Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment

Replicating Home Visiting Programs With Fidelity: Baseline Data and Preliminary Findings

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ChapinHall at the University of Chicago

Replicating Home Visiting Programs With Fidelity: Baseline Data and Preliminary Findings

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Children's Bureau
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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)

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Deborah Daro
Bonnie Hart
Kimberly Boller
M.C. Bradley

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at the University of Chicago

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EXECUTIVE SUMMARY

The rapid expansion of early home visiting across the country has dramatically increased the level of public investment at both the state and, more recently, federal levels. Begun in 2008, the federal Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment (EBHV) initiative underscored the importance of states creating an infrastructure that would ensure that such increased investments resulted in sustainable, high quality, evidence-based home visiting programs. The EBHV program includes 17 subcontractors from 15 states. The home visiting models selected by the EBHV subcontractors for replication include Healthy Families America (HFA), Nurse Family Partnership (NFP), Parents as Teachers (PAT), SafeCare, and Triple P. Each subcontractor focuses on initiating or expanding the provision of one or more of these home visiting models and creating an infrastructure to sustain implementation beyond this immediate funding.

As part of its cross-site evaluation of this initiative, Mathematica Policy Research, in partnership with Chapin Hall at the University of Chicago, developed a common framework that states could use to monitor program implementation and fidelity across multiple evidence-based home visiting programs. Three core research questions guided the study:

1. Were the evidence-based home visiting programs selected by the subcontractors implemented and delivered with fidelity?

2. To what extent did the subcontractors modify national models to respond to their target populations and local service delivery contexts?

3. What contextual factors were associated with fidelity of implementation?

Fidelity is an important concept to track when taking a home visiting initiative to scale. As state administrators and local home visiting agencies implement Maternal, Infant, and Early Childhood Home Visiting (MIECHV), this information can be useful for targeting training and technical assistance and for performance reporting. This report describes how the EBHV cross-site evaluation is examining fidelity across a range of home visiting models. Program administrators can use fidelity data to demonstrate that public investments are achieving required service delivery levels associated with positive child and family outcomes. Systematically monitoring implementation across models can help state and local planners maintain quality standards and identify any need for adaptation to successfully engage and retain the target population. Using a common data collection framework enables planners to achieve the most efficient mix of interventions to maximize the fit between model characteristics, community resources, and population needs. Finally, tracking fidelity enables policymakers, program operators, and evaluators to clearly link practice to participant outcomes.

In the absence of careful monitoring of program implementation, an intervention can be considered ineffective when in fact the failure lies in the implementation process. Regularly assessing programs and holding them to clear performance standards gives program managers timely information necessary for identifying specific areas in which programs are not meeting expectations. In such cases, managers can provide appropriate technical assistance and enable programs to improve and succeed.

The purpose of this report is to present the underlying logic of the fidelity framework developed for this project; its key components and indicators; and its utility in summarizing the degree to which 44 implementing agencies (IAs) achieved, during the early phase of implementation, fidelity to their respective models in three important areas—home visitor and supervisory caseloads, service duration, and service dosage.

The EBHV Fidelity Framework

The framework was developed collaboratively by a small planning team of subcontractors and local evaluators led by members of the cross-site evaluation team. We also engaged in ongoing conversations with the national model developers to clarify common program characteristics and elements of fidelity appropriate for each model, drawing on the descriptive profiles of the models found in the literature. Our final selection of constructs and indicators focused on those elements appropriate across the EBHV models being implemented under the initiative and on those elements that could be captured in a reliable and consistent manner within the context of this evaluation.

In organizing this array of elements into a coherent framework, we clustered the constructs into two primary categories:

1. **Structural aspects** of the intervention that demonstrate adherence to basic program elements, such as reaching the target population, delivering the recommended dosage, maintaining low caseloads, and hiring and retaining well-qualified staff
2. **Dynamic aspects** of the provider-participant relationship and service content

In identifying specific indicators for each operational domain, we considered the following standards:

- **Explicit standard:** performance elements specifically identified in each model's program material or operational guidelines (caseloads, dosage, duration, and staff qualifications and training)
- **Implicit standard:** performance elements inferred from a review of each model's theory of change or underlying values as expressed in program material or operational guidelines (participant-provider relationship, responsiveness to participants' needs)
- **Efficiency or best practice standard:** performance elements cited in the literature as representing standards that improve the efficiency with which services are delivered (ability to identify and access target population and maintaining high enrollment and retention levels)

The specific standards used to select the constructs and related indicators incorporated in our fidelity framework reflect a mix of descriptive and benchmark performance measures. In some instances, the indicator is defined as the proportion of observations in which a common standard or benchmark was achieved (for example, percentage of home visitors with a bachelor's degree or proportion of cases retained at three months). In the majority of these instances, these indicators are included for descriptive purposes only in that one or more of the national models included in our sample have not established a consistent benchmark in these areas. As such, these indicators are not directly related to determining model fidelity but do provide important information on either staff characteristics or the service delivery process. In contrast, other indicators report the proportion of instances in which an IA achieved the standard set by its relevant national model (that is, the proportion of families who received the relevant model's recommended number of home visits during the initial enrollment period). To provide a more nuanced understanding of agency performance, we also examine the proportion of participants in which 90 or 80 percent of various model-specific standards were achieved.

The use of multiple indicators and rating systems provides important flexibility in maximizing the utility of this system for monitoring a program's fidelity. Rather than serving as a tool for making a single, summary judgment regarding implementation fidelity, the system is best conceptualized as a teaching or learning tool for guiding continuous program improvement.

Data Sources

Nine of the 17 subcontractors participating in the EBHV cross-site evaluation are the IA for the EBHV program and administer system-level and direct service activities. Eight subcontractors work with 2 to 14 IAs as part of the EBHV initiative. As of October 1, 2009, 50 IAs across the 17 subcontractors provided home visiting services to participants. Of these, 44 IAs agreed to provide data to the EBHV cross-site evaluation, including data that could be used to assess the fidelity with which home visiting models are being implemented. Three data sources (monthly program reports, the EBHV Fidelity Database, and the NFP – Efforts to Outcomes [ETO] system) provide elements for analysis of structural and dynamic aspects of fidelity. This report analyzes data describing service delivery between October 1, 2009 and December 31, 2010, at 44 IAs. Although most subcontractors used the cross-site evaluation EBHV Fidelity Database to provide some fidelity data about home visitors, supervisors, and participants, not all of the subcontractors or IAs provided all of the requested data. Data analyzed in this report reflect the characteristics and experiences of 1,795 participants; 227 providers; and 23,216 individual home visits.

Given the nature of the data presented, including small sample sizes or large differences in the amount of data provided per IA and across home visiting models, no statistical analyses were conducted for this report. As more data are available and analyzed for the final report, the cross-site team should be in a better position to assess representativeness of the data and determine whether statistical tests to assess differences across models or type of IA, for example, are warranted.

Preliminary Findings

The EBHV initiative was designed, in part, to explore whether high quality programs can be implemented in real-world settings and if this replication process can be facilitated or enhanced through the development of infrastructure improvements. Although these data are preliminary and reflect only the first 18 months of operation, the main findings include the following:

- Subcontractors and IAs embrace many of the practice elements recommended by the national models. Specifically, agencies are hiring qualified staff and enrolling participants consistent with the characteristics of those individuals targeted for and likely to benefit from services.
- Most families served by these home visiting programs face a number of socioeconomic challenges, including young maternal age, single parent status, limited education, and low income. Although the characteristics of participants varied somewhat across the five models in our sample, at least one-third of the participants served by each model experienced multiple socioeconomic risk factors.
- Most home visitors delivering all of the models had a bachelor's degree or higher, suggesting this workforce is primarily professional.
- Home visitors brought a range of skills to their jobs, including prior experience delivering home-based interventions and working with new parents.

- In the majority of cases, the ethnicity of the providers reflected the ethnicity of the home visiting program's target population.
- Most home visitors in our sample operated with caseloads below expected levels. Adjusting for variation in the recommended full-time caseload across models, 91 percent of the IAs maintained average caseloads at or below levels recommended by their respective models, whereas 78 percent had average caseload levels below the models' standards. Twenty of the 35 IAs in our sample reported that all of their home visitors had average caseloads below model standards.
- Approximately one-fourth of our participant sample left services before completing the recommended course of service. During the first six months of enrollment most families received less than 80 percent of the visits recommended by their respective models.
- Thus far we do not observe any discernible patterns in the characteristics of the families who received fewer services or who left these programs early. Indeed, the proportion of families experiencing these outcomes was consistent across all risk levels, suggesting the reason families remain actively engaged in voluntary programs is only partially determined by their personal characteristics.

Given the variability in the performance on key benchmarks observed across agencies implementing a common national model as well as multiple IAs operating under the auspice of a single subcontractor, these early findings do suggest that diverse factors influence the achievement of program fidelity. National model guidelines, training, and monitoring systems might not, in and of themselves, generate high model fidelity among their affiliates. Local organizational characteristics and contextual issues—such as the depth and quality of the local service system and the availability of qualified staff—also might contribute to how program models are implemented and sustained over time. In fact, selection of any specific home visiting program is not a random event. Local services agencies, their funders, and, in some cases, potential program participants choose the program they believe best fits their needs and strengths. This is particularly true in the case of the EBHV subcontractors, all of which had to author a collaborative proposal to secure funding.

When used for program improvement, the types of data described in this report can go beyond a performance monitoring function to inform program management and promote collective problem solving. Data such as these, collected and analyzed longitudinally, provide usable, actionable information at the family, staff, supervisor, and agency levels. The cross-site evaluation final report, expected for delivery to the Administration for Children and Families (ACF) and the Health Resources and Services Administration (HRSA) in spring 2013, will include a chapter on the fidelity findings using all of the data collected through June 2012 as well as multivariate analyses that bring together the fidelity, systems, and process study data. The 35 IAs that collected family-level fidelity data and agreed to participate in the cost study will contribute to analyses that assess home visit costs by model and by IA. These types of analyses, the first to use common measures and indicators across five different home visiting models, will contribute to MIECHV implementation as well as to the broader field of home visiting and provision of early childhood services. By focusing on staff- and family-level data paired with characteristics of home visits, the status of systems infrastructure development activities, and implementation successes and challenges, the EBHV final report will assess how variation in infrastructure development and degree of implementation predicts fidelity. The final report will build on the work conducted for this report and extend the lessons from it for practice, policy, and research.

I. INTRODUCTION

Central to the replication of evidence-based programs is the need to ensure that such replications faithfully adhere to the program's original operational guidelines and intent. Replicating with model fidelity is viewed as a necessary, if not sufficient, condition for ensuring that programs yield the range of outcomes observed in clinical trials of these efforts. To that end, most evidence-based programs take great care to ensure that organizations replicating their efforts have sufficient capacity to support the work; that direct service providers are well trained in the model and are provided adequate supervision to ensure their compliance with core practices, standards, and principles; and that program content is sufficiently detailed in clearly articulated service protocols. Although funding agencies and local officials often document the number of families reached with a given strategy, program developers often assume primary responsibility for working with local implementing agencies (IAs) and providers to ensure ongoing quality and model fidelity. In the area of prenatal and early childhood home visiting, the major national models have followed this pattern, establishing extensive training programs and, in the case of one model, a detailed management information system (Daro 2010).

The rapid expansion of early home visiting across the country has dramatically increased the level of public investment at both the state and, more recently, federal levels. The Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment initiative underscored the importance of states creating an infrastructure that would ensure that such increased investments resulted in sustainable, high quality, evidence-based home visiting programs. As part of its cross-site evaluation of this initiative, Mathematica Policy Research, in partnership with Chapin Hall at the University of Chicago, developed a common framework that states could use to monitor program implementation across multiple evidence-based home visiting programs. The purpose of this report is to present the underlying logic of this framework, its key components and indicators, and its utility in summarizing the degree to which 44 IAs achieved, during the early phase of implementation, fidelity to their respective models in three important areas–home visitor and supervisory caseloads, service duration, and service dosage.

Child abuse prevention policy and practice has undergone a gradual evolution over the past 50 years, responding to evidence supporting the positive impact on parent-child relationships and child outcomes of intervening early in a child's life. Beginning with Henry Kempe's landmark work on child maltreatment in the 1960s (Kempe 1976), supporting new parents has been an integral component of the prevention agenda. More recently, advances in neuroscience, molecular biology, and genomics now give us a much better understanding of how early experiences, for better or worse, are built into our bodies and brains, and further underscore the importance of providing support to pregnant women and new parents (Shonkoff et al. 2011). The empirical base on how best to provide this support also has improved. The seminal work of David Olds and his colleagues showing initial and long-term benefits from regular nurse home visiting initiated during pregnancy and continued through a child's first two years of life provided robust empirical support for intervening early (Olds et al. 2007). Although impressive, such evidence may not have been sufficient leverage for change had the political and practice climates not been receptive to its message. Hawaii's success in establishing the first statewide early childhood home visiting system and the longstanding efforts of early national home visiting models such as Parents as Teachers, the Parent Child Home Program, and the Home Instruction for Parents of Preschool Youngsters program (HIPPY) shaped the policy landscape by demonstrating that such programs could be established in diverse contexts and embedded within existing educational and health care delivery

systems. These efforts also demonstrated that most new parents, regardless of socioeconomic circumstances were receptive to offers of support (Daro 2011).

This evidence base has been met by a corresponding emphasis on investing in models that have documented their success by applying increasingly rigorous evaluation strategies. Over the years, program evaluators have placed greater emphasis than in the past on establishing formal control groups, developing more precise measurement tools, and applying more rigorous designs in assessing program impacts. Across a range of social service and health interventions, state and federal policies increasingly directed investments toward programs that have the most robust evidence of impacts and that adhere to a growing set of formal performance standards. Decisions to initiate or continue a given social service or health program increasingly center on the quality of the data supporting both its efficacy and effectiveness.

Despite a great deal of progress and the emergence of evidence-based models that demonstrate modest impacts on targeted outcomes, a significant gap persists in outcomes for the most vulnerable children and families compared to their peers (Halle et al. 2009; Love et al. 2005). As policymakers, program developers, and researchers assess next steps, one question is whether the existing interventions are fully implemented as planned. That is, could part of the persistence of outcome gaps and relatively modest impacts be the result of implementation failures (Durlak and DuPre 2008)? Across disciplines (prevention, child welfare, and early childhood care and education), the assessment of fidelity to evidence-based interventions has emerged as a central issue with the potential for improving service delivery, family engagement, and outcomes (Bagnato et al. 2011; Berkel et al. 2011; Fixsen et al. 2005; Fixsen et al. 2009).

A. The EBHV Initiative

The Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment (EBHV) initiative was designed to build knowledge on how best to identify and construct the infrastructure needed to implement, scale up, and sustain evidence-based home visiting programs with high fidelity. Initially funded by the Children's Bureau within the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (HHS), the program is now funded through the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) included in the Affordable Health Care Act 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 program includes 17 subcontractors from 15 states. The home visiting models selected by the EBHV subcontractors for replication include Healthy Families America (HFA), Nurse Family Partnership (NFP), Parents as Teachers (PAT), SafeCare, and Triple P.[1] Although all

[1] These are not the only national models in operation. Other national home visiting models with comparable goals and target populations include, among others, the Parent-Child Home Program, HIPPY, and the federal Early Head Start home visiting option. The summer 2008 federal grant announcement required applicants to select home visiting programs that met specified criteria to be considered an evidence-based model. During the grant review process, an independent panel of peer reviewers evaluated applications based on the criteria listed in the announcement to determine if the programs proposed by the applicant met standards related to evidence-based models. The criteria used in the 2008 federal grant announcement were not related to the criteria for evidence of effectiveness for MIECHV.

of these models use home visiting to enhance parental capacity and promote healthy child development, they differ in terms of their theoretical approach, target population, service duration, and outcome priorities. Key features of these models include the following:

- **Healthy Families America (HFA)** is a multiyear, intensive, home-based program for new parents identified during pregnancy or birth who demonstrate an elevated risk for maltreatment on the basis of a standardized risk assessment administered to all children born within the program's service area. Services focus on promoting healthy parent-child interaction and attachment, increasing knowledge of child development, improving access to and use of services, and reducing social isolation.
- **Nurse Family Partnership (NFP)** is a multiyear, intensive, home-based program targeting pregnant first-time, low-income mothers who self-refer or are directed to the program by local health and social service programs or practitioners. Services focus on improving parent-infant bonding, improving maternal health behaviors and life choices, and improving cognitive skills and healthy child development.
- **Parents as Teachers (PAT)** is a multiyear, intensive, home- and group-based program provided to any parent who requests assistance with child development knowledge and parenting support. Services focus on increasing parental knowledge of early childhood development, improving parenting practices and skills, and providing early detection of developmental delays and health issues among children.
- **SafeCare** is a 24-week program providing bimonthly home visits for families with children from birth to age 5 that focuses on altering parental behavior in three core domains: (1) health, (2) safety, and (3) parent-child interaction. Home visits focus on training parents to use health reference materials and access appropriate treatment, identify and eliminate safety and health hazards, and increase positive parent-child interactions.
- **Triple P**, as implemented within the context of this initiative, provides weekly home visits for 24 to 26 weeks targeting families with children up to age 8. Services focus on promoting the development, growth, health, and social competencies of children and improving parental competence, resourcefulness, and self-sufficiency.

As we note throughout the report, these and other variations across the models, implementing agencies, and community contexts affect the characteristics of the families enrolled in services, the home visitors employed by the programs, and the specific activities implemented during the home visits. More specific descriptions of these models are presented in Appendix B.

Each subcontractor focuses on initiating or expanding the provision of one or more of these home visiting models and creating an infrastructure to sustain implementation beyond this immediate funding. As noted in Table I.1, the subcontractors differ in their specific role with respect to program operations and in the number of models they elected to implement. Seven subcontractors are local or state public entities responsible for directly implementing the home visiting services or for funding local community agencies to deliver those services. In these cases, the subcontractors also have a strong oversight role in managing these investments and in creating an infrastructure to support ongoing implementation and expansion. In contrast, 10 subcontractors are private health care, community service, or academic institutions that either provide direct services (as is the case with 6 subcontractors) or partner with other local public or private providers to

implement home visiting services. These subcontractors also are engaged in a variety of other activities to support program sustainability and infrastructure development at the local community or state level (Del Grosso et al. 2011; Paulsell et al. in preparation). The diversity of these 17 subcontractors provides a rich context for examining the implementation pace and quality of home visiting models developed under a variety of management scenarios.

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

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

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

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

Similar diversity exists in the group of IAs the subcontractors engaged in delivering their selected home visiting program models. Forty-four of these IAs have contributed data to this report (Table I.2 and Appendix A). Although this pool of agencies is not a random sample of all agencies working with EBHV subcontractors to provide their selected home visiting models, they capture the range of agencies engaged in this work. For example, the analysis sample for this report include a range of public agencies, such as public health departments or local school districts, as well as community-based agencies such as family support centers, local medical centers, or YWCAs. The implementing agencies in this sample are located in a variety of geographic settings including densely populated urban neighborhoods, rural communities, and small towns. Many have prior experience with home visiting and the target populations being served. Of the 44 IAs in the sample, 52 percent

had previously used the national model that is being supported through the subcontractors' EBHV efforts, and 48 percent were new providers of these models.

B. EBHV Cross- Site Evaluation

Mathematica Policy Research and its partner Chapin Hall at the University of Chicago are conducting a cross-site evaluation of the initiative. The study is designed to document the subcontractors' implementation efforts and identify those strategies most successful in achieving the initiative's core objectives of building infrastructure to support the widespread adoption, implementation, and sustainability of home visiting programs. In keeping with the increased emphasis within the social service community on encouraging continuous program improvement, the evaluation is utilization-focused and structured in a way to provide meaningful and time-sensitive feedback to the subcontractors and their IAs. Reflecting the overall goals of the initiative, the cross-site evaluation focuses on three components—fidelity, system and infrastructure development, and program costs[2] (Koball et al. 2009). In addition, the evaluation also includes a process study to document implementation challenges and successes.

With respect to program fidelity, the study team was guided by three core research questions:

1. Were the evidence-based home visiting programs selected by the subcontractors implemented and delivered with fidelity?
2. To what extent did the subcontractors modify national models to respond to their target populations and local service delivery context?
3. What contextual factors were associated with fidelity of implementation?

This report describes the development and structure of the fidelity monitoring system implemented by the cross-site evaluation team and presents a look at early implementation of the home visiting models based on data obtained through this system. The diversity of program models supported under this effort provides an important and unique opportunity to create a fidelity framework that is applicable across models. Also, the system captures the characteristics of participants, providers, and service delivery procedures of interest to those supporting these and other interventions focusing on early parent support. The framework and resulting data bring a new

[2] Family and child outcomes were originally included in the evaluation design but had to be dropped because of changes in the funding available for the cross-site evaluation.

Table I.2. Implementing Agency Characteristics

State	Subcontractor/Implementing Agency	National Model	Year of Initial Program Certification	Adaptations Planned
CA	**County of Solano Department of Health and Social Services**	NFP	2010	Targeting a new population (foster youth)
CA	**Rady Children's Hospital, San Diego**			
	Fresno County Department of Children and Family Services	SC	2010	None
	Madera County Department of Social Services	SC	2010	None
	Tulare County Health and Human Services Agency	SC	2010	None
CO	**Colorado Judicial Department**			
	Denver Juvenile and Family Justice TASC	SC	2009	None
DE	**Children & Families First**	NFP	2010	None
HI	**Hawaii Department of Health**			
	Child and Family Service	HFA	2010	Adding supports to reduce environmental stressors
	YWCA Hawaii Island	HFA	2010	Same as above
IL	**Illinois Department of Human Services**			
	Advocate Illinois Masonic Medical Center	HFA	2001	None
	ChildServ	PAT	2005	None
	Clay County Health Department	HFA	1999	Provide additional concrete supports (car seats)
	Evanston District 65	PAT	2007	None
	Family Focus Aurora	HFA	2001	Enhanced outreach to reach teen population
	Family Focus Aurora	PAT	2006	None
	Healthy Families Chicago	HFA	1995	None
	Kane Kares	NFP	2000	None
	Mt. Vernon United Methodist	NFP	2007	None
	Parent University/Jump Start	PAT	2004	None
	Shawnee Adolescent	HFA	1994	None
	Visiting Nurses Association	HFA	1994	Doula services, mental health consultant

State	Subcontractor/Implementing Agency	National Model	Year of Initial Program Certification	Adaptations Planned
	Williamson Early Childhood	PAT	2005	Adopted three additional curricula: Groups for Young Moms and Young Dads, Money Management, and High 5 Low Fat nutrition program.
	YWCA	PAT	2008	Enhanced staff training (for example, certification on Ages and Stages screening; training for CPR, AED, choking and basic first aid)
MN	**Minnesota Department of Health State Treasurer**			
	St. Paul–Ramsey Counties	NFP	2008	None
	Supporting Hands	NFP	2008	None
NJ	**New Jersey Department of Children and Families**			
	Caring for Kids, Inc.	PAT	2003	Established formal partnership with counseling services
	Hudson Perinatal Consortium	NFP	2009	None
	United Way of Greater Union County	NFP	2010	None
NY	**Society for the Protection and Care of Children, Rochester**	PAT	2001	Offered participants additional clinical interventions (Incredible Years [IY], Interpersonal Psychotherapy [IPT], and Child-Parent Psychotherapy [CPP]).
OH	**Mercy St. Vincent Medical Center, Toledo**	HFA	2011	None
OK	**The University of Oklahoma Health Sciences Center**			
	Latino Community Development Agency	SC	2009	Cultural adaptation for Hispanic populations; also augmented program to address violence prevention and utilized motivational interviewing
RI	**Rhode Island KIDS COUNT**			
	Children's Friend and Service	NFP	2010	Augmented staff with dedicated interpreter, part-time social worker
SC	**The Children's Trust Fund of South Carolina**			
	Greenville Hospital System	NFP	2009	None
	South Carolina Department of Health & Environmental Control—Anderson County	NFP	2009	Enhanced basic support and referrals
	South Carolina Department of Health & Environmental Control—Berkeley/Charleston/Colleton/Dorchester Counties	NFP	2009	Enhanced basic supports and referrals

State	Subcontractor/Implementing Agency	National Model	Year of Initial Program Certification	Adaptations Planned
	South Carolina Department of Health & Environmental Control—Horry County	NFP	2009	Enhanced basis supports and referrals
	South Carolina Department of Health & Environmental Control—Lexington/Richland Counties	NFP	2009	Enhanced basic supports
	Spartanburg Regional Health Services	NFP	2009	None
TN	**Child and Family Tennessee**	NFP	2010	Offered Centering Pregnancy to participants lacking prenatal care.
TN	**Le Bonheur Community Health and Well- Being, Memphis**			
	Le Bonheur Center for Children and Parents	NFP	2010	Mental health consultation
TX	**DePelchin Children's Center, Texas**	Triple P	2009	Expand concrete resources (for example, gift cards and basic household goods)
UT	**Utah Department of Health**			
	Salt Lake Valley Health Department	NFP	2008	None
	Cache County	HFA	2009	None
	Weber County	HFA	2009	None
	Davis County	HFA	2009	None

Source: Monthly program reports, conversations with IA/subcontractor staff.

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

perspective on monitoring program implementation by creating a way for both states and individual evidence-based models to share responsibility for replicating programs with fidelity. By applying a common framework across models, this system underscores the importance of understanding key differences in participant characteristics, service focus, and content when considering program outcomes across different IAs or program models.

C. The Current Report

The report begins with an overview of the fidelity concept and how it was defined and applied in this specific study (Daro 2010). We then briefly describe our methodological approach and discuss the data limitations with respect to the study's core questions. We next provide descriptive information on the IAs, program models, participants, and providers included in our sample. Next, we present summary scores on indicators relating to three major structural fidelity constructs—home visitor and supervisory caseloads, service duration, and service dosage. Finally, we outline the utility of these data for improving program performance and state oversight of evidence-based home visiting programs.

The current data represent an initial review of implementation fidelity during the initiative's early stage, reflecting each IA's operations from October 1, 2009, through December 31, 2010, and thus provide a first look at early implementation of the EBHV initiative. Although more than half of the IAs had been operating for one or more years at the time we initiated data collection, others were just enrolling their first participants. As such, some of these data may reflect early implementation challenges as opposed to an agency's ultimate capacity to implement the various national home visiting models as designed. Participant recruitment, home visitor caseloads, participant retention, and the number and frequency of home visits may be less robust during initial implementation as agency staff work to familiarize themselves with the model and integrate themselves into a community's existing social service network. An additional limitation in this initial pool of data is the inconsistency with which some elements were collected or key elements were defined across all IAs. In reporting our findings, we have noted the inconsistencies; during the data collection process, we worked with subcontractors and their IAs to clarify data collection procedures moving forward.

II. EBHV FRAMEWORK FOR ASSESSING PROGRAM FIDELITY

At the most basic level, faithfully replicating programs that have been found effective in rigorous experimental studies is believed to provide a higher likelihood of achieving desired outcomes than replicating efforts which lack a strong evidentiary base (Fixsen et al. 2005). Investing in direct service programs with a proven track record offers policymakers a hedge on their investment and offers increased confidence that outcomes also can be replicated, offering program benefits to a larger proportion of the target population. Central to this hypothesis, however, is ensuring that sites replicating a model maintain fidelity to its original design and intent. Systematically monitoring implementation can help maintain program consistency and quality and identify any need to adjust the model's protocols. Indeed, agencies often modify program standards and content to fit local participants' needs, organizational capacity, and community context. In some cases, agency staff identify changes needed to accommodate the characteristics of their community and target population. In other cases, funding cuts or staff shortages drive the need for modifications. Although some model modifications can strengthen a program's effects, others, particularly unplanned changes, can have detrimental effects and may reduce the likelihood of achieving maximum impact.

An additional underlying, but often not explicit, assumption behind the replication process is that tested models have been defined with the specificity necessary to guide future replication efforts. Program models tested through randomized control studies may be replicated based on their theory of change or intended level of service content and dosage, not necessarily the way in which the program was implemented in the course of the trial. Because randomized trials judge the effectiveness of a program based on the average performance of the intervention and the control groups, limited attention is focused on any variability in the service experience of the intervention group, particularly when that group outperforms the control group. As such programs are taken to scale, understanding this type of variability becomes more critical to determining if replication efforts are of sufficient dosage and duration to achieve the desired impacts. Although often not achieving a model's expected service standards, well-implemented replication sites may operate in a manner quite similar to the way the program was implemented in one or more of its randomized trials. Because reports on these initial clinical trials often fail to document the quality of the program's implementation, local program managers have insufficient information for guiding their direct service work and investment decisions. As replication efforts of evidence-based programs become more commonplace, it is increasingly important to design and implement frameworks for defining program fidelity as well as data management systems that can track the implementation process at the level of specificity needed to ensure consistent replication.

A. Defining Fidelity

Researchers use several theoretical frameworks to define fidelity and address issues of appropriate modification. In summarizing work in this area, Carroll and colleagues identified five elements of implementation fidelity: (1) adherence to the service model as specified by the developer; (2) service exposure or dosage; (3) the quality or manner in which services are delivered; (4) participants' response or engagement; and (5) the understanding of essential program elements not subject to adaptation or variation (Carroll et al. 2007). The rise of implementation science and the need to replicate and scale up evidence-based programs with fidelity across a range of different disciplines from behavioral health and prevention to early childhood care and education has led to the proliferation of frameworks that attempt to identify a broad range of key implementation components (Bagnato et al. 2011; Berkel et al. 2011; Damschroder and Hagedorn 2011; Dane and Schneider 1998; Gearing et al. 2011; Hagermoser Sanetti and Kratochwill 2011). Many of these

frameworks relate specifically to the characteristics of the specific service model being implemented, and many include elements such as staff skills and training, supervision, service dosage and duration, as well as the manner in which services are provided and participants engaged. Researchers designing the national evaluation of MIECHV have further extended this work by advancing the idea of measuring implementation inputs that go beyond the specific service model itself and include the capacity of the implementing organization to provide an array of additional supports for staff as well as participants (Duggan and Supplee 2012; Knox et al. 2011). According to that framework, the capacity of the organization delivering the service, coupled with the service parameters and guidelines that constitute a specific intervention, offer a more inclusive array of those factors that may determine the characteristics and quality of the actual services delivered to families and children.

One of the most common ways in which funders assess the fidelity of a specific replication effort is its ability to provide participants the recommended level of service or dosage. As implementation science has progressed, this concept has become increasing more complex. Today, dosage is conceptualized in a variety of ways (Wasik et al. forthcoming). Generally dosage refers to the amount of an intervention. It is important to distinguish between the intervention *dosage intended* or required per the evidence-based model being implemented, the *dosage offered* by the service provider, and the *dosage received* by the intervention recipient. Dosage intended refers to how much and how often an intervention is intended to be offered according to the designers of the intervention or its funders. Dosage offered refers to how much of the intended intervention a provider actually makes available to families and children. Dosage received refers to how much of an intervention participants actually receive given how often services are offered and the challenges participants face in terms of taking them up—for example, a child's illness, which can prevent a family's receipt of an offered service.

For the purposes of this evaluation, we use the following definition of fidelity:

> *"Fidelity" refers to the extent to which an intervention is implemented as intended by the designers of the intervention. Fidelity refers not only to whether or not all the intervention components and activities were actually implemented, but whether they were implemented in the proper manner* (Daro 2010).

Although the home visiting models implemented in this initiative differ in terms of content and structure, they share certain core principles. Among the five models being implemented by the EBHV subcontractors, common practices or objectives of high quality implementation include the following:

- Belief that outcomes will be influenced by such factors as relatively low caseloads for home visitors
- Strong supervision
- Relative stability among an agency's home visitors and supervisors, which reduces the need to change a participant's home visitor during the enrollment period
- Ability actually to enroll a high proportion of the families referred for service
- Ability to maintain consistent contact with enrolled families as prescribed by the home visiting program model

In addition, many home visiting models set expectations regarding the importance of providing a sufficient service dosage to accomplish their stated objectives. Several models, such as HFA, NFP, and PAT, serve participants for multiple years in order to achieve the type of attitudinal and behavioral changes identified in their respective theories of change. In other cases, such as SafeCare and Triple P, service duration is determined by the point at which a program participant can demonstrate mastery of core concepts. Some families may master these skills in 2 or 3 visits, while others require up to 12 visits. Despite this variation in duration and dosage, most of the models require programs to offer services on a weekly or biweekly basis during the initial service period to facilitate participant engagement.

Finally, implementing evidence-based models with fidelity requires attention to factors that govern the participant-provider interaction and capture the manner in which participants' needs are identified and addressed during the home visiting process. The quality of the relationship between the home visitor and the parent may influence the effectiveness of home visiting services and the extent and quality of parent engagement and involvement (Korfmacher et al. 2007; Korfmacher et al. 2008; Roggman et al. 2008). Although there is variation across models about the appropriate content for each visit, all share common approaches with respect to careful assessment and responsive and respectful practice. For example, SafeCare guidelines instruct the home visitors to "encourage the parent to ask questions and express concerns" and ask that the provider's demeanor communicate "empathy, warmth, and understanding." PAT requires that parent educators "build and maintain rapport through interaction that is responsive to each family member's personal style." In short, each model places a high value on creating services that are relationship-based and emphasize building and maintaining rapport between program staff and families.

B. The EBHV Fidelity Framework

Our framework was developed collaboratively, beginning with a small planning team of subcontractors and local evaluators, which was led by members of the cross-site evaluation team, who reviewed various options and identified core elements of interest to all parties.[3] We also engaged in ongoing conversations with the national model developers to clarify common program characteristics and elements of fidelity appropriate for each model, drawing on the descriptive profiles of the models found in the literature (HomeVee website; see Appendix B for additional detail on program requirements in key domains). We conducted repeated reviews at all stages of the framework's development with EBHV subcontractors and federal staff through conference calls and annual, in-person meetings. Our final selection of constructs and indicators focused on those elements appropriate across the EBHV models being implemented under the initiative and on those elements that could be captured in a reliable and consistent manner within the context of this evaluation.

In organizing this array of elements into a coherent framework, we clustered the constructs into two primary categories:

1. **Structural aspects** of the intervention that demonstrate adherence to basic program elements such as reaching the target population, delivering the recommended dosage, maintaining low caseloads, and hiring and retaining well-qualified staff

[3] In addition to the national cross-site evaluation, through local evaluations each subcontractor is evaluating its own process and outcomes.

2. **Dynamic aspects** of the provider-participant relationship and service content[4]

It is important to consider both aspects of fidelity—the degree to which key program elements are replicated and the degree to which the service delivery process captures the intended character of the service relationship—to determine whether a home visiting model has been implemented as designed. Increasingly, many program evaluations embrace this dual understanding of fidelity and have focused on documenting the service delivery process as well as the more standard benchmarks of service dosage and duration (Bagnato et al. 2011; Chen 2005; Hebbeler and Gerlach-Downie 2002; Lee et al. 2008; Paulsell et al. 2010; Riley et al. 2008). Understanding both the structural elements and the manner in which services are delivered is particularly important in relationship-based programs such as those being implemented by the EBHV subcontractors.

In determining the relevance of each indicator to the various national models reflected in our sample, we considered three standards:

1. **Explicit standard:** those performance elements specifically identified in each model's program material or operational guidelines (caseloads, dosage, duration, staff qualifications and training)
2. **Implicit standard:** those performance elements inferred from a review of each model's theory of change or underlying values as expressed in program material or operational guidelines (participant-provider relationship, responsiveness to participant needs)
3. **Efficiency or best practice standard:** those performance elements cited in the literature as representing standards that improve the efficiency with which services are delivered (ability to identify and access target population, maintaining high enrollment and retention levels).

The specific standard used to select the constructs and related indicators incorporated in our fidelity framework reflect a mix of descriptive and benchmark performance measures (Table II.1). In the first column in Table II.1, we identify the specific constructs and indicators associated with each of our two primary categories—structural fidelity and dynamic fidelity. For each indicator, we use the second column to report on the standard used in determining the selection of that indicator and the third column to define our assumptions regarding how the indicator might or might not be used to determine if a given agency achieved model fidelity. In some instances, the indicator is defined as the proportion of instances in which a common standard or benchmark was achieved (percentage of home visitors with a bachelor's degree, proportion of cases retained at three months). In the majority of these instances, these indicators are included for descriptive purposes only in that one or more of the national models included in our sample have not established a consistent benchmark in these areas. As such, these indicators are not directly related to determining model fidelity but do

[4] Some researchers refer to these two elements as implementation fidelity, capturing the structural aspects of a program such as dosage and duration, and intervention fidelity, focusing on the manner in which services are delivered. O'Donnell (2008) refers to them as fidelity to structure and fidelity to process.

Table II.1. Fidelity Domains and Related Indicators

Indicator	Selection Standard[a]	Operating Assumption for Compliance
STRUCTURAL FIDELITY		
Service Referrals		
Percentage of total referrals during the observation period meeting model standards for characteristics of the target population	Efficiency, best practice standard	Programs operate more efficiently if they are receiving more appropriate referrals.
Staff Qualifications and Training		
Percentage of home visitors with at least a BA	Descriptive only	Education and experience levels of staff can affect program performance.
Percentage of staff (home visitors and supervisors) completing basic model training	Explicit standard	Models require a core set of trainings on program components for all staff.
Percentage of supervisors with at least a BA	Descriptive only	Education and experience levels of staff can affect program performance.
Percentage of staff and supervisors completing required continuing education	Explicit standard	Models require a core set of trainings on program components for all staff.
Home Visitor Caseloads		
Mean monthly home visitor caseload	Descriptive only	Maintaining home visitor caseloads is important to program operation.
Percentage of home visitors at or below required caseload for full observation period	Explicit standard	Model developers established the following target caseloads for full-time home visitors: • HFA—25 families • NFP—25 families • PAT—24 families (assume 48 visits per month per worker, seeing families twice a month) • SafeCare—19 families • Triple P—9 families for HV with BA; 10 families for HV with MA
Supervisory Caseloads		
Mean monthly supervisor caseload	Descriptive only	Maintaining supervisory caseloads is an important piece in program operation.

Indicator	Selection Standard[a]	Operating Assumption for Compliance
Percentage of supervisors at or below required caseload for full observation period	Explicit standard	Model developers established the following target caseloads for full-time supervisors: • HFA—6 HVs • NFP—8 HVs • PAT—6 HVs • SafeCare—6 HVs • Triple P—7 HVs
Supervisory Levels		
Mean hours of one-on-one supervision per month for home visitors	Efficiency, best practice standard	Regular one-on-one supervision is an important way for supervisors to monitor home visiting activities within a program.
Percentage of home visitors receiving at least one hour of one-on-one supervision for each week during the observation period	Efficiency, best practice standard	All home visitors should have access to regular supervision.
Mean number of group staff meetings per month over observation period	Efficiency, best practice standard	Group meetings, in addition to one-on-one supervision, provide opportunities for learning and sharing among staff.
Participant Enrollment and Duration		
Percentage of referrals receiving an initial home visit within one month of referral date	Implied standard	Not all models set specific expectations for the timing of the first home visit, but they do support timely enrollment.
Percentage of participants with at least one home visit who remain enrolled for at least three months or were still enrolled at the end of the observation period	Explicit standard	While there is variation in the recommended length of each program, all models assume contact with families will occur for at least three months (12 weeks).
Percentage of participants with at least one home visit who remained enrolled at least six months or were still enrolled as appropriate at the end of the observation period	Explicit standard	Models are designed to engage families for varying lengths of time. This standard applies to HFA, NFP, and PAT, all of which seek to retain families for at least 2-1/2 years.
Percentage of participants leaving the program who did not successfully complete the program	Implied standard	It is an implicit goal of all models to retain participants until program goals are achieved or curriculum is completed.
Mean duration for participants who left program during observation period (date of first visit to termination date)	Explicit standard	Programs aim to engage families for certain lengths of time. If participants are enrolled for too long or too short of a time, the program may need to investigate why that is.

Indicator	Selection Standard[a]	Operating Assumption for Compliance
Service Dosage		
Number of visits provided or weeks of enrollment (date of first visit to date of exit or end of observation period)	Descriptive only	Regular contact with families is the main focus of all program models. Comparing the number of visits per week for participants with varying service outcomes will give an indication whether service intensity differs for those who successfully complete the program versus those that do not.
Mean length of time between completed visits	Descriptive only	Length of time between visits is another way to look at the regularity of contact programs are having with families.
Percentage of participants who received the intended service dosage during initial six months of enrollment Percentage of participants who received at least 90 percent of the intended service dosage during initial six months of enrollment Percentage of participants who received at least 80 percent of the intended service dosage during initial six months of enrollment	Explicit standard	Model developers established the following expectations for average participant dosages: • HFA—24 visits • NFP—18 visits (estimated based on average gestational age at enrollment) • PAT —12 visits • SafeCare—average of twice a month for duration (12 visits) • Triple P—weekly for duration (26 visits)
Visit Planning		
Percentage of planned visits completed across all participants Percentage of participants where at least 50 percent of planned visits are completed Percentage of participants where at least 75 percent of planned visits are completed	Efficiency, best practice standard	Delivering services as scheduled is the most efficient way for programs to operate.
Percentage of completed home visits lasting at least one hour	Explicit standard	All models are designed with visits lasting at least one hour.
DYNAMIC FIDELITY		
Provider Perception of Relationship		
Percentage of providers rating WAI Tasking Subscale items on average $\geq$ 6[b] Percentage of providers rating WAI Bonding Subscale items on average $\geq$ 6[c]	Implied standard	All models reflect a commitment to a service delivery process that is perceived by the provider as collaborative, strength-based, and mutually respectful.

Indicator	Selection Standard[a]	Operating Assumption for Compliance
Percentage of providers rating WAI Goal Setting Subscale items on average $\geq$ 6 [d]		
Percentage of providers rating all WAI items on average $\geq$ 6		
Percentage of home visitors who consistently report very positive views (6 or 7) on more than two-thirds of the WAI items across all families		
Participant Perception of Relationship		
Percentage participants rating WAI Tasking Subscale items on average $\geq$ 6	Implied standard	All models intend the relationship to be positively perceived by the participant as well.
Percentage participants rating WAI Bonding Subscale items on average $\geq$ 6		
Percentage participants rating WAI Goal Setting Subscale items on average $\geq$ 6		
Percentage participants rating all WAI items on average $\geq$ 6		
Shared Perceptions		
Percentage of pairs with shared expectations on Goal Setting Subscale (sum within 4 points)	Implied standard	Providers and participants should have a shared understanding of key aspects of the service delivery experience—establishing a common understanding of the purpose of the intervention, developing a specific work plan, and building a strong relationship.
Percentage of pairs with shared expectations on Tasking Subscale (sum within 4 points)		
Percentage of pairs with shared expectations on Bonding Subscale (sum within 4 points)		
Content of Home Visits		
Mean percentage content covered across all visits	Implied standard	All the models have a core curriculum and content they want to deliver.
Percentage of visits in which 80 percent of planned content is delivered		

Indicator	Selection Standard[a]	Operating Assumption for Compliance
Responsiveness of Provider		
Percentage of visits involving unplanned or emergency assistance Percentage of participants in which at least one visit involved addressing an emergency Percentage of home visitors who addressed an emergency for 50 percent or more of their clients during the reporting period	Implied standard	Models note that they are responsive to families and deal with emergencies as they surface. How often providers observe and address these issues is important to observe.

[a] Additional descriptive information on how each model has defined core elements of the service delivery process is provided in Appendix B.

[b] Tasking Subscale items include questions related to perceptions of what needs to happen to reach service goals, relative priorities among goals, the capacity of the participant to obtain a new perspective, and the perception that things are moving along the right path.

[c] Bonding Subscale items include questions related to perceptions regarding the degree to which the participant and provider like each other, appreciate each other, trust each other, and feel confident in their ability to do the job or make the changes needed.

[d] Goal Setting Subscale items include questions related to perceptions of the degree to which the participant and provider agree on service goals, jointly develop mutual goals, and agree on the level of change needed to achieve goals.

BA = bachelor's degree; HFA = Healthy Families America; HV = home visitor; MA = master's degree; NFP = Nurse Family Partnership; PAT = Parents as Teachers; WAI = Working Alliance Inventory.

provide important information on either staff characteristics or the service delivery process. In contrast, other indicators report the proportion of instances in which an IA achieved the standard set by its relevant national model (that is, the proportion of families who received the relevant model's recommended number of home visits during the initial enrollment period). To provide a more nuanced understanding of agency performance, we also examine the proportion of participants in which 90 percent or 80 percent of various model-specific standards were achieved.

The use of multiple indicators and of multiple rating systems provides important flexibility in maximizing the utility of this system for monitoring a program's fidelity. Rather than serving as a tool for making a single, summary judgment regarding implementation fidelity, the system is best conceptualized as a teaching or learning tool for guiding continuous program improvements.

By focusing on fidelity standards or program elements common across a number of home visiting programs, the study offers state agencies as well as local and private funders that support a range of home visiting programs a common framework for tracking implementation fidelity across multiple models.[5] The ability to compare and contrast implementation elements across models may become more critical as states work to expand the availability of these services to more diverse populations and in more diverse community contexts.

[5] States are just one actor in implementing interventions; many service providers are locally or privately funded. This report focuses on implications for states in the context of implementing home visiting as part of MIECHV and the legislative emphasis on building statewide service delivery systems. However, the benefits of this study's conceptualization of fidelity are equally useful to any public or private funders of home visiting services.

III. DATA COLLECTION AND ANALYSIS METHODS

This chapter summarizes the data collection and analysis methods the cross-site evaluation team used to address the core research questions presented in Chapter I. Appendix A presents the methods in detail. Subcontractors, and their IAs, agreed to provide data to the EBHV cross-site evaluation, including data that could be used to assess the fidelity with which home visiting models are being implemented. Three data sources (monthly program reports, the EBHV Fidelity Database, and the NFP Efforts to Outcomes [ETO] system) provide elements for analysis of structural and dynamic aspects of fidelity. This report analyzes data describing service delivery for families who were new to the EBHV program between October 1, 2009 and December 31, 2010 at 44 IAs.

A. Fidelity Data Collection Approach

Fidelity data are collected locally by staff at IAs and transmitted to the EBHV cross-site evaluation team directly, through the subcontractor, or through the model developer. Data are transmitted on a monthly or quarterly basis. To maximize the collection of high quality data, in February 2010 the cross-site evaluation team hosted a webinar for subcontractors that focused on fidelity data collection and introduced the fidelity manual and data collection forms (Barrett, Zaveri, and Strong 2010). The training focused on the fidelity measures as well as procedures for training data collection staff at IAs, strategies for high quality data collection, and common data collection challenges. The cross-site evaluation fidelity training manual contained all necessary data collection forms (Appendix C).

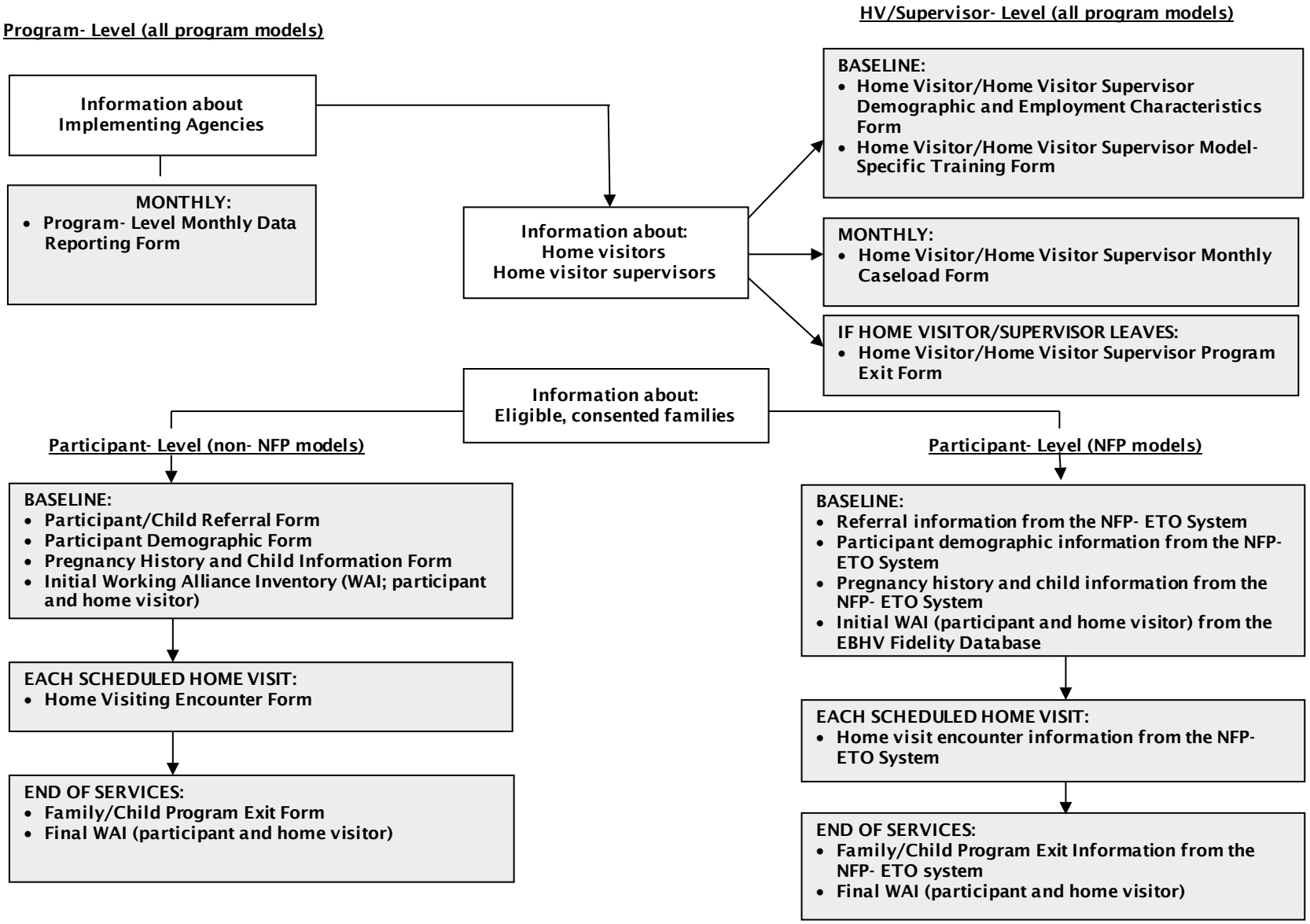
The fidelity data collection process involves obtaining program-, home visitor/supervisor-, and participant-level information (including information about each home visit) and the data collection schedule varies based on the relative stability of the information). (Figure III.1 provides a data collection schematic.) For example, demographic information for both home visitors and participants is collected only once in the EBHV Fidelity Database. However, home visitor and supervisor monthly caseloads are collected monthly, and home visit encounter information is collected for each scheduled home visit—regardless of whether the home visitor actually met with the participant. In addition, subcontractors implementing the NFP model only collect program-level and home visitor or supervisor information in the EBHV Fidelity Database. Participant-level data, with the exception of the Working Alliance Inventory[6] (WAI; adapted from Santos 2005), is provided to the cross-site evaluation team by the NFP's National Service Office (NFP-NSO) through the NFP-ETO data system.[7]

The majority of subcontractors are using the cross-site evaluation EBHV Fidelity Database to provide some fidelity data about home visitors, supervisors, and participants. Not all of the subcontractors or IAs provided all of the requested data. From the database, four extracts are

[6] As of December 31, 2010, few participants had left the program and therefore complete data (baseline and at exit) were not available and thus the WAI is not presented in this report but will be included in the cross-site evaluation final report.

[7] NFP shifted from the NFP-CIS (Client Information System) to the NFP-ETO system during early 2011. All NFP-CIS data were migrated into the NFP-ETO system and the EBHV cross-site evaluation team received extracts from the NFP-ETO system.

Figure III.1. Timing and Types of Data Collection



generated that contain the data on home visitors, supervisors, and participants (with identifying information removed). These extracts are sent to the cross-site evaluation team on a quarterly basis. A few subcontractors submit one or more of the required extracts in an alternative format from their pre-existing data collection system.

The EBHV cross-site evaluation team processes the data received. Data from all sources (monthly program reports, EBHV Fidelity Database, NFP-ETO, and pre-existing subcontractor data systems) are reviewed for errors, which are communicated to the subcontractor and data providers and resolved if possible. To support development of constructs based on similar data elements from multiple systems (for example, NFP-ETO, EBHV Fidelity Database, and subcontractors' pre-existing data systems) the data are cleaned and recoded to the extent possible.

Sample Variation in Data Elements Provided Across IAs. Although all 17 participating subcontractors agreed to share data with the cross-site evaluation team, not all IAs collected or contributed all data elements. This report is based on the data for participants served between October 1, 2009 and December 31, 2010 that the cross-site evaluation team had in-hand as of March 2011. The cross-site evaluation team received some data from all 17 subcontractors. Forty-four IAs, representing all five home visiting models, contributed data toward at least one part of the fidelity analysis. Appendix A provides an analysis of the reasons data are missing. Participant data are provided by 27 IAs. Thirty-five IAs provided staff data to the cross-site evaluation team through the EBHV Fidelity Database. Thirty-five IAs submitted monthly caseload data to the cross-site evaluation team for one or more periods. Twenty-seven IAs provided data on at least one home visit offered during the time period. Thirty-seven IAs provided at least one monthly program report.

B. Data Quality and Analytic Approach

The cross-site evaluation team examined the data to determine whether they were of sufficient quality to support the examination of a particular structural or dynamic fidelity indicator. Members of the team examined the frequencies and range of the data items that contributed to each indicator across the full dataset to see if there were patterns suggesting an indicator was problematic at any level—that is within an IA, across a particular home visiting model, across IAs within a subcontractor, or overall. The cross-site team worked closely with the NFP-NSO and the subcontractors to identify any irregularities or missing data problems and address them. Appendix A includes a summary of the strategies we used to ensure data quality.

The cross-site team conducted descriptive analyses of the analytic variables and fidelity indicators included in this report. Descriptive information is always presented at the participant, staff member or home visit level. For some IAs, not all participant or staff data was available. The prevalence of missingness in these data was problematic for some analyses. In order to report as much information as possible, items are presented even when they include missing data. The sample sizes listed in tables are the maximum sample sizes, but the actual sample varies by item. In some cases, when the sample size is significantly lower than the maximum due to missing data (defined as >20% missing), the distribution in the table is marked with an asterisk and should be interpreted carefully.

In addition to the data on staff and family characteristics, a risk scale was created to summarize the relative risk level among participants. This scale was adapted from the Early Head Start Research and Evaluation Project (ACF 2002). Five socioeconomic risk levels included: (1) receiving Temporary Assistance to Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP) or Supplemental Security Income (SSI) benefits; (2) being unemployed and not enrolled in

school; (3) having less than a high school education; (4) having been a teen at the time of one's first birth; and (5) being single. The factors are summed for each participant and they are defined as low- (0, 1, or 2 factors), medium- (3 factors), or high-risk (4-5 factors). In the case of missing data for one of the factors, the cross-site team used the mean of the other 4. If the data for more than one factor are missing, the risk scale is not calculated.

Fidelity indicators were calculated at the IA level and then averaged across all IAs for which that indicator is calculated. The number of IAs included varies from 5 to 38, depending on the data needed to calculate the indicator. As described in Chapter II and elaborated in Appendix A, the fidelity indicators included in this report are home visitor and supervisor caseloads, service duration, and dosage.

C. Limitations

The cross-site evaluation team has no direct involvement in the collection of data from the home visitors, home visitor supervisors, or participants. This provides an opportunity for variation in how data are collected, the timing of data collection, and the extent to which data are missing. The cross-site team worked with the EBHV subcontractors and IAs to minimize the potential for data inconsistencies. For example, the February 2010 subcontractor training webinar focused on the fidelity data collection processes and was intended, in part, to provide information to subcontractors that would make the data collection more systematic and the resulting data of similar quality across subcontractors. In June 2011, the cross-site evaluation team shared with each subcontractor the initial summary findings for their IAs from the fidelity analyses on the data through December 2010, including the amount of data provided. In addition to providing formative feedback on program operations, the goal was that initial sharing of findings would demonstrate the importance of collecting the data systematically for all IAs and encourage subcontractors to work closely with IAs to ensure data quality and completeness.

To minimize the data collection burden on IA staff, the database includes a very limited number of participant and service provider characteristics. Specific items were limited to those factors that supported our ability to document the extent to which IAs selected participants and providers in line with their respective model's recommended standards. In building the participant portion of the database we also were limited by the descriptive variables included in the NFP participant database because this was the primary source for participant characteristics for the majority of IAs. In this report and in the final report, the limited number of descriptive variables included in the database with respect to participant and provider characteristics and community context will restrict our ability to test a wide range of hypotheses regarding why certain fidelity indicators proved difficult for individual IAs to fully achieve.

Due to the variation in the data submitted by subcontractors, the number of subcontractors, IAs, home visitors, home visitor supervisors, and participants contributing to each analysis differs. Each table clearly presents the sample size for that analysis. The cross-site team cannot generalize the findings beyond the IAs and subcontractors that submitted data during the early phase of EBHV implementation. In addition, variation in the target population and service focus across the five models represented in our sample as well as the context in which each program was implemented also has contributed to some of the differences we observed within and across models in terms participant and staff characteristics. Given the nature of data presented, including small sample sizes or large differences in the amount of data provided per IA and across home visiting models, no statistical analyses were conducted for this report. As more data are available and analyzed for the final report, the cross-site team should be in a better position to assess representativeness of the data

and determine whether statistical tests to assess differences across models or type of IA, for example, are warranted.

IV. PROFILE OF PARTICIPANTS ENROLLING IN EBHV PROGRAMS

Within the context of program replication, it is important to understand the characteristics of the families served across programs and agencies. If the population served by a specific program is very different from that for which the program model was intended, that could affect both implementation and outcomes. As such, we examined the characteristics of families enrolled in the IAs to identify key subgroup differences and to determine if the participants in the sample reflect the types of families commonly enrolled in these program models. We enlisted the model developers in reviewing the findings; overall, they believe that the population samples described in this report are consistent with their experience and resemble the profiles they have observed in their national data bases or in studies conducted on their model's effectiveness and efficacy.[8]

A. Participant Demographic Profile

The vast majority of the 1,795 participants served by the 27 IAs[9] contributing participant level data to the study are female—100 percent of all participants receiving HFA, NFP and PAT, 91 percent of those receiving Triple P, and 68 percent of those receiving SafeCare (Table IV.1). This pattern does not indicate an absence of services to fathers or other males in the household. Rather, staff provided demographic information about one adult participant in the family, selecting the individual viewed as the target child's primary caretaker. The preponderance of females in the sample may reflect, in part, the emphasis at least two of the models (NFP and HFA) place on enrolling pregnant women and new mothers. In contrast, at least one model (SafeCare) targets a broader range of participants including parents recently released from jail, those with a history of domestic violence, and those in other situations that may result in fathers being a more explicit target for services. Indeed, virtually all of the models include strategies for engaging males and other adults in the home to improve their relationships with the children and supporting each other in their parenting roles. The EBHV fidelity data collection effort, however, does not provide specific documentation regarding the characteristics of fathers or other adults living in the household or whether others were present during the home visit (Chapter V).

Characteristics of program participants varied noticeably across models. Only one model, NFP, limits enrollment to women who are pregnant, a requirement reflected in the EBHV fidelity analysis sample. All of the participants in the NFP sample were enrolled during pregnancy (Table IV.1). The only other model that enrolled a substantial proportion of pregnant women was HFA, where 56 percent of those enrolled in programs following this model were pregnant at the time of enrollment. Those agencies implementing NFP in this sample also served the highest proportion of teen parents; 50 percent of the participants in NFP programs were under age 20 at the time of enrollment. In

[8] National model representatives confirmed the consistency of our sample with their understanding of their target populations in numerous conversations throughout the development of the report. Greatest variation between the characteristics of our sample and a model's overall participant sample occurred in those cases in which our sample included a relatively small number of agencies implementing a given national model or where the IA was targeted to a specific racial or ethnic group. In these cases, our sample may overestimate the diversity of a model's service population. These differences are noted in our presentation of the data.

[9] Twenty-seven IAs provided participant-level data including demographics and the socio-economic challenges facing their household.

contrast, only 9 percent of participants served by IAs implementing HFA and none of those enrolled in Triple P were teens. Agencies implementing Triple P served the highest proportion of women over age 30 (67 percent), followed by those agencies implementing SafeCare (28 percent).

IAs implementing four of the models provided information regarding the race of their participants (Table IV.1). Within our sample, African Americans comprised 47 percent of PAT participants, 45 percent of the NFP participants, and 35 percent of the HFA participants. Thirty-seven percent of those receiving HFA identified themselves as other or multiracial, reflecting the unique ethnic diversity of the communities served by the HFA IAs located in Hawaii—most of the HFA participants falling into the other category are Pacific Islanders. Over half (55 percent) of those receiving SafeCare were Hispanic, reflecting the fact that several EBHV IAs implementing SafeCare targeted Hispanic families. English was the primary language spoken by the majority of participants receiving all of the models, although a sizable percentage of participants receiving SafeCare (20 percent) and PAT (19 percent) indicated that their primary language was Spanish.

Table IV.1. Demographic Characteristics of Participants (percentages unless otherwise indicated)

	Healthy Families America	Nurse Family Partnership	Parents as Teachers	SafeCare	Triple P
Female	100.0	100.0	100.0	67.9	90.6
Pregnant at Enrollment	56.4*	100.0	13.3	15.2*	—
Age					
< 20	9.3	50.3	21.6	28.6	0.0
20–24	39.8	35.3	47.3	21.9	4.7
25–29	32.4	10.2	13.5	21.9	28.1
30+	18.5	4.3	17.6	27.6	67.2
Race or Ethnicity					
African American	34.9	44.7*	47.3	15.0	—
Hispanic	7.3	19.1	27.0	55.1	—
White	21.1	31.6	25.7	22.4	—
Other or multiple	36.7	4.6	0.0	7.5	—
Primary Language					
English	93.6	89.4	81.3	75.7	89.1
Spanish	1.8	8.5	18.7	19.6	10.9
Other	4.6	2.1	0.0	4.7	0.0
Marital Status					
Married or living with partner	20.2	8.5	14.7	26.4	41.3
Single, never married	71.6	89.7	81.3	62.3	15.9
Widowed, divorced, separated	8.3	1.8	4.0	11.3	42.9
Sample Size	**110**	**1,427**	**75**	**119**	**64**

Source: EBHV Cross-Site Fidelity Database and Nurse-Family Partnership Efforts to Outcomes (NFP-ETO), October 1, 2009, through December 31, 2010

Note: Twenty-seven implementing agencies contributed data to this analysis. Sample sizes vary due to missing data. Distributions marked with an asterisk (*) are missing values for at least 20 percent of the sample. Cells with dashes indicate that data were not available from the IA implementing Triple P. Because of rounding, categories do not always sum to 100.

Most participants in our sample were single. Over 70 percent of the participants receiving three of the models (HFA, NFP, and PAT) were single and never married at the time of enrollment. While those receiving SafeCare included a sizable proportion of single women (62 percent), over

one-quarter of the SafeCare sample (26 percent) were married or living with a partner at the time of enrollment. Triple P had the highest proportion of participants who were married or living with a partner (41 percent) or widowed, divorced, or separated (43 percent).

B. Participant's Initial Socioeconomic Profile

A sizable proportion of the participants receiving direct services from the IAs providing detailed participant demographic data had less than a high school education at the time of enrollment: 57 percent of those enrolled in PAT, 49 percent of those enrolled in SafeCare, 47 percent of those enrolled in NFP, and 34 percent of those enrolled in HFA (Table IV.2). Less than 5 percent of participants enrolled in any of these four program models had a postsecondary degree at the time they enrolled in services. Reflecting the high proportion of teen parents in their participant sample, a large proportion of those receiving NFP were currently in school at intake. Forty-six percent of the NFP participants were enrolled in school at the time services began, in contrast to 31 percent of those in PAT, 28 percent of those in SafeCare, and 25 percent of those in HFA.

Table IV.2. Socioeconomic Characteristics of Participants (percentages unless otherwise indicated)

	Healthy Families America	Nurse Family Partnership	Parents as Teachers	SafeCare
Educational Attainment				
Less than high school	34.3	47.4	56.8	49.0
High school diploma or GED	32.4	29.7	24.3	29.6
Some college or training, no degree	31.4	17.8	16.2	18.4
Associate's degree	1.9	2.0	1.4	2.0
Bachelor's degree or higher	0.0	3.0	1.4	1.0
Currently enrolled in school	24.8	45.6	31.1	28.3
Employment Status				
Full-time	4.6	13.6*	8.7	12.4
Part-time	16.5	24.1	36.2	13.3
Unemployed	78.9	62.4	55.1	74.3
Household Income				
Less than or equal to $6,000	44.7	37.6*	24.2	38.3*
Between $6,000 and $20,000	43.6	41.6	59.7	49.4
More than $20,000	11.7	20.8	16.1	12.4
Public Assistance				
Any assistance	100.0	91.6	97.3	90.7
WIC	88.1	74.7	77.3	54.2
Medicaid, SCHIP	61.5	74.1	53.3	61.7
TANF, SNAP, SSI	93.6	33.6	76.0	72.9
Unemployment insurance	1.8	2.1	1.3	0.0
Sample Size	**110**	**1,427**	**75**	**119**

Source: EBHV Cross-Site Fidelity Database and NFP-ETO, October 1, 2009, through December 31, 2010.

Note: Twenty-six implementing agencies contributed data to this analysis. Sample sizes vary due to missing data. Distributions marked with an asterisk (*) are missing values for at least 20 percent of the sample. No data on socioeconomic characteristics were available from the IA implementing Triple P. Because of rounding, categories do not always sum to 100.

GED = General Educational Development test; SCHIP = state children's health insurance program; SNAP = Supplemental Nutrition Assistance Program; SSI = Supplemental Security Income; TANF = Temporary Assistance for Needy Families; WIC = Special Supplemental Nutrition Program for Women, Infants and Children.

Fewer than half the participants in these four models were employed on either a full- or part-time basis at program enrollment. Unemployment levels at intake were highest among HFA participants (79 percent) and SafeCare participants (74 percent). As might be expected, participant

incomes are low, with fewer than 21 percent reaching annual incomes above $20,000, although this indicator is problematic because it has a substantial amount of missing data.[10] The vast majority of respondents were receiving some form of public assistance at the time of enrollment—over 90 percent of participants served by IAs offering HFA, NFP, PAT and SafeCare. In the case of HFA and PAT recipients, the most common forms of assistance were from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), or TANF, SNAP, and SSI. About three-quarters of NFP participants received WIC and Medicaid or the State Children's Health Insurance Program (SCHIP), while the most common forms of support for SafeCare participants were Medicaid and TANF, SNAP, and SSI.

It is important to keep in mind that all of these characteristics reflect the participant's status at the time of enrollment. Issues such as current school enrollment and employment may be particularly sensitive to change over time. In some cases, a model's theory of change suggests an intentional focus on assisting participants in reviewing their career trajectories and making plans to advance their education or skill development. In other cases, new parents may become more comfortable with alternative child care arrangements as their children age or the economic demands of a growing family require their participation in the workforce. As discussed in Chapter III, we will focus on these and other potential changes over time in the participants' socioeconomic profile in the EBHV cross-site evaluation final report.

C. Relative Socioeconomic Risk

While individual risk factors such as young maternal age, single parent status, and low income have measurable impacts on a parent's level of stress and capacity to meet the needs of his or her developing child, the presence of two or more of these factors compound these difficulties and may decrease the likelihood of program participation. The greater the number of risk factors or adverse experiences faced by an individual, the higher the likelihood that individual will experience social, emotional, or cognitive impairments (Dube et al. 2003; Shonkoff et al. 2011). These impairments, in turn, may make the parent less likely to enroll in preventive services and, if enrolled, to be consistent and active participants (Daro et al. 2007; McCurdy and Daro 2001). The added demands placed on providers to engage and retain these more reluctant participants may limit their ability to deliver a given program model at the recommended dosage or duration.

Building on this research and the conceptual work of the Early Head Start Research and Evaluation project (ACF 2002), we examined the degree to which program participants in this study presented any of five demographic risks—(1) receipt of public assistance, SNAP, or SSI; (2) being unemployed and not in school; (3) lacking a high school diploma or GED; (4) being a teen at the birth of the first child, and (5) having single parent status at the time of enrollment. We aggregated these factors, identifying the proportion of families served by all of the agencies implementing HFA, NFP, PAT, and SafeCare that presented with low (0, 1, or 2 factors), medium (3 factors), or high

[10] Obtaining accurate self-report data on household income is challenging. While home visitors ask participants questions regarding their income, such questions often are used to determine if a family qualifies for public assistance. Those families receiving or qualifying for such assistance are assumed to have financial challenges. More specific questions as to actual income levels may not be as high a priority for providers. Even when asked, participants may not know their household's annual income or may be reluctant to report income that is not the result of wages reported for tax purposes.

risk (4 or 5 factors).[11] While socioeconomic considerations are important factors in assessing a participant's potential risk for poor outcomes and a high level of need, they are not the only threats to an individual's well being or to her capacity to provide adequate care for her child. Many of the families enrolled in these programs face numerous psychosocial challenges including domestic violence, substance abuse and mental health issues, and a history of maltreatment as a child. As such, this index provides only a partial assessment of the relative risk families are facing as they enroll in programs with one of these four home visiting models. However, the index does provide a common measure for identifying potential differences across program caseloads, service receipt, and for understanding potential differences in outcomes.

The most common risk factors for those receiving HFA, PAT, and SafeCare were receipt of public assistance and being single; the most common risk factors for NFP recipients were being a single parent and a teen parent at time of first birth (Table IV.3). Having less than a high school education is less common among HFA participants than among those in the other three models. Receipt of public assistance is less prevalent among NFP participants than among those enrolled in the other three types of programs. Unemployment was less prevalent among NFP and PAT participants than among HFA and SafeCare participants.

One-third or more of participants served by each of the four models fall into the highest risk category (having four or five risk factors). NFP participants had the highest proportion of individuals with low or medium risk. The mean risk score on this specific index is lowest for NFP participants in contrast to families served by the other three models.

These patterns may not accurately reflect consistent differences across the models. IAs operating in very high risk communities may attract a participant group more likely to present greater socioeconomic risk regardless of the specific evidence-based model they use. Also, as noted earlier, a participant's ultimate risk for poor parental capacity may be determined by a number of factors not captured in this index, such as mental health issues, domestic violence, or substance abuse. On the other hand, programs such as NFP that explicitly target a population of mothers who access early pregnant care and are expecting their first child may serve, on average, a population less likely to present with a history of welfare use or poor educational outcomes. Programs targeting a broader range of participants, including those giving birth to their second or third child, may engage a participant population more likely to have a history of public assistance and educational and employment difficulties. While not a perfect predictor of relative risk at either the individual agency or model level, the variation observed in this sample across models suggest the need for caution on the part of evaluators and policymakers in making any direct comparisons across IAs or national models. Understanding the underlying dynamics of the population being served may be a prerequisite for reliably comparing implementation performance or outcomes across IAs.

[11] Consistent data on all variables in the risk index were not available for Triple P participants. In addition, the eventual level of risk for teen parents in the sample is unclear. Data on GED/high school completion status for this group may be confounded because they are too young to have graduated. Similarly, access to public assistance may be undercounted in those cases in which a teen mom is living with other adults who receive these income supports. Finally, our indicator of "single parent status" is based on a participant's marital status on time of enrollment. It is likely that many of these participants may be cohabitating with partners or living with family members who provide some assistance in meeting child rearing responsibilities.

Table IV.3. Combined Risk Score of Participants

	Percentages and Means			
	Healthy Families America	Nurse Family Partnership	Parents as Teachers	SafeCare
Risk Factors				
On TANF, SNAP, or SSI	93.6	33.6	76.0	72.9
Unemployed and not in school	59.6	35.1*	33.3	48.1
Less than high school education	34.3	47.4	56.8	49.0
Teen at time of first birth	54.1	50.3	58.7	58.1
Single parent	79.8	91.5	85.3	73.6
Risk Score				
Low (0–2)	21.1	40.0	24.0	33.6
Medium (3)	41.3	26.2	40.0	22.4
High (4–5)	37.6	33.9	36.0	43.9
Mean	3.2	2.7	3.1	3.0
(Standard deviation)	(1.0)	(1.3)	(1.1)	(1.3)
Sample Size	**110**	**1,427**	**75**	**119**

Source: EBHV Cross-Site Fidelity Database and NFP-ETO, October 1, 2009, through December 31, 2010.

Note: Twenty-six implementing agencies contributed data to this analysis. Sample sizes vary due to missing data. Distributions marked with an asterisk (*) are missing values for at least 20 percent of the sample. No data on participant risks were available from the IA implementing Triple P. Because of rounding, categories do not always sum to 100.

SNAP = Supplemental Nutrition Assistance Program; SSI = Supplemental Security Income; TANF = Temporary Assistance for Needy Families.

V. PROFILE OF HOME VISITORS AND SUPERVISORS

As with all relationship-based programs, home visiting programs place a heavy emphasis on hiring individuals with the knowledge and skills necessary to establish a positive relationship with participants and with the knowledge necessary to assist new parents in meeting their infants' needs. The home visiting models selected by EBHV subcontractors vary in their educational requirements for home visitors. Some models, such as NFP, require a specific educational level and degree (a BA in nursing); others set educational levels but are less specific with respect to a provider's field of practice (see Appendix B; PAT recommends a degree in early education or related field but will allow local IAs to hire parent educators who have graduated high school; Triple P requires postsecondary qualifications in health education, social services, or mental health; HFA and SafeCare have no specific educational criteria for staff). Given the diversity of the families the models serve, it is both understandable and appropriate that similar variation would be observed in the types of individuals hired to work with these families.

Beyond educational requirements, all models recommend that providers have some prior experience engaging new parents, working with newborns, or working with families in a home-based setting. During 2010 site visits to a sample of the IAs represented in this report, program managers reported going beyond model requirements and seeking candidates with prior experience and other professional characteristics and skills they deemed important. They reported seeking candidates who were comfortable working with families with many needs, hardworking, and passionate about the work and who could work independently while being comfortable receiving supervisory feedback (Del Grosso et al. 2011). Underlying all of these requirements is an explicit interest in ensuring that direct service staff has the skills and temperament to form and sustain strong relationships with the families on their caseload. Such relationships have been found predictive of the extent to which families enroll and remain engaged in voluntary services (Daro et al. 2007; Hebbeler and Gerlach-Downie 2002; Riley et al. 2008; Santos 2005).

A. Staff Employment and Demographic Characteristics

Staff characteristics have also emerged as important inputs to high quality service delivery and may affect program efficacy. The majority (79 percent) of the 227 direct service staff at 35 IAs[12] in the sample that provided staff data worked solely as home visitors, 10 percent functioned only as supervisors, and 10 percent provided supervision as well as home visits (Table V.1). Across the five models, the proportion of staff serving only as home visitors ranged from 77 to 82 percent. While none of the supervisors delivering Triple P also functioned as home visitors, at least one or more supervisors working in IAs that followed the other four models did so. Across models, almost all of the staff delivering home visits worked full-time.

With respect to demographic characteristics, over 95 percent of direct service staff was female. Staff implementing NFP included the largest proportion of direct service providers over 40 years old (52 percent), followed by PAT (42 percent), HFA (38 percent), SafeCare (23 percent), and Triple P (9 percent). In contrast to the other models, which had a more diverse work force in terms of age,

[12] Thirty-five IAs provided staff-level demographics, education, and experience.

Table V.1. Staff Demographic Characteristics (percentages unless otherwise indicated)

	Healthy Families America	Nurse Family Partnership	Parents as Teachers	SafeCare	Triple P
Role in HV Program					
Home visitor	76.9	82.3	76.7	76.7	81.8
Supervisor	15.4	9.7	9.3	3.3	18.2
Both	7.7	8.1	14.0	20.0	0.0
Employment Status					
Full-time	88.5	98.3	88.4	93.3	100.0
Part-time	11.5	1.7	11.6	6.7	0.0
Female	98.1	98.4	100.0	96.7	100.0
Age					
Under 20	3.8	0.0	0.0	0.0	0.0
20–29	20.8	21.0	25.6	26.7	63.6
30–39	37.7	27.4	32.6	50.0	27.3
40–49	18.9	22.6	27.9	13.3	9.1
50+	18.9	29.0	14.0	10.0	0.0
Race or Ethnicity					
Black	17.0	12.9	33.3*	13.3	0.0
Hispanic	34.0	8.1	23.8	43.3	36.4
White	35.9	79.0	38.1	30.0	63.6
Other or multiple	12.2	0.0	4.8	13.3	0.0
Sample Size	**61**	**69**	**54**	**31**	**12**

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

Note: Sample sizes vary due to missing data. Distributions marked with an asterisk (*) are missing values for at least 20 percent of the sample. Because of rounding, categories do not always sum to 100.

HV = home visitor.

the 12 home visitors employed by the one Triple P IA in this sample had a high concentration of workers in the 20 to 29 age range (64 percent).

While the workforce data potentially reflects the geographic location and characteristics of their participant populations (Table IV.1), IAs implementing HFA, PAT, and SafeCare hired a more diverse work force than those implementing NFP or Triple P (Table V.1). Roughly two-thirds of the staff members providing HFA, PAT, and SafeCare were Black, Hispanic, multiracial or other. In contrast, 79 percent of the NFP direct service staff and 64 percent of the Triple P staff were white. These characteristics also may be more reflective of the labor pool available to the specific IAs in this sample and their ability to best meet the language needs of their target population. It also may be that the two models (NFP and Triple P) that set high educational requirements for their staff may challenge local IAs' abilities to recruit and hire a racially diverse staff. We have previously documented that subcontractors and implementing agency staff report that although they attempt to match characteristics of home visitors to families, this is often a challenge (Coffee-Borden and Paulsell 2010; Del Grosso et al. 2011). Several program managers interviewed as part of our ongoing implementation study noted some difficulty in identifying and successfully recruiting home visitors in instances in which the model standards required advanced degrees or degrees in a specific discipline (Del Grosso et al. 2011).

B. Staff Education and Experience

As noted earlier, educational requirements for staff vary across the five models represented in our sample. Among our sample of direct service providers, each model's intended educational level was almost universally achieved (Table V.2). All but one NFP provider reported having at least a BA degree, and 97 percent reported that their highest degree was in nursing. All 12 of the staff delivering Triple P reported having at least a bachelor's or master's degree. As specified in the Triple P criteria, 82 percent of these staff received their degree in psychology, social work, or a related discipline. Models that did not set a specific educational level also were generally staffed with individuals who had at least a BA degree. The proportion of staff with this level of education included 46 of the 54 PAT staff; 25 of the 31 SafeCare staff; and 34 of the 61 HFA staff.

Table V.2. Staff Training and Experience (percentages unless otherwise indicated)

	Healthy Families America	Nurse Family Partnership	Parents as Teachers	SafeCare	Triple P
Educational Attainment					
High school diploma or GED	7.6	0.0	0.0*	3.3	0.0
Some college or training, no degree	15.1	0.0	4.8	10.0	0.0
Associate's degree	20.8	8.2	9.5	6.7	0.0
Bachelor's degree	45.3	72.1	45.2	46.7	27.3
Master's degree or higher	11.3	19.7	40.5	33.3	72.7
Field of Study					
Child development	25.0*	0.0	11.6	4.2*	0.0
Early childhood education	8.3	0.0	23.3	4.2	0.0
Psychology	12.5	1.6	11.6	25.0	54.6
Social work or social welfare	27.1	0.0	30.2	50.0	27.3
Nursing	2.1	96.7	0.0	0.0	0.0
Other	25.0	1.6	23.3	16.7	18.2
Prior experience in home visiting	58.5	80.3	60.5	56.7	72.7
Primary caregiver to a child	82.4	78.7	74.4	53.3	9.1
Fluent in a Foreign Language					
Spanish	24.6	10.1	16.7	41.9	41.7
Other	3.3	1.4	0.0	3.2	8.3
Sample Size	**61**	**69**	**54**	**31**	**12**

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

Note: Sample sizes vary due to missing data. Distributions marked with an asterisk (*) are missing values for at least 20 percent of the sample. Because of rounding, categories do not always sum to 100.

GED = General Educational Development test.

Home visitors and supervisors brought a range of other skills to their jobs—including prior experience. Although familiarity with home-based services is not an explicit criterion for the models, all of the models value prior experiences and seek personnel with some experience in providing human services or working with the model's target population. Eighty percent of the NFP staff reported prior experience in providing home-based interventions, as did 73 percent delivering Triple P. Less than two-thirds of the staff providing the other three models had such prior experience. Over three-quarters of the home visitors delivering HFA, NFP, and PAT are parents themselves and reported being the primary caregiver for at least one child. Perhaps reflecting the fact that the providers in our sample delivering SafeCare and Triple P were younger than those providing the other three models, a much smaller percentage of SafeCare staff (53 percent) and Triple P staff (9

percent) were parents themselves. In terms of foreign language abilities, over 40 percent of the SafeCare and the Triple P staff were fluent in Spanish. In contrast, one-quarter of the HFA staff, 17 percent of the PAT staff, and 10 percent of the NFP staff reported this skill. As noted above, this pattern may primarily reflect the nature of the populations being served by the IAs delivering these various models, with the proportion of Spanish-speaking families being particularly high at the sites delivering SafeCare (see Table V.1).

VI. CHARACTERISTICS AND CONTENT OF HOME VISITS

While the models in the EBHV evaluation share a number of program elements and theoretical frameworks, each has a unique theory of change and approach to achieving its core objectives (Appendix B; Del Grosso et al. 2011). Similar to the variations we observed in the characteristics of the home visitors and the families they serve across the five models represented in this sample, the content and focus of the home visits ranged widely as well.

A. Home Visits Planned and Provided

In considering the extent to which planned home visits were successfully provided to participants across models, potential variations in how this concept was defined and captured across IAs may limit the utility of these data and overinflate completion rates. As we discuss in this chapter, the information we analyze both summarizes what we learned and shines a light on these reporting issues.

Across the models, at least 75 percent of visits planned by home visitors at the 27 IAs included in the sample were delivered to families during our data collection period.[13] The proportion of visits completed by model ranged from 93 percent for Triple P to 75 percent for HFA (Table VI.1). The higher completion rates for Triple P may reflect the relatively short-term, focused nature of that intervention, increasing the likelihood that participants will accept most home visits. The trend also might reflect the specific skills in engaging participants among the home visitors working at the single IA implementing Triple P. In the absence of a more robust sample of IAs it is difficult to discern why completion rates varied across the models.

In addition to sample size concerns, it is also possible that the variation we observed reflects differences in how home visitors interpreted planned visits. For example, the NFP database captures only visits that have been *attempted* with families; visits that are rescheduled prior to the home visitor arriving at the home are not included in the total pool of planned visits. In some instances, home visitors at the IAs using the EBHV Cross-Site Fidelity Database to document visits may have counted some of these rescheduled visits as planned visits that were not successfully completed, thereby reducing their overall completion rates. In early 2011, all IAs were instructed to use the NFP definition of planned visits (only visits that have actually been attempted) in identifying when they should complete a home visit encounter form. As such, we anticipate having more consistent data on this indicator in subsequent fidelity reports.

All five models allow for the possibility of visits to occur in locations other than the home in order to accommodate a family's specific needs or to ensure the safety of the home visitor. However, the intended primary venue for delivering services to families across all these models is the participant's home. Reflecting this emphasis, the vast majority of the home visits documented in our sample (89 percent or more) occurred in the home. Although we do not have systematic

[13] As with the participant level data, several IAs provided only monthly summary data regarding provider characteristics, service caseloads, and enrollment levels. Twenty-seven IAs provided participant-level data including a summary of the activities undertaken during each completed home visit.

Table VI.1. Characteristics of Home Visits

	Percentages and Means				
	Healthy Families America	Nurse Family Partnership	Parents as Teachers	SafeCare	Triple P
Percentage of Planned Visits Completed	75.1	86.9	83.6	76.7	93.2
For Completed Visits:					
Visit location					
Participant's home	92.0	91.8	88.8	95.4	99.2
Other location	8.0	8.2	11.2	4.6	0.8
Visit duration					
0–59 minutes	12.7	6.3	15.0	23.9	11.7
60–89 minutes	65.0	57.9	70.2	52.9	39.5
90–119 minutes	20.3	29.8	7.3	15.8	42.3
120+ minutes	2.0	6.1	7.6	7.5	6.5
Sample Size	**765**	**16,871**	**648**	**1,011**	**615**

Source: EBHV Cross-Site Fidelity Database and NFP-ETO, October 1, 2009, through December 31, 2010.

Note: Sample sizes vary due to missing data. Planned visits are those which home visitors noted as expected but not completed. We present these data with caution given that the definition of planned visits (how to treat no-shows versus rescheduled visits) may have varied across implementing agencies. Because of rounding, categories do not always sum to 100.

information on where the other visits occurred, descriptive information provided by the IAs suggests that such visits took place in a variety of public venues (such as parks, community centers, and health clinics) as well as local businesses, such as restaurants. All five models recommend that visits last at least 60 minutes, although variation from this standard can occur if circumstances in the home require a shorter or longer intervention period. Most of the home visits in the sample achieved the 60-minute benchmark, although some variation from this target was observed across the five models. For example, while only 6 percent of the NFP visits lasted less than 60 minutes, almost one-quarter of the SafeCare visits lasted less than 60 minutes. The sample of Triple P visits included the largest proportion of visits (over 50 percent) lasting 90 minutes or longer.

B. Home Visit Content

The specific activities on which the EBHV evaluation requested that home visitors report had been determined in consultation with the national model developers (as noted in Chapter III and summarized in Appendixes A and B) and varied across models. In some cases, the national model developer focused on broad content areas or topics; in other cases, emphasis was placed on discrete program activities. In all cases, these categories represent the characteristics each model asks replication sites to document as part of their annual reporting requirements or through their administrative data systems. Home visitors reported on which topics or activities they spent time on as well as the proportion of time spent on each. While the number of home visits in each model sample is substantial (500 or more visits per model), the number of IAs contributing information to the cross-site evaluation on each model about home visit content is modest. Among the IAs that had data available on home visit content, only 1 followed the Triple P model, 2 implemented PAT, 3 used HFA, 5 followed SafeCare, and 16 implemented NFP. The limited sample of agencies providing any specific model does not allow us to determine if the variations we observed across models is a reflection of true differences in how a given model is delivered or merely a reflection of

how the specific set of IAs delivered that intervention. An IA's organizational culture or access to other support services within its community may impact the manner in which home visitors interact with families even when following a set of specific protocols. It is also important to note that our sample visits include those provided to participants early in their enrollment. In some instances—such as Triple P and SafeCare, where services are provided for a relatively short period of time (16 to 20 weeks)—our observation period is sufficient to capture the full service period. In the case of NFP, HFA, and PAT—which provide services for multiple years—our observation period offers an assessment of service content as delivered in the early months of enrollment when a participant is pregnant or has just given birth. It is possible that over time, the relative emphasis of activities may shift in response to a participant's changing needs. As such, these patterns should be considered indicative of the types and relative emphasis placed on different activities across models rather than as an absolute summary of universal or systemic variation in model operations.

For each model, we examine home visit content in two ways. First, we report the proportion of all visits involving the specific model in which the home visitor reported spending some time on the activity. In some cases, the model developers reported that certain activities were expected to be covered, to some extent, in most if not all visits. With the exception of formal assessments or administrative functions, many of the activities or topics listed on the forms are elements the national model developers viewed as priorities for the home visitors to address. Second, we also looked at the average proportion of time across all visits that home visitors indicated they had spent on each topic. The home visitors were instructed to allocate their time across all of the functions such that the total would include 100 percent of the time spent during the visit on planned activities. Unfortunately, not all home visitors faithfully followed this guideline. As such, the percentages presented in the following tables do not always equal 100 percent and represent estimates rather than absolute indicators of the average time spent on each function.

As summarized below, variation was found in the relative emphasis and consistency in how core service components, as defined by the model developers, are provided to program participants across models (Tables VI.2a through e).

HFA. The most prevalent activities (occurring in at least 50 percent of the 765 HFA home visits in our sample) focused on addressing parent-child interaction (efforts to improve maternal-infant bonding) child development concerns (conducting developmental screenings or instructing parents on developmental milestones), and family functioning (discussing relationships among spouses or other family members or addressing issues of sibling rivalry). About one-third of the visits involved some time addressing participant health-care needs and health care access concerns or environmental-related needs, such as addressing housing, safety, and infant basic care. The absence of a dominant theme across all visits is consistent with HFA's philosophy regarding participant-directed services. Home visitors are instructed to focus their time on those issues of central concern to the family and those in which the most targeted assistance or discussion is needed. Although about 20 percent of the visits covered administrative issues such as data collection or confirming contact information for family members, the average proportion of time spent on this activity during any visit was modest (around 6 percent).

Table VI.2a. Home Visit Content: Healthy Families America

	Percentage of All Visits with Some Time Devoted to the Activity	Average Percentage of Time Spent on Activity Across All Visits
Model-Specific Home Visit Topics or Activities:		
Parent-child interaction related activities	64.4	28.7
Child development–related activities	54.1	20.4
Activities related to family functioning	52.4	21.6
Health care–related activities	37.4	12.0
Addressing family's environmental needs	36.9	10.2
Administrative activities	19.5	5.8
Sample Size	**765**	

Source: EBHV Cross-Site Fidelity Database, October 1, 2009, through December 31, 2010.

Note: Three out of the 12 IAs implementing agencies that delivered the HFA model contributed data to this analysis. Because of rounding and incomplete data, categories do not always sum to 100.

NFP. The NFP visit data demonstrated strong consistency in the topics addressed across all visits, with over 85 percent of the almost 17,000 home visits covering each of the program's five target outcome areas—personal health, environmental health, life course, maternal role, and friends and family. This pattern is consistent with the guidance given to home visitors on the importance of addressing each of these core domains in each visit. Because our sample of visits reflect the initial enrollment period, the NFP participants receiving these visits were either pregnant or had only recently given birth. As such, the topics which consumed the greater proportion of time in this sample were activities related to maternal health and the maternal role in early infant development and care.

Table VI.2b. Home Visit Content: Nurse Family Partnership

	Percentage of All Visits with Some Time Devoted to the Activity	Average Percentage of Time Spent on Activity Across All Visits
Model-Specific Home Visit Topics or Activities:		
Personal health	98.0	32.2
Maternal role	95.6	31.9
Friends and family	92.9	12.5
Life course	89.4	12.7
Environmental health	87.4	10.7
Sample Size	**16,871**	

Source: EBHV Cross-Site Fidelity Database and NFP-ETO, October 1, 2009, through December 31, 2010.

Note: Sixteen out of the 19 implementing agencies that delivered the NFP model contributed data to this analysis. Because of rounding and incomplete data, categories do not always sum to 100.

PAT. As with NFP, a high proportion of all 648 PAT home visits (two-thirds or more) addressed three of the model's required activities—presenting and conducting a specific parent-child activity, book reading time, and ongoing assessment of parental needs. Formal assessment and screening of the child occurred during about one-third of all visits, reflecting the fact that these assessments are scheduled at periodic points during the enrollment period and are not activities planned for each visit. On average, a home visitor delivering PAT spent about one-third of her time

on the visit's planned parent-child activity and about one-quarter of the time assessing the participant's ongoing needs.

Table VI.2c. Home Visit Content: Parents as Teachers

	Percentage of All Visits with Some Time Devoted to the Activity	Average Percentage of Time Spent on Activity Across All Visits
Model-Specific Home Visit Topics or Activities:		
Ongoing assessment of parent status and needs	75.0	26.6
Presenting and conducting parent-child activity	74.0	36.5
Book reading time	68.0	17.6
Formal assessment and screening tasks	33.3	15.9
Sample Size	**648**	

Source: EBHV Cross-Site Fidelity Database, October 1, 2009 through December 31, 2010.

Note: Two out of the eight implementing agencies that delivered the PAT model contributed data to this analysis. Because of rounding and incomplete data, categories do not always sum to 100.

SafeCare. With the exception of assessment—an activity usually conducted at baseline or the end of one of its three required modules (child health, home safety, and parent-child/parent-infant interaction) to determine a participant's understanding of core concepts and skills addressed in each module (Lutzker and Bigelow 2002)—all of SafeCare's core components were addressed in 50 percent or more of the 1,011 home visits. Over two-thirds of the visits involved rapport building between the home visitor and the participant, observing the family, and providing feedback on the parent's ability to implement the specific skills introduced during the visit. Reflecting the behavioral nature of the intervention, home visitors spend more than half their time, on average, working with participants to master specific skills and assessing their competency in these skill areas. Formal assessments were incorporated into about one-third of all visits; they are generally planned at the onset and conclusion of each program module to assess if key skill levels not exhibited at the start of a given module have been reached after all sessions related to the topic have been provided.

Table VI.2d. Home Visit Content: SafeCare

	Percentage of All Visits with Some Time Devoted to the Activity	Average Percentage of Time Spent on Activity Across All Visits
Model-Specific Home Visit Topics or Activities:		
Rapport-building conversations	72.7	18.9
Observing parent practice skills and providing feedback	67.1	29.0
Explaining rationale or reason for behaviors	52.7	9.2
Modeling alternative behaviors	51.0	9.9
Describing target behaviors	49.6	8.2
Assessing parent at baseline or end of module	38.1	22.8
Sample Size	**1,011**	

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

Note: All five of the implementing agencies that delivered the SafeCare model contributed data to this analysis. Because of rounding and incomplete data, categories do not always sum to 100.

Triple P. Approximately 70 percent of the 615 visits included listening to and processing a parent's concerns and explaining or demonstrating a parenting strategy, principle, or procedure. In over 50 percent of the visits, the home visitor spent some time providing the participant with feedback or promoting self-evaluation by the parent. Consistent with other models, skill assessment activities occurred during 40 percent of the visits. During an average visit, home visitors spent approximately 30 percent of their time explaining or demonstrating a specific parenting strategy and about 25 percent of their time on assessment activities.

Table VI.2e. Home Visit Content: Triple P

	Percentage of All Visits with Some Time Devoted to the Activity	Average Percentage of Time Spent on Activity Across All Visits
Model-Specific Home Visit Activities:		
Explaining or demonstrating a parenting strategy, principle, or procedure	70.7	29.3
Listening and processing parent's concerns and input	69.9	17.3
Providing feedback or prompting self-evaluation by parent	51.1	11.5
Parental practice and implementation of strategies	43.6	12.2
Assessment activities	39.7	25.1
Sample Size	**615**	

Source: EBHV Cross-Site Fidelity Database, October 1, 2009, through December 31, 2010.

Note: The one implementing agency that delivered the Triple P model contributed data to this analysis. Because of rounding and incomplete data, categories do not always sum to 100.

On balance, the findings suggest home visits are focused on the core elements central to each model's respective theory of change. For example, HFA visits address a wide range of maternal and family needs as defined by the model's historical emphasis on preventing child abuse and neglect and the belief that threats to a child's well-being can emerge from a variety of sources both within and outside the family (Holton and Harding 2007). In contrast, PAT's historic emphasis on promoting parents as their child's first teacher is reflected in the time home visitors spend in encouraging literacy activities, including book reading (Zigler et al. 2008). SafeCare and Triple P home visits reflect the behavioral emphasis of these interventions, with home visitors spending the majority of their time helping participants obtain specific skills and using these skills to improve parental capacity and parent-child relationships (Gershater-Molko et al. 2003; Sanders et al. 2008). The consistency in which all core functions are incorporated into the NFP home visits are illustrative of that model's rigorous attention to the core elements embedded in its comprehensive theory of change (Olds et al. 2007).

While certain variation exists in the home visits offered by each model, the data also underscore the models' common commitment to strengthening parental capacity by raising awareness of the parent's role in nurturing child development, providing specific skills to better equip parents to meet their responsibilities, or improving a parent's ability to access and use important services. Specifically, the majority of time spent in the home focuses on enhancing parenting skills and strengthening parent-child relationships. This shared commitment and common objective are

important perspectives to consider in using home visiting as a foundational component for a more comprehensive system to strengthen optimal child development.

VII. ASSESSING THREE DIMENSIONS OF STRUCTURAL FIDELITY

The EBHV fidelity framework captures a number of factors commonly used to determine a program's service delivery structure and parameters (Berkel et al. 2011; Duggan and Supplee 2012). As discussed earlier, the framework includes both structural elements of service delivery—such as staff qualifications and training, caseloads, program duration, and service dosages—as well as the more dynamic elements—such as the content of services and the manner in which they are provided. Because of the preliminary nature of our current data, we are unable to address all aspects of the framework at this time. This chapter focuses on three structural elements of service delivery—home visitor and supervisory caseloads; service duration; and service dosage. All of the home visiting models being replicated by the EBHV subcontractors have specific guidelines in these three domains and emphasize staff training and ongoing support, the importance of maintaining reasonable caseloads, and providing participants sufficient exposure to the program as key outputs of the implementation system needed to achieve desired outcomes. Although these are not the only elements of interest in determining if a replication site is adhering to a model's standards or is delivering the program as intended, these elements do offer preliminary insights into the degree to which the IAs represented in our sample are replicating EBHV programs with fidelity. At this point in the data collection, these elements also are among the indicators most frequently documented by the IAs through the NFP-CIS database or the EBHV Cross-Site Fidelity Database. The small number of IAs providing data on these key constructs during this initial data collection period limits our ability to discuss other items in the fidelity framework, such as the quality of the provider-participant relationship, in this initial report. Findings regarding these elements as well as a more complete picture of caseloads, service duration, and family-level dosage received will be provided in the evaluation's final report.

Because of the preliminary nature of our current data, we present and discuss aggregate performance on each indicator rather than data by individual IA or program model. As noted elsewhere in this report, the number of agencies providing information on a specific model is limited and may not be fully representative of the implementation trajectory common for these models. Further, we observed notable variation in fidelity levels among those agencies implementing the same model, suggesting that the ability to implement with fidelity may be influenced by the characteristics and capacity of the IA as well as a given model's standards or oversight capacity. That said, we recognize that some readers may be interested in understanding how variation in model standards or benchmarks might influence how a given model is reflected in our indicators. Therefore, in boxes throughout this section, we provide brief snapshots of these and other indicators for four of the five models along with more detailed information on the specific parameters of the IA sample, by model.[14] Given the preliminary nature of these data and the fact that only a small sample of IAs are available for most models, we caution against making any direct comparisons across models based on this sample.

[14] This information has not been provided for Triple P because only one agency implemented this model.

A. Home Visitor and Supervisory Caseloads

The appropriate ratio between a home visitor and the number of families he or she serves at a given point in time is a matter of substantial discussion across several fields of practice. Although lower caseloads are generally viewed as more desirable, caseloads consistently below a given standard may signal an inability to recruit and retain the target population and have implications for cost per participant, an important indicator for funders. Stakeholders want as many families served as possible, making full caseloads desirable. On the other hand, it is not uncommon for program managers to create and funders to tolerate some cushion between actual and maximum caseload guidelines to protect an agency's ability to respond to a sudden increase in its target population or a potential loss of staff. What the exact size of this variation should be or what latitude might be most effective or efficient requires additional study.

Within this domain, we computed the sample mean, the standard deviation, and the range of scores across the 35 IAs providing data related to three indicators relevant to the topic of worker caseloads:

1. The mean monthly home visitor caseload for all full-time home visitors[15]
2. The percentage of home visitors at or below the caseload standard recommended by the relevant national model, adjusted for the home visitor's length of employment by the IA
3. The percentage of home visitors below the caseload standard recommended by the relevant model, adjusted for the home visitor's length of employment

The average full-time home visitor caseload among the IAs in our sample is 13.4, generally below the levels set by the national models (Table VII.1). As noted in Table II.2, four of the national models represented in this study intend for home visitor caseloads to be above this number, at levels ranging from 19 to 25; only one model sets home visitor caseloads below (at 10). Adjusting for variation in the recommended full-time caseload across models, 90.9 percent of the IAs maintained average caseloads at or below levels recommended by their respective models, while 78.3 percent of the IAs had average caseload levels below the models' standards. Indeed, 20 of the 35 IAs contributing data on this indicator reported that all of their home visitors had average caseloads below model standards, suggesting that the majority of these programs were not operating at full capacity during the reporting period. Because some IAs in our sample initiated services during this period, low caseloads may reflect the gradual increase in caseloads common among programs new to a community. However, when we examined average home visitor caseloads for the 16 IAs established prior to 2009 and the 19 IAs established in 2009 or later, we found no difference in the proportion of home visitors with caseloads below intended levels (78.5 percent versus 78.1 percent).

[15] This indicator focuses only on full-time home visitors to provide a consistent caseload figure across all IAs. If part-time home visitors were included in this indicator, the mean caseload for a given IA would vary based on the number of part-time staff in its sample. Those IAs with more part-time staff would have lower mean caseloads than those that employ only full-time home visitors. To avoid this inconsistency, we analyzed the caseloads of full-time home visitors only.

Table VII.1. Home Visitor and Supervisor Caseloads

	Mean	Standard Deviation	Low Score	High Score	Number of IAs
Mean Monthly Home Visitor Caseload	13.4	6.8	2.1	24.8	35
Percentage of Home Visitors at or below Recommended Caseload	90.9	18.4	33.3	100.0	35
Percentage of Home Visitors below Recommended Caseload	78.3	31.4	16.7	100.0	35
Mean Monthly Supervisor Caseload	4.1	1.9	1.0	10.0	21
Percentage of Supervisors at or below Recommended Caseload	83.3	34.2	0.0	100.0	28
Percentage of Supervisors below Recommended Caseload	76.2	37.8	0.0	100.0	28

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

Note: Only full-time staff are included in the mean caseload numbers to maintain comparability.

IA = implementing agency.

Twenty-eight IAs in our sample provided supervisory caseload data (see Table VII.1). In calculating supervisory caseload indicators, we included only those IAs that had at least one full-time supervisor. The seven remaining IAs providing staff-level data indicated that one or more of their supervisory staff also provide home visiting services. However, these seven IAs did not indicate the proportion of time these staff allocated to supervisory functions, making it difficult to calculate appropriate caseload levels. Consequently, we limited our analysis of the indicators in this report to full-time supervisors. Three indicators are reported for this construct:

1. The mean monthly supervisor caseload for all full-time supervisors
2. The percentage of full-time supervisors at or below the required standard
3. The percentage of full-time supervisors below the model standard

The models represented in the sample allow for supervisory caseloads of 6 to 8 home visitors per full-time supervisor (Table II.1). As with the sample's home visitor caseload numbers, supervisors are overseeing fewer home visitors than might be expected given these recommended levels. The average full-time supervisor among the IAs in our sample is supervising 4.1 home visitors, and, on average, 83.3 percent of the supervisors in each IA represented have an average caseload at or below recommended levels (Table VII.1). Twenty-one of the 27 IAs reported that 100 percent of their supervisors had caseloads below recommended levels. The three IAs in which all supervisors managed their models' suggested maximum number of home visitors had been operating for seven years or longer, suggesting that at least some of the variation may reflect start-up challenges. Indeed, when we compared the average supervisory caseloads for the 14 IAs implemented prior to 2009 to the 14 IAs implemented in 2009 or later, we found a notable difference; new IAs reported a higher proportion of their supervisors managing caseloads below model expectations than the older IAs (71.4 percent versus 81.0 percent).

B. Service Duration

A common structural indicator of model fidelity is the capacity of replication sites to retain participants for the specific period of time recommended by the national model. Among the models represented in our sample, three enroll families for a minimum of two years (HFA, NFP, and PAT) while the other two have substantially shorter service cycles (16 to 20 weeks for SafeCare and Triple P) (Table II.1). While our current data is insufficient to assess the ability of the longer-term programs to retain participants for the full, recommended service period, all of the models operate under the logic that a higher probability for achieving meaningful and sustainable impacts will occur if families can be retained for the full, intended service period. Twenty-seven IAs in our sample provided participant-level data indicating the length of time families had been enrolled. The four indicators for this construct include the following:

1. The percentage of participants who entered the program during the data collection period and remained enrolled for at least three months or were still enrolled at the time data collection ended (if less than three months)
2. The percentage of participants who entered the program during the data collection period and remained enrolled for at least six months or were still enrolled at the time data collection ended (if less than six months)
3. The mean duration for those who left the program during the observation period
4. The percentage of those who left the program during the data collection period who were identified by program staff as "early leavers" (that is, left before they completed program objectives)

On average, 90 percent of the families served by each IA in the analysis sample had received at least three months of service or were still enrolled at the end of the data collection period. This proportion dropped only slightly (to 81.9 percent) when we extended the length of enrollment to six months (see Table VII.2). In interpreting these retention trends, it is important to remember that they could be overestimates: not all participants in the sample had the opportunity to remain enrolled for this period of time. Given our 18-month observation period and the fact that participants are enrolled on an ongoing basis, not all of those who met the threshold for these indicators as of December 2010 will ultimately remain enrolled for three or six months, respectively. At the end of 2010, approximately one-third of the enrolled sample had been in the program for less than three months, and 54.1 percent had been enrolled for less than six months. Since we are not able to determine what percentage of these individuals will eventually reach these thresholds and because program staff may not yet have completed termination forms for all families who had enrolled during the data collection period for this report, we categorized them as meeting the standard for purposes of this report. Longer observation periods and a larger sample size will allow us to take a more rigorous look at the actual proportion of participants meeting these duration thresholds as well as conduct a more detailed examination of the characteristics of those participants who leave services early.

Table VII.2. Participant Enrollment Duration

	Mean	Standard Deviation	Low Score	High Score	Number of IAs
Percentage of Participants Enrolled for at Least Three Months	90.0	9.9	60.0	100.0	27
Percentage of Participants Enrolled for at Least Six Months	81.9	16.9	33.3	100.0	27
Mean Duration for Those Who Left Program During the Observation Period (weeks)	19.3	8.0	3.0	34.8	25
Percentage of Those Leaving Identified as Leaving Before Completing the Program	91.3	19.1	35.0	100.0	25

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

Note: Percentages of participants enrolled for three and six months include participants enrolled for shorter durations who were still enrolled at the end of the observation period (of these, 33.5 percent had been enrolled for less than three months and 54.1 percent had been enrolled for less than six months).

IA = implementing agency.

On average, those participants who enrolled and terminated services during our reporting period (438 participants, or 24 percent of the full sample) remained in the program for 19.3 weeks. The majority of these individuals (91.3 percent) left before successfully completing their respective program. As would be expected, this proportion varied across the models, with a notable percentage of participants leaving the shorter-term home visiting models only after they had successfully completed the program. Among those participants enrolled in the two short-term models, only 50 percent of them were judged by their home visitor as early leavers.

Although the sample is small, we did examine the characteristics of those participants who had enrolled in and left the longer-term programs during our data collection period. The absence of a sample of successful completers at this point makes it difficult to identify any unique demographic or risk factors that might account for a higher likelihood of leaving these programs early. It is interesting to note, however, that those who have already terminated services appear to mirror the general pattern of risk we observed in the full sample, with the families leaving the longer-term programs early being evenly distributed across all levels of the risk scale (Table VII.3). This pattern supports other research that suggests successful engagement in these types of voluntary programs is only partially determined by a participant's socioeconomic risk. Other factors, not captured in this initial report, such as the participant's general attitudes toward public services, their relationship with their home visitor, and the support for enrollment they receive from their social network may play a more central role in enrollment and retention decisions (Daro et al. 2003; Daro et al. 2007). A more detailed examination of the early service experiences as well as the demographic and socioeconomic characteristics of those who leave longer-term home visiting programs before completing the recommended course of service will be included in subsequent reports.

Table VII.3. Characteristics of Early Leavers from Longer-Term Models (HFA, NFP, and PAT) (percentages unless otherwise indicated)

Characteristic	Early Leavers
Race or Ethnicity	
Black	46.6
White	31.1
Hispanic	20.1
Other or multiple	2.3
Age	
< 20	51.0
20–24	34.6
25–29	10.6
30+	3.8
Risk Factors	
On TANF, SNAP, or SSI	34.7
Unemployed and not in school	37.6
Less than high school education	49.5
Teen at time of first birth	52.2
Single at intake	93.6
Risk Score	
Low (0–2)	36.7
Medium (3)	28.5
High (4–5)	34.9
Mean	2.8
Sample Size	**341**

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

Note: Includes HFA, NFP, and PAT participants who left their program during the data collection timeframe. Because of rounding, categories do not always sum to 100. This analysis assumes that families enrolled for fewer than six months are still enrolled if we did not have exit data on them. This may not be the case.

HFA = Healthy Families America; NFP = Nurse Family Partnership; PAT = Parents as Teachers; SNAP = Supplemental Nutrition Assistance Program; SSI = Supplemental Security Income; TANF = Temporary Assistance for Needy Families.

In the case of SafeCare, a shorter-term model, we compared the characteristics of the 23 participants who had successfully completed the recommended course of service to the 34 described by home visitors as early leavers. These data are based on the experiences of the five agencies implementing this model, all of which included both successful completers and early leavers. This preliminary analysis indicates that the early leavers included a more sizable proportion of African American, young parents (under age 24) raising their children in a single-parent household as compared to those successfully completing the program (Table VII.4). This group of early leavers also presented, on average, a greater number of overall risk factors, although no meaningful differences between the two groups were found in terms of their educational levels (roughly 50 percent of both groups lacked a high school education) or employment status (the majority of both groups were unemployed at the time of enrollment). In a somewhat counterintuitive finding, those successfully completing the program were more likely to have been receiving public assistance, SNAP, or SSI at the time of enrollment than the early leavers. While receipt of public assistance may reflect a greater level of economic need and therefore a potential barrier to successful service engagement, the presence of this risk factor might also reflect a greater ability among these families to seek out and secure public programs that can help compensate for their financial needs. This ability to manage the complex market of public financial aid may indicate a certain resilience or

capacity to problem solve not present in those less likely to engage in voluntary services successfully. Public assistance, particularly TANF, now requires compliance with a number of expectations. Sustaining involvement in such programs may be increasingly difficult for those with multiple risk factors or personal challenges. In addition to demonstrating a certain level of skills, consistent enrollment in TANF and SNAP can provide some stability to families with very low incomes, thereby improving their ability to sustain participating in support services such as home visiting. The ability of these data to either support or refute these trends is limited due to the small participant sample and the fact that data are from a single home visiting model. A fuller examination of these and similar trends with a larger participant sample engaged in a variety of models will be included in subsequent fidelity reports. Boxes VII.1 and 2 summarize the indicators for the HFA and NFP IAs.

Table VII.4. Participant Characteristics by Program Outcome for a Short- Term Program (SafeCare) (percentages unless otherwise indicated)

	Early Leavers	Successful Completers
Race or Ethnicity		
Black	12.5	4.4
White	25.0	34.8
Hispanic	50.0	52.2
Other or multiple	12.5	8.7
Age		
< 20	41.7	4.6
20–24	25.0	9.1
25–29	12.5	36.4
30+	20.8	50.0
Risk Factors		
On TANF, SNAP, or SSI	79.2	95.7
Unemployed and not in school	54.2	60.9
Less than high school education	45.5	47.6
Teen at time of first birth	75.0	45.5
Single at intake	95.8	65.2
Risk Score		
Low (0–2)	20.8	30.4
Medium (3)	16.7	26.1
High (4–5)	62.5	43.5
Mean	3.5	3.2
Sample Size	**34**	**23**

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

Note: Includes SafeCare participants who left their program during the data collection timeframe. Because of rounding, categories do not always sum to 100.

HFA = Healthy Families America; NFP = Nurse Family Partnership; PAT = Parents as Teachers; SNAP = Supplemental Nutrition Assistance Program; SSI = Supplemental Security Income; TANF = Temporary Assistance for Needy Families.

Box VII.1. Healthy Families America Structural Fidelity Indicators

Healthy Families America	
Staff Caseloads	
National model developers for Healthy Families America recommend a maximum caseload of 25 families per home visitor.	
Mean monthly home visitor caseload	15.2
Percentage of home visitors **at or below** recommended caseload	89.0%
Percentage of home visitors **below** recommended caseload	82.3%
Service Duration	
The Healthy Families America program is designed to engage families from birth until at least the child's third birthday.	
Percentage of participants enrolled for at least **three months**	98.7%
Percentage of participants enrolled for at least **six months**	98.1%
Service Dosage	
During the first six months of enrollment, Healthy Families America participants are intended to receive, on average, 24 home visits.	
Percentage of participants who received intended dosage during initial six months of enrollment	2.1%
Percentage of participants who received **90%** of intended service dosage during initial six months of enrollment	6.3%
Percentage of participants who received **80%** of intended service dosage during initial six months of enrollment	13.2%
Caseload data are from 9 implementing agencies. *Duration and dosage data are from 3 implementing agencies.*	

Box VII.2. Nurse- Family Partnership Structural Fidelity Indicators

Nurse Family Partnership	
Staff Caseloads	
National model developers for Nurse Family Partnership recommend a maximum caseload of 25 families per home visitor.	
Mean monthly home visitor caseload	16.5
Percentage of home visitors **at or below** recommended caseload	95.0%
Percentage of home visitors **below** recommended caseload	69.4%
Service Duration	
The Nurse Family Partnership program is designed to engage families from early in pregnancy until the child turns two years old.	
Percentage of participants enrolled for at least **three months**	92.1%
Percentage of participants enrolled for at least **six months**	85.6%
Service Dosage	
During the first six months of enrollment, Nurse Family Partnership participants are intended to receive, on average, 18 home visits.	
Percentage of participants who received intended dosage during initial six months of enrollment	49.4%
Percentage of participants who received **90%** of intended service dosage during initial six months of enrollment	56.8%
Percentage of participants who received **80%** of intended service dosage during initial six months of enrollment	66.3%
Caseload data are from 12 implementing agencies. *Duration and dosage data are from 16 implementing agencies.*	

C. Service Dosage

The concept of appropriate service dosage is currently under discussion in many fields. While service dosage is often measured as the number of service units or hours received during enrollment in a specific program, program implementers are increasingly considering issues of quality and relative intensity in determining if participants are receiving sufficient exposure to a program in order to achieve desired outcomes (Berkel et al. 2011; Durlak and DuPre 2008; Zaslow et al. 2010). In addition, greater attention is being paid to the frequency with which participants receive the number of services required or intended by a specific model. Given the voluntary nature of most prevention programs, participants are given wide latitude in determining how often and under what conditions they will agree to see a home visitor. Service dosage is, in part, determined by what the family may need and is willing to accept as much as by any staff or administrative issues on the program side or firm standards established in a model's operations manual.

For the current study, we employed a variety of indicators to address the question of service dosage, documenting both the absolute number of visits provided and the extent to which these service levels reflect model standards.[16] We computed the overall sample mean, standard deviation, and range of scores with respect to the number and frequency of home visits that were provided to participants enrolled in the 27 IAs that provided these data. The two indicators for this construct include the following:

1. The number of home visits provided per week of enrollment (a value of one means weekly visits)
2. The mean number of days between completed visits

IAs in our sample provided, on average, one home visit every other week, although this dosage ranged from about once a month (.02) to almost weekly (.80) (Table VII.5). The mean number of days between visits for this sample of IAs was 16.0 days, with a range of 8.9 days, on average, between home visits in some IAs to an average of 45.5 days in others.

Because the models differ in the frequency with which they recommend visits be offered to program participants, it is difficult to discern if this mean level conforms to model guidelines. To address this question, we created a set of indicators that captured the extent to which agencies were successful in providing the number of home visits recommended by the model they were implementing for a participant's first six months of enrollment. For those participants who had been enrolled for less than six months, the standard was adjusted to reflect a participant's actual length of enrollment. We report the extent to which the IAs achieved service dosage as intended by their

[16] There is some disagreement in the field about whether dosage thresholds should be set at the level obtained in the experimental studies that documented a model's efficacy as opposed to the service levels articulated in the model's service protocols. As noted by Durlak and DuPre (2008), participants in most interventions only receive 60 percent or less of the dosage intended by the model developers. Therefore, defining a high standard seems important. Here we present findings using relatively high thresholds.

Table VII.5. Dosage and Frequency of Home Visits

	Mean	Standard Deviation	Low Score	High Score	Number of IAs
Mean Number of Home Visits Provided per Week of Enrollment	0.5	0.1	0.2	0.8	27
Mean Length of Time Between Completed Home Visits (days)	16.0	6.6	8.9	45.5	27
Percentage of Participants Who Received Intended Dosage During initial Six Months of Enrollment	44.2	24.6	0.0	100.0	27
Percentage of Participants Who Received at Least 90 Percent of Intended Service Dosage During Initial Six Months of Enrollment	50.0	24.7	0.0	100.0	27
Percentage of Participants Who Received at Least 80 Percent of Intended Service Dosage During Initial Six Months of Enrollment	58.1	24.7	0.0	100.0	27

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

Note: Model-defined intended average six-month dosage drawn from developer documents and input from national offices: Healthy Families America—24 visits, Nurse Family Partnership—18 visits, Parents as Teachers—12 visits, SafeCare—12 visits, Triple P—26 visits.

respective models (Table II.1), presenting the overall sample mean, standard deviation, and range of scores with respect to three indicators:

1. The percentage of participants who received the model-intended service dosage during the initial six months of enrollment
2. The percentage of participants who received at least 90 percent of the intended dosage
3. The percentage of participants who received at least 80 percent of the intended dosage

On average, the IAs in our sample provided the intended number of home visits to less than half (44.2 percent) of their program participants (Table VII.5). Looking across the 27 agencies providing data, one agency achieved recommend services levels for all of their participants (the high score of 100 percent) while 6 agencies achieved this standard for 25 percent or fewer of their participants. (See Appendix D for IA-specific scores on the indicators.)

Given the challenges inherent in completing the recommended number of home visits, we also examined the extent to which the IAs provided at least 90 percent and 80 percent of the recommended levels. The proportion of families receiving this level of service was higher, but not substantially; overall, 50 percent of participants in each IA received 90 percent of the recommended number of home visits, and 58 percent received 80 percent (Table VII.5). As with our initial standard, only one IA continued to provide a consistently high level of service to all its participants even at these lower standards. Most IAs contributing data to this sample were unable to meet even these reduced thresholds for the majority of their participants.

A comparison of service dosage levels among the newer and more established IAs is limited by the fact that 22 of the 27 IAs reporting these data were new programs. Only 5 IAs reporting these

data provided services prior to 2009. While all the SafeCare sites in our sample began providing services in 2009 or later, IAs providing HFA, NFP, and PAT are found in both the old and new IA samples. Keeping in mind this imbalance between the two samples, it appears that the new IAs were more successful in achieving recommended service dosage than those providing services for a longer time. On average, 45.8 percent of the participants enrolled in the newer IAs received recommended service dosage during the initial enrollment period, a level of service achieved for only 37.0 percent of participants enrolled in the more established programs. An even greater difference was observed between the two groups of IAs when we considered the proportion of participants at the level of 80 percent of recommended dosage–60.6 percent of the participants served by the newer IAs achieved this benchmark in contrast to 47.0 percent of the participants in the more established programs.

Finally, we considered the impact of participants' cumulative level of socioeconomic risk on the service dosage they received during the initial enrollment period. As we observed in our preliminary examination of early leavers from the longer-term home visiting programs, cumulative socioeconomic risk appears to have little influence on initial service dosage levels (Table VII.6). Just under half of participants in all three levels of risk received service dosages at the level intended by the models in which they were enrolled; almost two-thirds of participants in each of these three groups received at least 80 percent of the recommended dosage. While each of the individual factors contributing to a participant's cumulative risk score reflect various socioeconomic challenges to

Table VII.6. Dosage Received by Participant Risk Level

	Combined Risk Score of Participant		
	Low (0–2)	Medium (3)	High (4–5)
Percentage of Participants Who Received Appropriate Service Dosage During Initial Six Months of Enrollment	48.5	45.2	47.1
Percentage of Participants Who Received at Least 90 Percent of Appropriate Service Dosage During Initial Six Months of Enrollment	54.6	52.7	54.3
Percentage of Participants Who Received at Least 80 Percent of Appropriate Service Dosage During Initial Six Months of Enrollment	63.5	61.2	64.3
Sample Size	**586**	**425**	**541**

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

Note: The table presents the percentage of participants within a risk category that received each of three dosage levels. The categories are not designed to add down rows or across columns. For example, starting in the first row, of those who were in the low risk category, 48.5 percent received the appropriate dosage during the observation period. Of those in the medium risk category, 45.2 percent received the appropriate dosage, and in the high risk category 47.1 percent did.

individuals meeting their parental obligations, the individual risk items had minimal impact on service dosage (Table VII.6a). A slightly lower proportion of participants who were single parents, unemployed at intake, and received public assistance at intake had the recommended service dosage during the initial enrollment period. As additional data becomes available, we will be able to examine patterns in greater detail as well as explore any variation in these distributions that may reflect differences in organizational tenure of the IA or model-specific factors.

Table VII.6a. Dosage Received by Individual Participant Risk Factors (percentages unless otherwise indicated)

	Dosage Level			
	Percentage of Participants Who Received Appropriate Service Dosage During Initial Six Months of Enrollment	Percentage of Participants Who Received at Least 90 Percent of Appropriate Service Dosage During Initial Six Months of Enrollment	Percentage of Participants Who Received at Least 80 Percent of Appropriate Service Dosage During Initial Six Months of Enrollment	**Sample Size**
Marital Status				
Married or living with partner	48.2	52.8	61.7	**193**
Single	45.3	52.7	62.5	**1,422**
Educational Attainment				
At least high school diploma	45.7	51.8	60.8	**812**
Less than high school diploma	48.9	56.6	66.1	**722**
Employment Status				
Employed	46.9	53.7	62.2	**780**
Unemployed	45.2	51.4	60.5	**484**
Teen Parent Status				
Age 20 or older at first child's birth	44.4	51.8	61.2	**885**
Less than age 20 at first child's birth	46.0	52.4	61.4	**861**
Public Assistance Receipt				
Does not receive welfare	46.3	53.0	63.3	**872**
Receives welfare	41.7	48.2	57.8	**604**

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

Note: The table presents the percentage of participants within a risk category that received each of three dosage levels. The categories are not designed to add down rows or across columns. For example, in the first column, of those who were married or living with a partner, 48.2 percent received the appropriate dosage during the observation period. Of those that were single, 45.3 percent received the appropriate dosage.

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Box VII.3. Parents as Teachers Structural Fidelity Indicators

Parents as Teachers	
Staff Caseloads	
National model developers for Parents as Teachers recommend a maximum caseload of 24 families per home visitor.	
Mean monthly home visitor caseload	13.7
Percentage of home visitors **at or below** recommended caseload	82.1%
Percentage of home visitors **below** recommended caseload	75.4%
Service Duration	
The Parents as Teachers program is designed to serve families from pregnancy through school entry.	
Percentage of participants enrolled for at least **three months**	97.3%
Percentage of participants enrolled for at least **six months**	95.3%
Service Dosage	
During the first six months of enrollment, Parents as Teachers participants are intended to receive, on average, 12 home visits.	
Percentage of participants who received intended dosage during initial six months of enrollment	22.3%
Percentage of participants who received **90%** of intended service dosage during initial six months of enrollment	23.6%
Percentage of participants who received **80%** of intended service dosage during initial six months of enrollment	25.0%
Caseload data are from 8 implementing agencies. *Duration and dosage data are from 2 implementing agencies.*	

Box VII.4. SafeCare Structural Fidelity Indicators

SafeCare	
Staff Caseloads	
National model developers for SafeCare recommend a maximum caseload of 19 families per home visitor.	
Mean monthly home visitor caseload	4.0
Percentage of home visitors **at or below** recommended caseload	97.1%
Percentage of home visitors **below** recommended caseload	97.1%
Service Duration	
The SafeCare program is designed to engage families for a period of 18 to 20 weeks.	
Percentage of participants enrolled for at least **three months**	77.3%
Percentage of participants enrolled for at least **six months**	62.1%
Service Dosage	
During the first six months of enrollment, SafeCare participants are intended to receive, on average, 12 home visits.	
Percentage of participants who received intended dosage during initial six months of enrollment	68.9%
Percentage of participants who received **90%** of intended service dosage during initial six months of enrollment	70.6%
Percentage of participants who received **80%** of intended service dosage during initial six months of enrollment	75.0%
Caseload data are from 5 implementing agencies. *Duration and dosage data are from 5 implementing agencies.*	

VIII. CONCLUSIONS AND NEXT STEPS

Model fidelity is an important concept to track when taking a home visiting initiative to scale. As state administrators and local home visiting agencies implement MIECHV, this information can be useful for targeting training and technical assistance and also for performance reporting. This report describes how the EBHV cross-site evaluation is examining fidelity across a range of home visiting models. Program administrators can use fidelity data to demonstrate that public investments are achieving required service delivery levels associated with positive child and family outcomes. Systematically monitoring implementation across models can help state and local planners maintain quality standards and identify any need for adaptation to successfully engage and retain the target population. Using a common data collection framework enables planners to achieve the most efficient mix of interventions to maximize the fit between model characteristics, community resources, and population needs. Finally, tracking fidelity allows policymakers, program operators, and evaluators to clearly link practice to participant outcomes. In the absence of careful monitoring of program implementation, an intervention may be considered ineffective when in fact the failure lies in the implementation process (Bagnato et al. 2011; Chen 2005; Durlak and DuPre 2008; Werner 2004). Regularly assessing programs and holding them to clear performance standards gives program managers timely information necessary for identifying specific areas in which programs are not meeting expectations. In such cases, managers can provide appropriate technical assistance and enable programs to improve and succeed.

The EBHV initiative was designed, in part, to explore whether high quality programs can be implemented in "real world" settings and if this replication process can be facilitated or enhanced through the development of infrastructure improvements. While these data are preliminary and reflect only the first 18 months of operation, the findings suggest that the subcontractors and IAs embrace many of the practice elements recommended by the national models. Specifically, agencies are hiring qualified staff and enrolling participants consistent with the characteristics of those individuals targeted for and likely to benefit from services. As of December 2010, the early period of EBHV implementation, the cross-site evaluation could not yet analyze how or if infrastructure development contributed to this performance. The final cross-site evaluation report will address those issues. Given the variability in the performance on key benchmarks observed across agencies implementing a common national model as well as multiple IAs operating under the auspice of a single subcontractor, these early findings do suggest that achieving program fidelity is influenced by diverse factors. National model guidelines, training, and monitoring systems may not, in and of themselves, generate high model fidelity among their affiliates. Local organizational characteristics as well as contextual issues such as the depth and quality of the local service system, and the availability of qualified staff also may contribute to how program models are implemented and sustained over time. In fact, selection of any specific home visiting program is not a random event. Local services agencies, their funders and, in some cases, potential program participants choose the program they believe best fits their needs and strengths. This is particularly true in the case of the EBHV subcontractors, all of which had to submit a collaborative proposal to secure funding. While the more complete sample and longer observation period available to us in the final report will allow for a fuller examination of the relative importance of program and contextual variations in achieving fidelity, the non-random nature of program selection will limit our ability to generalize any patterns we observe within and across models in our sample to the full universe of home visiting services.

A. Implementation Challenges

Replicating evidence-based programs with fidelity is a challenging task. This sample of IAs faced difficulty in sustaining full caseloads, retaining participants for the full course of service, and delivering a service dosage commensurate with model specifications. The majority of home visitors in our sample operated with caseloads below expected levels, approximately one-quarter of our participant sample left services before completing the recommended course of service, and during the first six months of enrollment the majority of families received less than 80 percent of the visits recommended by their respective models. The EBHV data suggest these issues are ongoing concerns all IAs face. These challenges are not surprising and are reflective of the range of issues often cited in the literature as among the reasons evidence-based programs struggle to achieve the impact levels observed in their randomized clinical trials (Durlak and DuPre 2008). Moving forward, we will be examining the potential influence of infrastructure reforms being promoted by the EBHV subcontractors such as universal intake systems, workforce enhancements, and more robust partnerships and service collaboratives may have on the ability of IAs to address these challenges.

B. Practice Lessons

The EBHV fidelity framework provides subcontractors and IAs with an important tool for documenting the characteristics and service experiences of their program participants in a time-sensitive manner. As such, we shared these preliminary findings with the subcontractors on several occasions (June 2011 and November 2011), highlighting key trends observed across sites as well as within their specific IAs. The cross-site evaluation team has noted that the fidelity information can be helpful in providing early warning signs of notable changes in the relative risk and challenges facing those families seeking services, allowing program managers to adjust staff training and supervisory efforts to ensure home visitors are aware of such changes and of the expanded array of service referrals which may be needed. An increase in the proportion of participants leaving services before completing the program or a notable drop in service dosage also might suggest the need for increased supervision or more intensive observation of service delivery.

When used for program improvement, the types of data described in this report can go beyond a performance monitoring function and inform program management and promote collective problem-solving. Data like these, collected and analyzed longitudinally, provide usable, actionable information at the family, staff, supervisor, and agency level. At the April 2012 National Conference on Child Abuse and Neglect, subcontractors presented on their use of the cross-site and locally collected fidelity data to address systems issues (including obtaining appropriate referrals) and improve supervision and staff capacity to use data for program improvement. Subcontractors report having "data parties," an idea promoted at one of ACF's first subcontractor meetings, where local evaluators and program staff come together to review key measures of service delivery and child and family well-being. The final report will provide additional examples of how the fidelity data have been used to inform and improve practice.

C. Data Limitations and Planned Improvements

As described in Chapter III and Appendix A, this preliminary analysis provides a glimpse of what is possible with the fidelity data but has a few important limitations, some that the cross-site team has addressed by improvements in the data collection approach or that will be addressed by having a longer observation period (through June 2012 for the final report). First, not all IAs

submitted data for each data element, limiting our ability to conduct thorough analyses across data sources. In addition, there were missing data issues within and across data sources and home visiting models that limit the generalization of the findings. The cross-site team worked closely with subcontractors and IAs to reduce missing data, correct and make data edits as needed, and ensure that the data collection systems were working properly. To that end, the cross-site team made some improvements to the EBHV Fidelity Database designed to identify data errors and streamline data entry. A second limitation is that this report provides a snapshot of early implementation (through December 2010). The relatively short data collection period did not encompass the intended family service period for the longer-term home visiting models and in fact, only a relatively small number of families were enrolled in any model long enough to "graduate." With more than two years of data, the final report will provide a fuller analysis of the characteristics of families and staff and the services families received. The expanded observation period and increased number of participants also will allow us to better specify the characteristics and service experiences of families who are unable or unwilling to complete the full course of service.

D. Final Report

The cross-site evaluation final report, expected for delivery to ACF and HRSA in spring 2013, will include a chapter on the fidelity findings using all of the data collected through June 2012 as well as multivariate analyses that bring together the fidelity, systems, and process study data. The 35 IAs that collect family-level fidelity data and agreed to participate in the cost study will contribute to analyses that assess home visit costs by model and by IA. These types of analyses, the first to use common measures and indicators across five different home visiting models, will contribute to MIECHV implementation as well as to the broader field of home visiting and provision of early childhood services. By focusing on staff- and family-level data and pairing it with characteristics of home visits, the status of systems infrastructure development activities, and implementation successes and challenges, the EBHV final report will assess how variation in infrastructure development and degree of implementation predicts fidelity. The final report will build on the work conducted for this report and extend the lessons from it for practice, policy, and research.

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APPENDIX A

METHODOLOGICAL DETAILS

A. Study Design: Data Sources, Sample, and Selection

There are 17 subcontractors participating in the EBHV cross-site evaluation. Nine subcontractors are the implementing agency (IA) for the EBHV program and administer systems level and direct service activities. Eight subcontractors work with from 2 to 14 IAs as part of the EBHV initiative. As of October 1 2009, across the 17 subcontractors, 50 IAs provided home visiting services to participants. Of these, 44 IAs agreed to provide data to the EBHV cross-site evaluation, including data that could be used to assess the fidelity with which home visiting models are being implemented. Three data sources (monthly program reports, the EBHV Fidelity Database, and the Nurse Family Partnership (NFP) – Efforts to Outcomes [ETO] system) provide elements for analysis of structural and dynamic aspects of fidelity. This report analyzes data describing service delivery between October 1, 2009 and December 31, 2010 at 44 IAs.

B. Fidelity Data Collection Approach

Fidelity data collection efforts are local and occur on a quarterly or monthly basis. Data are collected locally by staff at IAs and transmitted to the EBHV cross-site evaluation team directly, through the subcontractor, or through the model developer. To maximize the collection of high quality data, in February 2010 the cross-site evaluation team hosted a webinar for subcontractors that focused on fidelity data collection. The training focused on the fidelity measures as well as procedures for training data collection staff at IAs, strategies for high quality data collection, and common data collection challenges. The cross-site evaluation team developed a training manual and provided it to all 17 subcontractors.[1] The training manual contained all necessary data collection forms (see Appendix C of this report).

As described in Chapter III, Figure III.1 provides a schematic of the data collection process. Two elements should be noted. First, not all data elements are collected on an on-going basis. For example, demographic information for both home visitors and participants is collected only once in the EBHV Fidelity Database. However, home visitor and supervisor monthly caseloads are collected monthly, and home visit encounter information is collected for each scheduled home visit – regardless of whether the home visitor actually met with the participant. Second, subcontractors implementing the NFP model only collect program-level and home visitor or supervisor information in the EBHV Fidelity Database. Participant-level data, with the exception of the Working Alliance Inventory, is provided to the cross-site evaluation team by the NFP's National Service Office (NFP-NSO) through the NFP-ETO data system.[2]

The majority of subcontractors are using the cross-site evaluation EBHV Fidelity Database to provide some fidelity data about home visitors, supervisors, and participants. As discussed below, not all of the subcontractors or IAs provided all of the requested data. From the database, four de-identified extracts are generated that contain the data on home visitors, supervisors, and participants.

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[1] Barrett, Kirsten, Heather Zaveri, Debra A. Strong "Fidelity Data Collection Manual for the Evidence-Based Home Visiting to Prevent Child Maltreatment Cross-Site Evaluation." Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. 2010 Feb. Contract No.: GS-10F-0050L/ HHSP233200800065W. Available from Mathematica Policy Research, Princeton, NJ.

[2] NFP shifted from the NFP-CIS (Client Information System) to the NFP-ETO system during early 2011. All NFP-CIS data were migrated into the NFP-ETO system and the EBHV cross-site evaluation team received extracts from the NFP-ETO system.

These extracts are sent to the cross-site evaluation team on a quarterly basis. A few subcontractors submit one or more of the required extracts in an alternative format (for example, SPSS and Excel) from their pre-existing data collection system. Subcontractors using alternative formats were provided with the file layouts, an EBHV Fidelity Codebook that contained the variables in the file layouts, indicated the variable type (alpha, numeric, date, etc), and the response category values, and annotated instruments to help connect the various data forms with the EBHV Fidelity Codebook.[3] They were asked to adhere to these to the extent possible. A consequence of accepting alternative file formats is that some of the subcontractors have more missing data than others, as the files are usually generated via an existing database that pre-dated the EBHV cross-site evaluation and thus may not include all the items in the EBHV Fidelity Database.

The EBHV cross-site evaluation team processes the data received. Data from all sources (NFP-ETO, EBHV Fidelity Database, monthly reports, and pre-existing subcontractor data systems) are reviewed for errors, which are communicated to the subcontractor and data provider and resolved if possible. To support the combining of similar data elements from multiple systems (for example, NFP-ETO, EBHV Fidelity Database, and subcontractors' pre-existing data systems) the data are cleaned and recoded to the extent possible.

C. Data Sources

Monthly program reports. Each month the IA completes a monthly program report form (see Appendix C). The form captures information regarding: the program model implemented, enhancements to the standard program model, certification by the national model developer, and program capacity (funded participant slots, whether functioning at full capacity, number of families newly referred, number of referred families that met program criteria, and group meetings for home visitors and supervisors). Completed monthly program reports are transmitted to the cross-site evaluation team in paper form where they are entered electronically.

EBHV Fidelity Database. All subcontractors collect some information in the cross-site evaluation team-developed Access database. All subcontractors provide information about home visitors and home visitor supervisors, including demographic and employment data as well as model-specific training, monthly caseloads, and when, and why, the staff member stopped providing services as a part of the program. The data extracts are submitted to the cross-site evaluation team quarterly. Each extract is reviewed for errors, which are addressed with the subcontractor and corrections made where possible.

EBHV Fidelity Database for Subcontractors Implementing HFA, PAT, SafeCare, and Triple P. IAs providing home visiting using the Healthy Families America (HFA), Parents as Teachers (PAT), SafeCare or Triple P models collect additional data on their participants in the EBHV Fidelity Database. They provide information on referrals; demographic information for participants; pregnancy history and children born; and each home visit, including when the visit occurred, how long the visit lasted, where the visit occurred, and what topics or activities were the focus of the visit. Additionally, any IA collecting the Working Alliance Inventory (WAI), which assessed the relationship developed between the home visitor and participant, submits those data

[3] These materials were developed and shared with subcontractors as needed. The materials needed to be tailored to the particular home visiting model(s) the subcontractor was implementing.

through the EBHV Fidelity Database. As of December 31, 2010, few participants had left the program and therefore complete data (baseline and at exit) were not available and thus the WAI is not presented in this report but will be included in the cross-site evaluation final report.

NFP-ETO Data System. NFP IAs use the NFP-ETO data system to collect data on their participants and home visit encounters. The information is nearly identical to the information the HFA, PAT, Safe Care and Triple P IAs provided through the EBHV Fidelity Database and includes: referrals, demographic information, infant and maternal health, and characteristics of each home visit (date, length of visit, location, and topics or activities addressed). The IA enters data into the NFP-ETO system which is uploaded to the NFP-NSO data system. The NFP-NSO provides the cross-site evaluation team with a data extract for IAs which are a part of the cross-site evaluation and have a data sharing agreement in place with the NFP-NSO. The data extract contains selected items which were a part of the NFP-CIS system, which was in place during the design of the EBHV Fidelity Database, and informed the development of the EBHV Fidelity Database to ensure commonality of data across IAs irrespective of the model being implemented.

There were a few changes to items during the transition from the NFP-CIS to the NFP-ETO systems. To the extent possible the cross-site evaluation team addressed these changes to improve the congruence between data sources. In some cases, the response categories for an item changed. For example, see the slight restructuring of the response categories for total yearly household income in Table A.1. The NFP-ETO categories were retained resulting in slightly different income response categories for NFP programs and programs submitting data through the EBHV Fidelity Database. Similarly, the response options for the source of the referral were revised to include "self" and an unknown option. The NFP-ETO response categories for source of referral were re-coded to match those in the EBHV Fidelity Database. Other variables are collected differently in the NFP-ETO than in the NFP-CIS system. For example, race is collected as a text or character variable that the cross-site evaluation team will recode into binary race and ethnicity variables so that the NFP-ETO data is similar to the EBHV Fidelity Database data on race and ethnicity.

Table A.1. Changes in income response options from NFP- CIS to NFP- ETO

Initial (NFP-CIS) Response Options	New (NFP-ETO) Response Options
(1) Less than or equal to $3,000	(1) Less than or equal to $6,000
(2) $3,001 - $6,000	(2) $6,001 - $12,000
(3) $6,001 - $9,000	(3) $12,001 - $20,000
(4) $9,001 - $12,000	(4) $20,001 - $30,000
(5) $12,001 - $15,000	(5) $30,001 - $40,000
(6) $15,001 - $20,000	(6) Over $40,000
(7) $20,001 - $30,000	(7) Client is dependent on parent/guardian
(8) $30,001 - $40,000	
(9) Over $40,000	
(10) Don't Know	

Source: Clinical Information System Annotated Instrument List (Data Dictionary), 2006 and Personal Correspondence with NFP-NSO.

D. Sample Variation in Data Elements Provided Across IAs

Although all 17 participating subcontractors agreed to share data with the cross-site evaluation team, not all IAs collected or contributed all data elements. This report is based on the data for participants served between October 1, 2009 and December 31, 2010 that the cross-site evaluation team had in-hand as of March 2011. Table A.2 presents the specific data elements each IA contributed to this analysis. The cross-site evaluation team received some data from all 17

subcontractors. Forty-four IAs, representing all five home visiting models, contributed at least one data type to the fidelity analysis.

Table A.2. Summary of Data Contributed to the Cross- Site Evaluation for October 2009 – December 31, 2010 as of March 2011, by IA

IA	Model	Number of Participants [a]	Number of Staff [b]	Number of Monthly Caseload Reports [c]	Number of Home Visits [d]	Number of Monthly Program Reports [e]
1	HFA	25	7	28	105	5
2	HFA	22	5	25	145	5
3	HFA	0	4	64	0	3
4	HFA	0	6	95	0	3
5	HFA	0	13	126	0	3
6	HFA	0	5	64	0	3
7	HFA	0	5	80	0	3
8	HFA	0	6	81	0	3
9	HFA	63	10	77	772	3
10	HFA	0	0	0	0	3
11	HFA	0	0	0	0	3
12	HFA	0	0	0	0	3
13	NFP	100	5	51	871	10
14	NFP	80	0	0	705	0
15	NFP	72	0	0	1128	0
16	NFP	68	0	0	944	0
17	NFP	0	9	27	0	3
18	NFP	0	7	21	0	3
19	NFP	92	6	54	1165	0
20	NFP	53	6	26	566	10
21	NFP	70	0	0	842	3
22	NFP	129	5	20	2111	4
23	NFP	71	5	20	1110	4
24	NFP	122	6	21	2412	4
25	NFP	138	5	20	1567	4
26	NFP	96	5	20	1391	4
27	NFP	57	5	20	1378	4
28	NFP	60	5	22	427	4
29	NFP	131	0	0	1779	3
30	NFP	88	0	0	1028	1
31	PAT	0	13	132	0	3
32	PAT	0	6	96	0	3
33	PAT	0	3	50	0	3
34	PAT	0	7	86	0	3
35	PAT	0	7	94	0	3
36	PAT	0	4	64	0	3
37	PAT	38	6	67	640	3
38	PAT	37	8	83	144	15
39	SafeCare	40	7	73	412	0
40	SafeCare	5	2	28	55	0
41	SafeCare	30	5	49	482	0
42	SafeCare	37	12	122	305	14
43	SafeCare	7	5	12	72	3
44	TripleP	64	12	82	660	15
Total		**1,795**	**227**	**2000**	**23,216**	**169**

Source: Cross-site evaluation team tabulations of data from the EBHV Fidelity Database, NFP-ETO, extracts submitted from pre-existing systems, and hard copies of monthly program reports submitted to the cross-site evaluation team.

[a] Participant data comes from the following sources by model: Safe Care – EBHV Fidelity Database; NFP – NFP-ETO System; HFA – EBHV Fidelity Database; PAT – EBHV Fidelity Database; TripleP – EBHV Fidelity Database and own system.

[b] Staff data come from the EBHV Fidelity Database for all models.

[c] Monthly caseload data comes from the EBHV Fidelity Database for all models.

[d] Data on the home visit encounters comes from the EBHV Fidelity Database for Safe Care, HFA, PAT, and Triple P. Data on home visit encounters comes from the NFP-ETO system for NFP sites.

[e] Monthly progress report data are submitted in hard copy to Mathematica.

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

Participant data are provided by 27 IAs. The primary reason the participant data are not provided by 17 IAs is that data sharing agreements were not in place or did not support the sharing of these data. Participant data are missing from 17 IAs concentrated within 3 subcontractors. One state has 12 of the 17 IAs that did not contribute participant-level data because agreements between the IAs and state did not involve sharing participant-level data. Another state's two IAs had not approved sharing of data with the cross-site team as of the data submission deadline. Three of a third state's HFA IAs were unable to submit data by the deadline. The cross-site team is working with subcontractors to ensure that data can be submitted for the final report.

Thirty-five IAs provided staff data to the cross-site evaluation team through the EBHV Fidelity Database. Nine IAs did not provide staff data from the EBHV Fidelity Database to the cross-site evaluation team for the fidelity analysis. Six of the nine IAs that did not provide staff data are implementing NFP, indicating that they are not using the EBHV Fidelity Database to any great extent. The cross-site evaluation team does have staff data for all five models. Only two subcontractors provided no staff data that could be included in this initial report.

Thirty five IAs submitted at least one monthly caseload report to the cross-site evaluation team. The monthly caseload data are extracted from the EBHV Fidelity Database. The cross-site evaluation team did not receive monthly caseload data from 9 IAs. Six of the IAs which did not provide monthly caseload data are implementing NFP; one reason could be the lack of an ongoing reporting relationship between subcontractors and their IAs which may limit the subcontractor's ability to secure these data.

Twenty-seven IAs provided data on at least one home visit offered during the time period. Seventeen IAs did not provide any information on the home visits offered during the time period.

Thirty-seven IAs provided at least one monthly program report. Seven did not provide monthly program reports. The monthly program reports are the only data submitted to the cross-site evaluation team directly by the sites, which did not use the EBHV Fidelity Database; the different delivery mode may be part of the reason why monthly reports were not submitted differentially within and by subcontractors. Two subcontractors did not submit monthly program reports from any of their IAs in a format that could be used for the time period covered in this report.

E. Analytic Approach

In October 2010, trial subcontractor submissions from the EBHV Fidelity Database and NFP-ETO system were processed by the cross-site evaluation team. To address any data collection or data entry issues, the cross-site evaluation team provided feedback on the data submissions to the subcontractor and/or the IA submitting the data.

The cross-site evaluation team examined the data to determine whether they were of sufficient quality to support the examination of a particular structural or dynamic fidelity indicator. Members of the team examined the frequencies and range of each item across the full dataset to see if there were patterns suggesting collection for that item was problematic at any level – that is within an IA, across a particular home visiting model, across IAs within a subcontractor, or overall.

The cross-site evaluation team contacted the organization submitting the data to understand any issues identified within the EBHV Fidelity Database or monthly program reports. The cross-site team discussed the issues observed in the data and provided technical assistance to support the organization in correcting the data collection or entry issue moving forward. The organization was asked to submit documentation for any changes that needed to be made to the data. The cross-site evaluation team made the documented corrections in the course of preparing the data for analysis.

The cross-site evaluation team communicated with the NFP-NSO to understand issues related to the NFP-ETO data. In some cases, an item or its responses were changed during the migration from the NFP-CIS to the NFP-ETO system. For example, the income response categories were modified. In those cases, the cross-site evaluation team ensured the change was documented and used during the course of the analysis. Variables with clear data entry issues that could be rectified were corrected to support the analyses; for example a visit's start or stop time appearing as "11:00" would be changed to 11:00 AM. Unfortunately, other cases with unique data errors could not be corrected as it is not possible for the cross-site evaluation team to identify the particular family with the unexpected values and request a correction from the IA.

The cross-site evaluation team also addressed missing data within the submissions. Data in the EBHV Fidelity Database or monthly program reports which were missing were discussed with the subcontractors and/or the IAs and we asked them to submit a data correction document. The cross-site team corrected errors, including adding previously missing data, in the preparation of the data for analysis. Because the data sharing agreements between the cross-site evaluation team, NFP-NSO, and NFP IAs ensure that there is minimal identifiable information in the datasets provided, it is challenging to identify and correct missing data issues. However, in the case of missing demographic information in the first collection of demographic information, the cross-site team used demographic data collected later to fill in missing values.

F. Construction of Analytic Variables and Fidelity Indicators

1. Units of Analysis

Table A.2 shows the amount of data of each type contributed by each of the 44 IAs to these analyses. Throughout this report, the unit of analysis varies. Unless the sample size is specified as the "Number of IAs," data are presented at the individual participant, staff person, or home visit level.

Descriptive information is always presented at the participant, staff member or home visit level. For some IAs, not all participant or staff data was available. The prevalence of missingness in these data was problematic. In order to report as much information as possible, items are presented even when they suffer from missing data. The sample sizes listed in tables are the maximum sample sizes, but the actual sample varies by item. In some cases, when the sample size is significantly reduced due to missing data (defined as >20% missing), the distribution in the table is marked with an asterisk (*) and these should be interpreted carefully.

Fidelity indicators are calculated at the IA level and then averaged across all IAs for which that indicator is calculated. The number of IAs included varies from 5 to 38, depending on what data is needed to calculate the indicator.

2. Descriptive Information

The first step in the analysis was to look at the descriptive information available to begin to get a picture of the IAs included in the analysis. Means and frequencies of demographic variables were calculated for each agency's participants and staff. Some new categorical variables were created to simplify presentation. Summaries of participant and staff populations by model were presented to model developers[4] for their input on how well these reflected their models' national populations. In all cases, developers believed the populations being analyzed were not drastically different than expected.

A risk scale variable was calculated to summarize the relative risk level among participants. This scale was adapted from one used in the Early Head Start Family and Child Experiences Survey (Baby FACES; Vogel et al. 2011). Five socioeconomic risk factors are identified:

- Receiving TANF, SNAP or SSI benefits
- Being unemployed and not enrolled in school
- Having less than a high school education
- Having been a teen at the time of one's first birth
- Being single

The factors are summed for each participant and they are defined as low- (0, 1, or 2 factors), medium- (3 factors), or high-risk (4-5 factors). In the case of missing data for one of the factors, the mean of the other 4 is added. If the data for more than one factor is missing, the risk scale is not calculated. This is the case for all Triple P participants, because the IA delivering that model did not provide this information. That model's participants are excluded from analyses involving the risk scale.

A few notes of caution should be taken when looking at descriptive information presented in this report. As stated earlier, limited data and the prevalence of missingness necessitate the need to pay close attention to sample sizes, especially those items marked as "highly missing" (noted in tables with an asterisk). Another important qualification is that socioeconomic data on participants was not consistently collected at the time of their enrollment, and in some cases were recorded awhile after referral. To the extent that these characteristics (e.g. age, education, income) can vary over time, they should not necessarily be interpreted as baseline measures. Also, in some instances, multiple questions on the data collection forms contained conflicting answers around a certain topic (e.g. educational attainment). These cases were looked at and given the majority answer or highest level, depending on the data available.

[4] National model development staff involved throughout analyses included: Kathryn Harding (HFA), Molly O'Fallon (NFP), Karen Guskin (PAT), and Daniel Whitaker (SafeCare). For Triple P we consulted with Ron Prinz and Rita Bostick at the national level and Stacey Clettenberg, subcontractor director at the Texas Triple P site because decisions about local implementation and adaptation of Triple P were made by the subcontractor team. .

The next analyses looked at the home visits being conducted. The percent of home visits completed is presented with caution given that the definition of planned visits and how they were recorded differed across IAs. Some interpreted this as any visit that was scheduled but not completed, while others only counted no-shows (i.e. if the visit was rescheduled prior to the scheduled day and time, it was not counted as incomplete).

Because the five home visiting models being studied vary significantly, model-specific data collection forms were created to capture information about the content of the home visits. These Home Visit Encounter Forms were presented to development staff from each model prior to use. For each model a table is presented showing information on the topics and activities addressed during home visits. For all models except NFP, the Home Visit Encounter Form includes an additional category for time spent addressing emergencies during each visit. This time was removed and the other activities prorated to give percent of non-emergency time spent on each activity. The average percent of time does not sum to 100% due to miscalculations on the original data forms, as well as a small number of cases in which the entire visit was reported as having been spent dealing with an emergency.

3. Fidelity Indicators

The main part of the analysis was the creation of a framework of indicators designed to measure different aspects of program fidelity. This allows for looking at fidelity across different models that have differing levels of specification regarding what they expect from replication sites. The full list of fidelity indicators is presented in Table II.1. This section provides additional technical details about how indicators were constructed.

Home visitor and supervisor caseloads. When calculating mean caseloads for both home visitors and supervisors, only full-time staff were included because their caseloads would be expected to be comparable. National model development staff were asked to provide information on suggested maximum caseloads for workers delivering their models. These guidelines are included in Appendix B and Table II.1. To determine if a worker was at or below the required caseload level throughout the observation period, their monthly caseloads were compared to the level set by the model. For part-time staff or those who split their time between home visiting and supervising, their monthly caseload values were prorated for the percentage of time they work in each role.

Duration. Because the national models are designed to engage families for varying lengths of time, it is difficult to make comparisons about participant duration. To give an idea of how long families are staying enrolled, 3 and 6 month duration percentages were calculated. However, these values may overstate retention rates. Because of the limited data collection period, those families who were enrolled close to the end of the time frame (less than 3 months or less than 6 months) but remained enrolled through the end of data collection were counted as having reached each level of duration.

Dosage. Dosage is calculated as the number of visits a family received during the first 6 months of enrollment. For families who were enrolled for less than 6 months, their total number of visits was prorated for their length of enrollment. Model developers provided estimates for the average number of intended visits for the first six months of enrollment for their program, which are listed in Table II.1. To better illustrate what is happening with the families who are not receiving the full recommended dosage, indicators are also calculated which show the percentage of families receiving 90% and 80% of the intended visits.

Planned visits. As stated above, there was some confusion among agencies as to how to record planned, rescheduled and completed home visits. However, this is an important aspect of program operation and is presented in a series of indicators. No model specifically discusses expectations for completing planned visits, but for illustrative purposes, possible thresholds were established at 50% and 75% of planned visits being completed.

WAI and Subscales. The Working Alliance Inventory (WAI; Santos 2005) is adapted from the original version designed to measure the alliance or relationship between a therapist and client. It contains three subscales which measure the agreement on the goals of the program (Goal Setting), agreement on how to achieve the goals (Tasking), and the development of a personal bond between the home visitor and client (Bonding). As noted in Chapter II and above, the WAI indicators are not included in this report.

G. Data Limitations

The cross-site evaluation team has no direct involvement in the collection of data from the home visitors, home visitor supervisors, or participants. This provides an opportunity for variations in how data are collected, the timing of data collection, and the extent to which data are missing. The training offered in February 2010 focused on the fidelity data collection processes and was intended, in part, to provide information to subcontractors that would make the data collection more systematic and the resulting data of similar quality across subcontractors.

In June 2011, the cross-site evaluation team shared with each subcontractor the initial summary findings for their IAs from the fidelity analyses on the data submitted through December 2010, including the amount of data provided. The goal was that the initial sharing of preliminary findings would inform program improvement and emphasize the importance of collecting the data systematically for all IAs and submitting it to the cross-site evaluation team in a timely fashion.

Due to the variation in the data submitted by subcontractors, the number of subcontractors, IAs, home visitors, home visitor supervisors, and participants contributing to each analysis differs. Each table clearly presents the sample size for that analysis. The cross-site team cannot generalize the findings beyond the IAs and subcontractors that submitted data during the early phase of EBHV implementation. Given the nature of data presented, including small sample sizes or large differences in the amount of data provided per IA and across home visiting models, no statistical analyses were conducted for this report. As more data are available and analyzed for the final report, the cross-site team should be in a better position to assess representativeness of the data and determine whether statistical tests are warranted.

APPENDIX B

SUMMARY OF SUBCONTRACTOR- SELECTED HOME VISITING PROGRAM MODEL REQUIREMENTS

Table B.1. Summary of National Model Accreditation Requirements for Subcontractor-Selected Models

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

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

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

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

Table B.2. Summary of Home Visitor Education and Experience Requirements for Subcontractor-Selected Models

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

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

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

Table B.3. Summary of Training Requirements for Home Visitors and Supervisors for Subcontractor-Selected Models

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

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

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

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

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

Table B.4. Summary of Target Populations for Subcontractor- Selected Models

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

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

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

Table B.5. Summary of Expected Dosage and Duration of Subcontractor- Selected Models

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

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

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

Table B.6. Summary of Supervision Requirements Specified by the Subcontractor- Selected Models

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

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

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

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

APPENDIX C

DATA COLLECTION FORMS

C.1: Program- Level Monthly Data Reporting Form

C.2: Program- Level Annual Funding Report Form

C.3: Home Visitor / Home Visitor Supervisor Demographic And Employment Characteristics Form

C.4: Home Visitor / Home Visitor Supervisor Model- Specific Training Form

C.5: Home Visitor / Home Visitor Supervisor Monthly Caseload Form

C.6: Home Visitor / Home Visitor Supervisor Program Exit Form

C.7: Participant / Child Referral Form

C.8: Participant Demographic Form

C.9: Pregnancy History And Child Information Form

C.10: Home Visiting Encounter Form

C.11: Family / Child Program Exit Form

C.1: PROGRAM-LEVEL MONTHLY DATA REPORTING FORM

Grantee Name: _____

Service Delivery Location: _____

This form contains monthly information for:

Month:_____ Year: 2 0 __ __

Date form was completed: __ __ / __ __ / __ __ __ __

Reporting date should fall within the month following the month for which data are being reported. For example, if you are reporting for November 2009, the reporting date should fall between December 1 and December 31, 2009.

SECTION I: PROGRAM MODELS AND CERTIFICATION

1. List each home visiting model currently being implemented or planned to be implemented at your service delivery location. For each, indicate if it is currently implemented or if it planned to be implemented in the future.

   Once a model is marked as "currently implemented," the model does not need to be reported on for this item in subsequent months.

Home Visiting Model	Implementation Status
a.	☐ Currently implemented ☐ Implementation planned
b.	☐ Currently implemented ☐ Implementation planned

2. Describe any enhancements you are making to each home visiting model at your service delivery location.

   If no enhancements have been made to any home visiting model at this local site, check here and go to Question 3. ☐

Home Visiting Model	Describe Enhancements
a.	
b.	

3. List each home visiting model at this service delivery location. Then, for each, indicate if implementation of this home visiting model at this location has been certified by the national model developer. If so, record the certification date.

   Once implementation of the model is certified by the national model developer, the model does not need to be reported on for this item in subsequent months.

Home Visiting Model	**Implementation Certified by National Model Developer**
a.	☐ Yes → __ __ / __ __/ __ __ __ __ (date) ☐ No
b.	☐ Yes → __ __ / __ __/ __ __ __ __ (date) ☐ No

SECTION II: PROGRAM CAPACITY

4. For each home visiting model at this service delivery location, how many slots are currently funded (full capacity)?

Home Visiting Model	**Slots Currently Funded**
a.	__ ,__ __ __ (# of families)
b.	__ ,__ __ __ (# of families)

5. For each home visiting model at this service delivery location, indicate if the number of families that can be enrolled when this home visiting model is at full capacity and whether there has been a change in capacity since the previous month.

Home Visiting Model	**Capacity Status and Change in Full Capacity**
a.	Does current enrollment equal full capacity? ☐ Yes ☐ No Has there been a change in capacity? ☐ Yes ☐ No
b.	Does current enrollment equal full capacity? ☐ Yes ☐ No Has there been a change in capacity? ☐ Yes ☐ No

6. What is the total number of families that were newly referred for services through this home visiting model in the past month?

Home Visiting Model	**Number of Newly Referred Families**
a.	__ ,__ __ __ (# of families)
b.	__ ,__ __ __ (# of families)

7. Of all families reported as referred in the preceding item, how many met the criteria for participation in the home visiting program model?

Home Visiting Model	**Number of Newly Referred Families That Met Participation Requirements**
a.	__ ,__ __ __ (# of families)
b.	__ ,__ __ __ (# of families)

8. How many group meetings have occurred this month in which both home visitors and home visitor supervisors participated?

   If none, enter '0'.

Home Visiting Model	**Number of Group Meetings this Month**
a.	__ __
b.	__ __

9. On average, how long did each group meeting last?

   Your best estimate is fine.

Home Visiting Model	**Average Duration of Group Meetings**
a.	__ __ __(minutes)
b.	__ __ __(minutes)

C.2: PROGRAM-LEVEL ANNUAL FUNDING REPORT FORM

Grantee name: _____

Service Delivery Location: _____

This form contains annual information for:

January 01, 2 0 __ __ thru December 31, 2 0 __ __

Date form was completed: __ __ / __ __ / __ __ __ __

These questions should be answered in January of each year and cover funding received (monetary and in-kind) between January 1 and December 31 of the preceding year.

FUNDING SOURCES

1. Please list each source of funding for the implementation the home visiting program model(s) at this service delivery location between January 1 and December 31 of the preceding year. Then, provide the funding amount and the funding start and end dates.

The end date of funding may be actual or, if in the current year, estimated.

Funding Source	Amount	Funding Start Date (mm/dd/yyyy)	Funding End Date (mm/dd/yyyy)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

2. Describe any in-kind/non monetary donations that you have received in support of the home visiting program model(s) at this service delivery location between January 1 and December 31 of the preceding year. Please include both materials and volunteer labor. Please provide an estimate of the monetary value of the donation and the date of receipt.

Brief Description of in-kind donation	Estimated Monetary Value	Date of Receipt (mm/dd/yyyy)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

HOME VISITOR / SUPERVISOR ID: __ __ __ __ __ __ __

Record 7-digit unique ID assigned from the spreadsheet provided by Mathematica.

(Home visitor / supervisor first name) (Home visitor / supervisor last name)

C.3: HOME VISITOR / HOME VISITOR SUPERVISOR DEMOGRAPHIC AND EMPLOYMENT CHARACTERISTICS FORM

This form should be completed for <u>each home visitor and home visitor supervisor</u> involved in the home visiting program at this local site, as soon as they are identified as being involved with the program.

Grantee Name: _____

Service Delivery Location: _____

Date form was completed: __ __ / __ __ / __ __ __ __

Home visiting model that this home visitor/supervisor is working in:

Check one only.

☐ Triple P
☐ SafeCare
☐ Family Connections
☐ Parents as Teachers (PAT)
☐ Healthy Families America (HFA)
☐ Nurse Family Partnership (NFP)

SECTION I: DEMOGRAPHIC CHARACTERISTICS

1. Sex: ☐ Male ☐ Female

2. Age:

☐ Under 20 years
☐ 20-29 years
☐ 30-39 years
☐ 40-49 years
☐ 50-59 years
☐ 60 or older

3. Race/Ethnicity: *Check all that apply:*

☐ Black/African-American
☐ Asian/Pacific Islander
☐ White, non-Hispanic
☐ American Indian/Native American
☐ Hispanic/Latina
☐ Other (specify):_____

4. Has this home visitor/supervisor completed high school or a GED?

☐ Yes, completed high school
☐ Yes, completed GED
☐ No

5. Has the home visitor/supervisor completed education or vocational training other than high school/GED?

☐ Yes
☐ No ⟶ **Go to Question 8.**

6. Highest degree obtained:

☐ Vocational/technical training program
☐ Some college, no degree
☐ Associate degree
☐ Bachelors degree
☐ Masters degree (MA, MS, MSW, MFT, etc.)
☐ Professional degree (for example: LLB, LD, MD, DDS)
☐ Doctorate degree (for example: PhD, EdD)

7. Field of study:

☐ Child development
☐ Early childhood education/education
☐ Psychology
☐ Social work/social welfare
☐ Nursing
☐ Other (specify): _____

8. Is the home visitor/supervisor currently enrolled in any kind of school, vocational or educational program?

☐ Yes
☐ No ⟶ **Go to Question 10.**

9. Please indicate the degree/credential sought and the field of study.

a. Degree/Credential Sought:

☐ Vocational/technical training program
☐ Some college, no degree
☐ Associate degree
☐ Bachelors degree
☐ Masters degree (MA, MS, MSW, MFT, etc.)
☐ Professional degree (for example: LLB, LD, MD, DDS)
☐ Doctorate degree (for example: PhD, EdD

b. Field of Study:

- ☐ Child development
- ☐ Early childhood education/education
- ☐ Psychology
- ☐ Social work/social welfare
- ☐ Nursing
- ☐ Other (specify): _____

10. Has this home visitor/supervisor ever been the primary caregiver for a child?

- ☐ Yes
- ☐ No

SECTION II: EMPLOYMENT CHARACTERISTICS

11. Date on which home visitor/supervisor began working in this home visiting model:

__ __ / __ __ / __ __ __ __ (mm/dd/yyyy)

12. Role in the home visiting model:

- ☐ Home visitor
- ☐ Supervisor
- ☐ Both

13. Does this home visitor/supervisor usually work more than 35 hours per week? If no, please include number of hours worked in a typical week.

- ☐ Yes
- ☐ No ⟶ **# of hours worked in a typical week: __ __**

14. Of the hours that this home visitor/supervisor usually works, what percentage is allocated to home visiting and what percentage is allocated to supervision in a typical week? If this home visitor/supervisor does only one activity (home visiting or supervising), enter 100% for that activity.

a. Percent allocated to home visiting: __ __ __%
b. Percent allocated to supervising: __ __ __%

15. Does this home visitor/supervisor have prior experience delivering home-based interventions to families?

- ☐ Yes
- ☐ No

16. Is this home visitor/supervisor fluent in any of the following languages, to the extent that they can conduct home visits in that language?

Check all that apply.

☐ English
☐ Spanish
☐ Other (specify):_____

HOME VISITOR / SUPERVISOR ID: __ __ __ __ __ __ __

Record 7-digit unique ID assigned from the spreadsheet provided by Mathematica.

(Home visitor / supervisor first name) (Home visitor / supervisor last name)

C.4: HOME VISITOR / HOME VISITOR SUPERVISOR MODEL-SPECIFIC TRAINING FORM

This form should be completed for <u>each home visitor and home visitor supervisor</u> involved in the home visiting program at this local site.

Grantee Name: _____

Service Delivery Location: _____

Date form was completed: __ __ / __ __ / __ __ __ __

Home visiting model that this home visitor/supervisor is working in:
Check one only.

☐ Triple P
☐ SafeCare
☐ Family Connections
☐ Parents as Teachers (PAT)
☐ Healthy Families America (HFA)
☐ Nurse Family Partnership (NFP)

1. Has this home visitor/supervisor completed model-specific training or certification?

☐ Yes → **Date of completion:** __ __ / __ __ / __ __ __ __ → **End form.**
☐ No

HOME VISITOR / SUPERVISOR ID: __ __ __ __ __ __ __

Record 7-digit unique ID assigned from the spreadsheet provided by Mathematica.

(Home visitor / supervisor first name) (Home visitor / supervisor last name)

C.5: HOME VISITOR / HOME VISITOR SUPERVISOR MONTHLY CASELOAD FORM

Grantee Name: _____

Service Delivery Location: _____

This form contains monthly information for:

Month:_____ Year: 2 0 __ __

Reporting date: __ __ / __ ___ / __ __ __ __

Reporting date should fall within the month following the month for which data are being reported. For example, if you are reporting for November 2009, the reporting date should fall between December 1 and December 31, 2009.

Home visiting model that this home visitor/supervisor is working in:
Check one only.

- ☐ Triple P
- ☐ SafeCare
- ☐ Family Connections
- ☐ Parents as Teachers (PAT)
- ☐ Healthy Families America (HFA)
- ☐ Nurse Family Partnership (NFP)

1. Role in the home visiting model:

- ☐ Home visitor
- ☐ Supervisor of home visitors
- ☐ Both

2. If a <u>home visitor</u>, what is his/her current caseload of families served through this home visiting program model, as of __ __ / __ __ / __ __ __ __?

*Please enter **last** date of month for which you are reporting..*

__ __ __ (# of families)

3. If a <u>supervisor of home visitors</u>, what is the number of home visitors in this program model supervised by this staff person, as of __ __ / __ __ / __ __ __ __?

*Please enter **last** date of the month for which you are reporting..*

__ __ __ (#)

4. Average hours of one-on-one supervision provided to home visitors in this home visiting program model between __ __ / __ __ / __ __ __ __ and **__ __ / __ __ / __ __ __ __.**

Please enter dates of the month for which you are reporting.

__ __ (hours)

HOME VISITOR / SUPERVISOR ID: __ __ __ __ __ __ __

Record 7-digit unique ID assigned from the spreadsheet provided by Mathematica.

(Home visitor / supervisor first name) (Home visitor / supervisor last name)

C.6: HOME VISITOR / HOME VISITOR SUPERVISOR PROGRAM EXIT FORM

This form should be completed for <u>each home visitor and home visitor supervisor</u> that has been involved in the home visiting program model at this local site but is now no longer involved. It is completed once, at the time the individual leaves to program.

Grantee Name: _____

Service Delivery Location: _____

Date form was completed: __ __ / __ __ / __ __ __ __

Home visiting model that this home visitor/supervisor worked in:
Check one only.

- ☐ Triple P
- ☐ SafeCare
- ☐ Family Connections
- ☐ Parents as Teachers (PAT)
- ☐ Healthy Families America (HFA)
- ☐ Nurse Family Partnership (NFP)

1. What date did the home visitor/home visitor supervisor stop working in this home visiting model or take on another role in the model?

__ __ / __ __ / __ __ __ __ (mm/dd/yyyy)

2. Why is home visitor/supervisor no longer working in this home visiting model?

Please select the primary reason.

- ☐ Left the field
- ☐ Relocated/moved out of area
- ☐ Took a position with greater salary and/or responsibility
- ☐ Position eliminated
- ☐ Involuntarily separated (for example, fired or let go)
- ☐ Other:_____

FAMILY ID: __ __ __ __ __ __ __ __
This is the 8-digit unique ID assigned from the spreadsheet provided by Mathematica.

_____ _____
(Client's first name) (Client's last name)

C.7: PARTICIPANT / CHILD REFERRAL FORM

Grantee Name: _____

Service Delivery Location: _____

Date form was completed: __ __ / __ __ / __ __ __ __

This form should be completed for each participant at the time the referral for the home visiting program is received.

Home visiting model that this participant is referred to:
Check one only.

☐ Triple P
☐ SafeCare
☐ Family Connections
☐ Parents as Teachers (PAT)
☐ Healthy Families America (HFA)

1. Relationship of participant to the target child:

☐ Birth parent, adoptive parent or step parent
☐ Foster parent
☐ Grandparent
☐ Other relative
☐ Other nonrelative

2. Initial referral date to home visiting program: __ __ / __ __ / __ __ __ __ (mm/dd/yyyy)

3. Please indicate the primary referral source.

Check one only.

☐ WIC
☐ Pregnancy testing clinic
☐ Health care provider/clinic (other than hospital)
☐ School
☐ Current client
☐ Other home visiting program
☐ Medicaid
☐ Other (specify):_____

FAMILY ID: __ __ __ __ __ __ __ __
This is the 8-digit unique ID assigned from the spreadsheet provided by Mathematica.

_____ _____
(Client's first name) (Client's last name)

C.8: PARTICIPANT DEMOGRAPHIC FORM

Grantee Name: _____

Service Delivery Location: _____

Date form was completed: __ __ / __ __ / __ __ __ __

Home visiting model this participant is in:
Check one only.

☐ Triple P
☐ SafeCare
☐ Family Connections
☐ Parents as Teachers (PAT)
☐ Healthy Families America (HFA)

This form should be completed for each participant receiving home visiting services at the service delivery location.

DEMOGRAPHIC CHARACTERISTICS

1. **Is this participant in a treatment group, a control group, or a comparison group not receiving services from any of the following home visiting models: Positive Parent Program (Triple P), Parents as Teachers (PAT), SafeCare, Healthy Families America (HFA), Family Connections, or Nurse Family Partnership (NFP)?**

   ☐ Treatment
   ☐ Control
   ☐ Non-study comparison group
   ☐ Not applicable (non-experimental site)

2. **Sex:** ☐ Male ☐ Female

3. **Date of Birth: __ __ / __ __ / __ __ __ __** (mm/dd/yyyy)

4. **Race/Ethnicity:** *Check all that apply:*

   ☐ Black/African-American
   ☐ Asian/Pacific Islander
   ☐ White, non-Hispanic
   ☐ American Indian/Native American
   ☐ Hispanic/Latina
   ☐ Other (specify):__

5. Primary language spoken in the home?

☐ English
☐ Spanish
☐ Other (specify):_____

6. Was the participant born in the United States?

☐ Yes ⟶ **Go to Question 9.**
☐ No

7. What country was the participant born in?_____

8. How many years has the participant lived in the United States?

☐ One year or less
☐ More than one year: __ __ (number of years)

9. Marital status

☐ Married
☐ Single, never married
☐ Widowed
☐ Divorced
☐ Separated

10. Is the participant currently working in a job for pay?

☐ Yes, full-time (37 or more hours per week)
☐ Yes, part-time (less than 37 hours per week)
☐ No

11. Has the participant completed high school or a GED?

☐ Yes, completed high school
☐ Yes, completed GED
☐ No ⟶ Last grade completed? __ __ (grade level)

12. Has the participant completed education or vocational training other than high school/GED?

☐ Yes
☐ No

13. Highest level of education obtained:

- ☐ Vocational/technical training program
- ☐ Some college, no degree
- ☐ Associate degree
- ☐ Bachelors degree
- ☐ Masters degree (MA, MS, MSW, MFT, etc.)
- ☐ Professional degree (for example: LLB, LD, MD, DDS)
- ☐ Doctorate degree (for example: PhD, EdD)

14. Is the participant currently enrolled in any kind of school, vocational or educational program?

- ☐ Yes
- ☐ No

15. Has the participant or his/her child received public assistance within the past 6 months?

Examples of public assistance include TANF or welfare, Medicaid, food stamps, social security benefits, unemployment insurance benefits, State Children's Health Insurance Program, WIC, and government subsidized child care.

- ☐ Yes
- ☐ No ⟶ **Go to Question 17.**

16. What kind of public assistance has the participant and/or child received?

Check all that apply.

- ☐ TANF/Welfare
- ☐ Medicaid – participant
- ☐ Medicaid – child
- ☐ Food stamps
- ☐ Social Security
- ☐ Unemployment insurance benefits
- ☐ State Children's Health Insurance Program (SCHIP)
- ☐ WIC
- ☐ Government subsidized child care
- ☐ Other (specify)_____

17. What is the participant's total yearly household income before taxes? Please include all sources of income from which she/he benefits.

This includes income received from work as well as regular income received from public assistance programs, child support, and other sources from all members of the household, whether or not they are members of the participant's family.

Your best estimate is fine.

__ __ __, __ __ __.00 ⟶ If unable to provide amount, go to question 17a.

17a. Is the total yearly household…..

☐ less than or equal to $3,000?
☐ between $3,001 - $6,000,
☐ between $6,001 - $9,000,
☐ between $9,001 - $12,000,
☐ between $12,001 - $15,000,
☐ between $15,001 - $20,000,
☐ between $20,001 - $30,000,
☐ between $30,001 - $40,000 or
☐ over $40,000?
☐ Don't know

FAMILY ID: __ __ __ __ __ __ __ __
This is the 8-digit unique ID assigned from the spreadsheet provided by Mathematica.

(Client's first name) (Client's last name)

C.9: PREGNANCY HISTORY AND CHILD INFORMATION FORM

Grantee Name: _____

Service Delivery Location: _____

Date form was completed: __ __ / __ __ / __ __ __ __

This form should be completed for each participant receiving home visiting services at this service delivery location immediately after the first home visit.

Home visiting model that this participant is in:
Check one only.

☐ Triple P
☐ SafeCare
☐ Family Connections
☐ Parents as Teachers (PAT)
☐ Healthy Families America (HFA)

ASK QUESTIONS 1 THROUGH 4 <u>ONLY IF PARTICIPANT IS ENROLLED IN HOME VISITING MODEL THAT ENROLLS DURING PREGNANCY *AND* IS TARGET CHILD'S BIOLOGICAL MOTHER</u>

1. Is the participant currently pregnant?

☐ Yes ⟶ Estimated due date: __ __ / __ __/__ __ __ __
☐ No
☐ Don't know

2. How many times has she been pregnant?
If client is currently pregnant, do not count the current pregnancy.

__ __ (# of pregnancies)

3. How many live births has the participant had? __ __ (# of live births)

4. How old was the participant at the time of her first child's birth? __ __ (age)

☐ *Not applicable, participant pregnant with first child.*

5. Target child's date of birth: __ __ / __ __/__ __ __ __

If the client is pregnant with the target child at the time of enrollment, this field should be updated when the target child is born.

6. Do any other children under age 18 live in the home?
Please only include children whose primary caregiver is the client.

☐ Yes ⟶ __ __ (#)
☐ No ⟶ **DO NOT COMPLETE REMAINDER OF FORM**

7. Please provide date of birth of each additional child living in the home.

Child #1: __ __ / __ __/__ __ __ __
Child #2: __ __ / __ __/__ __ __ __
Child #3: __ __ / __ __/__ __ __ __
Child #4: __ __ / __ __/__ __ __ __
Child #5: __ __ / __ __/__ __ __ __
Child #6: __ __ / __ __/__ __ __ __
Child #7: __ __ / __ __/__ __ __ __
Child #8: __ __ / __ __/__ __ __ __

FAMILY ID: __ __ __ __ __ __ __ __
This is the 8-digit unique ID assigned from the spreadsheet provided by Mathematica.

(Client's first name) (Client's last name)

C.10: HOME VISITING ENCOUNTER FORM: SafeCare

Grantee Name: _____
Service Delivery Location: _____

Date form was completed: __ __ / __ __ / __ __ __ __

This form should be completed for <u>each family</u> after each scheduled home visit date.

1. **Primary home visitor ID: __ __ __ __ __ __ __**
   This is the 7-digit unique ID assigned from the spreadsheet provided by Mathematica.

   (Home visitor's first name) (Home visitor's last name)

2. **Date home visit scheduled:** __ __ / __ __ / __ __ __ __

3. **Was this visit completed?**

   ☐ Yes ⟶ **COMPLETE REMAINDER OF FORM.**
   ☐ No ⟶ **DO NOT COMPLETE REMAINDER OF FORM.**

4. **Duration of visit:** __ __ __ (# of minutes)

5. **Location of visit:** ☐ Participant's home ☐ Other location

6. **SafeCare module being provided:** ***(check all that apply)***

   ☐ Health
   ☐ Home safety
   ☐ Parent-child/parent-infant interactions
   ☐ Problem solving and counseling
   ☐ Motivational interviewing
   ☐ Violence prevention
   ☐ Safety planning
   ☐ Assisting with basic needs

7. **Please indicate the percent of time during the visit covering each of the following topics/activities:**

   Assessing parent (baseline or end of module) ..... __ __ __ %
   Describing target behaviors ..... __ __ __ %
   Explaining rationale/reason for behaviors ..... __ __ __ %
   Modeling alternative behaviors ..... __ __ __ %
   Observing parent practice skills and providing feedback ..... __ __ __ %
   Rapport building conversation(s) ..... __ __ __ %
   Unplanned or emergency event not part of the actual intervention ..... __ __ __ %

8. **Total percentage of all planned content covered during the visit**: __ __ __ %

FAMILY ID: __ __ __ __ __ __ __ __
This is the 8-digit unique ID assigned from the spreadsheet provided by Mathematica.

(Client's first name) (Client's last name)

C.10: HOME VISITING ENCOUNTER FORM: Triple P

Grantee Name: _____

Service Delivery Location: _____

Date form was completed: __ __ / __ __ / __ __ __ __

This form should be completed for <u>each family</u> after each scheduled home visit date.

1. **Primary home visitor ID: __ __ __ __ __ __ __**
   This is the 7-digit unique ID assigned from the spreadsheet provided by Mathematica.

   (Home visitor's first name) (Home visitor's last name)

2. **Date home visit scheduled:** __ __ / __ __ / __ __ __ __

3. **Was this visit completed?**

   ☐ Yes ⟶ **COMPLETE REMAINDER OF FORM**
   ☐ No ⟶ **DO NOT COMPLETE REMAINDER OF FORM**

4. **Duration of visit:** __ __ __ (# of minutes)

5. **Location of visit:**

   ☐ Participant's home
   ☐ Other location

6. **Please indicate the percent of time during the visit covering each of the following topics/activities:**

   Assessment activities ..... __ __ __ %
   Listening and processing parent's concerns and input ..... __ __ __ %
   Explaining or demonstrating a parenting strategy, principle, or procedure . __ __ __ %
   Parental practice and implementation of strategies ..... __ __ __ %
   Providing feedback or prompting self-evaluation by parent ..... __ __ __ %
   Unplanned or emergency event not part of the actual intervention ..... __ __ __ %

Total percentage of all planned content covered during the visit: __ __ __ %

FAMILY ID: __ __ __ __ __ __ __ __
This is the 8-digit unique ID assigned from the spreadsheet provided by Mathematica.

(Client's first name) (Client's last name)

C.10: HOME VISITING ENCOUNTER FORM: Parents as Teachers (PAT)

Grantee Name: _____

Service Delivery Location: _____

Date form was completed: __ __ / __ __ / __ __ __ __

This form should be completed for <u>each family</u> after each scheduled home visit date.

1. **Primary home visitor ID: __ __ __ __ __ __ __**
   This is the 7-digit unique ID assigned from the spreadsheet provided by Mathematica.

   (Home visitor's first name) (Home visitor's last name)

2. **Date home visit scheduled:** __ __ / __ __ / __ __ __ __

3. **Was this visit completed?**

   ☐ Yes → **COMPLETE REMAINDER OF FORM**
   ☐ No → **DO NOT COMPLETE REMAINDER OF FORM**

4. **Duration of visit:** __ __ __ (# of minutes)

5. **Location of visit:**

   ☐ Participant's home
   ☐ Other location

Please indicate the percent of time during the visit covering each of the following topics/activities:

Formal assessment and screening tasks ..... __ __ __ %
Presenting and conducting parent-child activity..... __ __ __ %
Book reading time ..... __ __ __ %
Ongoing assessment of parent status and needs ..... __ __ __ %
Unplanned activities (addressing immediate needs/referrals) ..... __ __ __ %

6. **Total percentage of all planned content covered during the visit**: __ __ __ %

ERASE THIS PAGE?

FAMILY ID: __ __ __ __ __ __ __ __
This is the 8-digit unique ID assigned from the spreadsheet provided by Mathematica.

(Client's first name) (Client's last name)

C.10: HOME VISITING ENCOUNTER FORM: Healthy Families America (HFA)

Grantee Name: _____

Service Delivery Location: _____

Date form was completed: __ __ / __ __ / __ __ __ __

This form should be completed for <u>each family</u> after each scheduled home visit date.

1. **Primary home visitor ID: __ __ __ __ __ __ __**
   This is the 7-digit unique ID assigned from the spreadsheet provided by Mathematica.

   (Home visitor's first name) (Home visitor's last name)

2. **Date home visit scheduled:** __ __ / __ __ / __ __ __ __

3. **Was this visit completed?**

   ☐ Yes ⟶ **COMPLETE REMAINDER OF FORM**
   ☐ No ⟶ **DO NOT COMPLETE REMAINDER OF FORM**

4. **Duration of visit:** __ __ __ (# of minutes)

5. **Location of visit:**

   ☐ Participant's home
   ☐ Other location

6. **Please indicate the percent of time during the visit covering each of the following topics/activities:**

   Child development related activities ..... __ __ __ %
   Parent-child interaction related activities ..... __ __ __ %
   Health care related activities ..... __ __ __ %
   Activities related to family functioning ..... __ __ __ %
   Addressing family's environmental needs ..... __ __ __ %
   Administrative activities ..... __ __ __ %
   Unplanned or emergency event not part of the actual intervention..... __ __ __ %

7. **Total percentage of all planned content covered during the visit**: __ __ __ %

FAMILY ID: __ __ __ __ __ __ __ __
This is the 8-digit unique ID assigned from the spreadsheet provided by Mathematica.

_____ _____
(Client's first name) (Client's last name)

C.11: FAMILY / CHILD PROGRAM EXIT FORM

Grantee Name: _____
Service Delivery Location: _____

Date form was completed: __ __ / __ __ / __ __ __ __

This form should be completed for <u>each family</u> that has been involved in the home visiting program at this service delivery location but is no longer involved. It is completed once, at the time the individual leaves the program.

Home visiting modeling this participant was in:
Check one only.

☐ Triple P
☐ SafeCare
☐ Family Connections
☐ Parents as Teachers (PAT)
☐ Healthy Families America (HFA)

1. **What date did services through the home visiting program model end?**
__ __ / __ __/__ __ __ __ (mm/dd/yyyy)

2. **Date of last home visit:** __ __ / __ __/__ __ __ __

3. **Primary reason services ended**
   - ☐ Program completed
   - ☐ Declined further participation (check primary reason below):
     - ☐ Returned to work
     - ☐ Returned to school
     - ☐ Receiving services from another program
     - ☐ Pressure from family members
     - ☐ Refused new home visitor
     - ☐ Dissatisfied with the program
     - ☐ Client feels she has received what she needs from the program
     - ☐ Incarcerated or other out-of-home placement for the mother
     - ☐ Other (specify):_____
   - ☐ Miscarried/ fetal death/infant death → __ __ / __ __ / __ __ __ __ (mm/dd/yyyy)
   - ☐ Moved out of service area
   - ☐ Unable to locate
   - ☐ Excessive missed appointments/attempted visits
   - ☐ Child no longer in family's custody (parental rights terminated)
   - ☐ Maternal death
   - ☐ Infant(s) delivered

☐ Reason unknown **(PLEASE MARK ONLY WHEN ALL EFFORTS TO DETERMINE THE PRIMARY REASON HAVE BEEN EXHAUSTED)**

APPENDIX D

SUPPLEMENTAL TABLES

Table D.1. Descriptive Statistics for all Fidelity Indicators

Indicator	Mean	Standard Deviation	Low Score	High Score	Number of IAs
STRUCTURAL FIDELITY					
Service Referrals					
Percentage of total referrals during the observation period meeting model standards for characteristics of the target population	81.1	24.2	12.7	100.0	34
Staff Qualifications and Training					
Percentage of home visitors with at least a BA	73.5	33.8	0.0	100.0	35
Percentage of staff (home visitors and supervisors) completing basic model training	99.2	4.8	71.4	100.0	35
Percentage of supervisors with at least a BA	93.5	25.0	0.0	100.0	31
Home Visitor Caseloads					
Mean monthly home visitor caseload	13.4	6.8	2.1	24.8	35
Percentage of home visitors at or below required caseload for full observation period	90.9	18.4	33.3	100.0	35
Supervisory Caseloads					
Mean monthly supervisor caseload	4.1	1.9	1.0	10.0	21
Percentage of supervisors at or below required caseload for full observation period	83.3	34.2	0.0	100.0	28
Participant Enrollment/Duration					
Percentage of participants with at least one home visit who remain enrolled for at least three months or were still enrolled at the end of the observation period	90.0	9.9	60.0	100.0	27
Percentage of participants with at least one home visit who remained enrolled at least six months or were still enrolled as appropriate at the end of the observation period	81.9	16.9	33.3	100.0	27
Percentage of participants leaving the program who did not successfully complete the program	91.3	19.1	35.0	100.0	25
Mean duration for participants who left program during observation period (date of first visit to termination date) (weeks)	19.3	8.0	3.0	34.8	25
Service Dosage					
Number of visits provided or weeks of enrollment (date of first visit to date of exit or end of observation period)					
For those still enrolled	0.6	0.2	0.2	0.9	27
For successful completers	0.7	0.1	0.5	0.8	5
For early leavers	0.4	0.1	0.2	0.7	25
Mean length of time between completed visits (days)					
For those still enrolled	14.5	7.3	8.3	46.8	27
For successful completers	11.2	2.9	9.0	16.2	5
For early leavers	13.2	4.3	4.3	27.5	25
Percentage of participants who received the intended service dosage during initial six months of enrollment	44.2	24.6	0.0	100.0	27
Percentage of participants who received at least 90 percent of the intended service dosage during initial six months of enrollment	50.0	24.7	0.0	100.0	27

Indicator	Mean	Standard Deviation	Low Score	High Score	Number of IAs
Percentage of participants who received at least 80 percent of the intended service dosage during initial six months of enrollment	58.1	24.7	0.0	100.0	27
Visit Planning					
Percentage of planned visits completed across all participants	83.9	8.2	63.0	95.1	27
Percentage of participants where at least 50 percent of planned visits are completed	96.8	4.5	83.8	100.0	27
Percentage of participants where at least 75 percent of planned visits are completed	75.7	15.8	40.0	97.5	27
Percentage of completed home visits lasting at least one hour	87.4	14.6	46.4	98.7	27
DYNAMIC FIDELITY					
Provider Perception of Relationship					
Percentage of providers rating WAI Tasking Subscale items on average $\geq$ = 6[s]	56.6	29.8	0.0	100.0	11
Percentage of providers rating WAI Bonding Subscale items on average $\geq$ = 6[b]	70.8	19.3	33.3	100.0	11
Percentage of providers rating WAI Goal Setting Subscale items on average $\geq$ = 6[c]	53.2	36.2	0.0	100.0	11
Percentage of providers rating all WAI items on average $\geq$ = 6	56.3	32.5	0.0	100.0	11
Percentage of home visitors who consistently report observing very positive views (6 or 7) on more than two-thirds of the WAI items across all families	47.7	32.7	0.0	100.0	11
Participant Perception of Relationship					
Percentage participants rating WAI Tasking Subscale items on average $\geq$ = 6	79.2	21.0	39.1	100.0	11
Percentage participants rating WAI Bonding Subscale items on average $\geq$ = 6	85.9	18.9	47.8	100.0	11
Percentage participants rating WAI Goal Setting Subscale items on average $\geq$ = 6	61.0	23.5	34.8	100.0	11
Percentage participants rating all WAI items on average $\geq$ = 6	75.9	24.2	34.8	100.0	11
Shared Perceptions					
Percentage of pairs with shared expectations on Goal Setting Subscale (sum within 4 points)	77.2	18.0	40.0	100.0	11
Percentage of pairs with shared expectations on Tasking Subscale (sum within 4 points)	81.5	17.4	40.0	100.0	11
Percentage of pairs with shared expectations on Bonding Subscale (sum within 4 points)	78.4	12.3	64.3	100.0	11
Content of Home Visits					
Mean percentage content covered across all visits	96.2	3.0	89.5	100.0	27
Percentage of visits in which 80 percent of planned content is delivered	95.1	4.6	80.2	100.0	27
Responsiveness of Provider					
Percentage of visits involving unplanned or emergency assistance	21.8	20.0	3.6	62.3	11
Percentage of participants in which at least one visit involved addressing an emergency	46.9	23.9	20.0	85.7	11
Percentage of home visitors who addressed an emergency for 50 percent or more of their clients during the reporting period	45.0	23.4	16.7	80.0	11

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

[a] Tasking Subscale items include questions related to perceptions of what needs to happen to reach service goals, relative priorities among goals, the capacity of the participant to obtain a new perspective, and the perception that things are moving along the right path.

[b] Bonding Subscale items include questions related to perceptions regarding the degree to which the participant and provider like each other, appreciate each other, trust each other, and feel confident in their ability to do the job or make the changes needed.

[c] Goal Setting Subscale items include questions related to perceptions of the degree to which the participant and provider agree on service goals, jointly develop mutual goals, and agree on the level of change needed to achieve goals.

BA = bachelor's degree; HFA = Healthy Families America; HV = home visitor; MA = master's degree; NFP = Nurse Family Partnership; PAT = Parents as Teachers; WAI = Working Alliance Inventory.

Table D.2a. Fidelity Indicator Scores for All Implementing Agencies (1- 9)

Indicator	Implementing Agency 1	2	3	4	5	6	7	8	9
STRUCTURAL FIDELITY									
Service Referrals									
Percentage of total referrals during the observation period meeting model standards for characteristics of the target population	97.6	100.0	64.3	100.0	53.6	100.0	56.5	12.7	100.0
Staff Qualifications and Training									
Percentage of home visitors with at least a BA	0.0	25.0	0.0	75.0	80.0	25.0	33.3	25.0	100.0
Percentage of staff (home visitors and supervisors) completing basic model training	71.4	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Percentage of supervisors with at least a BA	100.0	100.0	0.0	100.0	--	100.0	100.0	100.0	100.0
Home Visitor Caseloads									
Mean monthly home visitor caseload	12.6	11.4	23.6	12.4	10.0	16.5	23.3	19.7	7.1
Percentage of home visitors at or below required caseload for full observation period	100.0	100.0	33.3	100.0	100.0	100.0	80.0	100.0	87.5
Supervisory Caseloads									
Mean monthly supervisor caseload	2.5	4.0	3.0	5.0	6.7	--	--	3.4	3.9
Percentage of supervisors at or below required caseload for full observation period	100.0	100.0	100.0	100.0	0.0	100.0	100.0	100.0	100.0
Participant Enrollment/Duration									
Percentage of participants with at least one home visit who remain enrolled for at least three months or were still enrolled at the end of the observation period	96.0	100.0	--	--	--	--	--	--	100.0
Percentage of participants with at least one home visit who remained enrolled at least six months or were still enrolled as appropriate at the end of the observation period	96.0	100.0	--	--	--	--	--	--	98.2

Indicator	Implementing Agency								
	1	2	3	4	5	6	7	8	9
Percentage of participants leaving the program who did not successfully complete the program	100.0	--	--	--	--	--	--	--	100.0
Mean duration for participants who left program during observation period (date of first visit to termination date) (weeks)	3.0	--	--	--	--	--	--	--	24.2
Service Dosage									
Number of visits provided or weeks of enrollment (date of first visit to date of exit or end of observation period)									
For those still enrolled	0.4	0.5	--	--	--	--	--	--	0.4
For successful completers	--	--	--	--	--	--	--	--	--
For early leavers	0.7	--	--	--	--	--	--	--	0.3
Mean length of time between completed visits (days)									
For those still enrolled	15.9	19.8	--	--	--	--	--	--	18.2
For successful completers	--	--	--	--	--	--	--	--	--
For early leavers	7.0	--	--	--	--	--	--	--	10.3
Percentage of participants who received the intended service dosage during initial six months of enrollment	0.0	4.5	--	--	--	--	--	--	1.8
Percentage of participants who received at least 90 percent of the intended service dosage during initial six months of enrollment	0.0	13.6	--	--	--	--	--	--	5.3
Percentage of participants who received at least 80 percent of the intended service dosage during initial six months of enrollment	0.0	27.3	--	--	--	--	--	--	12.3
Visit Planning									
Percentage of planned visits completed across all participants	81.9	73.1	--	--	--	--	--	--	74.3
Percentage of participants where at least 50 percent of planned visits are completed	96.0	90.9	--	--	--	--	--	--	94.7
Percentage of participants where at least 75 percent of planned visits are completed	72.0	54.5	--	--	--	--	--	--	47.4

Indicator	Implementing Agency								
	1	2	3	4	5	6	7	8	9
Percentage of completed home visits lasting at least one hour	83.3	69.8	--	--	--	--	--	--	91.0
DYNAMIC FIDELITY									
Provider Perception of Relationship									
Percentage of providers rating WAI Tasking Subscale items on average $\geq$ = 6[s]	80.0	0.0	--	--	--	--	--	--	85.7
Percentage of providers rating WAI Bonding Subscale items on average $\geq$ = 6[b]	80.0	75.0	--	--	--	--	--	--	85.7
Percentage of providers rating WAI Goal Setting Subscale items on average $\geq$ = 6[c]	100.0	0.0	--	--	--	--	--	--	57.1
Percentage of providers rating all WAI items on average $\geq$ = 6	80.0	0.0	--	--	--	--	--	--	85.7
Percentage of home visitors who consistently report observing very positive views (6 or 7) on more than two-thirds of the WAI items across all families	80.0	0.0	--	--	--	--	--	--	71.4
Participant Perception of Relationship									
Percentage participants rating WAI Tasking Subscale items on average $\geq$ = 6	95.7	70.0	--	--	--	--	--	--	83.3
Percentage participants rating WAI Bonding Subscale items on average $\geq$ = 6	95.7	75.0	--	--	--	--	--	--	95.2
Percentage participants rating WAI Goal Setting Subscale items on average $\geq$ = 6	65.2	35.0	--	--	--	--	--	--	66.7
Percentage participants rating all WAI items on average $\geq$ = 6	91.3	55.0	--	--	--	--	--	--	81.0

Indicator	Implementing Agency								
	1	2	3	4	5	6	7	8	9
Shared Perceptions									
Percentage of pairs with shared expectations on Goal Setting Subscale (sum within 4 points)	69.6	55.0	--	--	--	--	--	--	90.5
Percentage of pairs with shared expectations on Tasking Subscale (sum within 4 points)	78.3	90.0	--	--	--	--	--	--	90.5
Percentage of pairs with shared expectations on Bonding Subscale (sum within 4 points)	69.6	75.0	--	--	--	--	--	--	66.7
Content of Home Visits									
Mean percentage content covered across all visits	100.0	96.2	--	--	--	--	--	--	95.0
Percentage of visits in which 80 percent of planned content is delivered	100.0	96.2	--	--	--	--	--	--	92.4
Responsiveness of Provider									
Percentage of visits involving unplanned or emergency assistance	17.4	10.4	--	--	--	--	--	--	7.6
Percentage of participants in which at least one visit involved addressing an emergency	20.0	36.4	--	--	--	--	--	--	30.2
Percentage of home visitors who addressed an emergency for 50 percent or more of their clients during the reporting period	60.0	25.0	--	--	--	--	--	--	25.0

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

[a] Tasking Subscale items include questions related to perceptions of what needs to happen to reach service goals, relative priorities among goals, the capacity of the participant to obtain a new perspective, and the perception that things are moving along the right path.

[b] Bonding Subscale items include questions related to perceptions regarding the degree to which the participant and provider like each other, appreciate each other, trust each other, and feel confident in their ability to do the job or make the changes needed.

[c] Goal Setting Subscale items include questions related to perceptions of the degree to which the participant and provider agree on service goals, jointly develop mutual goals, and agree on the level of change needed to achieve goals.

BA = bachelor's degree; HFA = Healthy Families America; HV = home visitor; MA = master's degree; NFP = Nurse Family Partnership; PAT = Parents as Teachers; WAI = Working Alliance Inventory.

Table D.2b. Fidelity Indicator Scores for All Implementing Agencies (10- 18)

	Implementing Agency								
Indicator	10	11	12	13	14	15	16	17	18
STRUCTURAL FIDELITY									
Service Referrals									
Percentage of total referrals during the observation period meeting model standards for characteristics of the target population	100.0	100.0	100.0	97.2	--	--	--	--	--
Staff Qualifications and Training									
Percentage of home visitors with at least a BA	--	--	--	100.0	--	--	--	--	100.0
Percentage of staff (home visitors and supervisors) completing basic model training	--	--	--	100.0	--	--	--	--	100.0
Percentage of supervisors with at least a BA	--	--	--	--	--	--	--	--	100.0
Home Visitor Caseloads									
Mean monthly home visitor caseload	--	--	--	11.0	--	--	--	--	10.8
Percentage of home visitors at or below required caseload for full observation period	--	--	--	100.0	--	--	--	--	100.0
Supervisory Caseloads									
Mean monthly supervisor caseload	--	--	--	4.0	--	--	--	--	--
Percentage of supervisors at or below required caseload for full observation period	--	--	--	100.0	--	--	--	--	--
Participant Enrollment/Duration									
Percentage of participants with at least one home visit who remain enrolled for at least three months or were still enrolled at the end of the observation period	--	--	--	91.9	87.3	94.4	100.0	--	--
Percentage of participants with at least one home visit who remained enrolled at least six months or were still enrolled as appropriate at the end of the observation period	--	--	--	80.8	83.5	80.6	98.5	--	--

Indicator	Implementing Agency								
	10	11	12	13	14	15	16	17	18
Percentage of participants leaving the program who did not successfully complete the program	--	--	--	100.0	100.0	100.0	100.0	--	--
Mean duration for participants who left program during observation period (date of first visit to termination date) (weeks)	--	--	--	17.0	11.6	27.2	34.8	--	--
Service Dosage									
Number of visits provided or weeks of enrollment (date of first visit to date of exit or end of observation period)									
For those still enrolled	--	--	--	0.6	0.7	0.5	0.6	--	--
For successful completers	--	--	--	--	--	--	--	--	--
For early leavers	--	--	--	0.3	0.4	0.3	0.4	--	--
Mean length of time between completed visits (days)									
For those still enrolled	--	--	--	15.9	11.3	13.2	15.1	--	--
For successful completers	--	--	--	--	--	--	--	--	--
For early leavers	--	--	--	18.5	10.3	12.5	15.3	--	--
Percentage of participants who received the intended service dosage during initial six months of enrollment	--	--	--	24.2	55.7	44.4	49.3	--	--
Percentage of participants who received at least 90 percent of the intended service dosage during initial six months of enrollment	--	--	--	31.3	65.8	45.8	58.2	--	--
Percentage of participants who received at least 80 percent of the intended service dosage during initial six months of enrollment	--	--	--	42.4	77.2	52.8	68.7	--	--
Visit Planning									
Percentage of planned visits completed across all participants	--	--	--	93.3	94.5	85.5	87.2	--	--
Percentage of participants where at least 50 percent of planned visits are completed	--	--	--	99.0	100.0	100.0	100.0	--	--
Percentage of participants where at least 75 percent of planned visits are completed	--	--	--	92.9	97.5	75.0	82.1	--	--

Indicator	Implementing Agency								
	10	11	12	13	14	15	16	17	18
Percentage of completed home visits lasting at least one hour	--	--	--	95.0	92.2	96.2	98.3	--	--
DYNAMIC FIDELITY									
Provider Perception of Relationship									
Percentage of providers rating WAI Tasking Subscale items on average $\geq$ = 6[a]	--	--	--	--	--	--	--	--	--
Percentage of providers rating WAI Bonding Subscale items on average $\geq$ = 6[b]	--	--	--	--	--	--	--	--	--
Percentage of providers rating WAI Goal Setting Subscale items on average $\geq$ = 6[c]	--	--	--	--	--	--	--	--	--
Percentage of providers rating all WAI items on average $\geq$ = 6	--	--	--	--	--	--	--	--	--
Percentage of home visitors who consistently report observing very positive views (6 or 7) on more than two-thirds of the WAI items across all families	--	--	--	--	--	--	--	--	--
Participant Perception of Relationship									
Percentage participants rating WAI Tasking Subscale items on average $\geq$ = 6	--	--	--	--	--	--	--	--	--
Percentage participants rating WAI Bonding Subscale items on average $\geq$ = 6	--	--	--	--	--	--	--	--	--
Percentage participants rating WAI Goal Setting Subscale items on average $\geq$ = 6	--	--	--	--	--	--	--	--	--
Percentage participants rating all WAI items on average $\geq$ = 6	--	--	--	--	--	--	--	--	--
Shared Perceptions									
Percentage of pairs with shared expectations on Goal Setting Subscale (sum within 4 points)	--	--	--	--	--	--	--	--	--
Percentage of pairs with shared expectations on Tasking Subscale (sum within 4 points)	--	--	--	--	--	--	--	--	--
Percentage of pairs with shared expectations on Bonding Subscale (sum within 4 points)	--	--	--	--	--	--	--	--	--

Indicator	Implementing Agency								
	10	11	12	13	14	15	16	17	18
Content of Home Visits									
Mean percentage content covered across all visits	--	--	--	94.3	95.3	97.9	99.0	--	--
Percentage of visits in which 80 percent of planned content is delivered	--	--	--	94.2	92.2	97.1	98.3	--	--
Responsiveness of Provider									
Percentage of visits involving unplanned or emergency assistance	--	--	--	--	--	--	--	--	--
Percentage of participants in which at least one visit involved addressing an emergency	--	--	--	--	--	--	--	--	--
Percentage of home visitors who addressed an emergency for 50 percent or more of their clients during the reporting period	--	--	--	--	--	--	--	--	--

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

[a] Tasking Subscale items include questions related to perceptions of what needs to happen to reach service goals, relative priorities among goals, the capacity of the participant to obtain a new perspective, and the perception that things are moving along the right path.

[b] Bonding Subscale items include questions related to perceptions regarding the degree to which the participant and provider like each other, appreciate each other, trust each other, and feel confident in their ability to do the job or make the changes needed.

[c] Goal Setting Subscale items include questions related to perceptions of the degree to which the participant and provider agree on service goals, jointly develop mutual goals, and agree on the level of change needed to achieve goals.

BA = bachelor's degree; HFA = Healthy Families America; HV = home visitor; MA = master's degree; NFP = Nurse Family Partnership; PAT = Parents as Teachers; WAI = Working Alliance Inventory.

Table D.2c. Fidelity Indicator Scores for All Implementing Agencies (19- 27)

Indicator	Implementing Agency								
	19	20	21	22	23	24	25	26	27
STRUCTURAL FIDELITY									
Service Referrals									
Percentage of total referrals during the observation period meeting model standards for characteristics of the target population	--	--	69.8	82.9	94.7	95.6	84.1	68.8	83.8
Staff Qualifications and Training									
Percentage of home visitors with at least a BA	50.0	100.0	50.0	--	100.0	100.0	100.0	100.0	100.0
Percentage of staff (home visitors and supervisors) completing basic model training	100.0	100.0	100.0	--	100.0	100.0	100.0	100.0	100.0
Percentage of supervisors with at least a BA	100.0	100.0	--	--	100.0	100.0	100.0	100.0	100.0
Home Visitor Caseloads									
Mean monthly home visitor caseload	11.7	12.8	12.1	--	24.3	22.3	20.1	18.1	21.3
Percentage of home visitors at or below required caseload for full observation period	100.0	100.0	100.0	--	100.0	100.0	100.0	100.0	60.0
Supervisory Caseloads									
Mean monthly supervisor caseload	4.0	--	--	--	4.0	--	--	--	4.0
Percentage of supervisors at or below required caseload for full observation period	100.0	100.0	--	--	100.0	--	100.0	100.0	100.0
Participant Enrollment/Duration									
Percentage of participants with at least one home visit who remain enrolled for at least three months or were still enrolled at the end of the observation period	--	97.8	88.7	90.0	89.9	90.1	95.9	81.9	90.6
Percentage of participants with at least one home visit who remained enrolled at least six months or were still enrolled as appropriate at the end of the observation period	--	90.2	84.9	87.1	86.8	87.3	90.2	72.5	84.4

Indicator	Implementing Agency								
	19	20	21	22	23	24	25	26	27
Percentage of participants leaving the program who did not successfully complete the program	--	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Mean duration for participants who left program during observation period (date of first visit to termination date) (weeks)	--	28.2	16.7	10.2	18.5	18.4	26.7	21.9	26.1
Service Dosage									
Number of visits provided or weeks of enrollment (date of first visit to date of exit or end of observation period)									
For those still enrolled	--	0.6	0.6	0.8	0.6	0.6	0.6	0.6	0.6
For successful completers	--	--	--	--	--	--	--	--	--
For early leavers	--	0.3	0.4	0.4	0.4	0.5	0.4	0.3	0.3
Mean length of time between completed visits (days)									
For those still enrolled	--	13.3	14.8	10.6	12.9	10.1	13.6	8.3	15.2
For successful completers	--	--	--	--	--	--	--	--	--
For early leavers	--	13.8	4.3	9.1	11.1	13.6	14.5	15.7	15.1
Percentage of participants who received the intended service dosage during initial six months of enrollment	--	50.0	47.2	60.0	58.1	57.7	58.2	37.0	51.0
Percentage of participants who received at least 90 percent of the intended service dosage during initial six months of enrollment	--	55.4	47.2	72.9	64.3	69.0	68.9	42.0	57.3
Percentage of participants who received at least 80 percent of the intended service dosage during initial six months of enrollment	--	62.0	64.2	78.6	73.6	80.3	77.9	51.4	68.8
Visit Planning									
Percentage of planned visits completed across all participants	--	81.1	94.5	86.8	86.3	85.0	80.6	87.9	82.2
Percentage of participants where at least 50 percent of planned visits are completed	--	91.3	98.1	98.6	100.0	98.6	94.3	99.3	96.9
Percentage of participants where at least 75 percent of planned visits are completed	--	62.0	94.3	85.7	75.2	77.5	73.8	84.1	77.1

Indicator	Implementing Agency								
	19	20	21	22	23	24	25	26	27
Percentage of completed home visits lasting at least one hour	--	95.7	98.7	96.1	96.8	83.8	98.0	70.7	96.8
DYNAMIC FIDELITY									
Provider Perception of Relationship									
Percentage of providers rating WAI Tasking Subscale items on average $\geq$ 6[s]	--	--	--	--	--	--	--	--	--
Percentage of providers rating WAI Bonding Subscale items on average $\geq$ 6[b]	--	--	--	--	--	--	--	--	--
Percentage of providers rating WAI Goal Setting Subscale items on average $\geq$ 6[c]	--	--	--	--	--	--	--	--	--
Percentage of providers rating all WAI items on average $\geq$ 6	--	--	--	--	--	--	--	--	--
Percentage of home visitors who consistently report observing very positive views (6 or 7) on more than two-thirds of the WAI items across all families	--	--	--	--	--	--	--	--	--
Participant Perception of Relationship									
Percentage participants rating WAI Tasking Subscale items on average $\geq$ 6	--	--	--	--	--	--	--	--	--
Percentage participants rating WAI Bonding Subscale items on average $\geq$ 6	--	--	--	--	--	--	--	--	--
Percentage participants rating WAI Goal Setting Subscale items on average $\geq$ 6	--	--	--	--	--	--	--	--	--
Percentage participants rating all WAI items on average $\geq$ 6	--	--	--	--	--	--	--	--	--
Shared Perceptions									
Percentage of pairs with shared expectations on Goal Setting Subscale (sum within 4 points)	--	--	--	--	--	--	--	--	--
Percentage of pairs with shared expectations on Tasking Subscale (sum within 4 points)	--	--	--	--	--	--	--	--	--
Percentage of pairs with shared expectations on Bonding Subscale (sum within 4 points)	--	--	--	--	--	--	--	--	--

Indicator	Implementing Agency								
	19	20	21	22	23	24	25	26	27
Content of Home Visits									
Mean percentage content covered across all visits	--	89.7	98.3	89.5	96.7	97.6	97.1	95.6	96.5
Percentage of visits in which 80 percent of planned content is delivered	--	86.5	97.4	80.2	95.2	97.1	96.6	98.4	94.3
Responsiveness of Provider									
Percentage of visits involving unplanned or emergency assistance	--	--	--	--	--	--	--	--	--
Percentage of participants in which at least one visit involved addressing an emergency	--	--	--	--	--	--	--	--	--
Percentage of home visitors who addressed an emergency for 50 percent or more of their clients during the reporting period	--	--	--	--	--	--	--	--	--

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

[a] Tasking Subscale items include questions related to perceptions of what needs to happen to reach service goals, relative priorities among goals, the capacity of the participant to obtain a new perspective, and the perception that things are moving along the right path.

[b] Bonding Subscale items include questions related to perceptions regarding the degree to which the participant and provider like each other, appreciate each other, trust each other, and feel confident in their ability to do the job or make the changes needed.

[c] Goal Setting Subscale items include questions related to perceptions of the degree to which the participant and provider agree on service goals, jointly develop mutual goals, and agree on the level of change needed to achieve goals.

BA = bachelor's degree; HFA = Healthy Families America; HV = home visitor; MA = master's degree; NFP = Nurse Family Partnership; PAT = Parents as Teachers; WAI = Working Alliance Inventory.

Table D.2d. Fidelity Indicator Scores for All Implementing Agencies (28- 36)

Indicator	Implementing Agency								
	28	29	30	31	32	33	34	35	36
STRUCTURAL FIDELITY									
Service Referrals									
Percentage of total referrals during the observation period meeting model standards for characteristics of the target population	93.8	51.6	77.3	100.0	100.0	100.0	33.3	64.5	100.0
Staff Qualifications and Training									
Percentage of home visitors with at least a BA	75.0	75.0	--	--	42.9	100.0	100.0	100.0	100.0
Percentage of staff (home visitors and supervisors) completing basic model training	100.0	100.0	--	--	100.0	100.0	100.0	100.0	100.0
Percentage of supervisors with at least a BA	100.0	100.0	--	--	100.0	100.0	0.0	100.0	100.0
Home Visitor Caseloads									
Mean monthly home visitor caseload	24.8	9.1	--	--	19.4	10.8	15.1	20.1	11.4
Percentage of home visitors at or below required caseload for full observation period	100.0	80.0	--	--	100.0	100.0	40.0	50.0	66.7
Supervisory Caseloads									
Mean monthly supervisor caseload	4.0	2.0	--	--	7.2	1.0	--	4.1	2.6
Percentage of supervisors at or below required caseload for full observation period	100.0	100.0	--	--	0.0	50.0	100.0	100.0	50.0
Participant Enrollment/Duration									
Percentage of participants with at least one home visit who remain enrolled for at least three months or were still enrolled at the end of the observation period	93.0	93.3	93.9	94.3	--	--	--	--	--
Percentage of participants with at least one home visit who remained enrolled at least six months or were still enrolled as appropriate at the end of the observation period	89.5	85.0	89.3	79.5	--	--	--	--	--

Indicator	Implementing Agency								
	28	29	30	31	32	33	34	35	36
Percentage of participants leaving the program who did not successfully complete the program	100.0	100.0	100.0	100.0	--	--	--	--	--
Mean duration for participants who left program during observation period (date of first visit to termination date) (weeks)	24.0	16.4	24.3	24.1	--	--	--	--	--
Service Dosage									
Number of visits provided or weeks of enrollment (date of first visit to date of exit or end of observation period)									
For those still enrolled	0.6	0.6	0.6	0.7	--	--	--	--	--
For successful completers	--	--	--	--	--	--	--	--	--
For early leavers	0.3	0.3	0.3	0.3	--	--	--	--	--
Mean length of time between completed visits (days)									
For those still enrolled	13.1	12.4	10.1	10.9	--	--	--	--	--
For successful completers	--	--	--	--	--	--	--	--	--
For early leavers	13.5	11.6	10.3	12.8	--	--	--	--	--
Percentage of participants who received the intended service dosage during initial six months of enrollment	70.2	25.0	55.0	46.6	--	--	--	--	--
Percentage of participants who received at least 90 percent of the intended service dosage during initial six months of enrollment	77.2	36.7	59.5	58.0	--	--	--	--	--
Percentage of participants who received at least 80 percent of the intended service dosage during initial six months of enrollment	80.7	45.0	73.3	63.6	--	--	--	--	--
Visit Planning									
Percentage of planned visits completed across all participants	90.3	93.2	86.7	95.1	--	--	--	--	--
Percentage of participants where at least 50 percent of planned visits are completed	98.2	100.0	98.5	100.0	--	--	--	--	--
Percentage of participants where at least 75 percent of planned visits are completed	87.7	93.3	86.3	95.5	--	--	--	--	--

Indicator	Implementing Agency								
	28	29	30	31	32	33	34	35	36
Percentage of completed home visits lasting at least one hour	96.8	98.5	95.9	95.7	--	--	--	--	--
DYNAMIC FIDELITY									
Provider Perception of Relationship									
Percentage of providers rating WAI Tasking Subscale items on average $\geq$ 6[a]	--	--	--	--	--	--	--	--	--
Percentage of providers rating WAI Bonding Subscale items on average $\geq$ 6[b]	--	--	--	--	--	--	--	--	--
Percentage of providers rating WAI Goal Setting Subscale items on average $\geq$ 6[c]	--	--	--	--	--	--	--	--	--
Percentage of providers rating all WAI items on average $\geq$ 6	--	--	--	--	--	--	--	--	--
Percentage of home visitors who consistently report observing very positive views (6 or 7) on more than two-thirds of the WAI items across all families	--	--	--	--	--	--	--	--	--
Participant Perception of Relationship									
Percentage participants rating WAI Tasking Subscale items on average $\geq$ 6	--	--	--	--	--	--	--	--	--
Percentage participants rating WAI Bonding Subscale items on average $\geq$ 6	--	--	--	--	--	--	--	--	--
Percentage participants rating WAI Goal Setting Subscale items on average $\geq$ 6	--	--	--	--	--	--	--	--	--
Percentage participants rating all WAI items on average $\geq$ 6	--	--	--	--	--	--	--	--	--
Shared Perceptions									
Percentage of pairs with shared expectations on Goal Setting Subscale (sum within 4 points)	--	--	--	--	--	--	--	--	--
Percentage of pairs with shared expectations on Tasking Subscale (sum within 4 points)	--	--	--	--	--	--	--	--	--
Percentage of pairs with shared expectations on Bonding Subscale (sum within 4 points)	--	--	--	--	--	--	--	--	--

Indicator	Implementing Agency								
	28	29	30	31	32	33	34	35	36
Content of Home Visits									
Mean percentage content covered across all visits	91.9	94.5	95.4	98.0	--	--	--	--	--
Percentage of visits in which 80 percent of planned content is delivered	88.3	92.7	94.2	98.1	--	--	--	--	--
Responsiveness of Provider									
Percentage of visits involving unplanned or emergency assistance	--	--	--	--	--	--	--	--	--
Percentage of participants in which at least one visit involved addressing an emergency	--	--	--	--	--	--	--	--	--
Percentage of home visitors who addressed an emergency for 50 percent or more of their clients during the reporting period	--	--	--	--	--	--	--	--	--

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

[a] Tasking Subscale items include questions related to perceptions of what needs to happen to reach service goals, relative priorities among goals, the capacity of the participant to obtain a new perspective, and the perception that things are moving along the right path.

[b] Bonding Subscale items include questions related to perceptions regarding the degree to which the participant and provider like each other, appreciate each other, trust each other, and feel confident in their ability to do the job or make the changes needed.

[c] Goal Setting Subscale items include questions related to perceptions of the degree to which the participant and provider agree on service goals, jointly develop mutual goals, and agree on the level of change needed to achieve goals.

BA = bachelor's degree; HFA = Healthy Families America; HV = home visitor; MA = master's degree; NFP = Nurse Family Partnership; PAT = Parents as Teachers; WAI = Working Alliance Inventory.

Table D.2e. Fidelity Indicator Scores for All Implementing Agencies (37- 45)

Indicator	Implementing Agency 37	38	39	40	41	42	43	44	45
STRUCTURAL FIDELITY									
Service Referrals									
Percentage of total referrals during the observation period meeting model standards for characteristics of the target population	100.0	36.0	95.1	--	--	--	100.0	--	44.5
Staff Qualifications and Training									
Percentage of home visitors with at least a BA	100.0	50.0	100.0	40.0	100.0	100.0	100.0	25.0	100.0
Percentage of staff (home visitors and supervisors) completing basic model training	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Percentage of supervisors with at least a BA	100.0	100.0	100.0	100.0	--	100.0	100.0	100.0	100.0
Home Visitor Caseloads									
Mean monthly home visitor caseload	12.2	18.0	2.6	3.0	3.6	3.9	2.1	7.6	5.0
Percentage of home visitors at or below required caseload for full observation period	100.0	100.0	100.0	85.7	100.0	100.0	100.0	100.0	100.0
Supervisory Caseloads									
Mean monthly supervisor caseload	3.0	2.9	--	10.0	--	--	--	--	4.1
Percentage of supervisors at or below required caseload for full observation period	100.0	100.0	--	0.0	--	--	33.3	--	100.0
Participant Enrollment/Duration									
Percentage of participants with at least one home visit who remain enrolled for at least three months or were still enrolled at the end of the observation period	--	94.6	100.0	70.3	60.0	83.3	72.7	100.0	79.4
Percentage of participants with at least one home visit who remained enrolled at least six months or were still enrolled as appropriate at the end of the observation period	--	94.6	96.0	59.5	60.0	33.3	57.6	100.0	46.0

Indicator	Implementing Agency 37	38	39	40	41	42	43	44	45
Percentage of participants leaving the program who did not successfully complete the program	--	66.7	100.0	76.5	100.0	43.5	60.0	--	35.0
Mean duration for participants who left program during observation period (date of first visit to termination date) (weeks)	--	31.7	14.1	12.1	3.6	19.0	12.5	--	15.7
Service Dosage									
Number of visits provided or weeks of enrollment (date of first visit to date of exit or end of observation period)									
For those still enrolled	--	0.5	0.2	0.5	0.3	0.9	0.4	0.8	0.8
For successful completers	--	0.5	--	0.8	--	0.8	0.8	--	0.7
For early leavers	--	0.2	0.4	0.6	0.7	0.4	0.5	--	0.5
Mean length of time between completed visits (days)									
For those still enrolled	--	21.4	46.8	13.4	11.1	9.3	17.0	8.9	8.7
For successful completers	--	16.2	--	9.7	--	9.0	10.7	--	10.4
For early leavers	--	27.5	17.8	10.7	11.8	13.9	15.3	--	15.0
Percentage of participants who received the intended service dosage during initial six months of enrollment	--	40.5	4.0	54.3	60.0	80.0	50.0	100.0	8.3
Percentage of participants who received at least 90 percent of the intended service dosage during initial six months of enrollment	--	43.2	4.0	60.0	60.0	80.0	53.1	100.0	20.0
Percentage of participants who received at least 80 percent of the intended service dosage during initial six months of enrollment	--	45.9	4.0	65.7	60.0	86.7	62.5	100.0	43.3
Visit Planning									
Percentage of planned visits completed across all participants	--	88.1	63.0	70.2	77.8	81.8	76.5	76.4	93.2
Percentage of participants where at least 50 percent of planned visits are completed	--	97.3	84.0	83.8	100.0	100.0	97.0	100.0	98.4
Percentage of participants where at least 75 percent of planned visits are completed	--	83.8	56.0	48.6	40.0	70.0	69.7	71.4	90.5

Indicator	Implementing Agency 37	38	39	40	41	42	43	44	45
Percentage of completed home visits lasting at least one hour	--	90.6	49.4	93.1	66.7	79.5	46.4	96.3	88.3
DYNAMIC FIDELITY									
Provider Perception of Relationship									
Percentage of providers rating WAI Tasking Subscale items on average $\geq$ = 6[a]	--	33.3	66.7	25.0	50.0	66.7	40.0	100.0	75.0
Percentage of providers rating WAI Bonding Subscale items on average $\geq$ = 6[b]	--	33.3	83.3	50.0	50.0	66.7	80.0	100.0	75.0
Percentage of providers rating WAI Goal Setting Subscale items on average $\geq$ = 6[c]	--	33.3	83.3	0.0	50.0	66.7	20.0	100.0	75.0
Percentage of providers rating all WAI items on average $\geq$ = 6	--	33.3	83.3	25.0	50.0	66.7	20.0	100.0	75.0
Percentage of home visitors who consistently report observing very positive views (6 or 7) on more than two-thirds of the WAI items across all families	--	0.0	66.7	25.0	50.0	66.7	40.0	100.0	25.0
Participant Perception of Relationship									
Percentage participants rating WAI Tasking Subscale items on average $\geq$ = 6	--	39.1	92.3	57.1	100.0	76.2	57.1	100.0	100.0
Percentage participants rating WAI Bonding Subscale items on average $\geq$ = 6	--	47.8	100.0	64.3	100.0	66.7	100.0	100.0	100.0
Percentage participants rating WAI Goal Setting Subscale items on average $\geq$ = 6	--	34.8	100.0	42.9	100.0	42.9	57.1	50.0	76.9
Percentage participants rating all WAI items on average $\geq$ = 6	--	34.8	100.0	42.9	100.0	61.9	71.4	100.0	96.2
Shared Perceptions									
Percentage of pairs with shared expectations on Goal Setting Subscale (sum within 4 points)	--	82.6	83.3	40.0	100.0	72.2	78.6	100.0	76.9
Percentage of pairs with shared expectations on Tasking Subscale (sum within 4 points)	--	87.0	83.3	40.0	100.0	61.1	85.7	100.0	80.8
Percentage of pairs with shared expectations on Bonding Subscale (sum within 4 points)	--	82.6	83.3	70.0	100.0	77.8	64.3	100.0	73.1

Indicator	Implementing Agency 37	38	39	40	41	42	43	44	45
Content of Home Visits									
Mean percentage content covered across all visits	--	98.4	100.0	95.4	100.0	99.8	99.2	90.9	96.3
Percentage of visits in which 80 percent of planned content is delivered	--	98.4	100.0	94.5	100.0	99.5	99.1	90.9	95.4
Responsiveness of Provider									
Percentage of visits involving unplanned or emergency assistance	--	62.3	41.2	3.9	50.0	3.6	11.2	14.5	17.4
Percentage of participants in which at least one visit involved addressing an emergency	--	84.2	51.4	23.1	60.0	30.0	29.7	85.7	65.6
Percentage of home visitors who addressed an emergency for 50 percent or more of their clients during the reporting period	--	80.0	71.4	16.7	33.3	40.0	33.3	80.0	30.0

Source: EBHV Cross-Site Fidelity Database and NFP-CIS, October 1, 2009, through December 31, 2010.

[a] Tasking Subscale items include questions related to perceptions of what needs to happen to reach service goals, relative priorities among goals, the capacity of the participant to obtain a new perspective, and the perception that things are moving along the right path.

[b] Bonding Subscale items include questions related to perceptions regarding the degree to which the participant and provider like each other, appreciate each other, trust each other, and feel confident in their ability to do the job or make the changes needed.

[c] Goal Setting Subscale items include questions related to perceptions of the degree to which the participant and provider agree on service goals, jointly develop mutual goals, and agree on the level of change needed to achieve goals.

BA = bachelor's degree; HFA = Healthy Families America; HV = home visitor; MA = master's degree; NFP = Nurse Family Partnership; PAT = Parents as Teachers; WAI = Working Alliance Inventory.