

Mother and Infant Home Visiting Program Evaluation (MIHOPE) Implementation Analysis Plan

Appendix A: Family Characteristics

September 21, 2015

As discussed in the memo to the Committee on the MIHOPE implementation analysis plan, there are many potential variables that capture the inputs of local program implementation, as identified in the study's Conceptual Framework,¹ which are hypothesized to influence the outputs of services delivered to families. These include variables related to family characteristics, staff characteristics, local program characteristics, and national model characteristics.

This appendix describes the potential measures of family characteristics that will be highlighted as part of the MIHOPE implementation study. Note that many of these measures will be used to describe the types of families served in MIHOPE programs. As indicated in the implementation analysis plan, multivariate analyses will include a more parsimonious set of the descriptive measures, using theoretical, programmatic, and policy relevance to guide the team in refining the explanatory model of inputs to the outputs of service delivery.² Some additional measures may be shown in appendixes if they are important but not central to the report.

MIHOPE programs, by design, serve disadvantaged families. Still, the targeted families are heterogeneous, varying in their risks and strengths as well as their motivations for enrolling in home visiting. Some of this variation is likely to reflect differences in the eligibility requirements of national models included in the evaluation (such as prenatal status and parity),³ but few risk factors are specified as eligibility criteria by the national models. Differences in family characteristics, both across and within programs, may provide insight about why service delivery varies across families.

¹See the Overview memo for detail on MIHOPE's Conceptual Framework.

²Specifically, see the section on "Quantitative Approach to Explaining Differences in Service Delivery" in the Implementation Study Analysis Plan memo,

³The target population for Early Head Start—Home Based Program Option (EHS) includes low-income pregnant women and families with children from birth to age 3, families at or below the federal poverty level, and children with disabilities. Services can begin prenatally or after birth. Healthy Families America (HFA) targets parents facing challenges such as single parenthood, low income, substance abuse, or domestic violence. Families are enrolled prenatally or within the first three months after a child's birth. Nurse-Family Partnership (NFP) serves low-income women and requires that they be pregnant (home visits must occur before the end of the 28th week of pregnancy) and first-time mothers. Parents as Teachers (PAT) has no specific eligibility requirements for participation, and local programs select the specific characteristics of their target population. Parents can enroll during the mother's pregnancy or after the birth of a child.

Potential measures of family characteristics

We propose to examine five broad categories of family characteristics:

- Maternal sociodemographic, household, and relationship characteristics
- Maternal health, well-being, and behaviors
- Prior and current use of services
- Reasons for enrolling in and expectations of home visiting
- Child characteristics

Many specific measures within these broad categories were included in the MIHOPE Report to Congress.⁴ We plan to use the same measures in the implementation report. These include characteristics of families and individuals identified by the authorizing legislation as “high risk.”⁵

The proposed measures within each of the broad categories are briefly described below. We are considering additional composite measures that collapse or combine individual measures. These include, for example, the composites proposed as confirmatory subgroups in the impact analysis (high maternal demographic risk, low psychological resources, and maternal depression and attachment style); and others created from widely used multi-item scales (such as “depressive symptoms” based on the 10-item Center for Epidemiologic Studies Depression Scale, or CES-D).

Maternal sociodemographic, household, and relationship characteristics

Maternal sociodemographic characteristics are shown in Appendix Table A.1. Many have been used in prior home visiting studies to examine patterns of engagement across families. For example, earlier research has shown that younger mothers may be more likely to enroll in home visiting, but older mothers are more likely to be enrolled longer and to receive more visits.⁶ Similarly, enrolling during pregnancy and, specifically, early in pregnancy, is associated with receiving more home visits.⁷

⁴Michalopoulos et al. (2015).

⁵The high risk populations identified in authorizing legislation are as follows: (A) Eligible families who reside in communities in need of such services; (B) Low-income eligible families; (C) Eligible families who are pregnant women who have not attained age 21; (D) Eligible families that have a history of child abuse or neglect or have had interactions with child welfare services; (E) Eligible families that have a history of substance abuse or need substance abuse treatment; (F) Eligible families that have users of tobacco products; in the home; (G) Eligible families that are or have children with low student achievement; (H) Eligible families with children with developmental delays or disabilities; (I) Eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

⁶Damashek, Doughty, Ware, and Silovsky (2011); Daro, McCurdy, Falconnier, and Stojanovic (2003); Duggan et al. (2000); McGuigan, Katzev, and Pratt (2003); O’Brien et al. (2012).

⁷Daro, McCurdy, Falconnier, and Stojanovic (2003); McCurdy et al. (2006); O’Brien et al. (2012).

Appendix Table A.1

Potential Measures of Maternal Sociodemographic, Household, and Relationship Status at Baseline

Characteristics	Reporter and source
<u>Maternal sociodemographic</u>	
Average age and young age (ages 15-20)	Mother; Baseline survey
Pregnancy status	Mother; Baseline survey
Pregnant, 28 weeks or less	
Pregnant, more than 28 weeks	
Given birth	
Pregnant and under age 21	Mother; Baseline survey
Birth history ^a	Birth certificate
First-time mother	
Mother has had previous births	
Race/ethnicity	Mother; Baseline survey
Non-Hispanic white	
Non-Hispanic black	
Hispanic	
Other	
Language other than English spoken in home	Mother; Baseline survey
English-speaking ability (not very well or at all)	Mother; Baseline survey
Employment over the last 3 years	Mother; Baseline survey
Monthly earnings	Mother; Baseline survey
Highest level of education	Mother; Baseline survey
Less than high school	
High school diploma or GED	
Some college	
Bachelor's degree or higher	
Currently taking education or training classes	Mother; Baseline survey
Planning on taking education or training classes	Mother; Baseline survey
<u>Household</u>	
Child's biological father lives in home	Mother; Baseline survey
Adult relative lives in home	Mother; Baseline survey
Number of nonadult siblings of focal child in home	Mother; Baseline survey
Moved more than once in past year	Mother; Baseline survey
Family member serving in the military	Mother; Baseline survey
Household experiences food insecurity ^a	Mother; Baseline survey
Sources of household income or benefits ^b	Mother; Baseline survey

(continued)

Appendix Table A.1 (continued)

Characteristics	Report and source
<u>Relationship status and quality</u>	
Relationship status of mother ^a	Mother; Baseline survey
Married to child's father	
In nonmarital relationship with child's father	
In relationship with partner other than child's father	
Not in relationship	
Father provides material support for child	Mother; Baseline survey

NOTES: ^aNot shown in Report to Congress.

^bSources include: earnings from other household members; TANF (Temporary Assistance for Needy Families); food stamps/SNAP (Supplemental Nutrition Assistance Program); WIC (Women, Infants and Children program); and disability insurance.

We will consider constructing measures of the other adults in the home (such as grandmother or other parental figure). Other kin in the home may provide familial social support for home visiting, or conversely, could serve as a proxy for home visitor-family conflict if the home visitor's guidance is at odds with that of other family members.

Maternal health, well-being, and behaviors

Baseline measures of maternal health and well-being are shown in Appendix Table A.2. Some are priority outcomes or benchmarks in Maternal, Infant, and Early Childhood Home Visiting (MIECHV) (for example, depressive symptoms, substance and alcohol use, and reports of intimate partner violence). These characteristics are proxies for a family's service needs that are related to specific outcomes, which we refer to as *outcome-specific* needs. We plan to identify subsets of families using these characteristics, and then assess family engagement and receipt of *outcome-specific services*, such as referrals and education. We also plan to examine differences in parents' attachment style (based on the Attachment Style Questionnaire, or ASQ) and locus of control (based on the Pearlin Mastery Scale, or PMS).

Appendix Table A.2

Potential Measures of Maternal Health, Well-Being, and Behaviors

Characteristics	Reporter and source
<u>Health and psychosocial well-being</u>	
Self-rated health status "poor" or "fair"	Mother; Baseline survey
Health problems limit activity "a lot"	Mother; Baseline survey
Current smoker	Mother; Baseline survey
Smoking permitted in home	Mother; Baseline survey
Binge drinking	Mother; Baseline survey
Illegal drug use	Mother; Baseline survey
Depressive symptoms (based on CES-D score at or above cutoff) ^b	Mother; Baseline survey
Anxiety (based on GAD-7 score at or above cutoff) ^b	Mother; Baseline survey
Attachment style (based on ASQ) ^{a,b}	Mother; Baseline survey
Relationship anxiety	
Relationship avoidance	
Mastery scores (based on PMS) ^{a,b}	
<u>Parenting related to child health and development</u>	
Intends to breastfeed	Mother; Baseline survey
Ever breastfeed focal child	Mother; Baseline survey
Weak empathy skills ^c	IT-HOME; Baseline survey
Home environment for learning ^c	IT-HOME; Baseline survey
Mother has weak conversational skills	
Home is cluttered/unclean	
Household has at least 10 books	
Evidence of recent alcohol or drug use	
<u>Intimate partner violence</u>	
Physical violence toward mother	Mother; Baseline survey
Psychological violence toward mother	Mother; Baseline survey
Physical violence perpetrated by mother	Mother; Baseline survey

NOTES: ^aNot shown in Report to Congress.

^bCES-D = Center for Epidemiological Studies of Depression Scale; GAD-7 = Generalized Anxiety Disorder Scale; ASQ = Attachment Style Questionnaire; PMS = Pearlin Mastery Scale.

^cBased on the IT-HOME (Infant-Toddler Home Observation for Measurement of the Environment).

Prior and current use of services

Measures of prior or current service receipt at baseline are shown in Appendix Table A.3. These measures can be used as indicators of potential unmet family needs. For example, if most mothers have insurance coverage for themselves at the time they enroll, or report that they do not need help in applying for insurance coverage, then we would not expect home visitors to focus on this area.

Appendix Table A.3
Potential Measures of Prior and Current Use of Services

Characteristics	Reporter and source
<u>Maternal health care</u>	
Initiated prenatal care in first trimester	Mother; Baseline survey
Has usual source of care	Mother; Baseline survey
Has place to go to for family planning ^a	Mother; Baseline survey
Insurance coverage (public, private, or uninsured)	Mother; Baseline survey
In past year, ever wanted/ needed help getting insurance for herself ^a	Mother; Baseline survey
Currently receiving help with applying for insurance for herself ^a	Mother; Baseline survey
<u>Child health care</u>	
Has usual source of care	Mother; Baseline survey
Insurance coverage (public, private, or uninsured)	Mother; Baseline survey
Since child's birth, ever wanted /needed help getting child insurance ^a	Mother; Baseline survey
Currently receiving help with applying for insurance for child ^a	Mother; Baseline survey
<u>Child care</u>	
Child receives care by someone other than mother on regular basis ^a	Mother; Baseline survey
Since child's birth, ever wanted/needed child care services for child ^a	Mother; Baseline survey
<u>Mental health, substance use, and domestic violence (DV) services</u>	
In past year, ever received help/treatment for:	Mother; Baseline survey
Mental health ^a	
Alcohol or substance use ^a	
DV or anger management ^a	
In past year, ever wanted/needed counseling for DV or anger management ^a	Mother; Baseline survey
Currently receiving help for DV or anger management ^a	Mother; Baseline survey

NOTES: ^aNot shown in Report to Congress.

Reasons for enrolling in and expectations of home visiting

Measures of reasons for enrolling in home visiting, expectations of home visiting, and preferences for home visiting activities are shown in Appendix Table A.4. As described in the Report to Congress, many mothers report non-outcome-specific, generic reasons for wanting services (such as “need advice or support”).⁸ However, the team will further analyze these responses, and consider whether use of specific responses (for example, regarding the desire or need for alcohol, drug, or domestic violence services at baseline) is feasible, given response rates and missing data patterns. The team may also be able to expand and refine the measures of reasons for enrollment shown in the Report to Congress to create indicators that cover all MIHOPE domains. We will also examine expectations of home visiting in two areas: (1) how frequently mothers think visits will occur, and (2) what mothers select as activities they would like as part of visits (such as receiving feedback on parent-child interactions or making and following plans on services needed).

Appendix Table A.4
Potential Measures of Reasons for Enrolling in and Expectations of Home Visiting

Characteristics	Reporter and source
<u>Reasons for enrolling and expectations of home visiting</u>	
Primary reasons for enrolling in home visiting	Mother; Baseline survey
Prenatal, maternal, and newborn health	
Child health and development	
Parenting support	
Family economic self-sufficiency	
Referrals and service coordination	
General advice and support	
Expectations for how often home visits will occur	Mother; Baseline survey
At least once a week	
Once every two weeks	
Once a month	
Once every few months	
Preference for activities to do in home visits (yes, no, indifferent) ^a	Mother; Baseline survey
Watch videos or read about being a parent	
Receive feedback on parent-child interactions	
Discuss own childhood experiences	
Make and follow plans to solve parenting problems	
Talk about personal feelings	
Get reassurance about being a parent	
Make and follow plans to continue education	
Make and follow plans to get services family needs	

NOTES: ^aNot shown in Report to Congress.

⁸Michalopoulos et al. (2015).

Child characteristics

Child characteristics (health, demographic, temperament) of the focal child are shown in Appendix Table A.5. These are baseline characteristics available only for families who enrolled after the birth of the focal child.

Appendix Table A.5
Potential Measures of Child Characteristics

Characteristics	Reporter and source
<u>Child health at birth</u>	
Birthweight or low birthweight status	Birth certificate
Gestational age or preterm birth status	Birth certificate
Child was placed in NICU ^{a,b}	Birth certificate
<u>Child demographics</u>	
Sex ^a	Mother; Baseline survey
Age at interview ^a	Mother; Baseline survey
<u>Child temperament scores (from EASI-II)^{a,b}</u>	
Cries easily	Mother; Baseline survey
Reacts frequently by getting upset or frightened	
Often fussy or cries	
Gets upset easily	
Reacts intensely when upset	

NOTES: ^aNot shown in Report to Congress.

^bNICU = Neonatal Intensive Care Unit; EASI-II = Emotionality, Activity, Sociability, Impulsivity.

Mother and Infant Home Visiting Program Evaluation (MIHOPE) Implementation Analysis Plan

Appendix B: Staff Characteristics

September 21, 2015

As discussed in the memo to the Committee on the MIHOPE implementation analysis plan, there are many potential variables that capture the inputs of local program implementation, as identified in the study's Conceptual Framework.⁹ This appendix describes the potential measures of staff characteristics of relevance for the MIHOPE implementation research, which will be used both to describe the characteristics of home visitors and supervisors and as explanatory variables in the multivariate analyses of service delivery.

Potential measures of staff characteristics

We propose to examine seven categories of staff characteristics:

- Sociodemographic, education, and experience
- Psychological well-being
- Expectations, attitudes, and beliefs
- Training and supervision
- Perceptions of implementation system and service environment
- Staff burnout and work attitudes
- Perceptions of programmatic changes resulting from Maternal, Infant, and Early Childhood Home Visiting (MIECHV)

Web-based surveys of home visitors and supervisors provide most of the information on specific measures within these categories; training and supervision logs provide detail on the amount and types of training and supervision received. Though many measures are available for both home visitors and supervisors, the characteristics of home visitors are of central relevance for understanding service delivery, as they are the frontline (most proximal) providers who interact with families. The measures discussed in this appendix are relevant for understanding both *general* service delivery patterns (for example, dosage and family responsiveness) and *outcome-specific* service delivery (for example, focus of content in home visits or referrals for services related to the MIECHV outcome domains).

⁹See the Overview memo for detail on MIHOPE's Conceptual Framework.

Sociodemographic, education, and experience

Appendix Table B.1 lists the proposed staff sociodemographic, education, and experience measures. Most of these measures were included in the Report to Congress, and we plan to show them in the implementation report (for example, age, race/ethnicity, education). In the multivariate analyses, we plan to examine how select staff characteristics are associated with measures of service delivery (both general and outcome-specific). For example, younger home visitors have been shown to enroll families longer and to conduct more home visits than older home visitors, suggesting that age of staff members is an important covariate.¹⁰ Education level or field of study may matter for explaining general service delivery (that is, family engagement and retention) as well as service targeting or tailoring to meet the needs of particular types of risks (outcome-specific service delivery), although few studies have explicitly examined the latter relationships.¹¹

Appendix Table B.1

Potential Measures of Staff Sociodemographic Background

Characteristics	Levels for which item is available ^a	
	S	HV
Average age and age categories	X	X
Race/ethnicity	X	X
Non-Hispanic white		
Non-Hispanic black		
Hispanic		
Other		
Bilingual ^b	X	X
Highest level of education	X	X
High school/GED or less		
Vocational technical training or some college		
Associate's degree or some training program degree		
Bachelor's degree		
Master's degree or higher		
Field of study ^b	X	X
Prior experience providing home visiting services	X	X

NOTES: ^aS = Supervisor; HV = Home visitor.

^bNot shown in Report to Congress.

¹⁰Daro, McCurdy, Falconnier, and Stojanovic (2003).

¹¹Harden (2010).

Psychological well-being

Appendix Table B.2 shows measures of psychological well-being for supervisors and home visitors. Psychosocial well-being of home visitors, as measured by depression and attachment style, is associated with home visitor burnout and turnover, how services are delivered, and how well families engage in home visiting.¹² Home visitors who rate high on attachment anxiety are less likely to respond to their families' psychosocial needs (such as intimate partner violence and poor maternal mental health.)¹³

Similar to the family baseline indicators, staff depressive symptoms were assessed with the 10-item Center for Epidemiologic Studies Depression Scale (CES-D), and staff attachment style by the 29-item modified Attachment Style Questionnaire (ASQ). We will examine distributions on the ASQ scales to determine cut-points and whether to use binary or continuous measures for relationship anxiety and relationship avoidance. We also assessed home visitor self-efficacy — how confident home visitors feel working to address specific outcomes in challenging situations (such as when a parent seems unmotivated).

Appendix Table B.2
Potential Measures of Staff Psychosocial Well-Being

Characteristics	Levels for which item is available ^a	
	S	HV
Depressive symptoms (based on CES-D)	X	X
Attachment style (based on ASQ)		
Relationship anxiety	X	X
Relationship avoidance	X	X
Self-efficacy		
For specific outcomes		X

NOTES: ^aS = Supervisor; HV = Home visitor.

¹²Burrell et al. (2009); McFarlane et al. (2010); Sharp, Ispa, Thornburg, and Lane (2003).

¹³McFarlane et al. (2010).

Expectations, attitudes, and beliefs

Appendix Table B.3 shows potential measures of home visitors' and supervisors' expectations, attitudes, and beliefs about addressing specific outcomes. For each priority outcome area, home visitors and supervisors rated their perceptions of their expectations, concerns, comfort level, and effectiveness in working to help mothers improve outcomes. We plan to test the associations of these perceptions with outcome-specific service delivery. For example, we will examine whether perceptions related to working with mothers to address mental health outcomes are associated with whether mental health is ever discussed, and the average number of visits where mental health is discussed.

Appendix Table B.3

Potential Measures of Staff Expectations, Attitudes, and Beliefs

Characteristics	Levels for which item is available ^a		
	S	HV	General or Specific
Perceived <i>expectations</i> for home visitor to address outcome ^b			
Specific outcome	X	X	Specific
<i>Concerns</i> that relationship with mother would be compromised if specific topic is discussed ^b			
Specific outcome		X	Specific
Perceived <i>comfort</i> in talking with mothers about outcomes ^b			
Specific outcome	X ^c	X	Specific
Perceived <i>effectiveness</i> at helping mothers address outcomes ^b			
Specific outcome	X ^c	X	Specific
Perceived <i>impacts</i> resulting from services provided ^b			
Specific outcome	X	X	Specific
Perceptions of service delivery			
Support for tailoring of services	X ^c	X	General
Clarity and coherence of role	X ^c	X	General

NOTES: Specific is used as shorthand for outcome-specific.

^aS = Supervisor; HV = Home visitor.

^bOutcomes include: prenatal health, maternal physical health, family planning and birth spacing, tobacco use, substance use, mental health, domestic violence, family economic self-sufficiency, breastfeeding, positive parenting, child preventive care, child development, and other (e.g., child care).

^cFor supervisors, items are asked in reference to their supervision of home visitors. This is different from questions that are asked of home visitors in reference to their work with families. For example, the effectiveness items ask supervisors about their perceived effectiveness in supervising home visitors in how they help mothers for each specific outcome, whereas the home visitor items ask about effectiveness in helping mothers for each specific outcome.

We also will examine home visitors' and supervisors' general perceptions of service delivery. Through 15 items that were specifically designed for MIHOPE, staff rated the support they receive for tailoring services and their perception of role clarity and coherence.

Training and supervision

Measures of training and supervision received by home visitors are shown in Appendix Table B.4. The proposed measures of training will describe the amount of training received by home visitors, both overall and for outcome-specific areas (for example, addressing mental health or intimate partner violence). The team will also examine the modality of training, including the use of role play and role play combined with observation. Prior research shows that effective training not only involves presentation of new information, but also allows trainees to practice new skills (role play) and receive feedback (observation).¹⁴ Similar to training, supervision received by home visitors will be described in terms of amount and frequency and by modality, both overall and for content-specific areas. The team will examine supervision received in the form of individual and group sessions. At the supervisor level, we can look at the overall frequency and modality of home visitor observation and feedback and the conditions under which the supervisor observes their home visitors. Both the length of supervisory sessions received and the frequency of supervisory sessions per home visitors can also be reported in reference to the national model standards.

¹⁴Durlak and Dupre (2008); Fixsen et al. (2005); Kraiger and Culbertson (2012).

Appendix Table B.4
Potential Measures of Training and Supervision

Characteristics	Levels for which item is available ^a		General or Specific
	S	HV	
<u>Training</u>			
Quantity (over 12 months)			
Number of months attending any training	X		General
Average number of training sessions per month	X		General
Average time spent in training per month	X		General
Number of months attending any training in each topic area ^b	X		Specific
Quantity and quality (over 12 months)			
Number of months attending any training involving role play	X		General
Number of months attending any training involving role play and observation	X		General
<u>Supervision of home visitors^c</u>			
Dosage (over 12 months)			
Home visitor's average time spent in supervision per month		X	General
Length of supervision session(s) meets or exceeds model standards for supervision session length (yes, no) ^d		X	General
Frequency of supervision			
Number of supervision sessions		X	General
Number of supervision sessions received meets or exceeds a specific proportion of expected sessions (yes, no) ^e		X	General
Number of supervision sessions in which specific topic discussed ^f		X	Specific
Discussion of specific topics in <i>any</i> session (yes, no)		X	Specific
Modality (over 12 months)			
Number of supervision sessions involving role play/modeling/practice		X	General
Number of home visitor's home visits observed by the supervisor ^g		X	General
Number of home visitor's home visits observed by the supervisor + received feedback		X	General
Average length of home visitor observation per month		X	General
Observation and feedback			
Supervisor observes home visitors (during visits or by video-recording) ^g	X		General
Conditions for conducting observation	X		
Frequency of observation for each home visitor	X		
Tool used for observation of home visit	X		
Type of feedback provided to home visitors	X		

(continued)

Appendix Table B.4 (continued)

NOTES: Specific is used as shorthand for outcome-specific.

^aS = Supervisor; HV = Home visitor.

^bThere are 29 topic categories for home visitors and 30 for supervisors. Examples of topics include: maternal prenatal and postpartum physical health; tobacco, alcohol, and other drug use; breastfeeding; education; family planning; domestic violence; child health; parent-child interaction; child abuse/neglect; administrative activities.

^bThe supervision logs measure the length of formal, informal, and group supervision. We can analyze these separately and/or combined depending on the particular analysis.

^dEHS national model standards do not require a specific length of supervision per month. Thus, EHS is excluded from this calculation. Additionally, PAT specifies a required length of supervision per month, whereas HFA and NFP specify a required length of supervision per week. As such, four weeks of data will be used to determine whether a PAT home visitor met the standard.

^eSuch as 100, 80 or 60% of expected supervision sessions per the model standard.

^fIndividual supervision content categories include: client status; planning/problemsolving re: client issues; planning/problem solving re: HV logistical/concrete issues; planning/problem solving re: HV burnout/exhaustion; general HV performance review; and general administrative topics/issues. Group supervision content categories include: training provided; administrative topics; case presentations; and other.

^gObservations might be conducted live or via recording. Could analyze separately and/or combined.

Perceptions of implementation system and service environment

Appendix Table B.5 shows potential measures of staff perceptions of the implementation system and the service environment. Home visitors' and supervisors' perceptions of the system and context may influence their comfort level, self-efficacy, and effectiveness in working with families to improve outcomes. These, in turn, may influence service delivery. For each priority outcome area, we plan to examine staff perceptions of key implementation system components (training, supervision, administrative and clinical supports) and of the service environment (access to and effectiveness of community service providers).

Appendix Table B.5
Potential Measures of Staff Perceptions of Implementation System and Service Environment

Characteristics	Levels for which item is available ^a		
	S	HV	General or Specific
Perceptions of the adequacy of training provided to help address outcomes ^b Specific outcome	X ^c	X	Specific
Perceptions of supervisor feedback to help address outcomes ^b Specific outcome	X	X	Specific
Perceptions of supervisor feedback after visit observation		X	General
Perceptions of whether program has useful strategies/tools to help address outcomes ^b Specific outcome	X	X	Specific
Home visitors' use and ease of use of electronic systems		X	General
Home visitors have easy access to consultants and find them helpful ^c Any	X	X	General
Specific types	X	X	Specific
Easy for families to get services from at least one service provider ^d Specific service type		X	Specific
Perceived effectiveness of service provider in meeting family's needs ^d Specific service type		X	Specific

NOTES: Specific is used as shorthand for outcome-specific.

^aS = Supervisor; HV = Home visitor.

^bOutcomes include: prenatal health, maternal physical health, family planning and birth spacing, tobacco use, substance use, mental health, domestic violence, family economic self-sufficiency, breastfeeding, positive parenting, child preventive care, child development, and other (e.g., child care).

^cAccess to consultants in the following areas are reported: prenatal health, maternal physical health, substance use, stress and mental health, healthy adult relationships, family economic self-sufficiency, parenting to support child development, and parenting to support child health.

^dSpecific service types include: prenatal care, maternal preventive care, family planning and reproductive health care, substance use treatment, mental health treatment, domestic violence shelter, domestic violence counseling/anger management, adult education services, job training and employment, pediatric primary care, child care, and early intervention.

burnout and work attitudes

Appendix Table B.6 shows potential measures of staff burnout and work attitudes. Staff burnout among home visitors is associated with organizational factors such as culture and climate, and individual staff demographic characteristics¹⁵ and psychosocial characteristics such as attachment anxiety.¹⁶ Staff burnout is also associated with turnover intentions,¹⁷ which in turn is associated with actual turnover among home visitors.¹⁸ Burnout may further affect the quality of home visitors' relationships with clients.¹⁹ We will measure staff burnout risk using the Organizational Social Context (OSC) measures of stress and engagement: emotional exhaustion, personalization, and personal accomplishment.²⁰ We will also assess work attitudes (job satisfaction and organizational commitment) using OSC individual-level items. We plan to analyze whether staff burnout is associated with service delivery.

Appendix Table B.6
Potential Measures of Staff Burnout and Work Attitudes

Characteristics	Levels for which item is available ^a		
	S	HV	General or Specific
Burnout risk (from OSC)			
Emotional exhaustion	X	X	General
Personalization	X	X	General
Personal accomplishment	X	X	General
Work attitudes (from OSC)			
Job satisfaction	X	X	General
Organizational commitment	X	X	General

NOTES: Specific is used as shorthand for outcome-specific.

^aS = Supervisor; HV = Home visitor.

¹⁵Lee et al. (2013).

¹⁶Burrell et al. (2009).

¹⁷DePanfilis and Zlotnik (2008).

¹⁸Buchbinder et al. (1998).

¹⁹Lee et al. (2013).

²⁰Glisson et al. (2008).

Perceptions of programmatic changes resulting from MIECHV

Finally, Appendix Table B.7 shows potential measures of staff perceptions of programmatic changes resulting from MIECHV. In MIHOPE's early planning stages, we learned that many local programs were experiencing substantial changes in program operations as a result of implementing the MIECHV program. To capture these changes and their associated potential burden or stress for staff, we developed a seven-item measure of staff perceptions regarding whether and how certain aspects of program operations have changed as a result of MIECHV. We plan to report each of these items individually.

Appendix Table B.7
Potential Measures of Staff Perceptions of Programmatic Changes
Resulting from MIECHV

Characteristics	Levels for which item is available ^a		
	S	HV	General or Specific
My work is much easier...much harder	X	X	General
My role is much clearer...less clear	X	X	General
My responsibilities are much greater...less	X	X	General
My program site operates more efficiently...less efficiently	X	X	General
Time I spend on documentation is much greater... much less	X	X	General
Quality of services program provides much higher...much lower	X	X	General
Program benefits for families much broader...more narrow	X	X	General

NOTES: Specific is used as shorthand for outcome-specific.

^aS = Supervisor; HV = Home visitor.

Mother and Infant Home Visiting Program Evaluation (MIHOPE) Implementation Analysis Plan

Appendix C: Service Plan

September 21, 2015

As discussed in the memo to the Committee on the MIHOPE implementation analysis plan, there are many potential variables that capture the inputs of local program implementation, as identified in the study's Conceptual Framework.²¹ This appendix describes the potential measures of local programs' service plans – which form the blueprint for program operations-- of relevance for the MIHOPE implementation research.²²

The service plan encompasses both specific plan elements, as well as the context in which these plans are developed. As will be described, these contextual aspects include clarity of communication from the national models (Early Head Start (EHS), Healthy Families America (HFA), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT)) and from state Maternal, Infant, and Early Childhood Home Visiting (MIECHV) agencies to the local programs, as well as influences of other organizations and funders on local programs. Together, these communications and paths of influence may influence local programs' service plans.

Potential measures of service plan

We propose to examine four broad aspects of the service plan:

- Intended recipients
- Intended outcomes
- Intended services
- Intended staffing

Specific measures for these aspects are drawn from web-based surveys of home visitors, supervisors, and program managers; interviews with and documents provided by the national models; and documents from local programs.

Intended recipients

Appendix Table C.1 shows potential measures of intended recipients of home visiting services. These measures characterize local programs' definitions of the families they target for services. Programs may be interested in some family characteristics, such as income and maternal age because of their association with a range of program outcomes. Other

²¹See the Overview memo for detail on MIHOPE's Conceptual Framework.

²²As noted in Appendix A of the Implementation Analysis Plan materials, many of these measures will be used to describe local program operations, and a more parsimonious set of the descriptive measures will be used in the multivariate analyses linking inputs to the outputs of service delivery.

characteristics, such as prior Child Protective Services (CPS) involvement, likely are associated more with specific outcomes in related domains.

Through various mediums, national models and state MIECHV agencies communicate their preferences and requirements to local programs regarding intended recipients of home visiting programs. We propose to measure local programs' perceptions regarding the clarity of these communications. These perceptions serve as proxies for the influence of national models and state MIECHV agencies on local program emphases. Competing influences regarding intended recipients may arise from other organizations, such as other organizations in the community or those who provide additional funding to the program. Thus, staff perceptions of additional influences are of interest, as well.

Appendix Table C.1
Potential Measures of Intended Recipients

Characteristics	Levels for which item is available ^a		
	NM	PM	General or Specific
Eligibility for enrollment criteria	X	X	Both
First-time mothers			
Teenage mothers			
Unmarried mothers			
Children with special health care needs			
Substance-using mothers			
Low-income status			
Prior Child Protective Services involvement			
Expectant mothers			
Other			
Individuals for whom program assumes responsibility for improving outcomes:	X	X	General
Child			
Mother			
Biological father			
Other father figure			
Child's other family caregivers			
Mother's other children			
Pregnancies and subsequent children			
Clarity of communication about intended recipients			
From national model developers		X	General
From state MIECHV agency		X	General
Influence of other organizations in prioritization of families (yes/no; if yes, which types of families [open-ended])		X	General

NOTES: Specific is used as shorthand for outcome-specific.

^aNM = National model; PM = Program manager.

Intended outcomes

Given the relevance of programs' outcome-specific goals (shown in Appendix Table C.2) as a starting place for understanding service delivery and program impacts, MIHOPE data are particularly comprehensive on this topic. MIHOPE assesses three aspects of outcome prioritization. The first is the priority assigned to each outcome by national model developers and local program staff members on a scale of 0 to 10. The second aspect is the local program manager's report of whether and how MIECHV has altered the local program's prioritization of each outcome. The third is a measure of the role of other influential organizations on the prioritization of outcomes.

There are several options for creating measures of local programs' prioritization of each outcome:

1. Use **an average program-level prioritization** (combining the program manager, supervisor(s), and home visitors' reports within each local program) for each outcome. This indicator would reduce measurement error by aggregating all reporters within programs, rather than relying on any one reporter.
2. **Average the home visitors' reports within a program**, since they are the "frontline" workers who navigate the translation of intended priorities to service delivery. Measurement error is also reduced because of the use of multiple reporters.
3. Similarly, create a **"higher level staff" average prioritization** (using program manager and supervisor responses), representing those who are further removed from (and yet should monitor and manage) home visitors in delivering actual services. The upper level staff responses are arguably less endogenous to service delivery, and thus may be preferred for the multi-variate analyses.
4. An alternative to [3] would examine and use the supervisors' reports (**as mid-level staff prioritizations**) and the program manager-level reports separately.

Another important aspect of a program's intended outcomes is how clearly the program articulates its intended goals. To examine this, we propose to look at the consistency of staff members' reports at the program level, and we have identified two possible ways of doing this:

1. The **difference between "frontline" staff** (the home visitors' average prioritizations within programs) **and upper level staff** (average of supervisors and program managers) would be a measure of dissonance or, alternatively, agreement between higher level staff and direct service providers.
2. Use the **variance (standard deviations) in the home visitors' responses** as a proxy for how well, and consistently, the program's goals have been communicated down to home visitors. Low variance would suggest high agreement and consistency; larger variance would suggest greater dispersion (disagreement) among home visitors in the same program.

Appendix Table C.2
Potential Measures of Intended Outcomes

Characteristics	Levels for which item is available ^a				General or Specific
	NM	PM	S	HV	
Prioritization of outcomes					Specific
Prenatal health	X	X	X	X	
Maternal physical health	X	X	X	X	
Family planning and birth spacing	X	X	X	X	
Tobacco use	X	X	X	X	
Mental health and substance use	X	X	X	X	
Intimate partner violence	X	X	X	X	
Breastfeeding	X	X	X	X	
Positive parenting behavior	X	X	X	X	
Child abuse and neglect	X	X	X	X	
Family economic self-sufficiency	X	X	X	X	
Birth outcomes	X	X	X	X	
Child preventive care	X	X	X	X	
Child development	X	X	X	X	
MIECHV changed priority of outcomes (listed above)		X			Specific
Influence of other organizations in prioritization of families (yes/no; if yes, which types of families [open-ended])		X			Specific

NOTES: Specific is used as shorthand for outcome-specific.

^aNM = National model; PM = Program manager; S = Supervisor; HV = Home visitor.

Intended services

Intended services, presented in Appendix Table C.3, are reflected in national model specifications and in local programs' policies and preferences for dosage, content, and techniques. Some of these were included in the Report to Congress. It is important for the implementation report to describe all of these aspects of intended services as well. For dosage, the implementation report will also note the program manager's report of how well national models have communicated expectations.

Appendix Table C.3
Potential Measures of Intended Services

Characteristics	Levels for which item is available ^a		
	NM	PM	General or Specific
<u>Duration and dosage</u>			
Preference for when services start (e.g., prenatally by certain time)	X	X	Both
Preference for how long services continue (e.g., by certain age of child)	X	X	
Preference for how long each visit should last (e.g., number of minutes)			
Clarity of communication about dosage requirements			General
From national model developers		X	
From state MIECHV agency		X	
<u>Content</u>			
Formal screening required, and when ^b	X	X	Specific
At specified time			
Only when home visitor or parent has concern			
Not required			
Policies on home visitor's provision of education and support if if screen is positive ^b	X	X	Specific
Written protocol and determined in consultation with supervisor			
Written protocol OR determined in consultation with supervisor			
No protocol and consultation not required			
Policies on home visitor's role in making referral ^b	X	X	Specific
Provide information to families			
Help family gain access to resource			
No policy			
Policies on home visitor's role in monitoring referral ^b	X	X	Specific
Expected to monitor			
Not expected to monitor			
No policy			
<u>Techniques</u>			
Encouragement of particular parenting techniques	X	X	General
Role modeling of positive parenting			
Observing and giving positive feedback			
Observing and giving constructive feedback			
Playing with child/direct interaction			
Encouragement of supportive strategies	X	X	General
Goal setting			
Problem solving			
Crisis intervention			
Emotional support			

(continued)

Appendix Table C.3 (continued)

NOTES: Specific is used as shorthand for outcome-specific.

^aNM = National model; PM = Program manager.

^bPolicies on screenings, education and support, and referrals were inquired about for five domains: maternal mental health, substance abuse, domestic violence, parenting, and child development.

Intended staffing

Most information shown in Appendix Table C.4 on intended staffing is drawn from national and local programs' documents. Variables on staff job qualifications, expectations of home visitors and supervisors, and staff hiring, recruitment, and roles and responsibilities will be developed from the coding of national model and local programs' documents and materials (such as job descriptions). The coding schemes and categorization of these are still being developed. Policies on supervisor and home visitor caseload size were ascertained through surveys and interviews.

Appendix Table C.4
Potential Measures of Intended Staffing

Characteristics	Levels for which item is available ^a		
	NM	PM	General or Specific
Maximum number of home visitors per supervisor	X	X	General
Number of cases on a full-time home visitor caseload	X	X	General
Home visitor and supervisor job qualifications	X	X	Both
Expectations of home visitors and supervisors	X	X	Both
Guidance provided to implementing agencies on staff recruitment, hiring, and roles/responsibilities	X	X	General

NOTES: Specific is used as shorthand for outcome-specific.

^aNM = National model; PM = Program manager.

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Appendix D: Implementation System

September 21, 2015

As discussed in the memo to the Committee on the MIHOPE implementation analysis plan, there are many potential variables that capture the inputs of local program implementation, as identified in the study's Conceptual Framework.²³ This appendix describes the potential measures of local programs' implementation systems of relevance for the MIHOPE implementation research. Implementation system components include staff development supports, administrative supports, clinical supports, linkages with other community-based service providers, and organizational dynamics.²⁴

Potential measures of implementation systems

The implementation systems of local programs encapsulate many aspects of infrastructure and organizational dynamics that support staff in their work. We expect that the presence and strength of specific supports, and their synergies, promote the ability of staff to provide services in ways that meet the needs of particular families. In MIHOPE, measures of the implementation system come from staff surveys and logs of training and supervision.

Staff development supports

Recruitment. The first two measures shown in Appendix Table D.1 relate to recruitment challenges experienced by programs. Taken together with the measures that describe the types of staff programs intend to hire (their qualifications and expected roles and responsibilities), discussed in Appendix C on Service Plans, indicators of actual recruitment allow us to trace how well programs are able to bring in staff with the expected or ideal qualifications.

Training adherence. Although training of home visitors is considered an individual staff characteristic (see Appendix B), some of the training variables can be captured and described at the program level. In particular, the team can analyze a training adherence indicator, which will show the percentage of programs whose staff (home visitors and supervisors) are up to date on training (based on program managers' reports).

Supervision adherence. Most of the supervision measures in MIHOPE were described in Appendix B as individual staff characteristics. However, some of these indicators can also be aggregated and analyzed at the program level as proxies for how well a local program maintains

²³See the Overview memo for detail on MIHOPE's Conceptual Framework.

²⁴As noted in Appendix A of the Implementation Analysis Plan materials, many of these measures will be used to describe local program operations, and a more parsimonious set of the descriptive measures will be used in the multivariate analyses linking inputs to the outputs of service delivery.

or uses supervision as a support for staff. Specifically, depending on the variation that exists within versus across local programs, measures of supervisory session adherence for home visitors (that is, the percent of home visitors per program that have received a particular threshold of the intended model's dosage) can be calculated and may be more useful for explanatory purposes at the level of the local program (if there is little within-program variation among home visitors).

Appendix Table D.1
Potential Measures of Staff Development

Characteristics	Levels for which item is available ^a			
	PM	S	HV	General or Specific
<u>Recruitment</u>				
Very/somewhat hard to recruit qualified candidates	X			General
Difficulty recruiting home visitors with specific qualifications ^b	X			General
<u>Up to date training of staff</u>				
Number of home visitors/supervisors up to date on training requirements	X			General
<u>Supervisory sessions meets or exceed model expectations</u>				
Percent of home visitors per program whose number of supervision sessions meets or exceeds a specific proportion of expected sessions (yes, no)			X	General

NOTES: Specific is used as shorthand for outcome-specific.

^aPM = Program manager; S = Supervisor; HV = Home visitor.

^bQualifications include: interest in home visiting; required education or degree; bilingual; has own transportation; other.

Administrative and clinical supports

The potential measures of administrative and clinical supports (Appendix Table D.2) capture a range of program characteristics that are hypothesized to improve program operations and service delivery.

Administrative supports. Maternal, Infant, and Early Childhood Home Visiting (MIECHV) emphasizes that the importance for states to build the administrative support structures programs need to help them deliver intended services, such as a management information systems (MIS), and also calls for states to engage in continuous quality improvement (CQI) to monitor and provide feedback on program performance. The indicators in Appendix Table D.2 will be used to describe the extent to which MIHOPE programs have such structures and practices in place, and whether particular activities are carried out.

Clinical supports. In describing clinical supports of programs, the team will examine measures of curriculum used, use of peer support, and the availability of professional consultants to support home visitors in their work with families. In addition to examining the number of curriculum used by local programs, we will report whether home visitors are encouraged to

supplement model curriculum, and how often topics or lessons discussed in home visits are driven by the family's choice or interest, the home visitor's choice, and/or program requirements (based on program managers' reports). At this time, we also plan to analyze three of the most commonly used curricula among local programs: Partners in Parenting Education (PIPE) for Nurse-Family Partnership (NFP), Parents as Teachers (PAT) Foundational Training, and Partners for a Healthy Baby. Nearly all (86 of 88) program managers reported that they required or recommended their home visitors use one of these three curricula. They will be coded for key aspects such as overarching theory or framework, instructional objectives, content, learner experiences, and clarity and ease of use. Access to professional consultants can be assessed for various types of professional services (e.g., mental health consultation, child development), but can also be operationalized as a general measure of consultant availability (by combining reports of availability across the services types).

Appendix Table D.2

Potential Measures of Administrative and Clinical Supports

Characteristics	Levels for which item is available ^a		
	PM	HV	General or Specific
<u>Administrative supports</u>			
Management information systems (MIS)			
Number of MIS used by local program	X		General
Use of MIS to generate reports	X		General
Other (non-home visitors) staff enter data in MIS	X		General
Continuous quality improvement (CQI)			
CQI activities carried out in past 12 months	X		Specific
Staff with dedicated time to support CQI activities	X		General
Routine monitoring of screening rates for...	X		Specific
Maternal depression			
Maternal substance use			
Intimate partner violence			
Child development			
<u>Clinical supports</u>			
Curriculum			
Number of curricula used by local program	X		General
Home visitors encouraged to supplement model curriculum	X		General
Topics can be driven by family, home visitor, and/or program requirements	X		General
Peer learning and access to consultants			
Formal opportunities for peer support provided	X		General
Access to professional consultants (internal or external) ^b			
Any	X		General
Specific types	X		Specific
Types of services provided by professional consultants (internal or external) ^b			
Provide direct services to families	X		Specific
Provide advice to home visitors	X		Specific
Both	X		Specific

NOTES: Specific is used as shorthand for outcome-specific.

^aPM = Program manager; HV = Home visitor.

^bAccess to consultants in the following areas are reported: prenatal health, maternal physical health, substance use, stress and mental health, healthy adult relationships, family economic self-sufficiency, parenting to support child development, and parenting to support child health.

Referrals and coordination

Referrals and coordination play an interesting role in MIHOPE, because they are both activities of local programs and home visitors, and they are also specifically noted as an outcome of MIECHV programs. Indeed, because one of the key roles of home visiting programs is to link families to needed services, these linkages are outcomes of interest in the impact analysis.

In the implementation study, we will examine not only actual referrals provided as program outputs, but also the factors that foster the referral and coordination process (Appendix Table D.3). These measures include whether local programs have memorandums of understanding (MOUs) in place with other service providers and or/centralized intake to bring in new families, whether they have designated points of contact for making referrals, and the types of other coordination they engage in with community service providers (including the frequency of communication and an overall rating of their coordination).

Appendix Table D.3
Potential Measures of Linkages for Referrals and Coordination

Characteristics	General or Specific
Formal agreements (MOUs) with service partners who refer families to local programs ^a	
Any	General
Centralized intake	General
Specific type	Specific
Frequency of referrals to community service providers who provide other services to families ^b	
Any	General
Specific type	Specific
Formal agreements (MOUs) with community service providers ^b	
Any	General
Specific type	Specific
Designated point of contact at community service providers ^b	
Specific types	Specific
Engages in joint activities with community service providers ^b	
Specific types	Specific
At least weekly (or monthly) communication with community service providers ^b	
Specific types	Specific
Has good/excellent coordination with community service providers ^b	
Specific types	Specific

NOTES: Specific is used as shorthand for outcome-specific. All measures shown in table are based on the program manager's reports.

^aReferral partners include hospitals, health departments, prenatal clinics, child welfare agencies, WIC programs, schools, pediatric clinics, and other.

^bSpecific service types include: prenatal care, family planning/reproductive health, substance use and mental health treatment services, domestic violence shelter, domestic violence counseling/anger management, adult education or employment services, pediatric primary care, child care, and early intervention.

Organizational dynamics

Organizational social context. The proposed measures of organizational culture and climate come from the Organizational Social Context (OSC), developed by Glisson and colleagues.²⁵ We plan to examine overall culture and climate categories (best, average, worst), as well as the culture subscales of rigidity, proficiency, and resistance, and the climate subscales of engagement, functionality and stress (Appendix Table D.4). These two dimensions of an organization's workplace context are based on supervisors' and home visitors' responses to OSC survey items, which are then aggregated at the local program level to form the latent constructs and subscales.

Caseloads and staffing. We also propose to examine staff caseloads and retention. High staff turnover is often a problem in human service fields and organizations, and has been found to compromise the quantity of services provided to families. For example, O'Brien et al. found that families who were visited by a home visitor who left her position received less home visits and were more likely to leave the program early.²⁶ Staff retention for each local program (Appendix Table D.4) will be measured as the percentages of supervisors and home visitors who have remained with the program (at various time points after the program began participating in MIHOPE), although we will not be able to separate out whether a staff member is leaving MIHOPE and going to another part of the agency, or leaving the agency altogether.

²⁵Glisson and Schoenwald (2005); Glisson et al. (2008).

²⁶O'Brien et al. (2012).

Appendix Table D.4
Potential Measures of Organizational Dynamics

Characteristics	Levels for which item is available ^a				General or Specific
	PM	S	HV		
<u>Organizational social context</u>^b					
Organizational culture (overall)		X	X		General
Rigidity subscale		X	X		
Proficiency subscale		X	X		
Resistance subscale		X	X		
Organizational climate (overall)		X	X		General
Engagement subscale		X	X		
Functionality subscale		X	X		
Stress subscale		X	X		
<u>Caseloads and staffing</u>					
Number of families in home visitor's caseload	X				General
Number of home visitors supervisor supervises	X				General
Staff retention					General
Percentage of home visitors who remained with program (at various time intervals post-kickoff)	X				
Percentage of supervisors who remained with program (at various time intervals post-kickoff)	X				

NOTES: Specific is used as shorthand for outcome-specific.

^aPM = Program manager; S = Supervisor; HV = Home visitor.

^bBased on the Organizational Social Context (OSC) scale.

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Appendix E: Community Context and Service Environment

September 21, 2015

As discussed in the memo to the Committee on the MIHOPE implementation analysis plan, the community context and local service environment comprise an important category of inputs of local program implementation, as identified in the study's Conceptual Framework.²⁷ This appendix describes the potential measures of community context and service environment, which will be used to both describe the communities within which families reside and local program operate, and to analyze the role of service provider availability and accessibility on *outcome-specific* service delivery, such as referrals made to connect families to particular services or support.

Potential measures of community context and service environment

The measures of community context tap into various elements of neighborhood demographics and conditions and the service environment (Appendix Table E.1).

Community context. Community environment measures are derived from two sources: (1) aggregate tract data from the U.S. Census 2010 and (2) the MIHOPE interviewer's observational ratings of conditions of the sample member's block. Census tract measures will be linked to the family through geocoding of the family's address at baseline. The Census tract indicators for each local site's study families will be averaged to create site-level indicators of the community served. Given the number of individual items available from the Census, the team may select a handful that have been found in prior literature to be among the most salient indicators of broader community-level disadvantage and barriers, such as residential or child poverty, racial/ethnic composition, median income or population density (as a proxy for urban vs. rural context). The interviewer observations will be combined to create an index of the quality of the neighborhood physical and social environment at the family level, as was done in the Early Head Start Family and Child Experiences Study (Baby FACES).²⁸

Service environment. The service environment measures are based on reports from the program manager, who was asked to name and provide contact information for local providers of specific service types and for other local home visiting providers. The local providers were then asked to complete a brief web-based survey, but it has proven to be challenging to collect data from these local providers.²⁹ At this time, we propose not including these data in implementation analyses because of the low response rate.

²⁷See the Overview memo for detail on MIHOPE's Conceptual Framework.

²⁸Vogel et al. (2015).

²⁹The target response rate for the community service provider survey was 60 percent. The actual response rate across all nominated service providers is 22 percent, ranging from 0 to 100 percent across local MIHOPE programs.

The measures of service accessibility and availability are outcome-specific. We propose to construct two types of composite variables from them. First, for resources pertinent to each specific outcome, we will create a composite measure of accessibility that reflects the facets of those indicators shown in Appendix Table E.1. Second, we will create a composite measure of the range of services available, to create a general indicator of the breadth of resources available.

Responses rates by provider type range from 6 percent for pediatric care providers to 30 percent for early intervention providers. Some service providers were nominated by multiple programs located in close proximity but only responded only to the survey associated with one program. Responses to many survey items are valid for all local programs that nominated the provider, such as the provider's assessment of service availability in the community and self-reports about accessibility of their own services. Using responses to these items for all local programs that nominated the provider will increase response rates somewhat. We are assessing the feasibility of examining levels of agreement between program managers and selected other community services providers about the availability of different types of services. For example, eight programs have response rates of 60 percent or higher, so we may be able to use them as case studies. The response rate for the other home visiting program survey is 31 percent, ranging from 0 to 100 percent across programs.

Appendix Table E.1

Potential Measures of Community Content and Service Environment

Characteristics	Levels for which item is available		General or Specific
	Community	Program	
<u>Community context</u>			
Community context (families' residential census tract)	X		General
Total population			
Population density (persons per square mile)			
Racial/ethnic composition			
% speaking a language other than English at home			
% of population in poverty			
Median household income			
Household type (lives alone, multigenerational)			
Occupancy versus vacancy status of housing			
Tenure (own versus rent)			
Commute time			
% of population with car			
Observed neighborhood quality index ^a	X		General
<u>Service Environment</u>			
Service provider availability			
Specific service type is available in community ^b		X	Specific
All service types available in community		X	General
Service provider accessibility			
Referrals not made for service type because of access issues ^b		X	Specific
For specific providers for each service type: ^c			
At least one provider to refer families		X	Specific
More than one provider to refer families		X	Specific
No waiting list for at least one provider		X	Specific
No difficulty for families to access service from at least one provider		X	Specific
Service provider rated as very/quite effective		X	Specific
Program names at least one provider across service types		X	General

NOTES: Specific is used as shorthand for outcome-specific.

^aBased on field staff observations of the sample member's block for the following 8 items: condition of housing units; condition of the street; presence of garbage, litter, broken glass; extent of drug-related paraphernalia, alcohol, or cigarettes; traffic volume; presence of children playing outside; presence of adults or teens fighting, drinking, or engaging in hostile behavior; sense of safety.

^bSpecific service types include: prenatal care, family planning/reproductive health, substance use and mental health treatment services, domestic violence shelter, domestic violence counseling/anger management, adult education or employment services, pediatric primary care, child care, and early intervention.

^cFor each specific service type, program managers were asked to name a specific provider (or more) and were then asked a series of questions on accessibility and effectiveness of those providers.

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