

# *Assessing* **Home Visiting Program** *Quality*

Final Report to the Pew Center on the States



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With the support of the Pew Center on the States, we have collected data for the creation of a home visiting program quality assessment tool. This report describes the procedures used to collect these data and describes our basic findings regarding the assessment tool. The views expressed are those of the authors and do not necessarily reflect the view of the Pew Center on the States or The Pew Charitable Trusts.

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# Assessing Home Visiting Program Quality

## Introduction

Across the United States, home visiting is increasingly recognized as an important service strategy for strengthening families of young children, even more so now that the federal government seeks to expand home visiting services through different initiatives, including funding the Maternal Infant and Early Childhood Home Visiting (MIECHV) program. Several nationally recognized models have provided evidence to varying extent of their impact on outcomes for children and families, and there have been efforts to aggregate outcomes from home visiting models as evidenced from experimental or quasi-experimental designs, such as the Home Visiting Evidence of Effectiveness website (<http://homvee.acf.hhs.gov/>). Some states have adopted a specific model for implementation of home visiting in their state. Other states fund a variety of evidence-based models, often selecting from several nationally recognized programs and allowing communities to select the model that best meets their local needs (Pew Center on the States, 2011).

There have been attempts to identify key quality program areas of effective home visitation, partly as a strategy to deal with concerns around the modesty or inconsistency in program results (Daro, 2006; Weiss & Klein, 2006; Johnson, 2009). These quality indicators include (but are certainly not limited to) aspects of timing of enrollment, intensity of visits, use of assessment or screening tools, cultural competence, training of visitors, program content or focus, and link to other community resources. At the present time, however, there is little guidance available as to how programs can be evaluated (or can evaluate themselves) on their level of adherence to these quality program areas. Some national models have proprietary

assessment tools that are used as part of their credentialing process. Healthy Families America (HFA), for example, requires an external site review covering quality indicators related to their 12 critical elements (Healthy Families America, 2008). Likewise, Parents as Teachers (PAT) provides a self-assessment procedure for programs affiliated with their model, which is currently being updated (K. Guskin, personal communication 2-15-12). For both of these reviews, programs pay for this process either in terms of site visits, assessment materials, or certification fees.

As noted earlier, multiple models are often blended or braided to provide services to meet their state and community needs. According to the Parents As Teachers National Center, approximately 71% of programs delivering Parents as Teachers Born to Learn services blend with other early childhood or parent support programs (National Center Parents as Teachers, 2007). There is a clear thematic similarity in vision, logic models and in quality indicators between the PAT and other recognized home visiting models, such as HFA, Early Head Start (EHS), Even Start and Nurse Family Partnership (Home Visiting Vision Statement, 2008). It is not clear, however, how well an assessment tool designed for one program model can actually be applied in a valid way to other program models as a way to guide program improvement. States that have decided to support multiple models are in need of a mechanism to identify and support quality programs, and programs that choose to develop their own model or to braid or blend multiple models must also think of how they can evaluate the quality of the services they provide using common benchmarks or quality indicators.

This final report presents the findings of a study to field test a comprehensive assessment tool to measure program implementation of best practice elements in home visiting programs. Named the Home Visiting Program Quality Rating Tool (HVPQRT), this measure was designed to be a practical, yet multi-dimensional evaluation of a program's capacity to provide high quality home visiting services to families with infants and toddlers (including the provision of prenatal home visiting). Three agencies worked as a team to oversee the identification of common best practices, operationalize these best practice elements in a practical program assessment, and examine the usability and inter-rater reliability of the assessment measure.

Impetus for this work also emerged from the professional experiences of the research team members engaged in various quality initiatives across two different states. In particular, it became increasingly apparent when working with different home visiting programs that even if staff from different programs could agree on broad dimensions of quality (e.g., providing intensive home visits), they had different definitions for these dimensions. This suggested value in developing a common rubric for quality indicators.

Ultimately, the aim of this applied research study was the development of a practical and reliable best practice assessment tool that works across program models. At the individual program level, this tool will aid in planning for service delivery improvement. Specifically, this measure is designed to provide operational anchors to key quality program areas for best practice as identified in the research literature, provide a means for programs and outside evaluators to practically review process elements as they relate to key quality program areas for best practice, and provide a specific method for sites to review their actual results in meeting identified criteria.

At the policy level, it can be used as part of a systematic review of program quality. As noted in a 2009 brief from Chapin Hall, "decision makers should look at evidence that highlights key features that seem to be common across various models and to select those options most compatible with local populations and community contexts" (Daro, 2009; pg 4). A tool that gathers evidence

of program quality in a standard manner across multiple programs and models can inform decision-making about where to focus needed resources for improvement efforts. Such an effort may also identify where systemic challenges consistently limit programs' ability to demonstrate quality services.

### Research Questions

The study was guided by three primary research questions.

- 1) What components of quality programming (best practice elements) can be identified and operationalized across different home visiting program models?
- 2) Can these components be reliably measured across models?
- 3) Can sites use the results to improve program quality and accountability, and inform policy and decision-makers?

Activities were carried out over an 18 month period, with two primary alterations from the research proposal. First, a self-assessment version of the rating tool for programs to use themselves was not completed. As detailed in the methods section, creation of the quality rating tool was an iterative process that required multiple drafts. During piloting, the decision was made to focus efforts on an external evaluation process when it became apparent that creating and testing a self-assessment version would require modifications that went beyond the scope of the project's time frame.

The second alteration is related to the final research question, using results to improve quality and accountability. In the course of this project, program directors were provided feedback based on the findings of the tool and were given the opportunity to provide their own feedback about their experience with the evaluation process and its perceived usefulness. We view these activities as only partial attempts to answer this final research question. How the HVPQRT can be used to inform policy and improve program quality is an ongoing research question, one that will be pursued as we continue to refine and evaluate the tool. This issue is further explored at the end of this report.

## *Background and Literature Review*

### **Identifying Common Best Practice Elements**

There have been multiple attempts to identify core elements of home visiting program quality specifically or early childhood intervention and prevention services more broadly. Many of these examples involve summarizing common best practice elements within and across program models that have demonstrated some level of effectiveness on child or family outcomes. Other attempts to identify core features include the articulation of specific program model standards or state regulations for home visiting programs. Examples for each of these are discussed below.

### **Summary Reviews**

Table 1 highlights findings from several overarching reviews of best practice elements within home visitation or prevention programs (Daro, 2009; Nation et al., 2003; Paulsell, Avellar, Sama Martin, & Del Grosso, 2010; Weiss & Klein, 2006).<sup>1</sup> In some instances, the best practice elements discussed within these reviews rely on empirical evidence surrounding the efficacy of particular home visiting program elements or strategies. Paulsell et al. (2010) and Daro (2009) both cite evidence from program evaluations showing specific program elements that relate to positive program outcomes (for example, linking prenatal enrollment in program services to stronger parenting outcomes; Daro, 2009).

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<sup>1</sup> Tables 1-3 are organized using the five broad dimensions of quality used in the Home Visit Program Quality Rating Tool. See Methods for more information on the process of developing these dimensions.

Table 1. **Dimensions of Quality and Best Practice Elements: SUMMARY LITERATURE AND REVIEWS**

Dimensions of Quality	Best Practice Elements			
	Family based prevention programs (Small, Cooney, and O’Conner, 2009)	What works in prevention: Principles of effective prevention programs (Nation et al. 2003)	Home visitation: The cornerstone of effective early intervention (Daro, 2009)	Changing the conversation about home visiting: Scaling up with quality (Weiss & Klein, 2006)
<b>Staff Competencies</b>	– Well-qualified, trained, and supported staff	– Well trained staff that can employ a variety of teaching methods	– Qualified staff, competent in working with young children and families	– Match staff qualifications with the specific needs of families and program goals
<b>Program Service Delivery</b>	– Sufficient dosage/intensity – Appropriately time	– Appropriate initiation of services – Appropriate dosage of services	– Early access to basic health care – Program extends over a period of time to allow for meaningful change	– Participants receive sufficient intensity of services
<b>Program Characteristics and Content</b>	– Theory-driven program model – Comprehensive content – Developmentally appropriate – Socioculturally relevant – Focus on fostering good relationships – Actively engaging	– Theoretically based program model – Offers comprehensive services – Socioculturally relevant – Provide opportunities to develop positive relationships – Reasonable caseloads	– Program theory of change – Links to other community resources – Broad risk assessment to determine family strengths and needs	– Program is clearly conveyed and consistent with program model/ curriculum – Child/focused activities/ curriculum – Link families to additional support systems
<b>Program Management and Development</b>	– Staff are well supported by program management – Program policies and guidelines for program documentation	– Organizational capacity to track and monitor service delivery and program outcomes	– High quality supervision that includes observation of the provider and participant – Solid organizational capacity	– Providing training for staff specific to their job roles and responsibilities
<b>Program Monitoring</b>	– Well documented – Committed to evaluation/refinement	– Program includes outcome evaluation – Program has clear goals and objectives	– Program demonstrates outcomes	– Use of management information for tracking and monitoring of service implementation and program outcomes

However, many program evaluations focus more generally on exploring the efficacy of home visiting as a service strategy (i.e. outcome-focused) and less on understanding specific program components that are essential for effective programs. Therefore, in other instances the best practice elements reflect a consensus or conventional wisdom within the field of aspects of program quality (e.g. program theory, use of assessment and screening tools), but have not necessarily been directly tested in research.

Given this, the initial identification of best practice elements used to create the measure discussed in this report relied on findings from research evidence as well as general consensus within the field. Common best practice elements (e.g., seen across multiple summary reviews) focus on: 1) timing of family enrollment in programs, 2) frequency and length of services, 3) use of assessment and screening tools, 4) education and experience level of home visitors, 6) program theory of change, and 7) program resource networks (Daro, 2006; Gomby, 2007; Johnson, 2009; Olds et al., 2004; Weiss & Klein, 2006).

In addition to reviews and summaries specific to home visitation, the initial identification of best practice elements drew on reviews and summaries of best practice elements for prevention programs in general (e.g. Nation et al., 2003; Small, Cooney, & O'Conner, 2009). These reviews typically summarized evaluations of a variety of prevention programs, including family support and child abuse prevention programs, with the purpose of identifying program elements that are common across effective programs. The best practice elements within this literature base generally overlapped with the elements identified in the literature

base specific to home visitation. However, there was a greater emphasis on the importance of having a theoretically based program, offering a comprehensive array of services to participants, the sociocultural relevance of program content, and attention to program outcomes and evaluation.

### State and Program Standards

Another source for identifying common best practice elements is examining specific program model standards or standards established by state funding or regulatory agencies. For example, Table 2 summarizes best practice elements that emerge from the state of Illinois' Early learning standards and Illinois State Board of Education (ISBE) standards for programs serving children age birth-to-three. Inclusion of these sources adds best practice elements that specifically relate to the content of child development curriculum and resources (e.g. curriculum covering a range of child development topics and staff training on multiple dimensions of child development) used by programs. Table 3 summarizes national program model standards that further identify best practice elements specific to effectively supporting families with young children. For example, one common standard across program models is a focus on positive parent-child relationships. Another common standard focuses on creating links to other community and/or early education services.

The review and synthesis of best practice elements across these sources contributed to the development of an initial extensive list of common best practice elements, which served as the basis for developing a final list of indicators that could be operationalized into a measurement tool of home visiting program quality applicable across different program models.

Table 2.

**Dimensions of Quality and Best Practice Elements: EXAMPLES OF STATE STANDARDS**

Dimensions of Quality	Best Practice Elements	
	IL-ELC (0-3 Common Best Practices)	ISBE Birth To Three Quality Program Standards
<b>Staff Competencies</b>	<ul style="list-style-type: none"> <li>– Staff knowledgeable about young children</li> </ul>	<ul style="list-style-type: none"> <li>– Qualified staff competent in working with infant/toddlers and families</li> </ul>
<b>Program Service Delivery</b>	<ul style="list-style-type: none"> <li>– Intensity of services</li> <li>– Transition planning</li> </ul>	<ul style="list-style-type: none"> <li>– Scheduling and intensity of services tailored to families</li> <li>– Seeks and facilitates family participation and partnerships</li> </ul>
<b>Program Characteristics and Content</b>	<ul style="list-style-type: none"> <li>– Relationship-based approach</li> <li>– Inclusion of parents and family members</li> <li>– Multidisciplinary coordination</li> <li>– Respect for family cultural/linguistic ability</li> <li>– Staff/family ratios</li> </ul>	<ul style="list-style-type: none"> <li>– Curriculum reflects centrality of adult/child interactions</li> <li>– Assures that families have access to comprehensive services</li> <li>– Curriculum reflects holistic &amp; dynamic nature of child development</li> <li>– Sensitive to and respects varying abilities and diversity in cultural, linguistic, and economic backgrounds</li> <li>– Curriculum promotes framework that is nurturing, predictable, and consistent, yet flexible</li> </ul>
<b>Program Management and Development</b>	<ul style="list-style-type: none"> <li>– Staff supervision and training</li> </ul>	<ul style="list-style-type: none"> <li>– Active role in community/system planning; collaborative relationships with other organizations</li> <li>– Ongoing staff development, training, and supervision</li> <li>– Continuity in staffing through supportive work environment, wages/benefits, and advancement</li> <li>– Informed leadership and supervision</li> <li>– Budget supports quality program service</li> </ul>
<b>Program Monitoring</b>	<ul style="list-style-type: none"> <li>– Screening and assessments</li> </ul>	<ul style="list-style-type: none"> <li>– Regular and systematic evaluation re: philosophy and goals of program</li> <li>– Regularly monitors children’s development</li> </ul>



Table 3.

**Dimensions of Quality and Best Practice Elements: PROGRAM STANDARDS**

Dimensions of Quality	Best Practice Elements			
	HFA 12 Critical Elements	EHS	Strengthening Families	PAT
<b>Staff Competencies</b>	<ul style="list-style-type: none"> <li>- Skilled, relationship oriented home visitors</li> </ul>	<ul style="list-style-type: none"> <li>- Low staff turnover</li> <li>- Staff morale is high</li> <li>- Staff are aware of and link families to other community services</li> <li>- Staff develop individual service plans for families</li> </ul>	<ul style="list-style-type: none"> <li>- Strengthen parents by providing comprehensive information on parenting reinforcing positive parenting</li> <li>- Staff appropriately responds to family crises</li> <li>- Foster child social and emotional development</li> <li>- Recognize early signs of abuse and neglect</li> </ul>	<ul style="list-style-type: none"> <li>- Staff aware of community resources</li> <li>- Staff has knowledge, skills, sensitivity to effectively work with all families</li> <li>- Sharing child development information</li> <li>- Knowledge of adult learning styles</li> <li>- Use 5 essential components of personal visit (rapport, observation, discussion, parent-child activity, summary)</li> </ul>
<b>Program Service Delivery</b>	<ul style="list-style-type: none"> <li>- Intense services, based on need</li> <li>- Begin prenatally or at birth</li> </ul>	<ul style="list-style-type: none"> <li>- Weekly home visits</li> <li>- Offers additional services (e.g. socializations, child care, parent education)</li> <li>- Inclusion of multiple family members in service delivery</li> <li>- Active participation of families</li> </ul>		<ul style="list-style-type: none"> <li>- At least monthly home visits, additional visits required for families with high needs</li> <li>- Program has clear and written plan for recruitment</li> </ul>
<b>Program Characteristics and Content</b>	<ul style="list-style-type: none"> <li>- Visits support parent, child, and parent-child relationship</li> <li>- Framework to deal with variety family experiences</li> <li>- Links relevant community services</li> <li>- Cultural competence</li> <li>- Reasonable caseloads</li> </ul>	<ul style="list-style-type: none"> <li>- Developed program goals, plans for each service area</li> <li>- Focus on parent-child relationship</li> <li>- Assist families in obtaining health, dental, and mental health services</li> <li>- Connections with other early education programs</li> <li>- Services individualized to family needs</li> </ul>	<ul style="list-style-type: none"> <li>- Linkages to other community resources</li> <li>- Facilitate friendships and mutual support among families</li> <li>- Value and support parents-culturally and linguistic sensitive services</li> </ul>	<ul style="list-style-type: none"> <li>- Staffing supports program design and goals (reasonable caseloads)</li> <li>- Program has clearly defined, written program goals and objectives</li> </ul>

Table 3 Continued.

**Dimensions of Quality and Best Practice Elements: PROGRAM STANDARDS**

Dimensions of Quality	Best Practice Elements			
	HFA 12 Critical Elements	EHS	Strengthening Families	PAT
<b>Program Management and Development</b>	<ul style="list-style-type: none"> <li>- HV trained on components</li> <li>- Ongoing effective supervision</li> </ul>	<ul style="list-style-type: none"> <li>- Staff receives regular supervision and obtains feedback on their performance</li> <li>- All staff receives training in multiple areas</li> </ul>	<ul style="list-style-type: none"> <li>- Staff receive training on multiple dimensions of child development</li> </ul>	<ul style="list-style-type: none"> <li>- Supervision occurs on a monthly basis</li> <li>- Program accesses consultants</li> <li>- Supervisor engages in quarterly supervision from administrator, peer mentor, or other professional</li> <li>- Annual professional development goals established and monitored. Sufficient funding to support program goals</li> </ul>
<b>Program Monitoring</b>	<ul style="list-style-type: none"> <li>- Standardized risk assessment</li> </ul>	<ul style="list-style-type: none"> <li>- Program conducted formal assessment and included broad range of staff, parents, and community members in self-assessment process</li> <li>- Risk assessment of families at enrollment, regular development assessments of children</li> </ul>		<ul style="list-style-type: none"> <li>- 5% of annual budget allocated to evaluation and self-assessment; written plan for data collection</li> <li>- Objective evaluation completed every 3 years</li> <li>- All enrolled children receive development screening</li> </ul>

The working draft of common best practice elements, organized by five broad dimensions of quality, was used as a framework to review existing measures of home visiting program quality and to complete a more thorough literature review focused on the empirical evidence supporting these common indicators. The benefit of these additional review processes was threefold. First, the more extensive reviews contributed to the face validity of the tool in regards to ensuring the inclusion of key best practice elements as identified by the field. Second, the reviews helped move beyond identifying general statements of best practice to defining specific indicators of quality. Third, the review of existing credentialing and/or assessment processes ensured that the assessment tool did not duplicate existing measures of home visiting quality.

## Measuring Quality

There is precedent for methods to operationalize or measure quality in home visiting programs. Existing methods include self-assessment and/or credentialing tools used by various program models, tools that closely assess specific best practice elements (e.g. relationship quality between home visitors and families), and comprehensive efforts to measure quality across multiple program sites or models.

### Self-Assessment/Credentialing Tools

Several existing measures of home visiting quality are used as a self-assessment or credentialing tool for specific program models. Healthy Families America (HFA), for example, has a self-assessment and external review process organized around their 12 critical elements of program quality (Healthy Families America, 2008). Likewise, Parents as Teachers (PAT), offers a self-

assessment process (currently being updated) focused on eight standards across four core service delivery components and four areas of program management (Weiss & Klein, 2006). A component of Early Head Start's (EHS) national evaluation included external assessments of implementation of the 24 EHS program performance standards (Kisker, Paulsell, Love, & Raikes, 2002). Similarly, Even Start provided programs with a self-assessment tool gauging adherence to 29 quality indicators (Even Start, 1994). Table 4 summarizes these self-assessment and credentialing tools.

The self-assessment/credentialing tools use a variety of data collection methods to assess program quality, including: record review, interviews, focus groups, observations, and program self-report. In reviewing the assessment/credentialing tools, we identified commonalities in best practice elements across the tools. We also noted best practice elements identified within the literature but not commonly measured by these tools. For example, there is a strong relationship between child and family outcomes and families receiving a sufficient frequency and length of program services (Nievar, VanEgeren, & Pollard, 2010; Sweet & Appelbaum, 2004). However, only HFA's assessment process directly measures the frequency and length of services families actually receive, while other tools are more likely to measure families' intended frequency and length of services. In reviewing the tools, we also noted that greater attention is paid to measuring global or structural elements of quality and less attention is paid to measuring process oriented elements of quality. This was most common within the broad dimensions of home visiting staff competencies and program management and development.

Table 4.

**REVIEW OF SELF-ASSESSMENT/CREDENTIALING TOOLS**

<b>Program</b>	<b>Even Start</b>	<b>PAT</b>	<b>HFA</b>	<b>EHS</b>
<b>Purpose</b>	Self Assessment Tool	Self Assessment Process	Self Assessment and External Review	External review of implementation of program performance standards
<b>Content Measured</b>	<p>Measures 29 program components</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>- Holistic approach</li> <li>- Common program message delivered across components</li> <li>- Program leadership</li> <li>- Staff development</li> <li>- Collaborations with a variety of agencies</li> <li>- Referrals for families</li> <li>- Programs service schedule is flexible and convenient</li> <li>- Staff development includes training on building cultural awareness and integrating family culture into services</li> </ul>	<p>Measures 190 quality indicators over 8 program areas, including:</p> <ul style="list-style-type: none"> <li>- Personal Visits</li> <li>- Group Meetings</li> <li>- Screening</li> <li>- Resource Network</li> <li>- Recruitment and Retention</li> <li>- Program Management</li> <li>- Professional Development</li> <li>- Evaluation</li> </ul>	<p>Organized around 12 critical elements of HFA:</p> <ul style="list-style-type: none"> <li>- Initiate services early</li> <li>- Standardized risk assessment</li> <li>- Voluntary services</li> <li>- Intense services</li> <li>- Cultural competence</li> <li>- Visits support parents, child, and parent-child relationship</li> <li>- Links to community services</li> <li>- Reasonable caseloads</li> <li>- Skilled and relationship-oriented home visitors</li> <li>- Ability to handle diverse family experiences</li> <li>- Staff training</li> <li>- Ongoing effective supervision</li> </ul>	<p>Measuring level of implementation on 24 program standards in the following areas:</p> <ul style="list-style-type: none"> <li>- Child and family development</li> <li>- Staff development</li> <li>- Community Partnerships</li> <li>- Program Management</li> </ul>
<b>Data Collection Methods</b>	Scale of 1 to 5, programs are asked to consider how descriptive the consideration is of their program (1 = Very descriptive, 5 = Not at all descriptive)	Self-Report Scales Data collected through record reviews, child and family assessments, and informal interviews.	Self –assessment process (1) Self-study, (2) Peer review site visit, (3) Response period. Data collected through record reviews and interviews. Ratings: 3-exceeds, 2-meets, 1-does not meet	Data collected through focus groups, interviews, observations, and record reviews. Programs rated on 5-point Likert scale with different anchors for each indicator.

For example, some existing tools assess the structures or resources to support staff competencies (e.g. professional development, training, supervision) and implementation of quality home visits (e.g. established curriculum, staff access to additional resources or consultation). However, less attention is paid to directly assessing individual home visiting staff competencies in regards to how staff integrate child development information into home visits, use specific strategies to facilitate positive parent-child interactions, or effectively problem solve with families around common issues that families might face.

### Specific Quality Measures

Several existing tools are designed to more closely assess the content and quality of individual home visits (see Table 5). Some of these tools document certain aspects of home visits, including: length of visits, content covered, activities completed, and participants. Other scales measure more dynamic aspects of home visits, including home visitor personal characteristics and qualities, interaction patterns, home visitor roles, and global measures of home visiting quality. A majority of these tools rely on external observations by trained observers while a few rely on home visitors' self-report/documentation. These tools were reviewed to get a sense of how existing tools measure the quality and content of individual home visits and to consider the feasibility of adopting an existing tool for the purposes of assessing individual home visiting staff competencies (e.g. facilitation of parent-child interaction, building rapport with families, sharing information on child development)

### Cross-Site/Program Measures of Quality

There are a few examples of existing processes or

measures that assess quality across multiple program models (see Table 6). One such comprehensive approach to assessing program quality is the ongoing cross-model evaluation by Mathematica Policy Research (Boller et al., 2011). Programs participating in Mathematica's multi-year Evidence Based Home Visiting (EBHV) cross-site evaluation enter data into a web based system on levels of adherence to the program model (e.g. dosage), program costs, and allocation of employee time to various program components (e.g. training, supervision, service delivery). Data is also collected during site visits (through semi-structured interviews and questionnaires) to provide comparative case studies of programs and identify common themes related to processes across successful program models (Koball et al., 2009). However, it appears that many of these data collection processes are meant to identify themes related to how programs successfully adopt and implement evidence based program model and not to identify common best practice elements across program models.

In summary, reviewing existing measures of program quality furthered the process of identifying common best practice elements while also beginning to define more specific indicators of best practice elements that are applicable across program models. The review process also provided insight on different types of program quality – from global and structural measures of quality to more micro or process-oriented measures of quality. In general, existing measures of quality tend to focus more on either global/structural elements of quality or process oriented elements of quality. This insight helped us to consider how we might incorporate both areas in order to comprehensively measure quality across program models.

Table 5.

**REVIEW OF INDIVIDUAL HOME VISIT MEASURES**

<b>Measure</b>	HV Encounter Form (Boller et al., 2011)	Home Visit Characteristics and Content Form (Boller et al., 2009)	Home Visit Rating Scale (HOVRS) (Roggman et al., 2006)	Home Visit Developmental Assessment Scale (HVDAS) (Keirn, 2003)	Home Visit Observation Form-Revised (HVOF) (McBride & Peterson, 1996)
<b>Description</b>	Form to document time, frequency, and content of home visits	Observation to document length, participants, content, and activities of home visits	Observational scale to assess quality of home visits	Scale to assess personal qualities of home visitors	Coding of content and quality of home visit sessions
<b>Content Covered</b>	<p>Tracks:</p> <ul style="list-style-type: none"> <li>- If scheduled home visit was completed</li> <li>- Length of visit</li> <li>- Location of visit</li> <li>- Topics covered and percentage of time devoted to topics</li> <li>- Percentage of planned content covered during visit</li> </ul>	<p>Documents:</p> <ul style="list-style-type: none"> <li>- Length of visits</li> <li>- Home visit participants</li> <li>- Language of home visits</li> <li>- Activities during visit</li> <li>- Time allocated for home visit activities</li> <li>- Topics covered during home visits</li> <li>- Distractions during home visit</li> </ul>	<p>Four scales to measure quality of home visitor strategies:</p> <ul style="list-style-type: none"> <li>- Responsiveness to family</li> <li>- Relationship with family</li> <li>- Facilitation of parent-child interaction</li> <li>- Home visitor nonintrusiveness</li> </ul> <p>Three scales to measure participant engagement:</p> <ul style="list-style-type: none"> <li>- Parent-child interaction</li> <li>- Parent engagement</li> <li>- Child engagement</li> </ul>	<p>Includes 30 home visitor skills, for example:</p> <ul style="list-style-type: none"> <li>- Rapport building</li> <li>- Empathy</li> <li>- Problem solving skills</li> <li>- Closing session skills</li> </ul>	<p>Codes five categories:</p> <ul style="list-style-type: none"> <li>- Individuals present</li> <li>- Interaction partners</li> <li>- Content addressed during interaction</li> <li>- Role of home visitor (intervention strategies)</li> <li>- Maternal engagement</li> </ul>
<b>Data Collection Methods</b>	Form filled out by home visitors	Completed by trained observers	Completed by trained observers	Completed through observation or self-assessment	Completed by trained observers, coding each category during 30-second intervals (10-minute intervals for maternal engagement)

Table 6.

**REVIEW OF CROSS-SITE/MODEL EVALUATIONS**

<b>Evaluation</b>	Evidence Based Home Visiting Cross Site Evaluation (Boller et al., 2011; Koball et al., 2009)	Baby Faces (Vogel et al., 2011)
<b>Description/ Purpose</b>	Cross-site and cross-model evaluation to identify strategies contributing to successful adoption, implementation, and implementation of high quality evidence based home visiting programs.	Baby Faces: Descriptive study of 89 EHS sites.
<b>Content Covered/ Measures</b>	<p>Measuring five evaluation domains:</p> <ol style="list-style-type: none"> <li>1. Systems change</li> <li>2. Fidelity</li> <li>3. Program costs and resources</li> <li>4. Parent and child outcomes</li> <li>5. Processes</li> </ol> <p>Using the Home Visit Encounter Form (Boller et al., 2009) to measure fidelity to structural components of program model (e.g. content covered, intended dosage of services, low caseloads).</p> <p>Using adapted version of the Working Alliance Inventory (Boller et al., 2011) and participant satisfaction forms to measure the quality and content of home visitor and participant relationships.</p> <p>Developed cross-site web based data system for programs to enter data on costs and time devoted to:</p> <ul style="list-style-type: none"> <li>- Training and supervision</li> <li>- Management and administration</li> <li>- Case management and service delivery</li> <li>- Screening</li> <li>- Evaluation</li> </ul>	<p>Gathering detailed information from program directors on:</p> <ol style="list-style-type: none"> <li>1. Program operations</li> <li>2. Services</li> <li>3. Management</li> <li>4. Characteristics of staff</li> <li>5. Characteristics of enrolled families</li> </ol> <p>Collecting information on participant families through:</p> <ol style="list-style-type: none"> <li>1. Parent interviews</li> <li>2. Staff Child Reports from teachers or home visitors</li> <li>3. Observations of Home Visits</li> <li>4. Direct Child Assessments</li> </ol> <p>Measuring content of home visits through the Home Visit Characteristics and Content Form (Boller et al., 2009).</p> <p>Measuring quality of home visits through the Home Visit Rating Scale-Adapted (Roggman et al., 2009).</p>
<b>Data Collection Methods</b>	Program self-report, existing data sources from program reporting requirements, observations, interviews, focus groups, document review	Program self-report, program director questionnaires, home visitor questionnaires, home visit/classroom observations, family interviews, family questionnaires, direct child assessments

## Evidence Base for Specific Indicators

After identifying common best practice elements and categorizing them within five broad dimensions of quality (see methods), a secondary review of the literature was conducted to assist in further definition of indicators of home visiting program quality. The working draft of common best practice elements served as a framework for this further literature review and searches within the literature base were conducted specifically on the best practice elements already identified. Additionally, in the course of the review, new potential indicators were identified and examined for inclusion into the working draft of the measure. Appendix B provides a summary of the literature base used to define best practice elements as well as specific indicators of these best practice elements. Tables are organized by five broad dimensions of quality (relating to the scales of the HVPQRT) and include examples of research related indicators of best practice elements. Due to the number of best practice elements (23) and the quality indicators (63) identified and used in the HVPQRT, a full summary of the literature is beyond the scope of this discussion, although representative research findings are included, when available, for each best practice element.

## Summary

As discussed by Daro (2010), comprehensive assessments of home visiting programs requires attention to structural aspects of programs (materials, resources, hiring well educated and qualified staff) as well as more dynamic aspects of programs (the content and nature of supervision sessions, work environment, home visitor-parent relationship quality). While the field recognizes and is moving towards more comprehensive

evaluations of programs as part of funded initiatives (e.g. Boller et al., 2011; Vogel et al., 2011), there are currently no tools that specifically measure both structural and dynamic aspects of program quality together that can be used across multiple program models.

Likewise, there are gaps within the empirical research base for home visitation in regards to assessing how specific aspects of program implementation influence program effectiveness. For example, there is little research on the impact of administrative aspects (such as leadership, work environment, supervision, and program monitoring) on home visiting program effectiveness and few measurement tools to address these issues, although this is generally recognized in the human service field as essential elements of program quality (e.g., Glisson, 2010; Durlak & DuPre, 2008). Daro (2010) discusses the multilayered nature of home visiting programs, whereby program operations occur at the level of the overall program down to individual participant experiences. One way that this may be represented is with an ecological model of home visiting program quality (see Figure 1). In an ecological model, program quality is conceived in a series of systems, beginning at the individual level with the quality of the home visitor and her (or his) interactions with the family over time in home visits. The ability of the home visitor to work effectively with a family, however, is influenced by the level of support received from the program, in terms of supervision, training and professional development opportunities, and curricula used. This support, in turn, is influenced by the organizational ability of the program, including its leadership and administration, fiscal management, organizational climate, and connection to the larger system of services in the community.



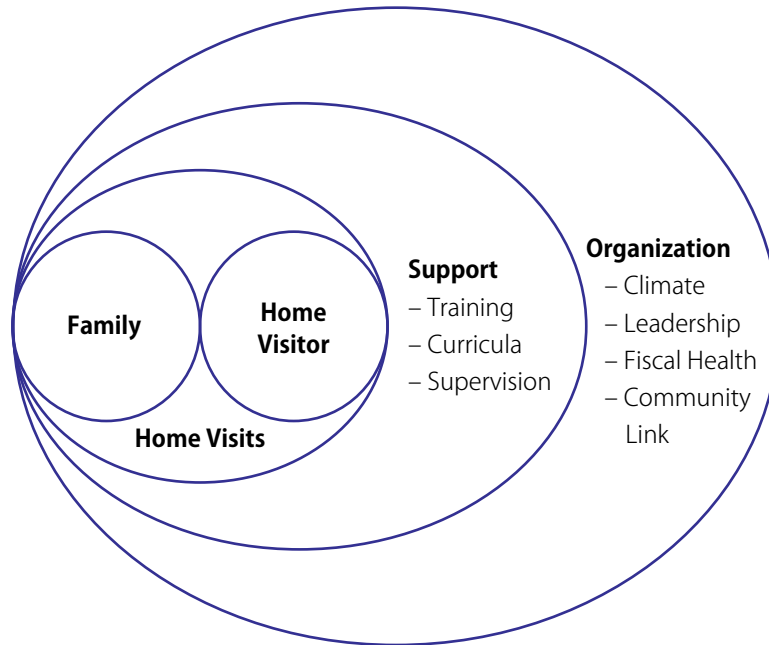


Figure 1: Ecological model of program quality

Understanding how program aspects (both structural and dynamic) at varying levels interact with or influence one another is important in providing an overall picture of program quality. As noted earlier, there are no current measurement tools that can assess and provide feedback to individual programs along these dimensions that are not proprietary and model-specific, or limited to a specific aspect of a home visiting program (e.g., the home visits themselves). The rest of this report details the efforts to develop and field-test a

tool that was designed to address this gap in the field of early childhood home visiting. Our approach to the development of this measure, as detailed below, was to start with information gleaned from a comprehensive review of the literature to create an initial list of quality content areas. Ultimately, however, we relied on the insights of program directors and other key stakeholders to help us define and operationalize the constructs of quality so that the final measure would be practical at the program level.

## Methods

This section details both the development of the quality rating measure, named the Home Visiting Program

Quality Rating Tool (HVPQRT), and the methods used in its initial field testing.

## Development

In the development of the tool we used an iterative approach that can be divided into six steps: i) literature review; ii) development of an initial list of quality constructs; iii) facilitated discussion with key stakeholders; iv) operationalization of constructs into measurable indicators; v) development of data collection and scoring guidelines; and vi) piloting and review. A timeline is presented in Appendix C.

Literature Review and Initial Quality Constructs. A summary review of the literature focused on best practices was detailed in the previous section. The 12 critical elements of HFA (Prevent Child Abuse America, 2001; see Table 7) served as a starting point because the Wisconsin Children's code, Chapter 48 specifically references these critical elements for the provision of state funded child abuse prevention programs and home visitation services [Wisconsin State Statutes Code § 48.983 (2009)].

Table 7. **HFA Critical Elements**

1. Initiate services prenatally or at birth
2. Use of standardized risk assessment
3. Voluntary services provided, with outreach
4. Intense services, but plan for increase or decrease based on family need
5. Cultural competence
6. Visits support parents, child, and the parent-child relationship

7. Provision of appropriate links to relevant community services
8. Reasonable caseloads
9. Skilled and relationship-oriented home visitors
10. Program has a framework for handling a variety of family experiences
11. Visitors receive training for essential components
12. Visitors receive ongoing effective supervision

These quality indicators were compared to other available delineations of quality across both home visiting programs and other early childhood services and prevention efforts. Areas of overlap from these multiple sources suggested emerging consensus on the dimensions of quality that was used to develop an initial list of broad quality constructs to begin discussions with key stakeholders. This initial list was organized around seven dimensions of quality:

- 1) Service delivery
- 2) Staff qualifications
- 3) Professional development
- 4) Program characteristics/content
- 5) Community partnerships/resource networks
- 6) Program monitoring
- 7) Program management and logistics

### Stakeholder Discussions

The summary framework was presented by the research team to home visiting program representatives as a starting point for discussion on identifying potential constructs of quality. Two teams were convened over several months to reach consensus on quality constructs: an Analysis and Design Team and an Advisory Team (See Appendix E for team member listings). The bulk of the initial design work was assisted by the Analysis and Design Team, comprised of home visiting program directors, administrators, and consultants. They met with the research team to review the materials early in the project and make initial decisions about quality content area. The Advisory Team included representatives from two of the major program models, Healthy Families America and Parents as Teachers, as well as other stakeholders at state government levels, or involved in large-scale training and professional development efforts.<sup>2</sup> This team provided an additional review of the quality constructs selected, to ensure that the proposed design would compliment and not duplicate the credentialing or certification process of the national models.

### Measurable Indicators

After the review by the Advisory Team of the quality constructs, the Analysis and Design Team continued to meet to provide feedback on actual drafts of the scales and subscales that would eventually represent those quality constructs and form the structure of the HVPQRT. The Analysis and Design Team also discussed documentation needs and the format of the measure, with an emphasis on what was practical to consider “in the real world” as well as providing feedback regarding conceptualizing the range of quality (e.g., thresholds of low, average, and high quality for specific dimensions). The team also provided feedback to the research team regarding the availability of data at the program level to measure the various quality indicators.

In addition, nine home visiting programs participating in a statewide project focused on collecting common outcome data were brought together to provide feedback to the research team regarding potential data collection methods for each of the quality indicators. Staff members from these programs also worked with the research team to articulate specific “operationalized” anchors for the indicators. This process provided the opportunity to determine if the criteria designated by the research team as representing the highest level of quality were feasible for programs to obtain. A full day feedback session was facilitated by research team members to gain insight from programs regarding the tool’s utility and face validity. Their feedback led to further refinements to the draft measurement tool, scoring thresholds, and the creation of a data collection and scoring manual to guide tool administration.

The Analysis and Design Team agreed to model the formatting of the quality assessment tool similar to the rubric of the Early Childhood Environmental Rating Scale (ECERS; Harms, Clifford, & Cryer, 2005). The ECERS uses a threshold scoring system across 43 items (grouped into 7 larger categories) using 7-point scales, with each odd-numbered scale point referencing a checklist of items used to make decisions about how high a setting can be scored for that item. The ECERS and its related measures are widely used in Quality Rating and Improvement Systems (QRIS) that many states use to document quality of child care and early childhood education settings (Tout, Zaslow, Halle, & Forry, 2009). In addition, its scoring format has been used with other early childhood quality rating tools, such as the HOVRS (Roggmann, Cook et al., 2008) and the Program Administration Scales (PAS; Talan & Bloom, 2004). It was expected that the familiarity of this scoring structure would aid in the long-term goal of dissemination of the HVPQRT.

2 Representatives from Nurse Family Partnership were invited but did not to participate in this review process.

The first draft of the assessment tool was organized into 195 indicators grouped into 61 subscales that fit six broad areas of home visiting program quality: 1) home visitor competencies; 2) service delivery; 3) program characteristics/content; 4) community partnerships/resource networks; 5) program management and development; and 6) progress monitoring. Compared to the initial list of seven domains (as noted on page 16), professional development was folded into program management.

### **Piloting and Review**

Representatives from the nine programs noted earlier participating in the common outcomes project conducted pilot-testing of the revised tool and associated scoring materials. Programs were asked to fill out sections of the measure as a self-assessment, as well as conduct a peer review of another home visiting program. The programs were paired with programs using a different model (e.g., PAT with HFA), and each program director or their designee acted as a peer evaluator for their partner program. For both self-assessment and peer assessment, raters were asked to take detailed notes about their scores, and consider items that were confusing or did not fit with their program operations. Raters were asked to comment on the ease of use of the measure, amount of background information or documentation needed, and the amount of professional judgment or interpretation that is needed for each item. Each site was also asked to track their time to complete the assessment and identify areas where the tool worked well and where further clarification was needed. Reviewers were asked to identify agreement between raters (self and peer) for each item. Reviewers were encouraged to discuss discrepancies and make recommendations for further refinement.

This information was shared with the research team. Feedback from this process suggested that the tool in its initial format was too long and overwhelming for many of the participants. They noted in many cases that the process of collecting the data took too long and consumed too many program resources. Often, programs simply failed to complete large sections of the tool because they ran out of time. They also noted the need for more clarity with the data collection and scoring guidelines, preferring specific guidance on scoring and the meaning of terms (e.g., implied quantity terms such as “many” or “most”). Based on this feedback, an intense period of scale reduction and revision was undertaken by the research team. A penultimate version of the assessment measure was created and the data collection and scoring materials were revised accordingly.

The initial tool development proposal provided for a one day site visit to be completed by an external evaluator. This was done to keep administration of the tool practical for programs.

Additionally, it was determined that a one-day visit provided a reasonable “snapshot in time” of program quality and distinguished the tool from the more extensive site visits conducted by national offices as part of a model specific credentialing or accreditation process. The initial draft of the tool piloted by the nine home visiting programs was too long and cumbersome to work in the context of a one-day site review, and the revisions were made with the one-day constraint in mind.

### Data Collection and Scoring Guidelines

Feedback from the Analysis and Design Team as well as the home visiting programs participating in the outcomes project indicated that further guidelines would be necessary for anybody wishing to use the scales to rate a program. Guidance would be needed both for what types of data should be collected and how to interpret the data to make scoring decisions. The following data collection methods were considered for potential use in assessing each quality indicator: Home visit observation, home visitor interview, supervisory session observation, on-line surveys, record/document review, client chart review, program manager/supervisor interviews, board member and community stakeholder interviews, focus groups and program participant feedback. In an effort to keep the assessment manageable for a one day site visit, one data collection method was selected for each quality indicator. Scoring guidelines were developed for each quality scale and included the following components: a general description of the intent of the quality assessment, data collection method and source information, suggested interview questions with corresponding checklists to aid in scoring, detailed scoring instructions with definitions, formulas for calculations when needed, and additional notes to assist with the assessment and scoring. Materials developed by the Evaluation Checklists Project at the Evaluation Center of Western Michigan University (Stufflebeam, 2000), were used to guide the development of checklists and associated scoring guidelines (see Appendix D for examples of data collection and scoring guide materials).

The data collection method selected for each quality indicator (see Table 8) was based on the following considerations: availability of the data via the proposed collection method, time and expense associated with the data collection method, and program acceptance of the data collection method. Many initial decisions about feasibility of data collection had to be rethought based upon initial feedback of the pilot sites. For example, while the research team had significant interest in conducting direct observations of home visits, it became clear that conducting observations of home visits presented too many logistical challenges in the context of a one day site review. Instead, the use of case vignettes (e.g., Anning, 2005; Heverly, Fitt, & Newman, 1984) provided an opportunity to collect meaningful information about home visitors' relationships with families and develop an understanding of how they approach their work with families without direct observation of a home visit. In the draft of the tool used for the field testing, home visitors were presented with three case vignettes representing common challenges for home visitors (e.g., a child with possible language delays, or a mother who showed some signs of post-partum depression) and were asked standard questions about their approach to working with this family (e.g., *"What further information would you want to collect about this situation?"*). Checklists and rating scales were developed to allow for quick scoring of individual home visitors responses. These results were aggregated across home visitors within a program to arrive at indicator scores for HVPQRT subscales (see Appendix D for an example).

Table 8.

DATA COLLECTION METHODS BY QUALITY SCALE

Quality Scale	Data Collection Methods
Home Visiting Staff Competencies	Home visitor interview with vignette responses, home visitor on-line questionnaire
Program Service Delivery	Record, review, program director interview, program and home visitor on-line questionnaires
Program Characteristics	Record review, program director and home visitor interviews
Program Management & Development	Record review, program director interview, home visitor on-line survey
Progress Monitoring	Record review, program director interview

In an effort to reduce the time necessary to conduct in-person interviews, two on-line surveys were developed for home visitors and program leadership staff that could be completed independently and ahead of site visits. Each of the surveys was designed to take approximately 10-15 minutes to complete. The on-line survey completed by home visitors collected data in the following areas: home visitor education and experience, management communication and decision-making, work environment, supervision and selected home visit information. Program management staff was asked to complete an on-line questionnaire prior to the site visit to collect data regarding training, program materials and policies and procedures. A member of the research team exported the data from Survey Monkey into Excel spreadsheets that included formulas to calculate scores used as part of the overall tool scoring.

Survey items were developed after review of existing literature and based on information gathered during facilitated meetings of the home visiting programs participating in the outcomes project. The construction

of survey items were informed by staff satisfaction materials compiled by the Advancing Excellence in America's Nursing Homes Campaign (Advancing Excellence in Long Term Care Collaborative, 2011). Additional resources used in survey item development included the Children's Hospital and Health System 2011 Leadership Enrichment and Achievement Process (Children's Hospital and Health System, 2011) and the Zero to Three Leadership Self-assessment Tool (Zero to Three, 2011). Survey items specific to reflective supervision were developed based on input from facilitated discussions with home visiting program directors and staff, interviews with home visiting trainers in Wisconsin responsible for the development of reflective supervision training and other relevant literature. Reflective supervision literature identified the importance of reflective supervision and demonstrated support for reflective supervision assessment (Minnesota Association for Children's Mental Health, 2011; Early Head Start National Resource Center, 2011; Home Visiting Forum, 2006). Similarly, various supervision models for parent support programs have

a shared learning approach to supervision (National Federation of Families for Children's Mental Health, undated brief).

The research team conducted two additional one-day site visits (one PAT, one HFA) to test the revisions to the tool and data collection methodology. Further refinements were made based on the experience of these site visits. The pilot feedback and information gathered from the additional sites visits led to collapsing various areas of the tool and a reduction in the number of indicators. These modifications led to the tool's current framework consisting of 5 scales, with each scale divided into 7-point subscales, ranging from 2-8 subscales. Each subscale specifies 2-5 rows of indicators. As noted earlier, the format of the measure is similar to other quality rating measures (e.g, ECERS, PAS, HOVRS), with specific indicators aligned to odd-numbered subscale points. The final subscale score is determined by examining the pattern of endorsed indicators. For example, a program that has a mix of indicators scored at 3 and 5 for a particular subscale may receive a final score of 4 for that subscale.

Examples of HVPQRT subscales and their related data collection and scoring guide are in Appendices A and D. The current version of the measure and its scoring guides is designed for external evaluators conducting one-day site visits. Future work will include development of a self-report version that can be used by the program staff to rate the quality of their own program.

## Field Testing

Once the measure was developed and revised based on initial piloting, field testing of the tool began. A protocol was developed, sending teams of two evaluators to program sites. Data would be collected concurrently by the two evaluators but ratings would be made independently in order to examine the extent to which two raters with the same information would arrive at the same ratings for each program<sup>3</sup>.

## Program Sampling

In the state of Wisconsin, 18 programs were identified as possible candidates for field testing the measure using purposeful sampling to ensure an adequate representation of programs by geographic region (rural, urban), population served, program size, and program model. Eleven programs in Wisconsin initially agreed to participate in field testing, however, one program subsequently did not participate due to loss of significant program funding.

To increase the sample of programs, data was also included from 11 home visiting programs from Illinois. As part of a larger evaluation of early childhood programs within the state conducted by the principal investigator, the HVPQRT was used as a framework for studying program quality for birth to three home visiting programs<sup>4</sup>. Thirty home visiting programs across the state (excluding the city of Chicago) are participating in this evaluation. Data from the first 11

3 Although the original proposal noted the development of a self-assessment tool and comparing scores of the self-assessment to an external evaluator, during the course of developing the tool a final decision was made to focus the examination of reliability on two external evaluators. This was, in part, due to feedback from the program sites that conducting a self-evaluation in addition to an external site review would be too burdensome. In addition, given the prolonged development of the version of the tool used by external evaluators, it was determined that there was not sufficient time during the grant period to develop and pilot an adequate self-assessment version. Although it is still a goal to develop a self-assessment version of the HVPQRT, the activity to do this does not fit into the time frame of the current project.

4 The HVPQRT was not initially designed for this evaluation, but one goal of the evaluation was to examine quality of the birth to three programs within the state, where services are predominantly provided through home visiting. Information gathered from sites in the early stages of the evaluation and review of the state's Birth to Three Program Standards (see introduction) suggested that program site visits that included a combination of interviewing and record review was the most feasible form of data collection. For this reason, the HVPQRT was a good fit for the evaluation, in that it provided needed structure and standard guidelines for collecting program quality information. Given that the tool existed in draft form, using two evaluators to examine inter-rater reliability was determined to be necessary to increase the confidence in the findings.

programs, with data collected within one month of the data collected from the Wisconsin program sites, was used for analysis.

### Evaluators

For the reliability pilot, programs were asked to review the tool and agree to a one day site visit by two external evaluators. For the Wisconsin based site visits, four external evaluators were hired in addition to three of the research team members (although five evaluators were initially recruited, one was unable to conduct any site visits). These home visiting professionals were trained on the assessment measure during a one day training session. The external evaluators had extensive home visiting knowledge and experience. Three of the four evaluators recently retired from active involvement in the home visitation field. All held Bachelors degrees and one a Masters degree. The one day training consisted of a review of the assessment measure, related scoring materials, and a walk through of the one day site visit.

For the Illinois based site visits, two of the research team members were joined by five external evaluators who were hired. The evaluators came from varied backgrounds and collectively had experience working in early childhood education, child development, home visiting, and research/program evaluation. All external evaluators had a minimum of a Bachelors degree with the majority holding a Masters degree or higher.

The Wisconsin-based site visit experiences informed the process for selecting external reviewers and their related training for the Illinois site visits. Based on initial feedback from the Wisconsin evaluators, the training was expanded for the Illinois external evaluators to a two day training and included additional time to practice interviews, review records and discuss scoring. Additionally, minor edits were made to the assessment tool and scoring materials to provide clarification to select areas.

### Conducting the Site Visits

Program directors from potential sites were initially contacted by a member of the research team to explain the research, invite them to participate, and answer any questions. Once sites agreed to participate, they were assigned a two-digit site identification code used for site scoring, and on-line data collection and analysis. Site visits were scheduled based on program and external evaluators' availability. Sites and evaluators were sent confirmation emails of the site visit date. The research assistant contacted each site to gather pre-visit program information and discuss documentation preparations and site visit expectations. Additionally, sites received a site visit preparation guide which included document preparation instructions and a copy of the assessment tool. External evaluators were sent site specific information to prepare for the site visit and included all materials needed for completing the visit. Sites were emailed links to online surveys and questionnaires organized by site identification code and a program management worksheet for completion prior to the visit. Individually identifiable information was not collected from home visiting participating staff in order to increase their comfort in answering questions about their workplace environment and supervision received. Evaluators received electronic files of on-line data one day after to the site visit.

At the beginning of the full day site visit, the purpose of the research was again explained to all site visit participants and informed consent as specified in the IRB process was obtained.<sup>5</sup> The primary activities completed during the site visit were individual home visitor interviews, including responses to case vignettes; review of program records and related documentation; and interviews with the program management staff. To keep interview based data collection manageable for larger programs, no more than four home visitors were

5 Consent was obtained separately for the online survey, as not all home visitors who completed the survey participated in the site visit interviews.



asked to participate in the site visit interviews. Programs were asked that the participating home visitors included both full-time and part-time home visitors, and a mix of newer and more experienced home visitors. In addition, at site visits where program data was not readily available from existing reports or data bases, a chart review was conducted using a minimum of 15 family charts. Home visitors participating in the site visit interviews were asked to provide a random sample of charts (e.g., every third family) from their families. The data collection and scoring guide specified a protocol for capturing and summarizing service delivery data (e.g., number of completed home visits in the past year) for each chart.

Both evaluators were instructed to be present for all interviews and record reviews and to complete data collection and scoring independently of each other by not discussing or reaching a score by consensus. Evaluators were asked to complete the scale scoring after the actual site visit, within one day of visit and before any subsequently scheduled site visits. Evaluators were also asked to comment on or identify areas in need of further refinement on all documents. All site visits were completed between October and December 2011. All evaluators' materials were returned to the research team for analysis.

Program directors received a brief narrative summary of the observed program strengths and potential areas for improvement (see Appendix F for an example). Individual program scores were not shared with programs given that the reliability research for the tool itself was still underway. Sites received a small stipend for participating in the research (e.g., an online gift certificate) and were asked to complete an on-line survey about their experience participating in the site visits. Upon completion of the Wisconsin site visits, the external evaluators participated in an additional conference call de-briefing session to provide feedback to the research team about their overall experience participating in the research, areas of strength and suggestions for improvement in the tool development process.

Including the programs used in initial piloting, a total of 30 home visiting programs participated in the development of the quality assessment tool, ranging in size from a program with only one part-time home visitor to a program with 17 home visitors (see Table 9).

Table 9. PARTICIPATING HOME VISITING PROGRAM DEMOGRAPHIC INFORMATION\*

Program Site/Location	Number of Home Vistors	Approximate Number of Families Served	Program Model Used	Geographic Description
<b>Applicability pilot sites</b>				
1. Site WI OP 1	4	100-150	PAT	Urban
2. Site WI OP 2	17	225	PAT	Urban/Rural
3. Site WI OP 3	5	200-250	PAT	Urban/Rural
4. Site WI OP 4	9	200	HFA	Urban
5. Site WI OP 5	.75	38	HFA	Rural
6. Site WI OP 6	10	459	PAT	Urban/Rural
7. Site WI OP 7	5	80-100	HFA	Urban
8. Site WI OP 8	1	16	PAT Blended	Urban
9. Site WI OP 9	4	39	PAT	Urban/Rural
<b>Reliability Field Testing Sites</b>				
10. Site WI 1	6	120	PAT	Rural
11. Site WI 2	3	35-40	PAT Blended	Urban
12. Site WI 3	14	148	EHS	Urban
13. Site WI 4	4	40	EHS	Urban
14. Site WI 5	3	70-90	PAT	Urban
15. Site WI 6	1	11	PAT	Urban
16. Site WI 7	4	100	PAT	Urban
17. Site WI 8	4	70	HFA	Urban/Rural
18. Site WI 10	9	189	PAT/HFA	Urban
19. Site WI 11	9	100	EHS	Urban
20. Site IL 1	3	100	PAT	Urban
21. Site IL 2	3	45	PAT	Rural
22. Site IL 3	1	18	PAT	Urban
23. Site IL 4	1	10	PAT	Urban
24. Site IL 5	5	45	PAT	Urban
25. Site IL 6	1	15	PAT	Urban
26. Site IL 7	2	35	Baby Talk	Urban
27. Site IL 8	1	20	Baby Talk	Rural
28. Site IL 9	3	40	PAT	Rural
29. Site IL 10	4	77	PAT	Urban
30. Silte IL 11	5	70	PAT	Urban

\* Program demographic information is based on program self reports on the number of home visitors and number of families served. Reported home visitor data did not include differentiation of part-time and full time employees. Similarly, some programs provide home visiting services at various intensities to families, including families served on limited, short term basis rather than intensive, long term basis. This contributes to the variation in staff to families served data reported.

## Results

This section presents results from the field-testing of the HVPQRT with 21 programs in Illinois and Wisconsin. Descriptive summaries of the subscales will first be presented, followed by the level of agreement between the two evaluators. We examine in more detail agreement level of evaluators by indicator row within subscales. We also examine variability among evaluators. We conclude by reviewing survey results from the programs reporting on their experience with the site visit and utility of the measure.

**Research Question 1:** What components of quality programming (best practice elements) can be identified and operationalized across different home visiting program models?

### Distribution of Scores

Table 10 shows the distribution of final scores across the 23 subscales, along with the percentage of missing scores. The subscales varied in their distribution of scores along the 7-point scale, although most showed a spread of at least 6 points (e.g., 1-6 or 2-7). Seven subscales (30%) show a more restricted range, with two

subscales in A (Home Visitor Qualities) showing only a four point spread in scores. For most subscales, the average rested between the scale points 3 and 4, or between “average” and “good.” Two subscales (A1 and D1, both focused on background and experience of staff) had higher averages, while three (A3, C1, and D7) had average scores below 3.

Because of the relatively small number of programs in this sample, it is difficult to say whether programs did not actually manifest characteristics across the full range of quality, or if scoring guidelines and scale construction placed constraints upon scoring that did not fully capture the range of quality seen (e.g., a scale may place unrealistic expectations on programs to demonstrate quality). For example, A3 (Working with Families), a subscale that measures the home visitor’s ability to form relationships with families and attend to differences among families, did not show any scores above 4. Although individual home visitors may have been rated highly in their relationship-formation with families based on the results of the interviews, aggregate results did not allow for any program to be scored in the excellent range for this subscale.

Table 10.

## SUMMARY OF SUBSCALES

	Mean (Std)	Range	Missing
<b>A: Home Visitor Qualities</b>			
A1 Education and Professional Experience	5.30 (1.49)	2-7	0
A2 Promotion of child development and well-being	3.07 (.81)	2-5	0
A3 Working with families	2.00 (.41)	1-4	0
A4 Referrals and follow-up	3.95 (1.03)	2-7	0
<b>B: Service Delivery</b>			
B1 Program recruitment and enrollment	3.52 (1.71)	2-7	0
B2 Prenatal enrollment	3.24 (1.66)	1-7	2%
B3 Frequency and length of services	3.89 (1.20)	2-6	4%
B4 Family outreach/involvement	3.19 (1.13)	1-6	0
B5 Transition plans	4.69 (1.72)	1-7	0
<b>C: Program Characteristics</b>			
C1 Program model	2.93 (1.08)	2-6	2%
C2 Program emphasizes child development and well-being	3.45 (1.68)	2-6	0
C3 Program emphasizes strong working relationships with families	4.07 (1.25)	2-6	0
C4 Services tailored to family strengths and needs	3.76 (1.47)	1-7	0
<b>D: Program Management &amp; Development</b>			
D1 Leadership qualifications – Management and staff supervisors	5.18 (1.34)	2-7	2%
D2 Leadership practice	3.35 (1.01)	1-6	2%
D3 Work environment	3.02 (1.89)	1-7	0
D4 Written policies and guidelines for program administration	4.08 (1.88)	1-7	2%
D5 Professional development	4.12 (1.49)	2-7	0
D6 Supervision	3.48 (1.36)	2-6	0
D7 Strategic planning	2.38 (1.76)	1-7	0
D8 Community Partnerships/Resource Networks	4.45 (2.01)	1-7	0
<b>E: Progress Monitoring</b>			
E1 Program monitoring	3.90 (1.47)	2-7	0
E2 Outcome measurement	3.43 (1.60)	1-6	0

**Research Question 2:** Can program quality components be reliably measured across models?

### Level of Agreement by Subscale

Each site visit was completed by two evaluators, who conducted the interviews and chart reviews together and scored independently of one another. Reliability for the HVPQRT is therefore assessed across all 21 site visits. Table 11 presents four statistics related to agreement between evaluators' subscale scores across the 21 site visits: percentage of exact agreement between evaluators' subscale scores, percentage of agreement within one point between evaluators' subscale scores, the Intra-Class Correlation (ICC) for each subscale, and the ICC for a single rater.

It is important to note that ICC is used here as a measure of inter-rater reliability and not a measure of internal consistency. The internal consistency of the HVPQRT is not reported because the comprehensive nature of the HVPQRT is unlikely to yield a unidimensional construct. In other words, programs are likely to show variable scoring across and within the subscales on the HVPQRT. The tool is specifically designed to identify both strengths and weaknesses within a program. Future validation work will explore the presence of several constructs within the HVPQRT through a factor analysis.

Intraclass Correlation is the ratio of true variance relative to the sum of true variance and random error variance. For inter-rater reliability, the error variance is random measurement error and systematic differences among evaluators. As the ratings among evaluators converge, the error variance is smaller and ICC is larger. Larger ICC indicates that the observed ratings more accurately reflect true differences among programs (rather than differences among evaluators). ICC differs from the more traditionally-used Pearson correlation by taking into account systematic mean differences among raters (evaluators scores can be highly correlated with one another but one evaluator could be systematically scoring higher or lower than another evaluator- using an absolute measure of ICC accounts for this possibility) (Shrout & Fleiss, 1979). The ICC Average measure is used when you want to rely on the average ratings provided by evaluators. It provides the reliability for the mean of ratings. The ICC Single measure is used when you want to rely on the single rating provided by an evaluator. It provides the reliability estimate of how reliable a single evaluator's rating is in comparison to other evaluators (McGraw & Wong, 1996). Intra-class correlations (ICC) range from 0 to 1.0, ICCs below 0.40 are considered low, ICCs between 0.40 and 0.59 are considered moderate, ICCs between 0.60 and 0.79 are considered substantial, and ICCs between 0.80 and 1.00 are considered excellent (Landis & Koch, 1977).

Table 11.

## INTER-RATER AGREEMENT

	% Extract Agreement	% Agree w/in 1 point	ICC Average	ICC Single
<b>A: Home Visitor Qualities</b>	<b>60</b>	<b>88</b>	<b>.61</b>	<b>.49</b>
A1 Education and Professional Experience	95	100	.99	.98
A2 Promotion of child development and well-being	43	86	.61	.44
A3 Working with families	67	95	.33	.20
A4 Referrals and follow-up	33	71	.53	.36
<b>B: Service Delivery</b>	<b>70</b>	<b>85</b>	<b>.88</b>	<b>.78</b>
B1 Program recruitment and enrollment	67	71	.76	.61
B2 Prenatal enrollment	86	95	.97	.95
B3 Frequency and length of services	67	76	.84	.71
B4 Family outreach/involvement	76	85	.87	.77
B5 Transition plans	52	95	.95	.90
<b>C: Program Characteristics</b>	<b>60</b>	<b>68</b>	<b>.64</b>	<b>.51</b>
C1 Program model	57	67	.52	.35
C2 Emphasizes child development and well-being	90	90	.95	.89
C3 Emphasizes strong working relationships with families	43	48	.32	.18
C4 Services tailored to family strengths and needs	48	67	.77	.62
<b>D: Program Management and Development</b>	<b>61</b>	<b>78</b>	<b>.81</b>	<b>.68</b>
D1 Leadership qualifications – Management and supervisors	81	86	.73	.58
D2 Leadership practice	61	76	.71	.55
D3 Work environment	76	85	.94	.88
D4 Written policies and guidelines for program administration	52	86	.87	.78
D5 Professional development	43	57	.74	.58
D6 Supervision	81	81	.82	.69
D7 Strategic planning	57	76	.75	.60
D8 Community Partnerships/Resource Networks	38	76	.90	.82
<b>E: Progress Monitoring</b>	<b>52</b>	<b>71</b>	<b>.72</b>	<b>.56</b>
E1 Program monitoring	57	76	.74	.59
E2 Outcome measurement	48	67	.69	.53

Evaluators were in exact agreement 62% of the time (with a range of 33-95% across the subscales); evaluators were within one point of each others' scores 79% of the time (with a range of 48-100% across the subscales). The ICC overall for the HVPQRT was 0.60, within the substantial range (Landis & Koch, 1977), but there was wide variation across subscales, ranging from low to excellent (0.18 to 0.98).

Across the 4 subscales in Scale A (Home Visitor Qualities), the percentage of exact agreement averaged 60% (range of 33% to 95%), with a percentage of agreement within one point of 88% (range of 71% to 100%). Because of the restricted range of some of the subscales, however (see Table 10), single ICCs were generally lower. Working with Families (A3), in particular, showed low correlations, suggesting the evaluators struggled with interpreting the data collection sources and arriving at similar scores, even within a relatively restricted range of scores seen across the sites.

Across the 5 subscales in Scale B (Service Delivery), the percentage of exact agreement averaged 70% (range of 52% to 86%), with a percentage of agreement within one point of 85% (range of 71% to 95%). Single ICCs ranged from .61 to .95 (average for B is .78). These scores suggest that the evaluators were better able to agree on information collected about program service delivery than with any other scale within the measure. Many of the questions asked in the data collection and scoring guides were relatively straightforward for this section and often required a review of program records, with minimal room for program staff interpretation. This may have aided in the evaluator's agreement. The lowest agreement was for subscale B1 (program recruitment and enrollment).

For Scale C (program characteristics), the percentage of exact agreement overall averaged 60% (ranging of 43% to 90% across the four subscales), with a percentage of agreement within one point of 68% (range of 48% to 90%). As with Scale A, the restricted range of some of the subscales further reduced their ICCs, ranging from .18 to .89. Also similar to Scale A, the subscale with the least amount of agreement (C3) focused on the program's emphasis on supporting staff in developing strong relationships with families. This further suggests the challenges in assessing this theoretically-important aspect of many home visiting program models.

For Scale D (Program Management and Development), the percentage of exact agreement overall averaged 61% (range of 38% to 81% across the eight subscales), with a percentage of agreement within one point of 78% (range of 57% to 86%). Single ICCs for the subscales ranged from .55 to .88 (average for D is .68). The highest agreement was found for D3 (work environment), while the lowest was for D2 (leadership practice), which also had a more restricted range (2-6) compared to other subscales in D.

Finally, across the 2 subscales in Scale E, the percentage of exact agreement averaged 52% and agreement within one point was 71%. The scale's single ICC was .56. Slightly stronger agreement was shown on Program Monitoring (E1) than assessment of the program's efforts in Outcome Measurement (E2). Evaluator feedback suggested that the data collection and scoring guides for E were the hardest to follow; they included questions that partially overlapped with questions asked for previous scales (e.g., outcomes as designated by the program model), but were conceptually different, leading to some confusion. This may account for the lower agreement for these two scales.

Because training for the evaluators was different between the site visits conducted in Wisconsin and in Illinois, we also examined the results by state. Caution must be taken in the interpretation of differences due to the reduced sample size, but examining the percentage agreement between sites visits conducted in the two states shows a higher level of agreement in Illinois than

in Wisconsin (see Tables 12 and 13, below). For each scale, exact agreement increased (with A showing the greatest increase in agreement), as did agreement within at least one point. This suggests that the more in-depth training that was conducted with the Illinois site visitors supported the evaluators in the rating decisions they made.

Table 12.

**Wisconsin Program Site Visits: AGREEMENT**

n = 10

Agreement	Scale (# of subscales)					
	All (23)	A (4)	B (5)	C (4)	D (8)	E (2)
<b>Exact</b>	50%	45%	56%	47%	48%	45%
<b>Within One</b>	26%	33%	24%	20%	27%	25%
<b>At Least Within One</b>	76%	78%	80%	67%	75%	70%
<b>Within Two</b>	13%	17%	12%	15%	13%	5%
<b>&gt; Two</b>	11%	5%	8%	18%	12%	25%

Table 13.

**Illinois Program Site Visits: AGREEMENT**

n = 11

Agreement	Scale (# of subscales)					
	All (23)	A (4)	B (5)	C (4)	D (8)	E (2)
<b>Exact</b>	64%	66%	72%	61%	66%	50%
<b>Within One</b>	16%	32%	13%	7%	13%	23%
<b>At Least Within One</b>	80%	98%	85%	68%	79%	73%
<b>Within Two</b>	14%	0%	15%	21%	15%	18%
<b>&gt; Two</b>	6%	2%	0%	11%	6%	9%

### Level of Agreement by Indicator Row

As noted in the methods section, each subscale is composed of anywhere from 2 to 5 indicator rows, and it is the pattern of scores for the indicator rows that determine the subscale score. Identifying areas of greatest disagreement at the level of the indicator rows will assist in targeting areas of the measure that are in

need of revision (either in the indicator row itself or the data collection and scoring guides). Indicator rows are only scored on odd-numbered scale points (e.g., 1, 3, 5, & 7)<sup>6</sup>, so that percent agreement between one point is not a relevant statistic. The following table presents the average percent of exact agreement and agreement within two points (e.g., the next-closest score from exact agreement) for indicator rows by scale.

<sup>6</sup> Because indicators are listed on these odd-numbered scale points, patterns of indicator row scores allows for subscales to receive an even-numbered score. For example, a program that has a mix of indicators scored at 3 and 5 for a particular subscale may receive a final score of 4 for that subscale.



Table 14.

**INDICATOR ROW AGREEMENT FOR SCALES**

Agreement	All Scales (63 IR)	Scale A (10 IR)	Scale B (13 IR)	Scale C (11 IR)	Scale D (24 IR)	Scale E (5 IR)
<b>% Exact</b>	68%	65%	76%	68%	74%	59%
<b>% Within At Least Two</b>	89%	97%	94%	87%	94%	78%
<b>a) IR With Exact Agreement &lt;60%</b>	16	5	1	3	5	0
<b>b) IR With Agreement Within 2 &lt;90%</b>	18	1	3	7	4	3
<b>a) + b)</b>	8	1	0	3	3	1

Across the 63 indicator rows, the percentage of exact agreement was 68%, with percentage of agreement within two points of 89%. Indicator row agreement was highest for those in the subscales for Scale B, and lowest for Scale E. Of the 63 indicator rows, 25% (16) show exact agreement less than 60% of the time (range 38-57%) and 28% (18) show agreement within 2 points less than 90% of the time. Eight indicator rows (13%) overlap on disagreement, showing both low (<60%) exact agreement and low agreement within 2 points (<90%). Examining the content of the indicator rows with lower agreement suggests that evaluators struggled to agree when assessing home

visitor and program focus on the helping relationship, individualizing services to families based on their need, the quality of the program model, sustainability and funding, and program monitoring efforts.

As noted in the Methods Section, across the measure, 13 indicator rows relied at least in part on data collected in an online survey. Data from these surveys were exported into a spreadsheet and provided to evaluators after the site visit, where they looked at the pattern of responses to arrive at a final indicator row score. Table 15 shows the subscales that relied in whole or in part on data provided by the online surveys.

Table 15.

**SUBSCALES WITH ONLINE SURVEY COMPONENTS**

Subscale	IR Using Online Survey (% of Total IRs for Subscale)
<b>A1 Education and Professional Experience</b>	2 (100%)
<b>B4 Family Outreach/Involvement</b>	1 (33%)
<b>C2 Emphasis on Child Development and Well-Being</b>	3 (100%)
<b>D2 Leadership Practice</b>	1 (33%)
<b>D3 Work Environment</b>	4 (100%)
<b>D4 Written Policies/Guidelines for Program Administration</b>	1 (50%)
<b>D6 Supervision</b>	1 (20%)

It would be expected that these indicator rows would show high agreement, as information is calculated and summarized without the input or interpretation of the evaluator. The percentage of exact agreement for these 13 indicator rows averaged 88%, with agreement within two points at 97%. Although agreement did improve considerably in these cases, there is still some indication that interpretation of the online summaries occurred when translating these numbers to a final score for the indicator row.

### Evaluator Variance

Overall, 11 evaluators were used across the 21 programs. Table 16 shows the average level of agreement each evaluator had with their partner. As can be seen, most evaluators had relatively strong agreement, within one point of their partner on subscales more than 70% of the time. Two evaluators had lower agreement. These two evaluators each did only two site visits, and it is possible that their reduced exposure to the scales and the process of conducting site visits contributed to their lower agreement with other evaluators. Overall, however, it appears that there was no single evaluator or group of evaluators responsible for the lower rates of agreement seen throughout the scales, although the agreement was generally higher for evaluators working in Illinois than in Wisconsin.

Table 16.

#### AGREEMENT BY EVALUATOR

Evaluator	Agreement				
	# of Site Visits	% Exact	% At Least Within One	% Within Two	% > Two
A (WI)	4	57%	76%	13%	11%
B (WI)	2	46%	67%	20%	13%
C (WI & IL)	6	59%	80%	13%	6%
D (WI)	2	48%	65%	15%	20%
E (WI & IL)	4	60%	79%	14%	7%
F (WI)	4	67%	82%	13%	5%
G (WI)	2	65%	85%	13%	2%
H (IL)	4	58%	72%	20%	8%
I (IL)	4	77%	84%	12%	4%
J (IL)	4	76%	88%	9%	3%
K (IL)	5	56%	77%	15%	8%

**Research Question 3:** Can sites use the results to improve program quality and accountability, and inform policy and decision-makers?

### Program Feedback

As noted in the methods section, program directors were asked to fill out a brief online survey shortly after the completion of the site visit in order to provide feedback regarding their experience with the HVPQRT and the site visit. This survey contained both scaled questions as well as open-text questions. Six Wisconsin programs and nine Illinois programs (i.e., 15 of 21 programs) responded to the survey and provided feedback.

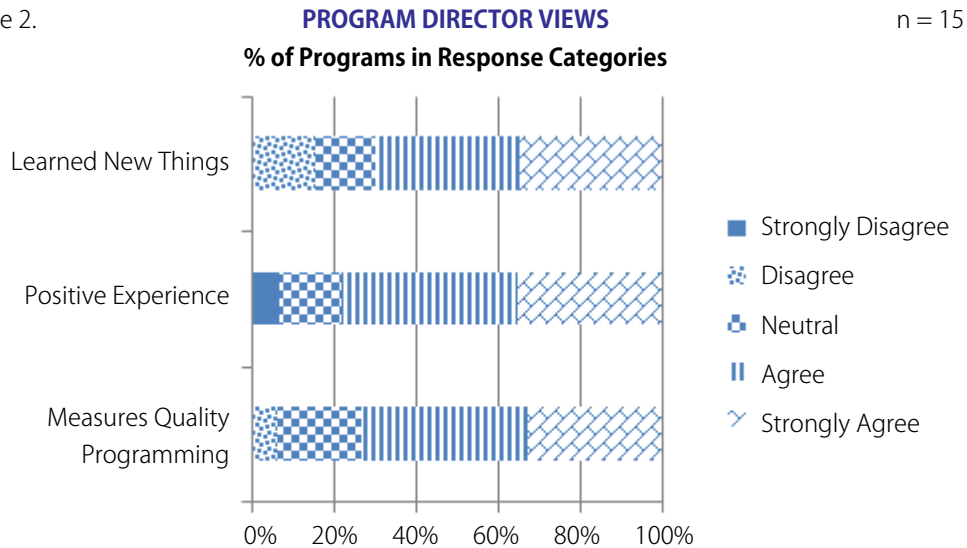
Sites were asked to rate the extent to which different aspects of the site visit were difficult or burdensome, such as scheduling, document preparation, filling out the online surveys, and participation in the interviews. One program found these elements to be difficult, with the vast majority finding the demands of the evaluation a reasonable commitment. Two programs noted that they wanted more time to prepare for the site visit, and some program directors wrote comments that the document preparation took longer than expected. It is interesting to note that evaluators provided anecdotal feedback that often during the site visit they had to work with programs to identify the specific documents and records they needed to score the measure, despite this initial preparation.

**Program directors were also asked the extent to which they agreed with the following statements:**

- The rating tool appears to measure aspects of home visiting we view as key to quality programming.
- Overall participation in the site visit was a positive experience.
- We learned some new things by participating in the site visit.

Their responses are summarized in Figure 2. For the most part, the 15 program directors who responded to the survey found that they did learn new things, found the site visit to be a positive experience, and that it measured aspects viewed as key to quality programming, although this was not a universal experience. One program, for example, reported the experience to be less than optimal. Eleven out of the 15 reported that they learned something new from the site visit. One element to consider in interpreting these findings is the timing of the promised feedback programs received from the evaluation team. All of these programs were asked about their experience of the site visit before they received summary feedback from the evaluators focused on their strengths and areas of improvement (see Appendix F). Receiving feedback sooner may make the process more useful to the program directors.

Figure 2.



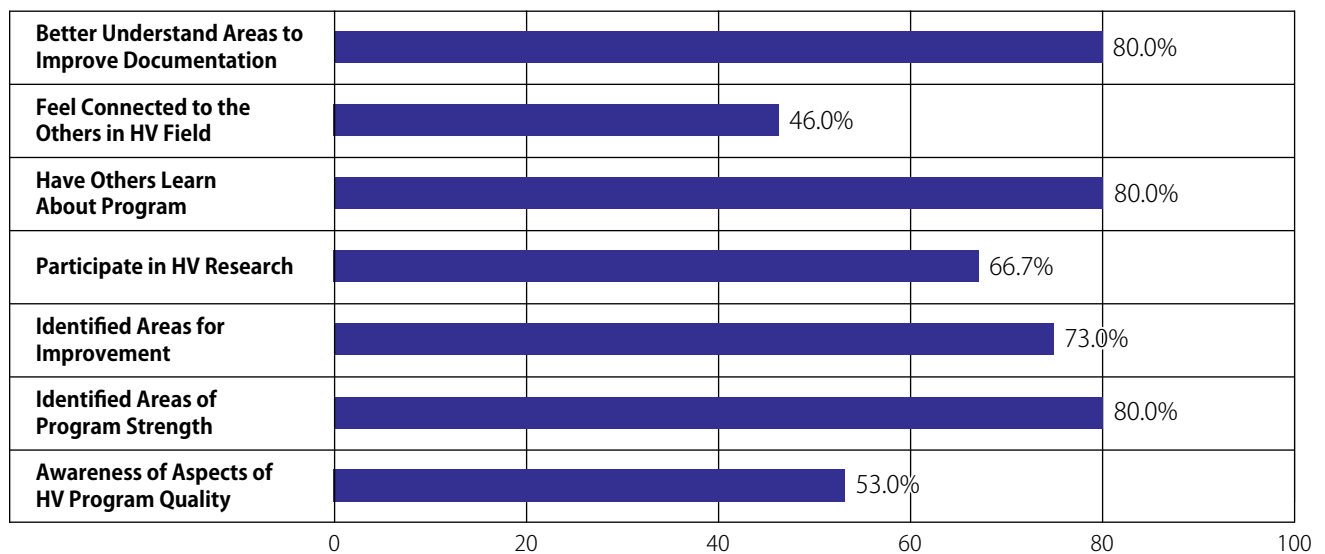
Program directors were also asked to indicate which specific aspects of the process they found beneficial. These results are shown below in Figure 3. There was a consistent emphasis that the measure identified areas of program strength and improvement, helped them to feel connected to others in home visiting field,

increased their knowledge of aspects of home visiting program quality, and gave them the opportunity reflect and discuss their work with others. Overall, these results suggest that the measure and the process of collecting data to score the measure provide a meaningful learning experience for programs.

Figure 3.

**ASPECTS OF THE EVALUATION FOUND TO BE BENEFICIAL**

n = 15



Programs were also asked to provide feedback on the extent to which the evaluation process was feasible for use in ongoing program monitoring and quality improvement. Although not all respondents left comments, the results do suggest again that program

directors found the evaluation process a useful experience that would provide information to aid in reports to funders and their own self-evaluation efforts. Table 17 lists some of the open text responses made by program directors.

Table 17. **SAMPLE COMMENTS REGARDING PROGRAM MONITORING AND QUALITY IMPROVEMENT EFFORTS**

Data supports our work and any data that our program can collect will only make us stronger and more efficient in our work with young children and families.

The documentation aspect of the visit was helpful in developing what type of documentation that we will provide for (funder) when presenting outcomes for the program year.

The questions regarding how the program is impacting the community or how does staff know that the program is working were useful questions. The data/numbers are already being tracked on several levels. However, the evaluation helped identify an area that we do not currently track.

The evaluation process provides a better understanding of what our program should be implementing and how we should be self-evaluating.

Found it specific and applicable to the (grant) and the jobs of the supervisor and parent educator. It has some rigor, but is not overly burdensome.

We have not had conversation with other program directors to compare and collaborate for a very long time. Sometimes one just wonders if other programs operate the same way, face the same issues with their families, or if what we do is perceived as having an impact on what services are available to families other than those we serve directly.

We had a positive experience and in participating saw opportunities for growth and evidence of strengths that we will be better at articulating, and tracking back to research and evidence, to describe our program.

Using a standardized tool for quality improvement is always a good thing. It helps us all be accountable to our own agency and to our funders and the community.

Yes, it would give guidance to state systems and larger organizations for shared language for program evaluation and would offer a simple process for agencies to use in their own self assessment.

The process was comprehensive yet condensed. It might be helpful to extend the length of the evaluation process from just one day to a day and a half or two days.

## Discussion

Home visiting is a general term used to describe a model of service delivery that has considerable variation in actual practice. It places heavy responsibility on a service provider to offer support and guidance to families away from an office or work environment. There exist no standard guidelines for what home visits

should focus on, how staff should be trained, and what support should be provided. This makes it difficult to judge programs on their ability to assist families with young children using a common rubric, and to offer constructive feedback in ways that can lead to program improvement.

The activities funded by Pew Center on the States, covering approximately 18 months of work, supported the development of a multi-dimensional quality rating tool for home visiting programs that could be used within the context of a one-day site visit. This tool was based on a review of the literature and feedback from experienced program directors and other knowledgeable stakeholders. Initial piloting led to the creation of data collection and scoring guidelines to promote a standard interpretation of the scale items. In addition, field testing provided feedback on the extent to which evaluators agree on the scoring of the tool. Staff from home visiting programs participating in the field testing reported their involvement was a worthwhile experience and that they obtained significant insight into the quality of their program. In most sections of the scale, programs scored over the whole range of scale points and as a group scored in the average range (a not unexpected finding), although there were some subscales that showed a more restricted range in scores. Given the extensiveness and variety of data needed to be collected and interpreted, overall agreement on scale and subscale scores is promising, but there are areas where evaluators struggle to agree with each other and where revisions of the tool will be needed to increase clarity and reliability. This discussion will focus on the challenges in conducting site visits and lessons learned from the process, study limitations, as well as necessary steps to improve reliability of the tool. We will also discuss policy implications of the research and future steps, including research needed to validate the measure.

### Challenges

There were four major challenges encountered during the development of the tool and its initial field testing: 1) balancing comprehensiveness with practicality; 2) determining the amount of training and guidance needed for scoring the tool; 3) practical challenges

in time allocation for the various aspects of design and data collection; and 4) recruiting representative programs.

### Comprehensive vs. Practical

From the beginning, the tool was designed to have practical use in the field, which dictated that it not be overly burdensome or complicated. At the same time, attempting to cover all of the different areas of functioning in a home visiting program—from the home visitor and conduct of individual home visits, to supervision and management, data tracking, and connection to the larger community – demanded a more comprehensive approach to assessing a program. Managing these two demands of providing as much feedback as possible while maintaining a minimal level of ease of use proved challenging, and considerable time was spent in discussion and piloting to strike a balance between these two opposing goals. Difficult decisions were made about methods of data collection and areas of focus.

One example of a difficult decision was eliminating direct observation of home visits. An early option to have the evaluator accompany staff on home visits was quickly rejected as too time-consuming and logistically challenging. In initial drafts of the tool, home visitors were asked to video-record home visits for review by the evaluator, and a few pilot programs were provided with handheld digital video cameras to experiment with this process. This strategy, however, was also ultimately rejected, as the process of having home visitors recruit families, record their visits, and upload files for viewing by the evaluator (all within a narrow time window surrounding the actual site visit) was seen by the pilot program staff as simply untenable. Only one program, experienced in video-recording as part of its supervision process, was able to provide recordings of single home visits made by two different home visiting staff.

Instead of direct observation of home visits, a heavier emphasis was placed on case vignettes as a proxy or analog method of collecting information on home visitor practices. Although the vignettes do not allow for a behavioral sample of what the home visitor would actually do at the home visit, this method does supply information on how home visitors think about common challenging issues they experience and the range of strategies they would consider employing to deal with the situation. During piloting of the tool home visitors frequently made spontaneous comments that the vignettes felt like situations they had previously encountered and were representative of the multitude of issues home visitors can face on any given home visit. A rather complex scoring protocol for combining home visitor responses to the three vignettes with responses to general interview questions may have contributed to lower agreement for the related subscales. Further analysis of individual responses and the associated scoring rules may provide insight to ways to improve the agreement in scoring the case vignettes and individual interview responses. Given the general receptivity of the case vignettes in this study, this data collection methodology holds promise for use in evaluating home visitors approach to working with families. But the struggle to achieve agreement also highlights the difficulties of accurately assessing how home visitors form relationships with families. Although relationship formation is often seen as a crucial element of home visiting quality (e.g., Paulsell, Boller, Hallgren, & Esposito, 2010), there are multiple ways a “good” relationship can be viewed (see Korfmacher, 2007).

Although direct observation of home visits is an important element of assessing home visiting program quality, ultimately, it is beyond the constraints of this particular quality rating tool in its current form. There has been, however, preliminary discussion of the feasibility of including an additional module to the tool in the future which includes direct home visit

observation. There do exist established measures that assess quality of actual home visits, such as the HOVRS (Roggmann et al, 2008) and the Home Visit Assessment Instrument (Wasik & Sparling, 1995), and it is possible that these measures could be used in conjunction with the HVPQRT to provide a fuller picture of a home visiting program and its operations. This combination is currently being piloted in the evaluation of the home visiting programs within the Illinois home visiting evaluation. After the site review using the HVPQRT, home visitors have been recruited to identify families in their caseloads to participate in case studies, using the HOVRS as a central component of data collection. Results from this aspect of the statewide evaluation of home visiting programs (due to be completed in June 2012) will further inform this issue and provide feedback regarding how these two data sources can be combined.

There were other decisions that were made in the attempt to balance comprehensiveness with practicality. One was the increased reliance on the interview with program leaders. For example, the preliminary design and data collection included interviews with members of a program’s board of directors and community stakeholders to assess management/leadership strengths and the program’s presence in the community. However, the one day site visit did not provide time to access board members and community stakeholders during the site visit. This information was ultimately collected via interview with the program management staff.

Initial drafts of the tool also relied more heavily on program directors and home visitors providing back-up for their interview responses with documentation from program records or case files. For example, when program directors were asked about relationships with other community agencies, their statements were to be verified against written documentation of these

relationships (e.g., a memorandum of understanding). During piloting, however, it became clear that:

- i) program directors were concerned about the amount of time it would take before the site visit to bring together all the documents asked for, and;
- ii) the interviews would take too long if verification of statements were required for most questions. For this reason, we eliminated many areas where we initially sought documentation, trusting instead the accuracy of the interviewee's response. It is an open question the extent to which program directors and home visitors do accurately report on their efforts during this interview, one that cannot be answered with the data collected in the current study. As part of ongoing validation work of the tool, it is necessary that this be examined, where time is built in for extended document review.

Additionally, the evaluators reported that in course of reviewing program records and documentation, they often needed to be flexible in terms of what documents could be used and the extent to which available documents met criteria outlined in the data collection and scoring guidelines. Revisions to the data collection and scoring guidelines will need to include guidance to evaluators as to the degree of flexibility allowed in accurately assessing documentation that captures the intent of the indicator but may be articulated in a variety of documents at the program level. It is to be expected that documentation systems will look different across programs. Given that this tool is designed to be used across multiple program models, it is necessary that the scoring guidelines be open enough to capture these differences while still allowing for a level of standardization and ease of data collection. This again highlights the tension between practical considerations and the desire to comprehensively assess program functioning.

### **Providing Guidance for Scoring**

One of the lessons learned in the process of piloting the tool was the need to provide increased guidance for collecting data and scoring the indicators and subscales. The data collection and scoring guide became an essential part of the tool, and became more detailed and elaborate with each draft. And as the tool and scoring guides became more complex, the need for training the evaluators became more apparent.

The training for the Wisconsin-based evaluators was relatively short. It lasted one day and included a walk-through of the scale, its scoring, and the data collection and scoring guides. The training time was constrained, in part, by scheduling issues. But it also based upon an assumption that, as experienced home visiting program administrators, they had a deeper understanding of home visiting program operations, so that detailed training would not be as necessary. Feedback from the evaluators after they had conducted the site visits and from the analysis of the data suggested that this assumption was at least partially incorrect. Given the complexity of the tool and its requirement for inference and judgment (despite the level of detail in the data collection and scoring guides), evaluators noted the need to have more detailed discussions of the indicators within the scales during training. In addition, because of difficulties scheduling site visits, a gap of approximately two months occurred between the training of the Wisconsin evaluators and the site visits. Several evaluators felt that this may have been too much time and expressed some concern over having lost some of the details necessary for accurate scoring. Finally, although the evaluators had considerable background experience and in home visiting, they often had more knowledge or experience with one model than another (e.g., PAT vs. Healthy Families). It is possible that this more substantial background knowledge of a particular program model compared to others had an impact on scoring.



Based on the emerging feedback from the Wisconsin evaluators (and the experience of research team members on their own site visits), as well as the acknowledgement that the evaluators in Illinois had less direct experience with home visiting programs, training on the tool was increased for the evaluators in Illinois. Training occurred over a two-day in-person meeting, with follow-up “homework” assignments and conference calls to resolve questions and issues in scoring. There was a greater emphasis on practicing tool administration through mock interviews and scoring examples. Results from the field tests suggest that this extended training was helpful, in that agreement between evaluators increased with the Illinois program sites compared to the Wisconsin sites (Tables 12 and 13).

There continued to be feedback provided by evaluators, however, that the data collection and scoring guides had sections where questions needed clarification or revision. In particular, questions for scale C (Program Content) and E (Program Monitoring) were noted by evaluators as confusing or difficult to score at times. It was recommended that questions for C and E be braided together during site visits to avoid repetition of questions and improve the flow, but feedback from evaluators suggested that this was more difficult to do than anticipated. This suggests that further refinements of the data collection and scoring guides are necessary and will be undertaken as the tool is revised.

### Practical Challenges

As is often the case, the research team underestimated the time commitment and resources necessary to successfully carry out this research as designed, both in their own work and in what was asked of the participants in the pilot and field-testing phase. The work exceeded the initial study design projections for staff time, although research team members were able to re-allocate other duties to allow additional time to complete the study.

The grantee organizations provided in-kind support to cover the additional staff time devoted to this research. Overall, the research team convened 16 full days of group in-person meetings for planning and designing of the HVPQRT, including 5 days with the Analysis and Design Team and three full-day piloting site visits.<sup>7</sup> This intensity of in-person meetings was not anticipated, and required additional commitment from Analysis and Design Team members. Often their involvement in the design and testing took time away from their program’s work with families without compensation.

The preliminary applicability pilot was a significant time commitment for sites. Representatives from the sites were asked to spend a day preparing for the visit, do self and peer assessment, both which took a full day and then report their findings. During this stage of the development, sites field tested selected sections of the tool and did not complete the full assessment using all sections of the tool. This feedback was instrumental in structuring the tool so that it could be completed in a one day site visit.

### Program Recruitment

As Table 9 suggests, there was an over-representation of Parents As Teachers programs. Although attempts were made to recruit a larger number of programs representing other program models, the make-up of home visiting programs within the two states made this more challenging. Parents as Teachers is the largest home visiting program in Wisconsin, with 52 programs employing over 300 parent educators in 34 counties (Parents Plus of Wisconsin, 2012). In Illinois, PAT is a popular program model for school districts as it traditionally has had a heavier emphasis on learning and early readiness. Although outreach was made to other program models supported by the grantee to participate in the evaluation in an attempt to over-sample non-PAT programs, the sample in Illinois

7 This does not include the independent work on developing drafts of the scales and data collection and scoring guides conducted by individual members of the research team.

ultimately represented the breakdown of program models within the state program network, with approximately 75% PAT.

There are a number of prominent home visiting program models not represented in the current sample, including Nurse Family Partnership, Triple P, HIPPPY, and Family Check Up. In future work with the HVPQRT, it is essential that these programs also be sampled and the experience of collecting information on these programs using this tool be carefully studied to ensure that the dimensions of program quality and the specific indicators are relevant to them as well.

### Study Limitations

As noted above, one study limitation is the sample selection. The predominance of PAT programs and smaller sampling of other program models participating in this study makes unclear the applicability and acceptance of the tool across a wide variety of program models. This is a target of future research. Because program involvement in this study was voluntary, it is possible that programs that view themselves as providing quality services were more inclined to participate. This potential self-selection bias may have impacted the distribution of scores we observed. In addition, there was an over-representation of smaller programs with fewer numbers of home visitors. Future research should target using the tool with larger programs. In addition, although the study involved home visiting programs from two states, it is possible that there are regional factors in play regarding how program quality is conceptualized and operationalized. For example, issues of cultural sensitivity and understanding may differ depending on region and population. Study of the tool with programs in other regions that serve different populations (e.g., tribal programs, larger urban areas) and are part of different service systems is an important step in its development.

A second study limitation is that reliability focused only on inter-observer agreement. The tool was used in the context of a one day site visit, so the stability of the scores is unknown. Future work should focus on examining how quality ratings change over time. In addition, because the research team was unable to complete and pilot a self-assessment version in the time period of the project, the agreement between external evaluation and the program staff's own rating of their program quality is also unknown.

Finally, the data sources used to determine scoring of the HVPQRT in this study are themselves untested and in need of focused validation work. For example, the online survey for home visitors regarding reflective supervision was developed specifically for use with the HVPQRT based on a review of the literature regarding best practice elements for supervision (see page 22). The research team was not able to find any existing measures of reflective supervision that could be used in this context, a limitation in the field overall. The case vignettes and scoring system used as part of the assessment of home visitor qualities is another example of an untested data collection process embedded within the HVPQRT. In both cases, the initial piloting was used to determine scoring thresholds, but a larger sample of responses would provide information on psychometric properties and for establishing thresholds for stronger and weaker responses.

### Future Steps

Future work involves revising the HVPQRT to increase its reliability and to conduct further research in order to demonstrate its validity.

#### Revising to Increase Reliability

As noted in the results, there are subscales where the inter-rater reliability is unacceptable, and the next phase of work on the HVPQRT must be focused on revising or

even eliminating subscales where agreement cannot be reached by evaluators. This will involve more in-depth analysis of the notes and scoring forms that were completed by the evaluators in the two states to determine exactly where in the subscales, indicator rows, and the data collection instruments are the specific areas of disagreement. This work can also inform the training of evaluators, another likely source of the low agreement seen in some areas of the tool. For example, clarifying scoring rules in a manual and providing more mock or in-vivo opportunities for practice scoring will likely help improve reliability.

### Establishing Validity

The HVPQRT must be validated against established quality indicators, both process indicators (such as other measures of the quality of home visits, or model-specific fidelity tools) and outcome indicators (such as improved child and family outcomes) in order to demonstrate that higher scores on the tool scales actually represent features of higher program quality. There are different components to demonstrating validity of the tool, all of which need to be undertaken in order to increase confidence that the tool is measuring what is supposed to be measuring.

The first component is validating the data collection process. Because the tool relies greatly on interviews and surveys of home visitors and program directors, we need to ascertain whether or not these participants are reporting accurately about their program, by verifying their statements with documentation (such as more in-

depth chart reviews). In addition, as noted above, it will be necessary to collect basic psychometric information on these scales and vignettes using a larger number of home visitors. The use of strategies such as cognitive interviewing may also be helpful in order to determine the extent to which respondents are interpreting the language of the embedded surveys the same.

The second component is linking tool ratings to other established measures of elements of program quality, including accreditation reports from the major program models, or home visit observations using validated instrument, such as the HOVRS,<sup>8</sup> or reports from families about their involvement and satisfaction with program services. A third component is linking tool ratings to program outcomes. That is, outcome indicators need to be collected on a representative sample of families within a program in order to determine whether quality ratings of programs are related to families showing stronger outcomes (in child or family functioning) over time. Examples would depend on the program's logic model, but would likely include such outcomes as breastfeeding rates, parent-child interaction or relationship assessments, or parent efficacy.<sup>9</sup>

Finally, a fourth component is examining whether or not the tool is responsive to quality improvement efforts that a program may make. In other words, if a program makes changes in how it operates in response to feedback received from the tool's use, will that be reflected in a change in score when the program is re-evaluated at a later time?

8 The current evaluation of home visiting programs in Illinois, HOVRS data is being collected on a subset of programs and families, which will allow an initial examination of this issue as well as piloting how home observations can be integrated into HVPQRT assessments.

9 In the current Illinois evaluation, parent-child interaction data from a subset of programs and families is being collected by home visitors using a standardized tool they have been trained to use as part of their home visits. This will provide initial information on links between program quality and program outcomes, although the small numbers (as well as the non-random selection of families) will make it unlikely that it can be used beyond exploratory analyses.

## Policy and Practice Implications

The HVPQRT was initially proposed and designed as a measurement tool with the potential for strong policy and practice applications. That is, it was designed to be a relatively practical and manageable process that put into one standard rubric multiple dimensions of program quality that would allow multiple parties (researchers, programs, policy stakeholders) to capture the strengths and challenges of home visiting programs no matter what program model used. Research, practice, and policy all have their particular assumptions and points of view (see Shonkoff, 2000), and this is certainly true regarding home visiting program quality.

The findings of the current study suggest that assessing home visiting program quality is a complex phenomenon. Although the research team originally envisioned the tool to fulfill a broad set of needs at both the policy and practice level, these findings suggest further analysis and development may provide more realistic expectations for a single assessment tool to meet multiple roles of a variety of stakeholders. When this tool is fully developed it may be best used as one mechanism in a multi-faceted approach to reviewing overall program quality. The HVPQRT was not intended to be a replacement for model specific credentialing/certification, but rather a compliment to any one model's quality processes.

One theme that emerged throughout this study was the value to programs themselves in reviewing program performance across multiple domains. The process of preparing for an external evaluator site visit and participating in the site visit itself was seen as a valuable opportunity to discuss their program operations and have meaningful discussion with staff on many aspects of program quality. From a practice perspective, this tool can be an asset for internal program management and quality improvement initiatives. The findings

suggest that managers seeking to identify areas for improvement and program strength will find it useful when planning organizational performance improvement activities. Program leaders may then make better-informed decisions based on the consensus of best practice elements across program models. One of the contributions of this study is it provides measurable attributes with specific anchor points for high quality programs. These indicators provide a road map for program leaders by suggesting a direction for improvement.

The efforts to increase the usefulness and practicality of the tool for programs created the challenge of providing a tool that can be used reliably for accountability, policy making or budgeting. Overcoming this challenge will require additional research to identify appropriate parameters for the tool, possibly including additional versions for different users. Additional development and testing of the tool is recommended before the tool can be used as a reliable mechanism to review overall program quality at the policy and decision making level.

The very nature of quality assessment and its complexities and limits requires careful consideration when identifying appropriate use of any one tool. Policy makers should proceed cautiously and avoid using any single measure as a basis for high stakes decision-making around home visiting program funding. Additionally, policies which are supportive of program quality improvement efforts should be considered an integral part of an infrastructure to support the field of home visitation. One way that continued use of the HVPQRT may be helpful is in defining the limits of program quality. That is, within a service system, if programs are regularly showing lower scores on certain indicators or subscales, this may be suggestive of places where home visiting programs are constrained in their ability to provide high quality services by the local community or system infrastructure.

For example, if a major source of funding for programs will only provide yearly grants or contracts with no guarantee or assumption of future funding, programs will be limited in how well they can demonstrate ongoing sound fiscal planning. As another example, home visitors in programs that exist in areas with few other community resources will have a much more difficult time demonstrating their ability to link families to relevant services. In both cases, a home visiting program is being rated on their ability to perform these functions (fiscal planning, service linkage), but they are constrained by the larger system in which it exists. Using

the HVPQRT to highlight these constraints over an entire system or large collection of programs is a potentially valuable mechanism for informing policy development for home visitation.

The HVPQRT is a work in progress. It has potential utility for home visiting programs and systems in its provision of a quality framework with measurable indicators across multiple domains and across multiple program models, but further development and testing is needed before increased use by the field.

## *Conclusion*

This study aimed to create a working draft of a cross model best practice assessment tool for the field of home visitation. In the course of its development, the research team strove to find the right balance between creating a comprehensive yet practical tool for a field which is still emerging and has considerable variation in actual practice. The process of creating an assessment tool included a thorough review of the literature as well as input from a variety of stakeholders throughout the development process. The working draft developed as part of this commissioned research shows promise to be a tool that is useful to programs and policy makers. In the course of its development the research team was able to identify common components of quality programming and specify operational anchors for measurement across multiple program models. The findings suggest this tool is useful to programs

in their quality improvement efforts. As development continues, the research team looks to increase the reliability and validity of the tool and provide guidance to the appropriate use of the tool for programs and policy makers.

In summary, as validity and reliability of this measure for evaluating home visitation programs is further demonstrated, it will advance the field of home visitation by providing a mechanism that addresses current gaps in assessment. The ability of the tool to assess program quality across various models and examine both structural and dynamic aspects of quality together in a single practical tool provides a new contribution to home visiting evaluation. This tool will also provide meaningful data for program administrators to guide quality improvement efforts.

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Appendix A

Selected sections from the

# Home Visiting Program Quality Rating Tool (HVPQRT)

*Developed by:*  
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DRAFT VERSION 11/7/2011

# A. Home Visitor Staff Qualities

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## *Subscale A2*

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**Scale: A. Home Visitor Staff Qualities**

**Subscale: A2. Promotion of child development and well-being**

	1	2	3	4	5	6	7
	<b>Low Quality</b>						
<b>1.1</b> A significant number ( $\geq 25\%$ ) of home visitors do not incorporate child development information into home visits.			<b>1.3</b> Most ( $\geq 75\%$ ) home visitors incorporate child development information into work with families in at least basic ways, such as using screenings or providing informational sheets to families.			<b>1.5</b> All home visitors incorporate child development information into work with families, using feedback from screenings and additional developmental information to plan home visits.	<b>1.7</b> All home visitors consistently incorporate child development information through activities which are <i>individualized</i> and use multiple methods to address developmental issues.
	<b>Average Quality</b>						
<b>2.1</b> A significant number ( $\geq 25\%$ ) of home visitors do not incorporate child health and safety information into home visits.			<b>2.3</b> Most ( $\geq 75\%$ ) home visitors incorporate health and safety information into work with families using screenings (health, safety, maternal mental health).			<b>2.5</b> All home visitors address issues of child health and safety in their work with families, including establishing medical homes for children and attending to the well-being of primary adults.	<b>2.7</b> All home visitors consistently incorporate child health and safety information through activities <i>individualized</i> to families that include multiple methods to address health and safety issues of the family.
	<b>Above Average Quality</b>						
<b>3.1</b> A significant number ( $\geq 25\%$ ) of home visitors do not facilitate positive parent-child interactions.			<b>3.3</b> Most ( $\geq 75\%$ ) home visitors show some evidence of knowledge of parent-child relationships in their work with families, at least informally monitoring the quality of the relationships.			<b>3.5</b> All home visitors focus on parent-child relationships in their work with families, including administering formal assessments of the parent-child relationship.	<b>3.7</b> All home visitors consistently focus on parent-child relationships, even when assisting families in other areas or dealing with crisis situations.
	<b>High Quality</b>						

**Comments:**

**Circle Final Score:** 1 2 3 4 5 6 7

DRAFT VERSION 11/7/2011



# B. Program Service Delivery

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## *Subscale B5*

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DRAFT VERSION 11/7/2011

**Scale: B. Program Service Delivery**

**Subscale: B5. Transition Plans**

	1	2	3	4	5	6	7
	Low Quality			Average Quality	Above Average Quality		High Quality
<p><b>1.1</b> Program does not consider transition plans for families graduating or leaving program or has no guidelines for transition plans.</p> <p><b>2.1</b> Home visitors do not plan for transitions in advance of final contact with family.</p>	<p><b>1.3</b> Program has at least informal guidelines and policies for transition plans.</p> <p><b>2.3</b> Transition plans and services are available, but may be limited to informal discussions or the provision of referrals.</p>	<p><b>1.5</b> Program has formal written guidelines and policies for transition plans that are basic.</p> <p><b>2.5</b> Transition plans are developed collaboratively between home visitors and families in advance (at least three months) of program completion, and home visitors assist families as they transition out of program (referrals, resources, etc.)</p>	<p><b>1.7</b> Program has formal written guidelines and policies for transition plans that are specific and comprehensive (outlining policies, procedures, and timelines for transition plans).</p> <p><b>2.7</b> Individualized transition plans are developed collaboratively well in advance (at least six months) of program completion with families. Home visitors assist families through transitions by providing resources through formal partnerships with community programs and services. Assistance is available for families regardless of the family's reason for leaving.</p>				
<b>Comments:</b>	<p style="text-align: center;"><b>Circle Final Score: 1 2 3 4 5 6 7</b></p>						

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# C. Program Characteristics

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## *Subscale C4*

DRAFT VERSION 11/7/2011

**Scale: C. Program Characteristics**

**Subscale: C4. Services Tailored to Family Strength and Needs**

	1	2	3	4	5	6	7
	Low Quality			Average Quality		High Quality	
<p><b>1.1</b> Program does not have a process in place for monitoring family needs.</p>			<p><b>1.3</b> Family needs assessments are conducted, at least in a limited way (e.g., only at intake, or only focused on demographic factors).</p>		<p><b>1.5</b> Family needs assessments are conducted initially and monitored, addressing comprehensive risk and protective factors through multiple methods, needs assessments are used to individualize services.</p>		<p><b>1.7</b> Family needs assessment includes multiple household/family members or contexts beyond parent and child.</p>
<p><b>2.1</b> Home visiting materials are not adapted to diversity of family needs.</p>			<p><b>2.3</b> Program adapts some home visiting materials to accommodate family diversity.</p>		<p><b>2.5</b> Home visiting materials are adapted to families' cultural, linguistic, and educational backgrounds.</p>		<p><b>2.7</b> Program collaborates with family, community, or cultural representatives to ensure relevance of program content and materials.</p>

**Comments:**

**Circle Final Score:** 1 2 3 4 5 6 7

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# D. Program Management and Development

## Subscale D5

DRAFT VERSION 11/7/2011

**Scale: D. Program Management and Development**

**Subscale: D5. Professional Development**

1	2	3	4	5	6	7
Low Quality		Average Quality		Above Average Quality		High Quality
<p><b>1.1</b> A significant number (<math>\geq 25\%</math>) of home visiting staff do not formally track training through individual professional development plans.</p>	<p><b>1.3</b> Most (<math>\geq 75\%</math>) home visiting staff have individual professional development plans that formally track training.</p>	<p><b>1.5</b> All home visiting staff have current professional development plans that articulate training goals and document progress towards goals, updated/reviewed within past 12 months.</p>	<p><b>1.7</b> All home visiting and management staff have professional development plans, updated/reviewed within past six months.</p>			
<p><b>2.1</b> Program has minimal pre-service orientation, and other professional development activities are provided only sporadically.</p>	<p><b>2.3</b> Professional development offered, at least in a limited way (e.g., to satisfy requirements for training outlined in the program model and curriculum).</p>	<p><b>2.5</b> Professional development includes program model and curriculum requirements and includes components tailored to individual staff needs.</p>	<p><b>2.7</b> Professional development is an ongoing multifaceted process that includes multiple adult learning styles, and is embedded into program activities.</p>			
<p><b>3.1</b> Program has little to no involvement of management staff in professional development.</p>	<p><b>3.3</b> Management staff are involved in professional development in at least a limited way (e.g., retrospective review of completed professional development hours).</p>	<p><b>3.5</b> Management staff is actively involved in planning individual staff professional development.</p>	<p><b>3.7</b> Staffs individual professional development plans are tied to performance reviews.</p>			
<b>Comments:</b>						
<b>Circle Final Score:</b> 1 2 3 4 5 6 7						

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# E. Progress Monitoring

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## *Subscale E2*

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DRAFT VERSION 11/7/2011

**Scale: E. Progress Monitoring**

**Subscale: E2. Outcome Measurement**

	1	2	3	4	5	6	7
	<b>Low Quality</b>		<b>Average Quality</b>		<b>Above Average Quality</b>		<b>High Quality</b>
<b>1.1</b>	Program does not track and report outcomes.		1.3 Program can identify family, and child outcomes and has established guidelines and processes for tracking progress and outcomes.		1.5 Program can demonstrate some impact on family and child outcomes. Outcomes are monitored on at least an annual basis.		1.7 Program can demonstrate clear effectiveness across multiple areas of child and family functioning, using a control or comparison group. Program monitors outcomes at least 2 times per year, and provides assistance to visitors in collecting accurate data.
<b>2.1</b>	Program does not have a governing body <i>or</i> governing body is not aware of program successes/ challenges.		2.3 Information from program evaluation is communicated to governing body, both successes and areas of challenge or areas in need of improvement.		2.5 Program communicates evaluation findings to multiple stakeholders.		2.7 Program communicates program results at least annually via written reports of progress on family and child outcomes; can articulate how program outcomes fit into community outcomes and uses the information to leverage funding and improve sustainability.
<b>Comments:</b>							
							<b>Circle Final Score:</b> 1 2 3 4 5 6 7

DRAFT VERSION 11/7/2011



### Evidence Base for Home Visiting Best Practice Elements and Quality Indicators

This literature review is organized by 5 dimensions of home visiting program quality that align with the scales of the HVPQRT. These dimensions are further divided into best practice elements (corresponding to HVPQRT subscales). Following each section, a table also summarizes the literature used as support for these dimensions. Some of the literature used in support of the dimensions is not specific to home visitation (i.e. effective strategies for youth prevention programs, studies of state child welfare agencies) or reflects a general consensus within the field of best practice elements. Refer to the footnotes after the tables to distinguish supporting literature that is based on empirical research within home visitation.

### Home Visiting Staff Competencies

#### Education and Professional Experience

Research findings on staff education and professional experience are somewhat inconclusive and mixed. Olds (2002) investigations of the Nurse-Family Partnership have shown that mothers visited by nurses tend to demonstrate greater benefits than mothers visited by paraprofessionals. However, Sweet & Appelbaum's (2004) meta-analysis indicated that the impact of staff education and professional experiences depends on the outcomes under consideration. For example, children with professional home visitors tended to demonstrate greater cognitive outcomes, however, children with paraprofessional home visitors tended to exhibit fewer signs of neglect and abuse (Sweet & Appelbaum, 2004). While the findings for child and parent outcomes are mixed, there is some evidence to suggest that staff education and professional experience contributes to their response to in-service trainings and ability to incorporate new knowledge into their work with families (Knoche, Sheridan, Edwards, & Osborn, 2010).

Additionally, staff professional experience positively correlates with the number of home visits families completed (Daro, McCurdy, Falconnier, & Stojanovic, 2003). Beyond a general view that more is better, however, there are not established thresholds for how much education or experience is needed for home visitors.

#### Promotion of Child Development and Well-Being

Home visits with more time spent on child focused activities and promotion of child development predict several program outcomes. Visits focused on promoting child development (relative to visits focused on other activities (e.g. paperwork, social support) significantly predict greater parental support for language development, higher overall scores for the quality of home learning environments, and higher child cognitive scores (Raikes et al., 2006). There is also research suggesting that mothers are more likely to be engaged in home visits when home visitors are discussing child development (Peterson, Luze, Esbaug, Jeon, & Kantz, 2007). In addition to focusing on child development, greater facilitation of positive parent-child interactions during home visits is related to: higher parental engagement, more secure attachment behaviors in children, and children's age appropriate cognitive development (Knoche, Sheridan, Edwards, & Osborn, 2010; Roggman, Boyce, & Cook, 2009).

#### Working with Families

The personal characteristics of home visitors impact the relationship quality between home visitors and parents, ultimately impacting program outcomes (Daro, 2000). For example, successful home visitors tend to hold non judgmental views of families, are relationship-oriented, and work collaboratively with families to plan goals and implement activities (Daro, 2000; Hebbeler & Gerlach-Downie, 2002). Home visitors' ability to effectively engage parents in program services relates to family retention rates and the intensity of services families

receives (Allen, 2007; Roggman, Cook, Peterson, & Raikes, 2008). Research investigating correlates of high parental engagement found several home visitor characteristics influenced parental engagement, including: acceptance, sociability, perspective, balancing multiple roles, and knowledge base to refer families to outside resources (Wagner, Spiker, Gerlach-Downie, & Hernandez, 2000), although there is little direct

research focused on the relationship between making referrals and program outcomes. Qualitative research interviewing parents found parents truly valued home visitors who were persistent, conscientious, and consistently followed through on delivering promised services and/or referrals (Brookes, Summers, Thornburg, Ispa, & Lane, 2003; Paris & Dubus, 2005).

Table B1.

## HOME VISITOR QUALITIES

Best Practice Element	Research Support
Education and Professional Experience	<ul style="list-style-type: none"> <li>• Effective prevention programs involve well-trained, supported, and competent staff (Daro, 2009; Nation et al., 2003; Small, Cooney, &amp; O'Connor, 2009).</li> <li>• Staffs' experience in home visitation approached significance in predicting the number of home visits families complete (Daro et al., 2003).**</li> <li>• Staffs' use of intervention strategies significantly correlated with their education level and experience in early childhood settings (Knoche et al., 2010). **</li> <li>• Home visits completed by professional staff (versus paraprofessional staff) were associated with higher program impacts on children's cognitive development and prevention of child abuse (Sweet &amp; Applebaum, 2004). **</li> </ul>
Promotion of Child Development and Well-Being	<ul style="list-style-type: none"> <li>• Staff in effective prevention programs provides comprehensive services to participants, actively engage participants in program services, and provide developmentally appropriate content (Nation et al., 2003; Small, Cooney, &amp; O'Connor, 2009).</li> <li>• Home visits with more time focused on child development predict greater cognitive and language development in children, greater parental support for language development, and higher overall scores for home learning environments (Raikes et al., 2006). **</li> <li>• Parents are more likely to drop out of programs if home visits are more staff-parent or family focused (versus child focused). Longer enrollment lengths are associated with more child focused home visits (Roggman et al., 2008). **</li> <li>• Children in intervention group for interventions designed to increase home visitor facilitation of positive parent-child interactions have more secure base behaviors and more age appropriate progress in cognitive development, relative to children in control group (Roggman et al., 2009). **</li> <li>• Global ratings of parent engagement in home visits are significantly higher when home visits have a greater focus on parent-child interactions (Knoche et al., 2010). **</li> <li>• Mothers are more likely to be engaged in home visit activities when staff discuss child development information using strategies that involve parents in direct interactions with their children rather than through conversation (62% high engagement in direct interactions versus 26% high engagement in strategies using conversation)</li> </ul>

	<b>(Peterson et al., 2007). **</b>
Working with Families	<ul style="list-style-type: none"> <li>• Staff in effective prevention programs focus on and are able to foster positive relationships with families (Nation et al., 2003; Small, Cooney, &amp; O'Connor, 2009).</li> <li>• Parental engagement in program services is related to home visitor characteristics, including: acceptance, sociability, perspective taking, ability to form meaningful relationship from the beginning of program services, and willingness to balance multiple roles (Wagner et al., 2000). **</li> <li>• Mothers in home visiting programs felt it was important that home visiting staff validated their feelings, recognized and affirmed their strengths as parents, and allowed mothers to feel connected and well cared for (Paris &amp; Dubus, 2005).</li> <li>• Parent home visitor relationship was the strongest predictor of the intensity of program services received, as rated by parent (Allen, 2007). **</li> </ul>
Referrals and Follow Up	<ul style="list-style-type: none"> <li>• Parental engagement in program services is higher when home visiting staff have the knowledge base to refer families to outside resources as necessary (Wagner et al., 2000).</li> <li>• Mothers in home visiting programs felt it was important that home visiting staff take the initiative in providing referrals and following through on services offered by checking back with families about referrals (Paris &amp; Dubus, 2005; see also Brookes et al, 2003).</li> </ul>

\*\* Literature is specific to home visitation and based on empirical research.

## Program Service Delivery

Program Recruitment and Enrollment. Identifying a target service population and ensuring that program participants reflect the target service population is an important step in assuring that program services are well matched to participants; thereby increasing program efficacy (Nation et al., 2003). Some national program models (e.g. Healthy Families America) have guidelines surrounding the target service population as well as timelines for ensuring that families receive services shortly after expressing their interest in program participation. Additionally, a meta-analysis by Sweet & Appelbaum (2004) found some evidence that targeted program enrollment improves program outcomes. However, Sweet & Appelbaum's (2004) meta-analysis was not able to disentangle the independent impact of targeted program enrollment from other program services. Outside of this general consensus and Sweet & Appelbaum's (2004) findings, there is limited research on the effects of program recruitment and

enrollment on program service delivery or program outcomes.

## Prenatal Enrollment

Attention to enrolling families prenatally or shortly after birth is associated with more positive birth outcomes (significantly reduced risk of delivering low birth weight babies for mothers who enrolled in Healthy Families programming at a gestational age of 24 weeks relative to mothers enrolling later) and longer enrollment lengths with higher completion of home visits (Lee et al., 2009; McCurdy, Gannon, & Daro, 2003). Initiating services prenatally or at birth is especially important for mothers with additional risk factors, whom may lack access to adequate health care and prenatal services (Daro, 2009). Lastly, Nurse Family Partnership, a home visiting programs targeting prenatal enrollment, has demonstrated significant and sustained positive impacts on family and child outcomes (Olds et al., 2004), although it is difficult to disentangle the influence of prenatal enrollment from other features of the program model.

### Frequency and Length of Services

While programs differ in their intended frequency of visits, research consistently suggests that families who complete more visits tend to show greater outcomes (Sweet & Appelbaum, 2004). Programs classified as “high-intensity” are more likely to have positive impacts on child and family outcomes (Kahn & Moore, 2010). Specifically, programs lasting for a year or more with an average of four or more home visits in a month are more likely to demonstrate positive outcomes (Kahn & Moore, 2010). Evaluations show a significant positive relationship between the frequency and length of program services and child cognitive outcomes, immunization rates, and fewer child injuries (Wagner, Spiker, Hernandez, Song, & Gerlach-Downie, 2001). In regards to parent outcomes, a meta-analysis found that effect sizes for changes in maternal behavior were greater than zero when visits occurred at least once a month (Nievar, VanEgeren, & Pollard, 2010). The effect sizes for changes in maternal behavior tripled in programs where visits occurred at least 5 times a month (Nievar et al., 2010).

### Transition Services

Research defining high quality early care and education emphasizes the importance of early care environments that are characterized by continuity and consistent care giving (Shonkoff & Phillips, 2000). Within early education, substantial attention is paid to providing continuity by developing and implementing transition plans for kindergarten. Considering this, there is agreement within the field that home visiting programs can also help facilitate continuity of care by providing families with transition plans and linking families with quality early care and education programs within their communities (Golden, Hawkins, & Beardslee, 2011). Transition plans for families are also thought to provide parents with support in continuing to achieve parenting goals once families are no longer receiving program services. For example, transition plans may play an especially important role for families with higher needs who require a variety of community resources/ services in order to meet or sustain their goals (Golden et al., 2011). Despite the implications of the importance of continuity derived from the field of early care and education, limited efforts have been made to explore the content and quality of transition plans within home visiting programs.

Best Practice Element	Research Support
Program Recruitment and Enrollment	<ul style="list-style-type: none"> <li>Effect sizes for child cognitive outcomes are higher for home visiting programs with targeted enrollment (Sweet &amp; Appelbaum, 2004). **</li> <li>Effective prevention programs provide services in a timely manner – when families express interest and are receptive to and in need of services (Nation et al., 2003).</li> </ul>
Prenatal Enrollment	<ul style="list-style-type: none"> <li>Prenatal enrollment is associated with significantly better birth outcomes – specifically associated with a significantly reduced risk of delivering a low birth weight baby (Lee et al., 2009). **</li> <li>Participants that enrolled in home visiting during pregnancy have longer enrollment lengths and complete more home visits (Daro et al., 2003). **</li> </ul>
Frequency and Length of Services	<ul style="list-style-type: none"> <li>Effective prevention programs have minimum requirements for the frequency of home visits to be completed (Wagner et al., 2000).</li> </ul>

Best Practice Element	Research Support
Frequency and Length of Services	<ul style="list-style-type: none"> <li>• Programs demonstrate greater effect sizes on child and family outcomes as the number and hours of home visits increase (Sweet &amp; Appelbaum, 2004). **</li> <li>• It is necessary for programs to have more than 12 visits per year, one visit a month, to achieve program effect sizes greater than zero. Effect sizes tripled in studies with 60 or more visits in a year, five visits in a month (Cassady &amp; VanEgeren, 2002). **</li> <li>• There is a significant relationship between the number of completed visits and positive child outcomes in cognitive development and physical health (Wagner et al., 2001). **</li> <li>• Duration of enrollment in program services significantly predicts parent support for language and literacy (Raikes et al., 2006). **</li> <li>• Parents who drop out of program services early had lower total scores on the HOME observation and were observed as less supportive of their child's play (Roggman et al., 2008). **</li> </ul>
Transition Plans	<ul style="list-style-type: none"> <li>• Effective prevention programs link participants to a wide array of community services (Nation et al., 2003; Small, Cooney, &amp; O'Connor, 2009).</li> <li>• Programs serving families with greater need (e.g. mothers suffering from depression) should provide explicit transition plans as families leaving home visiting programs (Golden et al., 2011).</li> <li>• Programs can facilitate continuity of care by providing explicit transitions to child care for children that are aging out of program services (Golden et al., 2011).</li> </ul>

\*\* Literature is specific to home visitation and based on empirical research.

## Program Characteristics and Content

### Program Model

A theoretically based program model ensures that programs have considered their program model and tied program objectives and outcomes to specific program components (Daro, 2009). The process of developing a well articulated theory of change can help programs identify and implement specific service components necessary for achieving meeting program objectives and outcomes (Small, Cooney, & O'Connor, 2009). In addition to a theoretically driven program model, the components within a model (e.g. specific activities and content) may be based in theory and/or empirical research. General consensus implies that programs are more likely to achieve outcomes when program activities and content are grounded

in empirical research and/or theory (Small et al., 2009; Nation et al., 2003). Additionally, home visiting staff awareness of the programs' theory of change is necessary for fidelity of implementation. Prior research demonstrates that vague or flawed theories of change limit home visitors' understanding of program goals and lead to inconsistent implementation of key performance standards; thereby limiting program effectiveness (Hebbler & Gerlach-Downie, 2002).

### Services Tailored to Family Strength and Need

There is a general consensus within the field that effective programs have initial and ongoing processes in place to assess family strengths and needs in order to individualize services (Peterson et al., 2004). In addition to ensuring services are relevant to family strength and needs, programs that are socioculturally relevant to

relevant to participants are more effective (Nation et al., 2003; Kumpfer, Alvarado, Smith, & Bellamy, 2002). For example, one empirical investigation of cultural relevance compared the results of interventions using the generic version of the Strengthening Families Program to interventions using culturally modified versions. Their results suggest that while overall results were only slightly better in the culturally modified interventions, recruitment and retention of families was 41% higher in the culturally modified interventions and completion rates went from 45% to 85% for particular subgroups of participants in the culturally modified interventions (Kumpfer et al., 2002).

#### **Program Emphasizes Child Development and Well Being**

Research to support this best practice element overlaps with research listed in table B1, home visitor promotion of child development and well being. Some of the citations (e.g. Knoche et al., 2010; Roggman, Boyce, & Cook, 2009) are intervention evaluations that augmented program materials and resources with professional development, coaching, and strategies meant to promote child development and well being. In these studies, home visitor practices are compared across programs that did or did not receive the intervention (treatment and control groups). For example, Knoche et al. (2010) assessed differences in home visitor practices across intervention and

control groups using a randomized control trial. These interventions lend credence to the importance of overall program support and emphasis on child development and well being, with an indirect impact on program outcomes achieved through changes in home visitor practices. However, there is little research on how variations across programs in standard program materials, resources, supervision, and professional development impact home visitor practice or program outcomes.

#### **Program Emphasizes Strong Working Relationships with Families**

As in the best practice element focused on child development and well-being, it is often difficult to disentangle the effects of home visitors' ability to form relationships with families from the programs' emphasis on strong working relationships. However, there is research to indicate that the home visitor-family relationship relates to family engagement and retention (Allen, 2007). There is also evidence that the home visitor caseload, which is controlled by the program and influences the home visitor-family relationship, predicts the number of completed home visits (Daro et al., 2003). Additional research is needed to understand how and if program emphasize on strong working relationships with families translates to home visitor's ability to form strong working relationships with families.

Table B3.

## PROGRAM CHARACTERISTICS AND CONTENT

Best Practice Element	Research Support
Program Model	<ul style="list-style-type: none"> <li>• Effective prevention programs are theory driven with explicit links between program elements and desired outcomes (Daro, 2009; Nation et al., 2003; Small et al., 2009; Weiss &amp; Klein, 2006).</li> <li>• Home visiting staff feels their job performance is improved through clear and shared program goals, along with quality standards and written policies or guidelines (Home Visiting Forum, 2006).</li> <li>• Effective home visiting programs tend to identify key program performance standards (Paulsell, Avellar, Sama Martin, &amp; Del Grosso, 2010).</li> <li>• Home visiting staffs with limited awareness of program goals and program theory of change are not able to successfully relay program expectations to parents, restricting program effectiveness (Hebbeler &amp; Gerlach-Downie, 2002).</li> <li>• Effect sizes for programs that are implemented with fidelity to their program model demonstrate 2-3 times greater effects than programs that are not properly implemented (Durlak &amp; DuPre, 2008).</li> </ul>
Program Emphasizes Child Development and Well Being	<ul style="list-style-type: none"> <li>• Home visits with more time focused on child development predict greater cognitive and language development in children, greater parental support for language development, and higher overall scores for home learning environments (Raikes et al., 2006). **</li> <li>• Parents are more likely to drop out of programs if home visits are more staff-parent or family focused (versus child focused). Longer enrollment lengths are associated with more child focused home visits (Roggman et al., 2008). **</li> <li>• Children in intervention group for interventions designed to increase home visitor facilitation of positive parent-child interactions have more secure base behaviors and more age appropriate progress in cognitive development, relative to children in control group (Roggman, Boyce, &amp; Cook, 2009). **</li> <li>• Global ratings of parent engagement in home visits are significantly higher when home visits have a greater focus on parent-child interactions (Knoche et al., 2010). **</li> <li>• Mothers are more likely to be engaged in home visit activities when staff discuss child development information using strategies that involve parents in direct interactions with their children rather than through conversation (62% high engagement in direct interactions versus 26% high engagement in strategies using conversation) (Peterson et al., 2007). **</li> </ul>
Program Emphasizes Strong Working Relationships with Families	<ul style="list-style-type: none"> <li>• Effective prevention programs focus on fostering positive relationships between staff and participants and helping participants to foster positive relationships with their family member and the community (Nation et al., 2003; Small et al., 2009).</li> <li>• Lower home visitor caseloads predict higher completion of home visits (Daro et al, 2003). **</li> <li>• Parent home visitor relationship was the strongest predictor of the intensity of program services received (as rated by parent) – accounting for 21% of the variance (Allen, 2007) **</li> </ul>

Table B3.

**PROGRAM CHARACTERISTICS AND CONTENT (CONTINUED)**

Best Practice Element	Research Support
Services Tailored to Family Strengths and Needs	<ul style="list-style-type: none"> <li>• Programs using a culturally modified version of a standard youth program demonstrated slightly higher impacts on child and family outcomes, significantly increased family recruitment and retention, and improved completion rates for particular subgroups of participants (Kumpfer et al, 2002).</li> <li>• Programs working with children and families at risk are more likely to succeed if they are responsive to family needs and promote family resiliency using a standardized assessment process at intake to identify a range of child and family issues (Peterson et al., 2004).</li> <li>• Programs that adapt services to the community and family needs have positive impacts on program outcomes (above standard program services) (Durlak &amp; DuPre, 2008).</li> <li>• Training home visitors in motivational interviewing to ask parents open-ended questions, engage in reflective listening, and understand parental values and motivation to change behaviors may relate to significantly higher retention rates (Girvein, DePanfilis, &amp; Daining, 2007).</li> </ul>

\*\* Literature is specific to home visitation and based on empirical research.

## Program Management and Development

### Leadership Qualifications and Practice

A commonality across effective prevention programs is well qualified and experienced leadership staff (Durlak & DuPre, 2008; Peterson et al., 2007). It is often seen as key that leadership staff are well educated within the field of early education and have sufficient experience in program management and sustainability. Within the fields of early care and education, leadership qualifications and practice are relatively well understood and outlined (Zero to Three, 2011). However, there is little empirical research investigating the impact of leadership qualifications and practice on actual program service delivery. Additionally, there is limited research on the supports and structures leadership staff need in order to implement high quality leadership practice.

### Work Environment

A positive work environment with the materials and support necessary to complete work is important in promoting positive staff morale, preventing burnout,

preventing staff turnover, and quality job performance (Home Visiting Forum, 2006). In focus groups and interviews with home visiting staff, the Home Visiting Forum (2006) found staff viewed several components of the work environment as essential to quality job performance. These components included: fair salary and compensation, adequate facilities, sufficient administrative support, supervisor availability, and peer to peer training or mentoring (Home Visiting Forum, 2006). Additionally, work environment significantly predicted child outcomes in state child welfare agencies—where agencies with higher rates of positive organizational climate demonstrated stronger outcomes in improving negative child behavior (Glisson, 2010).

### Professional Development

Home visiting staff requires both initial and ongoing professional development to support their key competencies and knowledge of children and families. Less pre-service and ongoing staff training is associated with weaker program outcomes (Gomby, 2005;



Yoshikawa, Rosman, & Hsueh, 2002). Additionally, ongoing staff development supports consistent implementation of program components, prevents staff burnout, bolsters staff qualifications and assists staff in processing difficult cases (Gomby, 2005; Yoshikawa et al., 2002). Evaluations of professional development interventions for home visiting staff also demonstrate the efficacy and benefits of ongoing professional development. For example, evaluations of professional development interventions completed by Roggman et al (2009) and Knoche et al. (in press) have found significant positive outcomes for children and families. Lastly, in qualitative interviews, home visitors expressed a need for professional development on a variety of topics related to early childhood, family systems, skills in conducting group services, and mentoring (Home Visiting Forum, 2006).

### Supervision

One commonality across programs with demonstrated efficacy is access to and requirements for ongoing high quality supervision (Paulsell et al., 2010). McGuigan, Katzev, & Pratt (2003) found that families were more likely to remain in home visiting programs when their home visitors received more hours of direct supervision. There is also a general consensus among

leading researchers within the field of high quality supervision as a key indicator of home visiting program quality (Daro, 2009; Weiss & Klein, 2006). In particular, reflective supervision is noted as an essential form of supervision for service providers in early childhood (e.g., Weatherston, Weigand, & Weigand, 2010), but there is little empirical evidence to support this claim.

### Written Policies and Strategic Plans

Although there is little indication that this has been studied specifically in home visiting programs, programs in prevention and human services with specific plans and policies are generally considered to be stronger in implementation (Durlak and DuPre, 2008). Written guidelines are related to program sustainability (Livet et al., 2008).

### Community Partnerships & Resource Networks

As with written policies and strategic plans, community collaborations are seen to enhance program implementation in prevention programs (Durlak & DuPre, 2008). Although resource and referral is often seen as a central component of home visiting programs, there is little research linking program efforts at these collaborations with increased effectiveness.

Table B4.

## PROGRAM MANAGEMENT AND DEVELOPMENT

Best Practice Element	Research Support
Leadership Qualifications	<ul style="list-style-type: none"> <li>• Effective prevention programs have well qualified and competent leadership (Peterson et al., 2004).</li> <li>• When staff perceive leadership as effective, they are more likely to implement program planning and sustainability efforts (Livet, Courser, &amp; Wandersman, 2008).</li> </ul>
Leadership Practice	<ul style="list-style-type: none"> <li>• Effective leadership staff is essential for quality program implementation and program ability to incorporate innovative strategies into existing services (Durlak &amp; DuPre, 2008).</li> </ul>

Table B4.

**PROGRAM MANAGEMENT AND DEVELOPMENT (CONTINUED)**

Best Practice Element	Research Support
Work Environment	<ul style="list-style-type: none"> <li>• Home visiting staff felt they need: fair salary and compensation; adequate facilities, equipment, and administrative support for quality job performance (Home Visiting Forum, 2006).</li> <li>• Organization climate significantly predicts child outcomes – child welfare agencies with engaged staff (staff with high job morale and satisfaction) demonstrate significantly stronger outcomes on child behavior (Glisson, 2010).</li> </ul>
Written Policies and Guidelines for Program Administration	<ul style="list-style-type: none"> <li>• Programs with more formalized policies and guidelines are more likely to engage in sustainability planning; higher levels of program formalization are associated with greater use of sustainability process use (Livet et al., 2008).</li> </ul>
Professional Development	<ul style="list-style-type: none"> <li>• Professional development for staff relates to the quality of early childhood program and quality predicts child developmental outcomes (Bowman, Donovan, &amp; Burns, 2000)</li> <li>• Effective prevention programs have specific pre-service training requirements (Paulsell et al., 2010).</li> <li>• Home visiting staff felt quality job performance requires professional development in: early childhood, family systems, supervision skills, skills conducting group services, proposal writing, and mentoring (Home Visiting Forum, 2006).</li> </ul>
Supervision	<ul style="list-style-type: none"> <li>• Effective prevention programs provide high quality supervision with minimum requirements for the frequency of supervision and supervisor observations of provider and participant (Daro, 2009; Paulsell et al., 2010; Weiss &amp; Klein, 2006).</li> <li>• Highly effective early childhood programs actively engage teachers and provide high-quality supervision (Bowman et al., 2000).</li> <li>• Families were more likely to remain in the program when their home visitors received more hours of direct supervision (McGuigan et al., 2003)</li> </ul>
Strategic Planning	<ul style="list-style-type: none"> <li>• Effective family prevention programs have strategic plans that include aspects of program funding and sustainability (Peterson et al., 2004).</li> <li>• Existing reviews of factors related to enhancing program implementation agree that funding and sustainability planning are essential for quality program implementation (Durlak &amp; DuPre, 2008).</li> <li>• Program planning and evaluation helps programs develop a shared vision for program goals and outcomes (Livet et al., 2008).</li> </ul>
Community Partnerships/ Resource Networks	<ul style="list-style-type: none"> <li>• Effective prevention programs have an understanding of the community with links to other community services, resources, and support (Daro, 2009; Peterson et al., 2004, Weiss &amp; Klein, 2006).</li> <li>• Community collaborations and partnerships enhance program implementation (Durlak &amp; DuPre, 2008).</li> </ul>

## Progress Monitoring

### Program Monitoring and Attention to Outcomes.

Just as a well-articulated theory of change is important for program efficacy, monitoring program service implementation and documenting outcomes is important for program fidelity, sustainability, and ongoing improvement efforts (Daro, 2006; Small et al., 2009). Guidelines and policies for monitoring program service delivery ensure that the program is aligned with the program performance standards and that there is a shared vision and goal among program staff. Additionally, ongoing processes for monitoring program services allows programs the opportunity to

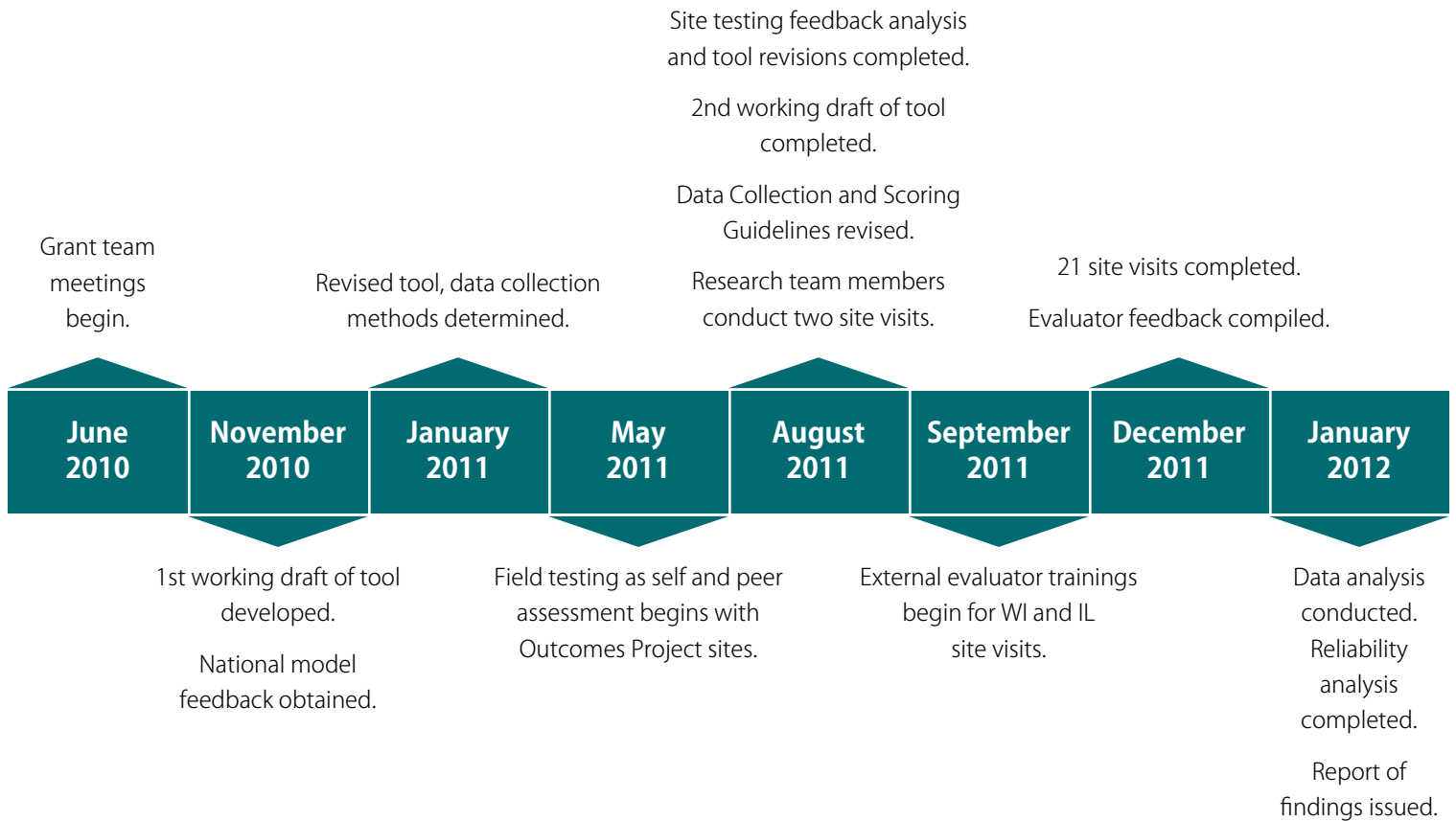
identify their strengths and areas for improvement. In this era of accountability, there is a strong emphasis on the importance of program documenting outcomes, and there are guides to programs that emphasize the need to track implementation and outcomes (e.g., ACF, 2010). The relationship between monitoring/evaluation and efficacy of the program has not been well-studied in early childhood home visitation, although Fixsen and colleagues, in their general overview of implementation across many different fields, notes the importance of an accurate monitoring and feedback system in place for quality program implementation (Fixsen, Naoom, Blase', Friedman, & Wallace, 2005).

Table B5.

### PROGRAM MONITORING

Best Practice Element	Research Support
Program Monitoring	<ul style="list-style-type: none"> <li>• Effective prevention programs are well documented and committed to program evaluation and refinement (Daro, 2006; Small et al., 2009; Fixsen et al., 2005).</li> <li>• Youth programs that monitor implementation obtain effect sizes for program outcomes that are 3 times larger than programs that report no monitoring efforts (DuBois, Holloway, Valentine, &amp; Cooper 2002).</li> </ul>
Outcome Measurement	<ul style="list-style-type: none"> <li>• Effective prevention programs are well documented and committed to program evaluation and refinement (Daro, 2006; Small et al., 2009).</li> </ul>

**Project Timeline**



Appendix D

Examples from HVPQRT Data Collection and Scoring Guides

**A2: Promotion of Child Development and Well-being**

- 1) HVPQRT Individual home visitor scoring materials for Indicator Rows 1 -3**
- 2) Example of case vignette**
- 3) Scoring Decisions (aggregation of home visitor scores)**

**B5: Transition Plans**

**C4: Services Tailored to Family Strengths & Needs**

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**Individual Home Visitor: Interview Questions about Home Visitor Practice**

**A2. Child Development and Well-being**

<p><b>CHILD DEVELOPMENT ACTIVITIES (IR1)</b></p> <p>1. How do you work with parents to help them understand their child's development?</p> <p>2. What kind of things do you do with families? How do you give them the information?</p> <p><i>Follow-up probes</i></p> <p>What kinds of screenings or assessments do you use in your work with families?</p> <p>How do you use them in your work? --How often do you do screenings? --How are they administered? --What do you do with the results?</p>	<p>___ Home visitor notes specific activities:</p> <p>___ Developmental screening (Name: _____)</p> <p>___ Regularly administered; Frequency: _____</p> <p>___ Parents fill out ___ Home visitor collaborates with family in administration</p> <p>___ Uses results to plan activities with families</p> <p>___ Uses results to refer for services (e.g. early intervention)</p>
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<p><b>PARENT-CHILD RELATIONSHIP (IR3)</b></p>	<p>3. During home visits, what does it look like when you are helping to promote the parent-child relationship?</p> <p>What kind of things do you do with the parent and child?</p> <p>What kinds of screenings or tools do you use to assess the parent-child relationship?</p> <p><i>Follow-up probes</i>          How do you use them in your work?          --How often do you assess this?          --What do you do with the results?</p> <p>_____ HV notes specific activities/approach to promote relationships</p> <p>_____ <b>Parent-child relationship screening/assessment</b></p> <p>Name of tool: _____</p> <p><i>Note: If mention ASQ-SE, ask how they specifically use it in regards to parent-child work</i></p>
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### Case Vignette Example

#### **To Home Visitor:**

We are going to shift gears here. I am now going to read you three vignettes that cover typical experiences that home visitors face. I'll ask you the same set of questions after each vignette. I am interested in your approach for dealing with each issue presented. There is no one "right" way to respond, so try answer them the best you can based on your experience working with families, with as much detail as you can. Here is the first one:

*NOTE: Provide Home Visitor with written vignette so that they can read along, but do not show them the checklist. Place a mark next to each checklist item when it is brought up spontaneously by the home visitor. The checklist is not to be used as a prompt for responses. It is not expected that home visitor responses will address every aspect of the checklist for each vignette.*

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a. You arrive for a visit with a family with a toddler 20 months old. You and the mother have both noticed that the child does not use many words, and what words she does have are understandable to the mother, but not to you. The mother has tried to bring this issue up with the child’s doctor, but the doctor did not seem concerned, so the mother was not sure what to do.

- a. What are the most important issues to address?
- b. What additional information would you want to know?
- c. What (else) would you do to help?

CHECKLIST: Place a check mark next to the descriptor when included in home visitor response.

Home Visitor notes:	Content Area
Providing information regarding toddler language development/delay	1 Child development
Using developmental screening tools to gather more information	
Strategies mother can use to promote language development	
Ruling out physical problem (e.g., hearing)	2 Child health/safety
Using child health screening tools to gather more information	
Problem-solving or facilitating mother’s relationship with child’s doctor (note: code both 2 and 7 if issue is discussed )	2 Child health/safety
Parent-child relationship and impact on child’s language development	7 Referrals for services
Focus on home visitor’s relationship with mother (e.g., her role with mother)	3 Parent-child relationship
Home visitor curious & asks multiple questions to better understand family	4 Relationship with family
Cultural/family language issues	5 Individualization of response
Reflects on role of own cultural background in thinking	6 Cultural considerations
Referrals for services (e.g, early intervention)	7 Referrals for services
Specific resources in community	
Other (Note):	
Other (Note):	

NOTES:

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## HOME VISITOR SUMMARY SCORING A2

This scoring section combines responses to interview questions and to vignettes to determine a single score representing the individual home visitor competencies. Review responses to *CHILD DEVELOPMENT/WELL-BEING* (pages 4-6) and *VIGNETTE SCORING SUMMARY*. Use the rating below that best represents the home visitor's skills. **Note that even scores are allowed here.**

### 1 Child Development

- \_\_\_ 1 Home visitor does not use screenings OR does not mention child development in any vignettes
- \_\_\_ 2
- \_\_\_ 3 Home visitor uses child development information in basic ways, mentions only once in vignettes
- \_\_\_ 4
- \_\_\_ 5 Home visitor plans visits with family using screenings, mentions child development activities in at least two vignettes
- \_\_\_ 6
- \_\_\_ 7 Home visitor individualizes child development activities to families, as noted in general response and in all three vignettes

### 2 Health & Safety

- \_\_\_ 1 Home visitor does not use screenings or does not mention child health/safety issues in any vignettes
- \_\_\_ 2
- \_\_\_ 3 Home visitor uses child health/safety information through screenings, mentions once in vignettes
- \_\_\_ 4
- \_\_\_ 5 Home visitor discusses medical home for child and well-being of parents, focus on child health in two vignettes
- \_\_\_ 6
- \_\_\_ 7 Home visitor has strong focus on child health, as noted in general response and in all three vignettes

### 3. Parent-Child Relationship

- \_\_\_ 1 Home visitor cannot articulate focus on parent-child relationship AND does not mention in any vignette
- \_\_\_ 2
- \_\_\_ 3 Home visitor shows some knowledge of parent-child relationships in work, AND mentions in at least 1 vignette
- \_\_\_ 4
- \_\_\_ 5 Home visitor administers parent-child relationship assessment AND mentions in at least 2 vignettes
- \_\_\_ 6
- \_\_\_ 7 Home visitor shows very strong focus on parent-child relationship in statements AND mentions in all 3 vignettes

*Record scores for this home visitor on DCSG for Section A*

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## **A.2 - Promotion of child development and well-being**

### **INTENT**

The intent of this scale is to assess the home visitor's ability to translate knowledge of infant/toddler development, health, and safety issues into their work with families. This includes their ability to incorporate issues of maternal health and well-being and its impact on child well-being, as well as the promotion of the parent-child relationship. It also includes use of different screening tools

### **DATA COLLECTION METHOD/SOURCE**

Home visitor interview (including case vignettes)

### **NOTES:**

Home visitor interviews are recorded on separate worksheets. Each worksheet ends with summary scores for the home visitor. Vignettes will be scored based on checklist documenting topics successfully addressed by home visitors in their responses, as well as a rating scale assessing the extensiveness and quality of the home visitor's ability to remain focused on the promotion of the parent-child relationship.

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**Summary sheet for individual home visitor reports**

Use the table below to record scores from pg 17 of Individual Home Visitor Scoring Materials for each home visitor interviewed

Content Area	Home visitor				Notes
	A	B	C	D	
1 Child Development					
2: Health & Safety					
3: Parent-child Relationship					

**Scoring Decision: A2**

Child Development (Indicator Row 1)	Health & Safety (Indicator Row 2)	Parent-Child Relationship (Indicator Row 3)
<p>A. <u>&gt;</u>75% of HV have score of 3 or more            ___ NO: Check 1.1 and stop            ___ YES: Check 1.3 and go to B</p> <p>B. All HV have score of 5 or more            ___ NO: Stop            ___ YES: Check 1.5 and go to C</p> <p>C. All home visitors have score of 7            ___ NO: Stop            ___ YES: Check 1.7</p>	<p>D. <u>&gt;</u>75% of HV have score of 3 or more            ___ NO: Check 2.1 and stop            ___ YES: Check 2.3 and go to E</p> <p>E. All HV have score of 5 or more            ___ NO: Stop            ___ YES: Check 2.5 and go to F</p> <p>F. All home visitors have score of 7            ___ NO: Stop            ___ YES: Check 2.7</p>	<p>G. <u>&gt;</u>75% of HV have score of 3 or more            ___ NO: Check 3.1 and stop            ___ YES: Check 3.3 and go to H</p> <p>H. All HV have score of 5 or more            ___ NO: Stop            ___ YES: Check 3.5 and go to I</p> <p>I. All home visitors have score of 7            ___ NO: Stop            ___ YES: Check 3.7</p>

**Subscale B5. Transition Plans**

**Intent:** The intent of this scale is to ensure that programs have intentional, proactive, and formal processes for assisting families to successfully transition out of program services.

**Data Collection Method/Source:** Program Director Interview.

<b>B5. Data Collection Worksheet: Transition Plans</b>	
<b>Indicator Row #1</b>	
<p>1. Are there written guidelines and policies for developing and providing transition plans for families that are exiting the program?</p> <p>If yes, how would you describe these guidelines?  <i>For example, are they:</i></p> <ul style="list-style-type: none"> <li>a) <i>Informal and flexible, home visitor decides how to proceed</i></li> <li>b) <i>Formal and general, they provide the home visitor with a general guide and timeline for developing transition plans</i></li> <li>c) <i>Formal and specific, they provide the home visitor with detailed guide and specific outline for developing transition plans.</i></li> </ul>	<p><b>*if no guidelines, mark indicator 1.1</b></p> <p>Based off program answers, are the guidelines:</p> <ul style="list-style-type: none"> <li>___ Informal (not documented) (1.3)</li> <li>___ Formal and Basic (1.5)</li> <li>___ Formal, Specific, and Comprehensive (1.7)</li> </ul> <p><b>*Use guidelines to mark the indicators satisfied in indicator row #1.</b></p>
<b>Indicator Row #2</b>	
<p>2. Are transition plans:</p>	<p>___ Mainly limited to informal discussions (2.3)</p> <p>___ Formally documented (2.5)</p> <p><b>*if limited to informal discussions, mark indicator 2.3. Must be formally documented to score 2.5 or higher.</b></p>
<p>3. When are transition plans developed?</p>	<p>___ Final home visit (2.1)</p> <p>___ Unclear or left to discretion of home visitor (2.3)</p> <p>___ At least 3 months before program exit (required for 2.5)</p>

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<p>4. Who is involved in developing transition plans? How do you develop them?</p>	<p>___ At least 6 months before program exit <b>(required for 2.7)</b></p> <p>___ Standard transition plans—mainly home visitor</p> <p>___ Collaboration with family and home visitor <b>(required for 2.5)</b></p> <p>___ Includes referral agencies <b>(required for 2.7)</b></p>
<p>5. What sources of support does the program or home visitor typically offer families as they transition out of the program and enact transition plans:</p> <p><i>Note: Interviewer can ask if specific sources are provided if they are not spontaneously mentioned</i></p>	<p>___ Referrals (e.g. child care, health care)</p> <p>___ Resources (e.g. brochures, information, etc.).</p> <p>___ Providing assistance to families in accessing transition services.</p> <p>___ Continued communication between visitors and family.</p> <p>___ Tapering off services as families transition.</p> <p>___ Formal partnerships with referral agencies used during transition (e.g. child care).</p> <p><b>*Must include at least 2 sources of support to score 2.5. Must include 3 or more sources of support to score 2.7.</b></p>
<p>6. Does the program provide transition services, to the extent possible, regardless of the families' reason for leaving? For example, do you attempt to find services for families relocating or coordinate with agencies where family relocates?</p>	<p>___ Transition plans limited to family leaving due to graduation or age out</p> <p>___ Transition plans include family leaving for other reasons (e.g., relocation) <b>(Required for 2.7)</b></p>

\*Use information gathered in questions 2-6 to mark indicators satisfied in indicator row #2 for subscale B5.

\*Transition plans must be at least informally discussed to score 2.3 or higher.

\*Transition plans must be formally discussed, completed at least three months in advance of program completion, developed collaboratively between home visitor and family, and include 2 or more sources of support in question 5 to score 2.5 or higher.

\*Transition plans must be formally discussed, completed at least six months in advance of program completion, include referral agencies, provide at least 3 sources of support for question 5, and attend to families leaving program for various reasons (relocating, lack of time, etc.) to score 2.7.

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### Subscale C.4 Services Tailored to Family Strengths & Needs

**INTENT:** The intent of this scale is to capture the ways in which the program allows tailoring of services to the unique needs of participating families. This is conceptualized as: i) the processes involved in assessing family need; and ii) how program materials are adapted to the diverse needs of participating families.

**DATA COLLECTION METHOD:** Program Director/Supervisor Interview

<b>Indicator Row 1: ASSESSMENT OF FAMILY NEED</b>		
1. How are family needs assessed when they first enter the program?	<input type="checkbox"/> Informal <input type="checkbox"/> Risk assessment only <input type="checkbox"/> Multiple methods used <input type="checkbox"/> Formal method(s) noted	<p><b>*If no method of assessing family needs, mark indicator 1.1.</b></p> <p>Note methods to assess needs &amp; strengths:</p>
2. Do you use specific tools or instruments?		
3. What areas of the family does it cover?	<input type="checkbox"/> Demographics <input type="checkbox"/> Risk factors <input type="checkbox"/> Protective factors or strengths <input type="checkbox"/> Family concerns/needs <input type="checkbox"/> includes additional family members	<p><b>*If limited to demographics or risk factors, mark indicator 1.3.</b></p>
4. How often are family needs reviewed and revised?	<input type="checkbox"/> Done at intake <input type="checkbox"/> Used as part of ongoing monitoring	
5. How are assessments of family strengths and needs used in tailoring program service delivery or content to individual families?	<input type="checkbox"/> Not used	

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<p><i>Examples: establish visit frequency, need for referrals, and specific program content</i></p>	<p>— Individualize services to families</p>
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**Checklist, C4, Indicator Row #1**

<b>Assessment of Family Needs</b>	Yes	No	Notes
No consistent method of assessing family needs (1.1)			
Family needs assessment occurs only initially and addresses only demographics/risk factors (1.3)			
Family needs addresses both protective factors/family strengths (1.5)			
Assessment of family strengths and needs used to individualize services to families (1.5)			
Family needs are reviewed on an ongoing basis (1.5)			
Multiple methods used to assess family needs and strengths (1.5)			
Family needs goes beyond immediate concerns of parent-child dyad (1.7)			

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Indicator Row 2: ADAPTION TO DIVERSE FAMILY NEEDS		Notes
<p>1. How are service materials adapted to meet the diverse needs of enrolled families?  <i>Examples:</i>                      Cultural relevance*                      Language                      Parent educational background/literacy level                      *Note culture can consider LGBTQ</p>	<p><input type="checkbox"/> No adaptations noted</p> <p><input type="checkbox"/> Language</p> <p><input type="checkbox"/> Literacy/Educational</p> <p><input type="checkbox"/> Cultural</p>	<p><b>List examples:</b></p> <p><b>NOTE: All 3 must be checked for 2.5</b></p> <p><b>NOTE: If program uses translators only, then score 2.3</b></p>
<p>2. What processes do you use to ensure the adapted materials are relevant to the families?                       How engaged are families in the process of making any changes?                       How do you involve <u>outside</u> members of community or cultural groups to review program content, materials, or services?</p>	<p><input type="checkbox"/> Internal review only</p> <p><input type="checkbox"/> Family collaboration</p> <p><input type="checkbox"/> Community input</p> <p><input type="checkbox"/> Cultural consultants</p>	<p><b>NOTE: At least 1 must be checked for 2.7</b></p>

**Checklist, C4, Indicator Row #2**

Service Adapted to Diverse Family Needs	Yes	No	Notes
Service materials are not adapted to diversity of family needs (2.1)			
Some adaptation of materials for diversity of family needs (1 or 2 items checked in question 1) (2.3)			
Adaptation of materials for diversity of family needs (3 items checked in question 1) (2.5)			
Adaptation of materials for diversity of family needs includes collaborations with at least one: family, community, or cultural representatives (2.7)			

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## Membership Team Lists

### Core Research Team

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### Analysis and Design Team

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Healthy Families America Program Representative: Bonnie Phernetton, Program Director, Family Services of NEW, Healthy Families of Brown and Door County

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### Advisory Team

Karen Guskin, Ph.D., Director of Research and Evaluation, National Center for Parents as Teachers, St. Louis, MO

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Ann Stueck, Infant and Child Health Nurse Consultant, Wisconsin Department of Health Services, Division of Public Health

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## Sample Site Visit Report

This report includes a summary of the data collected through the online surveys, interviews, and documentation review. If we also observed a group activity, results from this will be provided separately.

Evaluators used the recently-developed Home Visiting Program Quality Tool (HVPQRT) as a framework to guide their review of your program. The HVPQRT was developed to measure the quality of home visiting programs across 5 dimensions (or scales). Each scale is divided into more specific subscales. Programs are rated on each subscale using specific indicators that chart a progression from lower to higher quality features.

As part of your participation in the project, we agreed to provide feedback to you based on the evaluators' review of your program. We will not, however, provide you with specific numerical "scores." The reason for this is that the tool is still in the process of being field-tested. Although its content has been reviewed by home visiting experts and program leaders, we need to do further validity testing in order to be fully confident how differences in numbers represent true differences in program quality. That is, the evaluators may have reached agreement on whether a program scored high (or low) on a particular dimension (e.g., home visitors provide resources and referrals), but we need further testing to determine how meaningful the differences are between a program that did score high and one that scored lower.

The feedback we provide here, for that reason, is a text summary. Evaluators looked at the scores they provided and highlighted areas that they, in particular, saw as overall strengths of your program, as well as areas where you may consider quality improvement efforts. We also included some overall recommendations that may help you as you think about your program. We welcome any feedback or questions you may have. **It is important to note that the recommendations we provide are not in any way to be seen as mandates.** They are suggestions based on the perspective of outside observers using information they were able to collect in the course of the site visits. This document is not being shared with anyone else – it is provided to you only for your own program planning efforts.

## Scales and Subscales for Home Visiting Program Quality

### Scale A: Home Visiting Staff Qualities

1. Education and professional experience
2. Promotion of child development and well-being
3. Working with families
4. Referrals and follow-up

### Scale B: Program Service Delivery

1. Program recruitment and enrollment
2. Prenatal enrollment
3. Frequency and length of services
4. Family outreach/involvement
5. Transition plans

### Scale C: Program Characteristics

1. Program model
2. Program emphasizes child development and well-being
3. Program emphasizes strong working relationships with families
4. Services tailored to family strengths and needs

### Scale D: Program Management and Development

1. Leadership qualifications—Management and staff supervisors
2. Leadership practice
3. Work environment
4. Written policies and guidelines for program administration
5. Professional development
6. Supervision
7. Strategic planning
8. Community Partnerships/Resource Networks

### Scale E: Progress Monitoring

1. Program monitoring
2. Outcome measurement

## Strengths and Areas of Improvement by Scale

### Scale A: Home Visitor Staff Qualities

#### Strengths

1. **Relationship-building with families:** Home visitors are able to identify and employ specific strategies to promote positive relationships with families. Home visitors are committed to building positive and trusting partnerships with families.
2. **Connecting families with resources:** Home visitors have working relationships with various community resources and/or referral agencies. Home visitors are dedicated to connecting families with available community resources and attend inter-agency meetings to stay updated on available community resources.
3. **Experience with families.** All home visitors have a substantial amount of experience working with young children and their families.

#### Suggested Areas for Improvement

1. **Using developmental screenings:** Home visitors could increase the frequency at which they administer developmental screenings. They could use regularly scheduled developmental screenings to individualize home visiting activities/content and promote healthy child development.
2. **Working with families:** The program could provide additional support to home visitors on promoting positive relationships with families who are experiencing multiple stressors and those that are more difficult to engage in program services. Home visitors may also benefit from additional support around monitoring and facilitating positive parent-child interactions.

### Scale B: Program Service Delivery

#### Strengths

1. **Recruitment and enrollment:** The program has specific guidelines for the recruitment and enrollment of families. There is an established eligibility process to ensure the program is serving their target population. There are also established guidelines for enrolling families in services and a majority of families enroll within one month of contacting the program.
2. **Transition services:** The program has formal written guidelines and policies for developing transition plans as families leave the program. Transition plans are a partnership between home visitors and families and are developed well in advance of program completion. Home visitors continue to assist families as they transition out of the program.
3. **Family outreach:** The program offers quarterly supplemental family or socialization events.

#### Suggested Areas for Improvement

1. **Intended visit completion:** The program may benefit from ensuring that families are completing a substantial portion of their intended visits. This may be achieved by using the established data management system to monitor the percentage of intended visits families are completing.
2. **Encouraging family involvement:** In addition to offering quarterly supplemental family or socialization events, the program could work towards involving additional family members in regularly scheduled home visits and establishing structures to encourage parental involvement beyond home visits (e.g. parent council, advisory board).

## Strengths and Areas of Improvement by Scale (Continued)

### Scale C: Program Characteristics

#### Strengths

1. **Program model is strong:** The program uses an evidence informed model with a well-established curriculum that places consistent emphasis on the content areas of child development, child health and safety, and parent-child relationships.
2. **Supporting positive relationships with families:** Home visitors' caseloads are well managed and allow staff to devote sufficient time and attention to individual families. The program director also observes home visits, using a standard observational form, to monitor the quality of the relationship between home visitors and families.
3. **Services tailored to family strengths and needs:** Family needs assessments are conducted initially and are used to develop Individual Family Service Plans (IFSP) for all families. The program director and home visitors work together to tailor services to families' needs and strengths and continually monitor individual families' IFSP.

#### Suggested Areas for Improvement

1. **Program monitoring:** The program could work towards more formal identification of key program performance standards and a consistent method for monitoring program adherence to key performance standards. This would help ensure the program is being implemented with commitment to the program model/curriculum and to identify possible areas for program improvement.
2. **Awareness of program model:** Program leadership could work with staff to ensure they have a common understanding of the program model, goals, and expected outcomes for children and families. Program leadership could also provide ongoing support to staff to ensure their work with families during home visits supports the program model, goals, and outcomes.

### Scale D: Program Management and Development

#### Strengths

1. **Experienced leadership:** Management staff has substantial experience in the field of early childhood and management. Leadership staff has solid skills in communication and decision-making with the home visiting staff.
2. **Work environment:** Home visiting staff has the necessary materials and physical environment to do their job. Staff has sufficient access to computers and related technical support.
3. **Supervision:** Staff has the opportunity to reflect on their work during individual supervision sessions and group or peer-to-peer supervision sessions.

#### Suggested Areas for Improvement

1. **Strategic Planning:** The program does not currently have a written strategic plan. Developing a written strategic plan that incorporates needs assessment, short and long term goals, and specific action steps to achieve goals may assist in identifying program strengths and weakness and plan for program improvement efforts.
2. **Sustainability and funding:** The program has minimal planning for program sustainability and funding. The program could benefit from more engaging in more proactive and long term sustainability and funding planning.

## Strengths and Areas of Improvement by Scale (Continued)

### Scale E: Progress Monitoring

#### Strengths

1. **Data management:** The program has an established data management system, and program staff who are skilled in using the system are responsible for managing it and running program reports.
2. **Informal program monitoring:** The program at least informally monitors program service delivery and uses the established data management system to informally monitor program service delivery and guide program decisions.

#### Suggested Areas for Improvement

1. **Systems and guidelines for program monitoring:** Although it is helpful that the program informally monitors service delivery, more formal guidelines could help inform the program planning process and any improvement efforts.
2. **Child and family outcomes:** Currently, the program does not measure many child and family outcomes and could pay more attention to measuring and documenting child and family outcomes.

## Recommendations

Based on your strengths and challenges, we've created the following recommendations to help you improve/maintain the quality of your program. These recommendations are suggestions only; you are not required to implement them, but it is our hope that they will be helpful to you as you think about your program.

- **Continue to focus on core content areas.** Continue to use the focus on the core content areas of child development, child health and safety, and parent-child relationships provided through the program model/curriculum. Provide extra support to home visitors (through supervision and professional development) in more consistent use of developmental screenings to inform program service delivery and specific strategies for monitoring and facilitating positive parent-child interactions.
- **Continue monitoring program service delivery.** Continue the informal process of monitoring service delivery data and using the data management system to guide program decisions, while working towards developing a more formal system. A formal system for monitoring program service delivery will continuously guide ongoing program improvement efforts and ensure there is a shared program vision and goal among staff.
- **Work towards measuring child and family outcomes.** Measuring child and family outcomes are an important step in order to document the outcomes the program has achieved. One helpful source for thinking about evaluation is a guide developed by The Administration for Children and Families. It is available here: [http://www.acf.hhs.gov/programs/opre/other\\_resrch/pm\\_guide\\_eval/reports/pmguide/pmguide\\_toc.html](http://www.acf.hhs.gov/programs/opre/other_resrch/pm_guide_eval/reports/pmguide/pmguide_toc.html)