both the intervention and comparison groups who received support felt the state or regional TA received minimized their need for direct TA from the NSO at both time points.

Finally, supervisors/administrators were asked how much someone in their state/region helped them coordinate with the NSO for TA. At Time 3, the supervisors/administrators who believed that someone in their state or region helped them "quite a bit" or "very much" coordinate TA and support with the NSOs remained stable for intervention staff, but decreased for comparison program staff (50% intervention, 35% comparison). This percentage stayed the same from Time 1

for intervention sites, but was a decrease for comparison sites (Time 1: 51% intervention, 44% comparison).

To learn about who was providing home visiting program staff with TA and support, we asked program liaisons completing the TA logs to record the sponsor or presenter of each TA event. Evaluation team members then coded responses into nine categories: (1) Washington model leads (PAT or NFP model lead at Thrive), (2) Thrive (specific non-model lead staff or general reference to Thrive,[36]) (3) PAT or NFP national office, (4) government agency (e.g., department of public health or social services), (5) nonprofit organization, (6) academic institution or university (including associated individuals), (7) medical institution or hospital (including associated individuals), (8) MIECHV federal TA (Technical Assistance Coordinating Center [TACC]/Home Visiting-Improvement Action Center [HV-ImpACT]), and (9) other unassociated individual or unknown agency.[37] A tenth category, multiple presenters, was created during the analysis to describe TA events that were attributed to more than one presenter or sponsor.

Exhibit 17 shows findings regarding the source of TA and support for supervisors.

♦ Among intervention program supervisors,

   o The state model leads and Thrive were their two main sources of TA at both time points (36% and 17%, respectively, at Time 1; and 20% each at Time 3).

   o The reduction in percentage of TA from the model leads between Time 1 and Time 3 (from 36% to 20%; $p < .01$) is likely due in part to the PAT model lead position being vacant at Time 3. It could also be related to the increase in percentage of TA attributed to multiple presenters (from 4% to 13%; $p < .05$), since the most common combinations of multiple presenters were Thrive staff (including the NFP model lead) with DEL, and/or Department of Health (DOH). This increase in multiple presenters likely reflects increased partnership amongst these agencies as the HUB and the state's home visiting support infrastructure matured, resulting in more coordinated TA provision at Time 3.

♦ Supervisors in comparison programs received the majority of their TA from nonprofit organizations (30% at Time 1, 25% at Time 3), government agencies (26% at Time 1, 25% at Time 3), and the NFP or PAT national offices (19% at both time points).

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[36] The evaluation team did not instruct intervention program liaisons who completed the TA logs to differentiate between TA provided by the Washington HUB model leads and other Thrive staff. Those who attributed TA specifically to the model leads rather than to Thrive more broadly did so on their own accord, and we do not know how widespread this practice was. Nor do we know whether individuals who used this practice did so consistently.

[37] Entries that were coded as "other" were most commonly a person's or agency's name, with no other identifying characteristics that would facilitate an Internet search. At times, the person's role or job title would be known, but we were unable to associate the person with a particular type of organization.

Exhibit 17.   Percentage of TA Events by Sponsor/Presenter for Supervisors

Sponsor/Presenter	Intervention (%) Time 1 n = 30 (786)[a]	Intervention (%) Time 3 n = 24 (734)	Comparison (%) Time 1 n = 46 (1,349)	Comparison (%) Time 3 n = 44 (1,052)
WA model leads	36	20***	—	—
Thrive	17	20	—	—
Nonprofit organization	13	12	30	25+++
NFP/PAT national office	8	11**	19	19+++
Government agency	10	17***	26	25+++
Other agency or individual	5	4***	11	21+++
Academic institution/university	3	3**	6	3
Medical institution/hospital	4	1	3	5+++
Multiple presenters	4	13**	2	1+++
MIECHV Federal TA	1	<1**	3	1++

Source: TA log data (2014–17).

— Sponsor categories that were not relevant for comparison programs and therefore not coded in the TA logs.

Note: Differences tested for statistical significance were those between intervention staff at Time 1 and Time 3 (*p < .10; **p < .05; ***p < .01) and between intervention staff at Time 3 and comparison staff at Time 3 (+p < .10; ++p < .05; +++p < .01).

[a] The first n (not in parentheses) indicates the number of individuals we have data for, and the second n (in parentheses) indicates the total number of TA events collectively attended by the individuals we have data for. The chi-square tests conducted to determine whether differences between groups reach statistical significance were conducted using the event n.

Exhibit 18 shows findings regarding the source of TA and support for home visitors.

♦ Among intervention program home visitors,

  o Intervention home visitors attended events attributed to the model leads or Thrive much less frequently than their supervisors. This fits with the HUB service delivery model of primarily supporting supervisors. Nevertheless, as with supervisors, there was a decrease between Time 1 and Time 3 in the percentage of events intervention home visitors attended that were attributed to the model leads (from 12% to 7%; p < .05), while the percentage of events attributed to Thrive increased (from 4% to 13%; p < .01), as did those attributed to multiple presenters (from 3% to 8%, p < .01). There also was an increase in the percentage of events attributed to the PAT or NFP national office (from 6% to 17%; p < .01). Again, this was likely due in part to the PAT model lead vacancy, with the former model lead serving at the national office, and an increased reliance on Thrive staff to provide TA.

  o The most common TA sponsors/presenters for intervention home visitors continued to be nonprofits (35% at Time 1, 26% at Time 3), government agencies (13% at Time 1, 18% at Time 3), and "other" unassociated individuals or unknown agencies (14% at both time points).

♦ For comparison home visitors, the main sources of TA were these same groups: nonprofits (30% at Time 1, 24% at Time 3), government agencies (25% at Time 1, 17% at Time 3), and other individuals or agencies (16% at Time 1, 33% at Time 3).

Exhibit 18. **Percentage of TA Events by Sponsor/Presenter for Home Visitors**

TA Format	Intervention (%) Time 1 n = 114 (770)[a]	Intervention (%) Time 3 n = 121 (1,100)	Comparison (%) Time 1 n = 216 (3,147)	Comparison (%) Time 3 n = 197 (2,234)
WA model leads	12	7**	—	—
Thrive	4	13***	—	—
Nonprofit organization	35	26***	30	24
Other agency or individual	14	14	16	33+++
Government agency	13	18***	25	17
NFP/PAT national office	6	8	12	10
Academic institution/university	7	5**	11	8+++
Medical institution/hospital	6	1***	4	6+++
Multiple presenters	3	8***	1	2+++
MIECHV Federal TA	<1	—	1	1

Source: TA log data (2014–17).

— Sponsor categories that were not relevant for comparison programs and therefore not coded in the TA logs.

Note: Differences tested for statistical significance were those between intervention staff at Time 1 and at Time 3 (*p < .10; **p < .05; ***p < .01) and between intervention staff at Time 3 and comparison staff at Time 3 (+p < .10; ++p < .05; +++p < .01).

[a] The first n (not in parentheses) indicates the number of individuals we have data for, and the second n (in parentheses) indicates the total number of TA events collectively attended by the individuals we have data for. The chi-square tests conducted to determine whether differences between groups reach statistical significance were conducted using the event n.

To further investigate similarities and differences in TA sources among various types of programs, we compared NFP intervention programs, PAT intervention programs, NFP comparison programs, and PAT comparison programs with each other at Time 3 only.

As shown in Exhibit 19, we describe the sources of TA and support by model, as well as by treatment status at Time 3.

♦ PAT intervention programs did not receive TA from a state model lead at Time 3 since the position was vacant, but did receive a significant percentage of TA from Thrive staff (24%). In contrast, NFP intervention programs received a significant amount of TA from the NFP state model lead (20%), but attributed less TA to Thrive staff generally (11%).

♦ PAT intervention programs also received a substantial percentage of TA from the PAT national office (21%), whereas PAT comparison programs attributed a much smaller percentage of TA (5%) to the national office. Intervention programs likely received TA from

the former Washington state model lead, who in her new role as a regional lead was considered national office staff.

♦ PAT comparison programs received a greater percentage of TA from academic institutions (10%) than the other groups; this may have been due to one program in particular that was housed within a community college and likely received a greater percentage its TA from individuals associated with the school.

♦ Both NFP and PAT intervention programs attributed higher percentages of TA (8% and 13%, respectively) to multiple presenters compared to comparison programs. The percentage for PAT intervention was the highest, likely due to the regional lead at the PAT national office co-presenting with Thrive and DEL staff at times. When the NFP state model lead co-presented with other HUB staff, this was not coded as multiple presenters since she was a member of the HUB.

Exhibit 19.   Percentage of TA Events by Sponsor/Presenter at Time 3

Sponsor/Presenter	NFP Intervention (%) n = 61	NFP Comparison (%) n = 116	PAT Intervention (%) n = 106	PAT Comparison (%) n = 152
WA model leads	20	—	<1	—
Thrive	11	—	24	—
Nonprofit organization	21	19	18	31
NFP/PAT national office	7	21	14	5
Other agency or individual	13	26	5	31
Government agency	15	22	21	18
Academic institution/university	3	2	5	10
Medical institution/hospital	2	8	0	2
Multiple presenters	8	2	13	<1
MIECHV Federal TA	<1	1	0	2

Source: TA log data (2014–17).

— Sponsor categories that were not relevant for comparison programs and therefore not coded in the TA logs.

Note: Includes sponsor/presenter for events identified by all staff roles (supervisors, home visitors, and administrator/directors). Lack of notation does not indicate that no statistically significant differences were found; statistical comparisons about differences between groups were not conducted.

Content of training, TA, and coaching

We asked program liaisons to log the primary topic (content) area addressed by each TA event. Specifically, they chose from a drop-down menu of nine topic areas that were predetermined by the evaluation team to be most likely to be covered in the course of TA for home visiting program staff.[38]

Exhibit 20 shows findings regarding the content of TA and support for supervisors.

♦ For intervention program supervisors,
   o There were few notable changes between Time 1 and Time 3, aside from small but statistically significant increases in the percentage of TA events that addressed improving home visitor competencies (from 14% to 18%; $p < .05$), contract requirements (from 17% to 22%; $p < .05$), and data use for decision-making/program improvement (from 4% to 6%; $p < .05$). The last increase could be related to HUB staff's increased focus on Continuous Quality Improvement (CQI) in their work with programs.

♦ Comparing across intervention and comparison programs at Time 3, comparison programs received significantly less TA on contract requirements (13% of events for comparison vs. 22% for intervention, $p < .01$), and significantly more TA on improving home visitor staff competencies (22% of events for comparison vs. 18% for intervention, $p < .05$), program/agency guidelines for program administration (13% of events for comparison vs. 7% for intervention, $p < .01$), and connections and referrals (10% of events for comparison vs. 7% for intervention, $p < .01$).

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[38] Topic areas were connections or referrals, contract requirements, data collection training or evaluation, data use for decision-making or program improvement, hiring or retention, improving home visitor staff competencies, improving supervisor staff competencies, model requirements, and program or agency guidelines for program administration.

Exhibit 20.   Percentage of TA Events by Primary Topic Area for Supervisors

Primary Topic Area	Intervention (%) Time 1 n = 30 (798)[a]	Intervention (%) Time 3 n = 24 (738)	Comparison (%) Time 1 n = 46 (1,362)	Comparison (%) Time 3 n = 44 (1,075)
Improving home visitor staff competencies	14	18**	25	22++
Model requirements	22	19	15	16
Improving supervisor staff competencies	20	17	14	15
Contract requirements	17	22**	9	13+++
Program/agency guidelines for program administration	10	7	13	13+++
Connections/referrals	8	7	12	10+++
Data collection training/evaluation/study participation	6	4	6	4
Data use for decision-making/program improvement	4	6**	5	7
Hiring/retention	<1	<1	<1	<1

Source: TA log data (2014–17).

Note: Differences tested for statistical significance were those between intervention staff at Time 1 and at Time 3 (*p < .10; **p < .05; ***p < .01) and between intervention staff at Time 3 and comparison staff at Time 3 (+p < .10; ++p < .05; +++p < .01).

[a] The first n (not in parentheses) indicates the number of individuals we have data for, and the second n (in parentheses) indicates the total number of TA events collectively attended by the individuals we have data for. The chi-square tests conducted to determine whether differences between groups reach statistical significance were conducted using the event n.

Exhibit 21 shows findings regarding the content of TA and support for home visitors.

♦ For all home visitors regardless of program treatment status, improving staff competencies was the most frequent topic at the TA events they attended at both Time 1 and Time 3 (range of 48% to 58%).

○ This percentage increased between Time 1 and Time 3 for intervention home visitors (from 48% to 53%; p < .05).

♦ Similar to the finding for supervisors, there was a small but significant increase in the percentage of TA events attended by intervention home visitors that were about data use for decision-making/program improvement (from 2% to 4%; p < .01). A similar increase was not seen for comparison sites.

♦ At Time 3, compared with intervention home visitors, comparison home visitors received a larger percentage of their total TA on contract requirements (9% vs. 6%; p < .01) and a smaller percentage on data use for decision-making/program improvement (1% vs 4%; p < .01) and data collection/evaluation/study participation (1% vs. 4%; p < .01). These

differences between groups were small, however, and unlikely to be substantively meaningful.

Exhibit 21.   Percentage of TA Events by Primary Topic Area for Home Visitors

Primary Topic Area	Intervention (%) Time 1 n = 114 (773)[a]	Intervention (%) Time 3 n = 121 (1,126)	Comparison (%) Time 1 n = 216 (3,214)	Comparison (%) Time 3 n = 197 (2,266)
Improving home visitor staff competencies	48	53**	58	54
Model requirements	17	16	16	16
Program/agency guidelines for program administration	12	9**	8	11
Connections/referrals	9	4***	5	5
Contract requirements	5	6	6	9+++
Data collection training/evaluation/study participation	3	4	3	1+++
Improving supervisor staff competencies	3	4	1	3+++
Data use for decision-making/program improvement	2	4***	2	1+++
Hiring/retention	<1	0	1	<1

Source: TA log data (2014–17).

Note: Differences tested for statistical significance were those between intervention staff at Time 1 and at Time 3 (*p < .10; **p < .05; ***p < .01) and between intervention staff at Time 3 and comparison staff at Time 3 (+p < .10; ++p < .05; +++p < .01).

[a] The first n (not in parentheses) indicates the number of individuals we have data for, and the second n (in parentheses) indicates the total number of TA events collectively attended by the individuals we have data for. The chi-square tests conducted to determine whether differences between groups reach statistical significance were conducted using the event n.

Format of training, TA, and coaching

The format of TA is the modality through which the TA was provided. Using a drop-down menu, program liaisons indicated whether the TA event was (1) an in-person workshop, meetings, or training; (2) remote individualized (e.g., on the phone one on one); (3) a remote workshop, meeting, or training (e.g., webinar); (4) on-site or in-person individualized; or (5) in an "other" format.

Key findings regarding the format of TA received by supervisors are shown in Exhibit 22.

♦ The most common TA format for intervention program supervisors was in-person workshops, meetings, and trainings (35% of TA events at Time 1, 32% at Time 3). This TA format also was the most common among comparison program supervisors (53% of TA events at Time 1, 57% at Time 2), although in-person workshops, meetings, or training

represented a significantly larger proportion of the TA events for supervisors in comparison programs than for supervisors in intervention programs ($p < .01$ at Time 3).

♦ Intervention supervisors received approximately an additional one-quarter of their TA in the form of remote workshops, meetings, and trainings (21% of TA events at Time 1, 28% at Time 3; increase $p < .05$). A smaller percentage of TA and support events for comparison program supervisors included remote workshops, meetings, and trainings (19% of TA events at both time points; $p < .01$ compared with intervention at Time 3).

♦ Intervention program supervisors experienced a large percentage of their TA in the remote individualized format (33% of TA events at Time 1, 25% at Time 3; decrease[39] $p < .01$); the frequency of this format was much lower for comparison supervisors (15% of TA events at Time 1, 14% at Time 3; $p < .01$ compared with intervention at Time 3). Regular participation in remote, individualized TA was expected in the intervention group because HUB TA and support involved monthly calls with program supervisors to provide individualized coaching and support in areas of interest or concern, and these calls would be classified in the remote, individualized TA format.

♦ However, between Time 1 and Time 3, intervention program supervisors did experience a small but statistically significant increase in the percentage of their TA received in the on-site/in-person individualized format (7% of TA events at Time 1, 11% at Time 3; $p < .01$).

♦ At Time 3, relative to comparison supervisors, intervention supervisors still received a larger percentage of their total TA in remote formats (25% vs. 14% for remote individualized, $p < .01$; 28% vs. 19% for remote workshops, meetings, or trainings, $p < .01$) and a smaller percentage of their total TA as in-person workshops, meetings, or trainings (32% vs. 57%; $p < .01$).

Taken together, supervisors in intervention programs received a greater proportion of their TA in remote formats relative to supervisors in comparison programs. They also had greater distribution of TA and support across diverse formats whereas supervisors in comparison programs received a higher percentage of their TA events in one main format (i.e., in-person meetings, workshops, and trainings).

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[39] When the PAT state model lead shifted to working as a regional TA provider rather than a contractor with the HUB, expectations changed. She was expected to contact programs as appropriate according to their needs rather than complete a monthly individualized coaching and support call with each program. This shift might account for the drop in the percentage of TA events in the remote, individualized format among intervention group supervisors.

Exhibit 22.   Percentage of TA Events by Format for Supervisors

TA Format	Intervention (%) Time 1 n = 30 (786)[a]	Intervention (%) Time 3 n = 24 (740)	Comparison (%) Time 1 n = 46 (1,357)	Comparison (%) Time 3 n = 44 (1,076)
In-person workshops, meetings, trainings	35	32	53	57+++
Remote individualized	33	25***	15	14+++
Remote workshops, meetings, trainings	21	28**	19	19+++
On-site/in-person individualized	7	11***	10	9
Other	4	4	3	1+++

Source: TA log data (2014–17).

Note: Differences tested for statistical significance were those between intervention staff at Time 1 and at Time 3 (*p < .10; **p < .05; ***p < .01) and between intervention staff at Time 3 and comparison staff at Time 3 (+p < .10; ++p < .05; +++p < .01).

[a] The first n (not in parentheses) indicates the number of individuals we have data for, and the second n (in parentheses) indicates the total number of TA events collectively attended by the individuals we have data for. The chi-square tests conducted to determine whether differences between groups reach statistical significance were conducted using the event n.

Key findings regarding the format of TA received by home visitors are shown in Exhibit 23.

♦ As with supervisors, the most common format for TA events attended by home visitors was in-person workshops, meetings, and trainings. This was true of both intervention home visitors (59% of TA events at Time 1, 54% at Time 3) and comparison home visitors (71% of TA events at Time 1, 74% at Time 3) by even wider margins than for supervisors.

♦ Intervention home visitors attended more remote workshops, meetings, and trainings at Time 3 than Time 1 (20% vs. 13%; p < .01) and slightly fewer in-person workshops, meetings, and trainings at Time 3 than Time 1 (54% vs. 59%; p < .05).

♦ At Time 3, similar to their supervisors, intervention home visitors experienced a greater percentage of their TA in remote formats compared to comparison home visitors (20% vs. 12% for remote workshops, meetings, and trainings; p < .01; 5% vs 1% for remote individualized; p < .01). Intervention home visitors experienced a much smaller percentage of their TA total as in-person workshops, meetings, and trainings compared to comparison home visitors (54% vs. 74%; p < .01).

Exhibit 23.   Percentage of TA Events by Format for Home Visitors

TA Format	Intervention (%) Time 1 n = 114 (774)[a]	Intervention (%) Time 3 n = 121 (1,125)	Comparison (%) Time 1 n = 216 (3,208)	Comparison (%) Time 3 n = 197 (2,264)
In-person workshops, meetings, trainings	59	54**	71	74+++
On-site/in-person individualized	20	17	12	13+++
Remote workshops, meetings, trainings	13	20***	12	12+++
Remote individualized	6	5	4	1+++
Other	2	4**	1	<1+++

Source: TA log data (2014–17).

Note: Differences tested for statistical significance were those between intervention staff at Time 1 and at Time 3 (*p < .10; **p < .05; ***p < .01) and between intervention staff at Time 3 and comparison staff at Time 3 (+p < .10; ++p < .05; +++p < .01).

[a] The first n (not in parentheses) indicates the number of individuals we have data for, and the second n (in parentheses) indicates the total number of TA events collectively attended by the individuals we have data for. The chi-square tests conducted to determine whether differences between groups reach statistical significance were conducted using the event n.

Satisfaction and perception of training, TA, and coaching experiences

We expected that satisfaction with TA would be similar between intervention and comparison groups initially, but as the HUB developed over time, we would expect intervention programs to become more satisfied with the TA and rate its quality (e.g., access, timeliness, relevance, tailored) higher than staff in the comparison programs. Data provided here represent respondent views reported in the Program Practices Survey at two time points. In fall 2014, these data were from about 9–10 months after the HUB hired its core TA staff. At Time 3 (Spring 2017), respondents rated the quality approximately 30 months later in the implementation.

Satisfaction with and expectations for TA across delivery formats

TA can be delivered in many different formats. The Program Practices Survey asked about four types of TA formats:

♦ individualized support or coaching received on site or in person;

♦ individualized support or coaching received remotely (e.g., emails, phone);

♦ workshops, trainings, or group meetings on site or in person; and

♦ workshops, trainings, or group meetings received remotely (e.g., group webinars or phone conversations).

Satisfaction with TA

Supervisors and home visitors were asked about their satisfaction with TA in different formats that they reported receiving in the last 6 months. Some respondents indicated that they did not receive a particular format of TA and thus did not answer questions about satisfaction. (Exhibits 24 and 25).

♦ At Time 3, the number of supervisors/administrators that received each type of TA in the previous 6 months was between 73% and 91%; the percentage of home visitors who received each type of TA varied from 65% to 90%.

♦ Among all respondents at Time 3, Supervisors/administrators and home visitors were most likely to have participated in on-site or in-person workshops (91% of supervisors/administrators, 90% of home visitors) and least likely to have participated in support provided as brief emails or text messages (73% of supervisors/administrators, 65% of home visitors).

♦ Across all the TA formats, the majority of supervisor/administrator respondents in both intervention and comparison were satisfied or very satisfied with the TA they received in the last 6 months. There was more variability among home visitor respondents, who were slightly less likely to indicate that they were satisfied or very satisfied with support, a pattern that was present at Time 1 and Time 3.

♦ For each format of TA (individualized on site, remote workshop, etc.), supervisors/administrators were very similar in their reported satisfaction. At Time 1, satisfaction ratings were similarly high across formats, although supervisors/administrators from intervention sites were less likely to be satisfied with TA than supervisors/administrators in comparison groups.

♦ Intervention group supervisors/administrators were more likely to be satisfied with TA received as brief texts or emails, and on-site or in-person workshops than other types of TA. They were slightly less satisfied than comparison supervisors/administrators with TA received as remote individualized support, or in-person individualized support and equally as satisfied with TA received as remote workshops. Percentages ranged from 81% to 95% of supervisors in intervention programs reporting being satisfied/very satisfied and from 86% to 93% of supervisors in comparison programs were satisfied/very satisfied. At Time 1, 77% to 87% of intervention supervisors/administrators and 87% to 91% of comparison supervisors were satisfied with TA.

♦ Home visitors at intervention and comparison sites were likely to be satisfied or very satisfied with TA than home visitors at comparison sites. There were only two formats of TA for which comparison home visitors were more satisfied than intervention home visitors (on-site or in person workshops, and brief emails or texts). Percentages ranged from 72% to 86% of home visitors in intervention programs and 73% to 89% of home visitors in the comparison group. At Time 1, home visitors at intervention sites were less likely to be satisfied with TA than their counterparts at comparison sites (Time 1: 73-83% intervention, 83-90% comparison).

♦ Between Time 1 and Time 3, home visitors at intervention sites were significantly more likely to report satisfaction with remote individualized support (Time 1 63%, Time 3 79%, $p < .10$).

Exhibit 24.   Satisfaction With TA by Delivery Format for Supervisors/Administrators at Time 3
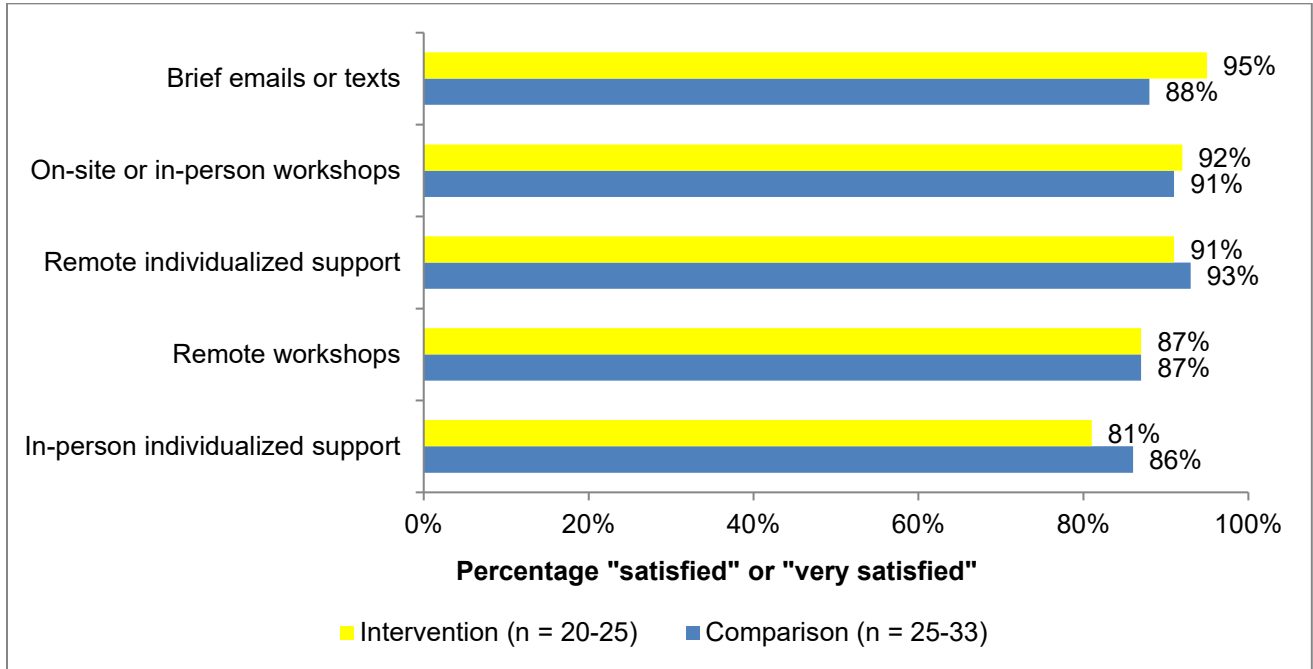
Source: Program Practices Survey, Spring 2017

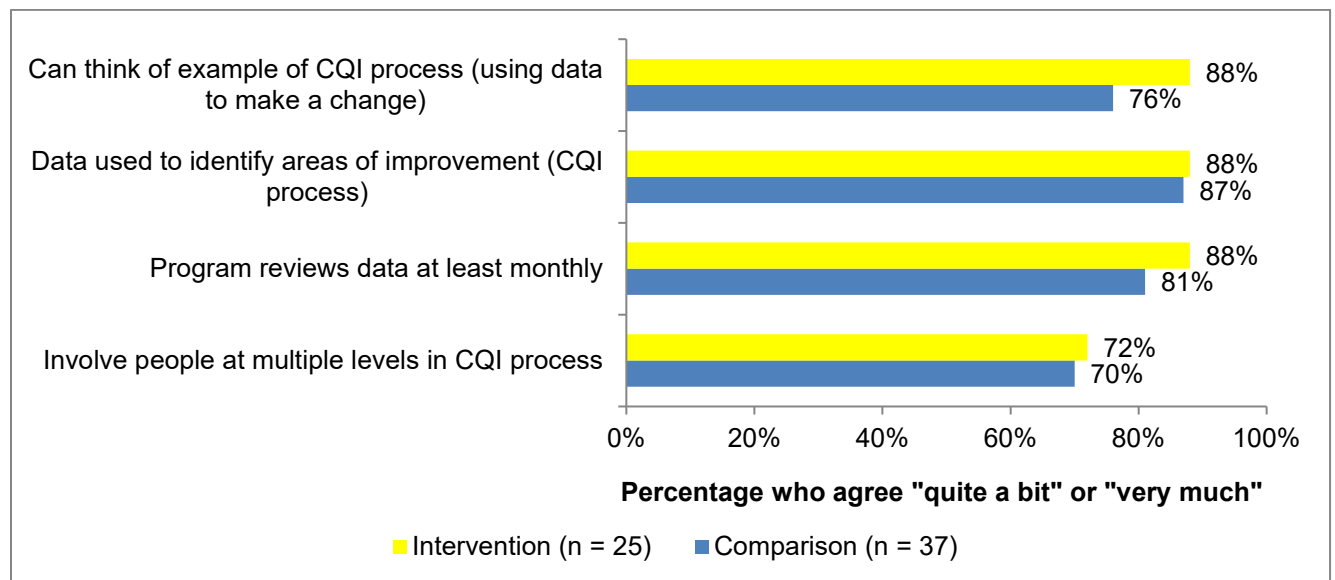Note: No between-group differences reached statistical significance.

Exhibit 25.   Satisfaction With TA by Delivery Format for Home Visitors at Time 3
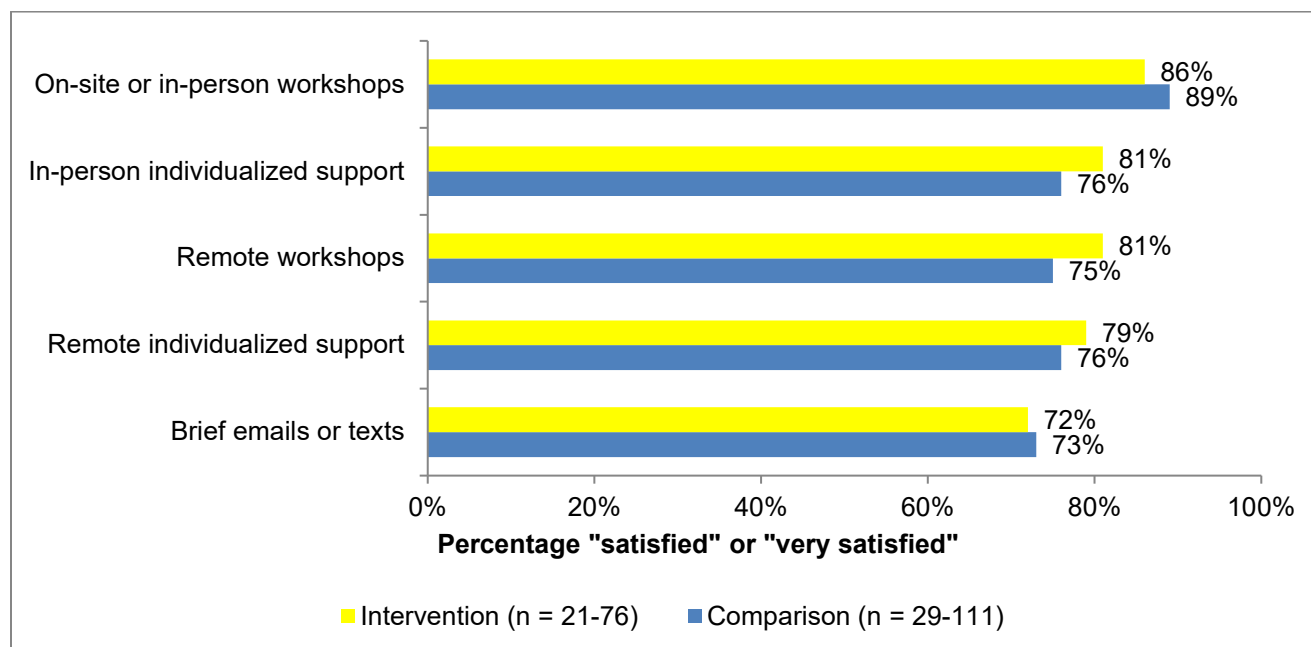
Source: Program Practices Survey, Spring 2017

Note: No between-group differences reached statistical significance

Perceived quality of TA and support

The Program Practices Survey included a series of questions for both supervisors/administrators and home visitors to gauge the characteristics of TA (e.g., "tailored to my needs," "easy or participate in or access"). Supervisors/administrators also were asked to reflect on the effects that TA had on their work (e.g., "helped me improve the way our program uses data to make decisions").

♦ Similar to Time 1 findings, the majority of supervisors/administrators in both intervention and comparison programs endorsed positive characteristics about TA. There were small positive and negative fluctuations between Time 1 and Time 3 among staff in both intervention and comparison programs.

♦ Home visitors in both intervention and comparison programs were less likely to endorse positive characteristics compared with supervisors/administrators at both time points. However, home visitors at intervention sites were more likely to feel that TA was provided in an appropriate format at Time 3 compared with Time 1 (Time 1: intervention 63% vs Time 3: intervention 75%).

Across the characteristics of TA considered in the survey, the perception of TA that was tailored to individual needs and grounded in a relationship with someone who "got to know me" were features with fairly low endorsement in both intervention and comparison program staff at both time points (see Exhibit 26 for Time 3 responses).

Exhibit 26.   Perception of TA as Tailored/Individualized and Relationship Based at Time 3
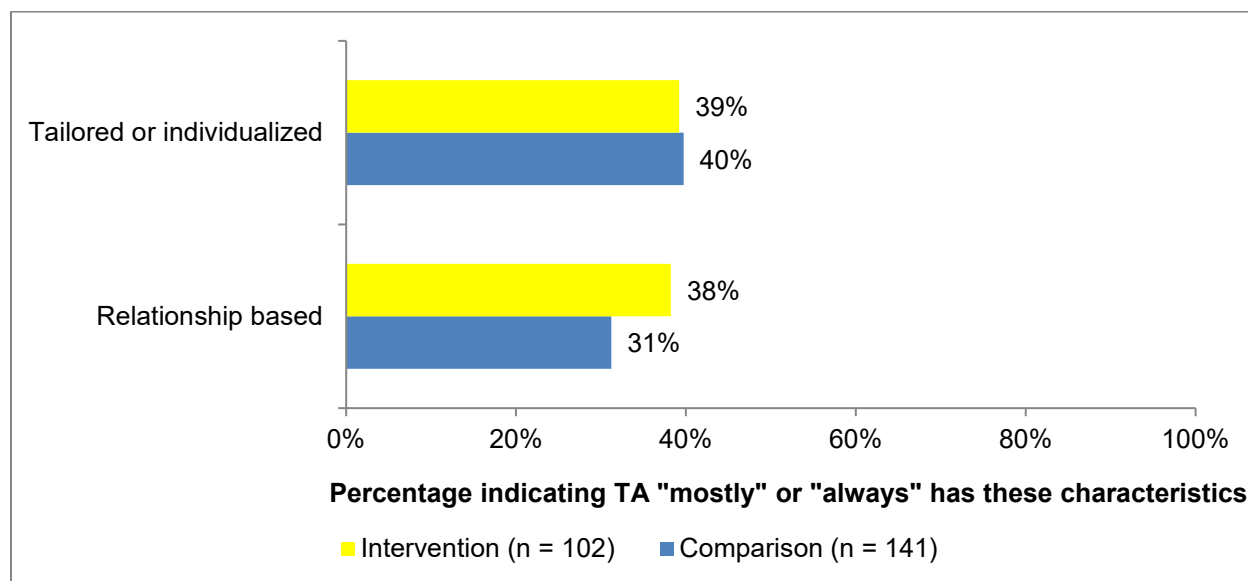
Source: Program Practices Survey, Spring 2017.

Note: No between-group differences reached statistical significance.

- Less than half of staff in both the intervention and comparison groups agreed that TA was "mostly" or "always" tailored to their needs at either time point.[40]

- From Time 1 to Time 3, respondents in the intervention group (Time 1, 33%; Time 3, 38%) were more likely to endorse TA as relationship based, whereas respondents in the comparison group (Time 1, 36%; Time 3, 31%) were less likely to describe TA as "mostly" or "always" relationship based.

Supervisors/administrators also shared information about their TA experiences and helpfulness in supporting staff needs. Data showed (Exhibit 27) the following:

- Relative to comparison supervisors/administrators, intervention supervisors/administrators were more likely to endorse at Time 3 that the TA was provided by someone who understood the program model (intervention 90%, comparison 71%). The small number of supervisors/administrators meant that this difference did not reach statistical significance, but the direction of the finding is consistent with Washington's use of state model leads.

- Supervisors/administrators in the intervention group were less likely to report that TA helped them identify training to address the needs of their staff when compared to the comparison group (50% intervention, 64% comparison). This pattern is consistent with findings at Time 1 (55% intervention, 69% comparison).

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[40] If staff reported receiving TA in any format, then survey questions asked them about the characteristics of their experiences with all of their TA overall. It is possible that responses about relationship-based or tailored TA were influenced by the reality that a number of the staff members had half or more of their TA provided to a group of people at once (e.g., trainings, group meetings, workshops). Those participating in group TA may be less likely to see that experience as tailored for their needs or very relationship-based.

♦ Perceptions about whether TA addressed supervisor's specific needs or questions decreased over time for the intervention group while increasing for the comparison group (intervention: Time 1, 68%; Time 3, 60%; comparison: Time 1, 69%; Time 3, 86%)

♦ Responses to questions about ease of coordination of TA (intervention: Time 1, 71%; Time 3, 70%; comparison: Time 1, 72%; Time 3, 64%), and providing support that "allowed me to more effectively support staff" (intervention: Time 1, 61%; Time 3, 60%; comparison: Time 1, 76%; Time 3, 71%) remained stable across years while supervisors/administrators.

Exhibit 27.   Perception of TA as Helpful in Role as Supervisor/Administrator at Time 3
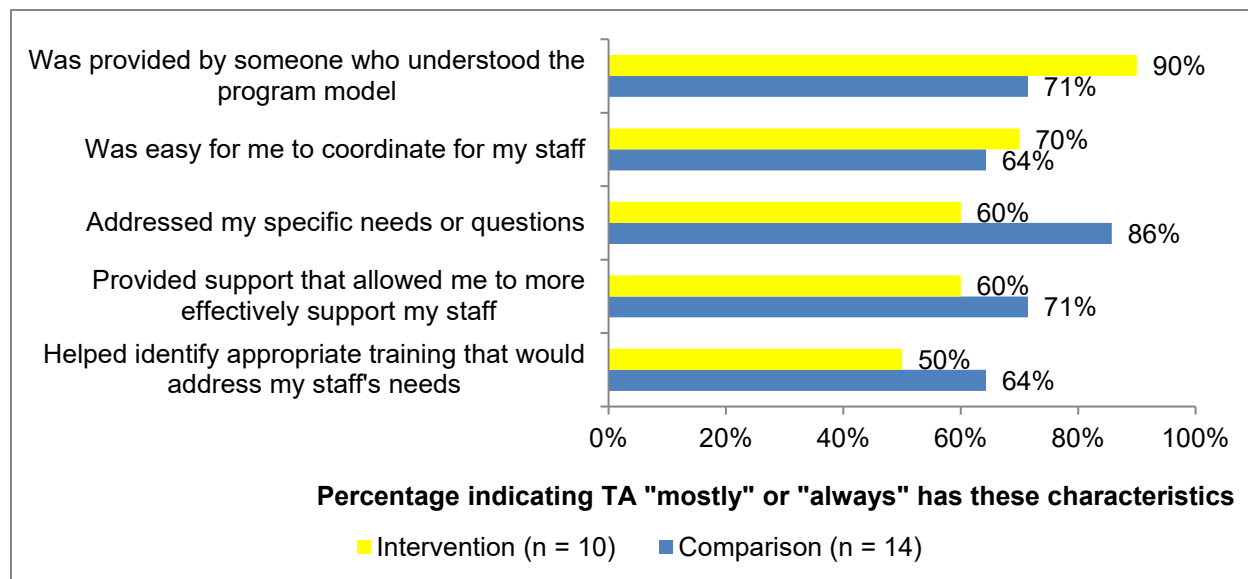
Source: Program Practices Survey, Spring 2017.

Note: No between-group differences reached statistical significance.

Programs' CQI activities

TA often involves supporting program staff members in implementing CQI processes to use their own data to inform decision-making and program improvement. In the Program Practices Survey, respondents were asked to report on the extent to which CQI activities occurred at their program. Specifically, they were asked how much the program (1) reviews data at least monthly to understand how the program is performing on benchmarks and other indicators of program success, (2) involves individuals at multiple levels in the CQI process, (3) uses data to identify areas for improvement, and (4) can think of an example where the program used data to make a change in policies, procedures, and activities. Data from respondents to the Program Practices Survey about CQI activities indicated the following (Exhibit 28):

♦ At Time 3, CQI activities were fairly strong. 70 to 88% of supervisors/administrators indicated that their program "quite a bit" or "very much" was implementing CQI practices as indicated by the four different survey items. This was true in both intervention and comparison groups.

♦ The item with the strongest agreement in both groups was that "Our program has used data to identify areas for program improvement" (intervention 88%; comparison 87%).

♦ The biggest increases between Time 1 and Time 3 for the intervention supervisors/administrators were in involving people at multiple levels in the CQI process (Time 1, 57%; Time 3, 72%) and that the respondent could think of an example where the program had used data to make programmatic changes after reviewing data (Time 1, 70%; Time 3, 88%).

♦ Comparison program staff reported a decrease in CQI processes over time especially with regard to involving people at multiple levels in the CQI process (Time 1, 82%; Time 3, 70%). There was also decrease in reporting thinking of an example where the program had used data to make programmatic changes (Time 1, 83%; Time 3, 76%).

♦ Reviewing data at least monthly remained about the same among supervisors/administrators in comparison programs and intervention programs (intervention: Time 1, 80%; Time 3, 88%; comparison: Time 1, 85%; Time 3, 81%).

These data are consistent with the HUB's efforts across the past three years to support programs in CQI practices, as there have been clear increases over time in the CQI activities undertaken by the intervention programs.

Exhibit 28.   Supervisor/administrator Reports About Programs' Implementation of CQI Processes at Time 3

Source: Program Practices Survey, Spring 2017.

Note: No between-group differences at Time 3 reached statistical significance.

Findings About Model Fidelity and Implementation Quality

Both NFP and PAT provide specific guidance and recommendations for implementing their respective models with fidelity (see Appendix F). Replicating home visiting models with fidelity helps to ensure that the intended outcomes are realized. Implementing with fidelity to the evidence-based home visiting model is one key outcome that the Implementation HUB is trying to influence. Providing the appropriate TA supports to help programs know about and implement practices that are associated with better child and family outcomes is one of the key areas of the HUB's focus. In addition to model fidelity are several best practices that are considered associated with implementation quality. To support model fidelity, programs need adequate capacity in their organization to meet recommended caseload guidance, as well as home visiting staff well trained in the model and provided adequate supervision to support evidence-based practices.

The evaluation team reviewed documents and consulted with staff from the NSO for both PAT and NFP to identify the criteria for model fidelity during the 2012–13 and 2014–15 years in which programs provided data. We also included information on specific practices that are associated with implementation quality, given the most recent review of evidence-based home visiting practices (Daro et al., 2012).

Exhibit 29 shows each of the constructs associated with model fidelity and implementation quality and the data sources used in the evaluation. Each construct may have one or more indicators that define it. Because these indicators can be different for different program models and/or are complicated to describe, the descriptive data about the indicators is under each construct in the text.

Exhibit 29.   Quality Implementation and Model Fidelity: Key Constructs and Data Sources for the Outcome Evaluation

Construct	NSO Export	Program Practices Survey	Home Visitor Snapshot Form	TA Log
Appropriate client enrollment	X[a]			
Frequency of visits to clients	X			
Duration of client participation	X			
Supervisor and home visitor caseloads	X	X		
Model-recommended staff meetings and/or cross-team meetings	X	X		
Expected staff qualifications	X			
Presence of clear, systematic approach for training new staff		X		
Staff turnover		X		
Content coverage during home visits			X	
Provider-participant relationship quality			X	
Consistently assess family strengths and needs		X	X	
Use of progress monitoring and assessment		X	X	
Referrals to expand program's outreach and effectiveness		X	X	

[a] Only NFP programs had data for this construct; target client populations for PAT are defined on an affiliate-by-affiliate basis.

In the sections that follow we review our criteria related to each indicator; if models used different guidelines, we also describe each model's recommendation for the criterion. Please see Appendix F for each model's guidance on implementing with fidelity. In addition, NFP has clear guidelines on enrolling target populations defined as pregnant (by 28 weeks), first-time mothers who voluntarily participate and are low income. Where the information is available, we also describe cutoffs for implementing these features with fidelity. We then show the percentage of programs[41] in the intervention and comparison groups that met those fidelity criteria at Time 1: 2012–13 and Time 3: 2015–16 for the five indicators that the two models share (Exhibits 30, 31, and 32).

Frequency of visits to clients

To develop rapport, maintain the necessary contact for families at risk, and provide sufficient time to support positive parental and child outcomes, both models ascribe to the belief that consistent contact with enrolled families leads to more positive outcomes. Both NFP and PAT have suggested guidelines about the frequency of home visits with families throughout the time the family is enrolled in the program.

Frequency of visits in NFP programs

NFP recommends visiting families early in the second trimester and then weekly until the child is born. Home visits are weekly for the first 6 weeks after the child is born and then every other week through the infancy and toddler phases, moving to monthly visits when the toddler is 20 months old. Export data from the NFP national office showed the following:

♦ Across all NFP programs participating in the RISE study, Time 1 and Time 3 export data showed that on average home visiting staff completed about 60%of the expected home visits.

  o The percentages of expected visits completed at Time 1 (63% intervention vs. 64% comparison) and Time 3 (66% intervention vs. 63% comparison) were not different between the groups or over time.

These data are consistent with the expected proportion of visits for some life stages of families but low for others. It is expected that staff complete 80% or more of expected visits during pregnancy, 65% or more of expected visits during infancy, and 60% or more of expected visits during the toddler phase. We could not split these data by the stage of the enrolled family (i.e., pregnancy, early after birth, later in the first and second years with the child) because the NSO was not able to provide the stage of each family given that we requested existing program-level data from the NSO database not family-level data. Without having specific information about visits with families by life stage, we were not able to apply a fidelity cutoff to the visit data and compare the extent to which intervention and comparison groups met that fidelity threshold. For example, if most of the families for this data collection period were in the pregnancy phase, these data might represent a much

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[41] The numbers of programs with export data in the following section across the two time points are as follows: Time 1 (2012–13) intervention NFP *n* = 7, intervention PAT *n* = 6, overall intervention *n* = 13, comparison NFP *n* = 15, comparison PAT *n* = 16, overall comparison *n* = 31; Time 2 (2014–15) intervention NFP *n* = 8, intervention PAT *n* =10, overall intervention *n* = 18, comparison NFP *n* = 15, comparison PAT *n* = 17, overall comparison *n* = 32.

lower visit frequency than is recommended/required by NFP. If most of the families were in the toddler phase, then these data might represent high fidelity for visit frequency. Therefore, use of overall frequency rather than comparison to specific NFP guidelines by life stage is a limitation in the data reported.

Frequency of visits in PAT programs

PAT recommends that families with one or fewer high needs receive at least 12 visits annually (i.e., monthly visits) and families with two or more high needs receive at least 24 visits annually. PAT further provides guidelines that at least 60% of families with one or fewer high needs receive at least 75% of the required visits in the program year and at least 60% of families with two or more high needs receive at least 75% of the required visits in the program year. In addition, PAT programs are required to deliver a minimum of nine group connections across the program year.[42]

NSO export data for programs in RISE showed the following:

- ♦ For meeting the criterion for required visits with families with one or fewer high needs,
  - o At Time 1, all participating PAT programs met the criterion.
  - o At Time 3, nearly all programs (96%) met the criterion (100% intervention vs. 93% comparison).
- ♦ For meeting the criterion for required visits with families with two or more high needs,
  - o At Time 1, nearly all PAT programs (95%) met the criterion (83% intervention vs. 100% comparison).
  - o At Time 3, visit frequency dropped to 79% of *programs* meeting the criterion (70% intervention vs. 86% comparison).[43]
- ♦ All the participating PAT programs met the criterion of delivering at least nine group connections per year at Time 1. For Time 3, nearly all programs (96%) met the criterion (100% intervention vs. 93% comparison).

Duration of client participation

Evidence-based home visiting models have been tested to show impacts based on use of a model designed to work with families over a specific period of time. The expectation of these two-generation models that provide services to both parents and their children is that programs need to work with families over time (and intensively) to yield positive outcomes for both parent and child. For instance, home visitors build relationships with parents and strive to promote positive parenting practices and expand understanding of child development across a range of child ages; these activities with parents provide a foundation that helps support sustained benefits. Duration of client participation is an important fidelity indicator because families who participate for the full

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[42] Group connections are events that parents can attend with their child to obtain information and social support and share experiences with their peers. Group connection formats can be presentations, community events, parent cafes, socializations/playgroups, and ongoing support groups.
[43] Conversations with staff at the NSO indicated that challenges with visit frequency among families with higher needs are not uncommon nationally.

length of the intended intervention have the opportunity to benefit from the full package of home visiting support.

Both NFP and PAT recommend that families participate for multiple years to receive sufficient services to reach intended outcomes (Daro et al., 2012). As described above, NFP aims to enroll families during pregnancy and keep them through the child's toddler phase (or when the child reaches about 2 years of age). The goal for NFP is to have 60% or more of families "graduating" or completing the toddler phase (for NFP Program Objectives, see Appendix F).

PAT's NSO does not have firm guidelines about the percentage of families expected to participate in the program for a full 2 years. However, the NSO expects each PAT program to be designed to offer services to families for at least 2 years,[44] and PAT recommends trying to keep families in the program for a minimum of 2 years, if appropriate. Drawing on guidance from the NSO and using

Caseload of families for home visitors

PAT export data, we calculated a proxy for program duration for the year in which programs were reporting. We took the number of families exiting the program during the year. Then we divided the number of families who had received at least 24 months of total service before exiting by the total number of families that left the program that year. This calculation served as a proxy for the percentage of families in a given year who participated for 2 years.

- ♦ On average, across all the PAT programs participating in RISE, 17% of the families that exited in 2012–13 had participated for 2 years (range from 0% to 61%).

- ♦ This percentage increased such that at Time 3 nearly a quarter (23%) were identified as participating for 2 years (range from 0% to 51%).

We also examined the average graduation rate, or percentage of families who had participated in NFP from pregnancy through the toddler phase. We found the following:

- ♦ At Time 1, on average programs reported 39% of families graduated or completed the toddler phase (ranging from 11% to 64%).

- ♦ At Time 3, on average programs reported 36% of families graduated or completed the toddler phase (range from 23% to 45%).

Given the export data available and fidelity criteria for each model, we computed information about the percentage of families that participated for 2 years in each of the home visiting models for each program. We then applied the NFP goal of 60% of families participating for 2 years and found the following:

- ♦ Time 1:
  - o For intervention programs, 17% reported that 60% or more of their families graduated or exited after participating for 2 years.
  - o For comparison programs, 3% reported that 60% or more of their families graduated or exited after participating for 2 years.

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[44] At both Time 1 and Time 3, export data for participating PAT programs showed that all programs reported that they were designed to provide services to families for at least 2 years.

♦ Time 3:

   o For both intervention and comparison programs, no programs reported that 60% or more of their families graduated or exited after participating for 2 years.

Exhibit 30 shows the percentage of programs that met their model's fidelity guideline. Data are collapsed across home visiting models to show percentages for intervention and comparison programs. For both intervention and comparison programs, the percentage of programs that met fidelity for duration of client participation was lower at Time 3 than at Time 1.

Exhibit 30.   Percentage of Programs That Met Duration of Client Participation Fidelity
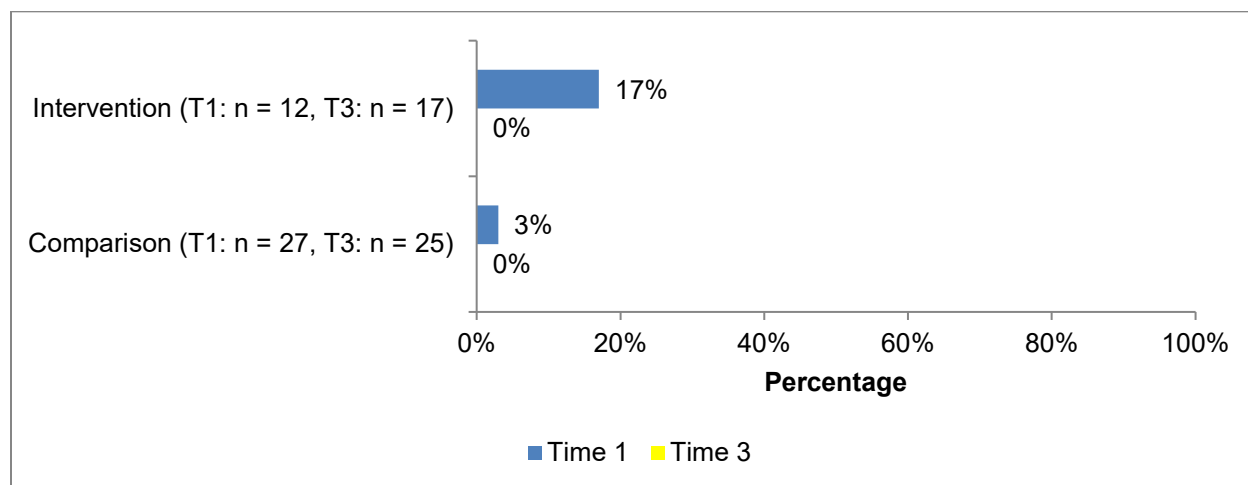
Source: Data export (2012–13 and 2015–16).

Note: No between-group differences at Time 1 or Time 3 reached statistical significance.

Caseloads for supervisors of home visitors

Related to visit frequency and duration, both NFP and PAT have guidelines about how many families each home visitor should have on his/her caseload to be able to adequately address the needs of families and children and produce positive outcomes for them. For 2012–13, NFP recommended home visitors have no more than 25 families on their caseload. NFP changed this recommendation to a target goal for caseloads to be between 23 and 25 families per nurse home visitor for 2014–15 and 2015-16. PAT recommends a maximum number of visits each month for home visitors, a proxy for caseload of families/clients. Parent educators working full time should complete no more than 48 visits per month during their first year and no more than 60 visits per month in their second year and beyond. See Appendix F for the PAT Caseload Guidance document for more information on expectations around caseload for PAT.

Caseloads based on NSO data export

Exported data about caseloads/visit load from the NSO showed that

♦ At Time 1, all PAT and 91% of NFP programs in the study reported following their model's guidelines with staff.

♦ At Time 3, all PAT programs and 61% of NFP programs reported adhering to these guidelines.[45]

Home visitor caseloads based on survey data

In addition, on the Program Practices Survey we asked staff with a home visiting caseload to report their current caseload.

♦ At both time points across all programs, staff reported currently serving between 16 and 17 families (Time 1: mean = 17.3, *SD* = 6.8, range = 0 to 32, *n* = 248; Time 3: mean 16.3, *SD* = 6.7, range 0 to 33, *n* = 208).

   o Time 1: Staff in the intervention group reported an average of 16.4 clients in their caseloads. Staff in the comparison group reported an average of 17.6 clients in their caseloads.

   o Time 3: Staff in the intervention group had an average of 16.0 clients in their caseloads and comparison staff had 16.5.

We also asked supervisors to report the expected number of families for home visitors to serve when the program was fully enrolled. On average at Time 1, supervisors reported they expected home visitors to carry a caseload of 20.7 (intervention 21.7, comparison 20.1). Supervisors reported similar expectations at Time 3, with supervisors expecting a caseload of 20.5 (intervention 20.4, comparison 20.5).

Programs serve different populations (e.g., risk, geographic region). Programs may reduce caseloads when first implementing a home visiting model as staff build capacity and/or increase caseloads slowly as the program gradually increases enrollment of families. To enact these practices, however, programs need to formally request a waiver.

Caseloads for supervisors of home visitors

There also are guidelines on the number of home visitors for each supervisor. Home visiting models establish guidance about supervisory caseload levels in order for staff to provide adequate supervision in terms of frequency of individual supervision meetings with staff and providing reflective supervision. NFP recommends supervisors have no more than 8 home visitors to supervise, and PAT recommends supervisors have no more than 12 parent educators.

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[45] Although the NFP NSO's guidance changed between 2012–13 and 2015-16, it was recommended to use the 2012–13 guidelines since the new guidelines had not been fully publicized and incorporated into practice in all programs yet in 2014 (personal communication, Molly O'Fallon, July 29, 2016).

Caseloads based on NSO data export

Exhibit 31 shows that all programs in the intervention and comparison groups met their model's fidelity criteria for supervision caseload at Time 1. Furthermore, 94% of programs in the intervention group and 92% of programs in the comparison group met these criteria during 2015–16.

Exhibit 31.   Percentage of Programs That Met Caseload Fidelity Guidelines
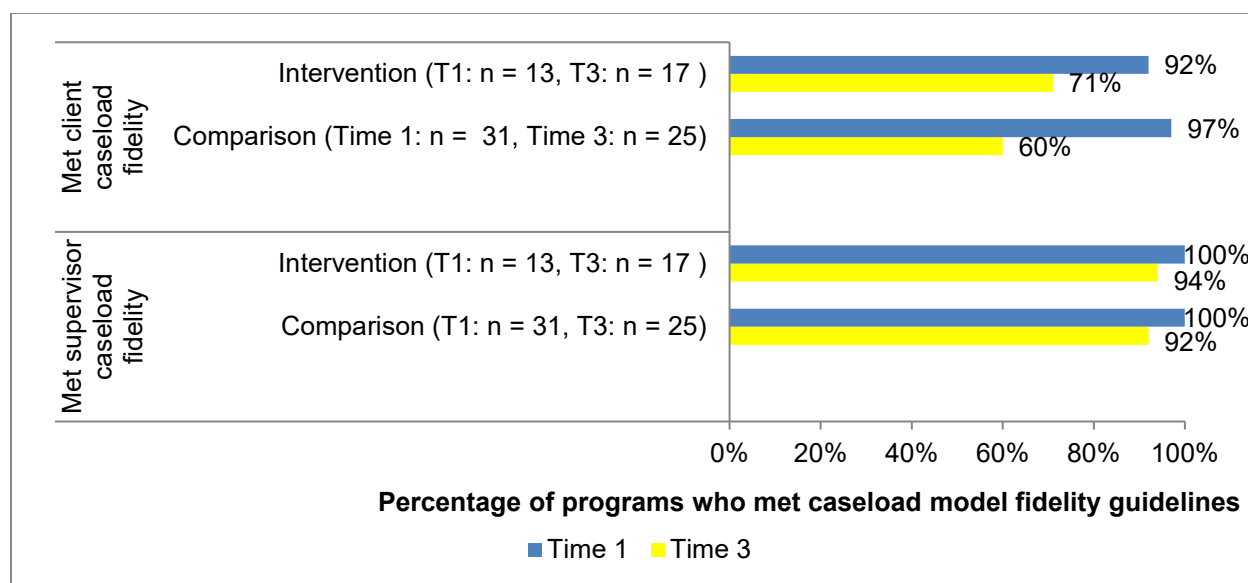
Source: Data export (2012–13 and 2015–16).

Note: No between-group differences at Time 1 or Time 3 reached statistical significance.

Caseloads based on survey data

In addition, on the Program Practices Survey we asked supervisors to report how many staff they supervised. Across all programs at Time 1, supervisors reported supervising an average of 4.8 staff (SD = 2.4), with supervisors in the intervention group reporting 4.2 staff (SD = 2.4) and supervisors in the comparison group reporting 5.1 staff (SD = 2.4). At Time 3, supervisors reported supervising an average of 4.6 staff (SD = 2.2), with comparison supervisors reporting supervising 4.5 home visitors and intervention staff supervising an average of 4.8 staff. In both the intervention and comparison programs, average supervisor caseloads were smaller than suggested guidance from either model (PAT = no more than 12 parent educators per supervisor; NFP = no more than 8 nurse home visitors).

Presence of model-recommended staff meetings and/or cross-team meetings

Ensuring staff are properly trained and supported to implement the model with fidelity is a focus of both models. NFP asks programs to conduct individual/team meetings and cross-team meetings twice monthly. NFP also asks programs to conduct case conferences. It describes these as two different types of meetings. NFP recommends programs provide 80% of the recommended twice-monthly individual/team/cross-team meetings as well as the recommended twice-monthly case

conferences. PAT asks program affiliates to be designed to provide 2 hours of staff meetings per month.

Data for programs in the RISE evaluation showed the following:

♦ At Time 1 (2012–13), 55% of NFP programs met the individual/team/cross-team meeting criterion and 77% met the case conference criterion.

♦ At Time 3 (2015–16), 83% of programs met the individual/team/cross-team meetings and 56% met the case conference meetings.

♦ In addition, 100% of PAT programs indicated they were designed to provide the suggested meeting schedule at both Time 1 and Time 3.

Exhibit 32 combines data from NFP and PAT programs to show the percentage of intervention and comparison programs that met their model's fidelity criteria for meetings. For intervention programs, the percentage of programs meeting model requirements for staff meetings and/or cross-team meetings increased from Time 1 to Time 3; the percentage remained around the same for comparison programs from Time 1 to Time 3.

Exhibit 32.   Percentage of Programs That Met Meeting and Staff Qualifications Criteria, by Time and Condition
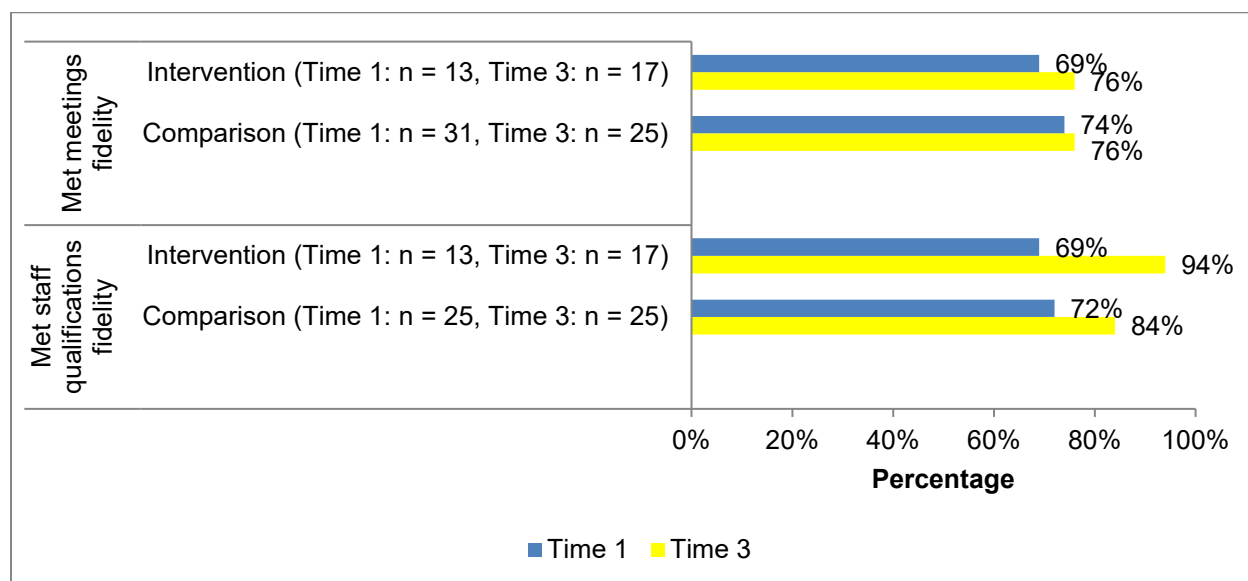
Source: Data export (2012-13 and 2015-16).

Note: No between-group differences at Time 1 or Time 3 reached statistical significance.

Staff qualifications to implement program model

Education and experience levels of staff can affect program outcomes. NFP requires home visitors and supervisors to be registered nurses with a minimum of a bachelor's degree. PAT requires that home visiting staff have, at minimum, a high school diploma or General Equivalency Diploma certificate and 2 years of previous supervised work experience with young children and/or parents. Thus, the criterion for the evaluation was to have all program staff meet their models' respective qualifications.

Exhibit 32 shows the percentage of programs meeting fidelity for staff qualifications. The percentage of programs meeting staff qualifications increased from Time 1 to Time 3 for both intervention and comparison programs. Also, whereas a slightly higher percentage of programs in the comparison group than the intervention group met the criterion for staff qualifications at Time 1 (intervention 69%, comparison 72%), by Time 3 a somewhat higher percentage of intervention programs than comparison programs met the staff qualifications criterion (intervention 94%, comparison 84%).

Presence of clear, systematic approach for training new staff in program

Effective program implementation requires a thoughtful approach to staffing. Specifically, after hiring new employees, it is important that new staff members receive a thorough orientation and necessary training to be successful. Thus, an indicator of quality implementation is the extent to which the program has a consistent approach for hiring and training new staff. Respondents reported the following:

♦ At Time 1, supervisors/administrators from comparison groups were somewhat more likely than those from the intervention group to report that they "quite a bit" or "very much" had a consistent training approach for orienting new staff (68% intervention, 79% comparison). However, this pattern was reversed at Time 3 where 84% of intervention supervisors and 81% of comparison supervisors endorsed this statement, although values were higher for both groups at this time point.

Staff turnover

Staff turnover is both an outcome and a contextual factor. It is potentially an indicator of whether staff feel adequately trained and supported to do a job that can easily result in fatigue and burnout. Some research supports the fact that implementing programs with adequate monitoring and support of staff predicts lower rates of staff turnover and lower levels of staff burnout and emotional fatigue (Aarons, Fettes, Flores, & Sommerfeld, 2009; Aarons & Palinkas, 2007; Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009). Thus, we expected lower rates of staff turnover in the intervention group given the expectation for greater TA and support provided by the Implementation HUB.

High staff turnover may make building staff capacity to implement evidence-based practices a challenge. Variability across programs may predict variation in outcomes in the other areas (model fidelity, implementation quality, staff competency, and self-efficacy). Finally, high staff turnover by definition prevents each home visiting participant from developing a trusting, stable relationship with their home visitor and ultimately predicts poor outcomes for families and children.

In RISE, staff turnover was examined by comparing whether the same staff members were currently employed in the program at Time 1, Time 2, and Time 3 on staff lists used for the Program Practices Survey. This estimate provides a proxy for staff turnover over time (Exhibits 33 and 34).

♦ In both intervention and comparison groups, about one-third of the program staff had left between Time 1 (fall 2014) and Time 3 (spring 2017) (37% intervention, 35% comparison). The range for intervention programs was 0% to 69% turnover; for comparison programs it was 0% to 60% turnover.

o Among PAT programs, 37% of staff had left between Time 1 and Time 3; for NFP
   programs, 34% of staff had left in the same time period.

Exhibit 33. Percentage of Staff Turnover in Intervention Programs From Time 1 to Time 3
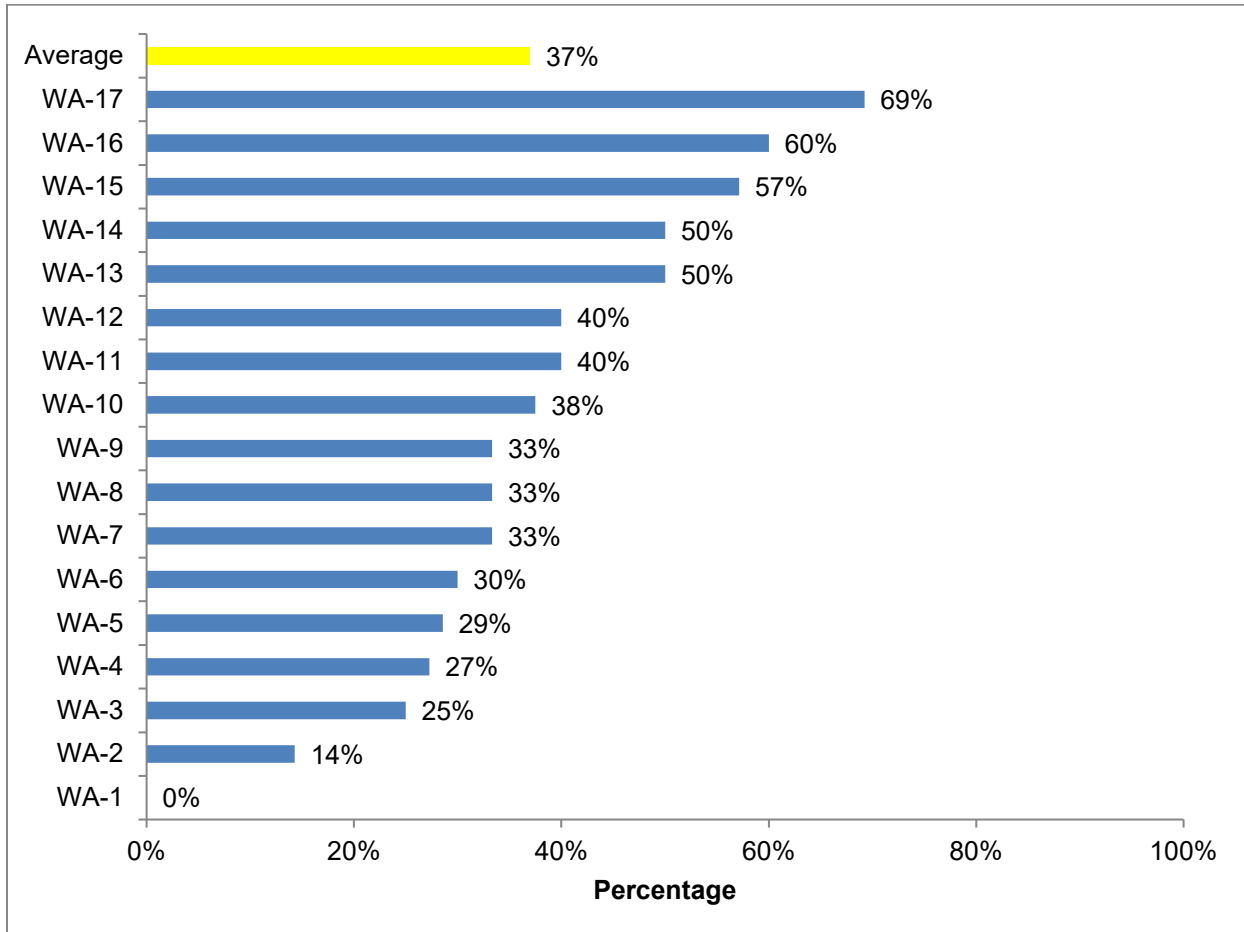
Source: Staff lists provided for 2014, and 2017 Program Practices Survey.

Note: Program numbers were assigned randomly based on the rank order of programs on the variable of interest.
Program numbers are *not* associated with a given program and are not held constant on program-level charts throughout
the report.

Exhibit 34.   Percentage of Staff Turnover in Comparison Programs From Time 1 to Time 3

Program	Percentage
Average	35%
C-24	60%
C-23	60%
C-22	57%
C-21	57%
C-20	50%
C-19	50%
C-18	50%
C-17	47%
C-16	40%
C-15	40%
C-14	40%
C-13	38%
C-12	35%
C-11	33%
C-10	33%
C-9	33%
C-8	25%
C-7	20%
C-6	20%
C-5	18%
C-4	18%
C-3	14%
C-2	0%
C-1	0%
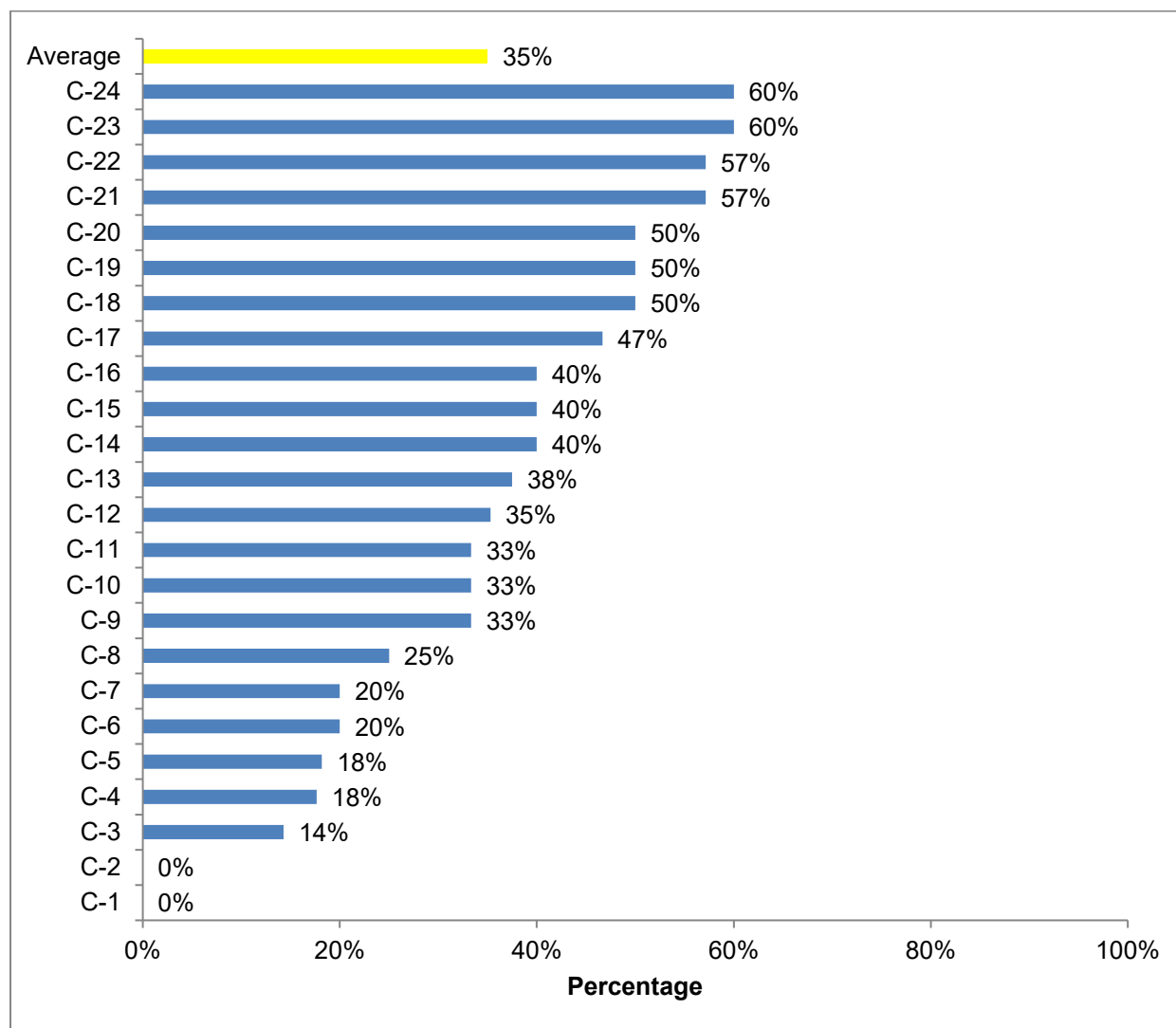
Source: Staff list provided for 2014, and 2017 Program Practices Survey.

Note: One program participated only in data export activities and is not represented in this data. Program numbers were assigned randomly based on the rank order of programs on the variable of interest. Program numbers are *not* associated with a given program and are not held constant on program-level charts throughout the report.

Assessments and progress monitoring

Because home visiting programs serve families with a wide range of strengths and challenges, effective assessment is important to tailor activities and/or prioritize plans for home visits. Given that home visiting focuses on promoting positive development in both parents and children, it is expected that programs with quality implementation incorporate effective assessment of family strengths and needs as well as progress monitoring of child development. Assessing families' strengths and needs is considered an indicator of quality implementation. Indeed, whole toolkits have been developed specifically to address this topic for the field (Korfmacher & Chawla, 2013). Like many other evidence-based home visiting models, both NFP and PAT provide guidance to

programs about their assessment practices and monitor how frequently these activities occur. (See Appendix F for information about NFP and PAT guidance on model fidelity and quality program implementation.) Findings presented here focus on the extent to which program staff consistently assessed families' strengths and needs, identified goals to achieve, and then used assessment information to plan activities, establish visit frequency, or make referrals.

Consistently assess family strengths and needs and monitor children's progress

Assessment practices were fairly similar between intervention and comparison programs at both Time 1 and Time 2, with a slight shift towards the use of written goals (rather than verbally agreed upon goals) in intervention programs at Time 2. Below we describe assessment and goal setting actions as described in the home visiting snapshot forms. Exhibit 35 provides information about the types of activities undertaken during home visits in both intervention and comparison sites. Among the activities examined were setting or planning goals, modifying them, or examining progress toward them, as well as informal or formal assessment of child or caregiver during the visit.

The development of shared goals is as an important mechanism for identifying types of assessment that may be needed, planning appropriate activities, and monitoring progress. The majority of home visitors indicated on the Home Visiting Snapshot forms that there were identified goals for families prior to their visits.

- ♦ At Time 2, 58% of visits at intervention programs and 52% of visits at comparison programs had written goals identified before the visit. This was a slight increase from Time 1 for intervention sites, where 52% of visits at intervention programs and 54% of visits at comparison sites had written goals.

- ♦ At Time 2, 28% of visit at intervention programs and 33% of visits at comparison programs had verbally agreed upon goals. At Time 1, it was 34% for intervention and 30% for comparison visits.

- ♦ At Time 2, 13% of visits at intervention programs and 15% of visits at comparison programs had no mutually agreed on goals with their families, similar to Time 1 (intervention 13% of visits, comparison 16% of visits).

Exhibit 35.   Actions Taken by Home Visitors During Home Visits at Time 2
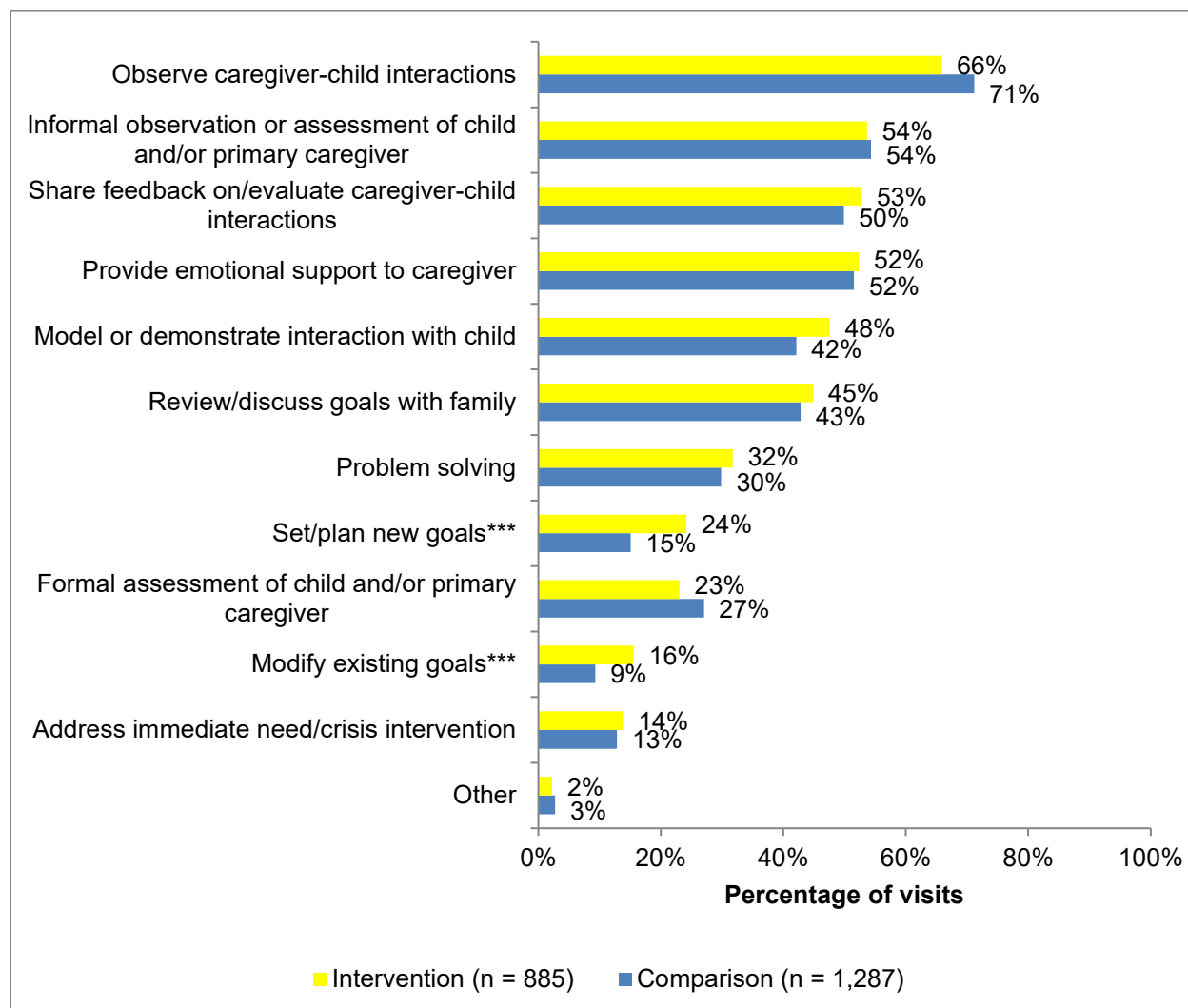
Source: Home Visiting Snapshot form.

*p < .10; **p < .05; ***p < .01.

In addition, a majority of visits included some focus on family goals as one of the activities during the visit. Intervention programs were more likely to focus on family goals during a visit: 62% of visits at intervention programs and 52% of visits at comparison programs included reviewing or discussing goals with a family, modifying existing goals, or setting and planning new goals (*p* < .05) at Time 3 (Time 1: 65% intervention, 58% comparison, *p* < .10).

At Time 2, most visits also involved some focus on assessments, with two-thirds (64%) of visits in intervention programs including either a formal assessment or informal observation/assessment of the child or caregiver and 68% of visits at comparison sites included these activities. This was in line with the findings at Time 2, where 65% of intervention and 69% of comparison programs conducted assessment activities.

Use of assessment and progress monitoring data

Quality implementation involves using data effectively to guide service delivery. Data from the Program Practices Survey revealed that most home visitors reported consistently using assessment information to inform practice decisions. For instance, they used assessment and progress monitoring information to guide visit content and activities, establish visit frequency, or make referrals. The majority of all home visitors reported using assessments to guide visit content.

♦ At Time 3, 58% of intervention and 63% of comparison home visitors reported using family-centered assessments to plan their visits "most of the time" or "almost always." This was a slight decrease from the percentage found in each group at Time 1 (66% intervention, 72% comparison).

♦ At Time 3, around 80% of home visitors (79% intervention, 81% comparison) reported using child assessment data to plan their visits "most of the time" or "almost always." These data were consistent with findings at Time 1 (intervention 81%, comparison 86%).

♦ At Time 3, home visitors from intervention programs were significantly more likely to report assessing child development using a formal instrument or screening tool at least every 6-8 months (94% intervention, 74% comparison; $p < .01$). This was similar to the pattern found at Time 1, although staff in the comparison group were less likely to report this practice between Time 1 and 3 (Time 1: 98% intervention, 91% comparison).

In addition, we asked supervisors to report whether few, some, many, or all of the home visiting staff they oversee (1) consistently conduct assessments and monitor progress and (2) consistently use information from assessments and progress monitoring to guide their work with families and children.

♦ All supervisors reported at Time 3 that "many" or "nearly all or all" of their staff consistently conducted assessments and monitored progress (100% intervention, 100% comparison). These data were similar to the very high values reported at Time 1 (96% intervention, 98% comparison). This best practice is very widely known among home visiting staff and their supervisors, and although there is some flexibility in how assessments and progress monitoring occur, there is a clearly articulated expectation that this should occur consistently and with regularity on home visits.

♦ Likewise, all supervisors stated that their staff members consistently used information from assessments and progress monitoring to guide their approach to upcoming work with the child and family (100% intervention, 100% comparison), which was similar to findings at Time 1.

Referrals expand program's outreach and effectiveness

An effective home visiting program works closely with other community organizations to support families in accessing needed services. One component of the TA that the HUB provides is support in facilitating conversations across organizations within a community or region that build program staff awareness of existing community resources and strengthen professional relationships and referral networks. Data from the Program Practices Survey showed the following:

♦ At both Time 1 and Time 3, the majority of supervisors reported "quite a bit" or "very much" having a system in place to receive referrals from diverse organizations (Time 1: intervention 81%, comparison 83%; Time 3: intervention 84%, comparison 81%).

♦ At Time 3, most supervisors in both groups indicated that "our program has worked to build or maintain strong relationships with other community organizations that refer families to us" "quite a bit" or "very much" (intervention 97%, comparison 88%). These responses represented were in line with those from Time 1 (intervention 97%, comparison 90%).

♦ Similar results were found for fostering strong relationships with other community organizations the program refers families to for support. At Time 3 a high percentage of supervisors agreed with the statement "quite a bit" or "very much" (Time 1: intervention 94%, comparison 89%; Time 3: intervention 88%, comparison 93%).

Exhibit 36 provides information on referral information obtained from the Home Visiting Snapshot form. The form showed that the majority of home visits in intervention programs involved some sort of referral activity, either in the form of initiating a new referral or following up on a referral that was previously initiated. At Time 2, Intervention programs were more likely to both initiate new referrals (25% of intervention visits; 18% of comparison visits, $p < .01$) and follow up on previous referrals (30% of intervention visits; 26% of comparison visits) when compared to comparison programs.

Exhibit 36.   Overall Referral Activity Occurring During Home Visits at Time 2
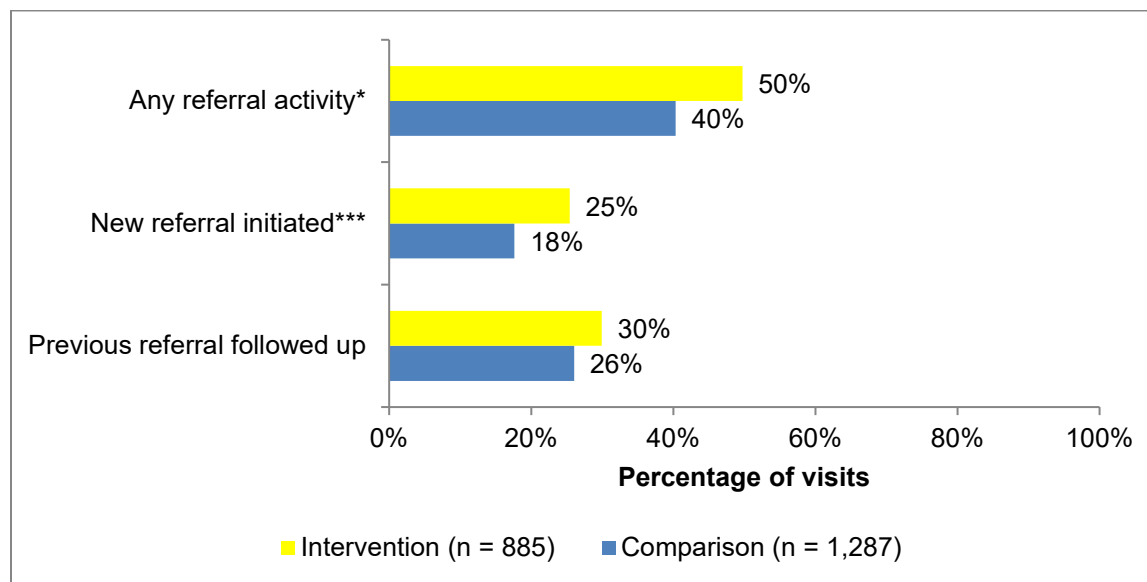
Source: Home Visiting Snapshot form.

*$p < .10$; **$p < .05$; ***$p < .01$.

Exhibits 37 and 38 show the content areas associated with various referrals made by program staff in each group for both new referrals and existing referrals.

Exhibit 37.   Topic of Referrals During Visits in Which New Referrals Were Initiated at Time 2
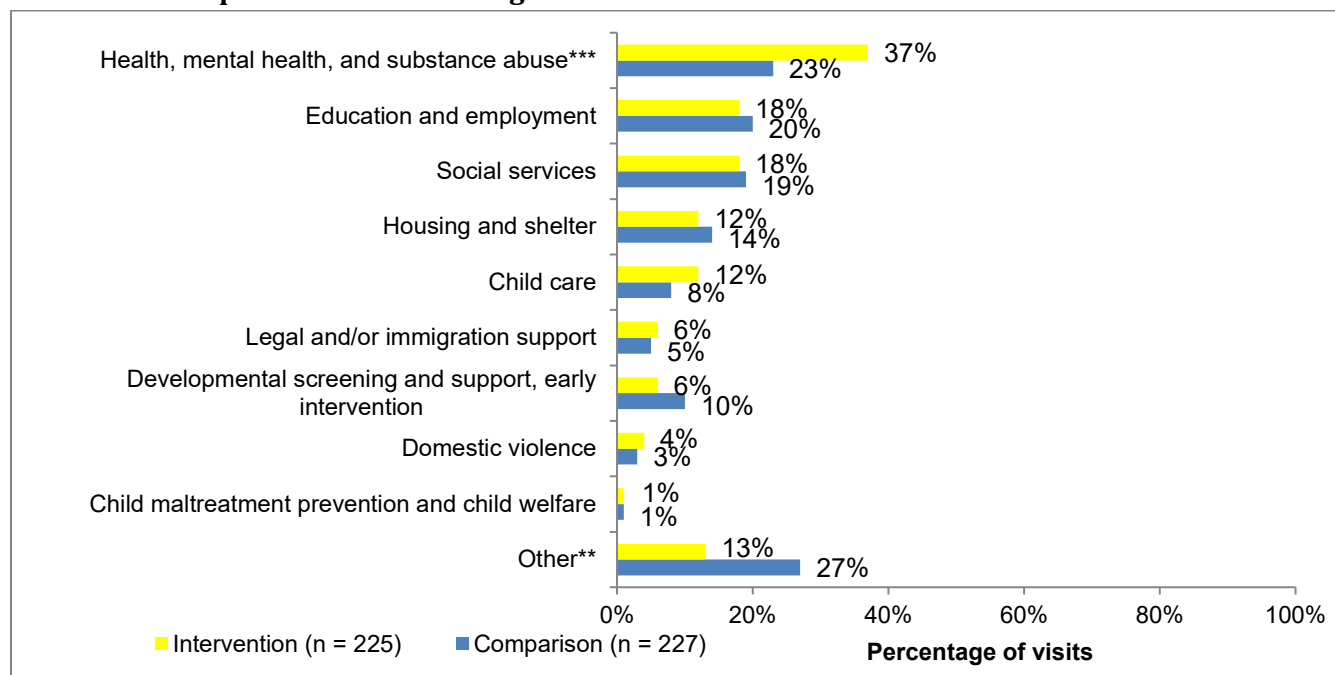
Source: Home Visiting Snapshot form.

Note: "Other" category primarily included referrals to local nonprofit agencies (e.g., "referred to local nonprofit for holiday giving tree event").

*$p < .10$; **$p < .05$; ***$p < .01$.

Exhibit 38.   Topics of Referrals That Were Followed Up on During Home Visits at Time 2
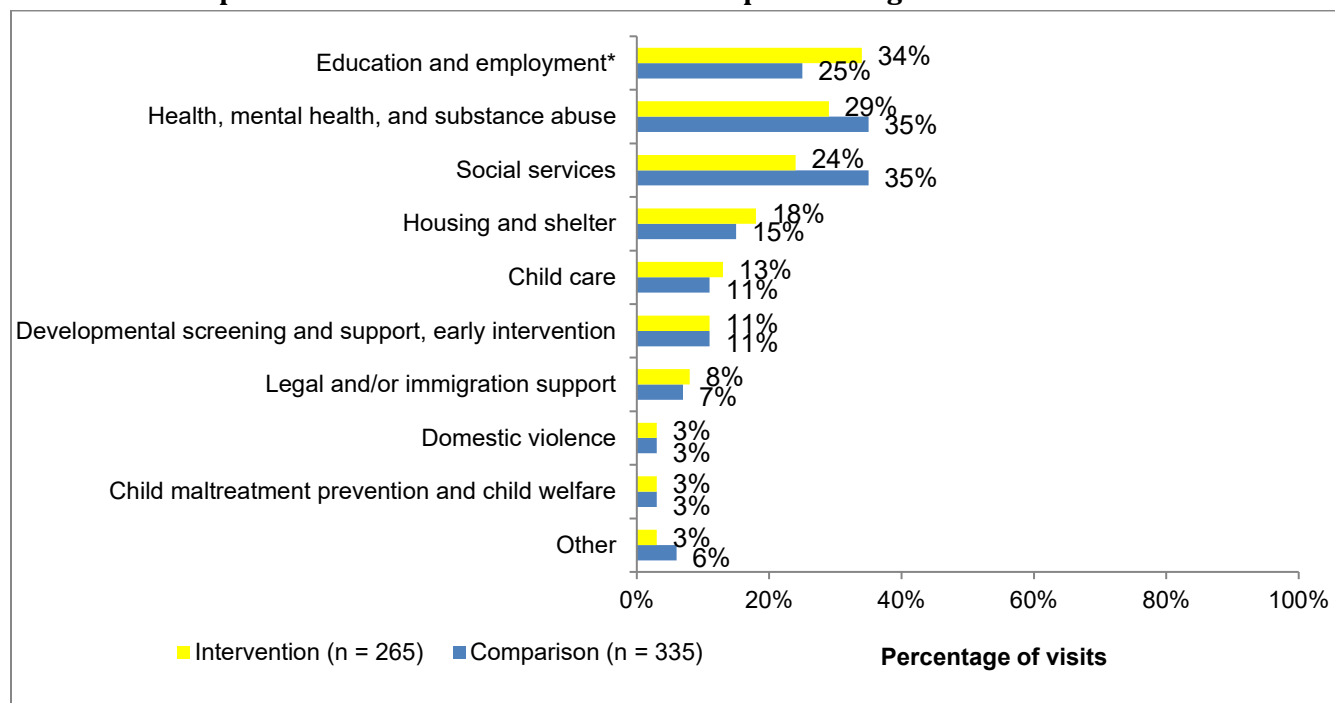
Source: Home Visiting Snapshot form.

Note: "Other" category primarily included referrals to local nonprofit agencies.

*$p < .10$; **$p < .05$; ***$p < .01$.

Content during and planning for home visits

Home visitors completing the snapshot form were asked to reflect on their preparation for each visit on a scale of 1 (*I am familiar with the family's situation, but I did not plan specific topics*) to 5 (*I planned specific activities and discussions to cover with the family*).

♦ At Time 2, the majority of home visitors indicated the highest level of preparation, with 60% of intervention and 59% of comparison visits falling into this category (Time 1: 59% intervention, 61% comparison).

♦ Around a quarter indicated their preparation level as 4 out of 5 with 25% of intervention and 27% of comparison visits falling into this category (Time 1: 27% intervention and 24% comparison).

♦ The mean score was 4.4 for intervention visits (*SD* = 0.95) and 4.4 for comparison visits (*SD* = 0.81) at Time 2.

In addition, home visitors provided information about how they selected the content they planned to cover during the visit (Exhibit 39).

Exhibit 39.   Methods Used to Select Visit Content at Time 2
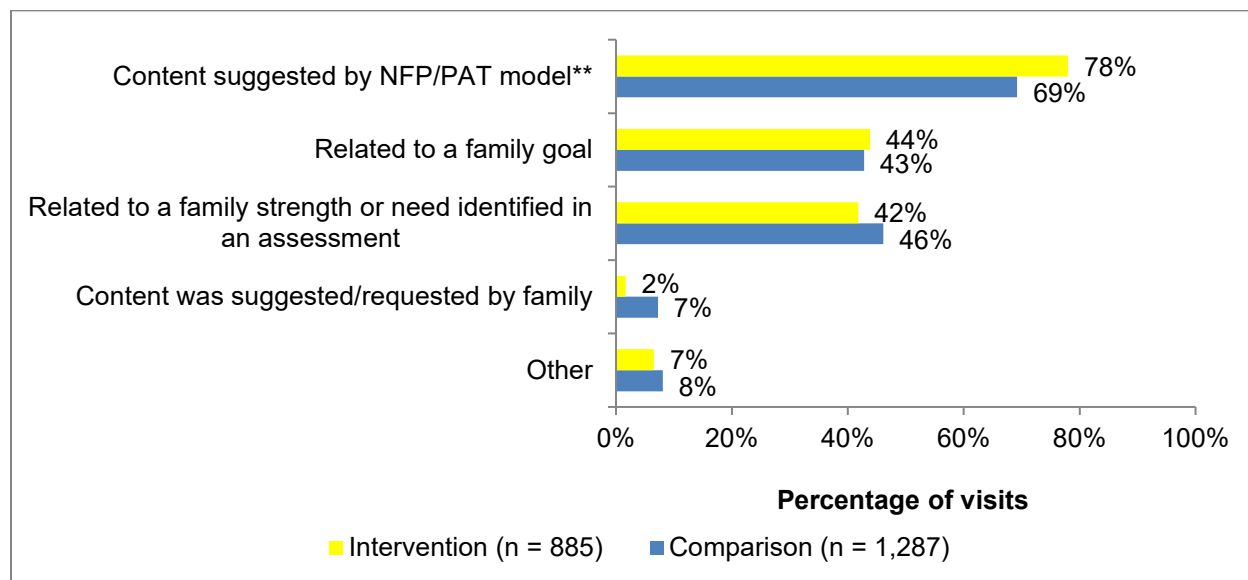
Source: Home Visiting Snapshot form.

Note: Data shown were drawn from a "check all that apply" format and therefore do not sum to 100%.

*p < .10; **p < .05; ***p < .01.

♦ In both groups, content suggested by the NFP or PAT model was the most commonly selected way to plan content in advance of the visit. At Time 2, intervention programs were significantly more likely than comparison programs to use model-suggested content (78% of intervention visits; 69% of comparison visits; *p* < .05).

♦ For about 40% of visits, staff in both groups reported considering family goals to plan the visit at Time 3. About the same percentage was observed for examining family strengths and needs in planning content for the visit.

♦ About 2% in both groups reported not planning specific content before visits.

♦ About 7% of visits at intervention sites and 8% of visits at comparison sites used "other" methods to prepare for home visits. Examples of these included completing scheduled assessments or planning content with a third party (e.g., planning a joint visit with early intervention representatives).

The Home Visit Snapshot form had a table of topics that home visitors might discuss with families during a home visit. The table listed parental and family topics (e.g., parental health, environment and home) as well as child topics (e.g., child development, child health). Home visitors were asked to indicate which topics were major topics of discussion (> 25% of a visit) [46] during each visit and could check all that apply. Exhibit 40 shows the following:

♦ On average, home visitors at intervention sites focused on 2.5 topics (SD = 1.8, range = 0–12 topics per visit).

♦ Home visitors at comparison sites focused on an average of 3.0 topics (SD = 2.3, range = 0–16 topics).

Exhibit 40.   Number of Major Topics Discussed per Visit at Time 2nm
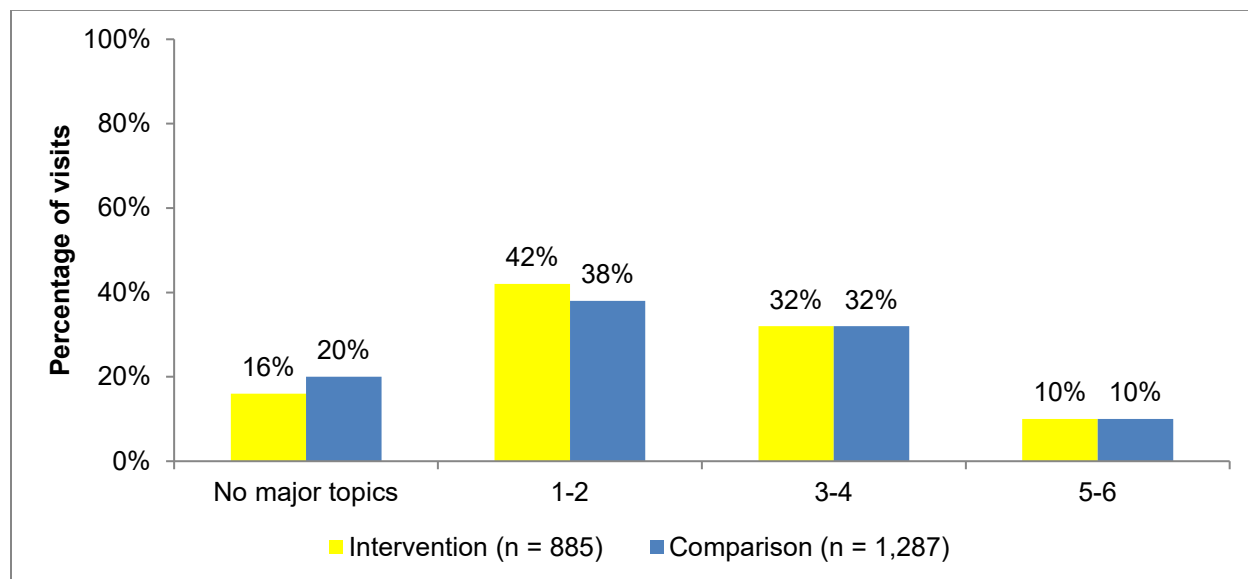
Source: Home Visiting Snapshot form.

Note: Visits could have no major topics if no specific topic was the focus for 25% or more of the visit. Thus, visit with "no major topics" could reflect discussion about many topics very briefly (i.e., < 25% of a visit) or a primary focus during the visit on an activity such as referrals or assessment without major discussion of one of the topic areas. There were no statistically significant differences between the two groups on any of these variables.

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[46] No guidance is available from the National PAT or NFP offices about the number of topics to cover in each home visit. Guidance is available about the timing of topics of when to address topics.

The number of topics covered could have been related to the length of the overall visit, or it could be an indicator of the depth of discussion about the topic. That is, individuals who covered fewer topics may have gone into more depth about them or talked about them and engaged in an activity (such as providing a referral or setting a goal) related to the topics. No information about the depth of discussion on a given topic during the visit is available for Time 1 or Time 2, but information about visit length found:

♦ On average home visits by intervention program staff were statistically significantly shorter ($p < .05$) than visits by comparison sites at Time 2. Intervention visits were 72 minutes on average (SD = 26.0 minutes, range 5-420 minutes) and comparison visits were 76 minutes (*SD* = 22.5, range 10-405 minutes). A similar pattern was present at Time 1 (intervention mean = 72 minutes, *SD* = 23.1, range 8–360 minutes; comparison mean = 75 minutes, *SD* = 20.1, range 15–196 minutes; $p < .10$) (see Exhibit 42).

Exhibit 41 shows the percentage of visits in which various content topics were addressed as major topics.[47]

♦ The majority of visits included discussion on parent-child interaction, behavioral and emotional care of child, child health, parental health, and child development stages and school readiness.

♦ The topics that were less likely to be discussed with families were domestic violence and safety planning, child health screening, use of social services, child care, parental health/mental health screenings, health insurance and health care, and substance abuse and mental health.

♦ It was possible that home visitors discussed several subtopics that were all classified within one content area (e.g., discussing tantrums, power struggles and discipline, and attachment all under the topic area of behavioral and emotional care of the child).

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[47] Home visitors were directed to consider topics that represented a focus for more than 25% of their visit. They could check all the topics that applied.

Exhibit 41.   Major Topics of Discussion During Home Visits at Time 2

Topic	Intervention	Comparison
Parent-child interaction	38%	39%
Behavioral and emotional care of child	23%	27%
Parental health	23%	23%
Child health	21%	25%
Education, employment, and housing	18%	17%
Child development, stages, and school readiness**	17%	29%
Physical care of child	17%	21%
Child routines and transitions	13%	18%
Social support	13%	16%
Developmental screening	10%	14%
Parental reproductive health and pregnancy	10%	13%
Substance abuse and mental health	9%	8%
Health insurance and health care	5%	6%
Screening about parental health/mental health	4%	4%
Child care	4%	6%
Use of social services	4%	5%
Screenings about child health	3%	4%
Domestic violence and safety planning	2%	3%

Percentage of visits

■ Intervention (n = 881)   ■ Comparison (n = 1,286)

Source: Home Visiting Snapshot form.

p < .10; **p* < .05; ***p* < .01.

Exhibit 42.   Major Topics of Discussion During Home Visits at Time 1
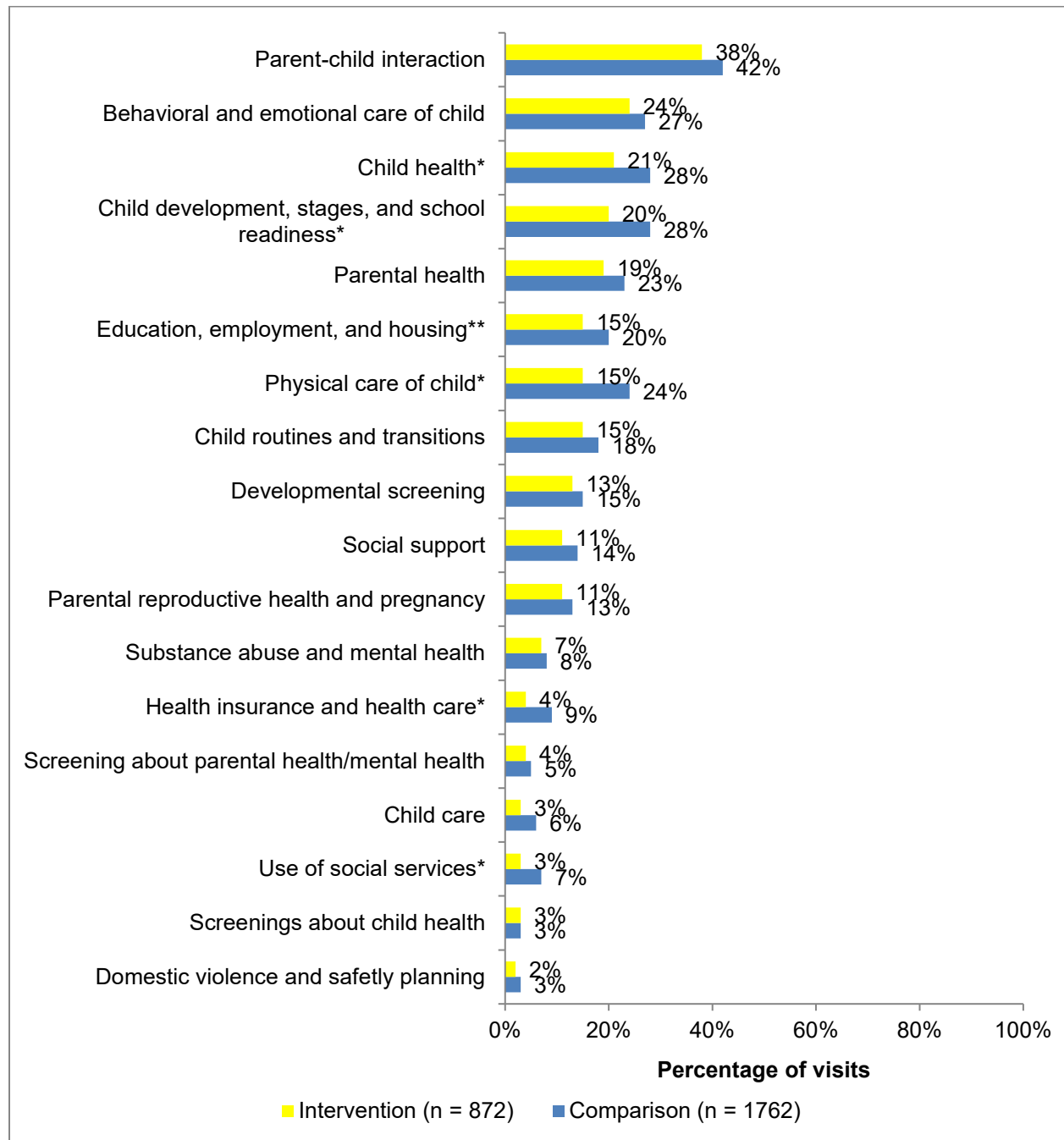
Source: Home Visiting Snapshot form.

*p < .10; **p < .05; ***p < .01.

These data suggest that, while intervention and comparison programs tended to focus on similar topics, there were some differences in topics discussed during visits at Time 2. Differences between intervention and comparison programs were significant for the topic of child development, stages,

and school readiness ($p < .05$) at Time 2 indicating intervention program staff were less likely to discuss this topic than comparison program staff. This was similar to findings at Time 1.

Provider participant relationship quality

The quality of the relationship between a home visitor and a parent can vary from visit to visit. The Home Visiting Snapshot form asked home visitors to reflect on the overall quality of the relationship with the parent, as well as the quality of the specific visit recorded on the form (Exhibit 43). In general, home visitors in both the intervention and comparison programs characterized the quality of their relationship with the parent as average or better.

Exhibit 43.   Home Visitor-Reported Quality of Relationship with Parent at Time 3
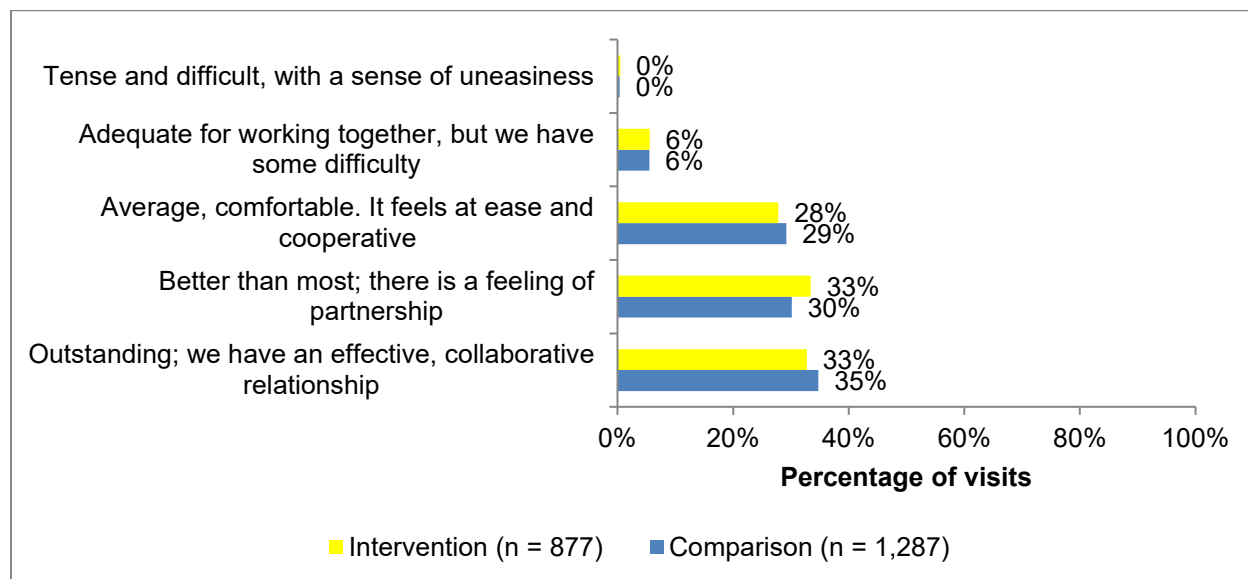
Source: Home Visiting Snapshot form.

Note: There were no statistically significant differences between the two groups on any of these variables.

The patterns were similar for the quality of the current home visit, with 64% of intervention and 59% of comparison home visits reported as "better than most" or "outstanding," which was in line with responses at Time 1.

Findings About Staff Competency and Self-Efficacy

Research has identified best practices for home visitors to use in working with families. The focus of the HUB has been to support supervisors in developing their home visiting staff's skills and capacity for effectively engaging and working with families. Exhibit 44 shows each of the constructs associated with staff self-efficacy and competency in the RISE evaluation and their data sources. Most data in this area were drawn directly from program staff completing the Program Practices Survey. However, as with the constructs for model fidelity and quality implementation, some constructs had more than one indicator.

Exhibit 44.   Key Constructs and Data Sources Used to Evaluate the Staff Competence and Self-Efficacy Outcome

Construct	NSO Export	Program Practices Survey	HV Snapshot Form	TA Log
Consistent, high-quality reflective supervision		X		
Staff behaviors that contribute to client retention and dosage		X		
Comfort collecting data/conducting screening and positive attitudes toward implementing evidence-based practices		X		
Staff understanding of model requirements being implemented		X		
Beliefs about the intervention's efficacy and that the home visiting makes a difference		X		

Consistent, high-quality reflective supervision

The availability of high quality supervision, especially reflective supervision, is important to support staff in their incredibly challenging work as home visitors (Eggbeer, Mann, & Seibel, 2007; Weatherston, Weigand, & Weigand, 2010). Often TA and support for programs is directed to helping leaders provide effective supervision and build reflective practice into different facets of the organization. In this section, we describe findings from the Program Practices Survey about supervision practices in intervention and comparison programs. Specifically, we consider the following findings related to supervision:

- The frequency, quality, satisfaction, and usefulness of supervision, including the availability of the supervision, staff satisfaction with supervision frequency, and the extent to which it was viewed as high quality
- Other opportunities for shared feedback including case conference meetings/group supervision meetings and joint home visits
- The features of supervision, including the extent of reflective supervision and practice and the degree of organizational support for supervision

Frequency, quality, satisfaction with, and usefulness of supervision

At Time 1, intervention and comparison staff reported similar frequency of both scheduled and actual supervision.

- Nearly all (96% of intervention and 96% of comparison) home visitors reported having scheduled supervision meetings "a couple times per month" or more frequently.
- Most home visitors also reported completing supervision meetings twice per month (93% intervention, 94% comparison). This frequency of supervision is consistent with program model guidance.

However, at Time 3 home visitors in the intervention group were slightly less likely to report scheduled and actual supervision than home visitors in comparison programs.

♦ At Time 3, 91% of home visitors in the intervention group reported having supervision meetings scheduled "a couple times per month" or more frequently compared with 97% of home visitors in comparison programs.

♦ The difference also was observed in the percentage of home visitors who reported actually completing supervision meetings twice per month (intervention 91%, comparison 96%).

Supervisor and home visitor satisfaction with the frequency of supervision was fairly high and similar across groups.

♦ At Time 1, approximately three-fourths of supervisors reported being "quite a bit" or "very much" satisfied with the frequency of supervision (intervention 70% vs. comparison 76%). This remained stable at Time 3 (intervention 70% vs. comparison 79%).

♦ At both time points, the majority of home visitors in both groups also reported being satisfied "quite a bit" or "very much" with the frequency of supervision (Time 1: intervention 78%, comparison 83%; Time 3: intervention 79%, comparison 84%).

♦ At Time 1 70% of intervention supervisors and 76% of comparison supervisors were satisfied with the quality of supervision they have provided; at Time 3 60% of intervention supervisors and 83% of comparison supervisors were satisfied with the quality of supervision ($p < .10$)

♦ The majority of home visitors were also satisfied with the quality of supervision they receive (Time 1: 73% intervention, 80% comparison; Time 3: 73% intervention, 78% comparison)

   o Additional analyses on supervision practices are included in the Exploratory Analyses section.

Both supervisors and home visitors were asked about the usefulness of supervision. Individuals shared the extent to which they believed that the supervision that was provided or received helped their home visiting services.

♦ The majority of supervisors could "quite a bit" or "very much" think of examples where their supervision had helped their staff member's home visiting (Time 1: intervention 85%, comparison 81%; Time 3: intervention 90%, comparison 75%).

♦ In contrast, about two-thirds of home visitors in both groups and at both time points could think of examples where supervision they received had helped their own home visiting practices (Time 1: intervention 68%, comparison 63%; Time 3: intervention 58%, comparison 64%).

Other opportunities for shared feedback

Many home visiting programs rely on group supervision or case conference meetings for shared learning and staff development. These forums encourage staff to reflect about their experiences and learn from others involved in the work. We asked program staff about the frequency and experience with group supervision or case conference meetings.

♦ At Time 3, the majority (72-90%) of supervisors and home visitors reported participating in monthly or weekly case conferences.

♦ At Time 3, 95% of supervisors in the intervention group reported sometimes or usually leading these supervision meetings compared with 50% of supervisors in the comparison group ($p < .01$). This was a change from Time 1 when similar numbers of intervention and comparison supervisors reported leading case conference meetings (70% intervention, 71% comparison). This was a significant change from Time 1 to Time 3 for intervention supervisors ($p < .05$).

Survey questions also asked home visitors whether their supervisors had conducted observations or joint home visits to provide them with feedback at least once or twice in the last 6 months.

♦ At both Time 1 and Time 3, home visitors in intervention programs reported that they were less likely to have had a joint home visit with their supervisor in the last 6 months than home visitors in comparison programs (Time 1: intervention, 60%, comparison 81%; Time 3: intervention 52%, comparison 69%, $p < .05$).

Reflective supervision and practice

The Program Practices Survey also included a variety of questions to enable us to better understand the extent to which program supervision incorporated reflective practices. Exhibit 45 provides supervisors and home visitors' perspectives about their experiences with supervision at both time points.

♦ Most supervisors reported that reflective supervision was "quite a bit" or "very much" a regular part of their practice (Time 1: intervention 89%, comparison. 86%; Time 3: intervention 95% intervention, comparison 92%). Time 1 to Time 3 differences for supervisors at intervention sites were significant at $p < .05$.

♦ Likewise, the majority of supervisors mostly or always used a reflective supervision approach during their supervision time (Time 1: intervention 82%, comparison 71%; Time 3: intervention, 80%, comparison 88%).

♦ Nearly all supervisors in both intervention and comparison groups also reported that their organizations "quite a bit" or "very much" supported use of reflective supervision.

Exhibit 45.   Supervisor Report on Extent of Reflective Supervision at Time 3
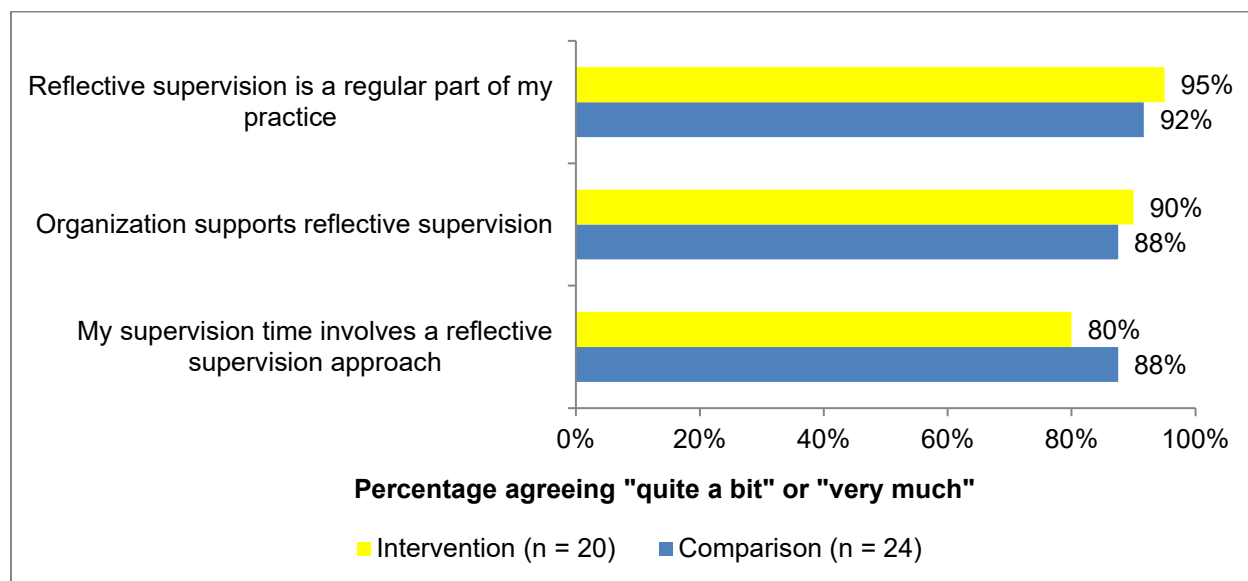
Percentage agreeing "quite a bit" or "very much"

	Intervention (n = 20)	Comparison (n = 24)
Reflective supervision is a regular part of my practice	95%	92%
Organization supports reflective supervision	90%	88%
My supervision time involves a reflective supervision approach	80%	88%

Source: Program Practices Survey, Spring 2017.

Note: No between-group differences reached statistical significance.

Supervisors also reported how familiar, knowledgeable, and comfortable they were with providing reflective supervision. The most notable difference between the two groups was in the training supervisors had received on reflective supervision.

♦   At Time 1, whereas about half of the intervention supervisors (52%) reported they had received training on reflective supervision, about three-fourths of comparison supervisors (75%) reported that they had received this training.

♦   At Time 3, the number of supervisors in the intervention group who reported that they had received training on reflective approaches had remained about the same (55%) while comparison supervisors were slightly less likely to have received training (67%)

♦   At Time 3, a smaller percentage of intervention supervisors reported feeling comfortable using reflective supervision (79%) than supervisors in the comparison group (96%); this finding reflects a small but statistically significant ($p < .1$) change over time. Slightly fewer intervention supervisors and slightly more comparison supervisors reported feeling comfortable with reflective supervision since Time 1 (intervention 89%, comparison 86%); although, the vast majority of supervisors in both groups report feeling comfortable.

♦   In addition, intervention supervisors were less likely to feel that they possess the skills and background to implement supervision with staff (Time 1: 74% intervention, 82% comparison; Time 3: intervention 65%, comparison 92%, $p < .05$)

Survey respondents also shared information about specific reflective practices observed in case conferences/group supervision meetings. In general, most staff in both groups agreed these reflective practices were occurring in group meetings. At Time 1 69% to 100% of supervisors "agreed" or "strongly agreed" that reflective practices were being implemented, compared to 72%

to 96% at Time 3. Among home visitors, 70% to 91% felt that reflective practices were used in their group meetings at Time 1 compared to 64-83% at Time 3.

Overall, staff seemed to be familiar with and aware of the importance of supervision being a regular and consistent aspect of any program delivering home visiting services and also that supervision should be delivered individually and in group settings, when appropriate, and by individuals well-trained and able to incorporate a reflective approach. Information provided about supervision was based on self-reported data that were obtained from the online Program Practices Surveys at Time 1 and Time 3; no outside observations were conducted to consider the extent of reflective practice that was occurring in programs.

Staff behaviors that contribute to client retention and dosage

Without conducting observations, it is hard to measure staff behaviors in the home as they work with families. We used items from the Home Visit Flags2 Scale (HV Flags2), developed by a team of researchers for use with home visitors. The statements from this scale reflect several best practices associated with home visiting work that, when implemented, help facilitate parent-child interactions, support positive parenting practices, and ultimately promote children's development and learning. Items describe presence or absence of parent-child engagement, focus on child development, involvement of additional family member(s), supporting parent understanding and follow-through, and emphasis on the parent's role as primary supporter of child's learning and development. The statements were conceptually derived from summaries of evidence on effective home visiting practices (e.g., Workgroup on Principles and Practices in Natural Environments & OSEP TA Community of Practice: Part C Setting, 2008). Prior research has found expected correlations between home visitor self-assessment on the HV Flags2 scale and observations of practices during actual home visits (Roggman, Cook, Boyce, & Innocenti, 2010). Exhibit 46 contains item-level findings for the positive statements about practice embedded in the HV Flags; we expected a high percentage of home visitors to respond that "many" or "most or all" visits are like each statement. Exhibit 48 contains data from the red flags items or negative practices within HV Flags2 (see Exhibit 49 for Time 1 data for comparison). If home visitors were implementing quality practices, then percentages on these negative flag items would be fairly low. Overall, home visitor responses were consistent with the expected direction, with fairly similar values across the intervention and comparison groups.

At Time 3, intervention home visitors were more likely than comparison home visitors to report that families and caregivers were doing more or new activities with their child because of the visits (56% intervention, 48% comparison). Between Time 1 and Time 3, home visitors at intervention programs were significantly more likely to report that parents say things like "we have been doing more activities like this because of the visits" (Time 1, 39%; Time 3, 56%, $p < .05$) (see Exhibit 47).

Exhibit 46.   Home Visitor Self-Assessment of Positive Practices in Home Visiting at Time 3

Percentage reporting "many" or "most" visits are like this

Item	Intervention (n = 81)	Comparison (n = 112)
During visit you comment on several parent-child interactions you observe that support child's development	99%	98%
Parent and child interact with each other during most of the visit time	91%	92%
Family tells you about things they have done together, talked about, or made together with child between visits	85%	80%
Child excitedly turns to the mother when you arrive, expecting something fun together	75%	78%
Parent tells you, "I really enjoy doing these activities with my child"	65%	67%
Parent says something like, "I feel more confident now about helping my child's development"**	65%	51%
Parent says something like, "we have been doing more activities like this because of the visits"	56%	48%
Additional family members are likely to be involved in the visit activities with the child	22%	22%

Source: Program Practices Survey, Spring 2017.

*p < .10; **p < .05; ***p < .01.

Exhibit 47.   Home Visitor Self-Assessment of Items on Home Visit about Positive Practices in Home Visiting at Time 1
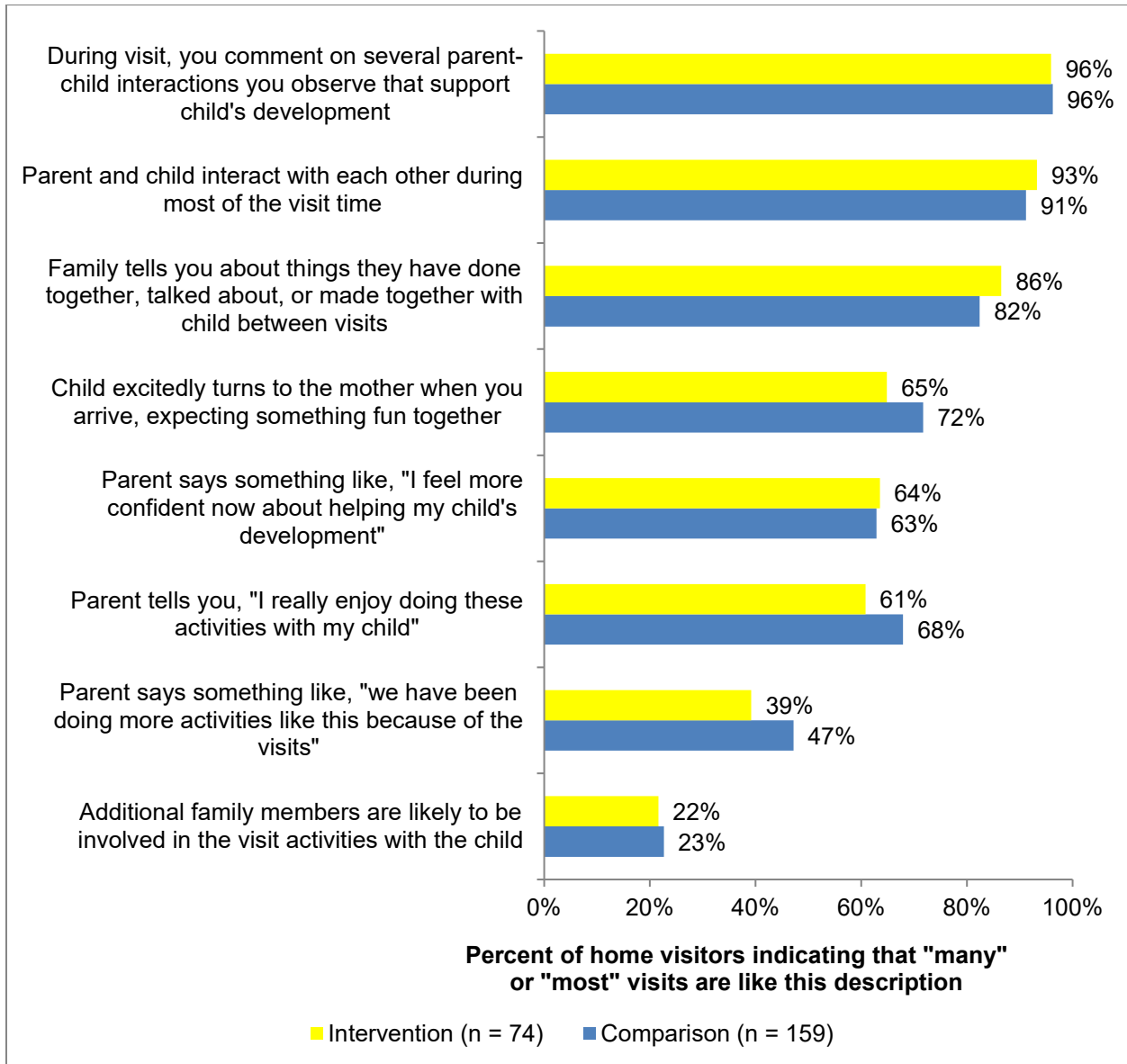
Source: Program Practices Survey, Fall 2014.

Below are the negative flag items that are negative practices that a program or supervisor might want to fewer home visitors endorsing as reflective of their home visits with families. In both the intervention and comparison groups, the negative flag items with the strongest endorsement had to do with statements that would be endorsed when a home visitor brings in external activities and works directly with a child during a visit rather than facilitating the parent's use of existing materials in the home to promote positive parent-child interactions and experiences.

Exhibit 48.   Home Visitor Self-Assessment of Negative Flag Items about Practices in Home Visiting at Time 3
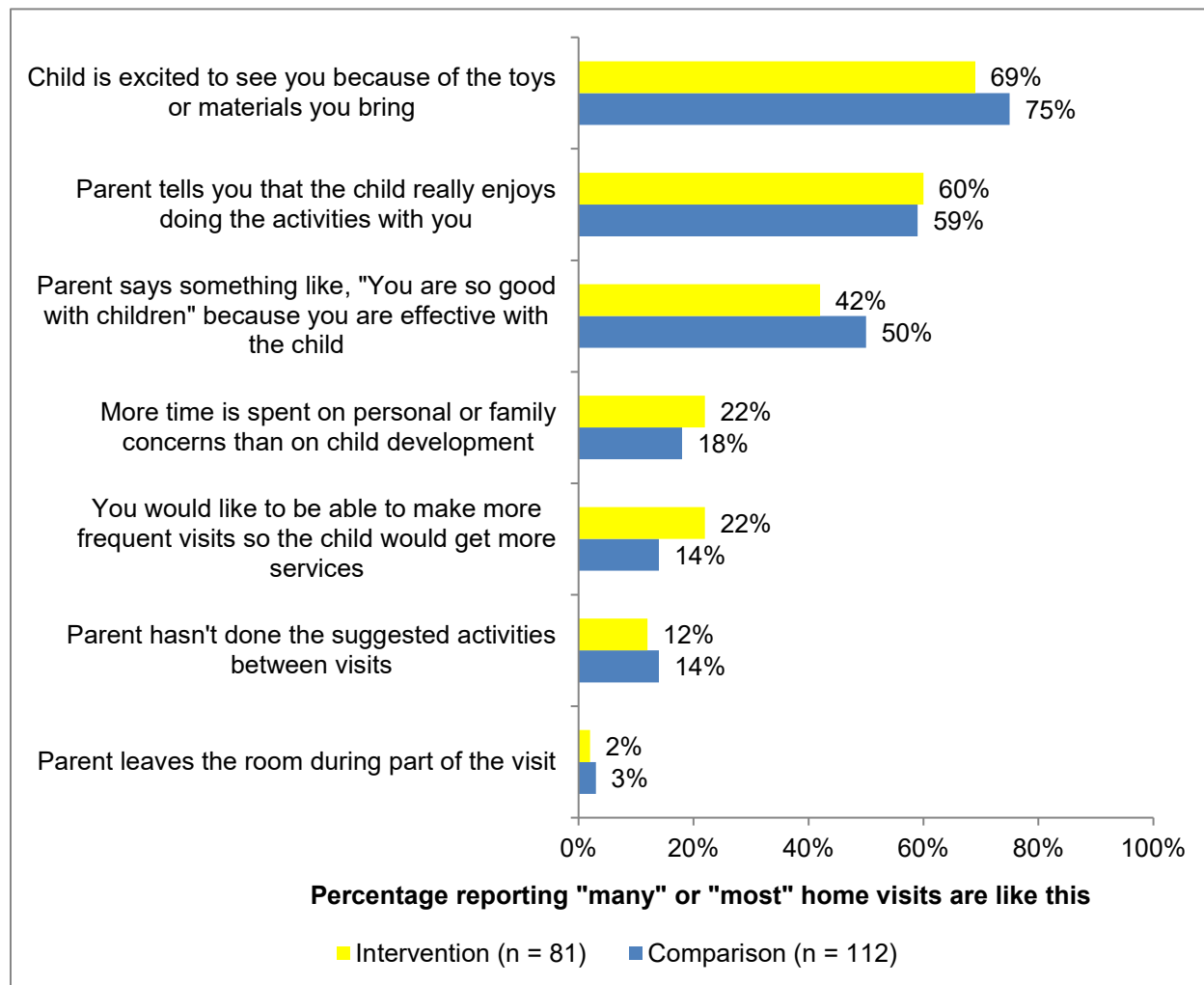
Source: Program Practices Survey, Spring 2017

Note: No between-group differences reached statistical significance.

Exhibit 49. **Home Visitor Self-Assessment of Negative Flag Items about Practices in Home Visiting at Time 1**
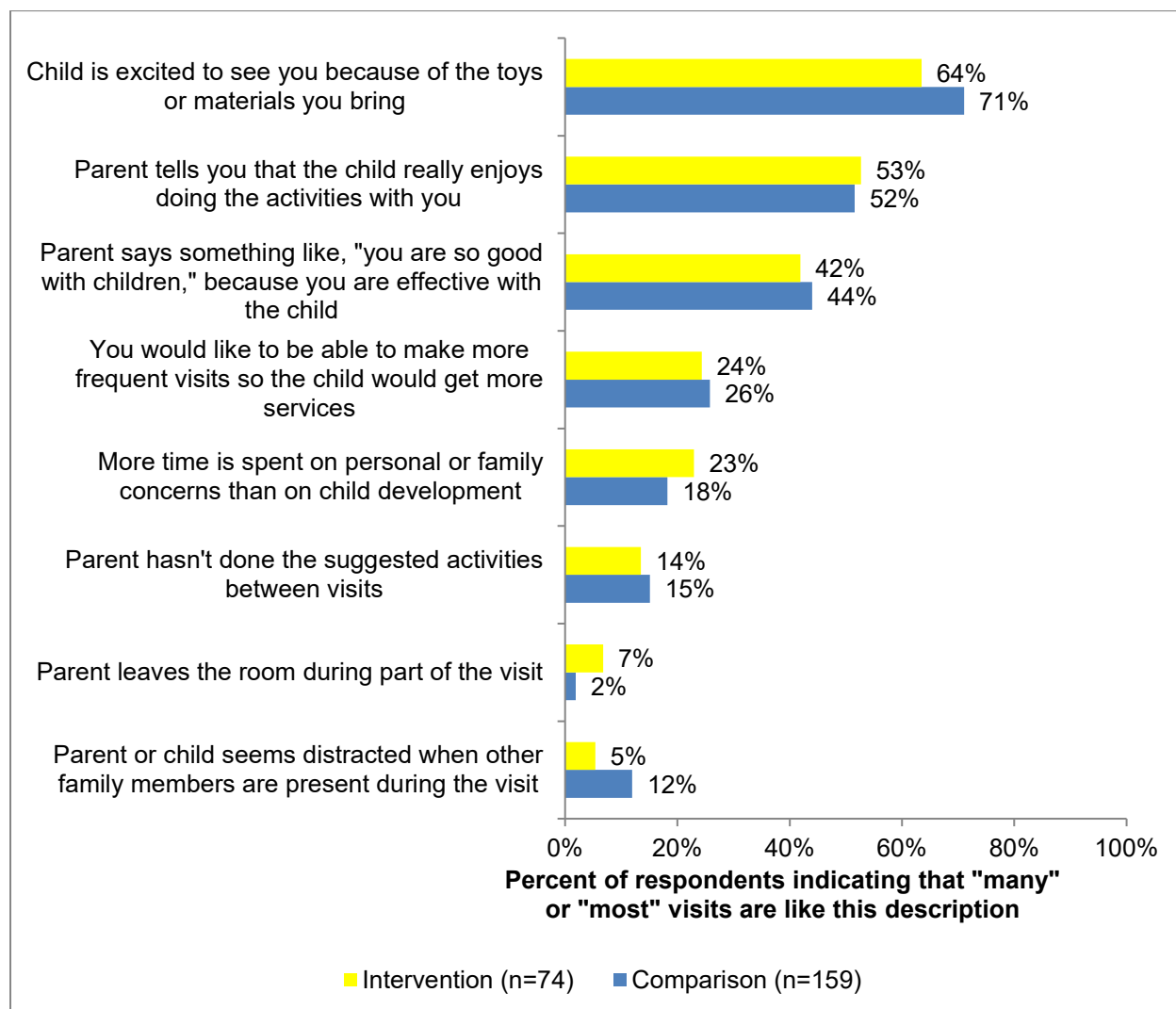
Source: Program Practices Survey, Fall 2014.

Supervisors also reported whether they rated most staff as implementing best practices. Nearly all supervisors (90% to 100%) in both intervention and comparison programs at Time 3 reported that many or all of their staff implemented these practices. However, fewer supervisors in both groups at both time points reported less staff actively participated in efforts to review data about the program and consider implications for program improvement, but this was still the majority of supervisors reporting that most staff participated in these activities (Time 1: 78% intervention, 79% comparison; Time 3: 72% intervention, 70% comparison). Additionally, both home visitors and supervisors felt comfortable implementing practices consistently with families at different stages or who have children of different ages, although relatively fewer staff reported comfort in working with older children (2 and 3 year olds) The same pattern was evident for both intervention and comparison groups and home visitors and supervisors.

Attitudes toward implementing evidence-based practices and data-based decision making

To promote the adoption of evidence-based practices, it is important to examine buy-in to key evidence-based principles.

♦ At both time points, most staff (ranging from 75% to 100%) endorsed the value of implementing evidence-based practices (e.g., facilitating parent's interactions with the child, coaching parents "in the moment," conducting assessments and monitoring progress) and believed it is important that their work be supported by research with slightly fewer at Time 3 endorsing the belief that the intervention be implemented in the same way as in the studies (Time 1: 90% intervention, 97% comparison; Time 3: 83% intervention, 75% comparison, $p < .10$).

♦ At Time 3, about 60% of both intervention and comparison staff agreed "quite a bit" or "very much" that clinical judgment or experience is more important than using a specific curriculum. These data indicate that some staff did have reservations about endorsing evidence-based practices only.[48]

Results regarding supervisor appraisal of staff use of assessments, participation in data reviews, knowledge of child development, and consistency in implementing the model when working with families were as follows.

♦ As reported above, nearly all of both intervention and comparison supervisors reported that many or all of their staff consistently implement best practices in assessing family and child strengths and needs and using the information to guide their work.

♦ 85% of intervention and 75% of comparison supervisors reported many or all of their staff actively participate in efforts to review data about the program and consider implications for program improvement (Time 1: 79% intervention, 78% comparison).

♦ Supervisors reported staff were comfortable implementing the model with different age groups, which also shows their confidence across the age groups.

♦ The majority of both intervention (96%) and comparison (92%) home visitors reported "quite a bit" or "very much" comfort in assessing family needs and strengths, which was in line with Time 1 results. See also the data presented earlier about assessments and progress monitoring.

Staff understanding of model requirements being implemented

At both time points, most if not all home visitors rated themselves high in understanding the goals of the model and how model requirements and activities relate to the goals of the model.

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[48] Neither NFP nor PAT would suggest that their models endorse using only a specific curriculum in practice. Both models provide core content that is evidence-based, but also emphasize the importance of home visitor knowledge and judgement to customize service delivery so that it is timed and tailored to best meet family needs and interests. Therefore, responses to this question may reflect a sense of the degree to which staff feel that the evidence-based content versus the clinical judgment is important.

Beliefs about the interventions efficacy and that home visiting makes a difference

In Exhibit 50, selected key items from the Early Interventionist Self-Efficacy Scale (EISES) are reported to describe how effective staff thought they were in implementing home visiting practices (Lamorey & Wilcox, 2005). Exhibit 51 shows self-efficacy findings from home visitors. Key findings were the following:

♦ In response to a global question, most home visitors in both conditions (Time 1: intervention 82%, comparison 86%; Time 2: intervention, 82%, comparison 84%) agreed or strongly agreed that throughout their time at the program, they had sufficient training to be able to implement the home visiting model effectively.

♦ Nearly all home visiting staff also felt comfortable and effective working with families.

♦ Between Time 1 and Time 3, significantly more home visitors reported that they knew how their specific home visiting activities related to the goals of NFP/PAT (Time 1, 89%; Time 3, 98%, $p < .05$)

Exhibit 50.   Home Visitor Self-Efficacy in Working with Families at Time 3
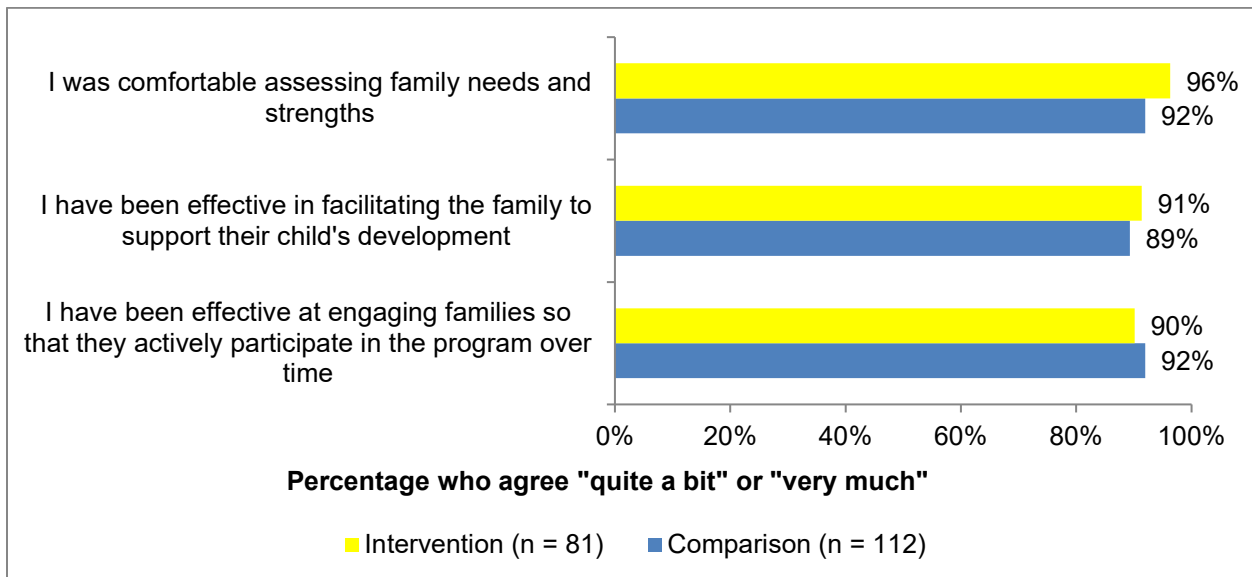
Source: Program Practices Survey, Spring 2017.

Note: No between-group differences reached statistical significance.

Exhibit 51.   Home Visitor Report of Self-Efficacy Implementing Best Practices at Time 3
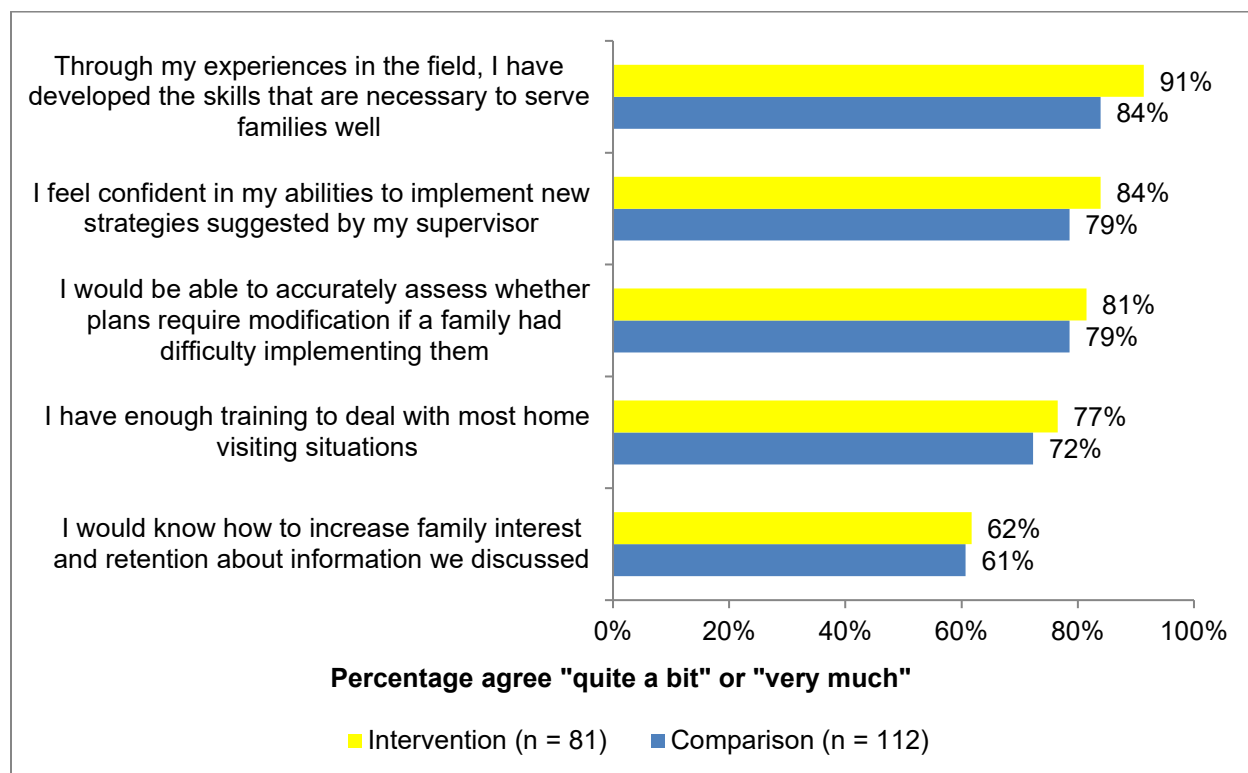
Source: Program Practices Survey, Spring 2017.

Note: No between-group differences reached statistical significance.

Outcome Evaluation Summary

The outcome evaluation examined whether the home visiting programs that received support from Washington State's centralized support system (Implementation HUB) differed compared with similar programs in other states on use of and satisfaction with training, TA, and coaching, model fidelity and implementation quality, and staff competency and self-efficacy. Using multiple methods in a longitudinal design, we compared findings from 18 programs in Washington receiving support from the HUB (intervention programs) with 32 programs in other states (comparison programs) to better understand more about TA and support experiences in these programs as well as consider how that relates to model fidelity, implementation quality, staff competency, and self-efficacy. Below we focus on impacts and trends from the beginning of the evaluation to the end of the evaluation (i.e., data collected on outcomes in late 2016 and early 2017).

Use and Satisfaction with Training, TA, and Coaching

Data showed that staff members across the states in the sample and in both groups were receiving TA throughout the project period. Intervention programs received much of their TA from the HUB at Thrive, including state model leads, whereas staff at comparison programs received TA from a broader range of **sources** (e.g., PAT and NFP NSOs, government agencies, and non-profit

organizations).[49] Interestingly, at Time 3, data showed a reduction in TA from state model leads and a corresponding increase in TA from the NSOs and government agencies. Supervisors and administrators from intervention programs were much more likely than similar staff from comparison programs to report having support from someone in their state/region that minimized their need for NSO TA or helped them coordinate with the NSO for TA.

Data for intervention programs between Time 1 and Time 3 also showed increases in the **amount of TA** received although not significant (from 3.5 to 3.8 hours on average). However, the average number of TA hours decreased for comparison group staff (from 5.8 to 4.5 hours) which was a statistically significant decrease. Thus, comparison staff continued to receive more TA on average but the difference between the two groups narrowed. At both time points and across both groups, supervisors received more TA per month than home visitors. This increase in TA and support over time is consistent with a developing organization that is enhancing staff capacity and establishing and gradually systematizing its approach to TA support.[50]

Data for intervention programs between Time 1 and Time 3 also showed increases in the extent to which staff described TA and support as having specific positive **characteristics.** Only about one-third of staff in both the intervention and comparison groups described the TA they received as relationship-based or tailored to their individual needs. However, the percentage of staff in intervention programs who endorsed their TA as "mostly" or "always" relationship-based did increase about 5% between Time 1 and Time 3 while staff responses from comparison programs dropped about the same percentage on this item.

Supervisors/administrators at both intervention and comparison programs reported actively engaging in **CQI** within their programs; a majority of respondents agreed "quite a bit" or "very much" with statements describing involvement in various types of CQI activities. At Time 3, respondents from comparison programs had about the same endorsement about the presence of each of the CQI activities than intervention program staff with the exception of being able to "think of an example of CQI process" which 88% of intervention staff endorsed compared with 76% of the comparison staff. However, respondents at intervention programs, compared to Time 1, showed increases in the extent to which they were involving people at multiple levels in the CQI process and could think of an example.

In terms of **content** of TA, building home visitor and supervisor competencies and meeting model requirements were key topics for TA at both Time 1 and Time 2 and in both groups. Over the same time period, supervisors at intervention programs participated in more TA focused on building home visitor competencies and had somewhat less TA about model requirements, improving

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[49] The exception was that intervention PAT programs began to use more TA from the NSO after the state model lead that was part of the HUB at Time 1 was reclassified as a regional TA provider for the NSO beginning July 1, 2015.

[50] Much information has been gathered about how the centralized system of support in Washington changed over the course of the project. Comparison programs were selected from states that had no known centralized system of TA support. However, little is known about the level of TA available to comparison programs or the extent to which it is provided by individuals and organizations still developing their TA and support approaches or those who have established longstanding experience. It also remains unknown whether and how the availability of MIECHV funding in other states resulted in changes in their training and TA efforts after the outset of the evaluation.

supervisor staff competencies, and program administration. Interestingly, there was an increased focus on contract requirements for intervention supervisors from Time 1 to Time 3. This was also true for comparison program supervisors. For home visitors in the intervention group, there was a decreased focus on program administration and connections/referrals from Time 1 to Time 3.

Information about the use of and satisfaction with training, TA, coaching and supports was drawn from TA logs and the Program Practices Survey. Together, the findings provide a picture of the kinds of supports that program staff in intervention and comparison programs received and how they characterized them. The increase in TA from Time 1 to Time 3 for intervention staff is consistent with receiving TA and support from a developing organization that is establishing and gradually systematizing its approach to TA support. The change over time for the intervention group is notable because the average amount of TA for comparison staff decreased over time. This also meant that, over time, the gap between the amount of TA received by intervention and comparison groups narrowed, although comparison program staff still received more average hours and TA events per month than intervention staff, even at Time 3.

These data reflect information about many different kinds of TA from all sources. Washington programs provided information about all of the TA they received, not just that which was provided by, or coordinated through, the HUB. Indeed, about half the TA and support that programs in Washington received was identified as having HUB staff, including those from Thrive or state model leads, as a primary source of the TA and support. It is possible that some of the remaining TA identified by intervention program staff also was coordinated through the HUB, but program staff did not recognize it as a HUB activity on the TA log. Comparison programs did not have any one source that provided so much TA, but rather they received a larger proportion of their TA from a range of sources.

Model Fidelity and Implementation Quality

The evaluation also considered model fidelity and implementation quality in both intervention and comparison groups. Data suggest that at least on the selected indicators, most programs in both groups are meeting the targets set forth by NFP and PAT. While there are some limitations in interpretation given the ways in which NSOs gathered these data and in how much we know about the stage of the family being visited, these data are consistent with common challenges observed in maximizing participation from families in home visiting programs.

Many programs were accomplishing these model fidelity and implementation quality indicators at a fairly high level in both intervention and comparison programs. Interestingly, enrollment and engagement (which also influences caseloads) is one area where there is continued room for growth; these areas also have been a focus for the HUB, as well as in many other states where MIECHV concerns are influencing practice. For example, the percentage of programs meeting the participation goal changed to 0 from 17% for intervention programs at Time 1 (and 3% for comparison programs at Time 1).

Export data from the NSOs generally showed fairly high fidelity of program implementation and implementation quality at both Time 1 and Time 3. Each variable had limitations, but within the constraints for each variable, the data were generally positive for both intervention and comparison programs.

♦ Data from both intervention and comparison NFP programs showed that about 60% of expected visits were completed, although the NFP data were not broken out by phase of family which would have provided more precise estimates of whether the programs were meeting targeted NFP visit frequency goals. The PAT export data were limited because they did not provide visit frequency at the individual client level by program. However, PAT programs were less likely to meet their visit targets for families with high-needs at Time 3 compared to Time 1 (for both intervention and comparison programs). For example, 83% of PAT intervention programs met this goal at Time 1 but only 70% did at Time 3.

♦ The findings about home visitor caseloads were consistent across both the export data and the Program Practices Survey data in that many programs had staff caseloads slightly below the target levels. In particular, based on NSO export data, there was a large decrease in the percentage of NFP programs meeting their caseload for families at Time 3. Overall, both intervention and comparison programs showed decreases in their ability to meet client caseload fidelity indicators at Time 3.

♦ Most programs met the fidelity or suggested guidelines for team meetings and case conferences, and most met the guidelines for staff qualifications and export data showed increases in programs ability to meet these criteria.

♦ Program staff turnover was approximately one-third in both groups. That is, about two-thirds of staff from Time 1 were still employed in the programs at Time 3. However, across programs, turnover ranged from 0% to 69%; programs with higher levels of staff turnover may face challenges in improving practices that influence implementation quality and model fidelity.

♦ Overall, both the Home Visiting Snapshot form and Program Practices Survey data showed that home visitors were conducting assessments both formally and informally of the child and family and that information from assessments was used to guide future visits and activities/topics with clients.

  o Nearly two-thirds of both intervention and comparison home visits involved some assessment, and the majority of home visitors in both groups reported using the data to plan visits. Home visits in intervention programs were significantly more likely to include formal assessments than home visits in comparison programs.

♦ Although the majority of respondents on the survey reported receiving and making referrals, data from the Home Visiting Snapshot form painted a slightly different picture, with intervention home visits involving more new referrals and more follow-up on existing referrals than comparison home visits. The majority of referrals were for mental health and substance abuse services, followed by education and employment services.

♦ On average, home visitors prepared quite a bit for their home visits, and most often planned visits by using content suggested by the NFP/PAT model.

♦ Home visitors from intervention programs discussed an average of 2.5 major topics each visit, which was slightly less than the 3.0 major topics reported on average by home visitors at comparison programs. Parent-child interaction was the most frequently discussed topic.

♦ In both intervention and comparison groups, home visitors rated their relationships with clients as average or better. A very small percentage rated their relationships as difficult.

These findings are consistent with levels of model fidelity and implementation quality that might be expected by programs who have access to TA and support that can help them implement evidence-based practices with quality and according to the expectations, guidelines, or requirements established by the home visiting model.

Staff Competency and Self-Efficacy

With regard to staff competency and self-efficacy, we found that staff report confidence and comfort implementing evidence-based practices. Data about staff competency and self-efficacy suggest staff in both programs have a high level of self-efficacy about their work and there is evidence that they are supportive of and implementing evidence based practices. Most programs also provide staff with support through team meetings, case conferences, and reflective supervision.

Staff in both programs also participated in TA support to further their work. The relatively few stand-out differences between intervention and comparison programs is not surprising given the relatively short duration of the study and the need for time to both build capacity in supervisors and then have them establish activities and systems with their staff to enhance the ongoing practice among home visitors. However, in a number of places, data show positive changes between Time 1 and Time 3 that suggest ongoing practice improvements. Some of these changes over time are stronger within the intervention group, which could mean that the Implementation HUB has built the capacity across the 4 years of implementation.

Findings regarding staff competency and self-efficacy in intervention and comparison programs suggested that:

♦ Most staff reported appropriate evidence-based home visiting practices that are supported by knowledgeable supervisors, engage families and children, and include reflective practice as part of their work with other practitioners and with families.

♦ Not all of the change from Time 1 to Time 3 was in the positive direction.

  o At Time 3, home visitors in the intervention group were slightly less likely to report scheduled and actual supervision with one in ten home visitors not reporting regular supervision.

  o At Time 3, reported quality of supervision remained fairly stable with the percentages of home visitors endorsing positive, high-quality supervision ranging around 60 to 84%.

  o Compared with supervisors in comparison programs, intervention program supervisors were more likely to report mostly or always using a reflective practice approach to supervision and this increased significantly from 89% at Time 1 to 95% at Time 3.

  o Although supervisors in intervention programs were reportedly implementing reflective practice, there was an increase in the percentage of intervention supervisors that indicated they felt knowledgeable about, had received training on, or possessed the skills and background to implement reflective supervision than supervisors in the comparison group.

♦ Generally, data about both positive and negative home visit practices tapped in the HV Flags2 yielded data in the expected directions for the intervention and the comparison groups. Data did not shift much between Time 1 and Time 3 for either group. Responses

suggested that additional TA support in both groups might focus on bolstering involvement of additional family members in visits, engaging the parent in extending or continuing activities with their child between visits, and shifting engagement of the child and visit activities away from an activity that the home visitor engages in with the child and toward a caregiver-child activity. Intervention home visitors were more likely to report families engaging in new activities because of the home visits between Time 1 and Time 3.

♦ Across a variety of quality home visiting practices, 90 to 100% of supervisors/ administrators in both intervention and comparison programs felt that "many" or "all or nearly all" of the staff were implementing these practices. Examples of these quality practices include the following: coaching parents on interactions in the moment; establishing relationships and keeping families engaged; addressing family concerns in curriculum; and being aware of how their own emotional response to situations might influence interactions (see Appendix G).

♦ Nearly all of both intervention and comparison supervisors reported that many or all of their staff consistently implement best practices in assessing family and child strengths and needs and using the information to guide their work. Nearly all home visitors affirmed that they are comfortable conducting these assessments.

♦ At both time points, most staff (ranging from 78% to 95%) endorsed the value of implementing evidence-based practices (e.g., facilitating parent's interactions with the child, coaching parents "in the moment," conducting assessments and monitoring progress) and believed it is important that their work be supported by research. Slightly fewer staff believed the interventions should be implemented in the same way as in the studies at Time 3 compared to Time 1 although intervention staff were more likely to endorse this statement than comparison staff at Time 3. At Time 3, more intervention and comparison staff agreed "quite a bit" or "very much" that clinical judgment or experience is more important than using a specific curriculum compared to Time 1. These data indicate that over time there were increases in endorsement of evidence-based practices.

♦ At both time points, most, if not all, home visitors highly rated their own understanding the goals of the model and how model requirements and activities relate to the goals of the model.

♦ In response to a global question, most home visitors in both conditions (Time 1: intervention 82%, comparison 86%; Time 3: intervention, 82%, comparison 84%) agreed or strongly agreed that throughout their time at the program, they had sufficient training to be able to implement the home visiting model effectively.

♦ Nearly all home visitors in both groups reported feeling efficacious about their work agreeing "quite a bit" or "very much" that they have been effective at facilitating parents to support their child's development and also effective at engaging families so that they actively participate in the program over time. Interestingly, home visitors were more likely to report that they understood how their specific home visiting practices related to the goals of the NFP/PAT models.

Exploratory Analyses

During the course of the evaluation, several additional ad hoc exploratory analyses of interest to DEL and Thrive were identified. In this section we describe the research question, expectation or hypothesis, analysis and findings for each exploratory analysis conducted. Note that these analyses were conducted only on Washington programs, and do not include the comparison group.

Leadership and Facilitative Administration

Implementation Science identifies several implementation drivers that are critical to successful implementation: competency driers (selection, training and coaching), leadership drivers (technical and adaptive leadership), and organization drivers (systems intervention, facilitative administration, decision support data system).[51] Variation in the extent to which these drivers are in place is therefore expected to impact differences in the quality of implementation and desired outcomes. Through the process of reviewing the RISE evaluation findings, other state and MIECHV reporting data, and implementing the HUB, the impact of differences in leadership and facilitative administration were identified as being of particular interest and relevance for further investigation for the Washington intervention sites. Specifically, we sought to better understand the following question: how are the implementation drivers of leadership, general facilitative administration, and data driven facilitation associated with key outcomes relating to training, TA, coaching, and support; quality implementation and model fidelity; and staff competency and self-efficacy.

To examine this question, we first identified all potential program practices survey items that home visitors responded to related to their program, leadership and administrators or supervisors may a priori, conceptually, relate to leadership or facilitative administration conceptually and practically. We then conducted an exploratory factor analysis on the survey items to identify the underlying constructs. The factor analysis was conducted using both principal components and varimax rotation methods. Principal components rotation allows for overlap or correlation between factors while varimax rotation does not allow for overlap or correlation between factors. A four-factor solution was the best fit for the data (eigen values > 1) and the varimax, orthogonal rotation was utilized to reduce overlap across factors for interpretive clarity so that each factor would be distinct from the other. Although four factors were initially produced, only three of the factors had adequate coherence using Cronbach's alpha. Thus, three factors were retained for analysis: (1) an overall leadership factor (α = .92), (2) a data driven facilitative administration factor (α = .88), and (3) a general facilitative administration factor (α = .63). Exhibit 52 below provides the loading screen and alpha for each factor. A composite, standardized variable was created for each of the three factors. Bivariate correlations were then run with the key indicators of each outcome construct (see Exhibits 53–55).

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[51] See the National Implementation Research Network (NIRN) website for more details: http://nirn.fpg.unc.edu/learn-implementation/implementation-drivers

Exhibit 52.   Item Loading for Each Factor

Program Practices Survey Item	Leadership (α = .92)	Data Driven Facilitative Administration (α = .88)	General Facilitative Administration (α = .63)
Administrators and supervisors have continually looked for ways to align program policies and procedures with the overall mission, values, and philosophy of the [NFP/PAT] program.	.72		
Administrators and supervisors have been very good at focusing our time on making changes to things that really matter at the home visitor level.	.83		
Administrators and supervisors have been fair, respectful, considerate, and inclusive in dealings with others.	.80		
Administrators and supervisors have established clear and frequent communication channels to provide information to home visitors and to hear about their successes and concerns.	.79		
Administrators and supervisors have been very good at giving reasons for changes in policies, procedures, or staffing.	.85		
Administrators and supervisors have actively and routinely sought feedback from home visitors and others about what is needed to help implement the [NFP/PAT] model effectively.	.82		
Our program has reviewed data at least monthly to see how we are performing.		.84	
Our program has used data to identify areas for improvement.		.90	
I can think of at least one example of when our program made a change in policies, procedures, or activities in response to or after reviewing data.		.74	
Our program has involved people at multiple levels to review data and consider how it might inform changes in practices or program decisions (e.g., home visitors, supervisors and administrators review data).		.77	
In the last 6 months, administrative policies and procedures have made it difficult to implement my home visiting role effectively.			-.59
In the last 6 months, administrators have made efforts to change or improve existing policies and procedures in response to identified staff concerns.			.73
In the last 6 months, administrators have shown interest in learning new things that might help them improve the program.			.61
Administrators are knowledgeable about the [NFP/PAT] program model and our home visiting activities.			.50

Exhibit 53.   Leadership and Facilitative Administration Correlated with Training, TA, Coaching and Support Outcome Indicators

Outcome Evaluation Construct	Data Source	Factor A: Leadership (α = .92)	Factor B: Data Driven Facilitative Admin (α = .88)	Factor C: General Facilitative Admin (α = .63)
Overarching: Training, TA, Coaching, and Support		Correlation coefficient (*r*) N	Correlation coefficient (*r*) N	Correlation coefficient (*r*) N
Amount of training, TA and coaching				
Average number of TA hours received by home visitors per month (note: this is program level variable)	TA Log	-0.05 197	-0.10 197	-0.15* 134
Changes made as a result of CQI activities				
Our program has reviewed data at least monthly to see how we are performing.	Survey	0.16** 163	0.29*** 163	0.23** 112
Our program has used data to identify areas for improvement.	Survey	0.11 163	0.26*** 163	0.05 112
I can think of at least one example of when our program made a change in policies, procedures, or activities in response to or after reviewing data.	Survey	0.21*** 163	0.30*** 163	0.14 112
Our program has involved people at multiple levels to review data and consider how it might inform changes in practices or program decisions	Survey	0.20*** 163	0.38*** 163	0.21** 112

Note: Significant correlations are shaded. The strength of the correlation is indicated by the degree of the shading.

*$p < .10$; **$p < .05$; ***$p < .01$.

Exhibit 54. Leadership and Facilitative Administration Correlated with Quality Implementation and Model Fidelity Outcome Indicators

Outcome Evaluation Construct	Data Source	Factor A: Leadership (α = .92)	Factor B: Data Driven Facilitative Admin (α = .88)	Factor C: General Facilitative Admin (α = .63)
Overarching: Quality Implementation and Model Fidelity		Correlation coefficient (*r*) N	Correlation coefficient (*r*) N	Correlation coefficient (*r*) N
Frequency of visits to clients				
Percent of expected visits completed (NFP only) (note: this is program level variable)	Data export	0.11 119	0.16* 119	-0.01 89
Required visits completed with clients with 1 or fewer needs (PAT only) (note: this is program level variable)	Data export	-0.09 146	-0.19** 146	-0.04 97
Required visits completed with clients with 2 or more needs (PAT only) (note: this is program level variable)	Data export	-0.06 159	0.06 159	-0.14 106
Duration of client participation				
Duration of client participation (met duration of client participation fidelity; note: this is program level variable)	Data export	-0.13** 278	-0.03 278	-0.22*** 195
Caseload size				
Caseload size	Survey	0.05 115	0.21** 115	0.14 107
Staff meetings and/or cross-team meeting				
How often have you participated in meetings with other home visitors where the group discussed specific cases and jointly considered strategies for working with the children/families?	Survey	0.15 101	0.22** 101	0.02 101
Staff qualifications				
Meeting expected staff qualifications criteria (note: this is program level variable)	Data export	0.07 278	-0.03 278	0.12* 195
Presence of clear, systematic approach for training new staff				
Presence of clear, systematic approach for training new staff	Survey	0.31** 60	0.30** 60	0.58* 11

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Outcome Evaluation Construct	Data Source	Factor A: Leadership (α = .92)	Factor B: Data Driven Facilitative Admin (α = .88)	Factor C: General Facilitative Admin (α = .63)
Staff turnover				
Staff turnover (note: this is program level variable)	Computed from survey	-0.04 271	-0.01 271	0.01 89
Content coverage during home visits				
Percent of visits that included modeling or demonstrating interaction with child	HV Snapshot	0.14 116	-0.10 116	-0.19** 107
Percent of visits that included observing caregiver-child interactions	HV Snapshot	-0.08 116	-0.09 116	-0.05 107
Percent of visits that included sharing feedback on/evaluating caregiver-child interactions	HV Snapshot	-0.01 116	-0.05 116	-0.11 107
Percent of visits that included addressing immediate need or crisis intervention	HV Snapshot	0.00 116	0.08 116	-0.02 107
Percent of visits that included providing emotional support to caregiver	HV Snapshot	0.02 116	0.00 116	-0.02 107
Percent of visits that included problem solving	HV Snapshot	0.02 116	0.11 116	-0.15 107
Provider-participant relationship quality				
How would you characterize the quality of your relationship with this parent	HV Snapshot	0.06 116	0.10 116	-0.01 107
How would you characterize the quality of this home visit with the family	HV Snapshot	0.05 116	0.11 116	0.03 107
Consistently assess family strengths and needs				
Percent of visits that included setting, modifying or reviewing/discussing goals	HV Snapshot	0.05 116	0.11 116	-0.02 107
Use of progress monitoring and assessment				
Percent of visits that included formal or informal observation or assessment of child and/or primary caregiver	HV Snapshot	0.04 116	-0.05 116	-0.15 107
Referrals to expand program's outreach and effectiveness				
Number of agencies referred to during visits	HV Snapshot	-0.06 116	0.23** 116	-0.18* 107

Note: Significant correlations are shaded. The strength of the correlation is indicated by the degree of the shading.

*p < .10; **p < .05; ***p < .01.

Exhibit 55.   **Leadership and Facilitative Administration Factors Correlated with Staff Competency and Self-Efficacy Outcome Indicators**

Outcome Evaluation Construct	Data Source	Factor A: Leadership (α = .92)	Factor B: Data Driven Facilitative Admin (α = .88)	Factor C: General Facilitative Admin (α = .63)
Overarching: Staff Competency and Self-Efficacy		Correlation coefficient (*r*) N	Correlation coefficient (*r*) N	Correlation coefficient (*r*) N
Consistent, high-quality reflective supervision				
How often have you had a scheduled time to meet with your supervisor individually?	Survey	0.07 101	-0.02 101	0.19** 101
How often has your supervisor actually met with you individually?	Survey	0.14 101	0.02 101	0.20** 101
I can think of examples of how my home visiting has improved as a result of supervision I received in the last 6 months.	Survey	0.34*** 101	0.23** 101	0.20** 101
Staff behaviors that contribute to client retention and dosage (HV Flags)				
Child excitedly turns to the mother when you arrive, expecting something fun together.	Survey	0.20** 102	0.15 102	0.00 102
Child is excited to see you because of the toys or materials you bring. (Reverse coded)	Survey	0.10 102	0.00 102	0.06 102
Comfort collecting data/conducting screening and positive attitudes toward implementing evidence-based practices				
I was comfortable assessing family needs and strengths	Survey	0.27** 102	0.19* 102	0.06 102
Based on experience, it has been important to deliver the [NFP/PAT] intervention in the same way as it was done in studies that found it to be effective.	Survey	0.29*** 165	0.18** 165	0.22** 113
Based on experience, it has been important to know that our home visiting practices are supported by research that shows they are effective.	Survey	0.14* 165	0.05 165	0.16* 113
Based on experience, clinical judgment or my experience has been more important than using a specific curriculum in work with families. (Reverse coded)	Survey	-0.08 165	-0.02 165	-0.05 113

Outcome Evaluation Construct	Data Source	Factor A: Leadership (α = .92)	Factor B: Data Driven Facilitative Admin (α = .88)	Factor C: General Facilitative Admin (α = .63)
Staff understanding of model requirements being implemented				
I was comfortable explaining the goals of the [NFP/PAT] model to families and others.	Survey	0.27*** 102	0.24** 102	0.21** 102
I knew how my specific home visiting activities related to the [NFP/PAT] program goals.	Survey	0.28** 102	0.11 102	0.17* 102
Beliefs about self-efficacy and that the home visiting makes a difference				
Throughout my time at this program, I have had sufficient training about my role as a home visitor to be able to implement the [NFP/PAT] program effectively.	Survey	0.30*** 102	0.15 102	0.04 102
I have been effective at engaging families so that they actively participate in the program over time.	Survey	0.35*** 102	0.21** 102	0.07 102
I have been effective in facilitating the family to support their child's development.	Survey	0.36*** 102	0.30*** 102	0.12 102

Note: Significant correlations are shaded. The strength of the correlation is indicated by the degree of the shading.

*$p < .10$; **p < .05; ***$p < .01$.

A number of significant findings suggests that leadership, data driven facilitation, and general facilitative administration are related to key outcomes in a breadth of areas.

♦ There are a number of positive and highly significant correlations relating to programs' abilities to make changes based on CQI. In particular, there is a consistent positive pattern among programs with higher rates of data driven facilitative administration and their ability to conduct CQI activities, as would be expected (Exhibit 53).

♦ There is a significant negative correlation between the duration of client participation and the factors of leadership ($p < .05$) and general facilitative administration ($p < .01$). Programs stronger on these factors may be able to stabilize families more quickly or serve their needs more efficiently, there by moving them through the program more quickly (Exhibit 54).

♦ All three factors are significantly and positively correlated with the presence of clear and systematic approaches for training new staff (leadership, $p < .05$; data driven facilitative administration, $p < .05$; general facilitative administration, $p < .10$) (Exhibit 54). Program supervisors and administrators are the staff responsible for establishing these practices, and programs that are higher on each factor are likely better equipped to generate and maintain these practices.

♦ Several items relating home visitors' comfort collecting data and attitudes on implementing evidence based practices are significantly positively correlated with the three factors (Exhibit 54). Program supervisors and administrators at programs with more effective leadership and administration may facilitate home visitors' buy in to concepts about collecting and using data, and the value of evidence based practices.

♦ There are a positive, significant correlations for items relating to home visitors' understanding of model requirements; more effective supervisors and administrators may be better able to communicate the goals of home visiting program and share concrete data pointing to its positive effects (Exhibit 55).

♦ Similarly, there are positive, significant correlations on home visitors' beliefs about their self-efficacy (Exhibit 55). Data driven programs with quality leadership and facilitative administration may be able to clearly demonstrate how home visiting makes a difference in the lives of families served, and may increase home visitors' feelings that they are competent and confident in their work.

These results provide preliminary evidence for a robust relationship between leadership and facilitative administration and program-level outcomes.

Additional Exploratory Analyses

Staff Turnover and Geography

In addition to the analyses of leadership and facilitative administration, the RISE evaluation team also conducted additional analyses of interest. One analysis compared the staff turnover rates in the past year at programs serving rural communities to those at programs serving non-rural communities. We expected that because rural programs often face a more challenging implementation context (e.g., traveling long distances between visits, less access to qualified staff), rural programs would have higher turnover rates than non-rural programs. A t-test was conducted comparing the two groups and, as expected, revealed that rural programs had higher turnover rates, with programs losing an average of 31% of their staff, compared to 24% at non-rural programs ($p < .05$).

Home visitors' Supervision Satisfaction and Home Visits

In order to explore the potential relationship between perceived supervision satisfaction and actions undertaken during home visits, the evaluation team linked home visitor level responses from the program practices survey to data gathered on the snapshot form. A correlation was run between selected items on the snapshot and an item from the survey that asked home visitors to reflect on their satisfaction with supervision sessions.

♦ There was no significant relationship between home visitors' satisfaction with supervision and the quality of their relationship with families.

♦ The snapshot form allowed home visitors to indicate which topics they discussed with families during home visits. Home visitors could select from a list of 18 topics relating to parental role (e.g., physical care of child), parental health, environment and home (e.g., domestic violence and safety planning), services and supports, and child health and

development. These were exploratory analyses, and as such, we did not have specific expectations for what topics discussed on home visits may be associated with home visitor satisfaction with supervision.

- ♦ A correlation with home visitor supervision satisfaction revealed four significant relationships:
  - ○ Home visitors who reported higher satisfaction with supervision were more likely to discuss the physical care of children ($p < .10$), and reproductive health and pregnancy ($p < .05$) topics during home visits.
  - ○ Home visitors who reported higher satisfaction with supervision were less likely to discuss parent-child interaction ($p < .05$), and child care ($p < .05$) topics during home visits.

Home visitors generally discussed multiple topics during their home visits (Time 3 M = 2.5 topics/visit) in addition to other activities conducted with the family during the visit (e.g., referrals, assessments). The negative association found between satisfaction with supervision and discussion of parent-child interaction is challenging to interpret, but it may be that home visitors who were more satisfied with their supervision were more likely to work with higher-risk families or those that required more emphasis on safety and stabilizing the family.

Rural Substudy

The **rural substudy** answered the primary research question: *What are the unique features of implementing evidence-based home visiting in rural communities?* It addressed this question from the perspectives of program staff with additional contextual information gathered from HUB and state staff. Data were collected through semistructured interviews, focus groups, and through disaggregating the outcome evaluation data by rural and non-rural programs. The methods and findings from the rural case study and outcome rural analysis are described below.

Rural Case Study

Purpose

In 2012, Washington was awarded competitive MIECHV grant funding to expand the implementation of evidence-based home visiting (EBHV) in the state. One priority of Washington's grant application was rural development, with the goal of building the home visiting system's capacity to reach rural and frontier areas of the state. Given this, funds were used both to expand existing EBHV programs already serving rural communities (hereafter referred to as expansion programs), as well as to start up new programs in areas that did not have EBHV (hereafter referred to as start-up programs).

The purpose of this rural case study section is to describe programs' experiences implementing EBHV within their rural communities, including their experiences expanding or starting up services using MIECHV funds, perceived successes and challenges of implementation, and receipt of implementation supports from Thrive Washington and other entities. The Implementation HUB at Thrive played an integral role in disbursing funds and providing various implementation supports to EBHV programs, including facilitating two rounds of a community planning process, described in more detail below.

Community Planning Process

To help meet the rural development goals of the grant, HUB staff at Thrive (with assistance from consultants) undertook a community planning process designed to build capacity in rural communities for starting up and successfully sustaining new EBHV programs.[52] In late 2012, staff used the state needs assessment and conversations with state-level key informants to identify five rural communities to invite to participate in the planning process. Staff then traveled to each community to facilitate multiple meetings (three, on average) among various stakeholders in order to help community members assess their resources, needs, and readiness to implement EBHV.

HUB staff's facilitation of the process entailed identifying key stakeholders, convening the meetings, sharing funding guidelines, presenting information about the PAT and NFP models through national representatives or the state leads, and preparing the stakeholders to select a model and endorse a lead implementing agency. This first round of meetings was considered "Phase I" of the community planning process and lasted approximately 6–7 months. Four of the five communities completed

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[52] Additional information and resources about the community planning process including a fact sheet, theory of action, lessons learned brief and continuum of strength and preparedness can be accessed at https://thrivewa.org/work/expanding-hv/

Phase I and submitted applications for the funding. Based on their readiness for implementation, three of the four applicants were then awarded funding.

"Phase II" of the community planning process for awardees then consisted of another series of three meetings. First, HUB and implementing agency staff jointly conducted a Parent Café where they convened community parents to inform how the agency would implement the EBHV program, and began identifying the client population. The agency then participated in a joint TA meeting with HUB staff and the state model lead to discuss their capacity assessment and draft an affiliate plan; all three funded communities chose to use the PAT model so they worked with the PAT state lead to obtain affiliate status. The final step of Phase II involved bringing community stakeholders back together to inform them of progress made in planning, and solicit input on implementation. Community partners could also discuss the process for referring to the EBHV program.

During Phase II, support of the implementing agencies was transferred from the community planning personnel to the state model lead and other TA providers at the HUB. The role of the former corresponded to the Exploration Stage of the Implementation Science stages, and the role of the latter corresponded to the Installation and Implementation Stages. Later in this report, we profile the implementing agency in one of these communities, *Alder Community Health Center*, as an example of a start-up program that experienced the community planning process.

After the state obtained additional MIECHV grant funding, a second round of the community planning process was launched in 2015. Three rural communities participated in the process and applied for funding, and one was funded. The second round of the process differed from the first in a few key ways: it was faster-paced (lasting approximately 4.5 instead of 6–7 months); the PAT state lead had transitioned from supporting Washington through the HUB to supporting the Northwest region through the PAT NSO, changing the support structure for Washington PAT programs and prospective affiliates; and an external review process was used to make funding decisions.

Data Collection Methods and Sample

Data were collected for the rural case study in two phases. The first was a planning phase (January–February 2017) that consisted of interviews with key informants at DEL and the HUB, accompanied by a review of relevant written documents, to learn about the history of the rural development work and community planning process. Through these interviews, the evaluation team heard from DEL and HUB staff about their role in administering the MIECHV funds and supporting rural programs' expansion or start-up. We also heard about their perceptions of the successes of implementing EBHV in rural communities, and of the community planning process in particular, as well as the challenges or barriers faced.

This information prepared us for the second phase of data collection (March 2017), which consisted of site visits to four of the rural communities receiving MIECHV expansion funds. These sites were selected to represent four different categories, or types, or programs: 1) expansion site, rural only, 2) expansion site, mixed rural and urban, 3) start-up site, participated in community planning process, and 4) start-up site, did not participate in community planning process. We used information gathered during the planning phase to develop interview and focus group protocols to use with program leaders (i.e., supervisors and administrators) and home visitors, respectively. The

protocols focused on understanding the history of the EBHV program and the agency housing it, the context of the rural community the program serves, program staff's perceptions of the successes and challenges of implementing EBHV in that community, experiences pertaining specifically to expansion or start-up, and program staff's experience of implementation supports from the HUB and other entities.

Data collected across these two phases were then systematically analyzed to generate the findings described below. First, we will give a high-level summary of our main cross-cutting findings, below. Next, we provide portraits of each of the four sites in order to convey the range of experience of rural development in Washington state. Then, we discuss each of our main findings in detail, using examples from specific sites. We end with recommendations for future practice.

Key findings across sites included:

- Successful hiring and retention of the appropriate staff is important for a program's long-term success. Using nurses, who have high levels of formal education, as staff compounds hiring difficulties in rural communities that already have a restricted labor pool. The PAT model allows for more flexibility in hiring.

- Once hired, staff who feel supported are more likely to stay. Pay and quality of life (e.g., hours worked, travel burden, paperwork burden, feeling supported by leaders and peers) have an impact on staff mental health and morale.

- A growing proportion of home visitor staff time is now spent on documentation and data collection, although thus far, programs have had limited success in using these data to inform their practice.

- Staff dissatisfaction leads to turnover, which then contributes to client attrition (i.e., many clients of departing home visitors exit the program due to loss of the relationship) and lower program capacity (i.e., new home visitors need training and carry lower caseloads.

- The ability to maintain full caseloads and operate at maximum capacity is important for a program's long-term success, and a strong referral network is necessary for maintaining full caseloads. Referrals are a product of trust built between two agencies; this relationship-building requires time and energy and is often disrupted when key staff turn over.

- The community planning process that ACHC experienced created many of the "conditions of success" described above, such as successful hiring and retention of staff, and ability to maintain full caseloads and operate at maximum capacity, and positioned the agency to more efficiently and effectively start up and sustain their EBHV program. HUB staff observed that there were benefits to participating in the community planning process even for communities that went through the process but were not awarded MIECHV funding, because their level of preparation left them well-positioned to seek other sources of support.

- A challenge of the community planning process was that, with only two models, it was difficult for the facilitators to avoid giving the impression that the PAT and NFP models were in competition with one another.

♦ Rural communities often have more success implementing NFP using a "regional" or "mentoring" approach, in which a higher capacity county supports a neighboring lower capacity county via contracting of staff or supervisors.

♦ HUB staff experienced both successes and challenges in supporting implementation of EBHV in rural communities. Programs cited staff turnover at the HUB, and the lack of an integrated PAT state model lead, as key barriers to their ability to access sufficient implementation supports.

Site Portraits

Start-up with community planning process – Alder Community Health Center

Description – Alder Community Health Center

Alder Community Health Center (ACHC) serves a primarily agricultural community located on the eastern side of the state, with a population consisting largely of immigrant Hispanic farmworkers. Many are Spanish speaking, but there is a substantial subgroup of indigenous Mesoamericans who speak Mixteco, and not necessarily Spanish or English. The agency was founded in the 1970s as a grassroots community health clinic aiming to meet the needs of underserved migrant workers and has grown into a multi-site organization offering a comprehensive system of care. In addition to core medical, dental, optometry, pharmacy, and laboratory services, the agency provides a range of family support services, including Women, Infants, and Children (WIC), Maternity Support Services (MSS), and behavioral health programs.

ACHC's service area includes the entirety of one county and portions of two neighboring counties. In 2011, the state needs assessment identified ACHC's primary service county as having high poverty and a high teenage pregnancy rate, among other challenges, and the agency was invited by Implementation HUB staff to participate in the newly conceptualized rural development community planning process. The aim was to prepare the community to apply for MIECHV funds to start up a new EBHV program. Following the planning process, the community endorsed ACHC as the implementing agency and chose to open a PAT program. The agency's experience with the community planning process and program start-up are described in further detail below.

Community needs – Alder Community Health Center

The main challenges of the community that ACHC serves are teen pregnancy and high poverty rates. Sparsely populated and rural, the community has few recreational opportunities appropriate for youth and limited economic opportunities outside of farm work. Once pregnant, many young girls drop out of school and become socially isolated, further limiting their future prospects and those of their children.

The PAT program was created to support these moms, as well as the Mixteco community, which faces additional challenges due to language barriers and immigration status. The ACHC home visitors often tailor the PAT curriculum to accommodate cultural differences, but they find that the adaptation goes both ways; participation in PAT teaches parents how to interact with their children in a way that furthers their development and prepares them for the American school system.

However, even with the PAT program in operation, the community has relatively few resources, and barriers to service are compounded by local providers needing to refer families already facing transportation and language challenges out for any type of specialized services. Follow-through on referrals is particularly difficult for migrants fearing deportation, a threat that has recently intensified. Drug abuse and domestic violence, reported by other rural case study sites as main problems, were less commonly cited as an issue for the ACHC immigrant population, although it is a growing concern, especially among the second generation.

Successes of the community planning process and program start-up – Alder Community Health Center

ACHC leaders viewed the community planning process very positively and considered it a success because it prepared them to successfully start and sustain their new PAT program. The structured nature of the series of meetings gave the community a dedicated time and space to make decisions, building trust and increasing buy-in from a wide range of community partners, many of which would later serve as referring partners to the EBHV program. Parent focus groups that were conducted as part of the planning process also served to identify potential clients, so once ACHC gained PAT affiliate status, the agency was able to quickly fill caseloads and reach maximum program capacity. The previously established strong referral network of community partners then served to sustain it. A program leader said,

> *For us, [the community planning process] was a win-win because along the way we establish the collaboration between the community partners. On day one, we already had people, eligible families for the program. In fact, by the time we trained -the first group of [home visitors], within a month, I think, we already had half a-a caseload waiting to enroll in the program. dozen. I think it took us two months to reach our caseload capacity. So everything kind of just fell into place for us.*

In the language of Implementation Science, investing time and energy into the Exploration Stage created "conditions of success" that allowed ACHC to install and implement the PAT program efficiently and effectively. Agency leaders felt the community planning process worked so well that they aimed to use it to facilitate a future expansion of their services.

ACHC leaders also described a positive relationship with the Implementation HUB staff and consultants who facilitated the community planning process. They noted that at the beginning of the process, they were "skeptical" due to previous experiences where "outsiders" came into their community and collected data or promised services with no follow up, but they found the third-party facilitation provided by the HUB was very useful in reducing competition and increasing cooperation among local agencies as they worked toward the common goal of supporting area families. A program leader summarized the situation this way:

> *One of the things that happens in communities, particularly in rural communities, is there is this friendly and sometimes not-so-friendly competition. Sometimes when one agency starts a dialogue, other agencies kind of get a little bit antsy about it and how it is going to impact the services they are providing. So, teen pregnancy was kind of one of those dialogues, and so the thing that was good about this [community planning process] meeting, is that by a neutral*

party, a third party, coming in it allowed the communication to be more open and without people feeling like they were crossing each other's turfs and things like that. So after the first meeting, I saw that there was good opportunity, that people didn't feel defensive and we were just focusing on the issue.

ACHC administrators also felt HUB staff "really listened to them" and were able to address questions and resolve concerns they had.

Receiving information about the two EBHV models, NFP and PAT, enabled ACHC leaders to make an informed choice based on the strengths and needs of their community. They chose PAT because it offered more flexibility, both in hiring staff and curriculum. They prioritized hiring home visitors who were most able to connect with and understand their clients, often via a close match in language and culture. The PAT model has less restrictive formal education requirements and would allow for a broader applicant pool, better enabling the agency to meet their hiring needs. ACHC also liked that the PAT curriculum focused on improving parent-child interactions and relationship quality, yet was flexible enough that home visitors could also spend time addressing families' basic needs.

Challenges of program start-up – Alder Community Health Center

When starting up their PAT program staff at ACHC faced challenges in conducting timely assessments of families and in training staff. First, it was difficult to meet the PAT model requirement of assessing families within 90 days of intake, because the fast pace in which they enrolled families meant they needed to conduct a large number of assessments early in the program's existence while they were still getting oriented and ordering materials. Second, the quick ramp up also made training staff and ensuring they were adequately able to use Visit Tracker difficult. As a completely new program, ACHC could not offer home visitors opportunities to observe home visits as part of their training; it is now standard practice at ACHC to use observation and shadowing as methods of training new staff.

Successes of implementing EBHV – Alder Community Health Center

ACHC staff considered the positive changes they saw in their clients' behaviors and life circumstances to be the greatest success of their PAT program. The home visitors found it personally gratifying when they observed changes in how parents interacted with their children, such as using more positive reinforcement and language, and when they saw parents gaining skills and becoming more empowered. One home visitor explained,

I think one of the first things that became a positive for me was the parents' interaction with their child, not only in play, but in communicating and learning to talk with their children which then in turn really turned around discipline in the home. I had several families that we were working with that and it was amazing, and then to have the parents come back and say, 'he's listening now. I don't need to yell and scream.'

Staff felt they have had an impact on their two target populations, teens and Mixteco-speaking moms, with the former staying engaged with and finishing school at higher rates, and the latter becoming more integrated into the larger community (e.g., by getting driver's licenses). By building

trusting relationships with families, home visitors were granted access to them, giving them opportunities to ensure children were being screened for developmental delays, moms were learning about healthy partner relationships, and fathers were participating in home visits at increasing rates.

ACHC staff considered their PAT program to be high-functioning in other ways as well, given their high caseloads, low staff and family turnover, and ability to obtain continued funding. Their program was at capacity, due in large part to referrals from the Women, Infants, and Children (WIC) and Maternity Support Services (MSS) programs also housed within the agency. They also often received referrals from outside agencies and from existing and former clients who referred their family members and friends, and to staff, this was validating and "felt like success." The staffing was stable with relatively low turnover, due in large part to home visitors feeling well-supported (described further below), and client retention was very high, with the vast majority staying on to be served for a full two years. Finally, although always a challenge, they were able to successfully obtain funding to operate the program past the end of the initial MIECHV grant. They also obtained funding to expand the PAT program's service area outside of the primary county for which they were awarded the MIECHV funds, in order to match the greater ACHC service area.

Challenges of implementing EBHV – Alder Community Health Center

ACHC staff described one set of challenges they faced in implementing the PAT program in terms of providing services to families. First among these challenges was completing the two visits a month required by the model for high-risk clients. Staff expressed that many of their clients were teens and farmworkers, who can have unusual schedules that make arranging visits difficult, and at times they cancel. The home visitors also had high caseloads, but after conducting a time study, the leadership determined that two visits a month per client is feasible.

The ACHC staff also found it challenging that many of their families were very high-need and seemed to continue to face challenges (e.g., fall into crisis or have unmet needs) when their two-year PAT service period ended. The agency was considering strategies for serving these families for longer periods of time, or finding other ways to support them. Leaders acknowledged that teen clients need resources to help set clear career paths in order to be able to really change their long-term outcomes, but there were few such opportunities in their local community. There were additional challenges to serving the Mixteco families, when at times interpreters were needed and cultural differences represented potential barriers to services. Home visitors often needed to tailor the curriculum and improvise assessments for both Mixteco- and Spanish-speaking families. Finally, home visitors expressed that learning to set and maintain boundaries with their clients was personally challenging. This was difficult for many due to a strong desire to help their clients and to the community's rural setting; clients and home visitors often run into each other unintentionally, or already know each other from outside of PAT.

ACHC staff discussed a second set of challenges that were administrative. At the forefront of these challenges were the data collection and documentation requirements placed upon them by their various funders and the EBHV model. For home visitors, this aspect of the job was constantly growing in complexity and demanding more and more of their working hours. Completing all of the necessary paperwork correctly and on time required a high level of organization and computer

competence. Some home visitors struggled with this more than others, but all staff reported being burdened to some degree by the sheer amount of documentation required. With many of her peers agreeing, one home visitor described the issue this way:

> *I think this is the one job that has so much paperwork, and all the places that I've worked with, they're mostly non-profit. [We're] grant-funded and so it is very, very overwhelming. You talk about the demand and it partly relies on us to just be organized and do our paperwork but I think sometimes there just isn't a balance where we carry, you know, a high caseload and then we have all this documentation and data to input on a daily basis. We don't only have the Visit Tracker website; we also do case notes here in the office and so we're getting pulled so many ways. For me, I think that is my biggest challenge – documentation.*

Second, agency administrators found it challenging to hire staff who could both connect well with their client base and meet high formal education requirements, so they prioritized the client connection and often hired paraprofessionals. The tradeoff was they then often needed to support these individuals more rigorously through in-service training, including strengthening their data collection and computer skills. An administrator recounted,

> *I recall our star [home visitor], initially when we did the interview, she was our weakest candidate because when she was on the computer, she was shaking due to her poor computer skills. She was almost falling apart because in the interview process we do these things, so we had hesitancy with her ability because the database is computer-based and all of that. So we took the risk on her because of just her passion for working with the families and she's become our star. It's because of that passion that we made the decision to hire her- she grew up as a farm worker, she loves working with the families, and understands families' challenges so she always works around them. On the other side of that spectrum, we had a [home visitor] that had a bachelor's degree in social work and we thought that she would be the most qualified and we ended up finding out that that was not necessarily the case.*

Lastly, ACHC leaders noted that maintaining steady funding was always a challenge, but so far they have been able to achieve this.

Implementation supports received – Alder Community Health Center

ACHC PAT program leaders received implementation support largely from HUB staff at Thrive and from the PAT model staff. Leaders described receiving contract support, assistance with CQI, and information about training opportunities for staff through the HUB. They were able to send some of their home visitors to the HUB-organized state Home Visiting Summit, as well as trainings about ACEs and domestic violence. They also found the connections and support that HUB staff and the PAT state lead provided helped them establish a successful PAT program and have been an invaluable resource for their program. The program supervisor noted that phone conferences with other PAT supervisors were helpful.

Home visitors received support from program leaders, as well as from their peers. Program leaders supported them via formal supervision and "moral support," as demonstrated by their policies, such as prioritizing opportunities for learning and skill development. Importantly, the home visitors also supported each other, through formally scheduled case-conferencing, and

informal debriefing and problem solving that occurred in their shared office space. They reported that this ability to "unload" with each other was critical in helping work through the fatigue and frustration that the job brings and reduced burnout. Many of the home visitors had been working together since program start-up and described themselves as a very cohesive and mutually supportive group.

ACHC also supported the PAT program internally. Although program leaders initially had to convince the agency leadership that services like WIC, MSS, and PAT fall under the purview of healthcare, the agency has since demonstrated clear support for them. During a federal fiscal crisis, the agency stepped in to provide the PAT program with stopgap funding, and, jointly with the contract from the HUB, to provide the home visitors with vehicles and mileage reimbursement. The PAT program also receives some additional resources for implementation from other community entities such as the school district, public library, and other local non-profits.

Implementation supports needed – Alder Community Health Center

ACHC staff reported being generally well-supported but described a couple of remaining needs. Home visitors expressed a need for further supports for managing data collection. Program leaders noted that model support from PAT was at times lacking, especially once the state lead role was broadened to become regional. They reported finding it most efficacious to address their questions and concerns directly to the PAT National Service Office.

Lessons learned – Alder Community Health Center

The ACHC PAT program start-up was by all accounts successful, due in large part to the agency's participation in the rural development community planning process. Staff attributed their success to a number of conditions, some that resulted from undergoing the planning process. First, the process fostered cooperation and buy-in from key players across the community, which created a strong referral network for the PAT program. Second, choosing the PAT model for its flexibility around hiring facilitated the creation of a staff that connected well with, and was extremely dedicated to, the client population. The home visitors were also cohesive and mutually supportive as a group. Third, program leaders expressed that staff flexibility is what ultimately enabled full caseloads; home visitors were willing to work nontraditional hours to meet the clients' needs. Also, driving long distances to visit families was less of a challenge for home visitors at ACHC because they were able to employ a regional model in which each staff member served a particular area. Although their clients moved often, it was usually within the same small area. Lastly, staff turnover was low because dedication to the families was high, and support for staff at all levels was also high, further increasing employee commitment.

Start-up without community planning process – Cedar County Health Department

Description – Cedar County Health Department

Cedar County is a scenic rural county, naturally beautiful with sweeping views of rivers and trees. The main population center was settled in the mid-19th century as a small frontier town and grew most rapidly in the early 20th century with the establishment of nearby lumber mills. The area suffered a significant loss of jobs beginning in the late 1980s with the decline of the lumber

industry, and the current economy offers largely low-paid, part-time positions in the service sector. Supported by data from state-mandated community needs assessments commenced in 1998, a dedicated group of community leaders has created coalitions and worked to address the underemployment and associated high social needs.

Cedar was identified through the 2011 statewide needs assessment as a high-need county, and the health department, which has a long history of providing maternal and child health services, was awarded (without engaging in an application process) MIECHV funds to start an NFP program. Although not ideal for planning, this experience was far from unusual; rapid disbursement of funds was an expectation of the MIECHV grant, so expedited EBHV program start-up or expansion was common practice in many states. The Cedar County NFP program operated for the duration of the MIECHV grant but closed at the end of 2016 due to intractable operational challenges described in more detail below.

Community needs – Cedar County Health Department

Cedar community faces a depressed economy and high rates of multigenerational poverty, drug abuse and overdose, mental health problems, and homelessness. Many mothers are poor and single, and they and their children are at increased risk for poor outcomes. Additionally, reductions in public health funding in recent years have limited the availability of services.

Successes of program start-up and implementing EBHV – Cedar County Health Department

Despite the eventual program closure, Cedar staff reported success in the connections they made and the services they provided during start-up and implementation. They considered their ability to get the NFP program publicized and known in the community, including through the local media, to be a success. They were also able to make connections with some referring agencies and to start building positive working relationships with them. The main successes of implementation were serving almost 100 families over the course of three years, seeing some of them graduate from the program, and seeing the difference the services made in some clients' lives. For example, a number of clients who were homeless were able to gain housing and employment with the help of the nursing support and the referrals they made. Staff found it personally rewarding to observe the families change in a positive way and to watch the children grow.

Challenges of program startup and implementing EBHV – Cedar County Health Department

Cedar staff described the program start-up process as "disorganized," "chaotic," and "very slow." They reported receiving a letter from DEL in October 2012 informing them that they had been selected to receive funding to start an NFP program, with little else that served as context or guidance. Although they were grateful for the unsolicited opportunity, staff described feeling like they "came in in the middle of a conversation" and struggled to orient themselves to the NFP model and all of the entities involved in the start-up process (e.g., Thrive HUB, DEL, the NFP NSO). Although some of the Maternal and Child Health department staff were aware of and interested in the NFP model, they had not prepared for or tested the feasibility of implementing it in their community. A leader remembered the situation this way:

The biggest challenge for us was we got contacted by all these people and we didn't know what was going on. We got contacted by the NSO. We didn't even know what the NSO was at the time. And then DEL was contacting us. I think the letter came from DEL and at the same time we were getting contacted by the NSO and we were so confused. We didn't know who these people were and how it all fit together.

The contract negotiation process was also difficult and protracted, in large part due to the bureaucracies of the county health department. They did not have a contract in place until February 2013 and did not begin serving clients until November, one full year after receiving the notification letter.

As the Cedar staff began implementing EBHV, they experienced persistent challenges, most notably high staff turnover, which ultimately led to the closing of the program. Turnover began almost immediately after the program's inception. The program had two home visitor positions, and one position turned over repeatedly within the first year. The program also lost its supervisor within the first year and eventually lost the nurse manager who oversaw the supervisor. Many factors contributed to the high rate of turnover, including staff personal issues (e.g., health challenges) beyond the program's control, but leaders described being housed in a county agency as a major constraint and challenge.

The NFP program was required to abide by the county's union-negotiated pay scales, and it became apparent that the pay was too low to attract and retain qualified applicants for a position that required a bachelor's degree in nursing. Despite the availability of MIECHV grant funding to pay higher salaries, the county commissioners were unwilling to modify or allow any flexibility in the pay scale. The Cedar leadership felt their "hands were tied" and found it extremely frustrating that "politics got in the way of providing services." They noted that given they were in a rural county with a depressed economy, the applicant pool for a job requiring high formal education was already small. Additionally, the work of a home visitor is demanding and requires ongoing professional development, so when compensation is not commensurate, candidates either do not apply, or they leave after a short time. Without any leverage to make the position more attractive to applicants, leaders knew the turnover would continue, and they felt the impasse with the county commissioners made sustaining the NFP program untenable. An administrator summarized the problem this way:

The [NFP] program had very high standards of what we had to do [for hiring], but you can't ask people to come and do this kind of a job and not reimburse them. But because this area kind of tends to pay lower than others, you know, it was very hard to try to talk to the [county] commissioners, or anybody else within the [county] structure. It made it very challenging to hire people, to keep people. [Be]cause people that are highly qualified... should be fairly reimbursed. And when they are not, it's hard to keep them and keep them motivated. We had a hard time keeping staff, frankly.

The Cedar program faced challenges in maintaining full client capacity; staff turnover and difficulties with getting referrals contributed to a low caseload. Leaders described an "ebb and flow" of clients and said that constantly needing to train new staff was an impediment to reaching program capacity. An administrator explained,

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Just about every time we'd get near full caseload capacity, somebody [on the staff] would leave. We had the potential.... You hire on a new [home visitor], they have to be trained and then the philosophy is you don't have them try to start more than like 3 [families] a month to get up to caseload because otherwise the [home visitor] would be overwhelmed because it's a learning process... So we were doing great, but if you lose a staff person, you've gotta go back. Then you can't add to the caseload because you are just trying to fill in the gaps.

The main contributor to low caseload, however, was a lack of referrals and not having a strong referral network. The biggest barrier to establishing stronger referral relationships was a tendency for area agencies to compete for clients, vying for the same families despite there being many more families in need of services than there were slots to serve them. For example, the NFP program had difficulty gaining access to teenaged moms because the local high school had an Even Start program that viewed the NPF program as competition.

The NFP program also did not have the benefit of in-house Women, Infants, and Children (WIC) and Maternity Support Services (MSS) referrals because these programs were located in non-profit organizations outside of the county health department. These programs and agencies, including a nearby PAT program also funded by Thrive, were defending their own interests rather than collaborating. Eventually, the Cedar NFP leaders asked Thrive to come to the community and act as a mediator, facilitating meetings where agencies could come to agreement regarding who would serve which clients based on client needs and program characteristics. An additional challenge was that referral relationships between agencies were often based on individual relationships built between staff, so when staff at either agency turned over, that referral relationship was lost.

The program experienced significant client attrition and cancellation of visits and struggled to serve clients in remote areas. Cedar leaders reported that many moms participated only through pregnancy and the first year of their child's life, and very few completed the full program. This attrition was likely due to many factors, but among them is staff turnover; clients often leave the program when their home visitor leaves because the relationship is lost, and they are not interested in building a new relationship with a new staff member. Client engagement was also low at times, with no-shows occurring despite reminders and visit confirmations by the home visitors. This is both a possible cause and a symptom of lack of rapport between home visitor and client, which can contribute to the client's attrition and to low job satisfaction and turnover for the home visitor.

Finally, Cedar leaders noted that, in this large rural county, clients on the border may access services more easily in a population center in a neighboring county closer in proximity to them, but county-based grant funding often does not allow for this. The Cedar program was also not permitted to serve clients living on their border in neighboring counties, despite those neighboring counties not having services of their own. Also, referring families for services across county lines can be more difficult because program staff are less familiar with those services. However, the reality in Cedar was that the NFP program served mostly families in the county's population centers, because program staff did not have the resources or the connections to market to the most rural parts of the county.

Implementation supports received – Cedar County Health Department

Cedar leaders reported receiving implementation supports from outside entities and providing their nurses with internal supports for conducting home visits. Program-level implementation supports came primarily from the NFP state model lead, which Cedar leaders considered "important and helpful." One administrator said,

> *[NFP state model lead] was very, very helpful. She's done the actual work. She knows the nursing work but then she also understands her level and she's got an oversight of all the other programs, plus she deals with the NSO. My perception was, she knew the NSO, she's accountable to the NSO to make sure the program's meeting fidelity, but she's accountable to Thrive because they gave the money and she helped us make sure that we were meeting the requirements of the contract.*

They also felt the NFP supervisor meetings were valuable because programs could share resources since "no one wants to reinvent the wheel."

The leaders, in turn, offered the home visitors supports, including holding staff meetings that alternated in focus on case conferencing and administrative discussions, weekly reflective supervision, and periodic case conferencing with WIC and the Department of Social and Health Services (DSHS) about clients they served jointly. The home visitors also shared an office space so they could support each other informally, and leaders occasionally facilitated opportunities for home visitors to case conference across programs, such as with a neighboring county's NFP program. This was helpful in reducing feelings of isolation and expanding learning opportunities, since the Cedar program only had two home visitors.

Implementation supports needed – Cedar County Health Department

Cedar administrators expressed that they did not feel adequately supported during program start-up and implementation, noting they needed both more model support and general operations support (e.g., with referrals). They identified needing a comprehensive orientation to the NFP model at start-up, with additional guidance on how to implement it within the context of their particular agency. They realized, in hindsight, that all of their leaders and administrators, including the person responsible for data collection and reporting, should have attended the NSO training in Denver early in the process, because the data collection requirements were especially confusing and demanding. They also tried to shadow a successful neighboring program early in implementation, but the mentorship began too late to be truly useful, and the mentor program, which was also facing challenges, was not the best example to learn from.

Cedar leaders felt that they could have benefited from more consistent contract management support from the Thrive Implementation HUB. Initially, they struggled to learn how different "pieces of the system" and the roles of various staff fit together. Later on, HUB staff turnover, compounded by the turnover of their own nurse manager and program supervisor, contributed to a lack of continuity in support. At one point, leaders "weren't sure who to go to for what" and they experienced at times a lack of communication and at other times much redundancy in communication. Additionally, agency leaders felt HUB staff could have been more immediately

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helpful and forthcoming when they appealed to them for assistance as their program struggled with low caseload and a sense of competition among area service providers.

Lessons learned – Cedar County Health Department

The experience of the Cedar NFP program highlights what, in retrospect, could have been done differently to better set the program up for implementation success. The overarching lesson from the Cedar program is that simultaneously conducting start-up work (e.g., gaining the buy-in of key players in the community, building a referral network, learning the EBHV model) and implementation made the program particularly susceptible to implementation challenges. For example, over the course of implementation, Cedar learned that they needed to increase the home visitor position salary in order to attract and retain qualified staff. However, being housed in a governmental agency with union pay scales prevented this, which in turn resulted in an inability to reduce persistently high staff turnover. If Cedar had been given the opportunity to go through the Implementation Science stage of Exploration rather than immediately entering into Installation, it is possible that Cedar would have identified the county commissioners' unwillingness to alter the pay scale as a "deal breaker" early on, or could have taken steps to try to obtain the commissioners' buy-in prior to committing to program start-up.

Cedar also learned that an EBHV program needs a robust referral network in order to be successful in the long term. This requires staff to spend time building relationships with partners, helping them see value in the service being offered, and dispelling any view of their program as competition to the partners. Again, Cedar did not have an opportunity to do this type foundational work *prior* to program installation and thus needed to concurrently build the referral relationships and their caseload, perpetuating conditions for low caseload. Since they came into the MIECHV grant not having specifically chosen the NFP model, Cedar also needed much more support in learning the model and understanding how to integrate it into their agency. This was made even more challenging by the need to simultaneously move forward with the tasks of program implementation, such as hiring staff and enrolling clients.

Cedar administrators expressed sadness and a profound frustration at the circumstances that made their program close. They had invested years of time and energy into start-up efforts and relationship building, learned many useful lessons through trial and error, and importantly, provided families with a valuable service. One leader expressed,

> *We worked so hard to get the program up and running and it was doing well and it was well received in the community and we know it benefits the client. It just felt so terrible to know that our commissioners were not willing to find a way to fund qualified staff to keep [home visitors] in our community, to keep services in our county.*

Despite the disappointing end to the Cedar County NFP program, NFP programming is, fortunately, still available to families in the Cedar area through a "regional model" of NFP implementation; beginning in early 2017, EBHV grant funding is being disbursed to and administered by a neighboring county's NFP program that hires, pays, and supervises home visitors who serve Cedar families.

Expansion – mixed rural/urban – Pine County Health Department

Description – Pine County Health Department

Home visiting staff described the Pine community as friendly and engaged – a place where people look out for each other – but also very diverse with several different populations and pockets of people including farmworkers, migrant Latinos from multiple subcultures such as Mixtec (indigenous people of Mexico), Ukrainians, students seeking professional education, and an environmentally conscious, naturalistic subculture. The diverse population and recent changes in industry in the area have resulted in a lack of a unified or singular community identity. Historically, the main industries were lumber and agriculture, but in the last 20 years the area has seen an influx of new infrastructure and types of employment that attract a different population of residents.

The Pine NFP program is located in the county health department and serves the county, which includes a large geographic area with clients typically residing 30–90 minutes away. The program opened in 2006 through a federal grant enabling the health department to partner with the local educational service district to conduct violence prevention work. This grant ended in 2010 and additional funding was scarce, given the coinciding economic recession and cuts to public health budgets. The NFP program was at risk of closing until it was revitalized when the county obtained MIECHV expansion funds in 2012. However, during the uncertain transition period, nearly all of the home visitor positions turned over. As a result, the program was in many ways back in an initial Implementation stage when the MIECHV funding came in. Strong leadership and consistency in the program administration have been important drivers for success, and the program has now has been running for more than 10 years.

Community needs – Pine County Health Department

Limited housing, the transient nature of clients, substance abuse, and limited availability of additional services were the Pine community's main challenges. Staff consistently reported that a lack of affordable housing was a major challenge. Competition for housing is high; the vacancy rate is estimated to be 1 percent, and clients may be living in cars or staying with friends. The clients served tend to be very transient, moving both within and out of the county, which was related to the lack of affordable housing as well as the county's location on the corridor of a highway that runs through a major metropolitan area. It is difficult to retain clients for the full duration of the EBHV model because they often move out of the area to find jobs or housing. Staff also noted that a very high percentage of their EBHV caseload had substance abuse issues, which impact other aspects of family life, such housing and employment. Having a high proportion of such high-risk families in a home visitor's caseload is very demanding and taxing.

Compared with the surrounding communities, Pine also has fewer services. For example, there are few mental health resources, and transportation to access to those that are available is a challenge for some clients (e.g., requiring an hour-long bus ride). Furthermore, the community lacks treatment programs that will serve moms and babies, so in order to access treatment, the family must either travel a long distance or move out of the county to be closer to treatment facilities.

Lastly, as is common in rural communities, staff described the county and clients as being very spread out. Home visitors often drive more than one hour to see clients and, because of the

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transient nature of clients, designating service areas or zones for home visitors was not an effective strategy for this program. Home visitors end up having to travel to where the family moves within the county, which happens often.

Successes of implementing EBHV – Pine County Health Department

The Pine EBHV program staff were able to work "deep and long-term" with families and worked with clients in a preventative capacity. Being able to "work upstream," was noted as particularly gratifying in contrast to nursing in the hospital setting. Home visitors felt that the program (NPF) is able to make the most impact on the relationship between the caregiver and baby. As one home visitor reported,

> *I find it really rewarding working upstream […] really being on the prevention end of things rather than seeing this problem and now all of a sudden trying to throw all these resources at it when it could have really been addressed […] earlier on. That's one of the things I love the most.*

Despite the possibility of ongoing challenges in the family's life after graduating from the program (e.g., housing instability), the home visitors are able to alter the way in which clients parent and take care of their child. Staff also described other tangible successes around subsequent pregnancies, such as increasing the extent to which clients plan for or extend the time until their next pregnancy, and around workforce supports, such as helping clients to graduate from high school and find jobs.

Challenges of implementing EBHV – Pine County Health Department

Frequent changes in national and state-level processes and requirements were burdensome and sometimes interfered with implementation. This included changes from the model and MIECHV such as a new data system, new versions of screening tools, responding to MEICHV benchmarks, and participating in evaluation. Adapting to these changes and meeting the documentation requirements of an evidence-based home visiting program can interfere with and take time and energy away from implementation. Furthermore, the additional time spent traveling to clients reduces time available for documentation and paperwork. As one home visitor said, *"It feels like there's constant pressure about paperwork … but the client has a life that is going on around our paperwork."* Thus balancing administrative needs with being client-centered is a challenge.

Characteristics of Pine's rural community contributed to feelings of isolation and difficulty building a strong referral network in the community. Home visiting work in a rural community can feel particularly isolating and recruiting qualified staff can be tricky when there is not a large pool to draw from. For Pine, building a strong referral network in the community has also been a challenge, particularly since losing their in-house Women, Infants, and Children (WIC) program. Building relationships with other community referral agencies has been hindered by turnover of staff in those partner agencies, requiring frequent rebuilding of relationships, and there were perceptions of competition for the same families among other maternal child health programs. Other obstacles to enrollment following referral included a drop in the birth rate and teen pregnancy over the last few years and fear in the migrant community of receiving services.

Home visitors regularly struggled with knowing where to start with a family with many risk factors. Home visitors also felt the need in the community is great for NFP services and were disheartened to serve only a fraction of the population with need.

Implementation supports received – Pine County Health Department

Home visitors and program leaders reported a high level of the support in the state and felt that the supports received from the HUB were very valuable. Pine program leaders noted that supports around implementation, contractual, continuous quality improvement (CQI) and other data supports from staff at Thrive and DOH have been helpful. Furthermore, receiving supports from a model-specific state lead, such as supervisor reflective practice calls, were deemed critical. Home visitors noted that the Washington State Home Visiting Summit was *"inspiring and … helpful to hear what other agency sites were doing and comparing notes in that way."* The HUB supports in combination with supports from the NSO, including the state-specific business development manager who identifies funding opportunities and supports around the data system, provided a strong support network for the program leaders.

Professional supports from within the program also were extremely helpful in supporting home visitors' work. Home visitors appreciated the supports they received through reflective supervision as well as the function their supervisors serve as a "hub" for the HUB and other training and TA opportunities. As they described it, the supervisor disseminated resources and identified opportunities for the home visiting staff. Supervisors offered training themselves and also supported home visitors to attend trainings external to the program when they found something interesting. Most of the trainings home visitors attended were within the state and included in-person and some virtual experiences. For example, home visiting staff have completed trainings on the Circle of Security, Adverse Childhood Experiences (ACEs), trauma-informed practices, infant mental health, prenatal depression and home visitor safety.

Implementation supports needed – Pine County Health Department

Pine home visiting staff could benefit from additional support around data and referrals. Both home visitors and program leaders reported that they could benefit from a more streamlined data system and reports that summarize key information to review with staff, rather than having to manually pull or request the information from multiple places. Another needed support was around increasing referrals, not just for the community but also across the state, such as through a centralized referral system. The staff described a vision for helping all EBHV programs in the state market home visiting, having referrals come to a centralized intake and referral system, and then funneling the referrals to different sites, as appropriate.

Lessons learned – Pine County Health Department

Conditions that enabled Pine's success included having strong community coalitions, professional support provided by the program leaders, and highly qualified staff. Pine home visitors and program leaders credited the supportive, involved, and caring community as a key condition for success, particularly the presence of strong community coalitions around early childhood, breastfeeding, and teen pregnancy. Home visitors felt that the professional support that they received from program leaders through reflective supervision, encouragement for self-care,

and opportunities for training were key for the home visiting program to realize success and impacts with families:

> *The reflective supervision and the support from the supervisors is key […] without those, I don't know that we could continue with the program, and the encouragement with self-care. There's just so many opportunities for training. I've never worked in a program where there was more opportunity to be an ongoing learner.*

Program leaders also implemented strategies for improving home visitors' day-to-day experience of their jobs. For example, they aimed to increase personal safety by having staff share calendars so they were aware of each home visitor's scheduled destinations, and they accompanied home visitors on visits if a potentially dangerous situation was anticipated. They attempted to reduce travel burden by assigning home visitors to geographic service areas, but, as discussed above, this strategy was ineffective because the client population is very transient and frequently moves between areas.

Also critical to the success of the program and supporting the implementation of EBHV was having qualified home visiting staff, a supervisor and an administrator who have values consistent with the model's foundation, and adherence to model fidelity in their various roles. Staff also emphasized the value of having home visitors who have experienced adversity and who have similar backgrounds to clients that they are serving, such as assigning a home visitor who is also a single mom to work with single mothers.

Another lesson learned from the Pine experience is that maintaining consistently full caseloads can be difficult without a robust referral network. The Pine EVHV program previously received many referrals from the WIC program, which until recently had been co-located at the Pine County Health Department. With the loss of that direct connection, staff were actively working to build referral relationships with other programs and agencies. Strategies included making in-person visits to potential partners and putting ads on the Spanish-language radio station.

Expansion – rural – Spruce Family Services

Description – Spruce Family Services

Home visiting staff described the community that Spruce Family Services serves as bountiful geographically and agriculturally, with diverse families who seek to help each other. Although the community covers a wide geographical area, it is isolated from other areas of the state, creating a small social sphere where most people know or are connected to each other. The population ranges from immigrant agricultural workers in small mountainous areas to more ecologically minded residents with a steady flow of tourists. Much of the service area for Spruce Family Services qualifies as frontier and remote according to the United States Department of Agriculture Economic Research Service. Although most clients live 20 minutes to an hour away, some home visitors serve clients in areas that take multiple hours to reach.

Spruce Family Services itself is a longstanding non-profit community agency. It began its work by providing Maternity Support Services (MSS) and infant case management supports, and was seeking ways to serve families beyond the child's first year of life and to address the prevalence of

substance abuse in their community. A decade ago, it launched a family support program with a three-year grant from the Council for Children and Families, and as this funding drew to an end, agency leaders planned to transition into a PAT program after learning about the model and finding it to be a promising fit for their community. They were able to fund the PAT program on a short-term basis using behavioral health funds collected via a county sales tax until they received MIECHV expansion funds in 2012. In addition to MIECHV funding, the program continues to receive funding through the county sales tax and is able to leverage both funding streams to serve a larger population of families.

Community needs – Spruce Family Services

The Spruce community faces a high incidence of substance abuse, challenges in adequately supporting immigrant and Spanish-only speaking families, and a lack of housing. The greatest need in the community is addressing parental drug use and substance abuse, particularly heroin and methamphetamine addiction. Although resources are available in the county to address addiction and substance abuse issues, there are not sufficient programs to fully respond to the level of need. In addition, immigrant families in some areas of the county are new to the country and are geographically and socially isolated from support systems. These families are hard to reach, often have different approaches to parenting than those promoted by the EBHV curriculum, and are often wary or fearful of receiving services. Further, a lack of inventory prevents many families from accessing housing; EBHV staff reported that it was common for clients to relocate frequently to temporary housing situations such as living with family or in mobile housing.

Additionally, for families with more specialized issues, such as having a child with an Autism Spectrum Disorder, there are few local services and families often must either travel long distances or relocate to access needed assistance.

Successes of implementing EBHV – Spruce Family Services

Spruce home visitors found success in seeing families meet their goals and parents' strengths shine. Home visitors felt that seeing parents and children doing well after they finish the program is very rewarding, such as a mother who decided to pursue her college degree in early education, a mother ending her substance abuse and securing employment and stable housing, and parents being empowered to better manage their child's behavior. While the community does not have many resources, home visitors noted that available community resources are valuable, and it is rewarding to connect families to resources they did not know were available or accessible. For example, one home visitor said,

> *Connecting our families to those resources that they didn't know were even here. I started with a mom when she was [first] pregnant and she was hooked on drugs […] now, she's in college, she has a job, [and] she got her own apartment. […] [So I was able to] connect her to the college and […] let her know that she can go to school. It doesn't matter what you have. You can definitely go and get an education.*

Home visitors also reported success in helping immigrant families new to the area and country to foster connections with other parents, developing a support system and sense of community, and empowering them to access resources from each other and not just through the home visitor.

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Program leaders emphasized that the Spruce EBHV program also helped to address challenges unique to the transient nature of the client population. Through their home visitor, families have someone who knows them and can follow and track if they relocate within the county, and that ultimately improves family outcomes because it helps to prevent and reduce gaps not just home visiting but in other services as well.

Challenges of implementing EBHV – Spruce Family Services

Spruce staff identified challenges related to the larger EBHV systems in which they operate, meeting the needs of the high-risk families whom they serve, and managing the emotional impact of their work. Spruce staff discussed challenges in being able to serve all families at risk, given the limitations and requirements of the larger EBHV system. For instance, Spruce staff felt that the risk categories that establish eligibility for services through MIECHV funding did not capture all of the risks of families in their community (e.g., lack of transportation, history of Child Protective Services referrals) and prevented high-risk families with only one risk factor, such as teen mothers, from receiving services. To overcome these barriers, the program utilized other funding sources, such as county funds, to serve at-risk families who did not meet the more stringent MIECHV eligibility requirements.

EBHV staff also remarked on the lack of a centralized and streamlined database and data collection procedures for all the data they collect through their work. The EBHV staff must navigate data collection, data entry, and reporting for the NSO, state MIECHV benchmarks, and external evaluations. This issue was particularly salient for Spruce staff at a Mother and Infant Home Visiting Program Evaluation (MIHOPE) site. In addition to increased data requirements, MIHOPE's randomization requirement meant that some eligible families were randomized to be part of a control group and could not receive home visiting services; this presented the practical challenges of meeting recruitment and caseload expectations and was also emotionally difficult for home visitors who wanted to serve all the eligible families.

Overall, staff noted that, while there is the potential for greater impacts with high-risk families, serving families with multiple risk factors takes an emotional toll. Home visitors take on the burdens of their clients and carrying that weight can be heavy and lead to burnout. Program leaders noted that staff were often drawn to home visiting because they have been a client themselves or have experienced challenges in their own lives, which can lead to higher burnout and turnover. This increases the need for program leadership to support staff to be able to support their families:

> *At one time, at least half of our home visitors were former clients. How do we utilize that, but [also] how do we really protect them and support them?*

Spruce also faced competition for qualified staff from private behavioral health organizations that provided benefits that, as a non-profit organization, Spruce was not able to offer.

A lack of anonymity, geographic dispersion, and cultural considerations also presented challenges to the implementation of EBHV. Providing services in a small community means that many people are connected. Home visitors commented that they often ran into one or more clients in a day, outside of their work, and for those who grew up in the community, they often knew clients from their personal life. While the connected nature of the community can foster stronger

bonds and familiarity with the program among families, home visitors are not anonymous and must make conscientious efforts to maintain confidentiality and professional boundaries. The geographic dispersion also means longer travel time to homes, which impacts available time for administrative tasks, such as data collection, preparing for visits, and timekeeping. Cancellations, which were frequent, had a greater impact when the home visitor traveled 90 minutes to see just one family, instead of two or three. Home visitors noted that they tried to create efficiencies by clustering visits by geographic area.

Spruce staff also identified the challenge of meeting the needs of all family members while implementing an EBHV model. In families with multiple risk factors, it can be difficult to focus on supporting the child's development and caregiver-child interactions, because managing family needs can easily usurp much of the home visit. Moreover, there are many high-need immigrant families in the most remote areas of the Spruce community. In order to effectively engage and support immigrant families, Spruce home visitors must be able to not only speak families' home language (primarily Spanish), but they must also be able to overcome families' fear of repercussions from accessing services and to adapt the PAT curriculum to families' culture. For instance, even though there are free, local English classes that offer childcare, clients are hesitant to go for fear of being apprehended. Program leaders also noted that they had had success in finding and hiring bilingual staff, but they were working toward hiring staff from within the immigrant community, which has been a challenge.

Implementation supports received – Spruce Family Services

Spruce home visitors and program leaders received valuable implementation supports from the Thrive Implementation HUB, targeted trainings, and peer support. Program leaders valued the accessibility of the HUB and the mutual respect between HUB and state staff. They also were grateful for the HUB's role in connecting and bringing the EBHV programs around the state closer together:

We know PAT programs all over the state right now because of the HUB.

With the support of the HUB, Spruce provided Adverse Child Experiences (ACEs) training to their staff, which led to valuable insights about home visitors' experiences and the risk factors present in their own lives. Program leaders noted that some staff had all of 10 ACEs and many had 6 or 7. This highlighted the need for greater efforts to protect the wellbeing and attend to the self-care of their staff. EBHV staff also reported accessing training supports offered in the state outside of the Spruce community. Several staff attended a Know Your Rights training to be able to support immigrant families to know their rights and access relevant resources.

Finally, home visitors also emphasized that among their greatest supports are those that they receive from each other, through problem solving, working together, and sharing experiences and information.

Implementation supports needed – Spruce Family Services

The Spruce EBHV staff identified areas for increased or additional implementation supports including supports for the PAT model specifically, advocacy around streamlining the

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requirements of multiple entities, opportunities for sharing among EBHV programs across the state, and supports for case conferencing for home visitors. Spruce program leaders noted that one of the strengths of the HUB and state system was that supports for both of the EBHV models in the state were embedded within the HUB from the beginning. However, because of staff transitions in the past year or two, there has been a lack of PAT model-specific supports and representation at the HUB. Spruce is eagerly anticipating an increase in PAT-model specific supports that the HUB will soon provide.

Spruce program leaders also identified a need for increased advocacy from the HUB or state on behalf of the local EBHV implementing agency staff to increase consistency and reduce redundancy in the requirements of state, NSO, and federal entities. Increased advocacy support would alleviate current burdens of EBHV programs, that have to advocate for their own needs and reconcile requirements with the mission of home visiting.

While Spruce program leaders credited the HUB with helping to bring programs across the state together, staff would like to have more facilitated opportunities to connect and share with other EBHV programs. Staff discussed ideas such as having a statewide supervisor listserv or an online forum for communicating directly with one another.

At the home visitor level, there is a need for increased opportunities for program leadership to support case conferencing and to problem solving. Home visitors noted a desire for more opportunities to share among each other and with the administration (i.e., there is not always sufficient time for case conferencing during staff meetings). While home visitors expressed an appreciation for the reflective supervision that they receive, which is provided by an individual with an infant mental health background contracted from outside the PAT program, some also expressed that their reflective supervision experience could be improved. Some home visitors felt that because the individual providing reflective supervision is outside of the PAT program and does not provide home visiting services, it can be difficult for this individual to relate to and problem solve strategies specific to their work.

Lessons learned – Spruce Family Services

Key factors that enabled the success of the Spruce EBHV program include characteristics of the agency in which the EBHV program is housed, braiding multiple funding streams, and the qualities and commitment of the staff. The PAT program is located in a well-established, non-profit agency that has been around for more than 40 years and is well known in the community. Most families already have heard of or know about the agency before they are referred to EBHV; this promotes a sense of credibility and trust among families in the EBHV program.

Another key factor in Spruce's success was the co-location of the EBHV program and multiple other maternal and child programs, such as Maternal Support Services (MSS), infant case management services, Parent Child Assistance Program (PCAP) for mothers struggling with substance abuse, Medicaid, a drop-in center, parenting classes, a Tools of the Mind preschool program, mental health providers, a postpartum depression support group, and lactation consultation. As a result of this proximity, the EBHV program has a very strong referral network with the other programs and is better able to support the whole family. Program staff noted that many of their families are getting multiple points of contact and different services from within Spruce Family Services. When families

come in for other services and may be good candidates for EBHV, the other programs can refer to PAT in-house. In essence, the agency serves as an informal centralized in-take for the community because it offers so many maternal and child programs. The EBHV program is not just co-located with the other programs, but program leaders also have staff work or at least train in more than one program, which helps to create cohesion and a more holistic approach to serving families. Cross-staffing and training across programs also strengthens referrals and communication across services.

Spruce program leaders reported being mindful of sustainability and the value of braiding multiple funding sources to allow for flexibility in meeting families' needs (e.g., families at-risk as well as high-risk families). For instance, the program is able to serve teen mothers who do not present with any other risk factors. By braiding funding, Spruce is able to bring in a variety of resources that a program that is solely MIECHV funded would not be able to do.

> *[Because we braid our funding,] we have the opportunity to find the right timing and match what the family's needs are with the right program at the right time.*

However, a challenging byproduct of diversified funding is that the already-complex data collection requirements associated with conducting EBHV are further amplified by having multiple funders to report to. Using a combination of documents and charts, Spruce leaders attempted to summarize and explain to the home visitors the relationships with various funders, and the rationale behind each data collection task. Despite these efforts, documentation remained a source of frustration for many home visitors and program leaders.

The qualities and dedication of the staff were critical assets to the Spruce EBHV program's success and longevity. Staff were described as dynamic, passionate, caring, intelligent, and highly skilled. Program leaders noted that the PAT staff is diverse in their experiences and areas of expertise, including staff who were previously clients themselves, staff who provide EBHV services through PCAP, early childhood educators, and former nurses and mental health professionals. Having staff who represent and can identify with the clients they serve, and who also have expertise in multiple domains is an asset to the program. Leaders also acknowledged the need to promote self-care among home visitors, since many have experienced challenges in their own lives and are at risk for re-traumatization while working with clients. Home visitors also identified a need for more supports, both in the form of additional case conferencing with program leaders, and in increased opportunities to problem-solve and debrief with peers.

Discussion of Key Cross-Cutting Findings

Our four profiled EBHV programs were both similar to and very different from each other due to a number of factors that were equally as defining of their character as the rural status that united them. In order to paint a broader picture of rural programs' MIECHV implementation experiences, we purposely selected sites that represented a combination of start-up and expansion programs, NFP and PAT models, those serving a mainly rural community versus a mixed rural and urban community, and programs that did or did not participate in the community planning process. The four sites and their primary characteristics were as follows,

- ♦ Alder Community Health Center (ACHC): PAT start-up program that served a mainly rural community and participated in the community planning process
- ♦ Cedar County Health Department: NFP start-up program that served a mainly rural community that did not participate in the community planning process
- ♦ Pine County Health Department: NFP expansion site that served a mixed rural/urban community
- ♦ Spruce Family Services: PAT expansion site that served a mainly rural community

Additionally, the specific community context of each of the four programs varied greatly; for example, ACHC served a predominantly Hispanic migrant population in an agricultural community, while Spruce had a significant number of migrant clients but still served mostly White families living in an area that was rural but very popular with tourists. Despite the differences, we did see some commonalities across the four programs:

- ♦ Staff at all four programs cited seeing positive change in the behavior and circumstances of their clients as their primary and most important success.
- ♦ Some challenges common to all sites were the data collection and documentation burden, and the stress inherent to working with high-needs clients experienced by home visitors.
- ♦ Common challenges related to being a rural program included having fewer available resources in the community, needing to refer clients outside of the community especially for specialty services, transportation challenges for both clients and home visitors, and a restricted labor pool which affected the ability to hire and retain qualified EBHV program staff.

Notable findings gleaned from across the four sites as are follows:

- ♦ **Successful hiring and retention of the appropriate staff is important for a program's long-term success.** This is consistent with the Selection (Competency) Driver, under Implementation Science. Successful hiring is dependent on a program's ability to attract qualified applicants; this requires congruency between the offered working and living conditions (including pay, community characteristics etc.), and the requirements of the positions they are hiring for.
  - o **Using nurses, who have high levels of formal education, as staff compounds hiring difficulties in rural communities that already have a restricted labor pool.** Health departments and hospitals also tend to have unionized workforces and more rigid pay structure rules, so an NFP program may not have any discretion in adjusting pay as a means to attract and retain staff. *This was a challenge for the Cedar County NFP program, which needed to hire bachelor's-level nurses using a pay scale that was too low to be attractive. Hiring and retention was less of a challenge for the Pine County NFP program, possibly due in part to their location being more desirable, and higher pay.*
  - o **The PAT model allows for more flexibility in hiring.** PAT programs can hire individuals with lower formal education but who may better reflect and connect with clients. The drawback is the program may need to conduct more in-service training of

paraprofessionals once hired, but some programs are willing to accept this trade-off. *ACHC used this strategy, as did Spruce, where some home visitors were former clients.*

♦ **Once hired, staff who feel supported are more likely to stay.** Support can come from leaders (through formal supervision, moral support, and setting the tone and priorities of the program), from peers (through informal opportunities to debrief and "unload," and formal case-conferencing), and opportunities to grow their skills (through availability of training and professional development). This is consistent with a number of Implementation Drivers, including the Training and Coaching (Competency) Drivers, the Facilitative Administration (Organization) Driver, and the Leadership Drivers. *The level of peer support at ACHC was notably high; leader support at Pine was notably high; Spruce home visitors described adequate peer support but desired more leader support; and Cedar did not have consistently strong leader or peer support, as they struggled with persistent turnover of both home visitors and supervisors.*

o **Pay and quality of life (e.g., hours worked, travel burden, paperwork burden, feeling supported by leaders and peers) have an impact on staff mental health and morale.** *The Cedar program closed due to an inability to retain staff, which resulted largely from low pay and overall low support. Spruce also experienced a higher rate of home visitor turnover.*

♦ **A growing proportion of home visitor staff time is now spent on documentation and data collection, although thus far, programs have had limited success in using these data to inform their practice.** This represents a Decision Support Data System (Organization) Driver challenge. Duplicative data collection was particularly frustrating for program staff; they felt that at times they were reporting the same data in multiple places (e.g., for MIECHV benchmarks, to the models, Thrive, and other funders) and expressed a need for more coordination or data sharing among funders. *This was expressed by staff at all four sites.* The paperwork burden also negatively impacts home visitors' overall job satisfaction. *Spruce was particularly impacted by this, likely due to their funding coming from multiple sources.* The increase in data collection requirements also has implications for hiring staff. Paraprofessionals who have less formal education and computer experience may find it particularly challenging to meet this demand of the position. *This was the ACHC experience.*

♦ **Staff dissatisfaction leads to turnover, which then contributes to client attrition (i.e., many clients of departing home visitors exit the program due to loss of the relationship) and lower program capacity (i.e., new home visitors need training and carry lower caseloads.** *This was a challenge for Cedar; it is unclear if home visitor turnover at Spruce impacted client attrition, but they operated at full capacity, largely due to a strong referral network.*

♦ **The ability to maintain full caseloads and operate at maximum capacity is important for a program's long-term success, and a strong referral network is necessary for maintaining full caseloads.** Having other programs, such as WIC or MSS, co-located within an agency to refer from internally can be a major advantage. *ACHC and Spruce had this, while Pine and Cedar did not.* Building a robust external referral network is also important;

fostering collaboration instead of competition among community agencies makes this possible. Potential conflicts over "turf" can be avoided by establishing agreed-upon upon referral guidelines based on client characteristics and program priorities. This is consistent with the Systems Intervention (Organization) Driver. *Cedar had difficulty gaining referrals because other agencies viewed them as competition for clients, despite the fact that potential clients outnumbered available slots; they needed to bring HUB staff in to mediate.*

- o **Referrals are a product of trust built between two agencies; this relationship-building requires time and energy and is often disrupted when key staff turn over.** *This was a challenge for the Pine and Cedar programs.*

♦ **The community planning process that ACHC experienced created many of the "conditions of success" described above, such as successful hiring and retention of staff, and ability to maintain full caseloads and operate at maximum capacity, and positioned the agency to more efficiently and effectively start up and sustain their EBHV program**. The successes of the planning process demonstrated that investing in Exploration as an Implementation Science stage leading up to and distinct from Installation is worthwhile in the long term. The community planning process fostered support (buy-in) for the new ACHC PAT program from across the community, and promoted cross-agency collaboration rather than competition. It enabled the community to make an informed choice of EBHV model that best fit their needs; PAT allowed flexibility in visit content and staff hiring. A strong internal and external referral network, built through cross-agency collaboration, allowed them to quickly reach and maintain maximum program capacity. And finally, the flexibility in hiring allowed for the creation of an effective and cohesive staff, which contributed to low turnover. In general, the community planning process was viewed positively enough that ACHC staff reported wanting to use it internally as part of future efforts to expand their services. DEL and Thrive HUB staff also reported considering using it to develop capacity in other under-resourced communities, such as minority or immigrant communities.

- o **HUB staff observed that there were benefits to participating in the community planning process even for communities that went through the process but were not awarded MIECHV funding, because their level of preparation left them well-positioned to seek other sources of support.**

♦ **A challenge of the community planning process was that, with only two models, it was difficult for the facilitators to avoid giving the impression that the PAT and NFP models were in competition with one another.** Inherent characteristics of the process (i.e., constraints resulting from the funding amount and short timeline) also left NFP at a disadvantage. NFP programs are often housed within county health departments and hospitals, which have bureaucracies that require longer decision-making timeframes.

♦ **Rural communities often have more success implementing NFP using a "regional" or "mentoring" approach, in which a higher capacity county supports a neighboring lower capacity county via contracting of staff or supervisors.** This is because many rural county health departments are lower capacity departments that focus on enforcing health and safety regulations, and do not independently have the infrastructure required to provide direct services such as NFP programming. This pooling of resources in order to

better meet service delivery expectations is consistent with the Systems Intervention (Organization) Driver. *The Pine NFP program was able to provide contracted supervision to a neighboring county as the latter started its program, and the Cedar program ultimately employed a regional model by transitioning its client base to a neighboring county's program.*

♦ **HUB staff experienced both successes and challenges in supporting implementation of EBHV in rural communities.** Programs needed both model-specific and general operations support (e.g., with contracts), and they found support from the HUB to be invaluable, but also lacking in some ways. HUB staff reported their successes included model support provided by the NFP state model lead; the role it played as convener, bringing programs together and connecting them with one another; work conducted with programs on increasing their capacity for CQI; and rural development through the community planning process. Challenges faced included finding it harder to support the start-up of rural NFP programs; finding it harder to support rural programs that were smaller and had less capacity; contextual challenges among rural programs such as high staff turnover and the need for lower caseloads; and trying to dispel the "myth" that rural programs receive less TA than their urban counterparts because they are farther away.

  o **Programs cited staff turnover at the HUB, and the lack of an integrated PAT state model lead, as key barriers to their ability to access sufficient implementation supports.** The PAT programs generally felt that model-specific support was lacking, and at times in direct conflict with information received from the HUB. The need to increase supportive alignment across systems relates to the Systems Intervention (Organization) Driver.

Outcome Rural Analyses

Introduction and Methods

The RISE team hypothesized that programs located in rural communities in Washington might differ from programs located in urban and or mixed rural/urban settings on key outcome constructs: use of training, TA, coaching and support; quality implementation and model fidelity; and staff competency and self-efficacy. The rural setting provides unique opportunities as well as challenges for programs implementing evidence based home visiting; geographic isolation and fewer resources in the vicinity can result in fewer services for clients and less support for program staff.

To understand how rural programs differ from programs located in urban or mixed settings, the RISE team conducted an analysis on key outcome items from the three major outcome constructs where differences might be expected based on geographic location. Using baseline data provided by the NFP and PAT NSOs at the start of the evaluation, programs were coded as serving communities that were rural, urban, or mixed (both urban and rural). Of the 18 programs in Washington, 11 serve rural communities, three serve urban communities, and four serve mixed communities[53]. For this analysis, the urban and mixed categories were collapsed (referred to as "non-rural").

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[53] Among PAT programs, five are rural, one is urban, and four are mixed. Among NFP programs, six are rural and two are mixed.

Key items were identified in each outcome data source (Program Practices Survey, TA log, Home Visiting Snapshot, NSO export data, and turnover analysis). Using the most recent data for each data source,[54] we conducted descriptive analyses and significance tests (*t*-tests for continuous data; *z*-scores for population proportions; chi-square for categorical and ordinal data) to compare differences between rural and non-rural programs. Across the outcome constructs, significant findings were identified for training, TA, coaching, and support, and for staff competency and self-efficacy. No significant differences were found between rural and non-rural programs on items relating model fidelity and implementation quality, or on measures of staff turnover. Significant findings are discussed below.

Rural Outcome Analysis Findings

Training, TA, coaching, and support

♦ On average, supervisors at rural programs received significantly more TA hours per month than their non-rural counterparts (8.7 hours vs. 5.3 hours; *p* < .10) at Time 3. Rural home visitors also received more TA hours per month compared with non-rural home visitors (3.3 hours vs. 2.9 hours), but the difference did not reach statistical significance. These findings suggest that the common perception that rural programs receive less TA than non-rural programs due to their geographic remoteness is not accurate in the case of these 18 programs in Washington. This may be due, in part, to deliberate efforts on the part of the HUB to actively support rural programs, and to the ability to bypass geographic barriers by providing TA in "remote" formats such as virtually or on the phone.

To test the hypothesis regarding HUB support, we examined whether rural programs received a significantly different proportion of their TA from Thrive staff, the WA state model leads, and the NFP or PAT NSOs, as compared to non-rural programs (Exhibit 56).

○ We found no significant differences in the percentage of TA attributed to Thrive staff in rural versus non-rural programs, for either supervisors or home visitors.

○ Rural supervisors did attribute significantly more of their TA to the WA state model leads compared to non-rural supervisors (27% vs. 3%; *p* < .10), however. There are a number of potential explanations for this. First, this could be related to sample composition. At Time 3, PAT program staff did not attribute any TA to the PAT state model lead because the position was vacant. Thus, the fact that there is a near-even split between NFP and PAT among rural programs (6 vs. 5), while non-rural programs are predominantly PAT (5 vs. 2), could be contributing to this finding. Second, it is possible that rural NFP supervisors relied more heavily on the NFP model lead because she has an extensive background working in and with rural programs. Third, it is possible that rural NFP supervisors relied more heavily on the model lead because they had less access to other sources of TA. We found no significant difference in percentage of TA attributed to the state model leads for rural versus non-rural home visitors (8% vs. 4%).

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[54] See Exhibits 10 and 11 for Outcome Evaluation Data Sources and Timing. One rural NFP program closed in December 2016, and thus was not represented in the most recent Program Practices Survey, but did submit snapshot forms and TA logs.

- On the other hand, rural home visitors attributed significantly more of their TA to the NFP or PAT NSOs compared to non-rural home visitors (13% vs. 4%; $p < .10$). Again, this could be related to access; rural home visitors may have less access to other sources of TA (e.g., non-profit, or government agency). Here, we found no significant difference in percentage of TA attributed to the NFP or PAT NSOs for rural versus non-rural home supervisors (13% vs. 15%).

Exhibit 56. Percentage of TA Events by Sponsor/Presenter for Rural vs. Non-rural Staff at Time 3

Sponsor/Presenter	Rural Supervisors (%) n = 11	Non-rural Supervisors (%) n = 12	Rural Home Visitors (%) n = 63	Non-rural Home Visitors (%) n = 51
WA model leads	27	3*	8	4
Thrive	18	14	13	18
NFP/PAT national office	13	15	13	4+

Source: TA log data (2016–17).

Note: Differences tested for statistical significance were those between rural and non-rural supervisors (*$p < .10$; **$p < .05$; ***$p < .01$) and between rural and non-rural home visitors at Time 3 (+$p < .10$; ++$p < .05$; +++$p < .01$).

- ♦ To test the hypothesis regarding rural programs receiving more TA in "remote" formats, we examined whether rural programs, compared to non-rural programs, received a significantly different proportion of their TA in the following formats: in-person workshops, meetings, and trainings; on-site/in-person individualized; remote individualized; and remote workshops, meetings, and trainings (Exhibit 57).
  - We found no significant differences in the percentage of TA received as in-person workshops, meetings, and trainings or TA received in a remote individualized format for rural versus non-rural programs, for either supervisors or home visitors.
  - Rural home visitors did receive a significantly smaller percentage of their TA in on-site/in-person individualized format compared to non-rural home visitors (5% vs. 26%; $p < .05$), however. The finding was similar for rural supervisors compared to non-rural supervisors (6% vs. 29%), but the difference did not reach statistical significance, likely due smaller sample size. This supports the common perception that rural staff receive less face-to-face TA due to geographic isolation, although the rate of in-person workshops (above) did not differ between rural and non-rural programs. It is possible that the cost of travel for TA providers is better justified when they are scheduled to meet with a group of staff (as would be the case with workshops, meetings, and trainings), but is less justifiable for individualized one-on-one interactions. With workshops and trainings, it is also possible that the program staff, rather than the TA providers, traveled to attend events held at a centralized location.
  - Rural home visitors received a significantly greater percentage of TA as remote workshops, meetings, and trainings compared to non-rural home visitors (32% vs. 12%;

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p < .05), however. Again, this supports rural staff receiving a larger proportion of their TA remotely, although in-person workshops, meetings, and trainings was still the most prevalent TA format for all staff (supervisors and home visitors, rural and non-rural). There was no significant difference in percentage of remote workshops for rural (31%) versus non-rural (24%) supervisors.

♦ Supervisors and administrators at rural programs were significantly more likely to be "satisfied" or "very satisfied" with in-person workshops that they participated in during the last six months when compared with non-rural supervisors (rural 100%, 80% non-rural; *p* < .10). During the 6-month period reflected in survey responses, respondents were likely to have attended cohort meetings hosted by the HUB. The higher level of satisfaction among rural programs may reflect rural programs' satisfaction with the opportunity to connect with staff across programs.

Exhibit 57.   Percentage of TA Events by Format for Rural vs. Non-rural Staff at Time 3

TA Format	Rural Supervisors (%) *n* = 11	Non-rural Supervisors (%) *n* = 12	Rural Home Visitors (%) *n* = 63	Non-rural Home Visitors (%) *n* = 51
In-person workshops, meetings, trainings	33	35	59	52
Remote individualized	27	10	3	3
Remote workshops, meetings, trainings	31	24	32	12++
On-site/in-person individualized	6	29	5	26+++
Other	2	2	1	6

Source: TA log data (2016–17).

Note: Differences tested for statistical significance were those between rural and non-rural supervisors (**p* < .10; ***p* < .05; ****p* < .01) and between rural and non-rural home visitors at Time 3 (+*p* < .10; ++*p* < .05; +++*p* < .01).

Staff competency and self-efficacy

♦ Home visitors at rural sites were significantly less likely than their non-rural counterparts to report meeting with their supervisors "a couple times per month" or more frequently (rural 86%, non-rural 97%; *p* < .10). However, rural home visitors were about as likely as non-rural home visitors to report that supervision sessions were scheduled "a couple times per month" or more frequently (rural 89%, non-rural 94%). This indicates that rural programs may place a similar value on supervision, but that in actuality it takes place less often, possibly due to logistical challenges related to the rural setting (e.g., more staff time spent on the road traveling rather than in the office).

♦ Home visitors at rural programs were significantly more likely to agree "quite a bit" or "very much" that it is "important to deliver the NFP/PAT intervention in the same way it was done in studies that found it to be effective" (rural 90%, non-rural 75%; *p* < .05),

demonstrating positive attitudes towards evidence based home visiting. This suggests that belief in evidence based practices may be a strength across rural home visiting programs, as it provides a framework for home visitors to conduct work effectively despite potential challenges of the rural context (fewer opportunities for face-to-face supervision, fewer opportunities to connect with other programs, etc.).

♦ On a survey item relating to best practices associated with home visiting work, home visitors at rural sites were significantly less likely to report that during "many" or "most" visits "the child excitedly turns to the mother when you arrive, expecting something fun together" (rural 66%, non-rural 87%, p < .05). This suggests that home visitors at rural programs may not be doing as much facilitation of effective parent-child interactions during home visits as their non-rural counterparts. Home visitors at rural programs may benefit from TA and support on this topic.

Rural Substudy Summary

While providing evidence based home visiting services in a rural setting may present additional or unique implementation challenges, the lack of significant differences on model fidelity and implementation quality items suggest that rural programs are just as capable of reaching fidelity and quality implementation. There are several commonalities and points of convergence in the results of the rural case study and rural outcome analysis.

♦ **Rural home visiting can be isolating work; programs value and are eager for more opportunities to stay connected and share across-programs.** The isolating nature of home visiting was a cross-cutting theme in the rural case study and the outcome analyses revealed that rural programs were more likely to satisfied with in-person workshops. Although rural staff receive more TA hours than non-rural staff, more of their TA is received in remote formats and they receive noticeably less in-person individualized TA.

♦ **The travel time involved in providing home visiting services in a rural area is a feature that can present a barrier to quality implementation.** Travel time and dispersion of clients was a common cross-cutting challenge identified in the rural case study site visits. The added travel time may reduce the time available for important activities outside of home visits, such as supervision. In the outcome analysis, home visitors at rural sites were significantly less likely to report actually meeting with their supervisors a couple times a month or more frequently that home visitors in non-rural programs.

♦ **Although there are unique barriers, rural programs also have many strengths.** One such strength found across methods was the dedication of staff to implementing evidence based home visiting. IN the outcome analysis, rural home visitors reported significantly more positive attitudes towards implementing evidence based home visiting than non-rural home visitors.

♦ **Overall, there were few differences between rural and non-rural programs, which suggests that by and large the implementation drivers of successful implementation of evidence based home visiting are not unique to rural areas.** For instance, undergoing a community planning process and exploration phase work would help any new start-up home visiting program put into place the implementation drivers in order to be successful.

However, it may be that for lower-resourced communities with very high-risk populations, attending to the implementation drivers and completing exploration prior to implementation are even more critical for rural EBHV programs.

Key Implications and Recommendations

Based upon the information from the additional year of the outcome evaluation from a wide variety of sources at both the individual- and program-level, and the findings from the rural substudy, we developed a set of key implications and recommendations for the HUB and state to consider as it continues to build its home visiting system and supports.

- ♦ Support transmission from **supervisors to home visitors** by developing a consistent message about expected indirect benefits from TA and provide HUB TA staff with strategies to use with supervisors to encourage further transmission of ideas and changes.

- ♦ Develop a consistent message about expected indirect benefits from TA and provide HUB TA staff with strategies to use with supervisors to encourage further transmission of ideas and changes.

- ♦ To support change in both program and system level outcomes, **clarify how HUB work** is connected to program and systems level outcomes and specify the amount of time HUB staff are expected to focus on program-focused vs. systems-focused activities.

- ♦ To support change in practice around a specific topic, generate an **annual TA plan** with emphasis on specific topics; include planned activities that supplement individualized TA work.

- ♦ **Use the community planning process whenever time and resources permit.** Dedicating time and energy to Exploration, as a stage leading up to and distinct from Installation, is worth the upfront investment, because it creates conditions that enable the agency to implement its chosen EBHV model more efficiently and effectively. Additionally, using the community planning process to prepare multiple communities to apply for competitive grant funding gives the granting entity latitude to fund only those communities that have demonstrated readiness to implement.

- ♦ **Get true buy-in, in the form of a deep commitment to facilitating a program's success, from the agency's key decision-makers, as this can be critical for the program's longevity.** Without a willingness from leaders to find creative solutions to problems that may arise, and at times, to challenge the status quo, some roadblocks to implementation may prove insurmountable.

- ♦ **Communities should choose an EBHV model keeping both client needs and program staffing needs in mind.** They must be able to meet the needs of the families, and the requirements of the model, with the applicants available to them in their particular community.

- ♦ **Support home visiting staff with a robust system of supervisory and peer supports to reduce burnout and turnover.** Opportunities for skill development, collective problem solving, and emotional "unloading" are important, as are policies demonstrating respect for home visitors' overall quality of life. The HUB and local program leaders can create a supportive environment for staff through both formal and informal means. The formal

supports include reflective supervision and opportunities for professional development, while the latter includes instituting policies that value home visitors' daily experience and setting a warm and caring tone in the workplace.

♦ **Employ home visitors with varied backgrounds and a deep skill set to serve clients well, and support their continued professional growth and self-care.** Strategies can include holding meetings to address specific topics such as how to set boundaries with clients, and providing regular opportunities for home visitors to lighten their emotional burden through effective supervision and conferencing with peers.

♦ **Programs need a strong referral network to sustain their caseloads.** Relationship building with external partners is particularly important if there is no internal source of referrals.

♦ **If possible, co-locate an EBHV program with other maternal or child services within an agency.** Advantages include a ready source of referrals and a single point of entry into a network of services that may represent a more holistic approach toward serving families.

♦ **Open communication channels among local agencies to dispel the tendency to compete with one another for clients, and build referral relationships instead.** This may be best accomplished via third-party facilitation by a common funder, such as the Thrive HUB, or through existing community coalitions. Guidelines for matching clients to programs should be mutually agreed upon, so that slots at all agencies are filled, and families receive services that are the best fit for their needs.

♦ **Rural home visiting can be isolating work; programs value and are eager for more opportunities to stay connected and share across-programs.** Rural programs received more remote TA than non-rural programs but report the highest satisfaction with in-person workshops. Thus, it may be worth increasing opportunities for in-person TA when possible as the results suggest it may have a greater impact.

Plans for Further Evaluation and Dissemination

Dissemination is an important part of making evaluation work useful. Throughout the project, we have strived to share information broadly with others in order to maximize its potential benefits. To date our dissemination has included the following activities:

♦ Annually, we have developed a report summarizing current evaluation findings along with a summary or brief and discussed it with project partners.

♦ Presentations have been shared with the core evaluation team, leadership across organizations, and with HUB staff.

♦ The RISE team developed a short infographic summarizing descriptive information from the overall sample with all of the participating home visiting programs.[55]

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[55] Information was described about all programs participating in the evaluation rather than for intervention and comparison groups separately. This approach was adopted to maximize sharing of information and still avoid any potential of biasing intervention and comparison data collected later in the evaluation.

♦ A symposium was assembled involving three states in which we presented information about the evaluation at ACF's National Research Conference on Early Childhood (Schachner, Hudson, Barton, Gaylor, & Chen, 2016, July).

♦ A poster symposium including findings from six states was presented at the Society for Research in Child Development conference in Spring 2017 (Schachner, Gaylor, Hudson, Chen, & Barton, 2017, April).

♦ A session joint session with the state and New Hampshire will be presented at the MIECHV All Grantee Meeting in September 2017 on using implementation science to evaluate home visiting service systems.

Future dissemination plans include sharing information about findings at regional and/or national meetings and working jointly with state staff to develop one or more articles documenting key findings from the evaluation. For instance, a panel workshop on findings and lessons learned from MIECHV evaluation in six states was submitted for the Home Visiting Applied Research Collaborative (HARC) and National Home Visiting Summit in January 2018. At the conclusion of the project, we also anticipate sharing an infographic about study results with the participating programs and coordinating with national TA centers and NSO's to share highlights from the project and information that might inform their ongoing work with programs.

Concluding Remarks

There was a high level of participation in the RISE Home Visiting Evaluation across both intervention and comparison groups. Findings represent the varied beliefs and perceptions across participants in the system, with information gained using multiple types of methods and data sources. Taken together, evaluation data suggest that the HUB is providing TA and support that is increasingly in its intensity over time to home visiting programs in Washington. Programs with HUB TA and support are demonstrating effective model fidelity and implementation quality and have staff with fairly high levels of competence and self-efficacy. On most indicators, these intervention programs and their staff are not significantly different from a set of comparison programs across 18 states. Findings may be influenced somewhat by the short duration for TA effects to emerge as well as the presence of a slightly stronger representation of staff from rural programs in Washington than in comparison states. Also, programs involved in Washington all were MIECHV-funded compared to a mix of MIECHV- and non-MIECHV-funded programs in the comparison group.

References

Aarons, G. A., Fettes, D. L., Flores, L. E., Jr., & Sommerfeld, D. H. (2009). Evidence-based practice implementation and staff emotional exhaustion in children's services. *Behaviour Research and Therapy, 47*(11), 954-960. doi:10.1016/j.brat.2009.07.006

Aarons, G. A., & Palinkas, L. A. (2007). Implementation of evidence-based practice in child welfare: Service provider perspectives. *Administration and Policy in Mental Health & Mental Health Services Research, 34*, 411-419.

Aarons, G. A., Sommerfeld, D. H., Hecht, D. B., Silovsky, J. F., & Chaffin, M. J. (2009). The impact of evidence-based practice implementation and fidelity monitoring on staff turnover: Evidence for a protective effect. *Journal of Consulting and Clinical Psychology, 77*(2), 270-280. doi:10.1037/a0013223

Avellar, S. A., & Supplee, L. H. (2013). Effectiveness of home visiting in improving child health and reducing child maltreatment. *Pediatrics, 132*, S90-S99. doi:10.1542/peds.2013-1021G

Caliendo, M., & Kopeinig, S. (2008). Some practical guidance for the implementation of propensity score matching. *Journal of Economic Surveys, 22*(1), 31-72.

Daro, D., Hart, B., Boller, K., & Bradley, M. C. (2012). *Replicating home visiting programs with fidelity: Baseline data and preliminary findings*. Princeton, NJ: Mathematica Policy Research.

Eggbeer, L., Mann, T. L., & Seibel, N. L. (2007). Reflective supervision: Past, present, and future. *Zero To Three, 28*(2), 5-9.

Gaylor, E., Schachner, A., Barton, L., Hudson, L., & Chen, W.-B. (2016). *RISE Home Visiting Evaluation: Annual Report 2016- Selected Findings from Years 1, 2, and 3 of the Evaluation*. Menlo Park, CA: SRI International.

Gaylor, E., Winer, A., Barton, L., Chen, W.-B., & Hudson, L. (2014). *RISE Home Visiting Evaluation: Annual Report 2016- Selected Findings from Year 1 of the Evaluation*. Menlo Park, CA: SRI International.

Gaylor, E., Winer, A., Barton, L., Chen, W.-B., & Hudson, L. (2015). *RISE Home Visiting Evaluation: Annual Report 2016- Selected Findings from Years 1 and 2 of the Evaluation*. Menlo Park, CA: SRI International.

Hallgren, K., Boller, K., & Paulsell, D. (2010). *Better beginnings: Partnering with families for early learning home visit observations*. Princeton, NJ: Mathematica Policy Research.

Heckman, J., Ichimura, H., Smith, J., & Todd, P. (1998). Characterizing selection bias using experimental data. *Econometrica, 66*(5), 1017–1098.

Hedeker, D., & Gibbons, R. D. (2006). *Longitudinal data analysis*. New York, NY: John Wiley & Sons.

Karoly, L. A., Kilburn, M. R., & Cannon, J. S. (2005). *Early childhood interventions: Proven results, future promise*. Santa Monica, CA: RAND.

Korfmacher, J., & Chawla, N. (2013). *Toolkit of recommended curricula and assessments for early childhood home visiting*. Geneva: UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent states (CEECIS). Retrieved from http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/Home_Visiting_Program_Quality_Rating_Tool_report.pdf.

Lamorey, S., & Wilcox, J. M. (2005). Early intervention practitioners' self-efficacy: A measure and its applications. *Early Childhood Research Quarterly, 20*, 69-84.

Lechner, M. (2002). Some practical issues in the evaluation of heterogeneous labour market programmes by matching methods. *Journal of the Royal Statistical Society: Series A (Statistics in Society), 165*, 59-82. doi:10.1542/peds.2013-1021G

Michalopoulos, C., Bloom, H. S., & Hill, C. J. (2004). Can propensity score methods match the findings from a random assignment evaluation of mandatory welfare-to-work programs? *Review of Economics and Statistics, 86*(1), 156-179.

Patient Protection and Affordable Care Act, Pub. L. No. 111–148 (2010).

Ravallion, M. (2001). The mystery of the vanishing benefits: An introduction to impact evaluation. *The World Bank Economic Review, 15*(1), 115-140. doi:10.1093/wber/15.1.115

Roggman, L., Cook, G., Boyce, L., & Innocenti, M. (2010). *HVFlags: A self-reflection tool for home visitors*. Logan, UT: Utah State University.

Roggman, L. A., Cook, G. A., & Jump Norman, V. K. (2008). Parent satisfaction with the home visitor and home visit: A survey for parents. In L. A. Roggman, L. K. Boyce, & M. S. Innocenti (Eds.), *Developmental Parenting: A Guide for Early Childhood Practitioners* (pp. 206-208). Baltimore, MD: Paul H. Brookes.

Roggman, L. A., Cook, G. A., Jump Norman, V. K., Christiansen, K., Boyce, L. K., & Innocenti, M. S. (2008). Parent satisfaction with the home visitor and home visit: A survey for parents. In L. A. Roggman, L. K. Boyce, & M. S. Innocenti (Eds.), *Developmental Parenting: A Guide for Early Childhood Practitioners* (pp. 209-217). Baltimore, MD: Paul H. Brookes.

Rosenbaum, P. R., & Rubin, D. B. (1983). The central role of the propensity score in observational studies for causal effects. *Biometrika, 70*(1), 41–55.

Rosenbaum, P. R., & Rubin, D. B. (1984). Reducing bias in observational studies using subclassification n the propensity score. *Journal of the American Statistical Association, 79*, 516-524.

Rosenbaum, P. R., & Rubin, D. B. (1985). Constructing a control group using multivariate matched sampling methods that incorporate the propensity score. *American Statistician, 39*, 33-38.

Schachner, A. C. W., Gaylor, E., Hudson, L., Chen, W.-B., & Barton, L. (2017, April). *Researching Implementation Support Experiences (RISE): The Washington state MIECHV evaluation*. Poster presented at the Taking evidence-based home visiting to scale: Findings from state Maternal Infant and Early Childhood Home Visiting evaluations at the 2017 Society for Research on Child Development Biannual Meeting, Austin, TX.

Schachner, A. C. W., Hudson, L., Barton, L., Gaylor, E., & Chen, W.-B. (2016, July). *Researching Implementation Support Experiences (RISE): The Washington state MIECHV evaluation*. Paper presented at the State of states' Maternal, Infant, and Early Childhood Home Visiting (MIECHV) evaluations at the Association for Children and Family's National Research Conference on Early Childhood, Washington, DC.

Stark, D. R., Gebhard, B., & DiLauro, E. (2014). *The maternal, infant, and early childhood home visiting program: Smart investments build strong systems for young children*. Washington, DC: Zero to Three Policy Center.

Washington State Institute for Public Policy. (2014). *Benefit-cost results*. Olympia, WA: Author. Retrieved from http://www.wsipp.wa.gov/BenefitCost/Pdf/3/WSIPP_BenefitCost_Child-Welfare

Weatherston, D., Weigand, R. F., & Weigand, B. (2010). Reflective supervision: Reflection as a cornerstone for competency. *Zero To Three, 31*(November), 22-30.

Workgroup on Principles and Practices in Natural Environments, & OSEP TA Community of Practice: Part C Setting. (2008). *Agreed upon practices for providing early intervention services in natural environments*. Retrieved from http://www.ectacenter.org/~pdfs/topics/families/agreeduponpractices_finaldraft2_01_08.pdf

Appendix A
Overview of the Home Visiting Services Account (HVSA)

HOME VISITING SERVICES ACCOUNT

Over the past decade, and especially in the past four years, Washington has increasingly prioritized home visiting to meet the needs of our most vulnerable children and families. Evidence shows that when families receive home-based support:

Children are healthier and better prepared for school
Parent-child bonds are stronger | Abuse and neglect are less likely

Keys to Washington's Home Visiting System

In a unique and successful public-private partnership, Thrive by Five Washington and the Department of Early Learning collaborate to administer the Washington Home Visiting Services Account (HVSA). There are four key functions in the HVSA.

■ Serve families: With home visiting, families are better equipped to give their children a great start in life. The HVSA continues to expand to serve more families; it has 36 grantees with the capacity to serve approximately 2,100 families statewide in state fiscal year 2015. We know that the earliest years are most important for development, and to have the greatest impact, the HVSA invests in our youngest learners. About 95 percent of children served are under age 3.

■ Ensure high quality: The HVSA is focused on maintaining and improving quality by building capacity and focusing on accountability. Important investments in quality assurance and evaluation enable the use of data to inform policy and practice. Measuring success requires the HVSA to invest in evaluation and continuous quality improvement initiatives.

■ Centralize program support: Training and technical assistance benefit home visitors and the families they serve. The HVSA provides individualized and targeted coaching and training that will add up to more than 750 hours in state fiscal year 2015.

■ Empower communities: The HVSA portfolio opens the door to diverse models and programs, to meet diverse community needs. Three programs in rural areas were launched as the result of a yearlong community-specific planning process. In state fiscal year 2015, the HVSA funding is reaching at least 21 Washington counties, plus a tribal-specific home visiting program in the coming year.

What is Home Visiting?

Either before their child's birth or in their child's first few years of life, families are voluntarily matched with trained professionals who provide information and support related to children's healthy development, the parent-child relationship, and the importance of early learning in the home. The benefits of home visiting span more than one generation.

Investing in Families

Pivotal Moment in Home Visiting

Federal funding is in year four of a five-year grant. State and federal funds are leveraged with private dollars. Maintaining existing public and private investment in home visiting will sustain current services but not enable expansion. DEL and Thrive are developing a finance and sustainability strategy for the HVSA.

HVSA Funding Streams
State Fiscal Year 2014-15 *Projected*

Private: 18%
Federal: 71%
State: 11%

Total Investment: $15 million

HOME VISITING BENEFITS FAMILIES STATEWIDE

One Family's Story

For young parents who have a history of abuse, it can be challenging to achieve enough stability to give their children a great start in life. Carrie* is one such mother, who was homeless and struggling with heroin addiction when she became pregnant. She had a harrowing childhood, with a history of emotional, physical and sexual abuse, and all of her immediate family members suffered from addiction or mental health problems.

Carrie stopped using heroin when she learned she was pregnant, but her baby was born early and addicted to methadone. Carrie joined parent support groups and received some support from a transitional housing program before enrolling in home visiting.

After only a few months of home visiting, Carrie and her daughter are demonstrating positive changes in their relationship. The home visitor brings a book to every visit, and offers information about daughter Rachel's developmental stages and milestones.

"The handouts help me to have more realistic expectations about what Rachel can do," Carrie says. "And I can practice the activities with her and look forward to what she will be able to do in the next stage."

In the open and trusting relationship that the home visitor developed with Carrie, she was able to guide Carrie to play and bond with Rachel. Mother and daughter read together every day, and Rachel is reaching or exceeding all her developmental milestones. She's a happy toddler, social and learning to self-regulate — skills that will be foundational for success in school and life. For now, she carries books with her wherever she goes and turns the pages herself, babbling to pretend like she's reading.

"Now I see she does all kinds of things ahead of schedule," Carrie says.

Carrie is also taking an impressive leadership role, volunteering to have a state lawmaker visit her home and show how home visiting has changed the trajectory for her family's life.

*Names changed to maintain confidentiality

840

families enrolled in HVSA-funded programs lived in western Washington July 1 - Sept. 30, 2014*

725

families enrolled in HVSA-funded programs lived in eastern Washington July 1 - Sept. 30, 2014*
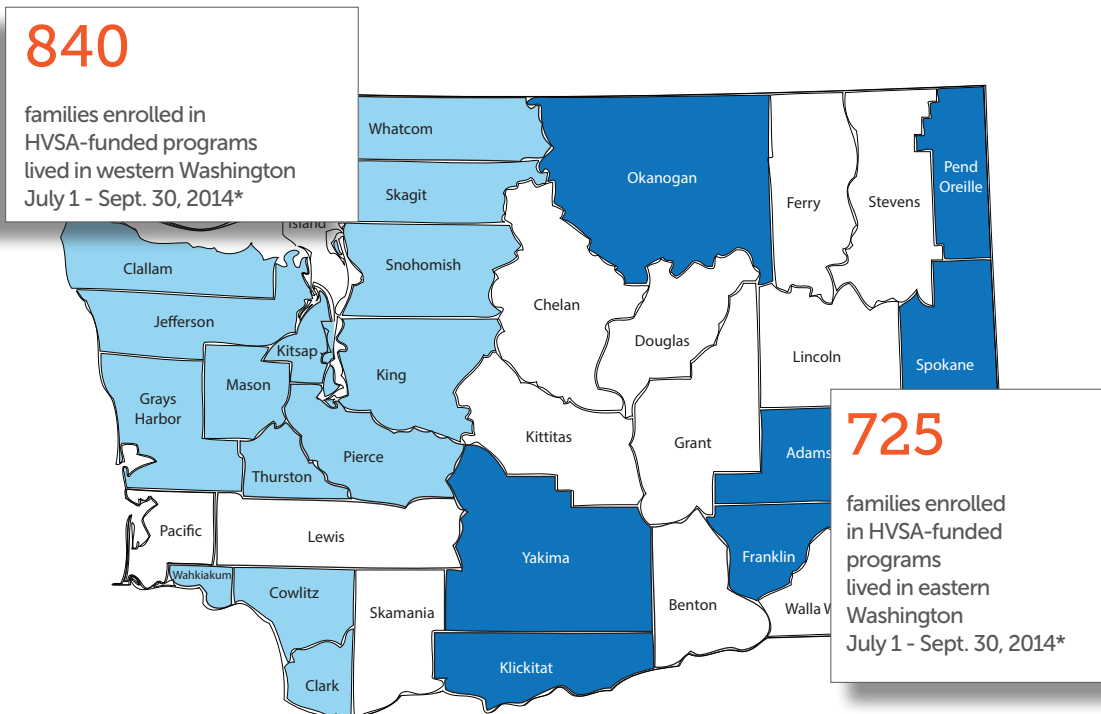
Families Enrolled, By Geography

Washington is geographically diverse, and its many regions have different communities, needs, and resources. The HVSA values investing funds in communities across the state—especially in those communities that are under-resourced. For a complete list of programs, visit **thrivebyfivewa.org/hvsa-wa**

Map counties: Whatcom, Skagit, Island, Clallam, Jefferson, Snohomish, Chelan, Okanogan, Ferry, Stevens, Pend Oreille, Kitsap, King, Douglas, Lincoln, Spokane, Grays Harbor, Mason, Kittitas, Grant, Adams, Pierce, Thurston, Pacific, Lewis, Benton, Franklin, Walla Walla, Wahkiakum, Cowlitz, Skamania, Yakima, Klickitat, Clark

* Latest figures available from July 1, 2014, to Sept. 30, 2014. Some programs are new, and because of the intensive nature of home visiting, it can take months to reach full enrollment. Full enrollment of all current HVSA-funded slots would be about 2,100 families.

MORE INFORMATION

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Washington State Department of
Early Learning

Appendix B
Logic Models Related to Implementation
HUB Activities

Washington State MIECHV Formula FY11 Model
Thrive Implementation HUB – Supports for LIA's Logic Model

Washington State MIECHV Formula FY11 Logic Model

Values:

- Integrated and interactive approach to EBHV program implementation and policy development
- Application of implementation science framework
- Use of participatory research principles
- Use of parent and community voice to inform planning, policy and implementation at multiple levels

RESOURCES	ACTIVITIES	OUTPUTS	Short-term Outcomes	Medium-Term Outcomes	Long-term Outcomes
• Families and Communities • Funding • Leadership and Innovation • Staffing and supervision at multiple levels • Data, Research and Evaluation • Collaborations and partnerships • Policies • Publications, materials & messages • Consultants	**Service Delivery and Access** • Make evidence-based, research-based and promising program models more widely available and accessible to local communities. • Build capacity to increase access to home visiting services in rural, tribal and other underserved communities. • Conduct culturally competent outreach to recruit and retain families in home visiting programs in underserved communities.	**Service Delivery and Access** • Grants with programs in 7 geographic areas to implement NFP and/or PAT are completed and signed • Conduct community development work for: community need; model fit; and capacity.	Ensure high-quality, culturally competent home visiting services meet the needs of local communities are available and accessible to at-risk families across the state. Ensure high-quality services and effective implementation of home visiting models and programs. • Increased technical assistance, CQI, mentoring and feedback supports through the implementation hub • Increased capacity of data system to capture home visiting benchmarks across models • Increased effective use of data, research and best practices to inform decision-	• Improved local and state capacity to support home visiting services • Decreased gaps in EBHV services in high need communities • Increased access and utilization of implementation hub supports in local communities. • Improved quality and fidelity of implementation • Increased knowledge re: current conditions of children and families in Washington; data and research, and best practices • Increased benefit for participating families in local EBHV programs	• Families receive services that align with their needs • Home visiting programs are delivered with fidelity • Child and Family Impact: Improved benefit for participating families from home visiting services **Benchmark Goals:** • Improve maternal & newborn health • Reduced child injury and maltreatment • Improve school readiness & child academic achievements

RESOURCES	ACTIVITIES	OUTPUTS	Short-term Outcomes	Medium-Term Outcomes	Long-term Outcomes
	Quality and Accountability • Increase the capacity to collect and analyze meaningful data at the program, model and systems levels for use in home visiting program improvement efforts. • Support communities in using these data for continuous quality improvement and ongoing learning in their organizations. • Build professional development opportunities, training, and technical assistance for specific models/programs to support quality implementation of home visiting services.	**Quality and Accountability** • Select MIECHV benchmark measures • Program training on: assessment tools; reporting; national model trainings; application of implementation science; and cultural competency • Every 6 months, capacity is assessed and implementation plans and improvement plans are in place • Consultation-coaching through site visits, trainings and regular individual program calls • Established program data collection systems • Quarterly program reports • CQI course corrections	making • Increased professional development opportunities, training, and technical assistance for specific models		• Reduction in domestic violence • Improve family economic self-sufficiency • Disparities in health, social and education outcomes are reduced

Thrive Implementation HUB - Supports for LIA's Logic Model
July 1, 2012 – June 30, 2014

Updated 8/29/13

Resources	Key Activities	Activity Detail	Outputs/Frequency	Goal and Objectives

1. Thrive Implementation HUB Team Staff (HUB Team):
 a. 1 FTE Home Visiting (HV) Director
 b. 1 FTE HV Senior Manager of Program Administrator (PA)
 c. 1 FTE HV Rural Development Specialist
 d. 1 FTE HV Manager
 e. 1 FTE NFP State Lead
 f. 1 FTE HV Project Coordinator
 Grants Management
 a. .8 FTE Senior Grants Manager
 b. .8 Grants Coordinator (vacant as of Sept. 2013)
 2. Subcontracted HUB Team Staff
 a. 1 FTE PAT State Lead
 b. 1 FTE PCHP State Lead
 3. Subcontracted HUB services in support of LIA's
 a. NIRN
 b. Dovetailing
 c. Evaluation Team – TBD
 d. HUB LIA Coaching Development -TBD
 e. HUB Staff Coaching - TBD
 f. MIECHV Intervention/CQI TTA Consultant -TBD`
 g. ORS – Promoting Equitable Access (PEA)
 4. Funding
 a. Private Funding
 b. State funding
 c. MIECHV Formula
 d. MIECHV Competitive
 5. GIFTS System
 6. DEL
 7. Local Implementing Agencies (LIA's)
 8. Children and families
	1. **Maintain sufficient HUB Team staffing and expertise to support LIA's**
	 2. Subcontract to provide specialized HUB Team Staff to support LIA's
	 3. Subcontract to provide Implementation Science, TTA, coaching, supervision, racial equity, CQI planning and evaluation supports related to quality of implementation of HV services by LIA's
	 4. Administer HVSA funding to LIA's
	 5. Administer GIFTS system to enhance subcontracting, reporting, monitoring, fiscal and data management of LIA's
	 6. Work collaboratively with DEL to implement HVSA evaluation and oversight activities in support of LIA's
	 7. Utilize a portfolio approach to fund a range of HV models implemented by LIA's
	 8. Support LIA's to serve and impact diverse geographic, racial/ethnic, and other demographic diversity
		1. Maintain sufficient HUB Team and Grants Management staffing to support LIA's to implement quality of HV programs
		 a. Hired 1 FTE HV Director to replace outgoing 1 FTE HV Director, August 2012
		 b. Hired new position, 1 FTE HV Senior Manager of PA. September 2012
		 c. Hired 1 FTE HV Rural Development Specialist - October 2012
		 d. Hired 1 FTE HV Manager – to replace vacant .5FTE HV Manager position December 2012
		 e. Hired 1 FTE NFP State Lead (moved to Thrive staff position) December 2012. Position previously was subcontracted through NFP National
		 f. Hired 1 FTE HV Project Coordinator to replace vacant .5FTE HV Coordinator position - June 2013
		 2. Subcontract to provide specialized support to LIAs and HUB
		 a. Subcontracted directly with PAT National for 1FTE PAT State Lead - September 2012 (Previously subcontracted with local nonprofit)
		 b. Subcontracted with PCHP National office for 1 FTE PCHP State Lead June 2013. Position pending finalist interviews to be completed September 2013
		 3. Subcontract to provide training, services, and supports related to quality of implementation of HV services by LIA's :
		 a. Subcontracted with NIRN to provide Implementation Science training for HUB Team Staff in support of LIA's. Renewal of subcontract March 2013
		 b. Subcontracted with Dovetailing to support the HUB's rural development work of matching EBHV programs to LIA's in select rural communities. October 2012 – Renewal September 2013,
		 c. Evaluation Team –TBD, subcontract to implement an evaluation plan for the portfolio of LIA's in cohort 1, 4, 5, 7 (rural) and to coordinate evaluation activities with other evaluations of HVSA LIA's. Private funds, beginning October 2013
		 d. Coaching, CQI and TTA – TBD. Subcontract to support HUB Team and LIA staff in activities/skill building regarding staff development, CQI related program supports, and TTA supports. Beginning September
			1. Thrive HUB Team Staff and Grants Management
			   a. HV Director
			    • Direct/manage all aspects of Implementation HUB resources, activities, outputs, HUB Team staff and subcontracted supports of LIA's. Daily/Ongoing
			    • Coordinate with NFP, PAT, PCHP, NIRN, Dovetailing & Evaluation Team and DEL, in planning and implementing HUB supports to LIA's. Ongoing
			    • Ensure NFP, PAT & PCHP state leads are supported in providing statewide TTA to LIA's. At least weekly 1:1 meetings.
			    • Provide 1:1 supervision of Thrive HUB Staff in support of their work with LIA's. Weekly
			    • Engage PCHP national office and PCHP state lead to providing statewide TTA to local PCHP programs. Ongoing
			    • Work with PCHP National Office, local PCHP programs, and PCHP State Lead in developing benchmark evaluation plan. Pending
			    • Participate in the HUB's weekly LIA CQI process
			   b. HV Senior Manager of PA
			    • Work closely with PAT, PCHP, NIRN, Dovetailing, Evaluation Team, in developing scopes of work to support LIA's - Annually/ongoing management
			    • Collaborate with DEL in developing annual HVSA subcontract that defines HUB services and supports to LIA's - Annually/ongoing management
			    • Work with DEL to address administrative issues related to LIA's. Monthly or more frequently as needed
			    • Participate in the HUB's weekly LIA CQI process
			   c. HV Rural Development Specialist
			    • Plan, coordinates, and engage select rural communities in a process to match EBHV's to community and LIA capacity. Daily/Ongoing
			    • Travel to select rural communities to engage community members in face to face community meetings to assess HV needs and local LIA HV capacity
			    • Coordinate with PAT and NFP State Leads to support capacity building of rural LIA's. Ongoing
			    • Coordinate with Senior Grant Manager to administer Cohort 7 LIA's funding. On going
			    • Participate in the HUB's weekly LIA CQI process
			   d. HV Manager
			    • Provide initial site visit with each new LIA to review contract, logic model development, baseline capacity assessment review, and agreement on an implementation improvement plan - Varies by cohort/LIA
			    • Participate in full-day orientation and trainings that to support LIA's around subcontract compliance, invoicing, important dates, reporting requirements, and HUB-provided supports - Annually
			    • Plan and/or participate in trainings based on LIA program needs. At least quarterly
			    • Support NFP and PAT state leads and national models in providing statewide TTA to local NFP and PAT programs. At least weekly
			    • Orient PCHP state lead to providing statewide TTA to local PCHP programs. Pending.
			    • Design, lead and assure follow up to the HUB's weekly LIA CQI process
			    • Supervises Program Coordinator. Daily
			    • Provide 1:1 time with PAT State Lead. Weekly
			   e. NFP Nurse State Lead
			    • Provide HV model specific TTA to LIA's surrounding CQI and fidelity requirements. Daily
			    • Participate in training based on LIA program needs. Monthly
			    • Review progress of LIA contractual deliverables, quality of service and logic model progress at least monthly, by phone or in-person.
			    • Participate in weekly HUB meetings learning about LIA's
			    • Support LIA in meeting multiple evaluation and research requirements. Ongoing
			    • Work with multiple evaluator in conducting LIA research and evaluations. As needed/ongoing
			   f. HV Project Coordinator
			    • Support HV Director, HV Manager, and Senior Grants Manager in their roles in supporting LIA's. Daily
			    • Participate in the HUB's weekly LIA CQI process
			   g. Senior Grants Manager
			    • Conduct an annual contract renewal process with current HVSA funded home visiting (HV) programs to include an updated capacity assessment and logic model. Provides TTA to LIA's in support of the renewal process. Varies by Cohort
			    • Conducts LIA RFP/Selection process per funding stream requirements. Provides TTA to LIA's to support them through process. Varies by cohort.
			    • Works with HV Manager and State Leads to develop TTA tracking system to LIA's. At least weekly
			    • Develop, adopt and implement a policy manual for LIAs. In process/ongoing.
			    • Collect and issue quarterly reports on LIA data
			    • Conduct due diligence activities to support program integrity of LIA's. Quarterly with more in depth annually due diligence review
			    • Administer the GIFTS system and provide TTA in support of LIA's using GIFTS. Ongoing
			    • Write, develop and negotiate all LIA subcontracts. Varies by cohort
			    • Provide TTA to LIA's on GIFTS system and HUB Team members. Ongoing/as needed
			   h. Grants Coordinator – pending hire
			    • Supports the functions of Senior Grants Manager in work with LIA's. Daily/ongoing
			 2. Specialized Home Visiting Team Staff
			   a. PAT State Lead
			    • Provide HV model specific TTA to LIA's surrounding CQI and fidelity requirements. Daily
			    • Coordinate and participate in two, 5 day PAT foundational trainings for approximately 60 PAT LIA staff. September 2012 and May 2013
			    • Participate in other training based on LIA program needs. Monthly to Quarterly
			    • Review progress of LIA contractual deliverables, quality of service and logic model progress at least monthly, by phone or in-person
			    • Participate in weekly HUB meetings learning about LIA's
			    • Support LIA in meeting multiple evaluation and research requirements. Ongoing
			    • Work with multiple evaluator in conducting LIA research and evaluations. As needed/ongoing
				Goal
				
				 The Implementation HUB shall support LIA's in serving families with high quality HV services
				
				 Objectives
				 1. Ensure the Implementation HUB is adequately staffed and supported to:
				   a. Act as a centralized support to LIA's in achieving fidelity to home-visiting models
				   b. Enhance and expand the capacity and number of LIA's providing high quality HV services
				   c. Provide ongoing monitoring, training, technical assistance and supports to LIA's that ensures quality and accountability
				   d. Support LIA's in participating in program evaluations that informs their approach to effectively provide high quality HV services to children and families
				   e. Engage in an implementation science informed approach to promote continuous quality improvement of LIA's that builds the HV field
				   f. Identify and implement racial equity strategies to support LIA's capacity to engage and serve diverse families experiencing issues related to accessing high quality HV services
				 2. Utilize a braided funding approach to leverage public and private investment in supporting a portfolio of LIA's implementing high quality HV programs
				 3. Utilize GIFTS technology to effectively and efficiently subcontract, monitor, collect data and support LIA's in meeting billing, reporting, evaluation and other requirements
				 4. Work collaboratively with DEL in their oversight role to:
				   a. Guide HVSA systems development in support of LIA's
				   b. Provide stewardship of state and federal funding by ensuring that accountability and reporting requirements of the HUB and LIA's are met
				   c. Implement and coordinate evaluations of the HUB and LIA's to meet funding requirements and to disseminate evaluation findings to build the field of HV across the state.
				 5. Utilize a portfolio approach to invest in local LIA's that:
				   a. Balances grant distributions statewide
				   b. Addresses racial/ethnic, and other demographic diversity
				   c. Offers flexibility and choice to LIA's in selecting from a number of evidence based and promising practice HV models that best match LIA capacity and the communities that they serve

2013 pending an LIA survey. Subtracts anticipated to be in place October 2013 – January 2014

  e. ORS PEA – Subcontract to work with Thrive and the HUB in identifying, implementing and evaluating racial equity strategies to strengthen Thrives, and specific to HV, the HUB's and LIA's ability to effectively engage and serve diverse families. Private funding, September 2013

4. Administer HVSA funding to LIA's per funders requirements
   a. Private Funding, Cohort 5, October 2012
   b. State funding, Cohort 1 and 4, July 2012
   c. MIECHV Formula, Cohort 3, October 2012
   d. MIECHV Competitive, Cohort 6 and 7, October 2012 for Cohort 6, January 2014 for Cohort 7,

5. Administer GIFTS subcontracting, reporting, monitoring, and fiscal and data system. Ongoing
   a. Train LIA's in using GIFTS system to run funding processes – Varies by Cohort
   b. Support LIA's in entering financial and LIA quarterly report data – Ongoing
   c. Utilize GIFTs to support HUB Team track TTA and implementation science stages of LIAs. Beginning June 2013 – Ongoing

6. Work collaboratively with DEL to implement HVSA evaluation and oversight activities in support of the HUB and LIA's. Ongoing

7. Utilize a portfolio approach to fund a range of models and programs through LIA's located across the state. Ongoing

8. Support LIA's to serve and impact diverse geographic, racial/ethnic, and other demographic diversity. Ongoing

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- Participate in weekly 1:1 meetings with the Home Visiting Manager
  b. PCHP State Lead – pending hire
  - Participate in an annual training based on LIA program needs. Daily
  - Provide HV model specific TTA to LIA's surrounding CQI and fidelity requirements. Daily
  - Review progress of LIA contractual deliverables, quality of service and logic model progress at least monthly, by phone or in-person
  - Participate in the HUB's weekly LIA CQI process
  - Support LIA's in working with Evaluation Team to developed benchmark evaluation plan. Ongoing

3. Subcontract to provided training, services and supports
   a. NIRN
   - Build Implementation Science informed competencies to promote effective implementation of LIA's HV programs via transferable skills and knowledge of HUB Team. Includes quarterly in person 3 day long training, ongoing support and biweekly conference calls
   - Skills and knowledge supported by NIRN training and consultation to transfer to LIA's
     → group process and strategic thinking
     → joint problem solving and CQI
     → reflective practice and facilitative administration
   - Teach and support HUB Team Members to effectively support LIA's through:
     → implementation team structures
     → formal and practical knowledge of intervention, implementation, improvement cycles, drivers, stages of implementation and systems change
     → application of an implementation science informed approach in developing a HV site selection process
   b. Dovetailing – Approximately .25 FTE
   - Support Rural Development Specialist in select rural counties to match EBHV to community LIA capacity and community need
   - Coordinate with PAT and NFP State Leads to support capacity building of rural LIA's
   - Assist Rural coordinator in developing recommendations to fund rural LIA's
   c. Evaluation Team – TBD. Approximately 1.1 FTE
   - Capacity building in evaluation skills for LIA's such as data management, quality data collection, and use of data for decision-making
   - Collaboration with other research and evaluation efforts of LIA's
   - Alignment of LIA's with standardized "benchmark" data measures identified by the state
   - Support of quality assurance related to data collection activities by LIA's
   - Synthesis and analysis of data about participants, implementation and LIA outcomes
   - Reporting and communication of evaluation findings with LIA's
   d. Coaching, CQI and TTA – TBD
   - Subcontracted supports for both the HUB team and LIA's.
   - Selection of specific services and supports are in discussion by HUB Team in response to HUB Team and LIA feedback on the identification of unmet needs and emerging issues related to the provision of high quality HV services.
   e. ORS PEA – Approximately .25 FTE
   - Capacity building to identify, implement and evaluate racial equity strategies to be implemented by the HUB Team in support of the use of a racial equity lens in its work
   - Support LIA's in engaging and serving diverse families experiencing equity issues in accessing high quality HV services.

4. Funding to LIA's in subcontracts:
   a. Private funding – approximately $2,587,778 annually
   b. State funding – approximately $934,000 annually. To increase to $1,434,000 in 2013
   c. MIECHV Formula –approximately $989,225 annually
   d. MIECHV Completive approximately $5,466,089 annually

5. GIFTS System
   a. Subcontracting, monitoring, reporting, and data collection for 43 LIA contracts in 5 cohorts. 30 LIA's added, 4 renewed, between July 2012 and October 2013 in 5 separate funding processes. A new rural cohort is expected to be added January 2014.
   b. GIFTS system enhanced beginning July 2013 to track specific TTA provided to LIA's by HV manager, and State model leads.

6. DEL
   a. Collaborate with DEL in jointly developing a number of governing and collaborative structures that directly and indirectly support the provision of supports to LIA's through the HUB
   b. Collaborate with DEL on multiple LIA evaluations
   c. Participate in CQI efforts with DEL to inform LIA supports
   d. Collaborate with DEL in their oversight role to ensure HUB and LIA's accountability.
   e. Report to DEL on each LIA implementation and activity reports quarterly.

7. Portfolio of LIA's.
   a. 31 separate nonprofits implementing 43 separate LIA programs
   b. 14 PAT LIA's and 19 NFP LIA's
   c. 10 additional LIA's representing 4 additional models: PCHP, EHS, STEEP, and PFEL
   d. 25 Western WA LIA's, 18 Eastern WA LIA's
   e. 3-4 additional LIA's to be added in Cohort 7 –Rural LIA's January 2014

8. Children and families served by LIA's
   a. 1155 families served as of June 2013. Capacity of LIA's to serve families expanded from 270 families to over 1700 between July 2012 and October 2012
   b. 58% Western WA, 42% Eastern WA
   c. 39% Latino, 35% White, 11% Black, 6% Multiple, 5% Native American, 4% Asian/Pacific Islander

Appendix C
Steps and Criteria in Selection of Comparison Programs for Outcome Evaluation

Step	PAT	NFP
Step 1: Identify programs that meet minimal selection criteria	Located in the United States and outside the state of WA Active affiliate implementing PAT using the 2011 program model in a non-school-based setting Not participating in Design Options for Home Visiting Evaluation(DOHVE) NSO reported that state was not implementing centralized TA	Located in the United States and outside the state of WA Active affiliate implementing the NFP model Not participating in DOHVE or Social Impact Bond (SIB) NSO reported that state was not implementing centralized TA
Step 2: Conduct nearest neighbor propensity score matching	Variables used: Agency type (community-based organizations/government other than health; health agency; early intervention/Part C; other; multiple categories/mixed) Enrollment (total # of children served) Percentage of families served with 2 or more high-risk characteristics Percentage of families served who are African American Percentage of families served who are Spanish speaking Length of time conducting PAT (1-2 years; 3 or more years) Geographic location (rural, urban, mixed) Receives MIECHV funding or not Identify programs with effective matches, including an oversample of potential programs for review	Variables used: Agency type (community-based organizations/government other than health; hospital; public health agency; other; multiple categories/mixed) Enrollment capacity (# of families that program could serve) Length of time conducting NFP (1-2 years; 3 or more years) Geographic location (rural, urban, mixed) Receives MIECHV funding or not Identify programs with effective matches, including an oversample of potential programs for review

Step	PAT & NFP
Step 3: Confirm whether programs identified through Step 2 have any extenuating state and/or program characteristics	The same set of questions were considered for both PAT and NFP at this stage: Does state have centralized support structure using implementation science framework (similar to HUB)? Are there extenuating program issues that make the program a poor candidate (e.g., recent director/lead supervisor turnover, major national office concerns about program implementation, excessive data collection demands based on participation in several extra initiatives or studies)? Is the program targeting an unusual risk population quite discrepant from the matching intervention program? (e.g., serves a tribal population but not matched to a Washington tribal site)? Are some programs better/worse matches than others because both are multisite programs (e.g., overarching umbrella agency with teams or sites in multiple locations)? Is the program participating in other initiatives or studies that would significantly influence the TA they receive (e.g., Home Visiting Collaborative Improvement and Innovation Network - HV CoIIN)?

Step	PAT & NFP
Step 4: Balance comparison site characteristics	If several programs were identified as effective matches through PSM and were appropriate in step 3, SRI reviewed the characteristics of each program for face validity and to cluster selections in as few states as possible. In some cases, the same program was selected to serve as a comparison site match for two or more programs in the intervention group and data from these programs may be weighted during analysis, if necessary.
Step 5: Recruitment	Upon contract execution in September 2013, SRI began work with the national PAT and NFP offices to describe the evaluation and contracted for NSO staff time to identify potential comparison sites and support contacts with those programs to facilitate recruitment of selected programs for participation. Comparison sites were recruited through a three-phase process. First, the PAT and NFP national program offices spoke about the study to the state leads (PAT) and regional nurse consultants (NFP) overseeing states or regions with programs targeted for recruitment. The state leads and nurse consultants were then asked to contact programs selected for recruitment by email and provide a brief introduction to the study. In some instances, PAT programs function in states without state leads. For these programs, the PAT national program office provided an email introduction directly to the program. Finally, SRI contacted programs by email and phone to describe the study requirements in detail and request their participation. Programs agreeing to participate were asked to sign a participation agreement form acknowledging the study requirements.

Appendix D
Outcome Evaluation – TA Log Template and Instructions

TA Log Template and Instructions

TA Log Instructions

What is the RISE Home Visiting Evaluation TA log?

For the RISE Home Visiting Evaluation we have developed a log for program liaisons to record the kinds of technical assistance received by staff on a quarterly basis. We hope this information will help us learn what kinds of support are most helpful for programs and staff.

What do you mean by "technical assistance"?

By technical assistance (TA), we mean the support provided to home visitors, supervisors, and administrators to support professional development, improve program practices, and address questions and concerns. Technical assistance can take many forms such as trainings, workshops, webinars, individualized consultation, coaching, or sharing resources**.** TA includes support that is both face-to-face and delivered remotely using the internet or phone. TA can come from a variety of sources: Thrive by Five Implementation HUB staff (including model state leads), the model national offices, MIECHV TA network, state or regional TA organizations or providers, or from other sources.

How is the TA log set-up?

We have created an excel template for you to use to log your TA. We have pre-customized the TA log excel template with your staff names and roles entered. *For noting changes to staff members:* If new staff join, please add new columns for them in the TA log sheet, AND fill out the "Staff Joined" table found under the "Staff Changes" tab. If staff left, do not delete them from the TA log sheet, but do fill out the "Staff Left" table found under the "Staff Changes" tab.

- The first tab includes the instructions.
- The second tab includes example entries.
- The third tab is the actual TA log. Columns B, C, and D have drop down menus that you will be able to choose from as you document each TA activity or event. When you click on the cell, a drop down arrow appears. Click on that and the drop down menu options appear.

  For each TA activity or event, please document the following fields:
  – Name of the event/activity (type in – Column A). NOTE: please be as descriptive as possible with the name of event such that someone outside your organization would be able to understand what the event was.
  – TA type and Location (select from drop-down menu – Column B)
  – Primary topic of event/activity (select from drop-down menu – Column C)
  – Secondary topic of event/activity (select from drop-down menu – Column D) NOTE: only select a secondary topic if the primary topic is not sufficient

- Presenter or Sponsor (conference or agency) (type in as many as relevant – Column E)
- Date of event/activity (Column F) NOTE: if you are unsure of the date that an event occurred, please put an approximate date
- Number of hours (Column G)
- Program staff that participated or attended (remaining columns)
- The fourth tab provides a space to record staff changes.
- The fifth and sixth tabs list the categories that are in the drop down menus as well as definitions of each of the TA types and topics.

Most programs have one person complete the TA log by looking at sign-in sheets and professional development requests, and scheduled events such as site visits. Liaisons may also check-in with other staff to gather information about any specific individualized phone calls or consultations. If your program already collects the kind of information indicated above, please talk with the RISE contact and we will consider if there is a way we can use your existing documentation in place of the excel file provided.

What should I count as TA in the log?
Things that you should count in the TA log include:
- Workshops, meetings and trainings either in-person or remote via phone or web.
  - Including self-guided training modules (e.g., recordings or those made available electronically from the national model office)
- Site visits or individualized face to face meetings.
- Coaching and consultation phone calls with state model leads, HUB staff, or other TA providers that help to connect you with resources/put you in touch with community contacts and are **20 minutes or longer.**
- Emails with or from state model leads, Thrive HUB staff, or other TA providers that help to connect you with resources, or put you in touch with community contacts. NOTE: it can be difficult to determine when to include emails on the TA log. Please ask yourself to consider if the email conversation or newsletter was substantive enough that it guided your program practice or educated you about a change to be made to your program. If this is the case, you should record the email on the TA log.
- Meetings or case conferences conducted with the support of someone *outside* your organization, such as a mental health consultant (i.e., a meeting that brings outside expertise or guidance as a way to improve program practices).
- Include TA on wide ranging topics, including, but not limited to broad general program support, professional development, and model-specific training.
- Include TA provided to your program manager/director if applicable.

What should I _not_ count as TA in the log?

Things that you should _not_ count in the TA log include:

- Supervision (e.g., weekly meetings with supervisors) and team meetings. We consider supervision and most team meetings as a part of regular program responsibilities and not additional training and TA so there is no need to include meeting and activities related to internal supervision. NOTE: it can be difficult to determine when to exclude these types of meetings from the TA log. Please ask yourself to consider whether the leader of the meeting was someone in-house (e.g., supervisor, program manager), rather than someone external to your program (e.g., national office staff, state MIECHV lead, a mental health consultant). If so, you should exclude this from the TA log.

- Coordinating logistics around TA (e.g., scheduling a training or site visit).

- Brief emails and texts answering quick questions, such as the date that a report is due, or "listserv" type emails going to a large group of recipients that you _do not_ make substantive use of. (This type of support is important, but tedious to log. Instead, we will ask about availability of this type of support on the survey instead of documenting in the TA log.)

Where and how often do I need to send you my TA log?

- You will receive an email reminder from RISE staff shortly before TA logs are due each quarter.

- Prior to submitting your TA log, please verify that _all necessary fields_ have been completed for each entry (name of event/activity, TA type and location, primary topic of event/activity, presenter or sponsor, date, number of hours, and staff) and you have noted any staff changes. Try not to leave any blanks, other than in the "secondary topic" or "comments" columns.

- Please send your TA log to your Diego Garcia (diego.garcia@sri.com) or the evaluation team contact that you have been communicating with so far.

Who should I contact if I have questions?

The RISE evaluation team member whom you have been in contact with so far or you may email RISEEvaluation@sri.com or call (877) 697-5675 for assistance.

	A	B	C	D	E	F
1	**Example activities to include**					
2	Name of event/activity	**TA type and Location** (select from drop down menu)	**Primary topic of event/activity** (select from drop down)	event/activity (if applicable, select from drop down)	**Presenter or Sponsor** (conference or agency)	Date (MM/DD/YY)
3	Example 1: Domestic violence training	*In-person workshops, meetings, trainings*	*Improving home visitor staff competencies*	*Improving supervisor comp*	Thrive by Five WA	6/6/2014
4	Example 2: Phone consultation on hiring new staff	*Remote individualized (TA, coaching, consultations)*	*Contract requirements*	*Hiring and retention*	Linda Clarke, WA PAT state model lea	6/6/2014
5	Example 3: Children's Justice Conference	*In-person workshops, meetings, trainings*	*Improving home visitor staff competencies*		Dept child family services (state)	6/1/2014
6	Example 4: Model Coaching Phone Call	*Remote individualized (TA, coaching, consultations)*	*Hiring and retention*	*Improving supervisor comp*	Linda Clarke, WA PAT state model lea	6/21/2014
7	Example 5: State-wide PAT Conference	*Remote individualized (TA, coaching, consultations)*	*Model requirements (including model fidelity and assessment training)*		Linda Clarke, WA PAT state model lea	6/4/2014
8	Example 6: MIECHV Benchmarks Collection Webinar	*Remote workshops, meetings, trainings*	*Data collection trainings, evaluation and study participation*		WSU	6/10/2014
9	Example 7: National office monthly call	*Remote individualized (TA, coaching, consultations)*	*Model requirements (including model fidelity and assessment training)*		NFP National Office	6/28/2014
10	Example 8: Case conference with outside mental health consultant	*In-person workshops, meetings, trainings*	*Improving home visitor staff competencies*		*Mental Health Consultant, name*	6/28/2014
11	Example 9: HVSA webinar	*Remote workshops, meetings, trainings*	*Contract requirements*		*Thrive by Five WA*	6/28/2014
12	Example 10: Enrollment and Capacity review	*In-person workshops, meetings, trainings*	*Contract requirements*		*Thrive by Five WA*	6/28/2014
13	Example 11: Hearing screening training	*In-person workshops, meetings, trainings*	*Improving home visitor staff competencies*	*Program or agency guideli*	*Santa Clara County Health Departme*	6/28/2014
14	Example 12: ETO/Visit Tracker technical support	*Remote individualized (TA, coaching, consultations)*	*Data use for decision-making and program impro*	*Model requirements (inclu*	*National Office*	6/28/2014
15	Example 9: Email for Reflective Supervision Resource	*Remote individualized (TA, coaching, consultations)*	*Improving supervisor competencies*		*Quen Zorrah, WA NFP State Nurse Con*	6/29/2014
16						
17	**Example activities to exclude**					
18	Phone call with RISE Evaluation staff					
19	Weekly team meeting with local program staff *only*					
20	National office newsletter					
21	Email setting up site visit					
22	One-on-one staff supervision session					

Tabs: Instructions | **Examples** | QuarterlyTAlog | Staff Changes | TA types definitions | TA topics definitions

	A	B	C	D	E	F	G	H	I	J	K
1	Date: XX/XXXX - XX/XXXX	Program name:						Supervisor	Nurse home visitor	Nurse home visitor	
2	Name of event/activity	TA type and Location (select from drop down menu)	Primary topic of event/activity (select from drop down)	Secondary topic of event/activity (if applicable, select from drop down)	Presenter or Sponsor (conference or agency)	Date (MM/DD/YY)	Number of hours	Staff 1	Staff 2	Staff 3	Comments
3			Contract requirements								
4			Contract requirements								
5			Improving home visitor staff con								
6			Improving supervisor competen								
7			Program or agency guidelines fo								
8			Hiring and retention								
9			Data collection trainings, evaluat								
			Data use for decision-making an								
			Connections and referrals (inclu								

	A	B	C	D	E	F	G
1	Please list any staff changes that occurred during **this quarter**:						
2		STAFF JOINED				STAFF LEFT	
3	Names of New Staff Members	Role	E-mail address	Date Joined		Names of Staff Members Who Have Left	End Date
4							
5							
6							
7							
8							
9							
10							
11							
12							
13	*If no staff changes occurred during this quarter, please leave blank.						

Instructions / Examples / QuarterlyTAlog / **Staff Changes** / TA types definitions / TA topics definitions

Dropdown Menu Category Options

TA Types	*Definitions*
Onsite/in-person individualized (TA, coaching, consultations)	Individualized, face-to-face meetings, consultations or site visits about your or your program's specific questions or needs
Remote individualized (TA, coaching, consultations)	Coaching phone calls or web-based meetings specific to your program's needs. A series of extended email discussions may be counted if it is the equivalent about 20 minutes or longer phone call.
In-person workshops, meetings, trainings	In-person, face-to-face group workshops, meetings, or trainings, not individualized
Remote workshops, meetings, trainings	Group phone- or web-based workshops, meetings, or trainings
Other (noted in comments)	Other sources of support or training that do not fit into one of the other types. Please specify in comments.

Primary topic of event/activity	*Definitions*
Model requirements (including model fidelity and assessment training)	Model specific trainings related to meeting model essential requirements, model-specific assessments, reporting requirements, etc.
Contract requirements	Activities specific to compliance with enrollment, budget, grant and reporting requirements for funders
Improving home visitor staff competencies	Activities to develop home visitor knowledge and skills such as child development, domestic violence prevention, mental health, behavior management, developmentally appropriate care, child health, etc.
Improving supervisor competencies	Reflective supervision, group supervision, leadership, teaming skills, identifying trainings for staff, communication skills, etc.
Program or agency guidelines for program administration (not model specific)	Adjustments and alignment of policies or practices of the program or agency to support the implementation of evidence-based home visiting
Hiring and retention	Strategies or issues related to staff recruitment, hiring, satisfaction and retention
Data collection trainings, evaluation and study participation	Trainings related to specific data collection or assessment tools, evaluation methods, etc.
Data use for decision-making and program improvement	Using observations, data and/or self-assessments for making adjustments to practices or policies and continuous quality improvement activities
Connections and referrals (including community system coordination)	Community contacts, resource documents, other sources of support or training, connections with other agencies and services for families, etc.
Other (noted in comments)	Other topic that does not fit into one of the other topics. Please specify in comments.

Appendix E
Outcome Evaluation – Home Visiting Snapshot Form (2016)

Home Visiting Snapshot Form

Provide your OWN name below. Do **not** include any identifiable client information (names, addresses, etc.)

Home visitor (your) first name:

Home visitor last name:

Date visit completed: month / day / year

Today's date: month / day / year

Duration of visit:

visit start time : ☐ am ☐ pm   visit end time : ☐ am ☐ pm

▶ *Did this visit end earlier than expected?* ☐ Yes ☐ No

When did this family first enroll in the program?

month / day / year   ▶ Or check here ☐ *if this was an initial visit*

Please check the box showing the age of the youngest child in the family:

☐ Pregnancy   ☐ 1 year-old (12-24 months)   ☐ Preschool (36-60 months)
☐ Infancy (birth-12 months)   ☐ 2 year-old (24-36 months)

Prior to this visit, did you have identified goals for this family? *(Mark [X] one only.)*

☐ Yes, we have written goals
☐ Yes, we have broad goals or areas to focus on that were verbally agreed upon
☐ No, we do not have mutually agreed upon goals at this time

Describe the preparation that occurred prior to this visit. *(Mark [X] only one.)*

I am familiar with the family's situation, but I did not plan specific topics

1	2	3	4	5
☐	☐	☐	☐	☐

I planned specific activities and discussions to cover with the family

How did you select the content you *planned* to cover during this visit? *(Mark [X] ALL that apply.)*

☐ It was related to family goal   ☐ It was related to family strength/need identified in an assessment
☐ It was related to content suggested by the NFP/PAT model
☐ I did not plan specific content prior to the visit
☐ Other:

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For each topic covered during the home visit, indicate how much time was spent on it. Leave the boxes blank if you did not discuss or address a topic.

Note: 25% of a 30 minute visit is 7 ½ minutes; 25% of a 60 minute visit is 15 minutes.

Parental and Family Topics	We touched on this briefly (<25% of visit)	This was a major topic (>25% of visit)
Parental role		
Physical care of child	☐	☐
Behavioral and emotional care of child (e.g., discipline, behavior problems, and attachment)	☐	☐
Parent-child interaction	☐	☐
Parental Health	*briefly*	*major*
Health (e.g., health behaviors, nutrition, and exercise)	☐	☐
Substance abuse and mental health	☐	☐
Reproductive health and pregnancy	☐	☐
Screening about health or mental health (specify):	☐	☐
Environment and home	*briefly*	*major*
Domestic violence and safety planning	☐	☐
Education, employment, and housing	☐	☐
Social support (e.g., family and friends)	☐	☐
Services and supports	*briefly*	*major*
Child care	☐	☐
Use of social services (e.g., WIC, TANF, and SNAP)	☐	☐
Health insurance and health care (including well-child visits)	☐	☐
Other service or support (specify):	☐	☐
Child Topics	*briefly*	*major*
Developmental screening (specify):	☐	☐
Child development, stages, and school readiness	☐	☐
Child health (e.g, nutrition, exercise, mental health, child safety, oral health, and sleep)	☐	☐
Routines and transitions (e.g., bed times and meal times)	☐	☐
Screening about child health (specify):	☐	☐
Other parental, family, or child topic (specify):	☐	☐
Other parental, family, or child topic (specify):	☐	☐

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During this visit did you initiate or follow up on a referral for the child, parent, or family member to any of the agencies below?

Types of agencies	Initiated new referral to	Followed up with parent about referral to
Social services (e.g., TANF, WIC, and SNAP)	☐	☐
Housing and shelter	☐	☐
Child maltreatment prevention and child welfare	☐	☐
Domestic violence	☐	☐
Developmental screening and support, or early intervention	☐	☐
Education and employment	☐	☐
Health, mental health, and substance abuse	☐	☐
Child care	☐	☐
Legal and/or immigration support	☐	☐
Other (specify):	☐	☐

Did you do any of the following during this visit? *(Mark [X] ALL that apply.)*

- ☐ *Formal* assessment of child and/or primary caregiver
- ☐ *Informal* observation or assessment of child and/or primary caregiver
- ☐ Model or demonstrate interaction with child
- ☐ Observe caregiver-child interactions
- ☐ Share feedback on/evaluate caregiver-child interactions
- ☐ Address immediate need or crisis intervention
- ☐ Other:
- ☐ Set/plan *new* goals
- ☐ Modify *existing* goals
- ☐ Review/discuss goals with family
- ☐ Provide emotional support to caregiver
- ☐ Problem solving

Did you set new goals, modify existing goals, or identify a referral need during this visit? If yes, complete the table in the box below. If no, skip ahead to the next question.

When you considered goals or referrals on this visit, what information, if any, did you and your client consider?	A formal* assessment of… Family needs or strengths	A formal* assessment of… Child needs or strengths	An informal** assessment of… Family needs or strengths	An informal** assessment of… Child needs or strengths	None
To set **new goals**, we used…	☐	☐	☐	☐	☐
To **modify goals**, we used…	☐	☐	☐	☐	☐
To identify a **referral** need we used…	☐	☐	☐	☐	☐

Formal refers to screening, progress monitoring, and norm-referenced tools.
**Informal* refers to systematic observations, interviews, and information gathering.

How would you characterize the quality of your relationship with this parent? It is… *(Mark [X] one only.)*

- ☐ tense and difficult, with a sense of uneasiness.
- ☐ adequate for working together, but we have some difficulty.
- ☐ average, comfortable. It feels at ease and cooperative.
- ☐ better than most; there is a feeling of partnership.
- ☐ outstanding; we have an effective, collaborative relationship.

How would you characterize the quality of this home visit with the family? It was... *(Mark [X] one only.)*

- ☐ filled with interfering distractions; or visit was crisis-oriented.
- ☐ adequate for sharing information and completing some activities.
- ☐ average; activities went well and the parent was cooperative.
- ☐ better than most; the family and I collaborated and learned together.
- ☐ outstanding; what every home visit is intended to be, with parent and child engaged together.

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Thank you!

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Appendix F
Key Documents from PAT and NFP Regarding
Implementation Fidelity Guidelines

PAT Essential Requirements for Affiliates
NFP Program Objectives

The following are the essential requirements for an organization to become and remain a Parents as Teachers affiliate with approval to implement the Parents as Teachers model. Implementation and service delivery data that address the essential requirements are reported at the end of each program year on the Affiliate Performance Report (APR).[1] New affiliates' intentions to comply with these requirements are initially demonstrated through the Affiliate Plan.

Areas		Essential Requirements
Organizational Design	Infrastructure and Staffing	1. Affiliates provide at least two years of services to families with children between prenatal and kindergarten entry.
		2. The minimum qualifications for parent educators are a high school diploma or GED and two years' previous supervised work experience with young children and/or parents.
	Leadership and Administration	3. Each affiliate has an advisory committee that meets at least every 6 months.
		4. The affiliate follows the standard guidelines regarding copyright, trademark and logo use established by Parents as Teachers.
	Supervision	5. Each month, parent educators working more than .5 FTE participate in a minimum of two hours of individual reflective supervision and a minimum of two hours of staff meetings and parent educators working .5 FTE or less participate in a minimum of one hour of reflective supervision and two hours of staff meetings.
		6. Each supervisor, mentor or lead parent educator is assigned no more than 12 parent educators, regardless of whether the parent educators being supervised are full-time or part-time employees.
Training and Professional Development	Training for New Parent Educators and Supervisors	7. All new parent educators in an organization who will deliver Parents as Teachers services to families attend the Foundational and Model Implementation Trainings before delivering Parents as Teachers; new supervisors attend the Model Implementation Training.[2]
	Competency-based Professional Development and Annual Recertification	8. Parent educators obtain competency-based professional development and renew certification with the national office annually.
Family-Centered Assessment and Goal Setting	Assessment	9. Parent educators complete and document a family-centered assessment within 90 days of enrollment and then at least annually thereafter.
	Goal-setting	10. Parent educators develop and document goals with each family they serve.

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[1] All affiliates in existence prior to 1/2011 must be providing services that comply with each essential requirement by July 1, 2014.Data submitted by affiliates to the national office on the 2014-2015 APR (and annually thereafter) will be utilized to measure performance.

[2] Organizations newly implementing the Parents as Teachers model must receive approval for their Affiliate Plan before registering staff for Foundational and Model Implementation Training. Parent educators certified prior to January 1, 2011, who are with an existing program must attend Foundational Training and a Model Implementation Retraining prior to July, 2014; supervisors who have been with an existing program must attend a Model implementation Retraining prior to July, 2014.

Areas		Essential Requirements
Parents as Teachers Model Components	Personal Visits *Personal visits are delivered by model certified parent educators and defined by their focus on 3 major areas of emphasis: parent-child interaction, development-centered parenting and family well-being.*	11. Parent educators use the foundational visit plans and planning guide from the curriculum to design and deliver personal visits to families.
		12. Families with 1 or fewer high needs characteristics receive at least 12 personal visits annually and families with 2 or more high needs characteristics receive at least 24 personal visits annually.
		13. Full time 1st year parent educators complete no more than 48 visits per month during their first year and full time parent educators in their 2nd year and beyond complete no more than 60 visits per month.
	Group Connections *Group connections are staffed by at least 1 model certified parent educator or supervisor and are focused across the program year on the 3 major areas of emphasis.*	14. Affiliates deliver at least 12 group connections across the program year.
	Screening	15. Screening takes place within 90 days of enrollment for children 4 months or older and then at least annually thereafter (infants enrolled prior to 4 months of age are screened prior to 7 months of age). A complete screening includes developmental screening using PAT approved screening tools, along with hearing and vision screening[3], and completion of a health record. Developmental domains that require screening include language, intellectual, social-emotional and motor development.
	Resource Network	16. Parent educators connect families to resources that help them reach their goals and address their needs.
Evaluation & Continuous Quality Improvement	Family Feedback	17. At least annually, the affiliate gathers and summarizes feedback from families about the services they've received, using the results for program improvement.
	Affiliate Performance Report	18. The affiliate annually reports data on service delivery and program implementation through the Affiliate Performance Report; affiliates use data in an ongoing way for purposes of continuous quality improvement.[4]

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[3] If an affiliate is unable to use OAE or pure tone audiometry, parent report or documentation that the child's hearing has been checked by a healthcare provider within the last 12 months can be used as the hearing screening portion of the complete annual screening.

[4] Timely reporting requires that the Affiliate Performance Report be completed no later than August 15.

NFP Program Objectives

A quick reference of NFP's Program Objectives for implementing agency program implementation monitoring

Revised November 2011

Nurse-Family Partnership
National Service Office
1900 Grant Street, Suite 400
Denver, CO. 80203-4304
Phone: 866.864.5226, 303.327.4240
Fax: 303.327.4260
www.nursefamilypartnership.org

Nurse-Family Partnership Program Objectives

Nurse-Family Partnership objectives help implementing agencies track fidelity to the NFP program model and monitor outcomes related to common indicators of maternal, child, and family functioning. The objectives are drawn from the program's research trials, early dissemination experiences, and current national health statistics (e.g., National Center for Health Statistics, Centers for Disease Control and Prevention; Healthy People 2020). The objectives provide guidance for quality improvement efforts and are long-term targets for implementing agencies to achieve over time.

These are the first iteration of objectives for guiding program performance. The National Service Office will continue to review national trends emerging in Efforts to Outcomes (ETO™), as well as changes in national indicators of relevant maternal, child, and family functioning, to identify areas where the objectives may need to be modified. Equally important will be implementing agencies' own experiences in working with the objectives. Actual experience will inform any updates to the objectives so that they will be useful in improving performance of the NFP model, both nationally and in every implementing agency.

Objectives Concerning Fidelity to Program Model

Program is reaching the intended population of low-income, first-time clients:

1. 75% of eligible referrals are enrolled in the program.
2. 100% of enrolled women are first-time clients (no previous live birth).
3. 60% of pregnant women are enrolled by 16 weeks gestation or earlier.

Program attains overall enrollment goal and recommended caseload:

4. A caseload of 25 for all full-time nurses within 8-9 months of program operation.

Program successfully retains clients in program through child's second birthday:

5. Cumulative program attrition is 40% or less through the child's second birthday.
6. 10% or less for pregnancy phase.
7. 20% or less for infancy phase.
8. 10% or less for toddler phase.

Although attrition rates may exceed the target objectives defined above when nurse home visitors are first learning the program model (i.e., initial three year program cycle), we believe that program staff needs to attempt with care to develop strategies to fully engage clients in the program through the child's second birthday. In examining current rates of attrition among our national sample of NFP clients, we note considerable variability among programs, with an overall average of about 65% attrition through the child's second birthday (15% pregnancy, 33% infancy, and 17% toddler). Thus, we have established an intermediate objective of reducing attrition nationally by 12-15% over the next five years.

To encourage progress toward this intermediate goal, we encourage individual implementing agencies to work toward reducing client attrition by 2-3% each year, targeting those reasons why clients drop out of the program early that are likely to be most amenable to change (e.g., declined further participation, missed appointments, failure to notify agency of address changes, etc.)

Nurse home visitors maintain established frequency, length, and content of visits with families:

9. Percentage of expected visits completed is 80% or greater for pregnancy phase.
10. Percentage of expected visits completed is 65% or greater for infancy phase.
11. Percentage of expected visits completed is 60% or greater for toddler phase.
12. On average, length of home visits with clients is a minimum of 60 minutes.
13. Content of home visits reflects variation in developmental needs of clients across program phases:

Average Time Devoted to Content Domains during Pregnancy	
Personal Health	35-40%
Environmental Health	05-07%
Life Course Development	10-15%
Maternal Role	23-25%
Family and Friends	10-15%
Average Time Devoted to Content Domains during Infancy	
Personal Health	14-20%
Environmental Health	07-10%
Life Course Development	10-15%
Maternal Role	45-50%
Family and Friends	10-15%
Average Time Devoted to Content Domains during Toddlerhood	
Personal Health	10-15%
Environmental Health	07-10%
Life Course Development	18-20%
Maternal Role	40-45%
Family and Friends	10-15%

Objectives Concerning Maternal and Child Outcomes

Reduction in smoking during pregnancy:

14. 20% or greater reduction in the percentage of women smoking from intake to 36 weeks pregnancy.
15. On average, a 3.5 reduction in the number of cigarettes smoked per day between intake and 36 weeks pregnancy (among women who smoked 5 or more cigarettes at intake).

Percentages of preterm and low birth weight infants demonstrate progress toward Healthy People 2020 objectives:

16. Preterm birth rate of 11.4%.

17. Low birth weight (LBW) rate of 7.8%.

The national target objectives listed above are for all women, irrespective of risk. Clients enrolled in the NFP typically are at higher risk for having preterm and low birth weight infants because, on average, they are younger, low income, less educated, first-time clients drawn from diverse racial and ethnic populations. While it is a national goal to eliminate disparities in health outcomes, women from economically disadvantaged and/or minority populations currently demonstrate higher rates of preterm and low birth weight infants. Thus, the progress that NFP agencies can achieve realistically in reaching Healthy People 2020 objectives may vary based on the composition of the population served.

Child health and development:

18. Completion rates for all recommended immunizations are 90% or greater by the time the child is two years of age

Maternal life-course development:

19. Rate of subsequent pregnancies within two years following birth of infant is 25% or less

20. Mean number of months women (18 years or older) employed following birth of infant is:

- 5 months from birth to 12 months
- 8 months from 13 to 24 months

Appendix G

Outcome Evaluation – Online Program Practices Survey Content (2017)

X1

2017 Program Practices Survey

X2

WELCOME!

This survey will help us learn more about the systems of support available to home visiting programs and what it takes to best meet program and staff needs.   The survey will take approximately 15-30 minutes, depending on your role to complete.

The questions focus on:

- the kinds of support, training, and technical assistance available to program staff
- staff experiences with available support
- the influence of support on staff and program practices

Your answers are important to improve the kinds of supports available to home visiting programs and their staff.

This survey is voluntary. Your responses will be kept confidential. Survey results will only be reported in summaries across groups of participants. No information that identifies you will be shared publicly, with any technical assistance providers, with your supervisor, or with any other personnel in your program. Your participation is greatly appreciated, and though there is no direct benefit to you, your program will receive a modest incentive based on the number of staff who complete the survey. The incentive will be used by your director or supervisor to benefit your program and staff.

This survey is part of an evaluation made possible by federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding. It is being conducted by SRI International, a non-profit research institute (www.sri.com). If you have questions or concerns, please contact Laura Hudson at 650-859-4719 or laura.hudson@sri.com.

Consent

Please select one option below:

❍ I have read the consent information above and agree to participate in this survey now. (1)
❍ I will return to take the survey at a later time. (2)

Display If I have read the consent information above and agree to participate in this survey now. Is Selected

X3

Click "Next" to begin your survey.

Display If Please select one option below: I will return to take the survey at a later time.
Is Selected

X4

Do not click "Next", just close the browser now and use the link to return to take the survey when it is more convenient.

X5

2017 Program Practices Survey

X6

Oops! No box was selected.

Consent2

Please select one option below:
- ❍ I have read the consent information on the previous page and agree to participate in this survey now. (1)
- ❍ I will return to take the survey at a later time. (2)

X7

Click "Next" to begin your survey.

X8

Do not click "Next", just close the browser now and use the link to return to take the survey when it is more convenient.

X9

2017 Program Practices Survey

X10

Your answers are important to improve the kinds of supports available to home visiting programs and their staff. More detail about the survey was provided on the first page of the survey.

Consent3

Please select one of the options below: (Required)

❍ I have read the consent information earlier and agree to participate in this survey now. (1)

❍ I will return to take the survey at a later time. (2)

❍ No, I do not want to take the survey. (3)

X11

Click "Next" to begin your survey.

X12

Do not click "Next", just close the browser now and use the link to return to take the survey when it is more convenient.

X13

Click "Next" to close your survey and receive no more contact about it.

X15
A NOTE ABOUT SAVING YOUR SURVEY ANSWERS:
Most find that the survey is easily completed at one time. However, in case of interruptions, please be assured that your answers will save each time you click "next" at the bottom of a page. You can click on the same survey link from your email and return to the survey to complete it at another time. Also, feel free to use the "next" and "back" buttons to navigate forward and back to see your responses to questions.

2017 Program Practices Survey

BACKGROUND

Let's start by asking a few background questions based on your work in the last 6 months….

Q1_a

Is this the organization you currently work for: {Org}?

○ Yes (1)
○ No (2)

> Display This Question:
>   If Is this the organization you currently work for: {Org}? No Is Selected

Q1_ax

Please clarify:

Q2_a

Select the model you are currently implementing:

○ NFP (1)
○ PAT (2)

Q2_ax

Comments:

Q3_a

Do you work full-time or part-time for your organization?

○ Part-time (1)
○ Full-time (2)

> Display This Question:
>   If Do you work full-time or part-time for your organization? Part-time Is Selected

Q3_aHRS

How many hours per week do you work? (Enter whole number only.)

    Hours per week: (1)

Q3_ax

Comments:

2017 Program Practices Survey
BACKGROUND (Continued)

Q3_b
Do all of your hours working involve the {Q2_a} program?
❍ No (1)
❍ Yes (2)

Display This Question:
     If Do all of your hours working involve the {Q2_a} program? No Is Selected
Q3_bx
What other programs or program models do you work on and how much time do you work on each?   (Examples of others might include PCHP, HFA, or STEEP home visiting or also managing WIC outreach for public health department.)

Q4_a
Which of these best describes your role in your program over the last 6 months?
❍ Program director or administrator (1)
❍ Supervisor (2)
❍ Home visitor (e.g., PAT parent educator or NFP nurse home visitor) (3)
❍ Director/administrator and supervisor (4)
❍ Supervisor and home visitor (who substitutes as needed, but does not carry a regular caseload) (5)
❍ Supervisor and home visitor (who carries a caseload) (6)
❍ Director/administrator, supervisor, and home visitor (who substitutes as needed, but does not carry a caseload) (7)
❍ Director/administrator, supervisor, and home visitor (who carries a caseload) (8)

Q4_ax
Additional information:

X20

2017 Program Practices Survey

X21

BACKGROUND (Continued)

Q4_b

Approximately how many families are in your current {Q2_a} home visiting caseload? (Enter whole number only, leave as 0 if none.)

    # of families currently in home visiting caseload: (1)

Q4_bx

Comments/further description:

Display This Question:

If Which of these best describes your role in your program over the last 6 months? Supervisor Is Selected

Or Director/administrator and supervisor Is Selected

Or Supervisor and home visitor (who substitutes as needed, but does not carry a regular caseload) Is Selected

Or Supervisor and home visitor (who carries a caseload) Is Selected

Or Director/administrator, supervisor, and home visitor (who substitutes as needed, but does not carry a caseload) Is Selected

Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

Q5_a

How many families do you expect home visitors to have in their caseload when the program is fully enrolled? (Enter whole number only, leave as 0 if none.)

# of families expected to have in a caseload when program is fully enrolled: (1)

Display This Question:

If Which of these best describes your role in your program over the last 6 months? Supervisor Is Selected

Or Director/administrator and supervisor Is Selected

Or Supervisor and home visitor (who substitutes as needed, but does not carry a regular caseload) Is Selected

Or Supervisor and home visitor (who carries a caseload) Is Selected

Or Director/administrator, supervisor, and home visitor (who substitutes as needed, but does not carry a caseload) Is Selected

Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

Q6_a

How many years have you worked as a {Q2_a} supervisor? (Enter whole numbers only, leave as 0 if none.)

Years: (1)

Months: (2)

Display This Question:

If Which of these best describes your role in your program over the last 6 months? Home visitor (e.g., PAT parent educator or NFP nurse home visitor) Is Selected

Or Supervisor and home visitor (who carries a caseload) Is Selected

Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

Q6_b

How many years have you worked as a {Q2_a} home visitor? (Enter whole numbers only, leave as 0 if none.)

Years: (1)

Months: (2)

How many years have you been involved in the field of home visiting? Include time in your current role as well as in any past roles or other home visiting models. (Enter whole numbers only, leave as 0 if none.)

    Years: (1)
    Months: (2)

Q8_a

Do MIECHV funds pay for any part of your position or pay for the services for clients whom you or your home visiting staff serve?

❍ Yes (1)
❍ No (2)
❍ Don't know (3)

Q8_ax

Comments or additional explanation:

X24

2017 Program Practices Survey

X25

YOUR STAFF'S HOME VISITING PRACTICES

Q9

Thinking about the staff you supervise, in general in the last 6 months, how many of your staff…   (Check one response for each row.)

	Few of my staff (1)	Some of my staff (2)	Many of my staff (3)	All or nearly all of my staff (4)
a. Consistently facilitate the parent's interactions with the child rather than interact with the child directly on home visits? (Q9_a)	○	○	○	○
b. Consistently establish relationships and keep families engaged during home visits? (Q9_b)	○	○	○	○
c. Consistently address family concerns and weave in key ideas from the curriculum into the visit? (Q9_c)	○	○	○	○
d. Are knowledgeable about early childhood development? (Q9_d)	○	○	○	○

e. Are aware of how their own emotional response to situations influence their interactions with others (e.g., families or staff)? (Q9_e)	○	○	○	○
f. Consistently coach parents "in the moment" of interaction to reinforce actions and build their skills? (Q9_f)	○	○	○	○
g. Consistently conduct assessments and monitor progress? (Q9_g)	○	○	○	○
h. Consistently use information from assessments and progress monitoring to guide their approach to upcoming work with the child and family? (Q9_h)	○	○	○	○
i. Actively participate in efforts to review data about our program and consider implications for program improvement? (Q9_i)	○	○	○	○

Q9_x
Comments:

X26
2017 Program Practices Survey
X27
YOUR STAFF'S HOME VISITING PRACTICES (Continued)

Q10
Thinking across all the staff you supervise, in general in the last 6 months, how many of your staff are consistently implementing the ${q://QID29/ChoiceGroup/SelectedChoices} model with fidelity when working with families… (Check one response for each row.)

	Few of my staff (1)	Some of my staff (2)	Many of my staff (3)	All or nearly all of my staff (4)	Our program doesn't serve this age group (5)
a. during pregnancy? (Q10_a)	○	○	○	○	○
b. during infancy (birth to 12 months)? (Q10_b)	○	○	○	○	○
c. who have 1 year olds (12 to 24 months)? (Q10_c)	○	○	○	○	○
d. who have 2 year olds (24 to 36 months)? (Q10_d)	○	○	○	○	○
e. during the preschool years (36 to 60 months)? (Q10_e)	○	○	○	○	○

Q10_x

Comments:

X28
2017 Program Practices Survey
X29
YOUR STAFF'S HOME VISITING PRACTICES

Q11
In general, based on what you have observed in the last 6 months…   (Check one response for each row.)

	Few of my staff (1)	Some of my staff (2)	Many of my staff (3)	All or nearly all of my staff (4)
a. How many of your staff are knowledgeable about early childhood development? (Q11_a)	❍	❍	❍	❍
b. How many of your staff actively participate in efforts to review data about our program and consider implications for program improvement? (Q11_b)	❍	❍	❍	❍
If Select the model you are currently implementing: NFP Is Selected c. How many of your staff doing supervision are knowledgeable about the expected NFP model fidelity expectations? (Q11_c1)	❍	❍	❍	❍
If Select the model you are currently implementing: PAT Is Selected c. How many of your staff doing supervision are knowledgeable about the expected PAT essential requirements? (Q11_c2)	❍	❍	❍	❍
d. How many of your staff doing supervision are conducting effective reflective supervision? (Q11_d)	❍	❍	❍	❍

Q11_x
Comments:

X30

2017 Program Practices Survey

X31

YOUR PERSONAL HOME VISITING PRACTICES

Q12

Thinking about your caseload in the last 6 months, rate how often these statements describe what
happens during your {Q2_a} home visits with children and families. (Check one response for
each row.)

	Few visits are like this (1)	Some visits are like this (2)	Many visits are like this (3)	Most visits are like this (4)
a. Parent and child interact with each other during most of the visit time. (Q12_a)	○	○	○	○
b. Parent leaves the room during part of the visit. (Q12_b)	○	○	○	○
c. Child excitedly turns to the mother when you arrive, expecting something fun together. (Q12_c)	○	○	○	○
d. Child is excited to see you because of the toys or materials you bring. (Q12_d)	○	○	○	○
e. During visit, you comment on several parent-child interactions you observe that support child's development. (Q12_e)	○	○	○	○
f. More time is spent on personal or family concerns than on child development. (Q12_f)	○	○	○	○
g. Additional family members are likely to be involved in the visit activities with the child. (Q12_g)	○	○	○	○
h. Parent or child seems distracted when other family members are present during the visit. (Q12_h)	○	○	○	○
i. Family tells you about things they have done together, talked about, or made together with child between visits. (Q12_i)	○	○	○	○
j. You would like to be able to make more frequent visits so the child would get more services. (Q12_j)	○	○	○	○
k. Parent says something like, "We have been doing more activities like this because of the visits." (Q12_k)	○	○	○	○
l. Parent hasn't done the suggested activities between visits. (Q12_l)	○	○	○	○
m. Parent tells you, "I really enjoy doing these activities with my child." (Q12_m)	○	○	○	○
n. Parent tells you that the child really enjoys doing the activities with you. (Q12_n)	○	○	○	○
o. Parent says something like, "I feel more confident now about helping my child's development." (Q12_o)	○	○	○	○
p. Parent says something like, "You are so good with children," because you are effective with the child. (Q12_p)	○	○	○	○

q. I leave the visit feeling as if I need support with how to handle a situation that came up. (Q12_q)	○	○	○	○

Q12_x
Comments:

X32

2017 Program Practices Survey

X33

YOUR PERSONAL HOME VISITING PRACTICES (Continued)

Q13_a

How often do you receive the support you need about how to handle a specific situation that occurred on a home visit?
❍ Almost never (1)
❍ Some of the time (2)
❍ Most of the time (3)
❍ Almost always (4)

Q13_b

How often do you receive timely support about how to handle specific home visiting issues?
❍ Almost never (1)
❍ Some of the time (2)
❍ Most of the time (3)
❍ Almost always (4)

Q13_x

Comments:

X34

2017 Program Practices Survey

X35

WORKING WITH FAMILIES

q14

Thinking about your work with families in the last 6 months…   (Check one response for each row.)

	I disagree strongly (1)	I disagree quite a bit (2)	I disagree somewhat (3)	I neither agree nor disagree (4)	I agree somewhat (5)	I agree quite a bit (6)	I agree strongly (7)
a. If my supervisor suggests that I change some of my strategies for working with families, I would feel confident that I have the necessary skills to implement the change. (q14_a)	❍	❍	❍	❍	❍	❍	❍
b. If a family did not remember information we had covered in a previous visit, I would know how to increase their interest and retention for the next visit. (q14_b)	❍	❍	❍	❍	❍	❍	❍
c. I have enough training to deal with most situations encountered in providing home visiting services to families and their children. (q14_c)	❍	❍	❍	❍	❍	❍	❍
d. Through my experiences in the field, I have developed the skills that are necessary to serve families well. (q14_d)	❍	❍	❍	❍	❍	❍	❍
e. If a family had difficulty implementing plans we have developed, I would be able to accurately assess whether the plans required modification. (q14_e)	❍	❍	❍	❍	❍	❍	❍

f. Throughout my time at this program, I have had sufficient training about my role as a home visitor to be able to implement the {Q2_a} program effectively. (q14_f)	○	○	○	○	○	○	○

X36

2017 Program Practices Survey

X37

WORKING WITH FAMILIES (Continued)

Q15

In the past 6 months, in my work with families… (Check one response for each row.)

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
a. I have been effective at engaging families so that they actively participate in the program over time. (Q15_a)	❍	❍	❍	❍	❍
b. I have been effective in facilitating the family to support their child's development. (Q15_b)	❍	❍	❍	❍	❍
c. I was comfortable assessing family needs and strengths. (Q15_c)	❍	❍	❍	❍	❍
d. I was comfortable explaining the goals of the {Q2_a} model to families and others. (Q15_d)	❍	❍	❍	❍	❍
e. I knew how my specific home visiting activities related to the {Q2_a} program goals. (Q15_e)	❍	❍	❍	❍	❍

X38

2017 Program Practices Survey

X39

WORKING WITH FAMILIES (Continued)

Q16

In the last 6 months, I have consistently implemented the {Q2_a} model in the way it was intended when working with families…   (Check one response for each row.)

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)	I don't serve that group (6)
a. …during pregnancy (Q16_a)	❍	❍	❍	❍	❍	❍
b. …during infancy (0 to12 months) (Q16_b)	❍	❍	❍	❍	❍	❍
c. …who have 1 year olds (12 months to 24 months) (Q16_c)	❍	❍	❍	❍	❍	❍
d. …who have 2 year olds (24 to 36 months) (Q16_d)	❍	❍	❍	❍	❍	❍
e. …during the preschool years (36-60 months) (Q16_e)	❍	❍	❍	❍	❍	❍

Q16_x

Comments:

2017 Program Practices Survey
WORKING WITH FAMILIES

Q17

Based on your experience in the last 6 months…   (Check one response for each row.)

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
a. ...it has been important to deliver the {Q2_a} intervention in the same way as it was done in studies that found it to be effective. (Q17_a)	○	○	○	○	○
b. ...it has been important to know that our home visiting practices are supported by research that shows they are effective. (Q17_b)	○	○	○	○	○
c. ...clinical judgment or my experience has been more important than using a specific curriculum in work with families. (Q17_c)	○	○	○	○	○

X42

2017 Program Practices Survey

X43

GATHERING INFORMATION WHEN WORKING WITH FAMILIES

Consider how you usually gather and use information in your {Q2_a} work with families in the last 6 months.

Q18_a

How frequently do you assess family strengths and needs? (NOTE: Do count it if you use targeted questions to determine needs and strengths whether or not it is a formal assessment / screening tool.)
- ❍ No assessment (1)
- ❍ Only near enrollment (2)
- ❍ Only near enrollment and near exit (3)
- ❍ Near enrollment, and annually review and revise information (4)
- ❍ Near enrollment and every 3-6 months review and revise information (5)
- ❍ Near enrollment and at least monthly review and revise information (6)
- ❍ Near enrollment and at every visit (7)
- ❍ Other (8)

Q18_ax

Please specify:

Q19_a

What approach do you use for family-centered assessment of strengths and needs? (Check all that apply.)
- ❑ Targeted questions about strengths and needs (not specific to an assessment tool) (1)
- ❑ Assessment tool(s) (2)
- ❑ Other (3)
- ❑ None (4)

Q19_ax

Please specify the other approach(es) you use:

X44

2017 Program Practices Survey

X45

GATHERING INFORMATION WHEN WORKING WITH FAMILIES (Continued)

Q20_a

How often do you use information from family-centered assessments to plan what you do at the next home visit? (For example, you might use it to plan new activities or topics, establish visit frequency, or make referrals.)

❍ Almost never (1)
❍ Some of the time (2)
❍ Most of the time (3)
❍ Almost always (4)

Q21_a

How frequently do you assess child development with a formal instrument or screening tool?

❍ No assessment (1)
❍ Only near enrollment (2)
❍ Only near enrollment and near exit (3)
❍ Near enrollment and annually review and revise developmental status information (4)
❍ Near enrollment and every 3-6 months review and revise developmental status information (5)
❍ Near enrollment and at least monthly review and revise developmental status information (6)
❍ Other (7)

Q21_ax

Please specify:

Q22_a

What specific assessment tools, screening tools, or instruments do you use to assess child development? (Check all that apply.)

❑ a. No assessment or screening tool (1)
❑ b. Screening tool(s) (2)
❑ c. Assessment tool(s) (3)

Q22_bx

For Item "b", please specify the screening tool(s), if you know the name(s):

Q22_cx

For Item "c", please specify the assessment tool(s), if you know the name(s):

Q23_a

How often do you use information from child development assessments to guide what you do at the next home visit? (For example, you might use it to identify an activity to work on with the child/family, make specific referrals, or establish visit frequency.)

○ Almost never (1)
○ Some of the time (2)
○ Most of the time (3)
○ Almost always (4)

Display This **Page**:

    If Which of these best describes your role in your program over the last 6 months? Program director or administrator Is Selected

X46

2017 Program Practices Survey

X47

SUPERVISION IN OUR {Q2_a} PROGRAM

Staff often are individually supported by supervisors to enhance their work with families and to help them grow as professionals. Supervision can occur in many forms, such as:
- one-on-one discussion or observation and feedback,
- debriefing sessions,
- instruction, or
- other individualized on-the-job training and support.

In questions where we use the term "reflective supervision," we mean:

Reflective supervision goes beyond individual guidance with an employee that supports effective performance or discusses issues and advises on approaches for working with specific clients in casework. Reflective supervision involves attention to all of the relationships and how each of these relationships affects the other (practitioner and supervisor; practitioner and parent; and parent and infant/toddler/child). There is especially attention to the emotional content of work and how reactions to the content affect the work. It is characterized by active listening and thoughtful questioning by both parties. The role of the supervisor is to help the supervisee discover solutions, concepts, and perceptions on her/his own without much interruption from the supervisor. Reflective practice extends these ideas outside an individual one-to-one setting into group discussions and into work directly with families.

Q24

How familiar are you with reflective supervision? (Check one response for each row.)

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
a. I am familiar with it. (Q24_a)	○	○	○	○	○
b. I received training on it. (Q24_b)	○	○	○	○	○
c. I feel knowledgeable about it. (Q24_c)	○	○	○	○	○
d. It is a regular part of my practice supervising others. (Q24_d)	○	○	○	○	○
e. I have trained or mentored others in using it. (Q24_e)	○	○	○	○	○

X48

2017 Program Practices Survey

X49

SUPERVISION IN OUR {Q2_a} PROGRAM

Q25_a

Are you responsible for supervising the staff who conduct supervision with {Q2_a} home visitors?
- ❍ No (1)
- ❍ Yes, some of them (2)
- ❍ Yes, all of them (3)

X50
2017 Program Practices Survey

X51
SUPERVISION IN OUR {Q2_a} PROGRAM

Q25_b
How often does your supervision of those implementing {Q2_a} involve a reflective supervision approach?
○ Never (1)
○ Rarely (2)
○ Sometimes (3)
○ Mostly (4)
○ Always (5)

Q26_a
How much of the time do you expect the supervisors over the {Q2_a} program to be using reflective supervision?
○ Never (1)
○ Rarely (2)
○ Sometimes (3)
○ Mostly (4)
○ Always (5)

Q26_ax
Comments:

Display This **Page**:
    If Which of these best describes your role in your program over the last 6 months? Supervisor Is Selected
    Or Director/administrator and supervisor Is Selected
    Or Supervisor and home visitor (who substitutes as needed, but does not carry a regular caseload) Is Selected
    Or Supervisor and home visitor (who carries a caseload) Is Selected
        And Select the model you are currently implementing: NFP Is Selected
        And Approximately how many families are in your current {Q2_a} home visiting caseload?
# of families currently in home visiting caseload: Is Less Than   5
    Or Supervisor and home visitor (who carries a caseload) Is Selected
        And Select the model you are currently implementing: PAT Is Selected
        And Approximately how many families are in your current {Q2_a} home visiting caseload?
# of families currently in home visiting caseload: Is Less Than   6
    Or Director/administrator, supervisor, and home visitor (who substitutes as needed, but does not carry a caseload) Is Selected
    Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected
        And Select the model you are currently implementing: NFP Is Selected
        And Approximately how many families are in your current {Q2_a} home visiting caseload?
# of families currently in home visiting caseload: Is Less Than   5
    Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected
        And Select the model you are currently implementing: PAT Is Selected
        And Approximately how many families are in your current {Q2_a} home visiting caseload?
# of families currently in home visiting caseload: Is Less Than   6

X52
2017 Program Practices Survey
X53
EXPERIENCES WITH PROVIDING SUPERVISION

Staff often are individually supported by supervisors to enhance their work with families and to help them grow as professionals. Supervision can occur in many forms, such as
- one-on-one discussion or observation and feedback,
- debriefing sessions,
- instruction, or
- other individualized on-the-job training and support.

In questions where we use the term "reflective supervision," we mean:
Reflective supervision goes beyond individual guidance with an employee that supports effective performance or discusses issues and advises on approaches for working with specific clients in casework. Reflective supervision involves attention to all of the relationships and how each of these relationships affects the other (practitioner and supervisor; practitioner and parent; and parent and infant/toddler/child). There is especially attention to the emotional content of work and how reactions to the content affect the work. It is characterized by active listening and thoughtful questioning by both parties. The role of the supervisor is to help the supervisee discover solutions, concepts, and perceptions on her/his own without much interruption from the supervisor. Reflective practice extends these ideas outside an individual one-to-one setting into group discussions and into work directly with families.

Q27
How familiar are you with reflective supervision? (Check one response for each row.)

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
a. I am familiar with it. (Q27_a)	❍	❍	❍	❍	❍
b. I received training on it. (Q27_b)	❍	❍	❍	❍	❍
c. I feel knowledgeable about it. (Q27_c)	❍	❍	❍	❍	❍
d. It is a regular part of my practice supervising others. (Q27_d)	❍	❍	❍	❍	❍

Q28_a
How many {Q2_a} staff do you supervise? (Enter whole number only, leave as 0 if none.)

Q28_ax
Comments:

X54

2017 Program Practices Survey

X55

EXPERIENCES WITH PROVIDING SUPERVISION (Continued)

Q28_b

You have indicated that you are a supervisor, but have entered "0" as the number of staff that you supervise. Is this correct?

○ No (1)
○ Yes (2)

X56

Please use the "Back" button below to go back and either revise your role or the number of staff that you supervise.

X57

2017 Program Practices Survey

X58

EXPERIENCES WITH PROVIDING SUPERVISION (Continued)

This section asks about your work supervising staff who are implementing the {Q2_a} program. If you supervise staff implementing more than one program model, please consider only the supervision for the {Q2_a} program in the last 6 months.

Q29_a

How often does your supervision time with staff involve a reflective supervision approach? To review the definition of reflective supervision, click here.
- ○ Never (1)
- ○ Rarely (2)
- ○ Sometimes (3)
- ○ Most of the time (4)
- ○ Always (5)

Q30_a

How long have you provided individual reflective supervision to home visitors? To review the definition of reflective supervision, click here.
- ○ I have not provided individual reflective supervision (1)
- ○ Less than 1 year (2)
- ○ 1 to 2 years (3)
- ○ 2 to 3 years (4)
- ○ 3 to 4 years (5)
- ○ 4 to 5 years (6)
- ○ More than 5 years (7)

X59

2017 Program Practices Survey

X60

EXPERIENCES WITH PROVIDING SUPERVISION (Continued)

Q31

Please indicate how much you agree with the following statements…   (Check one response for each row.)

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
a. It is a priority for me to provide supervision sessions to staff at regular intervals. (Q31_a)	❍	❍	❍	❍	❍
b. The organization I work for supports reflective supervision. (Q31_b)	❍	❍	❍	❍	❍
c. I can think of examples of how the home visiting of my staff has improved as a result of supervision I provided in the last 6 months. (Q31_c)	❍	❍	❍	❍	❍
d. I have the skills and background to implement reflective supervision with my staff. (Q31_d)	❍	❍	❍	❍	❍
e. I am very satisfied with the quality of the supervision sessions I have held in the last 6 months. (Q31_e)	❍	❍	❍	❍	❍
f. I am very satisfied with the frequency of supervision sessions I have held in the last 6 months. (Q31_f)	❍	❍	❍	❍	❍

2017 Program Practices Survey
EXPERIENCES WITH PROVIDING SUPERVISION (Continued)

Q31_g

In the last 6 months, I wanted staff to have…
- ○ A lot less frequent supervision (1)
- ○ A little less frequent supervision (2)
- ○ A little more frequent supervision (3)
- ○ A lot more frequent supervision (4)

Q32_a

How comfortable are you in using reflective supervision when you supervise home visitors? To review the definition of reflective supervision, click here.
- ○ Not at all comfortable (1)
- ○ Somewhat comfortable (2)
- ○ Comfortable (3)
- ○ Very comfortable (4)
- ○ Do not use this approach (5)

X63

2017 Program Practices Survey

X64

EXPERIENCES WITH PROVIDING SUPERVISION (Continued)

Thinking about your supervision of {Q2_a} staff in the last 6 months, to what extent are the following principles being used within the individual supervision you provide?

Q33

Typically, in individual supervision…   (Check one response for each row.)

	Strongly disagree (1)	Disagree (2)	Somewhat agree (3)	Agree (4)	Strongly agree (5)
a. We create a safe place to explore the home visitors' feelings about their work. (Q33_a)	❍	❍	❍	❍	❍
b. There is a respectful give and take between myself and the home visitors. (Q33_b)	❍	❍	❍	❍	❍
c. I can hold the home visitors' thoughts and feelings without trying to fix them. (Q33_c)	❍	❍	❍	❍	❍
d. I help the home visitors think about how their assumptions and experiences influence their practice. (Q33_d)	❍	❍	❍	❍	❍
e. I collaborate with the home visitors to solve problems of practice. (Q33_e)	❍	❍	❍	❍	❍
f. I make it safe to talk about situations that are not going well. (Q33_f)	❍	❍	❍	❍	❍
g. I provide uninterrupted focus on the home visitors' work with families during the individual meeting time. (Q33_g)	❍	❍	❍	❍	❍
h. I believe that the home visitors I supervise are receiving the right amount of reflective supervision to support them in their work. (Q33_h)	❍	❍	❍	❍	❍
i. My relationship with the home visitors provides a model for how I hope they work with families. (Q33_i)	❍	❍	❍	❍	❍
j. I guide the home visitors to explore the perspectives of everyone involved. (Q33_j)	❍	❍	❍	❍	❍
k. We maintain a focus on the baby or child's perspective. (Q33_k)	❍	❍	❍	❍	❍

Q33_x

Comments:

X65

2017 Program Practices Survey

X66

EXPERIENCES WITH PROVIDING SUPERVISION (continued)

Q34_a

Are you currently leading your team in a meeting where the group discusses specific cases and jointly considers strategies for working with the children/families? (Note: This meeting might be considered a case conference, a group supervision session, consultation, or a portion of a staff meeting with a specific, intentional focus on case discussions.)
❍ We don't have these kinds of meetings/case conferences. (1)
❍ We have these meetings, but I don't lead those meetings. (2)
❍ Yes, I sometimes lead the team in this kind of meeting/case conferences. (3)
❍ Yes, I usually lead the team in this kind of meeting/case conference. (4)

Q34_b

Does this meeting occur at a regularly scheduled interval?

❍ No (1)

❍ Somewhat (2)

❍ Yes (3)

Q34_c

How often do these meetings occur?

❍ Never (1)

❍ Annually (2)

❍ Once or twice in the last 6 months (3)

❍ 3 to 5 times in the last 6 months (4)

❍ Monthly (5)

❍ A couple times per month (6)

❍ Weekly (7)

❍ Two or more times per week (8)

X67

2017 Program Practices Survey

X68

EXPERIENCES WITH PROVIDING SUPERVISION (continued)

Consider case conference meetings with NFP staff in the last 6 months.

X69

EXPERIENCES WITH PROVIDING SUPERVISION (continued)

Consider group meetings where you have discussed specific cases with PAT staff in the last 6 months.

Q35

Typically, within the case conference or group meeting discussing cases… (Check one response for each row.)

	Strongly disagree (1)	Disagree (2)	Somewhat agree (3)	Agree (4)	Strongly agree (5)
a. The group members listen carefully to the presenter sharing the case. (Q35_a)	❍	❍	❍	❍	❍
b. The group explores meaning and perspective(s) about what is presented. (Q35_b)	❍	❍	❍	❍	❍
c. Group members hold solutions until the presenter is ready. (Q35_c)	❍	❍	❍	❍	❍
d. Group members feel safe expressing strong feelings. (Q35_d)	❍	❍	❍	❍	❍

Q35_x

Comments:

X70

2017 Program Practices Survey

X71

EXPERIENCES WITH PROVIDING SUPERVISION (continued)

Q35_2

At this time, how would you rate your level of adoption of reflective practice principles*?   (Check one response for each row.)

	Not yet in practice (1)	Initiating (2)	Emerging (3)	Mostly implemented (4)	Fully implemented (5)
a. In my case conference of group meeting discussing cases (Q35_e)	❍	❍	❍	❍	❍
b. Individually with home visitors (Q35_f)	❍	❍	❍	❍	❍

X72

*Examples of reflective practice principles include: create a safe, trusting relationship; attend to parallel process; pause and reflect; explore different perspectives; consider behavior in the context of relationships; explore thoughts and feelings; pay attention to self-regulation and co-regulation; maintain a clear sense of roles and boundaries; value the importance of repair in relationships; pay attention to my experience and how it influences my practice; develop collaborative relationships; and maintain a focus on the baby/child's perspective.

X73

2017 Program Practices Survey

X74

EXPERIENCES WITH RECEIVING SUPERVISION

Staff often are individually supported by supervisors to enhance their work with families and to help them grow as professionals.   Supervision can occur in many forms, such as

- one-on-one discussion or observation and feedback,
- debriefing sessions,
- instruction, or
- other individualized on-the-job training and support.

These questions ask about your experiences with individual supervision and in group case conferences and meetings.   As a reminder, your individual responses will not be shared with anyone outside of the research team.

Q36

How often…   (Check one response for each row.)

	Never (1)	Annually (2)	Once or twice in the last 6 months (3)	3 to 5 times in the last 6 months (4)	Monthly (5)	A couple times per month (6)	Weekly (7)	Two or more times per week (8)
a. ...have you had a scheduled time to meet with your supervisor individually? (Count supervision meetings that are face-to-face, by phone, webinar, etc.) (Q36_a)	❍	❍	❍	❍	❍	❍	❍	❍
b. ...has your supervisor actually met with you individually? (Count supervision meetings that actually occurred, regardless of whether scheduled in advance or not.) (Q36_b)	❍	❍	❍	❍	❍	❍	❍	❍
c. ...has your supervisor observed you working directly with families? (Count video and joint visits.) (Q36_c)	❍	❍	❍	❍	❍	❍	❍	❍
d. ...has your supervisor shared feedback about observations of you on home visits? (Q36_d)	❍	❍	❍	❍	❍	❍	❍	❍

Q36_x
Comments:

X75

2017 Program Practices Survey

X76

EXPERIENCES WITH RECEIVING SUPERVISION (Continued)

Q37

Please indicate how much you agree with the following statements…   (Check one response for each row.)

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
a. I can count on the fact that supervision sessions will occur at regular intervals. (Q37_a)	❍	❍	❍	❍	❍
b. I am very satisfied with the quality of the supervision sessions I have had in the last 6 months. (Q37_b)	❍	❍	❍	❍	❍
c. I can think of examples of how my home visiting has improved as a result of supervision I received in the last 6 months. (Q37_c)	❍	❍	❍	❍	❍
d. I am very satisfied with the frequency of supervision sessions I have had in the last 6 months. (Q37_d)	❍	❍	❍	❍	❍

Q38

In the last 6 months, I wanted to have had…
❍ A lot less frequent supervision (1)
❍ A little less frequent supervision (2)
❍ A little more frequent supervision (3)
❍ A lot more frequent supervision (4)

Q38_x

Comments:

X77

2017 Program Practices Survey

X78

EXPERIENCES WITH RECEIVING SUPERVISION (Continued)

In questions where we use the term "reflective supervision, we mean:

Reflective supervision goes beyond individual guidance with an employee that supports effective performance or discusses issues and advises on approaches for working with specific clients in casework. Reflective supervision involves attention to all of the relationships and how each of these relationships affects the other (practitioner and supervisor; practitioner and parent; and parent and infant/toddler/child). There is especially attention to the emotional content of work and how reactions to the content affect the work. It is characterized by active listening and thoughtful questioning by both parties. The role of the supervisor is to help the supervisee discover solutions, concepts, and perceptions on her/his own without much interruption from the supervisor. Reflective practice extends these ideas outside an individual one-to-one setting into group discussions and into work directly with families.

Q39_a

How often does your supervisor use a reflective supervision approach in supervision about {Q2_a} work?
- ○ Never (1)
- ○ Rarely (2)
- ○ Sometimes (3)
- ○ Most of the time (4)
- ○ Always (5)

X79

2017 Program Practices Survey

X80

EXPERIENCES WITH RECEIVING SUPERVISION (Continued)

Consider your experiences with individual supervision in the last 6 months…   (Check one response for each row.)

Q40

Typically, in individual supervision…

	Strongly disagree (1)	Disagree (2)	Somewhat agree (3)	Agree (4)	Strongly agree (5)
a. My supervisor provides a safe place to explore my feelings about my work. (Q40_a)	❍	❍	❍	❍	❍
b. There is a respectful give and take between my supervisor and me. (Q40_b)	❍	❍	❍	❍	❍
c. My supervisor can hold my thoughts and feelings without trying to fix them. (Q40_c)	❍	❍	❍	❍	❍
d. My supervisor helps me think about how my assumptions and experiences influence my practice. (Q40_d)	❍	❍	❍	❍	❍
e. My supervisor collaborates with me to solve problems of practice. (Q40_e)	❍	❍	❍	❍	❍
f. My supervisor makes it safe to talk about situations that are not going well. (Q40_f)	❍	❍	❍	❍	❍
g. My supervisor provides uninterrupted focus on my work with families during the individual meeting time. (Q40_g)	❍	❍	❍	❍	❍
h. I am receiving the right amount of reflective supervision to support me in my work. (Q40_h)	❍	❍	❍	❍	❍
i. My relationship with my supervisor provides a model for how I want to work with families. (Q40_i)	❍	❍	❍	❍	❍
j. My supervisor guides me to explore the perspectives of everyone involved. (Q40_j)	❍	❍	❍	❍	❍
k. My supervisor and I don't forget about the baby or child's perspective. (Q40_k)	❍	❍	❍	❍	❍

Q40_x

Comments:

X81

2017 Program Practices Survey

X82

EXPERIENCES WITH RECEIVING SUPERVISION (Continued)

Q41_a

How often have you participated in meetings with other home visitors where the group discussed specific cases and jointly considered strategies for working with the children/families? (Note: This meeting might be considered a case conference, a group supervision session, a consultation, or a portion of a staff meeting with a specific, intentional focus on case discussions.)

- ❍ Never (1)
- ❍ Annually (2)
- ❍ Once or twice in the last 6 months (3)
- ❍ 3 to 5 times in the last 6 months (4)
- ❍ Monthly (5)
- ❍ A couple times per month (6)
- ❍ Weekly (7)
- ❍ Two or more times per week (8)

X83

2017 Program Practices Survey

X84

EXPERIENCES WITH RECEIVING SUPERVISION (Continued)

Q42

In general, as a case conference group or at a group meeting discussing cases in the last 6 months…   (Check one response for each row.)

	Strongly disagree (1)	Disagree (2)	Somewhat agree (3)	Agree (4)	Strongly agree (5)
a. The group members listen carefully to the presenter. (Q42_a)	❍	❍	❍	❍	❍
b. The group explores meaning and perspective(s) about what is presented. (Q42_b)	❍	❍	❍	❍	❍
c. Group members hold solutions until the presenter is ready. (Q42_c)	❍	❍	❍	❍	❍
d. Group members feel safe expressing strong feelings. (Q42_d)	❍	❍	❍	❍	❍

Q42_x

Comments:

X85

2017 Program Practices Survey

X86

EXPERIENCES WITH RECEIVING SUPERVISION (Continued)

Q43
At this time, how would you rate your level of adoption of reflective practice principles*? (Check one response for each row.)

	Not yet in practice (1)	Initiating (2)	Emerging (3)	Mostly implemented (4)	Fully implemented (5)
a. In my case conference or group meeting discussing cases (Q43_a)	❍	❍	❍	❍	❍
b. Individually with my supervisor (Q43_b)	❍	❍	❍	❍	❍
c. In my work with families (Q43_c)	❍	❍	❍	❍	❍

X87

*Examples of reflective practice principles include: create a safe, trusting relationship; attend to parallel process; pause and reflect; explore different perspectives; consider behavior in the context of relationships; explore thoughts and feelings; pay attention to self-regulation and co-regulation; maintain a clear sense of roles and boundaries; value the importance of repair in relationships; pay attention to my experience and how it influences my practice; develop collaborative relationships; and maintain a focus on the baby/child's perspective.

Q43_x
Comments:

X88

2017 Program Practices Survey

X89

EXPERIENCES WITH RECEIVING SUPERVISION (Continued)

Q44

At this time, how would you rate your level of adoption of reflective practice principles*? (Check one response for each row.)

	Not yet in practice (1)	Initiating (2)	Emerging (3)	Mostly implemented (4)	Fully implemented (5)
a. Individually with my supervisor (Q44_a)	❍	❍	❍	❍	❍
b. In my work with families (Q44_b)	❍	❍	❍	❍	❍

X90

*Examples of reflective practice principles include: create a safe, trusting relationship; attend to parallel process; pause and reflect; explore different perspectives; consider behavior in the context of relationships; explore thoughts and feelings; pay attention to self-regulation and co-regulation; maintain a clear sense of roles and boundaries; value the importance of repair in relationships; pay attention to my experience and how it influences my practice; develop collaborative relationships; and maintain a focus on the baby/child's perspective.

Q44_c

Comments:

2017 Program Practices Survey

X92

EXPERIENCES WITH TRAINING, TECHNICAL ASSISTANCE, AND COACHING

Throughout the rest of this survey, "technical assistance" (TA) is used to refer to the kinds of supports available to home visiting programs.

Examples of technical assistance (TA) might include the following types of support:
- Training
- Workshops or conferences
- Coaching
- Site visits
- Consultation
- Facilitating individual connections to resources

Display This Question:
    If Select the model you are currently implementing: NFP Is Selected

X93

Technical assistance can focus on a variety of topics, such as grantee requirements, model fidelity or essential requirements, program implementation, or skill building on specific content.

Please consider technical assistance you receive from many different sources. For example, TA may be provided by:
- State technical assistance providers
- Regional technical assistance providers
- NFP nurse consultants
- The NFP national service offices
- MIECHV-related TA providers (e.g., MIECHV leads, TACC, DOHVE)
- State or national professional organizations
- Other organizations and individual resources

X94

Technical assistance can focus on a variety of topics, such as grantee requirements, model fidelity or essential requirements, program implementation, or skill building on specific content.

Please consider technical assistance you receive from many different sources. For example, TA may be provided by:

- State technical assistance providers
- Regional technical assistance providers
- PAT state model leads
- The PAT national service offices
- MIECHV-related TA providers (e.g., MIECHV leads, TACC, DOHVE)
- State or national professional organizations
- Other organizations and individual resources

X95

Please do not count TA received from your supervisor in your responses.

2017 Program Practices Survey
EXPERIENCES WITH TRAINING, TECHNICAL ASSISTANCE, AND COACHING (continued)

Q45

Overall, in the last 6 months, how satisfied have you been with…   (Check one response for each row. To review the definition of TA, click here.)

	Not satisfied (1)	Somewhat satisfied (2)	Satisfied (3)	Very satisfied (4)	Did not receive (5)
a. The individualized support or coaching you received on-site or in-person? (e.g., face to face meetings, site visits about you or your program's specific questions or needs) (Q45_a)	❍	❍	❍	❍	❍
b. The individualized support or coaching you received remotely via phone, webinar, or a series of emails? (e.g., face to face phone calls, web meetings, or an extended series of email exchanges about you or your programs' specific questions or needs) (Q45_b)	❍	❍	❍	❍	❍
c. The workshops, meetings, or trainings you attended on-site or in-person? (e.g., face-to-face group workshops, meetings, or trainings at your program or another location) (Q45_c)	❍	❍	❍	❍	❍
d. The workshops, meetings or trainings you participated in remotely via phone or webinar? (e.g., group phone- or web-based workshops, meetings, or trainings) (Q45_d)	❍	❍	❍	❍	❍
e. The connections to resources and referrals you received? (e.g., community contacts, resource documents, other sources of support or training, other programs/staff with similar characteristics or facing similar challenges) (Q45_e)	❍	❍	❍	❍	❍
f. The TA support you received via brief emails and/or text messages? (e.g., responses to brief questions via text/email) (Q45_f)	❍	❍	❍	❍	❍

Q46_a

About how often does TA using emails or text messages occur? (To review the definition of TA, click here.)

❍ Weekly (1)
❍ Monthly (2)
❍ Quarterly (3)
❍ Once or twice a year (4)

Q47_x

Comments:

X98

2017 Program Practices Survey

X99

EXPERIENCES WITH TRAINING, TECHNICAL ASSISTANCE, AND COACHING (continued)

Q48

Thinking about the amount of training, technical assistance, coaching and support you received in the last 6 months, it was:

❍ A lot less than what I needed (1)
❍ A little less than what I needed (2)
❍ About right (3)
❍ A little more than what I needed (4)
❍ A lot more than what I needed (5)

X100

2017 Program Practices Survey

X101

EXPERIENCES WITH TRAINING, TECHNICAL ASSISTANCE, AND COACHING (continued)

Q48_2

Thinking just about the individualized support and coaching you received in the last 6 months, how often was this TA…   (Check one response for each row. To review the definition of TA, click here.)

	Never (1)	Rarely (2)	Sometimes (3)	Mostly (4)	Always (5)
a. Tailored to my individual needs? (Q48_a)	○	○	○	○	○
b. Grounded in a relationship where the TA was provided by someone who got to know me? (Q48_b)	○	○	○	○	○

Display This **Page**:
 If Which of these best describes your role in your program over the last 6 months? Director/administrator and supervisor Is Selected
  And Overall, in the last 6 months, how satisfied have you been with...
  - Did not receive Is Not Equal to 6
 Or Supervisor and home visitor (who substitutes as needed, but does not carry a regular caseload) Is Selected
  And Overall, in the last 6 months, how satisfied have you been with...
  - Did not receive Is Not Equal to 6
 Or Supervisor and home visitor (who carries a caseload) Is Selected
  And Select the model you are currently implementing: NFP Is Selected
  And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 5
  And Overall, in the last 6 months, how satisfied have you been with...
  - Somewhat satisfied Is Not Equal to 6
 Or Supervisor and home visitor (who carries a caseload) Is Selected
  And Select the model you are currently implementing: PAT Is Selected
  And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 6
  And Overall, in the last 6 months, how satisfied have you been with...
  - Did not receive Is Not Equal to 6
 Or Director/administrator, supervisor, and home visitor (who substitutes as needed, but does not carry a caseload) Is Selected
  And Overall, in the last 6 months, how satisfied have you been with...
  - Did not receive Is Not Equal to 6
 Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected
  And Select the model you are currently implementing: NFP Is Selected
  And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 5
  And Overall, in the last 6 months, how satisfied have you been with...
  - Did not receive Is Not Equal to 6
 Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected
  And Select the model you are currently implementing: PAT Is Selected
  And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 6
  And Overall, in the last 6 months, how satisfied have you been with...
  - Did not receive Is Not Equal to 6

X102

2017 Program Practices Survey

X103

EXPERIENCES WITH TRAINING, TECHNICAL ASSISTANCE, AND COACHING (continued)

Across all the different types of training, TA, and coaching you received in the last 6 months, overall, how often would you say it…   (Check one response for each row. To review the definition of TA, click here.)

	Never (1)	Rarely (2)	Sometimes (3)	Mostly (4)	Always (5)
a. Was useful for my work as a supervisor / administrator. (Q49_a)	❍	❍	❍	❍	❍
b. Was available when I needed it. (Q49_b)	❍	❍	❍	❍	❍
c. Was easy for me to participate in or access. (Q49_c)	❍	❍	❍	❍	❍
d. Was easy for me to coordinate for my staff. (Q49_d)	❍	❍	❍	❍	❍
e. Was provided in an appropriate format (e.g., on-site, remotely, individualized, large group formats). (Q49_e)	❍	❍	❍	❍	❍
f. Was provided by someone who understood my program model. (Q49_f)	❍	❍	❍	❍	❍
g. Addressed my specific needs or questions. (Q49_g)	❍	❍	❍	❍	❍
h. Helped me identify appropriate training that would address the needs of my staff. (Q49_h)	❍	❍	❍	❍	❍
i. Provided support to me that allowed me to more effectively support my staff. (Q49_i)	❍	❍	❍	❍	❍

Q49_2

In the last 6 months, how often would you say it…

	Never (1)	Rarely (2)	Sometimes (3)	Mostly (4)	Always (5)	Not needed (6)
j. Helped me better support our home visiting staff with assessment of family strengths and needs. (Q49_j)	○	○	○	○	○	○
k. Helped me address requirements from my funder or program effectively. (Q49_k)	○	○	○	○	○	○
l. Helped me improve the way I supervise my staff. (Q49_l)	○	○	○	○	○	○
m. Provided me with tools and resources that helped me implement supervision practices consistent with our program model. (Q49_m)	○	○	○	○	○	○
n. Helped me improve my leadership skills. (Q49_n)	○	○	○	○	○	○
o. Helped me work within the systems of my organization or improve the system in order to accomplish important tasks. (Q49_o)	○	○	○	○	○	○
p. Helped me improve the way our program uses data to make decisions. (Q49_p)	○	○	○	○	○	○

Q49_x
Comments:

X104

2017 Program Practices Survey

X105

EXPERIENCES WITH TRAINING, TECHNICAL ASSISTANCE, AND COACHING (continued)

Q50

Across all the different types of training, TA, and coaching you received in the last 6 months, overall, how often would you say it…   (Check one response for each row. To review the definition of TA, click here.)

	Never (1)	Rarely (2)	Sometimes (3)	Mostly (4)	Always (5)
a. Was useful for my work as a home visitor. (Q50_a)	❍	❍	❍	❍	❍
b. Was available when I needed it. (Q50_b)	❍	❍	❍	❍	❍
c. Was easy for me to participate in or access. (Q50_c)	❍	❍	❍	❍	❍
d. Was provided in an appropriate format (e.g., on-site, remotely, individualized, large group formats). (Q50_d)	❍	❍	❍	❍	❍
e. Was provided by someone who understood my program model. (Q50_e)	❍	❍	❍	❍	❍
f. Addressed my specific needs or questions. (Q50_f)	❍	❍	❍	❍	❍

Q50_x

Comments:

X106
2017 Program Practices Survey
X107
EXPERIENCES WITH TRAINING, TECHNICAL ASSISTANCE, AND COACHING (continued)

Q51_1
Across all the different types of training, TA, and coaching you received in the last 6 months, overall, how often would you say it…   (Check one response for each row. To review the definition of TA, click here.)

	Never (1)	Rarely (2)	Sometimes (3)	Mostly (4)	Always (5)
a. Was useful for my work as a home visitor. (Q51_a)	❍	❍	❍	❍	❍
b. Was useful for my work as a supervisor / administrator. (Q51_b)	❍	❍	❍	❍	❍
c. Was available when I needed it. (Q51_c)	❍	❍	❍	❍	❍
d. Was easy for me to participate in or access. (Q51_d)	❍	❍	❍	❍	❍
e. Was easy for me to coordinate for my staff. (Q51_e)	❍	❍	❍	❍	❍
f. Was provided in an appropriate format (e.g., on-site, remotely, individualized, large group formats). (Q51_f)	❍	❍	❍	❍	❍
g. Was provided by someone who understood my program model. (Q51_g)	❍	❍	❍	❍	❍
h. Addressed my specific needs or questions. (Q51_h)	❍	❍	❍	❍	❍
i. Helped me identify appropriate training that would address the needs of my staff. (Q51_i)	❍	❍	❍	❍	❍
j. Provided support to me that allowed me to more effectively support my staff. (Q51_j)	❍	❍	❍	❍	❍

How often would you say it…

	Never (1)	Rarely (2)	Sometimes (3)	Mostly (4)	Always (5)	Not needed (6)
k. Helped me better support our home visiting staff with assessment of family strengths and needs. (Q51_k)	❍	❍	❍	❍	❍	❍
l. Helped me address requirements from my funder or program effectively. (Q51_l)	❍	❍	❍	❍	❍	❍
m. Helped me improve the way I supervise my staff. (Q51_m)	❍	❍	❍	❍	❍	❍
n. Provided me with tools and resources that helped implement supervision practices consistent with our program model. (Q51_n)	❍	❍	❍	❍	❍	❍
o. Helped me improve my leadership skills. (Q51_o)	❍	❍	❍	❍	❍	❍
p. Helped me work within the systems of my organization or improve the system in order to accomplish important tasks. (Q51_p)	❍	❍	❍	❍	❍	❍
q. Helped me improve the way our program uses data to make decisions. (Q51_q)	❍	❍	❍	❍	❍	❍

Q51_x

Comments:

Display This **Page**:

       If Which of these best describes your role in your program over the last 6 months? Supervisor Is Selected

       Or Director/administrator and supervisor Is Selected

       Or Supervisor and home visitor (who substitutes as needed, but does not carry a regular caseload) Is Selected

       Or Supervisor and home visitor (who carries a caseload) Is Selected

              And Select the model you are currently implementing: NFP Is Selected

              And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 5

       Or Supervisor and home visitor (who carries a caseload) Is Selected

              And Select the model you are currently implementing: PAT Is Selected

              And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 6

       Or Director/administrator, supervisor, and home visitor (who substitutes as needed, but does not carry a caseload) Is Selected

              And Select the model you are currently implementing: NFP Is Selected

              And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 5

       Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

              And Select the model you are currently implementing: PAT Is Selected

              And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 6

       Or Program director or administrator Is Selected

       Or Supervisor and home visitor (who carries a caseload) Is Selected

              And Select the model you are currently implementing: NFP Is Selected

              And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 5

       Or Supervisor and home visitor (who carries a caseload) Is Selected

              And Select the model you are currently implementing: PAT Is Selected

              And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 6

       Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

              And Select the model you are currently implementing: NFP Is Selected

              And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 5

       Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

              And Select the model you are currently implementing: PAT Is Selected

              And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 6

X108

2017 Program Practices Survey

X109

EXPERIENCES WITH TRAINING, TECHNICAL ASSISTANCE, AND COACHING (continued)

In the last 6 months…   (Check one response for each row. To review the definition of TA, click here.)

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
a. There was someone in my state or region who provided me with TA support. (Q52_a)	❍	❍	❍	❍	❍
b. There was someone in my state or region who helped me coordinate with the national ${q://QID29/ChoiceGroup/SelectedChoices} office for TA support. (Q52_b)	❍	❍	❍	❍	❍
c. The TA support I received at the state or regional level minimized my need to contact the national ${q://QID29/ChoiceGroup/SelectedChoices} office directly for support. (Q52_c)	❍	❍	❍	❍	❍

Q52_x

Comments:

Display This **Page**:

   If Which of these best describes your role in your program over the last 6 months? Home visitor (e.g., PAT parent educator or NFP nurse home visitor) Is Selected

X110

2017 Program Practices Survey

Q111

EXPERIENCES WITH TRAINING, TECHNICAL ASSISTANCE, AND COACHING (continued)

Q53

In the last 6 months…   (Check one response for each row. To review the definition of TA, click here.)

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
a. There was someone in my state or region who provided me with TA support. (Q53_a)	❍	❍	❍	❍	❍
b. The TA support I received at the state or regional level minimized my need to contact the national ${q://QID29/ChoiceGroup/SelectedChoices} office directly for support. (Q53_b)	❍	❍	❍	❍	❍

Q53_x

Comments:

2017 Program Practices Survey

EXPERIENCES WITH TRAINING, TECHNICAL ASSISTANCE, AND COACHING (continued)

Q53

The amount of TA and support people receive will vary from month to month. In an average month, how much time do you expect to participate in TA, coaching, and support? (Enter whole numbers only, leave as 0 if none.)

_____ hours and (1)
_____ minutes per month (2)

Q53_x2

Comments:

Display This **Page**:

     If Which of these best describes your role in your program over the last 6 months? Supervisor Is Selected

     Or Director/administrator and supervisor Is Selected

     Or Supervisor and home visitor (who substitutes as needed, but does not carry a regular caseload) Is Selected

     Or Supervisor and home visitor (who carries a caseload) Is Selected

        And Select the model you are currently implementing: NFP Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 5

     Or Supervisor and home visitor (who carries a caseload) Is Selected

        And Select the model you are currently implementing: PAT Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 6

     Or Director/administrator, supervisor, and home visitor (who substitutes as needed, but does not carry a caseload) Is Selected

        And Select the model you are currently implementing: NFP Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 5

     Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

        And Select the model you are currently implementing: PAT Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 6

     Or Program director or administrator Is Selected

     Or Supervisor and home visitor (who carries a caseload) Is Selected

        And Select the model you are currently implementing: NFP Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 5

     Or Supervisor and home visitor (who carries a caseload) Is Selected

        And Select the model you are currently implementing: PAT Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 6

     Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

        And Select the model you are currently implementing: NFP Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 5

     Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

        And Select the model you are currently implementing: PAT Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 6

X114

2017 Program Practices Survey

X115

PROGRAM SUPPORTS FROM AN ADMINISTRATOR / SUPERVISOR'S PERSPECTIVE

These questions ask about how the administration and leadership functions in your program. By administrators, we are referring to those who make decisions about the organization, policies, and procedures. This may be you, others, or a combination. In some programs, administrative actions

may be shared by directors and supervisors, in others, one person may have these responsibilities.

Q54

Thinking broadly about your program…   (Check one response for each row.)

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
a. In the last 6 months, administrative policies or procedures made it difficult for me or my staff to implement home visiting effectively. (Q54_a)	❍	❍	❍	❍	❍
b. In the last 6 months, there has been administrative support to ensure that staff are fully trained to implement their roles in the ${q://QID29/ChoiceGroup/SelectedChoices} program effectively. (Q54_b)	❍	❍	❍	❍	❍
c. In the last 6 months, administrators have changed policies and procedures to allow staff to better implement the program. (Q54_c)	❍	❍	❍	❍	❍
d. As significant changes occur, administrators do a comprehensive review of the organizational structure and roles to ensure that they support effective implementation of the ${q://QID29/ChoiceGroup/SelectedChoices} program. (Q54_d)	❍	❍	❍	❍	❍

Q54_x

Comments:

X116

2017 Program Practices Survey

X117

PROGRAM SUPPORTS FROM A HOME VISITOR'S PERSPECTIVE

These questions ask about how well the administration and leadership in the program supports your work as a home visitor. By administrators, we are referring to those who make decisions about the organization, policies, and procedures that impact everyday functioning as a home visitor. In some programs, administrative actions may be shared by directors and supervisors, in others, one person may have these responsibilities.   As a reminder, your individual responses will not be shared with anyone outside of the research team.

Q55

Thinking about your program…   (Check one response for each row.)

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
a. In the last 6 months, administrative policies and procedures have made it difficult to implement my home visiting role effectively. (Q55_a)	❍	❍	❍	❍	❍
b. In the last 6 months, administrators have made efforts to change or improve existing policies and procedures in response to identified staff concerns. (Q55_b)	❍	❍	❍	❍	❍
c. In the last 6 months, administrators have shown interest in learning new things that might help them improve the program. (Q55_c)	❍	❍	❍	❍	❍
d. Administrators are knowledgeable about the ${q://QID29/ChoiceGroup/SelectedChoices} program model and our home visiting activities. (Q55_d)	❍	❍	❍	❍	❍

Q55_x

Comments:

Display If Which of these best describes your role in your program over the last 6 months?
Supervisor Is Selected

  Or Director/administrator and supervisor Is Selected

  Or Supervisor and home visitor (who substitutes as needed, but does not carry a regular
caseload) Is Selected

  Or Supervisor and home visitor (who carries a caseload) Is Selected

   And Select the model you are currently implementing: NFP Is Selected

   And Approximately how many families are in your current {Q2_a} home visiting caseload?
# of families currently in home visiting caseload: Is Less Than 5

  Or Supervisor and home visitor (who carries a caseload) Is Selected

   And Select the model you are currently implementing: PAT Is Selected

   And Approximately how many families are in your current {Q2_a} home visiting caseload?
# of families currently in home visiting caseload: Is Less Than 6

  Or Director/administrator, supervisor, and home visitor (who substitutes as needed, but does
not carry a caseload) Is Selected

   And Select the model you are currently implementing: NFP Is Selected

   And Approximately how many families are in your current {Q2_a} home visiting caseload?
# of families currently in home visiting caseload: Is Less Than 5

  Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

   And Select the model you are currently implementing: PAT Is Selected

   And Approximately how many families are in your current {Q2_a} home visiting caseload?
# of families currently in home visiting caseload: Is Less Than 6

  Or Program director or administrator Is Selected

  Or Supervisor and home visitor (who carries a caseload) Is Selected

   And Select the model you are currently implementing: NFP Is Selected

   And Approximately how many families are in your current {Q2_a} home visiting caseload?
# of families currently in home visiting caseload: Is Greater Than or Equal to 5

  Or Supervisor and home visitor (who carries a caseload) Is Selected

   And Select the model you are currently implementing: PAT Is Selected

   And Approximately how many families are in your current {Q2_a} home visiting caseload?
# of families currently in home visiting caseload: Is Greater Than or Equal to 6

  Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

   And Select the model you are currently implementing: NFP Is Selected

   And Approximately how many families are in your current {Q2_a} home visiting caseload?
# of families currently in home visiting caseload: Is Greater Than or Equal to 5

  Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

   And Select the model you are currently implementing: PAT Is Selected

   And Approximately how many families are in your current {Q2_a} home visiting caseload?
# of families currently in home visiting caseload: Is Greater Than or Equal to 6

PROGRAM SUPPORTS FROM AN ADMINISTRATOR/SUPERVISOR'S PERSPECTIVE
(continued)

This section focuses on approaches for implementing your home visiting model and addressing
needed changes. Thinking about your program in the last 6 months, administrators and
supervisors (including yourself) have…

X120

PROGRAM SUPPORTS FROM A HOME VISITOR'S PERSPECTIVE (continued)

This section focuses on approaches for implementing your home visiting model and addressing needed changes. Thinking about the administrators and supervisors in your program, in the last 6 months…

Q56

(Check one response for each row. To review the definition of administrators and supervisors, click here.)

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
a. Administrators and supervisors have continually looked for ways to align program policies and procedures with the overall mission, values, and philosophy of the {Q2_a} program. (Q56_a)	❍	❍	❍	❍	❍
b. Administrators and supervisors have been very good at focusing our time on making changes to things that really matter at the home visitor level. (Q56_b)	❍	❍	❍	❍	❍
c. Administrators and supervisors have been fair, respectful, considerate, and inclusive in dealings with others. (Q56_c)	❍	❍	❍	❍	❍
d. Administrators and supervisors have established clear and frequent communication channels to provide information to home visitors and to hear about their successes and concerns. (Q56_d)	❍	❍	❍	❍	❍
e. Administrators and supervisors have been very good at giving reasons for changes in policies, procedures, or staffing. (Q56_e)	❍	❍	❍	❍	❍
f. Administrators and supervisors have actively and routinely sought feedback from home visitors and others about what is needed to help implement the {Q2_a} model effectively. (Q56_f)	❍	❍	❍	❍	❍

Q56_x

Comments:

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     If Which of these best describes your role in your program over the last 6 months? Supervisor Is Selected

     Or Director/administrator and supervisor Is Selected

     Or Supervisor and home visitor (who substitutes as needed, but does not carry a regular caseload) Is Selected

     Or Supervisor and home visitor (who carries a caseload) Is Selected

        And Select the model you are currently implementing: NFP Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 5

     Or Supervisor and home visitor (who carries a caseload) Is Selected

        And Select the model you are currently implementing: PAT Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 6

     Or Director/administrator, supervisor, and home visitor (who substitutes as needed, but does not carry a caseload) Is Selected

        And Select the model you are currently implementing: NFP Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 5

     Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

        And Select the model you are currently implementing: PAT Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 6

     Or Program director or administrator Is Selected

     Or Supervisor and home visitor (who carries a caseload) Is Selected

        And Select the model you are currently implementing: NFP Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 5

     Or Supervisor and home visitor (who carries a caseload) Is Selected

        And Select the model you are currently implementing: PAT Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 6

     Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

        And Select the model you are currently implementing: NFP Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 5

     Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

        And Select the model you are currently implementing: PAT Is Selected

        And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 6

X121

2017 Program Practices Survey

X122

PROGRAM SUPPORTS FROM AN ADMINISTRATOR/SUPERVISOR'S PERSPECTIVE (continued)

Thinking now just about yourself, in the last 6 months… (Check one response for each row.)

	Strongly disagree (1)	Disagree (2)	Agree (3)	Strongly agree (4)
a. When I see a change needed to improve program policies or procedures, I am confident I can implement the needed change. (Q57_a)	○	○	○	○
b. I have the support I need from others to implement my role. (Q57_b)	○	○	○	○
c. I can find work-arounds to accomplish needed administrative changes for our program even when barriers make it challenging. (Q57_c)	○	○	○	○
d. I know how specific activities of home visitors relate to the ${q://QID29/ChoiceGroup/SelectedChoices}'s program goals. (Q57_d)	○	○	○	○
e. I am comfortable explaining the goals of the ${q://QID29/ChoiceGroup/SelectedChoices} model to others. (Q57_e)	○	○	○	○

Q57_x

Comments:

Display This **Page**:

If Which of these best describes your role in your program over the last 6 months? Supervisor Is Selected

Or Director/administrator and supervisor Is Selected

Or Supervisor and home visitor (who substitutes as needed, but does not carry a regular caseload) Is Selected

Or Supervisor and home visitor (who carries a caseload) Is Selected

And Select the model you are currently implementing: NFP Is Selected

And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 5

Or Supervisor and home visitor (who carries a caseload) Is Selected

And Select the model you are currently implementing: PAT Is Selected

And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 6

Or Director/administrator, supervisor, and home visitor (who substitutes as needed, but does not carry a caseload) Is Selected

And Select the model you are currently implementing: NFP Is Selected

And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 5

Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

And Select the model you are currently implementing: PAT Is Selected

And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Less Than 6

Or Program director or administrator Is Selected

Or Supervisor and home visitor (who carries a caseload) Is Selected

And Select the model you are currently implementing: NFP Is Selected

And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 5

Or Supervisor and home visitor (who carries a caseload) Is Selected

And Select the model you are currently implementing: PAT Is Selected

And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 6

Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

And Select the model you are currently implementing: NFP Is Selected

And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 5

Or Director/administrator, supervisor, and home visitor (who carries a caseload) Is Selected

And Select the model you are currently implementing: PAT Is Selected

And Approximately how many families are in your current {Q2_a} home visiting caseload? # of families currently in home visiting caseload: Is Greater Than or Equal to 6

X123

2017 Program Practices Survey

X124

OUR PROGRAM

These questions ask about how your program usually functions. Thinking about the last 6 months…   (Check one response for each row.)

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
a. Our program has implemented a consistent approach to sharing and discussing information about the program's enrollment and retention numbers with all staff. (Q58_a)	❍	❍	❍	❍	❍
b. Our program has implemented a consistent and thoughtful process to ensure that we hire effective home visiting staff. (Q58_b)	❍	❍	❍	❍	❍
c. Our program has implemented a consistent process for training and coaching new staff after they are hired. (Q58_c)	❍	❍	❍	❍	❍
d. Our program has a system in place where we receive referrals from diverse organizations in the area. (Q58_d)	❍	❍	❍	❍	❍
e. Our program has worked to build or maintain strong relationships with other community organizations that refer families to us. (Q58_e)	❍	❍	❍	❍	❍
f. Our program has worked to foster strong relationships with other community organizations that we refer families to for additional support. (Q58_f)	❍	❍	❍	❍	❍

Q58_x

Comments:

2017 Program Practices Survey
USING DATA AND RESEARCH TO INFORM PRACTICE
These questions ask about how information is used and how your organization makes decisions.   The term data refers to information that is systematically gathered. Examples include things like surveys, evaluation results, assessment or screening tools, or summary reports from routine home visiting forms and intake or exit information.

Q59
Based on your experience in the last 6 months… (Check one response for each row.)

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
a. our program has reviewed data at least monthly to see how we are performing. (Q59_a)	❍	❍	❍	❍	❍
b. our program has used data to identify areas for improvement. (Q59_b)	❍	❍	❍	❍	❍
c. I can think of at least one example of when our program made a change in policies, procedures, or activities in response to or after reviewing data. (Q59_c)	❍	❍	❍	❍	❍
d. our program has involved people at multiple levels to review data and consider how it might inform changes in practices or program decisions (e.g., home visitors, supervisors and administrators review data). (Q59_d)	❍	❍	❍	❍	❍

Q59_x
Comments:

2017 Program Practices Survey

TELL US ABOUT YOURSELF

Q60_a

What best describes your gender?
- Male (1)
- Female (2)
- Prefer not to state (3)

Q61_a

About how old are you?
- 18-25 (1)
- 26-35 (2)
- 36-45 (3)
- 46-55 (4)
- 56-65 (5)
- Older than 65 (6)
- Prefer not to state (7)

Q62_a

What is the highest level of education you have completed?
- Some high school (1)
- High school/GED (2)
- Associates degree/some college (3)
- 4-year college degree (4)
- Some graduate school (5)
- Graduate degree (masters or higher) (6)
- Prefer not to state (7)

Q63_a

What is your professional training? (Check all that apply)
- ❑ Bachelors Prepared Nurse (1)
- ❑ Licensed Practical Nurse (2)
- ❑ Registered Nurse (3)
- ❑ Business Administration (4)
- ❑ Community Health Worker (5)
- ❑ Early Childhood Educator (6)
- ❑ Family Support Specialist (7)
- ❑ Human Resource Management (8)
- ❑ Infant Mental Health Specialist (9)
- ❑ Marriage and Family Therapist (10)
- ❑ Parent Educator (11)
- ❑ Psychologist (12)
- ❑ Social Worker (13)
- ❑ Teacher (14)
- ❑ Other (15)
- ❑ Prefer not to state (16)

Display This Question:
    If What is your professional training? Other Is Selected

Q63_ax

Please specify other:

Q64_x

Comments:

2017 Program Practices Survey

TELL US ABOUT YOURSELF (Continued)

Q65_a

Which of these describes you? (Check all that apply)
- ❑ African (1)
- ❑ African-American, not of Hispanic origin (2)
- ❑ American Indian or Alaskan Native (3)
- ❑ Asian or Pacific Islander (4)
- ❑ Latino/Hispanic (5)
- ❑ White, not of Hispanic origin (6)
- ❑ Other/multi-racial (7)
- ❑ Prefer not to state (8)

> Display This Question:
>   If Which of these describes you? Other/multi-racial Is Selected

Q65_ax

Please specify:

Q66_a

Can you use a language other than English at work?
- ❍ No (1)
- ❍ Yes, in a limited way (2)
- ❍ Yes, fluently (3)

> Display This Question:
>   If Can you use a language other than English at work? Yes, in a limited way Is Selected
>   Or Yes, fluently Is Selected

Q66_b

Which language(s)? (Check all that apply)
- ❑ Spanish (1)
- ❑ Cantonese (2)
- ❑ Hmong (3)
- ❑ Laotian (4)
- ❑ Mandarin (5)
- ❑ Persian (6)
- ❑ Russian (7)
- ❑ Vietnamese (8)
- ❑ Other (9)

> Display This Question:
>   If Which language(s)? Other Is Selected

Q66_bx

Please specify:

Q67_a

Is there anything else that is important for us to know about you, your program, or your experiences with technical assistance and support in the last 6 months?

❍ No (1)
❍ Yes (2)

Display This Question:
    If Is there anything else that is important for us to know about you, your program, or your experiences Yes Is Selected

Q67_ax

Please specify:

2017 Program Practices Survey

X133

This concludes the survey. Thank you for your participation!
Click "Submit" to save your responses and close your survey.

X134

Thank you for your consideration.
Click "Submit" to close your survey and receive no further contact.

Appendix H
Experiences in Rural Programs—Semi-Structured Rural Case Study Planning Interview Protocol (2017)

Phone ____   Interviewer: _____   Note taker: _____

Rural Case Study Planning Interview
PHONE

INFORMAL GREETINGS.

Introduce self as SRI, independent evaluator. Ask if participant received the Information Sheet for Participating in Research via email. Ask if participant has any questions or concerns. Once any questions or concerns have been addressed, notify the participant you will begin recording.

START RECORDING.

Remind participant that the purpose of the interview is to help us learn more about how the Thrive Implementation HUB is supporting the implementation of evidence-based home visiting programs in rural communities. We will ask questions about the HUB's community planning process work and the successes and challenges of that work, as well as questions about supporting rural programs in general. Her/his responses will help us develop an understanding of this work, as well as inform the questions we will ask home visiting program staff when we conduct site visits as part of the Rural Case Study.

Ensure clear definition of Community Planning Process Work: Today, during the interview we will talk about the HUB's community planning process work. So, we want to take a minute to make sure you know that when we use that term, we are referring to the supports and funding provided by the HUB to rural communities for implementing evidence based home visiting, NFP or PAT. There have been 2 rounds so far. The first round was called the "Rural Home Visiting Project" and the second round was called the "Expanding Home Visiting Services in Rural Communities" project.

Across the interview questions, you may find that not all questions apply to you in your role. If that is the case, just let us know and we can skip those questions. All responses will be kept **confidential** by SRI International staff. Only emerging themes and broad viewpoints will be described. Your responses will not be linked to you in a way that identifies your name or role.

Background

1) Can you describe the HUB's community planning process, from your perspective?

   a. What were/are the goals of this work?
   b. Did implementation science influence this work? If so, how? (e.g., was implementation science used as a framework?)
   c. How did Round 2 compare to Round 1?

2) What is your understanding of how the community planning process came to be a priority for Thrive?

   a. In other words, what is the history of the program?
   b. How has the process evolved since its original inception? (e.g., application of the process to other areas of Thrive's work aside from supporting rural programs, and outside of home visiting)

3) How would you describe your particular role in connection to the community planning process work?

   a. Did your role change between Round 1 and Round 2? If so, how?

Successes and Challenges

4) What have been some of the **successes** of the **community planning process work** with programs?

   a. (Probe) Can you share an example? (Encourage specifics, go beyond broad areas of success, what makes you think of that as a success?)
   b. (Probe if haven't hit on it yet) How has the community planning process made a difference in program quality, model fidelity, or sustainability? Has it produced positive results for children and their families?
   c. (Probe if haven't it on it yet) How has implementation science played a role in these successes, if at all? (e.g., were programs that went through the community planning process more likely to progress quickly through the implementation stages? Are certain IS drivers more likely to be in place for programs that have gone through the community planning process?)

5) What have been **challenges** of the **community planning process work** with programs?

   a. (Probe) Are these challenges still in place? If so, what can be done to address them? If not, what steps did you take to successfully address them?
   b. (Probe) Given that all the funded programs thus far have selected PAT as their model, are there challenges specific to implementing NFP in rural communities that are hard to overcome even with the community planning process work?

Now we'd like to shift gears a bit and talk more generally about supporting evidence based home visiting programs in rural communities.

6) What have been some of the HUB's **successes** in supporting **rural programs implementing evidence based home visiting**? (including programs that did not receive community planning supports)

   a. (Probe) Can you share an example? (Encourage specifics, go beyond broad areas of success, what makes you think of that as a success?)
   b. (Probe if haven't hit on it yet) How has the HUB's support made a difference in program quality, model fidelity, or sustainability? Has it produced positive results for children and their families?
   c. How has implementation science played a role in these successes, if at all?
   d. (Probe if haven't hit on it yet) What successes, if any, are specific to start-up vs. expansion rural programs?

7) What have been the **challenges** of supporting **rural programs implementing evidence based home visiting**? (including programs that did not receive community planning supports)

   a. (Probe if haven't hit on it yet) What challenges, if any, are specific to start-up vs. expansion rural programs?
   b. (Probe) Are these challenges still in place? If so, what can be done to address them? If not, what steps did you take to successfully address them? (Probe) Are there challenges specific to implementing NFP as a model in rural areas?

Lessons Learned & Wrap-Up
8) Thinking back across the HUB's work to support rural programs implementing evidence-based home visiting, what are some of the bigger lessons learned that you would pass on as advice to others looking to better support rural programs in their state?

      a.   (probe) Lessons learned beyond what is in the rural home visiting project summary document (Round 1)? New lessons learned from Round 2?

9) Next, we will be doing focus groups and interviews with 3-4 rural case study sites – one startup that participated in the community planning process, one startup that did not participate in the community planning process, and 1-2 expansion sites (one serving a mixed rural/urban area and one serving rural only). To help inform our questions for the program staff, is there anything in particular that you would like learn from the programs about implementing evidence based home visiting programs in a rural community?

10) Is there **anything else** that you think is important for us to know? Do you have any questions for us?

Appendix I
Experiences in Rural Programs—Semi-Structured Rural Case Study
Site Visit Liaison Interview Protocol (2017)

Facilitator: _____ Co-facilitator/Note taker: _____

Program Liaison Interview Protocol

Introduction (10 min)

Hello, and thank you for meeting with us today. We are <NAME> and <NAME>. We work at SRI International, a non-profit research organization. We are conducting a study on behalf of Washington's Department of Early Learning (DEL) to learn how the Thrive Implementation HUB is supporting the implementation of evidence-based home visiting programs in rural communities, and to find out what other supports programs may want or need in the future. This case study on rural programs is part of the RISE Home Visiting Evaluation, supported by the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, that we have been conducting for the past few years.

We are here to learn from you about your experiences <STARTING UP AND > implementing a <NFP OR PAT> program here in <COUNTY NAME>. We will be asking you questions about what your community is like, what makes it unique, what doing home visiting here is like, and what the successes and challenges of your work are. We also want to know how you think programs like yours can best be supported.

The information we gather from you and a few other rural programs will be shared with DEL, Thrive Washington, and hopefully, the larger home visiting field, as a way for others to learn from your experience. The programs that were selected to participate in this rural case study, such as yours, were chosen because they received MIECHV funds through Thrive to start up or expand their services. They also may or may not have participated in the Community Planning Process (also called rural home visiting expansion) that Thrive facilitated, which assessed and aimed to increase the readiness of communities to implement evidence-based home visiting.

We have information sheets that are similar to a consent form for you to read over that describe the risks and benefits of participating in this interview. DISTRIBUTE INFO SHEET AND REVIEW WITH THE GROUP. Because only a few sites are participating in the rural case study and some of the information we will be reporting is unique to each site, we will be unable to maintain site anonymity. However, you as individuals will never be named, and we will report findings aggregated across individuals and programs as much as possible. We will do the utmost to protect your confidentiality and minimize the risk of participating in this interview. Any feedback seen as sensitive will be carefully worded to protect your and your program's interests. Any quotes used to explain an idea will be carefully reviewed to ensure that others cannot identify the speaker. We will also give you the opportunity to review what we write about your program before it is widely distributed. Do you have any questions or concerns?

<ONCE QUESTIONS ARE ADDRESSED> Please note we are going to start **audio recording** the discussion so that we can be more accurate in capturing what you say.

START RECORDING.

Ensure clear definition of the HUB: Since our conversation today will involve discussing the Thrive Implementation HUB, we want to make sure everyone is thinking of the same thing when we use that term. When we say "Implementation HUB," we are referring to the centralized system of supports for home visiting that Thrive Washington has been developing with support from the Washington Department of Early Learning and Department of Health. The HUB is the team within Thrive working with home visiting programs on activities such as the community planning process to support implementation of home visiting, training, coaching, site visits, and technical assistance across many different topics. Current HUB staff include Quen Zorrah, Liv Woodstrom, Melanie Krevitz,

Rural Case Study Liaison Interview Protocol   March 2017

Isidro Rodriguez, and Catherine Blair, among others. <FOR PAT PROGRAMS> Linda Clark used to act as PAT model state lead through the HUB, but now she is works with programs on behalf of PAT National exclusively in a regional capacity. HUB staff communicate mostly with program supervisors, although they do work with home visitors on occasion.

(If applicable) ensure clear definition of the Community Planning Process: We will also be talking about the HUB's community planning process work during this interview. When we use that term, we are referring to the process the HUB undertook to help prepare rural communities that wanted to start an evidence-based home visiting program, assess their readiness to do so, and decide who to fund. There have been two rounds of this process so far. Your community participated in the first round, beginning in late 2012/early 2013, and was one of three that were funded. We know this was a long time ago, so we are asking you to do your best to dig up some old memories.

OK, any questions before we get started?

Background (20 min)

1) Can you describe to us the history of this <NFP OR PAT> program?
   a. (Probe) When it was established? How did it come to be housed within <AGENCY NAME>?
2) Can you tell us about the agency that the <NFP OR PAT> program sits within?
   a. (Probe) What is the history of the agency? Are there other services provided, aside from home visiting?
3) Can you tell us about your role here, and describe the general administrative and supervisory structure of the home visiting program? What about for the agency?
4) How is the home visiting program funded (in addition to MIECHV)? How is the agency funded?
5) How many FTEs do you have in the home visiting program?
6) What is approximate total caseload for each full time home visitor?
7) What do the families that you serve in the home visiting program tend to look like? (E.g., demographics, level of risk)
8) How did you determine what your geographic service area would be? How far do home visitors typically travel to visit families?

Successes, Challenges, and Supports (20 min)

9) From a supervisor or administrator's point of view, what have been the major successes of implementing this <PAT OR NFP> program in <COUNTY NAME>? These can be for the program as a whole, or for you as an individual.
   a. (Probe) Can you share an example? (Encourage specifics, go beyond broad areas of success, what makes you think of that as a success?)
   b. (Probe) What were the conditions that enabled this success? (E.g., characteristics or qualifications of the staff, support for leadership, access to training or coaching)
10) What have been the major challenges? These challenges can be for the program as a whole, or for you as an individual.
    a. (Probe) Can you share an example? (Encourage specifics) E.g., recruiting and retaining staff, distance to families, caseload expectations, organizational supports or lack thereof, funding criteria, home visitor safety, lack of community resources for training and referral
    b. (Probe) What were the conditions that contributed to these challenges? (E.g., characteristics or qualifications of the staff, leadership or supervisory support, access to training or coaching)
    c. (Probe) What would it take to overcome these challenges?
11) In what ways does this community being rural influence what the successes and challenges are?

      a. (Probe) Are there any challenges that are specific to implementing your particular model in a rural community such as this? E.g., recruiting staff that meet both the model criteria and the needs of the community

12) What supports do you as a supervisor/administrator receive to help you better do your work?
      a. (Probe) What supports have you received from the Thrive Implementation HUB over the past three years? The HUB includes individuals such as Melanie, Isidro, Quen, and Liv.
      b. (Probe) Has being rural affected your ability to access supports? If so, how? What unique experiences do you have being a rural provider?
      c. (Probe) Are these supports effective?
      d. (Probe) What else do you need?

Expansion or Start-up Experience (15 min)

Now we're going to ask about your experiences with the MIECHV funding administered through Thrive.

13) Can you describe to us the expansion/start-up/community planning process (as applicable) that resulted from receiving MIECHV funding?
14) What role did you play in this expansion/start-up/community planning process?
15) From a supervisor or administrator's point of view, what were some of the successes of this expansion/start-up/community planning process? Had you been through a process similar to this before?
16) What were some of the challenges?
      a. (Probe) What do you think could have been done differently that would have helped the process go more smoothly?

Lessons Learned & Wrap-Up (10 min)

17) What advice would you give to other leaders looking to expand or start evidence-based home visiting programs in their rural communities?
18) What advice would you give to those looking to *support* those leaders?
19) Is there anything else you want us to know?

Thank you again for joining us here today, and for your candid participation in our discussion. As a thank you for participating in this case study, we will be providing your program with a $XXX check or gift card. [Discuss any other next steps and where to go next.]

Appendix J
Experiences in Rural Programs—Rural Case Study
Site Visit Focus Group Facilitation Protocol (2017)

Facilitator: _____ Co-facilitator/Note taker: _____

Introduction (10 min)

Hello, and thank you for meeting with us today. We are <NAME> and <NAME>. We work at SRI International, a non-profit research organization. We are conducting a study on behalf of Washington's Department of Early Learning (DEL) to learn how the Thrive Implementation HUB is supporting the implementation of evidence-based home visiting programs in rural communities, and to find out what other supports programs may want or need in the future. This case study on rural programs is part of the RISE Home Visiting Evaluation, supported by the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, that we have been conducting for the past few years. Some of you may have taken our surveys in the past.

We are here to learn from you about your experiences <STARTING UP AND > implementing a <NFP OR PAT> program here in <COUNTY NAME>. We will be asking you questions about what your community is like, what makes it unique, what doing home visiting here is like, and what the successes and challenges of your work are. We also want to know how you think programs like yours can best be supported.

The information we gather from you and a few other rural programs will be shared with DEL, Thrive Washington, and hopefully, the larger home visiting field, as a way for others to learn from your experience. The programs that were selected to participate in this rural case study, such as yours, were chosen because they received MIECHV funds through Thrive to start up or expand their services. They also may or may not have participated in the Community Planning Process (also called rural home visiting expansion) that Thrive facilitated, which assessed and aimed to increase the readiness of communities to implement evidence-based home visiting.

We have information sheets that are similar to a consent form for you to read over that describe the risks and benefits of participating in this focus group. DISTRIBUTE INFO SHEET AND REVIEW WITH THE GROUP. Because only a few sites are participating in the rural case study and some of the information we will be reporting is unique to each site, we will be unable to maintain site anonymity. However, you as individuals will never be named, and we will report findings aggregated across individuals and programs as much as possible. We will do the utmost to protect your confidentiality and minimize the risk of participating in this focus group. Any feedback seen as sensitive will be carefully worded to protect your and your program's interests. Any quotes used to explain an idea will be carefully reviewed to ensure that others cannot identify the speaker. We will also give you the opportunity to review what we write about your program before it is widely distributed. Do you have any questions or concerns?

<ONCE QUESTIONS ARE ADDRESSED> Please note we are going to start **audio recording** the discussion so that we can be more accurate in capturing what you say.

START RECORDING.

It would be great if we could start by having you all introduce yourselves to us by going around the room and sharing your name, role, and how long you have been with the <NFP OR PAT> program, so we have a little context for our conversation.

Ground Rules
Before we get into the questions, we want to go over a few ground rules for the discussion.

- Please **be respectful of others' opinions**. We want this to be a safe space where each person feels free to share their viewpoint, even if it differs from what others have said. Keep in mind that we're just as interested in negative comments as positive comments; hearing all viewpoints helps us understand the big picture of what is going on.
- In addition, we encourage you to **respond to each other**—we'd like this to be a conversation, not just a question-answer session.
- Also, please **speak only one at a time** as it helps us be more accurate in capturing what you say.
- Lastly, please double **check your cell phones and other gadgets to make sure they are off or silent.** If you need to take a call, please step out of the room so the discussion can continue.

Ensure clear definition of the HUB: Since our conversation today will involve discussing the Thrive Implementation HUB, we want to make sure everyone is thinking of the same thing when we use that term. When we say "Implementation HUB," we are referring to the centralized system of supports for home visiting that Thrive Washington has been developing with support from the Washington Department of Early Learning and Department of Health. The HUB is the team within Thrive working with home visiting programs on activities such as the community planning process to support implementation of home visiting, training, coaching, site visits, and technical assistance across many different topics. Current HUB staff include Quen Zorrah, Liv Woodstrom, Melanie Krevitz, Isidro Rodriguez, and Catherine Blair, among others. <FOR PAT PROGRAMS> Linda Clark used to act as PAT model state lead through the HUB, but now she is works with programs on behalf of PAT National exclusively in a regional capacity. HUB staff communicate mostly with program supervisors, although they do work with home visitors on occasion.

(If applicable) ensure clear definition of the Community Planning Process: We will also be talking about the HUB's community planning process work during this focus group. When we use that term, we are referring to the process the HUB undertook to help prepare rural communities that wanted to start an evidence-based home visiting program, assess their readiness to do so, and decide who to fund. There have been two rounds of this process so far. Your community participated in the first round, beginning in late 2012/early 2013, and was one of three that were funded. We know this was a long time ago, so we are asking you to do your best to dig up some old memories.

OK, any questions before we get started?

Icebreaker: Word Wall Activities (10 min each)

We are going to start by doing two Word Wall activities to help us get to know you and your community.

1) First, we'd like you to think of three words or phrases that come to mind that you would use to describe your community. You can write anything, it can be positive, negative, have something to do with the rural character of the area, or not. Take a few minutes to think of three things, and when you are ready, write them up on the Word Wall. We will then talk about what we see as a group.
   a. Now let's see what folks have written. Can you share a little more about your thinking behind these? Do these resonate with others in the room?
   b. (Probe) What are some of the characteristics that you think make this community unique?
   c. (Probe) How much is being rural a part of the community's character?
   d. (Probe) In what ways is this area similar to or different from other communities, to your knowledge?

2) Next, we'd like you to think of <u>three words or phrases</u> that come to mind that you would use to describe what it's like to do evidence-based home visiting work in this community. In other words, what is it like to implement PAT/NFP in this community?
    a. Can you share a little more about your thinking behind these? Do these resonate with others in the room?

Successes, Challenges, and Supports (15 min)

Now let's talk specifically about the **successes and challenges** of doing home visiting work in this community, and the **supports** you may be receiving to help you do this work.

3) In the past three years, what have been some of the successes of implementing this <PAT OR NFP> program in <COUNTY NAME>? These can be for the program as a whole, or for you as an individual.
    a. (Probe) Can you share an example? (Encourage specifics, go beyond broad areas of success, what makes you think of that as a success?)
    b. (Probe) What were the conditions that enabled this success? (E.g., characteristics or qualifications of the staff, leadership or supervisory support, access to training or coaching)

4) In the past three years, what have been some of the challenges of implementing this <PAT OR NFP> program in <COUNTY NAME>? These challenges can be for the program as a whole, or for you as an individual.
    a. (Probe) Can you share an example? (Encourage specifics) E.g., recruiting and retaining staff, distance to families, caseload, home visitor safety, lack of community resources for training and referral
    b. (Probe) What were the conditions that contributed to these challenges? (E.g., characteristics or qualifications of the staff, leadership or supervisory support, access to training or coaching)
    c. (Probe) What would it take to overcome these challenges?

5) In what ways does this community being rural influence what the successes and challenges are?
    a. (Probe) Are there any challenges that are specific to implementing your particular model in a rural community such as this? E.g., recruiting staff that meet both the model criteria and the needs of the community

6) What supports have you received to help you do your work, and who is providing these supports?
    a. (Probe) What supports have you received from the Thrive Implementation HUB over the past three years? The HUB includes individuals such as Melanie, Isidro, Quen, and Liv.
    a. (Probe) Has being rural affected your ability to access supports? If so, how? Do you feel the level of resources available in your community is adequate for you to do your work?
    b. (Probe) Are these supports effective?
    c. (Probe) What else do you need?

Expansion or Start-up Experience (10 min)

Now we're going to ask about your experiences with the MIECHV funding administered through Thrive.

For Expansion Programs (Skagit, First Step):

We know that your program received MIECHV funds, administered through Thrive, to expand services to more and/or different families (e.g., higher risk families, rural families).

7) Can you tell us about this expansion process, and your experience with it? (E.g., who did you expand to, and how did you decide to do this? What did you do during this time?)

a. (Probe) Were there successes or challenges specific to the expansion?
b. (Probe) What supports did you receive during this expansion process, and from whom?
c. (Probe) In retrospect, were there other supports that would have been helpful for you to receive? (E.g., specific data that state agencies or Thrive could have supplied)

For Start-up Program that did NOT experience the Community Planning Process (Cowlitz):

We know that your program was founded largely using MIECHV funds that the state received.

8) Can you tell us about the start-up process, and your experience with it? (E.g., how did the decision to start a program come about? What did you do during this time?)
    a. (Probe) Were there successes or challenges specific to the start-up process?
    b. (Probe) What supports did you receive during this start-up process, and from whom?
    c. (Probe) In retrospect, were there other supports that would have been helpful for you to receive?

For Start-up Program that DID experience the Community Planning Process (Columbia Basin):

We know that your community participated in the HUB's Community Planning Process, in which the HUB helped your community prepare to start an evidence-based home visiting program, apply for MIECHV funding, and then once awarded, begin to build the program. As home visitors, many of you may not have been present during the planning process, but we'd like to hear how you experienced the start-up afterwards.

9) What was your experience during the community planning process, and then the program start-up? (E.g., what were the steps to the start-up? What did you do during this time?)
    a. (Probe) Were there successes or challenges specific to the start-up process?
    b. (Probe) What supports did you receive during this start-up process, and from whom?
    c. (Probe) Are there ways that the start-up was influenced by the fact that the community went through the planning process? (E.g., helping to establish relationships with community partners and build a strong referral process)
    d. (Probe) In retrospect, were there other supports that would have been helpful for you to receive?

Lessons Learned & Wrap-Up (5 min)

10) Thinking back across your experience implementing <NFP OR PAT> in your community for the past three years, what are some of the bigger lessons learned that you would pass on as advice to others looking to _implement_ evidence-based home visiting programs in rural communities in their state?

11) Related to this, what are some of the bigger lessons learned that you would pass on as advice to others looking to _support_ rural programs in their state?

12) Is there anything else that you think is important for us to know? Do you have any questions for us?

Thank you again for joining us here today, and for your candid participation in our discussion. As a thank you for participating in this case study, we will be providing your program with a $XXX check or gift card. [Discuss any other next steps and where to go next.]