Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment

Evidence-Based Home Visiting Systems Evaluation Update: Infrastructure-Building Plans and Activities in 2011

December 7, 2012

MATHEMATICA Policy Research

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

ChapinHall at the University of Chicago

Evidence-Based Home Visiting Systems Evaluation Update: Infrastructure-Building Plans and Activities in 2011

Contract Number:
GS-10F-0050L/HHSP233200800065W

Mathematica Reference Number:
06552-702

Submitted to:
Children's Bureau
Office on Child Abuse and Neglect
Children's Bureau, ACYF, ACF, HHS
8th Fl, Rm 8111, 1250 Maryland Ave, SW
Washington, DC 20024
Project Officer: Melissa Lim Brodowski

Submitted by:
Mathematica Policy Research
P.O. Box 2393
Princeton, NJ 08543-2393
Telephone: (609) 799-3535
Facsimile: (609) 799-0005

Co-Project Directors: Kimberly Boller, Deborah Daro (Chapin Hall at the University of Chicago)

December 7, 2012

Diane Paulsell
Margaret Hargreaves
Brandon Coffee-Borden
Kimberly Boller

Suggested citation:

Paulsell, Diane, Margaret Hargreaves, Brandon Coffee-Borden, and Kimberly Boller. "Evidence-Based Home Visiting Systems Evaluation Update: Infrastructure-Building Plans and Activities in 2011" Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. 2012 December. Contract No.: GS-10F-0050L/HHSP233200800065W. Available from Mathematica Policy Research, Princeton, NJ.

Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment

MATHEMATICA Policy Research

ChapinHall at the University of Chicago

CONTENTS

TABLES

I. INTRODUCTION AND BACKGROUND

In 2008, the Children's Bureau (CB) in the Administration for Children and Families (ACF) at the U.S. Department of Health and Human Services (DHHS) entered into cooperative agreements with 17 subcontractors in 15 states to support the implementation of home visiting programs with the potential to prevent child maltreatment. Each subcontractor funded through the Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment (EBHV) subcontractor cluster selected one or more home visiting models to implement for the first time in its state or community or to enhance, adapt for a new target population, or expand. The initiative, initially funded by ACF/CB, is now supported through the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) included in the Affordable Care Act (ACA) of 2010 (P.L. 111-148). Primary oversight for the State Formula grant program is now provided by the Health Resources and Services Administration (HRSA) at DHHS, the federal agency charged with implementing MIECHV in partnership with ACF, and the former subcontractors are now supported through subcontracts to their states.

The EBHV initiative included three unique features when it was initially funded by ACF/CB. First, the EBHV funds were not intended to cover the cost of direct home visiting services. Rather, subcontractors were to leverage their federal funds with other funding sources to operate their selected home visiting models. To leverage funds, subcontractors partnered with ongoing home visiting programs or leveraged other sources to fund home visiting in cooperation with EBHV. Second, EBHV was funded as a five-year initiative, with the first year devoted to planning and the remaining four years focused on implementation. Third, each subcontractor was required to conduct process, outcome, and economic evaluations. Subcontractors identified local evaluators to conduct the evaluations.

The conceptual underpinning for the EBHV initiative is that, through system change activities, subcontractors would build infrastructure necessary to accomplish three overarching goals:

1. Support **implementation with fidelity** to the home visiting program models
2. Support **scale-up** of the home visiting models—replicating the program model in a new service area, adapting the model for a new target population, or increasing the enrollment capacity in an existing service area
3. Support **sustainability** of the home visiting model beyond the end of the grant period

Although the 17 subcontractors are working toward common goals, they vary in their planned approaches and infrastructure-building activities. Subcontractors are working in diverse organizational settings and with diverse sets of partners to implement their selected home visiting models. Some subcontractors serve as the implementing agency (IA) for their selected home visiting models. Others contract or partner with another IA to deliver the home visiting services, and a few are implementing state-level initiatives that support home visiting programs but do not involve direct management of the programs. In addition, subcontractors are at different stages of implementation and scale-up.

Mathematica Policy Research and its partner, Chapin Hall at the University of Chicago, are conducting a national cross-site evaluation designed to identify successful strategies for supporting the implementation, scale-up, and sustainability of subcontractor-selected home visiting models (Koball et al. 2009). To examine subcontractors' system change efforts, the cross-site evaluation

team is using a design based on subcontractors' logic models for building the infrastructure capacities needed to achieve implementation with fidelity, scale-up, and sustainability of their home visiting models. Articulating a "theory of change," or logic model, helps make explicit the underlying strategies and assumptions used to build or change complex child service systems (Hodges et al. 2010; Levison-Johnson and Wenz-Gross 2010).

This report provides a snapshot of subcontractors' plans for achieving their targeted outcomes and the EBHV goals and their actual infrastructure-building activities in year 3 of the initiative, roughly at the midpoint of implementation. EBHV subcontractors are operating in complex, dynamic, and unpredictable environments. As they adapt to these changing conditions, their plans and activities change, potentially altering the initiative's outcomes. Tracking these changing conditions and the evolution of subcontractors' plans and activities as they adapt can provide a rich picture of how complex system interventions operate over time and provide lessons and guidance for how to build infrastructure capacity that supports implementation with fidelity, scale-up, and sustainability of EBHV programs.

This brief snapshot adds to earlier work by the cross-site evaluation team that documented subcontractor plans at the end of a one-year planning period and infrastructure-building activities during the planning and early implementation period. The report addresses two main research questions at approximately the midpoint of the funding period:

1. What EBHV initiative goals did subcontractors expect to achieve, and how did they plan to do so?
    - What people and institutions did they expect to engage at each infrastructure level?
    - What infrastructure-building strategies did they expect to implement?
    - What infrastructure-building short-term results and long-term outcomes did they expect to achieve?
2. In what types of infrastructure-building activities did subcontractors actually engage?
    - How were subcontractors' activities influenced by economic and other contextual factors?
    - How did infrastructure-building activities change over time?
    - What were subcontractors' perceived successes in progressing toward their targeted infrastructure-building outcomes and the EBHV goals?
    - What challenges and barriers impeded subcontractors' progress toward their targeted infrastructure-building outcomes and the EBHV goals?

Additional data collection activities conducted in 2012 will provide another look at how subcontractors' plans and infrastructure-building activities have continued to evolve. A future report will include analysis of infrastructure-building plans and actual activities and how these are related to progress toward the EBHV goals of implementation with fidelity, scale-up, and sustainability.

The rest of this chapter provides background information on the EBHV subcontractors and their infrastructure-building activities, along with an explanation of the data sources and analytic approach used for this report. In Chapter II, we discuss the updated subcontractor logic models. In Chapter III, we describe changes in the context in which subcontractors implemented their projects,

the infrastructure-building activities in which they engaged in year 3, and subcontractors' perceptions of their most important successes and challenges. Chapter IV provides a brief synthesis of key findings and describes next steps in the evaluation. Appendix A presents subcontractor logic models.

A. The EBHV Subcontractors and Their Activities

The EBHV subcontractors are developing the infrastructure capacities needed to support the selected program models. Capacity is defined as "the skills, motivation, knowledge, and attitudes necessary to implement innovations, which exist at the individual, organizational, and community levels" (Wandersman et al. 2006). Infrastructure development involves eight types of infrastructure capacity, which the cross-site evaluation team has categorized into three key areas (Table I.1). First, in the foundation area, subcontractors are engaging in planning and collaboration activities to create the conditions for systems change to support the implementation, scale-up, and sustainability of home visiting programs. Second, in the implementation area, subcontractors are supporting home visiting service delivery by building program operations and workforce development capacities. Third, in the sustaining area, subcontractors are engaging in activities to ensure ongoing support for home visiting programs by increasing fiscal capacity, building community and political support, communicating with key stakeholders, and conducting quality assurance monitoring and program evaluation. Moreover, subcontractors are working to build infrastructure at several levels—national, state, community, and IA—to achieve the EBHV initiative's goals. A multilevel, ecological perspective is important for understanding the successful implementation of infrastructure change initiatives such as EBHV (Durlak and DuPre 2008; Hargreaves and Paulsell 2009). Moreover, implementation is a process that occurs in stages that are often overlapping and recursive (Metz and Bartley 2012; Fixsen et al. 2005).

Table I.1. Infrastructure Capacities and Examples of Activities

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

Sources: Flaspohler et al. 2008; Coffman 2007.

Summary of Findings from the Planning Year and Early Implementation

Site visits and telephone interviews conducted during spring 2010 revealed that, during the early implementation phase of the EBHV initiative, all 17 subcontractors engaged to some degree in all eight areas of infrastructure-building activity (Del Grosso et al. 2011).

Foundation Area

All 17 subcontractors did extensive planning with partners. Subcontractors that were newly implementing home visiting models focused on selecting a model, contracting with IAs to provide direct services, developing community partnerships to build support for local programs, and engaging new funders. Subcontractors supporting ongoing models focused on planning for workforce training, creating central intake systems, and developing data management systems. The subcontractors also formed community- and state-level partnerships with service providers and advocacy organizations to build community and political support, partnered with local funders and state government agencies to secure funding, and formed local partnerships to facilitate service referrals and adopt common risk assessment and screening tools. Although these are foundation activities, that does not mean they are done only at the start of an initiative. Planning and collaboration are required during all stages of implementation.

Implementing Area

To support program operations, subcontractors created project steering committees to oversee program operations, developed referral networks at the community level, and helped IAs apply for certification as model programs from national home visiting model purveyors. Most subcontractors developed and implemented processes and practices for monitoring program fidelity; developed and implemented local or statewide training plans; and helped hire, train, and certify home visiting staff in model programs.

Sustaining Area

To build fiscal capacity, subcontractors reported developing a sustainability plan or starting a sustainability working group and leveraging state and county financial support for their home visiting programs. To develop a communications infrastructure, subcontractors increased their capacity to disseminate program information and host speakers to give presentations on home visiting topics. Subcontractors communicated directly with state agencies, legislators, or their governor to build and develop ongoing community and political support for home visiting. In addition, many worked indirectly through partners, stakeholders, and program participants to reach out to state and local government leaders for support. To increase their evaluation capacity, all subcontractors engaged external or internal evaluators for their local EBHV evaluation. Other evaluation activities included collecting program evaluation data and creating an evaluation committee or working with partners to implement and manage their EBHV evaluation.

Barriers and Challenges

Subcontractors encountered several barriers that hindered or slowed infrastructure development, including unanticipated resource constraints, opposition to evidence-based programs at the local or state level, difficulty justifying to state policymakers the need for a continuum of home visiting services, and concerns about local evaluation plans.

The 17 EBHV subcontractors are geographically diverse, representing 15 states (Table I.2). Most are private, nonprofit organizations or state agencies. Subcontractors are implementing five different home visiting models; most are implementing one model, but four subcontractors are implementing multiple models (Table I.3). The subcontractors work within diverse organizational

settings to support the implementation of the home visiting models. Seven subcontractors are IAs that are directly implementing the home visiting model they selected; six contract or partner with one or more IAs to deliver services; and four are state agencies managing statewide home visiting initiatives. Ten subcontractors are focusing on building infrastructure to support home visiting primarily at the state level, and seven are building infrastructure primarily at the local level. Ten are newly implementing their selected home visiting models; the others are continuing to implement existing models or expanding them to new geographic areas or target populations.

Table I.2. EBHV Subcontractors' Characteristics and Implementation Status

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

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

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

Table I.3. Home Visiting Program Models Implemented by EBHV Subcontractors

Home Visiting Program Model	Target Population	Number of Subcontractors Implementing Model
Nurse Family Partnership	First-time pregnant women < 28 weeks gestation	11
Healthy Families America	Pregnant women or new parents within two weeks of infant's birth	5
Parents as Teachers	Prenatal or birth up to age 5	3
SafeCare	Birth to age 5	3
Triple P	Birth to age 12	1

Source: Koball et al. 2009 and subcontractor updates.

B. Data Collection and Analysis

This section describes the data sources and analytic approach used for this report.

1. Data Sources and Collection Procedures

The research team used two main data sources for this report: (1) subcontractor progress reports submitted to ACF/CB for the periods October 2010 through March 2011 and April through September 2011, and (2) semistructured telephone interviews with subcontract directors in May and June 2011. Two-person teams conducted telephone interviews lasting approximately 1.5 hours with directors (and, in some cases, other key staff) from all 17 EBHV subcontractors. In preparation for the interviews, interview team members participated in an hour long training that reviewed the interview protocol and note-taking and reporting requirements.

Before the interview, a senior member of the interview team drafted an updated logic model based on the subcontractor's earlier logic models (from the project proposal and updates in 2008) and most recent implementation plan. The interview team then sent this draft logic model to the subcontractor for review before the interview. During the first portion of the interview, the researchers used the draft logic model as the foundation for a guided discussion to revise the list of inputs, activities, short-term outputs and outcomes, and long-term outcomes for the subcontractor's initiative. The second portion of the interview focused on changes made in implementation plans since the previous year, significant events that had affected infrastructure-building activities, and subcontractors' perceptions of their most important successes and challenges in progressing toward their targeted outcomes and the three EBHV goals. After the interview, the two-person team revised the draft logic model and developed a short summary of the interview; subcontract directors reviewed and approved both documents. Appendix A presents final logic models for each subcontractor.

2. Data Analysis

Qualitative analysis of the telephone interview data, logic models, and progress reports was an iterative process using thematic analysis (Patton 2002; Ritchie and Spencer 2002). The evaluation team developed a coding scheme organized according to key research questions and infrastructure-building activities. Interview teams produced a detailed write-up of each telephone interview using a consistent template designed to ensure comparability across interviews. A two-person analysis team

used the qualitative analysis software package, Atlas.ti (Scientific Software Development 1997), to organize and code the data. Researchers retrieved data on particular questions across all participants, infrastructure capacities, systems outcomes and goals, systems levels, whether developing primarily state or local infrastructure, and whether implementing new or expanding programs. The analysis team then identified emerging themes related to the capacities most relevant to key events, successes, and challenges subcontractors have experienced.

Researchers coded the activities reported in the subcontractor progress reports according to each of the eight infrastructure-building activities, then tabulated the number of subcontractors that had engaged in each type of activity in either of the reporting periods.

II. ONGOING PLANNING FOR EBHV INFRASTRUCTURE BUILDING

In the first three years of the EBHV initiative, the project's 17 subcontractors worked to design and implement projects to build evidence-based home visiting service systems with supportive infrastructure. As noted in Chapter I, the three overarching goals of the EBHV subcontractors are to (1) implement home visiting services with fidelity to program models, (2) support scale-up of the models, and (3) support sustainability of the programs beyond the end of the funding period. The subcontractors did not take a one-size-fits-all approach to working toward these goals, but planned various approaches to building their systems and supporting infrastructure. To understand their overall system-building plans, at the outset of the EBHV initiative in 2008, we reviewed their applications and asked the subcontractors about their EBHV project targeted outcomes and goals, the kinds of infrastructure they planned to build to support their home visiting systems, and how they were planning to create that infrastructure capacity and with what kinds of partners. As described in Chapter I, to update our understanding of their overall plans, in 2011 the cross-site evaluation liaison for each subcontractor drafted an updated logic model based on what we learned from site visits in 2010 and subsequent interactions. We then worked with the subcontractors to review their original strategies, targeted short-term results, and long-term outcomes and revise them as appropriate. Consistent with the cross-site evaluation's system design and an ecological understanding of the nested levels of influence on children that are interrelated, interactive, and dynamic, we modified the draft logic models and documented their 2011 project strategies, targeted short-term results, and long-term outcomes at several levels (Bronfenbrenner 2005; Hargreaves and Paulsell 2009).[1,2] Appendix A presents these 2011 program logic models.

This chapter briefly examines the subcontractors' 2011 logic models to identify similarities and differences in their infrastructure-building plans based on the three EBHV goals they targeted, the home visiting models they selected, and the scope of their initiatives. Because the subcontractors were operating in unique circumstances and implementing different home visiting models, we wanted to know whether variation existed in their approaches to developing the structures, processes, and relationships needed to support home visiting programs. Which of the three EBHV goals (implementation with fidelity, scale-up, and sustainability) did the subcontractors seek to achieve? What kinds of infrastructure did they plan to build to achieve those goals? Did their choice of home visiting model influence their system-building plans? What partners did they plan to work with at each system level?

[1] The cross-site system evaluation design originally specified five levels of activity: national, state, community, organization, and core operations. However, because the subcontractors did not differentiate between the activities implemented at the core operations level and the larger organizational level, these two levels were collapsed into one organizational/IA level in the 2011 logic models.

[2] As of spring 2011, some subcontractors had conducted or were in process on one or more of their planned activities and in some cases achieved short-term results. We acknowledge that this varied by subcontractor, but for the purposes of this chapter, focus on the status of their plans as of 2011. Chapter III presents subcontractor reports of what was actually achieved as of spring 2011.

Because the subcontractors were working in complex, shifting environments (including funding arrangements, political support, and program leadership), we anticipated seeing changes in the subcontractors' logic models as they adapted to their changing conditions (Hernandez and Hodges 2003). Changes in the environment, however, did not translate into significant changes in subcontractors' planned strategies, targeted short-term results, and long-term outcomes. Although their 2011 logic models often included more detail than the information provided in 2008, their overall content remained essentially the same. For example, one subcontractor planned to increase evaluation capacity by creating a statewide home visiting information system. When new national benchmark home visiting performance measures were set by the MIECHV program, the subcontractor made some changes in plans for its state's home visiting data system, but did not change the targeted outcome of having a statewide data system.

A. Relationship Between EBHV Goals and Planned Infrastructure- Building Activities

In 2008, all 17 EBHV subcontractors except one were targeting all three EBHV goals (implementation with fidelity, scale-up, and sustainability) (Del Grosso et al. 2011).[3] In addition, all subcontractors reported working on all eight types of infrastructure-building activities (see Table I.1). Subcontractors' 2011 logic models confirmed their plans to engage in all eight infrastructure activities. The logic models, however, indicate that subcontractors did not plan to engage in all eight activities in their work toward each of the three EBHV goals. In subcontractor logic models, activities related to building planning and collaboration infrastructure supported all three goals (Table II.1).[4] Operations and workforce development activities supported implementation with fidelity and scale-up. Communications, community and political support, fiscal capacity, and evaluation activities were intended to support scale-up and sustainability.

B. Relationship Between Program Models and Planned Infrastructure-Building Activities

As reported in Chapter I, the subcontractors selected five different home visiting models for implementation (see Table I.2). In general (despite differences in training and data collection requirements across models), infrastructure-building plans (such as collecting and reporting program process and outcome data, developing program implementation plans, and training and certifying home visitors) did not differ greatly by EBHV program model. A few minor differences by model were related to model-specific training.

[3] In 2008, one subcontractor did not target the EBHV sustainability goal, but it added that goal later.

[4] It is not uncommon to find that an activity is expected to affect more than one targeted output or outcome. The Cornell Office for Research on Evaluation (2009) uses "pathway models" to identify the "…through-lines that connect the activities to outputs and outcomes."

Table II.1. EBHV Goals and Infrastructure Capacity Activities

	Implementation Goal	Scale-Up Goal	Sustainability Goal
Foundation Capacity Area			
Planning	X	X	X
Collaboration	X	X	X
Implementation Capacity Area			
Operations	X	X	
Workforce Development	X	X	
Sustaining Capacity Area			
Communications		X	X
Community and Political Support		X	X
Fiscal Capacity		X	X
Evaluation		X	X

Source: Subcontractor spring 2010 site visits and 2008 and 2011 interviews and logic models.

C. Relationships Between Project Scope and Planned Infrastructure-Building Activities

We also explored similarities and differences between the EBHV subcontractor logic models that focused on statewide infrastructure building and those that focused on local infrastructure building. Not surprisingly, locally focused subcontractors were more likely to identify strategies, targeted short-term results, and long-term outcomes at the community level, while state-focused subcontractors identified more strategies, short-term results, and long-term outcomes at the state level.

D. Infrastructure Development Partners

To implement infrastructure-building activities, in 2011 the subcontractors reported that they planned to work with a wide range of partners at each system level.

- ***National Level.*** All subcontractors named ACF (the original EBHV funder) as a partner, and four also named HRSA. Other federal agencies included the Centers for Disease Prevention and Control (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Office of Justice Programs (OJP). The subcontractors also named the national developers of all five EBHV models as partners, as well as the cross-site evaluation team and technical assistance provider.
- ***State Level.*** All 17 contractors named several state agencies as partners, including departments of health, human services, education, and children and family services. Many subcontractors also listed state children's policy offices or bureaus, such as the Maternal and Child Health Bureau, the Governor's Office of Children's Care Coordination, and Office of Child Abuse Prevention. Statewide coalitions, associations, and state affiliates of national advocacy groups were also identified as partners, including Kids Count, Prevent Child Abuse, Voices, and Ounce of Prevention organizations and various children's alliances. Other partners included state universities and legislative offices.

- ***Community Level.*** All subcontractors named county governments as partners, including county child welfare, social service, health, and police departments. Community coalitions were also identified as key players, including local family councils, home visiting and early success coalitions, First 5 initiatives (in California), and community advisory and child welfare boards. United Ways and local foundations were also identified as funding partners.
- ***Implementing Agency Level.*** The subcontractors listed their IAs and local service providers as project partners.

III. CHANGES IN INFRASTRUCTURE- BUILDING ACTIVITY

During the first 18 months after grant award, EBHV subcontractors carried out a range of planning and early implementation activities to build the infrastructure needed to support evidence-based home visiting models in their state or community. Although the emphasis and intensity of the activities differed based on subcontractor characteristics, all 17 engaged in all eight types of infrastructure-building activities tracked by the cross-site evaluation (Del Grosso et al. 2011). Especially during the initial planning year, subcontractors focused heavily on activities in the foundation area (see Table I.1). They engaged in extensive planning and developed partnerships with a wide range of community and state agencies and private funders to plan for service provision, develop referral networks, build the home visiting workforce, generate support for the initiative, and secure funding.

Also during early implementation, subcontractors starting up home visiting programs new to their community or state (Table I.2) reported focusing on activities in the implementation area, such as recruiting and hiring staff, training staff and supervisors, and obtaining certification from national models. Subcontractors enhancing or scaling up existing home visiting programs also engaged in implementing activities, but with a focus on developing assessment, referral, intake, training, and evaluation-related data systems. Subcontractors that focused on building statewide infrastructure engaged in infrastructure-building activities at the state level to provide training, coaching, technical assistance, evaluation, and funding to support local home visiting programs. Subcontractors reported doing less communication and evaluation activities than planned. These activities were reprioritized in part to align with changes in local, state, and federal economic circumstances that affected public and private funding streams. Subcontractors focused considerably more attention than originally planned on building fiscal capacity.

This chapter reports on subcontractors' infrastructure-building activities in year 3 of the EBHV initiative, from fall 2010 through fall 2011. During year 3, EBHV subcontractors modified their planned infrastructure-building activities to adapt to several significant changes in the economic and policy context in which they were operating. This chapter begins by reviewing those changes in context. We then present infrastructure-building activities reported by subcontractors in year 3, highlighting steps they took to adapt to the new context while continuing to work toward the EBHV goals of implementation with fidelity, scale-up, and sustainability. The chapter also reports on subcontractors' perceptions about their most important successes in building infrastructure to support evidence-based home visiting and the ongoing challenges they faced in year 3. Data sources for this chapter include subcontractor progress reports for the periods October 2010 through March 2011 and April through September 2011 and telephone interviews conducted with subcontract directors in May and June 2011.

A. Changes in Context

Since the initial planning year for EBHV (fiscal year [FY] 2008), three important changes in the initiative's economic and policy context have affected the EBHV subcontractors: (1) the economic downturn that began in 2008, (2) a potential disruption in funding for the EBHV initiative, and (3) implementation of the federal MIECHV program. Although each of these changes occurred before year 3 of the initiative, we note them here because they significantly affected subcontractors' infrastructure-building activities in year 3 as they sought to adapt to the new context.

1. Economic Downturn

In December 2007, the United States entered a recession. State revenues fell sharply and the growth of state spending slowed in most states during FY 2008, the first year of the EBHV initiative. By December 2009, a survey of state budget officers found that "States are currently facing one of the worst, if not the worst, fiscal periods since the Great Depression" (National Governors Association and National Association of State Budget Officers 2009). The subcontractors faced state and local budget cuts and fewer funding opportunities through foundations (many of which had greatly diminished endowments due to the downturn) and private funders. By year 2 of the initiative, the economic situation had increased the challenges subcontractors faced in raising funds needed for direct home visiting services and required many subcontractors to expend significantly more time and resources to raise those funds than originally anticipated.

In year 3, subcontractors reported ongoing challenges with state budget cuts that affected not only their initiatives, but also partners with whom they exchanged referrals. In some communities, this resulted in more difficulty generating referrals from overwhelmed partners and finding resources in the community to meet families' social service needs. Some subcontractors had to scale back activities and staffing due to budget shortfalls, and others were challenged by delays in the release of state funds. Minnesota experienced an extended government shutdown.

2. Disruptions to Initiative Funding

In December 2009, ACF/CB announced that the discretionary funding for the EBHV initiative had been deleted from the federal budget after FY 2009 in anticipation "that mandatory funding will be provided for this activity in fiscal year 2010 as proposed by the Administration" (U.S. Congress 2009). Whether the funds might be replaced was unclear, leading to a period of uncertainty for the subcontractors. The funding uncertainty affected two aspects of the EBHV initiative. First, although EBHV funds were not meant to pay directly for home visiting services, most subcontractors had leveraged support from their partners based on receiving EBHV funds. For many subcontractors, the potential funding changes disrupted their relationships with partners and thus threatened the leveraged financial support. Some subcontractors revised their implementation plans to scale back or delay some EBHV activities or services to conserve resources for continued implementation in future years. Others found new partners to fill potential funding gaps. Second, subcontractors revised their evaluation plans to account for changes in planned home visiting operations to further conserve resources. ACF/CB asked subcontractors to maintain their local evaluations, but allowed subcontractors flexibility in scope and design in light of decreased funding. By year 3 of the initiative, most subcontractors reported that they had delayed evaluation activities, reduced the evaluation's sample size, or reduced the rigor of their evaluation design due to lack of evaluation funds.

3. MIECHV

As the EBHV subcontractors adapted to funding cuts in an already tight economy, health care reform was being debated. Proposed legislation included a national home visiting initiative that would provide federal funding to each state. The ACA, passed on March 23, 2010, included funding for MIECHV, which began in FY 2010. This initiative, administered by HRSA in partnership with ACF, provides $1.5 billion to states over five years to provide home visiting services for families with pregnant women and children ages birth to 5. As stipulated in the legislation, states must spend at least 75 percent of their funds on home visiting models with evidence of effectiveness as

determined by ACF, and they may spend up to 25 percent on promising programs that do not yet have sufficient research evidence. If promising models are selected, states must rigorously evaluate them. MIECHV aims to further the development of comprehensive statewide early childhood systems that emphasize the provision of health, development, early learning, child abuse and neglect prevention, and family support services for at-risk children through the receipt of home visiting services.

HRSA is implementing MIECHV in partnership with ACF, as well as other federal partners. HRSA and ACF announced that state funding would be determined through a formula that included supplemental funding if the state had received an EBHV grant in 2008. If their state applied for funding, EBHV sites would have the resources to implement their original plans as subcontractors to their states under MIECHV.[5] As of January 1, 2012, ACYF's role in administering the EBHV grant program ended; all former EBHV grantees are now supported through subcontracts to their states under the MIECHV State Formula grant program. By year 2, EBHV subcontractors were beginning to adapt to the rollout of MIECHV by coordinating their activities with state planning for MIECHV and exploring options for obtaining funds for scale-up through the new federal initiative. By year 3, most subcontractors were heavily involved in state MIECHV programs through joint planning efforts and direct funding arrangements. Five EBHV subcontractors serve as lead agencies in their state for MIECHV.

EBHV Subcontractors That Are MIECHV Lead Agencies

Hawaii Department of Health

Illinois Department of Human Services

Minnesota Department of Health

New Jersey Department of Children and Families

The Children's Trust of South Carolina

Utah Department of Health

Note: New Jersey Depart of Children and Families is overseeing implementation of MIECHV under contract with the New Jersey Department of Health.

B. Infrastructure- Building Activities

In year 3, subcontractors reported continued engagement in all eight infrastructure-building activities (see Table I.1). Types of activities and levels of engagement varied according to subcontractor characteristics. Levels of activity across infrastructure areas also reflect responses to changes in the economic and policy context discussed previously. In this section, we report on subcontractors' activity in the three infrastructure areas: foundation, implementation, and sustaining. For each area, we discuss subcontractors' perceptions of their successes and challenges in year 3.

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

1. Building Foundation Infrastructure

Subcontractors engaged in planning and developing strong collaborative relationships to establish firm foundations for their initiatives (Table III.1).

Building Planning Capacity. During the first 18 months of the initiative, subcontractors planning to implement home visiting models new to their state or local community reported focusing their planning efforts on identifying potential funders, selecting IAs to deliver home visiting services, and forming partnerships with other community service providers with whom they could exchange referrals (Del Grosso et al. 2011). Those that focused on enhancing or expanding existing models by building infrastructure at the state level reported planning activities to enhance training, referral, and data management systems.

By year 3, with implementation well under way, the focus on planning activities had decreased significantly, except for planning activities related to MIECHV. As subcontractors sought to adapt activities to account for the rollout of MIECHV in their states, 11 of the 17 subcontractors reported direct involvement in planning for their state's MIECHV program. Five of these subcontractors were leading the planning process. Moreover, nearly all planning activity occurred among subcontractors building infrastructure at the state level. Although all state-level subcontractors reported involvement in MIECHV planning, only one of seven subcontractors building local infrastructure reported direct involvement.

Beyond planning related to MIECHV, a few subcontractors reported activities required to make adjustments to existing plans based on lessons learned from the early implementation phase. For example, three subcontractors reported revising their logic model, strategic plans, or policies and procedures. Three subcontractors had reassessed staff training needs and developed a new training plan. In addition, a few especially complex planning efforts begun early in the life of the initiative were still under way (for example, planning for implementation of a universal risk assessment tool in New Jersey and a client-tracking system to be shared among community service providers in Tennessee).

Building Collaboration Capacity. In the planning and early implementation period, subcontractors reported three main types of collaboration activities: (1) forming partnerships at the state and local level with service providers and relevant advocacy organizations; (2) developing relationships with foundations, state agencies, and other potential funders to support sustainability; and (3) creating partnerships with potential referral sources to facilitate referrals to IAs, use of common risk assessment and screening tools, and development of central intake and referral systems (Del Grosso et al. 2011).

Similar to planning, collaboration activities that subcontractors reported focused on MIECHV in year 3, and subcontractors building state infrastructure were more likely to be engaged in these efforts that those building local infrastructure. Thirteen of the subcontractors reported maintaining a collaborative relationship with the MIECHV lead agency in their state or serving as the lead agency. Five subcontractors, all of which were building infrastructure at the state level, reported merging their EBHV steering committee or work group with the state's MIECHV planning committee. This facilitated the state's ability to build on work done by the EBHV subcontractor. Nine subcontractors reported increased collaboration with other home visiting programs in the state or community, in some cases by developing Memoranda of Understanding to formalize referral processes and collaborative relationships. These intensive efforts to increase ties among home visiting programs

Table III.1. Activities Implemented in Year 3 by Subcontractors to Build Foundation Infrastructure

Infrastructure-Building Activities	State-Level Subcontractors	Local-Level Subcontractors	All Subcontractors
Planning Activities			
Participated in planning for the state's MIECHV program	10	1	11
Attended MIECHV national webinars to support ongoing planning efforts	2	1	3
Reviewed or revised project logic model, strategic plan, or policies and procedures	2	1	3
Assessed feasibility of potential expansion and planned scale-up activities	2	1	3
Assessed staff training needs and created a training plan	3	0	3
Reviewed state MIECHV needs assessment data to identify areas of need in the state	2	0	2
Continued planning for a universal risk assessment tool	1	1	2
Planned for a client-tracking system to be shared by other community service providers	0	1	1
Collaboration Activities			
Maintained collaborative relationship with MIECHV state lead or served as state lead	9	4	13
Merged EBHV and MIECHV committees or work groups	5	0	5
Collaborated or developed Memoranda of Understanding with other home visiting programs in the state or local community	7	2	9
Participated in state-level coalitions, councils, and committees	5	4	9
Participated in local-level coalitions, councils, and committees	3	5	8
Participated in EBHV publications committee	3	2	5
Held community advisory board meetings	1	2	3
Held parent or family advisory board meetings	1	1	2
Collaborated with state partners on state's Race to the Top Early Learning Challenge proposal	1	0	1
Total Subcontractors	**10**	**7**	**17**

Source: Subcontractor progress reports for October 2010–March 2011 and April–September 2011.

and merge strategic planning processes reflect movement toward a critical goal of MIECHV and of EBHV subcontractors: to build comprehensive service systems for at-risk families with young children by offering a continuum of evidence-based home visiting services that can address the diverse needs of families in a state or community.

Most subcontractors also reported participating in state and local coalitions and committees. These included groups of service providers in the communities where IAs operated, as well as coalitions that focused on early childhood services, child abuse prevention, teen pregnancy, and other related issues of concern in the states. Five subcontractors reported participating in an EBHV publications committee through the Peer Learning Network. Three subcontractors also reported convening community advisory boards, and two reported convening parent and family advisory boards to provide input on program operations.

Challenges and Successes. In 2011, subcontractors did not report challenges or successes related to planning activities. The most intensive period of planning occurred during the initiative's initial planning year, and these activities had largely concluded by year 3. The rollout of MIECHV reinvigorated planning activities for many subcontractors and presented opportunities for them to engage in the state's planning process and further the EBHV goals of scale-up and sustainability of evidence-based home visiting models.

A few subcontractors reported that turf issues among agencies created challenges for collaboration. During the initial 18 months of the initiative, subcontractors reported that turf issues and a lack of trust among other home visiting programs and stakeholders were significant challenges. In some cases, other home visiting programs feared that introduction of an evidence-based model in the community or state might result in a shift of resources away from their programs to the model(s) selected by the subcontractor (Del Grosso et al. 2011). Based on subcontractor interviews in spring 2011, this challenge appeared to be overcome or much reduced for most subcontractors.

In fact, 13 of the 17 subcontractors cited their strong collaborative relationships with other home visiting programs, state and local government, local partners, and model developers and purveyors as one of their most important successes in year 3 of the initiative. These relationships facilitated referrals into the program and identification of community resources for enrolled families. They helped subcontractors identity supplemental funding sources to address funding shortfalls. Collaborative relationships also facilitated work with the state's MIECHV program to sustain and scale up evidence-based home visiting programs and, in some cases, create a continuum of evidence-based home visiting programs to meet the needs of diverse families.

2. Building Implementation Infrastructure

During 2011, subcontractors worked to build infrastructure to support program operations and develop the home visiting workforce to support implementation of the evidence-based home visiting programs with fidelity to program models (Table III.2).

Building Operating Capacity. During the first 18 months of the initiative, most subcontractors worked to build their program operations capacity by creating steering committees and advisory boards to oversee operations, developing local referral networks, supporting IAs to apply for model certification, and taking steps to expand existing models in their state or community (Del Grosso et al. 2011).

By year 3, program operations were under way at all sites. Of the 17 subcontractors, 11 reported engaging in recruiting and enrolling families into the program, and 9 reported conducting outreach to potential referral sources. For example, staff made presentations to staff in school districts, local hospitals, and court systems; participated in community resource fairs; and distributed program fact sheets. Sixteen subcontractors reported establishing steering committees in the early implementation period to oversee program operations, and seven reported that those committees were still meeting regularly in year 3. Subcontractors building local infrastructure reported holding family involvement events such as social gatherings, support groups, and graduation ceremonies. Subcontractors that focused on building infrastructure at the state level reported making monitoring visits to IAs and providing them with technical assistance.

Table III.2. Activities Implemented by Subcontractors to Build Implementing Infrastructure

Infrastructure-Building Activities	State-Level Subcontractors	Local-Level Subcontractors	All Subcontractors
Operations Activities			
Continued or scaled up recruitment and enrollment	5	6	11
Conducted outreach to potential referral sources	3	6	9
Held regular steering committee meetings	4	3	7
Held family involvement events: social gathering, support groups, graduation ceremonies	1	4	5
Made monitoring visits to IAs	3	1	4
Provided technical assistance to existing or potential IAs	3	1	4
Applied for, or obtained, model accreditation or affiliation	2	1	3
Developed a referral tracking system	1	1	2
Provided material support to families	2	0	2
Operated a central intake and referral system	1	0	1
Worked with developer to implement a fidelity monitoring system	1	0	1
Conducted regular case conferences with partners	0	1	1
Created a CQI plan	0	1	1
Workforce Development Activities			
Staff received training from model developer or purveyor	4	5	9
Staff received supplemental training on relevant topics	5	4	9
Provided coaching or consultation to home visitors or supervisors	4	4	8
Hired new home visitors	3	4	7
Hired other program staff	3	2	5
Staff obtained model certification	1	1	2
Identified staff training needs	2	0	2
Held community of practice meetings for supervisors	1	0	1
Total Subcontractors	**10**	**7**	**17**

Source: Subcontractor progress reports for October 2010–March 2011 and April–September 2011.

CQI = Continuous Quality Improvement; IA = implementing agency.

Building Workforce Development Capacity. Early workforce development activities for most subcontractors included monitoring fidelity, developing and implementing training plans, and hiring home visitors and supervisors (Del Grosso et al. 2011). Most subcontractors were engaged in similar activities in year 3, and there were few differences in the patterns of these activities between those building state and local infrastructure. Nine subcontractors arranged for training from the model developer or purveyor on the home visiting model, and the same number provided supplemental training to staff. For example, Illinois provided training on perinatal depression screening and strategies, identifying and obtaining help to address domestic violence, and substance abuse prevention. In addition to training, eight subcontractors reported providing coaching or consultation to home visitors or supervisors. For example, Minnesota provided support for supervisors in using reflective supervision techniques. Seven subcontractors reported hiring new home visitors, either to expand their programs or to replace home visitors who had left the program. Five subcontractors reported hiring other program staff, such as a clinical nurse to support all home visitors in a state, a data manger, or a research coordinator.

Challenges and Successes. Subcontractors reported several challenges in the implementation area, primarily due to the economic downturn. Subcontractors reported that the economic downturn increased families' social service needs when their state and local governments were cutting back on the services they offered, sometimes hindering families' capacity to participate in home visits as they struggled to meet basic needs. A few subcontractors reported that, due to funding cuts experienced by community partners that referred families into the program, they were struggling to obtain sufficient referrals. Five subcontractors reported freezing or delaying hiring or reducing staff due to budget reductions, in one case due to a state hiring freeze.

Despite these challenges, subcontractors reported successes in making progress toward EBHV goals. For example, seven subcontractors reported that they expected to receive MIECHV funds to expand the number of home visitors or sites providing home visiting services, thus progressing toward the goal of scale-up. Four subcontractors reported adding new staff. One subcontractor reported that MIECHV funds would reinstate early identification and screening activities previously eliminated due to state funding cuts. Another reported using MIECHV funds to build on a state home visitor training system created under EBHV. Six subcontractors cited their work to hire well-qualified home visitors or provide high quality training and support practice as successes in progressing toward the goal of high-fidelity implementation.

3. Building Sustaining Infrastructure

Subcontractors worked to build infrastructure to sustain their initiatives by engaging in a range of activities to obtain fiscal support, increase community and political support, disseminate information on their initiatives through various communication venues, and evaluate their initiatives (Table III.3).

Building Fiscal Capacity. To address funding shortfalls, in the first 18 months of the initiative, most subcontractors developed sustainability plans or formed sustainability work groups, leveraged county and state support, and reached out to potential new funding partners (Del Grosso 2011). By year 3, MIECHV had a major influence on activities to build fiscal capacity. Nine subcontractors applied for or received state MIECHV funds to support scale-up. Aside from applying for MIECHV funds, most fiscal activity was carried out by subcontractors building state infrastructure. Seven subcontractors reported working to obtain or sustain funding from a state or county agency, and the same number reported working to obtain or sustain funding from private funders. Many subcontractors looked to Medicaid as a potentially sustainable source of funds to support home visiting. Six reported working to obtain Medicaid reimbursement for home visits or resolve Medicaid billing issues. Only two subcontractors reported ongoing work through a sustainability committee.

Building Community and Political Support. To expand funding sources and gain momentum for implementing new home visiting models during the planning and early implementation phase, subcontractors sought endorsement and credibility from state and local opinion leaders, such as community organizations, academics, businesses, and political leaders (Del Grosso 2011). In year 3, subcontractors continued many of these activities. Twelve subcontractors, evenly split among those building state and local infrastructure, reported activities to educate local stakeholders about EBHV. For example, staff participated in community meetings and made presentations to local coalitions, mayors' offices, local public health agencies, and other local government officials on the benefits of home visiting and the importance of child abuse prevention.

Table III.3. Activities Implemented by Subcontractors to Build Sustaining Infrastructure

Infrastructure-Building Activities	State-Level Subcontractors	Local-Level Subcontractors	All Subcontractors
Fiscal Activities			
Applied for, or received, state MIECHV funds for scale-up	4	5	9
Worked to obtain or sustain funding from a state or county agency	5	2	7
Worked to obtain or sustain funds from a private funder	5	2	7
Worked to obtain Medicaid funds for home visits or resolve Medicaid billing issues	5	1	6
Continued the work of a sustainability committee	1	1	2
Prepared an NIH grant application	1	0	1
Researched potential funding sources	1	0	1
Community and Political Support Activities			
Conducted activities to educate local stakeholders about EBHV	6	6	12
Conducted activities to educate state legislators, state agency staff, and the governor's office about EBHV	6	1	7
Launched a marketing or public awareness campaign	2	1	3
Planned a state prevention conference	2	0	2
Received excellence award	1	1	2
Communication Activities			
Presented on EBHV at a conference or webinar	8	4	12
Placed articles in local press or newsletters or held a press conference	4	4	8
Developed website or webpage on national model's website	3	1	4
Featured in a TV interview or documentary	2	1	3
Prepared a public service announcement	2	0	2
Published or submitted a journal article	1	1	2
Staff provided training outside of EBHV network	0	2	2
Rebranded program with a new name	0	1	1
Evaluation Activities			
Continued local evaluation activities	10	7	17
Participated in cross-site evaluation and Peer Learning Network	10	7	17
Submitted plans to, or received approval from, an IRB	4	1	5
Modified evaluation design	3	1	4
Developed or maintained an MIS	2	2	4
Supported IAs in using the national model MIS	3	2	5
Worked with state to obtain administrative data	3	0	3
Hired staff to support evaluation activities	2	1	3
Negotiated agreement with national model to receive fidelity data for IAs	1	1	2
Integrated MIECHV benchmark measures into data collection activities	1	0	1
Finalized procedures for obtaining informed consent from sample members	0	1	1
Total Subcontractors	**10**	**7**	**17**

Source: Subcontractor progress reports for October 2010–March 2011 and April–September 2011.

Subcontractors, primarily those working to build infrastructure at the state level, also engaged in other activities to build support at the state level. Seven reported making presentations or providing information on the benefits of home visiting to state legislators or legislative staff, state agency staff, and governors' offices. Three subcontractors launched marketing or public awareness campaigns to promote the value of home visiting, and two planned state conferences on child abuse prevention that included a focus on home visiting.

Building Communications Capacity. In the first 18 months of the initiative, subcontractors focused less than originally anticipated on building communications capacity, because they prioritized other infrastructure needs related to addressing funding cuts and launching program operations (Del Grosso et al. 2011). During that period, subcontractors primarily worked on adding messages about EBHV to existing websites and newsletters and organizing, or participating in, conference presentations.

In year 3, subcontractors largely continued these activities, as they were still prioritizing the need to build fiscal, community, and political support, and they also focused on incorporating the MIECHV rollout into their plans and activities. Twelve subcontractors made presentations about EBHV at a conference or in a webinar, including webinars sponsored by MIECHV. Eight reported placing articles in the local press and newsletters or holding a press conference. Smaller numbers of subcontractors reported developing websites (three), participating in TV interviews (two), preparing public service announcements (two), and preparing journal articles for publication (two).

Building Evaluation Capacity. The EBHV initiative required subcontractors to contract with local evaluators to design and implement a local evaluation and to participate in the cross-site evaluation. In the first 18 months of the initiative, all subcontractors worked on contracting or partnering with a local evaluator. Ten established committees to work with the evaluator to design and implement the evaluation, and 12 reported collecting data. Subcontractors also participated in a Peer Learning Network established by the cross-site evaluation and the program training and technical assistance provider, FRIENDS, and could request technical assistance from the cross-site evaluation team as needed. By the end of the planning year, subcontractors had developed ambitious, and often rigorous, local evaluation designs to assess program effects on child and family outcomes. However, fiscal constraints, funding uncertainty, and requirements imposed by national model purveyors created challenges for implementing the designs. As described above, many subcontractors had to reduce sample sizes, reduce the rigor of their designs, or delay finalizing evaluations in the wake of these challenges. In addition to activities related to the local and cross-site evaluations, a few subcontractors also reported plans to build or expand existing program data systems for internal evaluation and program improvement (Del Grosso et al. 2011).

By year 3, evaluation activities were under way in all sites. All 17 subcontractors reported continuing local evaluation activities and participating in the cost-site evaluation and the Peer Learning Network. Five subcontractors reported interaction with an Institutional Review Board (IRB) to which they had submitted evaluation plans. In addition, although many subcontractors modified evaluation plans in the early implementation period, four reported making these modifications in year 3.

A number of subcontractors reported activities related to using management information systems (MIS) or administrative data for evaluation purposes. Four subcontractors reported developing or maintaining an MIS for collecting program data. Another five subcontractors reported providing support to IAs in using MIS operated by national model purveyors. Three subcontractors

reported negotiating with the state to obtain administrative data on the families enrolled in their programs. Two subcontractors reported successful negotiations with the national model purveyor to obtain fidelity data for their IAs on a regular basis for program monitoring and improvement.

Challenges and Successes. As noted earlier in the chapter, fiscal challenges created by the economic downturn and resulting in state and local budget constraints threatened the sustainability of the EBHV initiatives. State and local agencies and private funders cut back on funding, one state government shut down for several weeks, subcontractors experienced delays in getting funds approved by the state released to their IAs, and subcontractors experienced difficulties obtaining reimbursement for home visiting from state Medicaid programs. In this context, MIECHV provided timely resources to offset some lost resources and reduce the severity of fiscal challenges. Six subcontractors reported that MIECHV had stabilized funding for existing IAs, and as noted earlier, seven anticipated that MIECHV would support scale-up of their programs. Beyond MIECHV, a few subcontractors reported other fiscal successes in year 3: two reported obtaining funds from new funders, and one reported securing Temporary Assistance for Needy Families (TANF) funds to support home visiting.

Subcontractors reported no challenges and several successes in building community and political support for home visiting. For example, three subcontractors said they expected MIECHV to broaden support for home visiting in the state and increase awareness of its benefits for at-risk families and children. Another three subcontractors reported that advocacy efforts in the state had prevented cuts in state funds to support home visiting. Subcontractors did not report challenges or successes associated with building communications infrastructure.

With regard to evaluation activities, subcontractors reported that funding cutbacks and, to a lesser extent, requirements imposed by national model purveyors necessitated changes that scaled back evaluation plans. Seven subcontractors reported that they had reduced the rigor of their evaluation designs, and three reported delaying evaluation activities or reducing sample sizes due to lack of funds. Other challenges were related to the use of databases and MIS. Four subcontractors reported difficulties with obtaining fidelity data from the new database of a national model purveyor. Three subcontractors reported difficulties with using state databases and integrating MIECHV benchmark reporting in data collection and reporting activities. On the positive side, subcontractors noted that, despite setbacks, local evaluation activities are under way. Several reported obtaining useful early information from focus groups, feasibility assessments, and other evaluation activities. In addition, three subcontractors reported that early outcome data on families indicated positive results.

IV. CONCLUSIONS AND NEXT STEPS

The 17 EBHV subcontractors are working to build infrastructure necessary to accomplish three common goals: (1) implementation with fidelity, (2) scale-up, and (3) sustainability of home visiting program models. The subcontractors planned to implement a range of strategies for working toward these goals, in the context of complex and changing environments. In particular, subcontractors had to adapt their plans and activities to several changes in the economic and political context: the economic downturn, disruptions in funding, and the rollout of MIECHV.

An examination of subcontractors' 2011 logic models revealed that these changes in context did not translate into significant changes in subcontractors' planned strategies, targeted short-term results, or targeted long-term outcomes. The 2011 logic models also confirmed their plans to develop all three infrastructure areas and all eight types of infrastructure-building activities tracked by the evaluation: foundation area (planning and collaboration activities); implementation area (operations and workforce development activities); and sustaining area (fiscal, community and political support, communications, and evaluation activities). Overall, infrastructure-building plans and activities also did not differ by the home visiting program model subcontractors selected to implement.

In addition, the logic models revealed that infrastructure activities, targeted outcomes, and goals were linked in specific ways. Activities in the foundation area were intended to support all three EBHV goals. Subcontractors planned to carry out implementing area activities to work toward implementation with fidelity and sustainability. Sustaining area activities—fiscal, community and political support, communications, and evaluations—were intended to support scale-up and sustainability.

The evaluation team hypothesized that subcontractors might move through the infrastructure areas and activities in a sequential order, starting with the foundation area during an initial planning phase, then moving to the implementing area after program operations got under way and to the sustaining area after programs were established. An analysis of subcontractors' actual infrastructure-building activities, however, revealed that this was not the case. In response to changes in context, subcontractors worked on all three infrastructure areas to some extent simultaneously.

Thus, although changes in context did not alter subcontractors' planned strategies and targeted outcomes, these changes influenced the order in which infrastructure-building activities were actually carried out. For example, during an initial planning year, subcontractors developed detailed plans for their projects and established collaborative partnerships at the community, state, and national levels to support their work. After implementation began, they focused on the implementation area. When the MIECHV initiative was established, however, most subcontractors returned to activities in the foundation area, engaging in planning for implementing MIECHV in their states and communities. They also took steps to integrate EBHV and MIECHV activities and strengthen collaboration and coordination among home visiting programs operating in their states. These activities furthered progress toward the goal of building comprehensive state systems of support that offer a continuum of evidence-based home visiting services to meet the diverse needs of families with young children.

Another important example of how changes in context influenced the order in which infrastructure-building activities occurred relates to the economic downturn and disruptions in funding. In addition to disruptions in federal funding, many subcontractors faced significant loss of

state and local funding for home visiting, coupled with increased economic distress among enrolled families, both due to the economic downturn. At a time when subcontractors would be expected to focus heavily on the implementation area, they had to jump to the sustaining area to stabilize their funding. For example, they educated stakeholders at the community and state levels about the value of home visiting, advocated for maintaining state and local funding, worked with their states to obtain Medicaid reimbursement for home visiting, and applied for foundation and other private sources of funding. In addition, most reported applying for, or receiving, state MIECHV funds to stabilize and, in some cases, scale up home visiting services.

Thus, an important lesson for stakeholders working to build state and local systems to support evidence-based home visiting is the need for flexibility in how and when planned infrastructure-building activities are implemented. At the midpoint of the EBHV initiative, subcontractors had not significantly altered their plans and targeted outcomes, despite important changes in context that created daunting challenges for implementation and scale-up. Reports of their infrastructure-building activities, however, indicated subcontractors did not implement them in a sequential manner. In response to changing circumstances, they revisited activities in the foundation area and jumped ahead to the sustaining area in an effort to stabilize funding and move ahead with scale-up because of unanticipated roadblocks.

These findings about infrastructure-building to support evidence-based home visiting programs are broadly consistent with findings from implementation science about the stages in which implementation of evidence-based programs occurs (Metz and Bartley 2012; Fixsen et al. 2005). Although infrastructure-building to support implementation occurs at multiple system levels and implementation itself occurs primarily at the IA level, the sequence and content of activities are similar. According to Fixsen and colleagues (2005), implementation of evidence-based programs typically takes two to four years and occurs in four stages:

1. **Exploration:** Assess community needs and fit of an intervention
2. **Installation:** Acquire needed resources and prepare for implementation
3. **Initial implementation:** New program is put into practice and establish continuous improvement processes
4. **Full implementation:** Program is integrated into practice, organization, and systems settings

Sustainability planning and activities are embedded within all four stages, rather than a final stage that occurs after a program is fully implemented. The foundation area (see Table I.1) includes infrastructure-building to support activities typically carried out during exploration and installation stages such as planning, development of partnerships, and alignment of goals and strategies to prepare for implementation. The implementation area describes infrastructure-building activities to support the initial and full implementation stages including workforce development and program operations. The sustainability area encompasses infrastructure-building activities to support sustainability planning and activities. Both frameworks—the infrastructure-building areas described in Chapter I and Fixsen's stages of implementation—reinforce the notion that the steps in these change processes are overlapping and recursive, regardless of the system level at which they occur.

A final cross-site evaluation report will include a careful analysis of subcontractors' plans and activities through early 2012. The research team will also assess the extent to which subcontractors were able to achieve their targeted outcomes and the three EBHV initiative goals and how their

infrastructure-building plans and activities contributed to those achievements. This analysis will provide future program planners with important information on the strategies that are associated with successful system building, as well as factors that contributed to a lack of progress.

REFERENCES

Bronfenbrenner, Urie (ed.). Making Human Beings Human: Bioecological Perspectives on Human Development. Thousand Oaks, CA: Sage Publications, 2005.

Coffman, Julia. "A Framework for Evaluating Systems Initiatives." Washington, DC, Build Initiative Evaluation Symposium, April 2007.

Cornell Office for Research on Evaluation. "The Evaluation Facilitator's Guide to: Systems Evaluation Protocol." Ithaca, NY: Cornell Digital Print Services, 2009.

Del Grosso, Patricia, Margaret Hargreaves, Diane Paulsell, Cheri Vogel, Debra A. Strong, Heather Zaveri, Megan Hague Angus, Brandon Coffee-Borden, Russell Cole, Kirsten Barrett, Kimberly Boller, and Deborah Daro. "Building Infrastructure to Support Evidence-Based Home Visiting to Prevent Child Maltreatment: Two-Year Findings from the Cross-Site Evaluation of the Supporting Evidence-Based Home Visiting Initiative." Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, August 2011.

Durlak, Joseph H., and Emily P. DuPre. "Implementation Matters: A Review of Research on the Influence of Implementation on Program Outcomes and the Factors Affecting Implementation." American Journal of Community Psychology, vol. 41, 2008, pp. 327–350.

Flaspohler, Paul, Jennifer Duffy, Andrew Wandersman, Lindsey Stillman, and Melissa Maras. "Unpacking Prevention Capacity: An Intersection of Research-to-Practice Models and Community-Centered Models." American Journal of Community Psychology, vol. 41, 2008, pp. 183–196.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., and F. Wallace. Implementation Research: A Synthesis of the Literature. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, National Implementation Research Network, 2005.

Hargreaves, Margaret, and Diane Paulsell. "Evaluating Systems Change Efforts to Support Evidence-Based Home Visiting: Concepts and Methods." Washington, DC: U.S. Department of Human Services, Administration for Children and Families, Children's Bureau, 2009.

Hernandez, M., and Sharon Hodges. "Building Upon the Theory of Change for Systems of Care." Journal of Emotional and Behavioral Disorders, vol. 11, no. 1, 2003, pp. 19–26.

Hodges, Sharon, Kathleen Ferreira, Nathaniel Israel, and Jessica Mazza. "Systems of Care, Featherless Bipeds, and the Measure of All Things." Evaluation and Program Planning, vol. 33, no. 1, February 2010.

Koball, Heather, Heather Zaveri, Kimberly Boller, Deborah Daro, Jean Knab, Diane Paulsell, Margaret Hargreaves, Debra A. Strong, Lizabeth Malone, Patricia Del Grosso, and Yange Xue. "Cross-Site Evaluation of the Evidence-Based Home Visiting Grantee Cluster: Evaluation Design. Volume 1." Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, October 2009.

Levison-Johnson, Jody, and Melodie Wenz-Gross. "From Complexity to Reality: Providing Useful Frameworks for Defining Systems of Care." Evaluation and Program Planning, vol. 33, no. 1, February 2010.

Metz, Allison, and Leah Bartley. "Active Implementation Frameworks for Program Success." Zero to Three, March 2012.

National Governors Association and the National Association of State Budget Officers. "The Fiscal Survey of the States." Washington, DC: National Association of State Budget Officers, June 2009.

Patton, Michael Quinn. Qualitative Research and Evaluation Methods: Third Edition. Thousand Oaks, CA: Sage Publications, 2002.

Ritchie, Jane, and Liz Spencer. "Qualitative Data Analysis for Applied Policy Research." In The Qualitative Researcher's Companion, edited by A. Michael Huberman and Matthew B. Miles. Thousand Oaks, CA: Sage Publications, 2002.

Scientific Software Development. "Atlas.ti: Visual Qualitative Data Analysis, Management, and Model Building in Education Research and Business." Berlin, Germany: SSD, 1997.

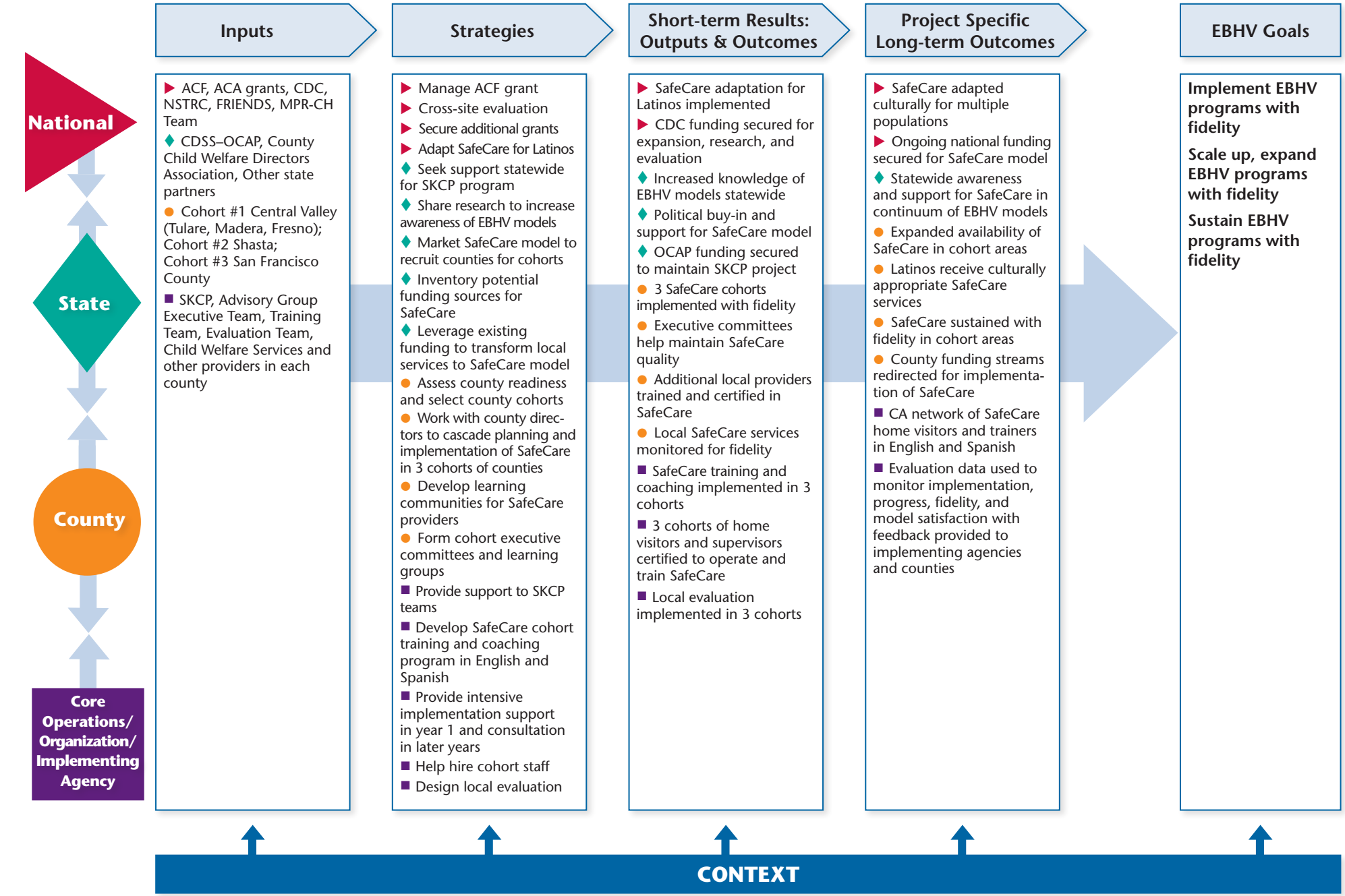
U.S. Congress. "Consolidated Appropriations Act, 2010." Pub. Law No. 111–117. 123 Stat. No. 3034. December 16, 2009.

Wandersman, A., E. Clary, J. Forbush, S. Weinburger, S. Coyne, and J. Duffy. "Community Organizing and Advocacy: Increasing the Quality and Quantity of Mentoring Programs." Journal of Community Psychology, vol. 34, 2006, pp. 781–799.

APPENDIX A

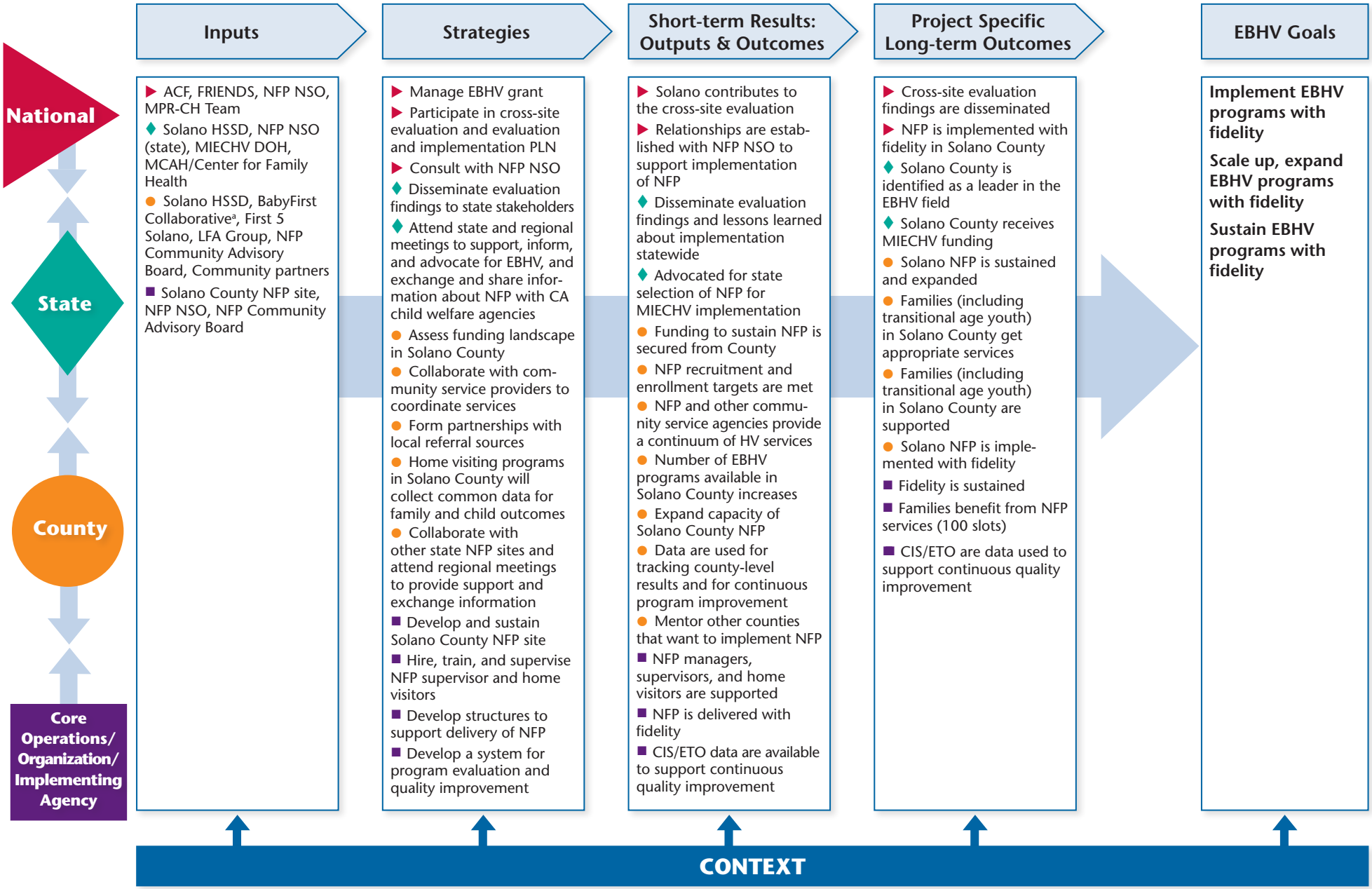
EBHV SUBCONTRACTORS' 2011 LOGIC MODELS

CA: RADY CHILDREN'S HOSPITAL, SAN DIEGO LOGIC MODEL



Notes: ACA = Affordable Care Act; ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; CA = California; CDC = Centers for Disease Control; CDSS = California Department of Social Services; EBHV = Evidence-Based Home Visiting; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago; NSTRC = National SafeCare Training and Research Center; OCAP = Office of Child Abuse Prevention at the California Department of Social Services; SKCP= Safe Kids California Project of the Chadwick Center for Children and Families at Rady Children's Hospital–San Diego

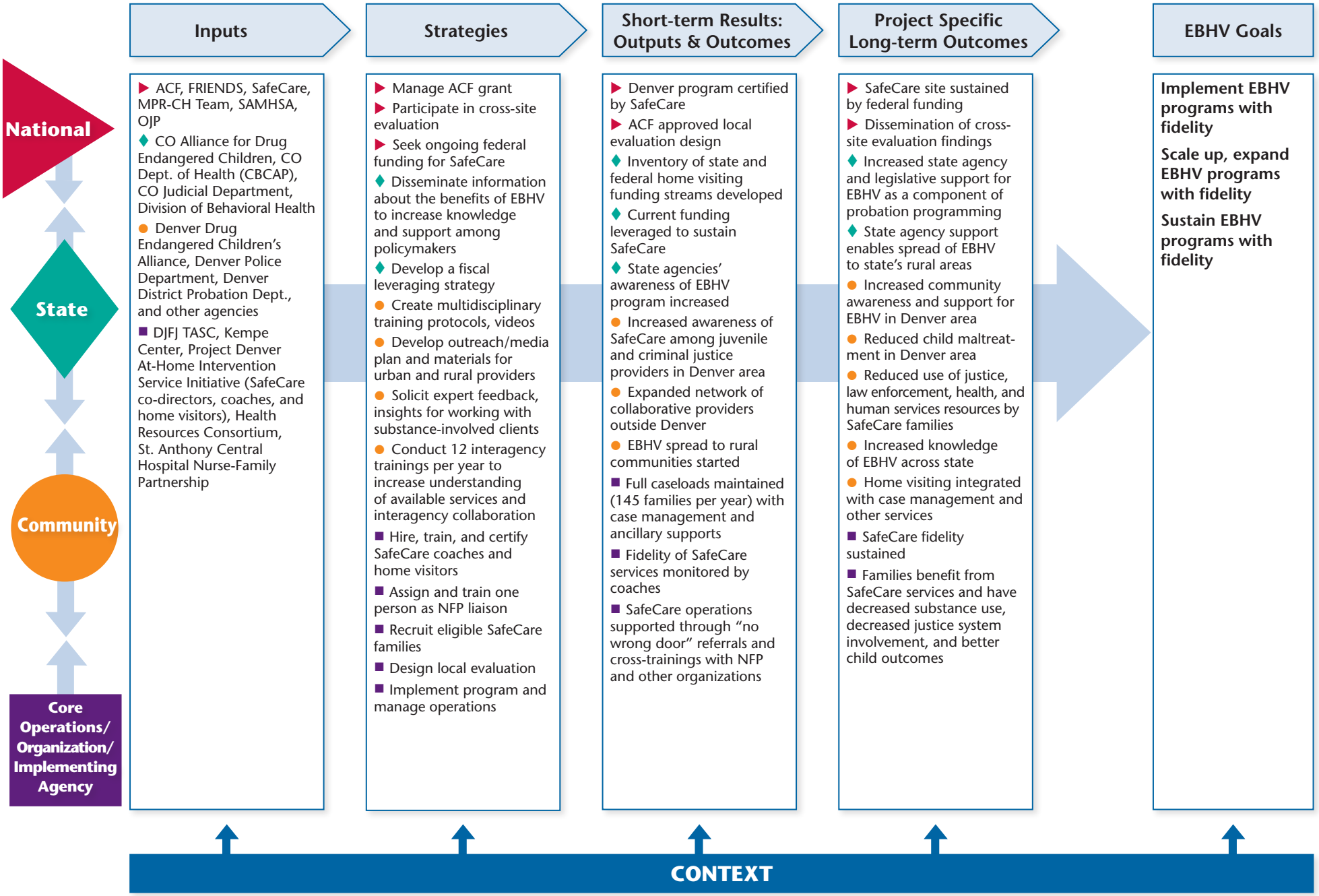
CA: COUNTY OF SOLANO DEPARTMENT OF HEALTH AND SOCIAL SERVICES LOGIC MODEL



Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; EBHV = Evidence-Based Home Visiting; CA = California; CIS/ETO = Nurse Family Partnership Clinical Information System/Efforts to Outcomes database; DOH = California Department of Public Health; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); MCAH = Maternal, Child, and Adolescent Health Program at the California Department of Health; MIECHV = Maternal, Infant, and Early Childhood Home Visiting Program; MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago; NFP = Nurse Family Partnership; NFP NSO = Nurse Family Partnership National Service Office; PLN = Peer Learning Network; Solano HSSD = Solano County Health and Social Services Department

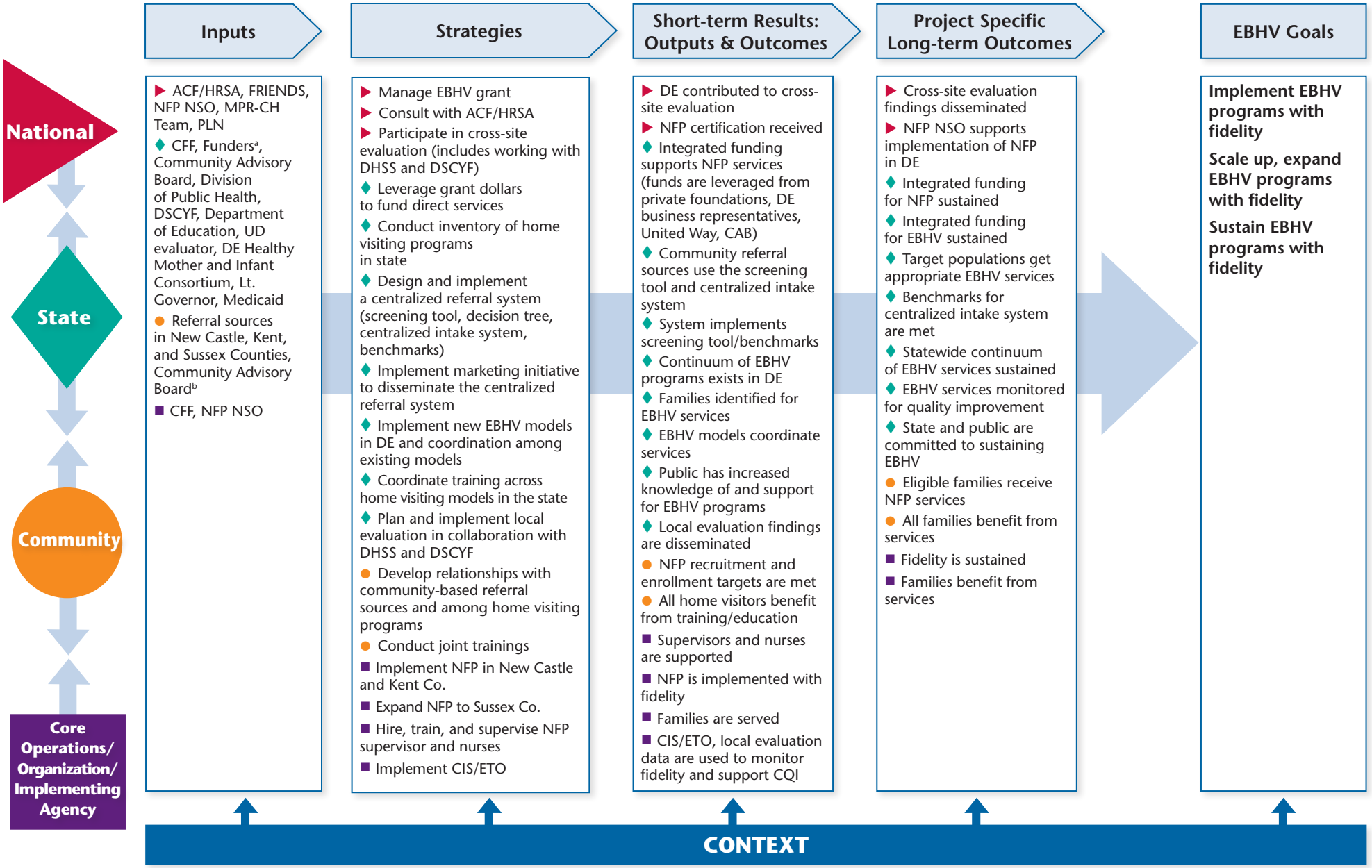
[a] The BabyFirst Collaborative is funded by First 5 and operated under the Public Health Division in the Maternal, Child, and Adolescent Health (MCAH) Bureau. Funded partners include: Solano County Health & Social Services, Solano County Prenatal Care Guidance, Solano Substance Abuse Services, Youth & Family Services, ABC Prenatal Program, Black Infant Health, Children's Nurturing Project, It's About My Baby, La Clinica-Great Beginnings, Nubian Mentoring Program, Partnership HealthPlan of California, and Planned Parenthood: Shasta-Diablo. Additional partners include: Families First, Inc., Child Start, Inc., Solano WIC, Solano Kids Insurance Program (SKIP), Child Haven, and the Solano Parenting Partnership.

CO: COLORADO JUDICIAL DEPARTMENT LOGIC MODEL



Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; EBHV = Evidence-Based Home Visiting; CBCAP = Community-Based Child Abuse Prevention; CO = Colorado; DJFJ TASC = Denver Juvenile and Family Treatment Accountability for Safer Communities; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago; NFP = Nurse Family Partnership; OJP = Office of Justice Programs at the U.S. Department of Justice; SAMHSA = Substance Abuse and Mental Health Services Administration

DE: CHILDREN AND FAMILIES FIRST OF DELAWARE LOGIC MODEL

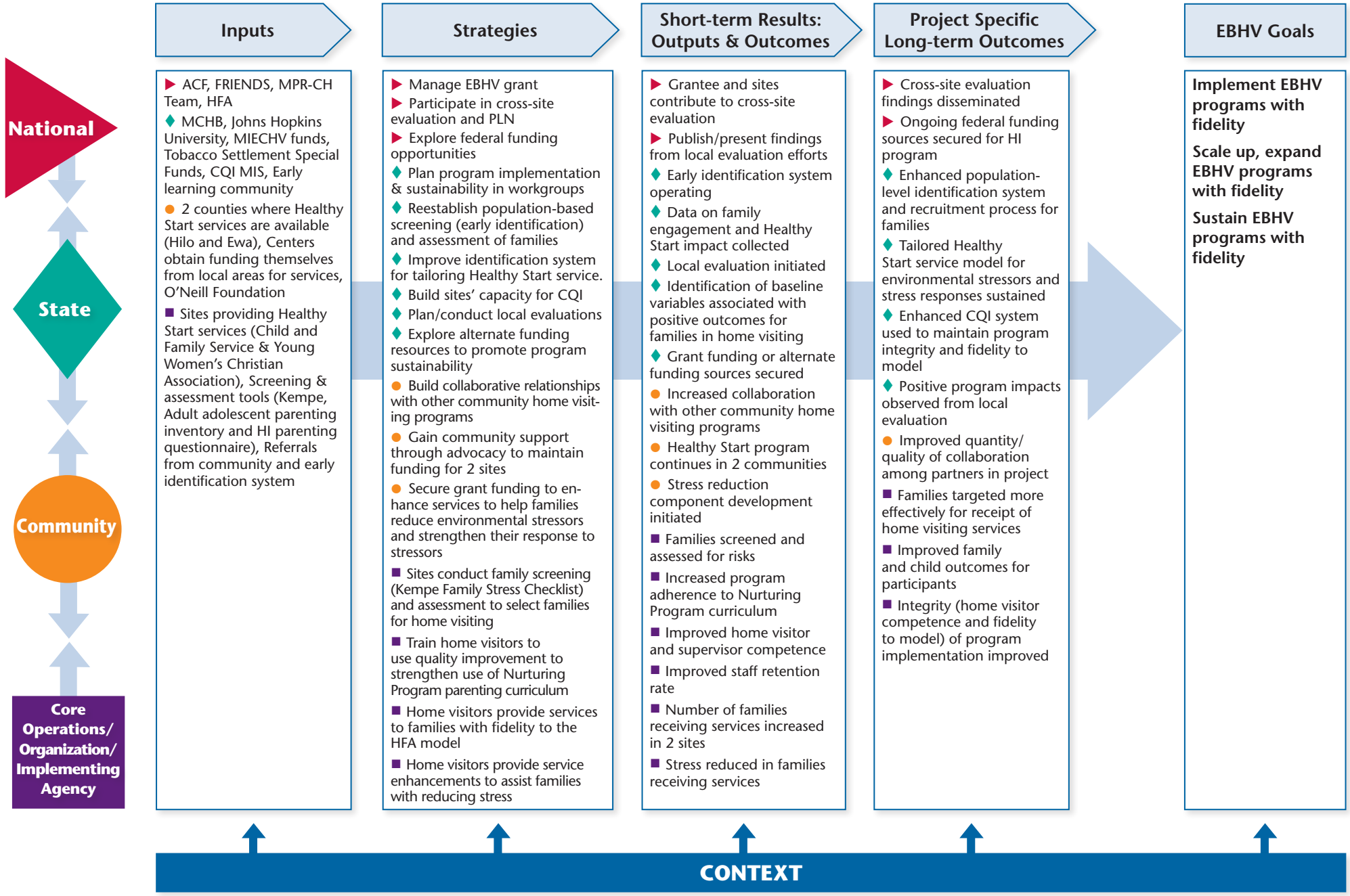


Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; CBCAP = Center for Community-Based Child Abuse Prevention; CIS/ETO = Nurse Family Partnership Clinical Information System/ Efforts to Outcomes database; Co. = County; CQI = Continuous Quality Improvement; DE = Delaware; DHSS = Delaware Health and Social Services; DSCYF = Department of Services for Children, Youth, and Their Families; EBHV = Evidence-Based Home Visiting; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); HRSA = Health Resources and Services Administration; MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago; NFP = Nurse Family Partnership; NFP NSO = Nurse Family Partnership National Service Office; PLN = Peer Learning Network; UD = University of Delaware

[a] Funders include United Way of Delaware, Division of Public Health, Prevent Child Abuse Delaware (CB-CAP), Eckerd Family Foundation, Blue Cross Blue Shield Foundation of Delaware, Longwood Foundation, Laffey-McHugh Foundation, and Gore.

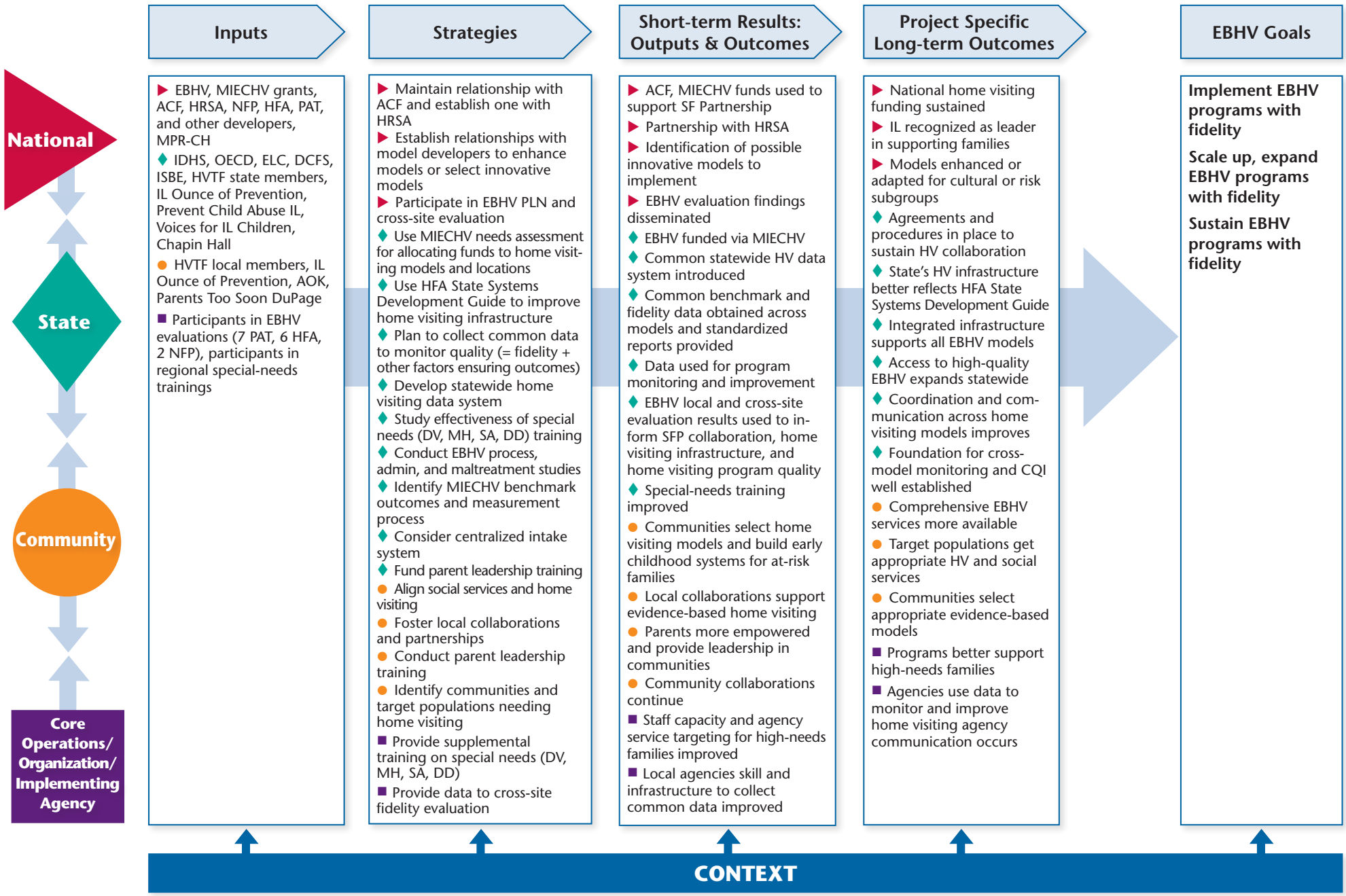
[b] Community Advisory Board (CAB) includes CBCAP; University of Delaware School of Nursing; Maternal & Child Health/Division of Public Health; Healthy Beginnings Program/Christiana Care Health System; Smart Start Program/Division of Public Health; Parents as Teachers; Early Head Start/University of Delaware; United Way of Delaware; ECCS/Division of Public Health; Child Death, Near Death, and Stillborn Commission; Office of the Child Advocate; and Department of Services for Children, Youth, and Families/Division of Prevention and Behavioral Services, Nemours Health and Prevention Services, Domestic Violence Coordinating Council.

HI: HAWAII DEPARTMENT OF HEALTH LOGIC MODEL



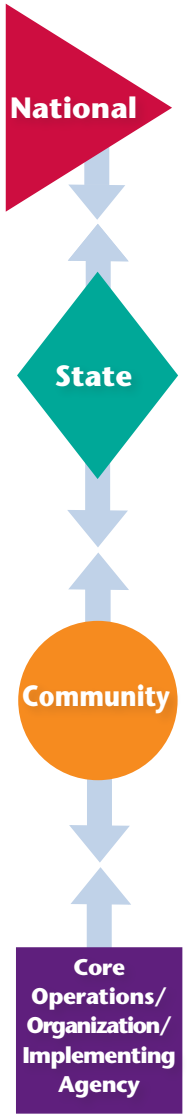
Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; CQI = Continuous Quality Improvement; EBHV = Evidence-Based Home Visiting; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); HFA = Healthy Families America; HI = Hawaii; MCHB = Maternal and Child Health Branch; MIECHV = Maternal, Infant, and Early Childhood Home Visiting Program; MIS = Management Information System; MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago; PLN = Peer Learning Network

IL: ILLINOIS DEPARTMENT OF HUMAN SERVICES LOGIC MODEL



Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; AOK = All Our Kids (AOK) Early Childhood Network; CQI = Continuous Quality Improvement; DCFS = Department of Children and Family Services; DD = Developmental Disability; DV = Domestic Violence; EBHV = Evidence-Based Home Visiting; ELC = Early Learning Council; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); HFA = Healthy Families America; HRSA = Health Resources and Services Administration; HVTF = Home Visiting Task Force; IDHS = Illinois Department of Human Services; IL = Illinois; ISBE = Illinois State Board of Education; MIECHV = Maternal, Infant, and Early Childhood Home Visiting Program; MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago; MA = Mental Health; NFP = Nurse Family Partnership; OECD = Office of Early Childhood Development; PAT = Parents as Teachers; PLN = Peer Learning Network; SA = Substance Abuse; SFP = Strong Foundations Partnership

MN: MINNESOTA DEPARTMENT OF HEALTH LOGIC MODEL

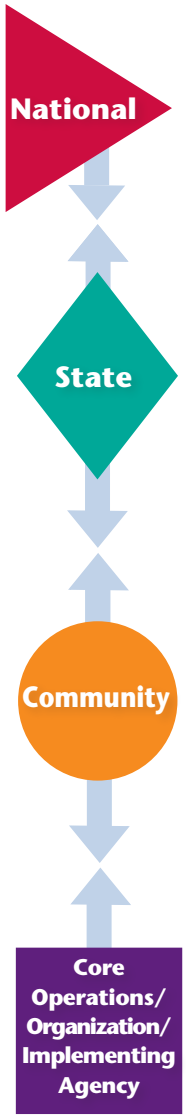


Inputs	Strategies	Short-term Results: Outputs & Outcomes	Project Specific Long-term Outcomes	EBHV Goals
▶ ACF, FRIENDS, MPR-CH Team, NFP NSO ♦ MN Departments of Health, Education, and Human Services; OMMH; tribal governments; University of Minnesota ● Local health departments; Local Public Health Association; Prevent Child Abuse MN; MN Head Start Association; MN Home Visiting Coalition; Early Childhood Funders Network; MN Council of Health Plans; MN Assoc. for Infant and Early Childhood Mental Health ■ 5 existing NFP programs in 17 local health departments; potential NFP sites 7–12 more counties	▶ Manage ACF grant ▶ Participate in cross-site evaluation ▶ Work with NFP NSO to certify new NFP sites and supplement NFP training for tribes ♦ Work with advisory board to select NFP special population ♦ Coordinate with other state agencies on reflective practice ♦ Disseminate EBHV information via newsletter, website, forums ♦ Seek to increase Medicaid reimbursement rates for home visiting ♦ Convene NFP Community of Practice meetings quarterly ● Provide EBHV information to tribal nursing directors; seek state funding for tribal NFP sites ● Offer trainings in reflective practice and infant mental health issues ● Help local agencies negotiate better Medicaid rates in contracts with health plans ■ Hire and train state NFP and reflective practice consultants ■ Design and conduct local evaluation ■ Provide support to ongoing and new EBHV programs through: Reflective practice coaching for supervisors and home visitors; Mini-grants to ongoing NFP programs for training expenses; NFP consultation and TA for potential NFP sites; Evaluation TA to local EBHV sites on how to use NFP data	▶ New NFP sites certified ▶ Tribal NFP supplement training developed by NFP NSO ▶ NFP CIS/ETO data provided to cross-site evaluation ♦ Increased awareness of EBHV benefits among state leaders ♦ State EBHV funding identified ♦ Coordination of reflective practice across state agencies ♦ American Indians selected for NFP special population project ♦ Coordination of professional development increased across NFP sites ● 3 tribes seek NFP certification; win OMMH and ACF grants ● 2 sites move to home visiting start-up ● Reflective practice retooled to group format to meet increased demand for service based on implementation lessons ● New tools created to measure change in reflective practice ● Infant mental health services to EBHV sites maintained ■ Reflective practice provided to two 18-month cohorts of EBHV supervisors and home visitors ■ New NFP site applications enabled by TA and consultation ■ Annual mini-grants expanded to support site implementation, training, and expansion costs of new sites ■ NFP CIS/ETO data collected ■ 9 NFP programs operational in 25 counties	▶ Statewide expansion of certified NFP sites in tribal and county agencies ▶ Cross-site and local evaluation findings disseminated ♦ Enhanced state-level EBHV reflective practice and NFP consultation infrastructure ♦ NFP Community of Practice statewide ♦ More state-level investment in building EBHV capacity ♦ State support for new NFP sites for special populations ● NFP expanded to 2 tribal sites (Fond du Lac, White Earth) ● Annual EBHV grants to local community health boards and tribal governments sustained ● Expansion of NFP to 16 NFP sites in 27–32 counties ● Regional capacity for reflective practice and infant mental health consultation sustained ■ NFP supervisor and home visitor workforce sustained ■ Quality and fidelity of NFP implementation maintained ■ Evaluation data used to improve EBHV services ■ Children and families benefit from EBHV services	**Implement EBHV programs with fidelity** **Scale up, expand EBHV programs with fidelity** **Sustain EBHV programs with fidelity**

CONTEXT

Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; CBCAP = Center for Community-Based Child Abuse Prevention; CIS/ETO = Nurse Family Partnership Clinical Information System/Efforts to Outcomes database; Co. = County; EBHV = Evidence-Based Home Visiting; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); MN = Minnesota; MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago; NFP = Nurse Family Partnership; NFP NSO = Nurse Family Partnership National Service Office; OMMH = Office of Minority And Multicultural Health; TA = Technical Assistance

NJ: NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES LOGIC MODEL



Inputs

- ▶ ACF grant, NFP NSO, PAT program office, FRIENDS, MPR-CH Team, HFA national office, CBCAP, HRSA Strengthening Families for Early Care and Education
- ♦ DCF, Home Visiting Workgroup, Ad Hoc committees[a], Johns Hopkins University, Deptment of Health and Senior Services, home visiting TA Partners (NFP NSO, PCANJ)
- ● Infrastructure Sites (Essex and Middlesex counties), EBHV sites (Hudson, Union, and Cape May counties), Funding Partners[b], Ad Hoc committees[c]
- ■ 3 new implementing agencies: Hudson (NFP), Union (NFP), and Cape May (PAT); 31 ongoing implementing agencies: HFA (23), PAT (1), and NFP (7)

Strategies

- ▶ Work with home visiting national offices implementation and evaluation standards
- ▶ Demonstrate the value of an integrated system of care
- ▶ Participate in EBHV cross-site evaluation and PLN
- ♦ Conduct statewide needs assessment to inform selection and monitoring of project sites
- ♦ Home Visitation Workgroup provides project oversight
- ♦ Create sustainability plan to obtain ongoing EBHV funding
- ♦ Collaborate and disseminate evaluation findings and advocate for EBHV with publicity materials
- ♦ Conduct state home visiting conference
- ♦ Use EBHV data system to monitor fidelity
- ♦ Integrate EHS into continuum of home visiting services
- ● Develop community-level coordination across models
- ● Build membership of local community boards for oversight
- ● Implement prenatal screening and risk assessment form and a central intake process in 2 infrastructure sites
- ● Collaborate to identify appropriate central intake location
- ● Work with private funders to sustain match commitments
- ■ Launch 3 new home visiting sites
- ■ Hire and train providers/home visiting for NFP, PAT, HFA
- ■ Provide TA and support to home visiting program project staff
- ■ Ongoing support (structured supervision, mandatory and ancillary training) to promote implementation with fidelity

Short-term Results: Outputs & Outcomes

- ▶ Grantee and sites participate in cross-site evaluation
- ▶ Advocate in conferences and findings shared in peer-reviewed publications
- ♦ 2 Infrastructure sites and 3 implementation sites selected
- ♦ Coordinated intake process finalized by state staff
- ♦ Negotiations started with Medicaid for NFP, PAT, HFA, and Head Start to increase sustainable funding for EBHV models
- ● Coordination improved across home visiting models in 2 infrastructure sites
- ● Prenatal screening and risk assessment form finalized
- ● Prenatal screening system and centralized intake piloted in 2 EBHV sites
- ● Funding for 2 communities is sustained by local partners
- ■ Home visiting staff are hired, trained, and certified as home visitors and supervisors in 3 new sites
- ■ 3 new NFP and PAT sites are operating at or toward capacity with full enrollment
- ■ NFP, PAT, and HFA programs are implemented with fidelity

Project Specific Long-term Outcomes

- ▶ National home visiting models strengthened/ improved by fidelity study
- ▶ Other states incorporate an integrated system approach
- ♦ Prenatal screening and central intake integrated into MCH for statewide implementation
- ♦ EBHV data systems informs subsequent state needs and utilization assessments
- ♦ Early Head Start as part of continuum of care
- ● Prenatal screening and centralized intake fully implemented in 2 infrastructure sites
- ● Families efficiently linked to appropriate level of services in 2 infrastructure communities
- ● Home visiting capacity expanded (more families served in existing sites) from MIECHV funds
- ■ Home visiting staff retained in 3 new sites
- ■ Fidelity sustained long term
- ■ Improved family and child outcomes

EBHV Goals

Implement EBHV programs with fidelity

Scale up, expand EBHV programs with fidelity

Sustain EBHV programs with fidelity

CONTEXT

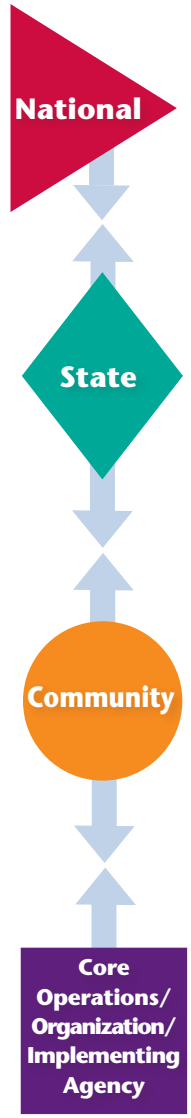
Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; CBCAP = Community-Based Child Abuse Prevention; DCF = New Jersey Department of Children and Families; EBHV = Evidence-Based Home Visiting; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); HFA = Healthy Families America; HRSA = Health Resources and Services Administration; MCH = Maternal And Child Health Consortia; MIECHV = Maternal, Infant, and Early Childhood Home Visiting Program; MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago; NFP = Nurse Family Partnership; NFP NSO = Nurse Family Partnership National Service Office; NJ = New Jersey; PAT = Parents as Teachers; PCANJ = Prevent Child Abuse New Jersey; PLN = Peer Learning Network; PPV = Public/Private Ventures; TA = Technical Assistance

[a] **State Ad Hoc committee participants include:** Department of Health (Perinatal, Early Childhood Comprehensive Systems, Project Launch); Department of Human Services (Medicaid, Division of Family Development, Substance Abuse, Mental Health); JJDPC; Education; Department of Children and Families (Early Childhood, home visiting, and other offices); MCH; PCANJ; Public/Private Ventures; Build NJ; Advocates for Children of New Jersey; NJ ACF target counties; NJ Medicaid HMOs; County funders; Policymakers Consumers (i.e., pregnant women and/or parents).

[b] **Funding partners include:** The Nicholson Foundation (one nurse at Union County NFP program); United Way agencies (Middlesex, Hudson, Union).

[c] **Community Ad Hoc committee participants include:** Health/Prenatal clinics; Federally Qualified Health Centers; Health Department; WIC; Family Success Centers; Differential Response; School-linked services; County welfare agency; Substance Abuse; Mental Health; Domestic Violence; Fatherhood; Early Childhood Home Visitation; MCH; PCANJ ; Public/Private Ventures; Medicaid HMOs; Local Funders; Consumers (i.e., pregnant women and/or parents).

NY: SOCIETY FOR THE PROTECTION AND CARE OF CHILDREN, ROCHESTER LOGIC MODEL



Inputs

- ▶ ACF grant, NFP NSO, PAT program office, FRIENDS, MPR-CH Team
- ♦ COPS funding, NY State Department of Health, NY Early Childhood Advisory Groups, State level childhood advocacy groups[a]
- ● BHC Collaborative partners[2], BHC Steering and Partnership Committees, 292 Baby Program, Perinatal Network, Funders[c], Medicaid Managed Care Programs, OB, pediatric providers
- ■ 1 existing PAT and 1 existing NFP site[d], Incredible Years, Child Parent Psychotherapy, and Interpersonal Psychotherapy programs and materials, Outreach workers who help the families stabilize and become able to benefit more fully from EBHV models

Strategies

- ▶ Manage EBHV grant
- ▶ Participate in cross-site evaluation and PLN
- ▶ Gain national recognition of BHC model via lobbying, conferences
- ▶ Seek ongoing federal funding for NFP and PAT programs
- ▶ Integrate trauma informed practices into EBHV
- ▶ Recognition as a model for getting funding as a patient-centered medical home
- ♦ Expand currently existing home visiting sites with BHC expertise before scaling up with new sites
- ♦ Use universal PRF across state to screen for home visiting
- ♦ Seek ongoing state Medicaid funding for BHC
- ♦ Work collaboratively with Healthy Mothers, Healthy Babies on MIECHV planning and implementation and create a coordinated system of home visitation
- ♦ Demonstrate cost/benefit of BHC to state
- ● Create/maintain steering committee for oversight of BHC project
- ● Increase community awareness of BHC services (NFP and PAT)
- ● Orient referral sources to available BHC services
- ● Coordinate and streamline referral process with prenatal and pediatric practices, as well as community referrals allowing for inter-agency referrals
- ● Refine decision tree for triaging families into most appropriate EBHV program
- ● Create BHC sustainability plan
- ● Alignment of community and state strategies
- ■ Add IY, CPP, and IPT services to NFP and PAT models to create combined BHC model
- ■ Hire and cross-train NFP and PAT project staff on BHC model and model components
- ■ Provide TA and support to ensure NFP and PAT fidelity
- ■ Conduct local impact evaluation of BHC model
- ■ Lower attrition in home visiting
- ■ Reduce transience

Short-term Results: Outputs & Outcomes

- ▶ Grantee and sites participate in cross-site evaluation
- ▶ Findings presented in conferences and peer-reviewed publications
- ▶ BHC staff becomes a PAT national trainer and maintains this status
- ♦ Statewide network of home visiting services strengthened
- ♦ State funding secured for BHC program and other EBHV programs during economic crisis
- ♦ Increased use of universal PRF appropriately gets families into coordinated care
- ● Community agencies made aware of EBHV services through inventory of local programs
- ● Gap analysis of Monroe County service needs versus service capacity conducted
- ● Promising practices (including use of EBHV) increases enrollment in services
- ■ Agreements made between participating home visiting agencies regarding family placement
- ■ All staff hired and trained
- ■ NFP and PAT models implemented with fidelity
- ■ BHC, NFP, and PAT programs evaluated for fidelity, impacts
- ■ Local providers and social workers work together to implement BHC model
- ■ Families consistently served by coordinated community agencies
- ■ Families persist in home visiting

Project Specific Long-term Outcomes

- ▶ Increased national recognition of BHC model
- ▶ Increased momentum to replicate BHC model nationally (via demonstration of cost-benefit and impact findings)
- ♦ Increased access to EBHV by at-risk families statewide
- ♦ Increased interest in replicating BHC model statewide
- ♦ BHC seen as cost-effective (and therefore sustainable with state dollars)
- ♦ Coordination with other EBHV programs to best treat the family
- ♦ Seek support reimbursement for mental health services by Medicaid fee for service
- ● Integrated network of EBHV services
- ● Efficient referral system coordinated across providers
- ● Ongoing local funding sustains BHC and other EBHV services
- ● Enough EBHV capacity to meet community needs
- ■ Increased access/utilization of EBHV, particularly by at-risk families
- ■ Families are appropriately matched to programs that best meet their needs
- ■ Families benefit from increased coordination among community agencies
- ■ Local evaluation shows positive impacts of BHC model

EBHV Goals

Implement EBHV programs with fidelity

Scale up, expand EBHV programs with fidelity

Sustain EBHV programs with fidelity

CONTEXT

Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; BHC = Building Healthy Children; CBCAP = Community-Based Child Abuse Prevention; COPS = Community Optional Preventive Services; CPP = Child Parent Psychotherapy; EBHV = Evidence-Based Home Visiting; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); HFA = Healthy Families America; IP = Interpersonal Psychotherapy; IY = Incredible Years; MIECHV = Maternal, Infant, and Early Childhood Home Visiting Program; MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago; NFP = Nurse Family Partnership; NFP NSO = Nurse Family Partnership National Service Office; NY = New York; PAT = Parents as Teachers; PLN = Peer Learning Network; PRF = Perinatal Referral Form

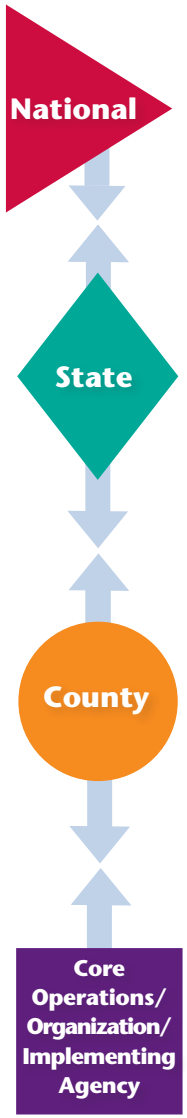
[a] Childhood Groups: Winning Beginnings, Home Visitation Group of Skylar Center for Analysis and Advocacy.

[b] Key collaborating partners include: Mt. Hope Family Center–Project Evaluator and CPP/IPT service provider; University of Rochester Medical Center Social Work Division–Pediatric social worker, enrollment and provision of outreach services; Monroe County Department of Human Services–Planning and advocate for long-term sustainability; Monroe County Department of Public Health–Nurse Family Partnership service provider as well as planning and long-term sustainability plans for the project (see copy of contract); Monroe County United Way planning process and long-term sustainability plans for the project

[c] Funders: United Way, Department of Human Services, Insurers (Medicaid managed care programs), DOB, and pediatric care providers.

[d] Implementing agencies include PAT: Society for the Protection and Care of Children; NFP: Monroe County Nurse Family Partnership.

OH: MERCY ST. VINCENT MEDICAL CENTER LOGIC MODEL



Inputs

- ▶ ACF, FRIENDS, MPR-CH Team, HFA national office
- ♦ Voices for Ohio's Children, Ohio Partnership for Stronger Families, Ohio Children and Families First Council, Ohio Department of Health
- ● Lucas County Family Council, Coalition Members[a]
- ■ Mercy St. Vincent Medical Center, St. Vincent Pediatric, Services, Help Me Grow

Strategies

- ▶ Manage EBHV grant
- ▶ Participate in cross-site evaluation and PLN
- ▶ Consult with HFA national office
- ♦ Participate in monthly meetings coordinated by OPSF on child abuse prevention for collaboration and coordination of services
- ♦ Provide family input to OPSF to understand the impact of home visiting in Ohio
- ♦ Leverage state funding sources for home visiting across the state
- ♦ Participate in Dept. of Health early childhood and home visitation stakeholder meetings
- ♦ Participate in quarterly meetings for the Ohio Infant Mortality Collaborative
- ● Develop consortium of early childhood social services agencies and home visitation agencies
- ● Maintain and enhance system for coordination of services
- ● Share data and results of local needs assessments
- ● Provide and participate in child abuse prevention activities, training, and meetings
- ● Provide direction for the Fatherhood Initiative and services for fathers
- ● Participate in the advisory group for Help Me Grow
- ■ Plan for HFA implementation
- ■ Recruit and train home visitors and provide ongoing professional development to ensure fidelity to model
- ■ Develop referral system from county early identification (Help Me Grow)
- ■ Recruit families, complete assessments, and provide home visiting services based on GGK and GGF
- ■ Refer families for needed services and ensure service receipt
- ■ Focus on father engagement, including monthly father meetings
- ■ Provide monthly parent groups

Short-term Results: Outputs & Outcomes

- ▶ Grantee and sites contributed to cross-site evaluation
- ▶ Relationships with HFA established to support implementation
- ♦ Participated in state-level activities for child abuse prevention
- ♦ Assisted in implementation of state needs assessment and formulation of MIECHV plan
- ♦ Funding opportunities identified
- ♦ Coordination of home visiting services throughout the state
- ● Formation of county-wide HVAC
- ● Increased communication among providers
- ● Gaps in services and barriers to participation identified
- ● System for service coordination developed
- ● Increased awareness of child abuse and neglect
- ● Increase awareness of child abuse and maltreatment
- ■ Implementation plan developed and revised
- ■ Home visitors recruited and trained
- ■ Referrals received from early identification system
- ■ Families recruited and retained
- ■ Families received screening, interventions, and home visits
- ■ Families referred to community services
- ■ Families receive services as needed

Project Specific Long-term Outcomes

- ▶ Cross-site evaluation findings disseminated
- ▶ HFA affiliation and accreditation
- ♦ Funding secured and sustained
- ♦ Home visiting programs in Lucas County coordinated with state initiative
- ● Increased capacity to provide child maltreatment services
- ● Service providers communicate regularly
- ● Child maltreatment service system coordinated throughout county
- ● Continue quarterly trainings for parents and providers sponsored by HVAC
- ■ Services delivered with fidelity to HFA model
- ■ Improve parent-child interaction
- ■ Families benefit from receipt of home visiting services

EBHV Goals

Implement EBHV programs with fidelity

Scale up, expand EBHV programs with fidelity

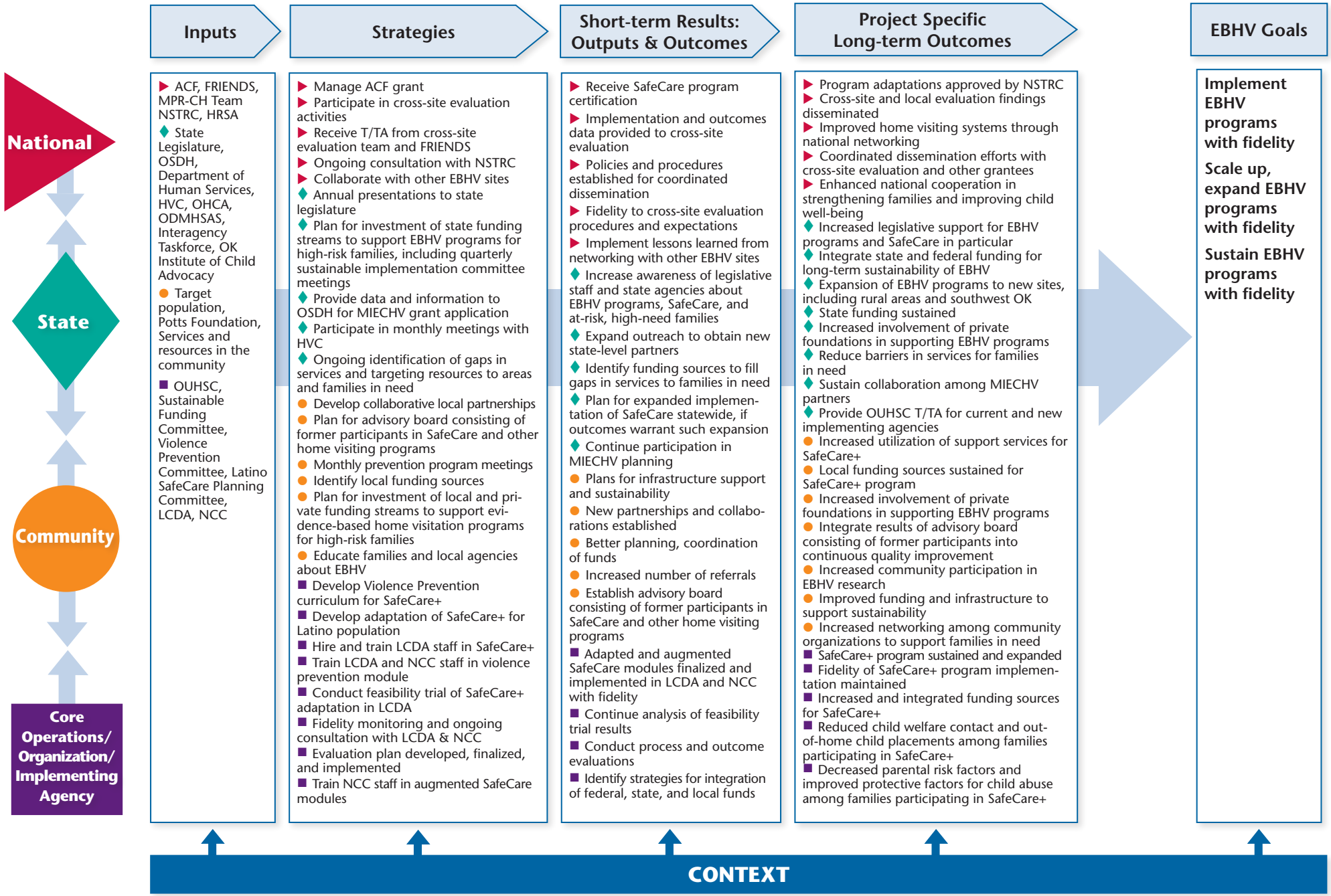
Sustain EBHV programs with fidelity

CONTEXT

Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; EBHV = Evidence-Based Home Visiting; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); GGF = Growing Great Families; GGK = Growing Great Kids; HFA = Healthy Families America; HVAC = Home Visitation Advisory Council; MIECHV = Maternal, Infant, and Early Childhood Home Visiting Program; OPSF = Ohio Partnership for Stronger Families

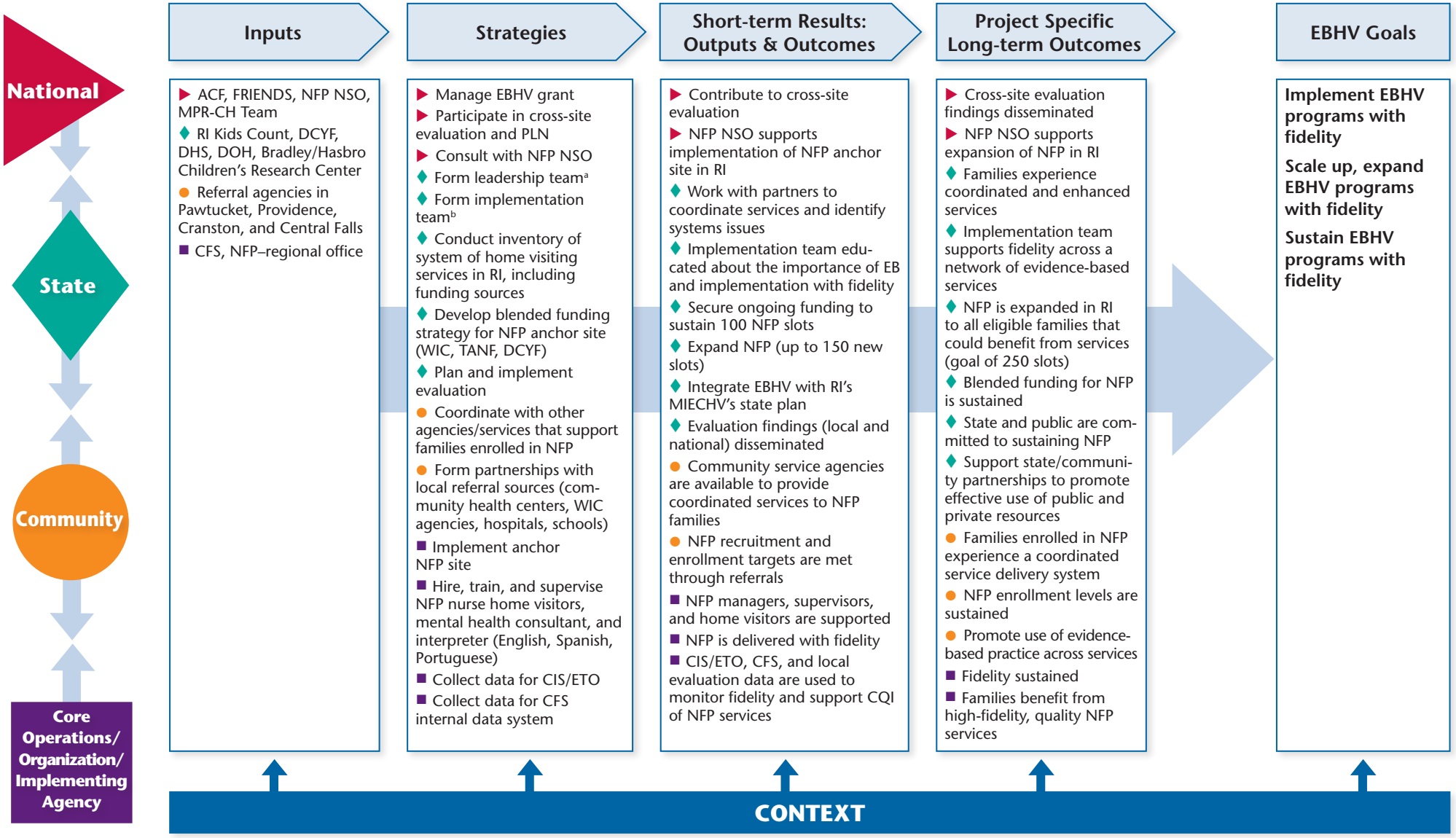
[a] Coalition Members: Lucas County Children's Services, Lucas County Family Council, Ohio Children's Trust Fund, Strengthening Families, Child and Family Abuse Task Force, NW Ohio Family and Child Abuse Prevention Center, Early Intervention, Help Me Grow, Head Start, Local CAPTA demonstration program: St. Vincent Mercy Medical Substance Exposed Newborn Project, National Exchange Club, Toledo Children's Hospital, Harbor Mental Health Services, Early Childhood Coordinating Council, Children's Trust Fund, Fatherhood Initiative, Neighborhood Health Association, Hospital Council of Northern Ohio, Help Me Grow Advisory Board.

OK: THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER LOGIC MODEL



Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; EBHV = Evidence-Based Home Visiting; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); HRSA = Health Resources and Services Administration; HVC = Home Visitation Coalition; LCDA = Latino Community Development Agency; MIECHV = Maternal, Infant, and Early Childhood Home Visiting Program; MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago; NCC = North Care Center; NSTRC = National SafeCare Training and Research Center; ODMHSAS = Oklahoma Department of Mental Health and Substance Abuse Services; OHCA = Oklahoma Health Care Authority; OK = Oklahoma; OSDH = Oklahoma State Department of Health; OUHSC = University of Oklahoma Health Sciences Center; T/TA = Training and Technical Assistance

RI: RHODE ISLAND KIDS COUNT LOGIC MODEL

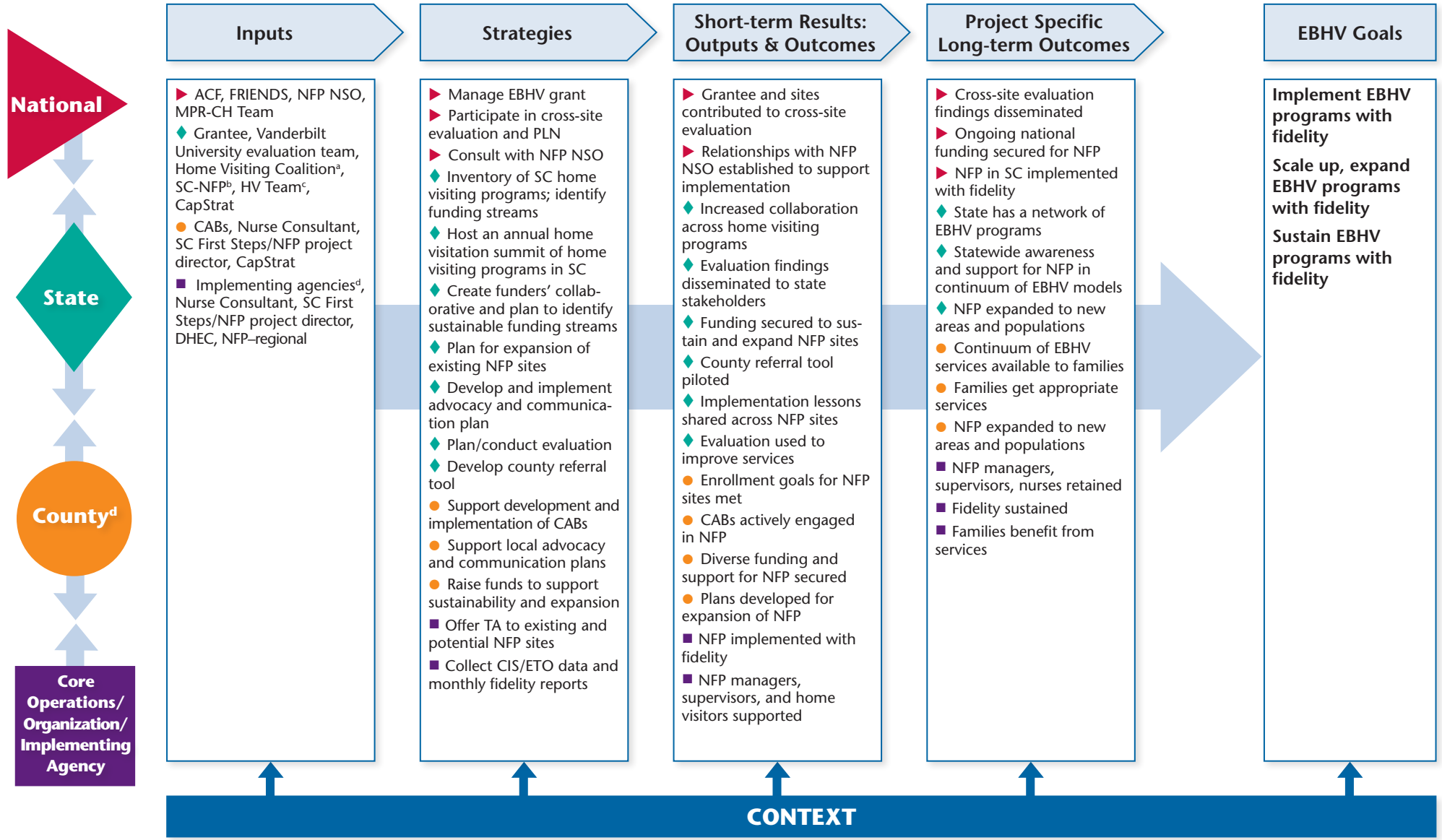


Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; EBHV = Evidence-Based Home Visiting; CFS = Children's Friend and Service; CIS/ETO = Nurse Family Partnership Clinical Information System/Efforts to Outcomes database; CQI = Continuous Quality Improvement; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); DCYF = Rhode Island Department of Children, Youth, and Families; DHS = Rhode Island Department of Human Services DOH = Rhode Island Department of Health; MIECHV = Maternal, Infant, and Early Childhood Home Visiting Program; MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago; NFP = Nurse Family Partnership; NFP NSO = Nurse Family Partnership National Service Office; PLN = Peer Learning Network; TANF = Temporary Assistance for Needy Families; WIC = Federal Special Supplemental Nutrition Program for Women, Infants and Children

[a] Leadership team includes Pediatrician and Director, Hasbro Hospital Teens with Tots Clinic (also chair of Teen Pregnancy Prevention Task Force); Obstetrician, Women & Infants Hospital (also chair of Prematurity Task Force); Pediatricians, Hasbro Hospital (also chair of RI chapter of American Academy of Pediatrics); Rhode Island Parent Information Network; Prevent Child Abuse Rhode Island; Department of Children, Youth and Families; Department of Human Services (TANF, Early Intervention, Medicaid); Department of Health (WIC and Maternal Child Health); Department of Education (early childhood initiatives coordinator); Neighborhood Health Plan of RI; United Health Care; Family Services (manager of Urban Core Family Care Community Partnership); Rhode Island KIDS COUNT; Children's Friend; Bradley Children's Research Center; Rhode Island Foundation; Nurse-Family Partnership National Service Office.

[b] Implementation team includes Department of Health (MIECHV coordinator, First Connections Coordinator, WIC); Department of Human Services (TANF); Department of Children, Youth and Families (DCYF); Providence Community Health Centers; Nurse Family Partnership National Service Office; Children's Friend; Rhode Island KIDS COUNT; Bradley Children's Research Center.

SC: THE CHILDREN'S TRUST OF SOUTH CAROLINA LOGIC MODEL



Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; CAB = Community Advisory Board; CIS/ETO = Nurse Family Partnership Clinical Information System/Efforts to Outcomes database; DDSN = South Carolina Department of Disabilities and Special Needs; DHEC = South Carolina Department of Health and Environmental Control; DMH = South Carolina Department of Mental Health; DHHS = South Carolina Department of Health and Human Services; DSS = South Carolina Department of Social Services; EBHV = Evidence-Based Home Visiting; ECCS = Early Childhood Comprehensive Systems; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); MIECHV = Maternal, Infant, and Early Childhood Home Visiting Program; MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago; NFP = Nurse Family Partnership; NFP NSO = Nurse Family Partnership National Service Office; PLN = Peer Learning Network; SC = South Carolina; TA = Technical Assistance.

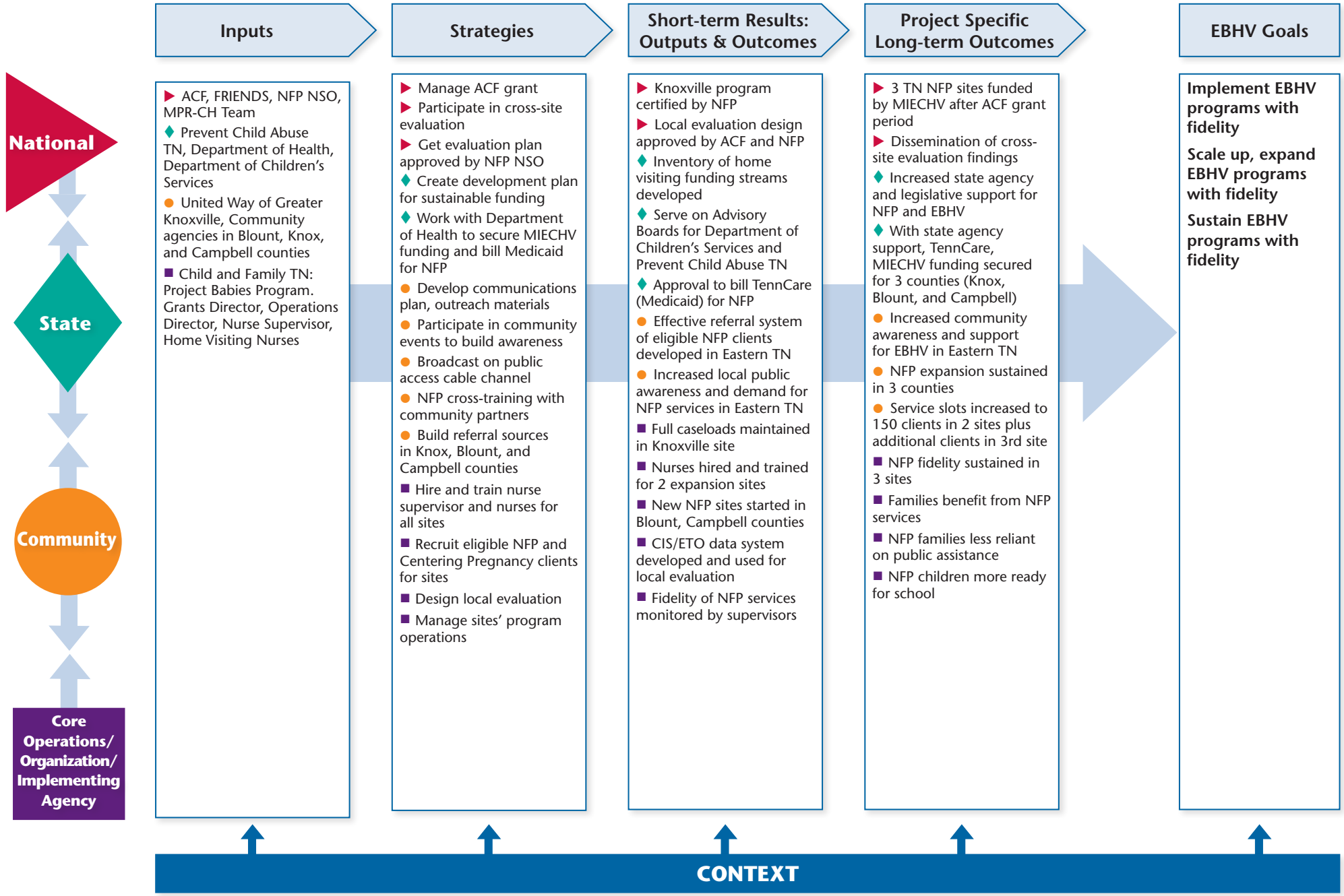
[a] Home Visiting Coalition (replaced the EBHV Advisory Team) includes SC Department of Alcohol and Other Drugs, DHEC, DDSN, DSS, Duke Endowment, ECCS, DHHS, DMH, SC Office of Research, and SC First Steps to School Success.

[b] SC-NFP includes BCBS/SC Foundation, Children's Trust (grantee), Duke Endowment, DHEC, DSS, First Steps, NFP – regional.

[c] Home Visiting Team includes representatives from home visiting programs and other service providers in SC including Triple P, ECCS, Parent-Child Home, Parents As Teachers, SC Department of Education/Family Literacy, DDSN, Healthy Families, Head Start, DSS, First Steps/Parenting, First Steps/NFP, Early Steps to School Success, Birth Matters, Fort Jackson Family Support Services.

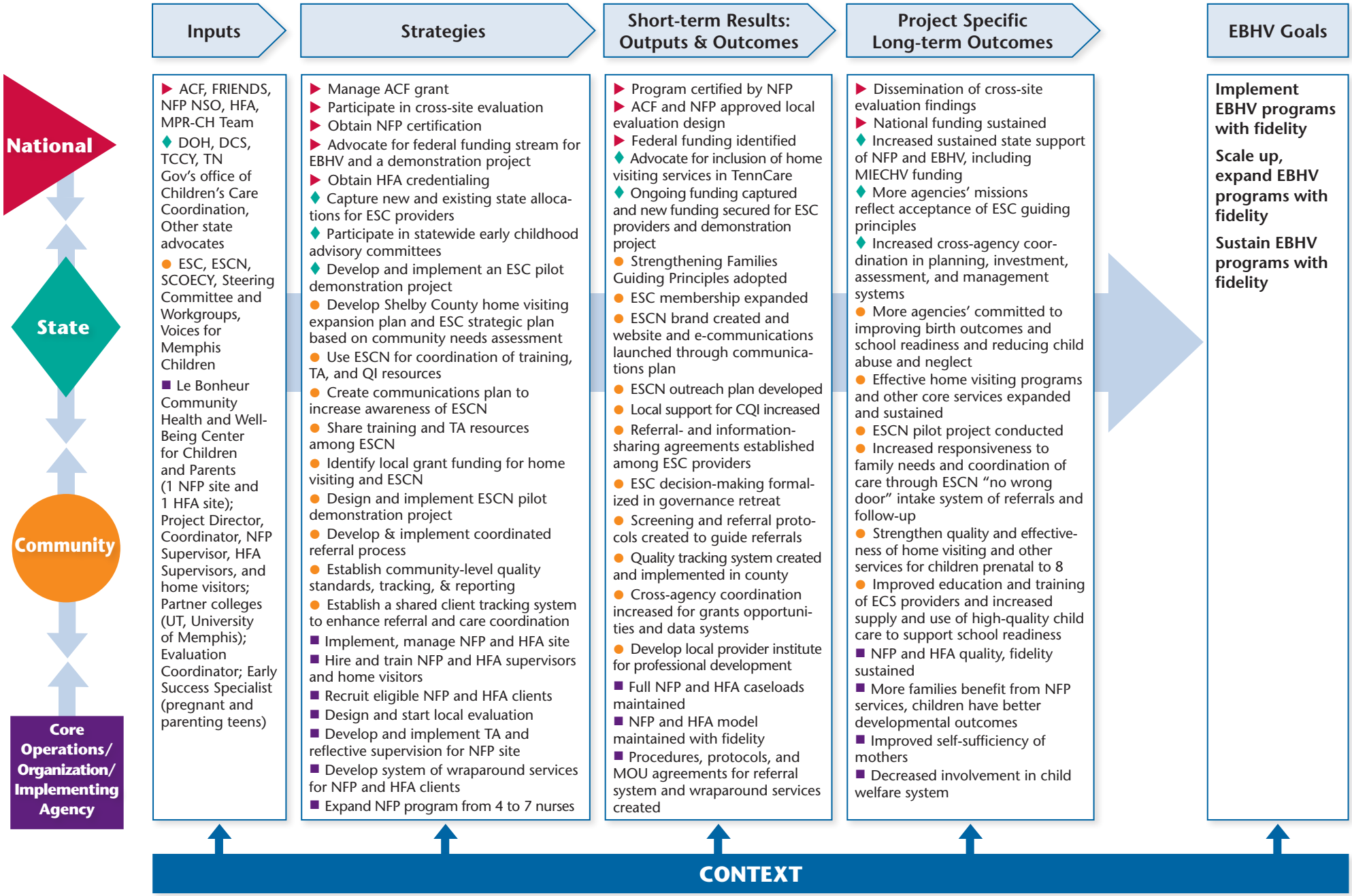
[d] Implementing agencies (counties) include Region 1 DHEC (Anderson County), Region 3 DHEC (Lexington/Richland Counties), Region 6 DHEC (Horry County), Region 7 DHEC (Charleston/Berkeley/Dorchester/Colleton Counties), Greenville Hospital System (Greenville County), and Spartanburg Regional Health System (Spartanburg County).

TN: CHILD AND FAMILY TENNESSEE LOGIC MODEL



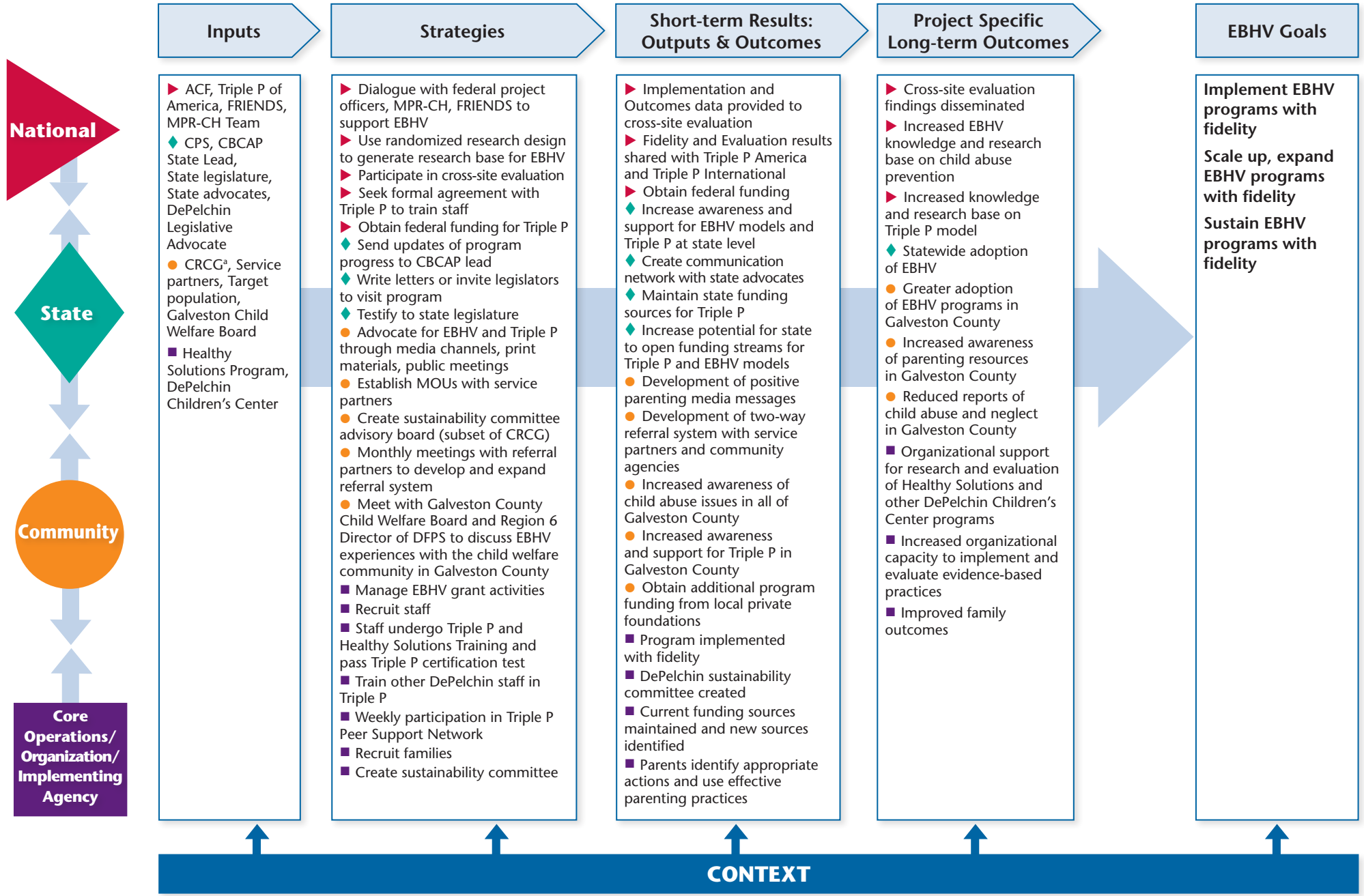
Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; CIS/ETO = Nurse Family Partnership Clinical Information System/Efforts to Outcomes database; EBHV = Evidence-Based Home Visiting; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); MIECHV = Maternal, Infant, and Early Childhood Home Visiting Program; MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago; NFP = Nurse Family Partnership; NFP NSO = Nurse Family Partnership National Service Office; TN = Tennessee

TN: LE BONHEUR COMMUNITY HEALTH AND WELL-BEING LOGIC MODEL



Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; CBCAP = Community-Based Child Abuse Prevention; CQI = Continuous Quality Improvement; DOH = Tennessee Department of Health; DCS = Tennessee Department of Children's Services; EBHV = Evidence-Based Home Visiting; ESC = Early Success Coalition; ESCN = Early Success Coalition Provider Network; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); HFA = Healthy Families America; MIECHV = Maternal, Infant, and Early Childhood Home Visiting Program; MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago; MOU = Memorandum of Understanding; NFP = Nurse Family Partnership; NFP NSO = Nurse Family Partnership National Service Office; SCOECY = Shelby County Office of Early Childhood and Youth; TA = Technical Assistance; TCCY = Tennessee Commission on Children and Youth; UT = University of Tennessee

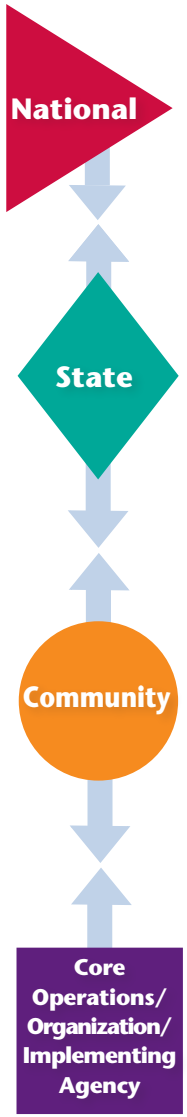
TX: DEPELCHIN CHILDREN'S CENTER LOGIC MODEL



Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; CBCAP = Community-Based Child Abuse Prevention; CPS = Texas Child Protective Services; DFPS = Texas Department of Family and Protective Services; EBHV = Evidence-Based Home Visiting; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago

[a] Community Resource Coordination Advisory Group (CRCG) consists of representatives from 50-60 social services agencies in Galveston County.

UT: UTAH DEPARTMENT OF HEALTH LOGIC MODEL



Inputs	Strategies	Short-term Results: Outputs & Outcomes	Project Specific Long-term Outcomes	EBHV Goals
▶ ACF, HRSA, FRIENDS, NFP, HFA, PAT, MPR-CH Team ♦ OHV, DOH, DHS, DSAMH, UPAT, CBCAP, Early Head Start, Early Intervention Services, Voices for Utah Children ● Salt Lake, Weber, Davis, Cache, Utah, and Uintah counties, United Way, Family Support Centers and other community-based agencies ■ 3 HFA sites with PAT curriculum, 1 NFP site, 4 UPAT sites, University of Utah	▶ Manage ACF grant ▶ Participate in cross-site evaluation ▶ Work with developers on program implementation ♦ Establish OHV to coordinate state home visiting service system ♦ Create EBHV steering and advisory committees for strategic planning and ACF grant oversight ♦ Seek TANF, other funding sources for home visiting ♦ Advocate for EBHV policies and programs ♦ Create OHV database and minimum data set to monitor local home visiting sites ● Help local EBHV sites to create linkages with local leaders and providers to increase coordination and referrals ● Identify rural communities with highest need for home visiting for EBHV expansion ■ Provide training grants, consultation and TA to EBHV sites, and some professional development to all home visiting programs ■ Design local evaluation ■ Seek funds to replace CBCAP grant for 4 home visiting sites (HFA and NFP)	▶ Partnerships with NFP, PAT, HFA developers ▶ ACF approved local evaluation design ♦ OHV designated as state lead for MIECHV ♦ State needs assessment, home visiting program inventory, State home visiting plan, and MIECHV SIR completed ♦ Existing TANF funding leveraged for OHV, EBHV ♦ State-level agency and political support for sustaining the OHV ● Options for expanding EBHV sites in current and future sites explored ● Increased coordination and referrals from local leaders, United Way, and providers ■ HFA, NFP, PAT services expanded to 250 families ■ 2 PAT sites expanded ■ OHV, PAT Visit Tracker and CIS/ETO data collected to monitor quality and fidelity of EBHV programs ■ Under revision to meet MIECHV Benchmark requirements	▶ Ongoing federal MIECHV funding secured ▶ Dissemination of cross-site evaluation findings ▶ EBHV developers support scale-up in Utah ♦ State, legislative support to grow EBHV services ♦ Multiple, diverse funding streams support home visiting ♦ Comprehensive, collaborative EBHV system is permanent part of state's continuum of care for families ♦ OHV data system expanded for PAT and MIECHV to monitor home visiting service quality statewide ● Increased community wareness and support for EBHV (NFP, HFA, PAT) ● Funding secured to expand home visiting to rural areas, rural services started ● Comprehensive, collaborative EBHV system at community level ■ HFA, NFP, PAT fidelity; quality improved in EBHV and other home visiting programs ■ Families benefit from home visiting services and have better child outcomes	**Implement EBHV programs with fidelity** **Scale up, expand EBHV programs with fidelity** **Sustain EBHV programs with fidelity**

CONTEXT

Notes: ACF = Administration for Children and Families at the U.S. Department of Health and Human Services; CBCAP = Community-Based Child Abuse Prevention; DOH = Utah Department of Health; DHS = Utah Department of Human Services; DSAMH = Utah Division of Substance Abuse and Mental Health; EBHV = Evidence-Based Home Visiting; FRIENDS = Family Resource Information, Education and Network Development Services (National Resource Center for Community-Based Child Abuse Prevention); HFA = Healthy Families America; HRSA = Health Resources and Services Administration; MIECHV = Maternal, Infant, and Early Childhood Home Visiting Program; MPR-CH = Mathematica Policy Research and Chapin Hall at the University of Chicago; NFP = Nurse Family Partnership; OHV = Office of Home Visiting; PAT = Parents as Teachers; PLN = Peer Learning Network; TANF = Temporary Aid to Needy Families; UPAT = Utah Parents as Teachers.