CHILD & FAMILY
RESEARCH PARTNERSHIP

The Texas Home Visiting Program

Taking Home Visiting Programs to Scale in Texas: Implementation Challenges and Resiliency

Deliverable #3: Program Implementation Evaluation for Texas Maternal, Infant, and Early Childhood Home Visiting Formula Grant, Annual Report
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EXECUTIVE SUMMARY

Purpose and Introduction

The Texas Health and Human Services Commission (HHSC) contracted with the Child and Family Research Partnership (CFRP) at the LBJ School of Public Affairs at UT Austin to evaluate the implementation and outcomes of the Texas Home Visiting Program (THV). CFRP is conducting an ongoing program implementation evaluation (PIE) study of THV and analyzing the extent to which THV is showing improvement in benchmarks established in collaboration with the federal funding agency (U.S. Department of Health and Human Services Health Resources and Services Administration; HRSA).

The overarching aim of PIE is to better understand the factors that enhance and limit the ability of home visiting program models to effectively scale-up and produce positive outcomes for families with young children. Home visiting programs have rapidly expanded across the country as an evidence-based policy choice for supporting families with young children. Selecting an evidence-based model, however, is not a guarantee of effectiveness. Implementation is a key determinant of whether or not children and families benefit from home visiting programs.[1] Careful monitoring of whether the programs are implemented and delivered with fidelity enables policy makers, program operators, and evaluators to clearly link participation in the program to participant outcomes.[2]

The purpose of the present report is to provide a descriptive analysis of the variation in service delivery across 23 home visiting programs that are being implemented in the 7 original THV communities encompassing 12 counties. THV has recently expanded to include two additional communities – Bexar and Wichita counties, but they have not yet been incorporated into PIE. This report also includes an analysis of THV's progress toward the federally-defined benchmark outcomes.

Findings

Now that the THV communities have completed or are nearing the completion of the second year of implementation and with far less missing data, it is possible to build upon the first-year and interim second-year reports with a careful examination of variation in service delivery across the THV programs. As implementation is a key determinant of whether or not children and families benefit from home visiting programs, careful monitoring of whether the program implementation adheres to the program's original design and purpose (i.e., model fidelity) is critical to ensuring that the program yields the range of outcomes observed in the randomized controlled trials. This report focuses on assessing the variation in multiple aspects of service delivery including reaching the target population, recruitment, dosage, and retention.

HOW MANY FAMILIES DOES THV SERVE?

To date, THV has enrolled 2,915 families and in August 2014, is currently serving 1,670 families. Recruiting high-risk families into THV remains a challenge for all programs, though less of a challenge compared to recruitment during the first year of serving families. Many programs reported being surprised at how challenging it has been to enroll families into their programs despite the high level of need. The development of a coordinated matching and referral system along with a THV brand was intended to help programs with that challenge, but the pressure for individual programs to meet their capacity numbers and program eligibility requirements limit the extent to which a matching system can effectively help programs with recruitment challenges. Most programs rely on finding their own referrals, many of which come through word of mouth, WIC and health care providers, and the local schools.

WHO IS THV SERVING?

THV continues to serve the high-risk Texan families that were targeted by MIECHV. The majority of families being served by THV are low-income, with a significant proportion of families living in poverty and almost a third living in extreme poverty (below 50% FPL). Overall, most of the guardians enrolled in THV are young, Hispanic females; though the characteristics of families in THV vary by program model. The available data suggest that the majority of NFP enrollees are teenagers and unmarried whereas the majority of HIPPY enrollees are older—between the ages of 30 and 44—and married. The majority of THV parent/guardians do not work, which may be conducive to their participation in the program. These same risk factors—being poor or low-income, a teenage parent, young, and single—that characterize so many THV families and make them eligible for participation in the programs also make it difficult for the programs to serve and retain them. These challenges are highlighted in the following chapters.

WHAT DOES THV PROVIDE FAMILIES?

Each home visiting program model has specific prescription of home visits (e.g., weekly home visits in EHS-HV and bimonthly visits in PAT), participants are supposed to receive. THV families are more likely to receive all of their intended home visits when analyses were restricted to the first six months of enrollment compared to the first year of enrollment. That is, families are more likely to receive the intended dosage early on in the program compared to later—a trend that most likely reflects declining family engagement in the program over time. Even though close to 80 percent of THV families receive almost two-thirds (60%) of their visits (either over their first year or over their first six months), it is unclear whether receiving two-thirds of the intended program will benefit families to the same extent that receiving the full program might.

THV families are much more likely to receive some elements of their program curriculum than other elements. They are more likely to have received a referral for an identified need, been screened for cigarette use and domestic violence, and have a child who has received at least one ASQ screening than they are to have received information on birth spacing or injury prevention, or be screened for depression. This varies across the program models, which is not unexpected given the different populations targeted by each model and their varying goals.

The THV programs use parent meetings and group socializations as an additional opportunity to provide parents with information or services related to the benchmarks. Given the difficulties that home visitors describe in delivering the program curriculum in the midst of unpredictable family needs and crises, as well as having to work around cancellations and no shows, parent meetings are an important tool for programs to ensure families are receiving the services and information they are supposed to.

All of the THV programs still struggle to meet the expectations for service delivery prescribed by the program model with regard to both dosage and program content. The primary barriers to providing families with the full dosage of the program are the characteristics of the high-risk and high-need families they are serving. The very characteristics that make these families in need of and eligible for the program make them difficult to reach and serve. The primary barrier to delivering program content is dosage – not being able to meet with families in order to serve them.

HOW LONG DO FAMILIES STAY IN THV?

Though interviews and reports from the home visiting program coordinators and home visitors show the challenges associated with keeping families engaged and retaining them in the program, there is very little quantitative data available on retention in THV. Almost 70 percent of data on whether families exited a program because they completed the program or because they dropped out are missing. Improving the quality of data on retention is a critical area of improvement moving forward for both Continuous Quality Improvement (CQI) and future evaluation efforts focused on retention.

HOW ARE FAMILIES BENEFITING FROM THV?

Compared to the data from the THV data system, the qualitative data collected from home visiting program staff provide a more detailed perspective on the progress THV has made to date on the benchmark outcomes and how THV families are benefitting in each of those areas. Data from the THV data system suggest that families are in fact benefiting from their participation, but the extent to which they are benefiting varies and whether or not it will be sizeable enough to be visible at the community level remains to be seen.

CHAPTER 1: INTRODUCTION

Purpose and Objectives

The Texas Health and Human Services Commission (HHSC) contracted with the Child and Family Research Partnership (CFRP) at the LBJ School of Public Affairs at UT Austin to evaluate the implementation and outcomes of the Texas Home Visiting Program (THV). CFRP is conducting an ongoing program implementation evaluation (PIE) study of THV and analyzing the extent to which THV is showing improvement in benchmarks established in collaboration with the federal funding agency (U.S. Department of Health and Human Services Health Resources and Services Administration; HRSA). CFRP is also evaluating communities' engagement of fathers in home visiting services and factors related to family retention in home visiting programs in separate evaluation studies. The results of those evaluations will be produced in separate reports. The process and implementation evaluation spans from the initiation of THV in August 2011 through the end of funding in 2016. This report relies on information collected from the initiation of THV through August 2014, but focuses primarily on implementation activities during the second year of serving families—September 2013-August 2014.

The overarching aim of PIE is to better understand both the factors that enhance and those that limit the ability of home visiting program models to effectively scale-up and produce positive outcomes for families with young children. The purpose of the present report is to provide a descriptive analysis of the variation in service delivery across the 23 home visiting programs that are being implemented in the 7 original THV communities across 12 counties. THV has recently expanded to include 6 new programs in 2 additional communities—Bexar and Wichita counties—but they have not yet been incorporated into PIE. This report also includes an analysis of the extent to which THV is showing improvement in the federally-defined benchmark outcomes.

Background and Motivation

OVERVIEW OF THE TEXAS HOME VISITING PROGRAM

With the Maternal, Infant, and Early Childhood Home Visiting program (MIECHV) formula and developmental grants awarded in fiscal years 2010 and 2011, respectively, HHSC created the Texas Home Visiting Program (THV). THV aims to ensure that Texas children ages zero to five are healthy and prepared for school by promoting a seamless delivery of health and human services in high-need communities. With the formula funding, MIECHV provided Texas the opportunity to create local early childhood comprehensive systems (ECCS) that encompass evidence-based home visiting programs in high-need communities across the state.

With funding from a developmental grant, HHSC incorporated three interventions to strengthen the home visiting models included in THV and support the development of a local ECCS: 1) using the Early Development Instrument (EDI) and the Transforming Early Childhood Community Systems (TECCS) process as a means to build a data-driven, local early childhood

system focused on school readiness; 2) developing home visiting referral, matching, and intake systems to better meet the needs of families and help them find the support necessary to thrive; and 3) enhancing the ability of home visiting programs to provide family-centered approaches to services by developing strategies to better engage fathers in home visiting services and their children's lives.

HHSC conducted a county-level needs assessment and identified 7 communities across 8 counties that would benefit most from THV. With additional grant funding in 2013 and 2014, HHSC increased service to 2 additional communities (Bexar and Wichita counties) and expanded programs in the original 7 communities for a total of 29 programs serving families in 9 communities across 14 counties. PIE includes the new programs (Cameron, Midland, and San Patricio counties, and the City of Amarillo, which includes some of neighboring Randall County) that are expansions of the original communities. The 6 new programs in Bexar and Wichita counties have not yet begun serving families and thus, have not been incorporated into PIE. This report only includes data from the original 7 communities and their expansion programs and focuses primarily on data collected during THV's second year of serving families, which spans from September 2013 to August 2014.

Texas selected 4 evidence-based home visiting program models for THV based on the programs' existing national- and state-level infrastructures and because the 4 models, cumulatively, serve a broad range of target populations. The 4 models include Early Head Start – Home Visiting (EHS-HV); Home Instruction for Parents of Preschool Youngsters (HIPPY); Nurse Family Partnership (NFP); and Parents as Teachers (PAT).

HRSA requires THV to collect program data across 6 benchmark areas and demonstrate improvement among families participating in the program. The 6 benchmark areas include:

1. Improved maternal and newborn health;
2. Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits;
3. Improvement in school readiness and achievement;
4. Reduction in crime or domestic violence;
5. Improvements in family economic self-sufficiency;
6. Improvements in the coordination and referrals for other community resources and supports.

Each of the program models collects data on participating families, including demographic information about children and their parents or guardians, and information for the 35 process and outcome measures that HHSC developed to show improvement in the federal benchmarks. Currently, 3 of the 4 home visiting program models use separate data systems to input their data. To examine data from all 4 home visiting programs, HHSC contracted Cooper Consulting to create a new database that incorporates needed data from each of the programs' respective

systems. The THV data system was launched in spring 2013, but is still being prepared for full use by the programs and HHSC due to ongoing data quality issues.

THV is currently implementing 23 home visiting programs in 7 communities across 12 counties that serve approximately 1,700 families, and has supported the development of local early childhood comprehensive systems (ECCS) in each community. The communities selected to participate in the THV program and the evidence-based home visiting programs being implemented in each community are presented in Table 1. A profile for each of the original 7 communities is presented in Appendix A. Each profile includes the organizational chart for the THV program in that community, population characteristics, and an update on the status of each community in regards to their ECCS, EDI, matching system, father engagement strategies, and CQI processes.

Table 1. Original THV Communities and Program Models Implemented

Community	City of Primary Contractor	Programs
Cherokee and Anderson Counties	Jacksonville	PAT, HIPPY
Dallas County	Dallas	PAT (3), HIPPY
Ector and Midland Counties	Odessa	PAT, HIPPY, NFP
Gregg County	Longview	PAT, HIPPY, NFP
Hidalgo, Willacy, and Cameron Counties	McAllen	PAT, HIPPY, NFP
Nueces and San Patricio Counties	Corpus Christi	PAT, HIPPY, EHS-HV, NFP
Potter County and the City of Amarillo	Amarillo	PAT, HIPPY, EHS-HV, NFP

OVERVIEW OF THE EVALUATION

CFRP is conducting an ongoing, mixed-methods study to evaluate the implementation of THV and analyze the extent to which THV is showing improvement in the federal benchmarks.

The 5 overarching aims of the process and implementation evaluation are to determine:

1. Is there variation in the services delivered to families and in family outcomes across the THV programs?
2. To what extent does the identified variation in outcomes differ from what should be expected from the prior research and the program models' randomized controlled trials (RCTs)?
3. Does variation in implementation (e.g., the motivations and capacities to participate in THV; program infrastructure and staffing; communication, trainings, technical

assistance; and marketing and outreach) or variation in the THV elements (e.g., ECCS and the use of the EDI and TECCS; the development of a referral, matching, and intake system; or efforts to increase father engagement in home visiting) account for the variation in service delivery across THV programs?

4. To what extent does the variation in service delivery explain variation in family outcomes across the THV programs?
5. What policy implications for future implementation and scale-up efforts emerge from the implementation of THV?

To answer these questions, CFRP analyzes THV documentation and materials (e.g., grant proposals and state contracts), and the communities' monthly and quarterly reports submitted to HHSC; observes various in-person meetings and conference calls involving all THV stakeholders as well as ECCS meetings in the THV communities; and conducts interviews and community visits with all THV stakeholders. CFRP also analyzes demographic and benchmark data entered into the THV data system by each of the 23 home visiting programs. Additional detail on the data sources and methodology for the overall evaluation can be found in Appendix B. The detailed methodology for this report is presented in Chapter 2.

CFRP did not have the ability to randomly assign home visiting programs to communities or families to participate in home visiting programs within communities, and therefore cannot attribute causal impacts of home visiting programs on family outcomes. It is important to note that this evaluation is not attempting to measure the effect that specific home visiting program curricula or model implementation has on family outcomes. Rather, CFRP is using the variation in implementation across the 23 programs in the 7 THV communities to assess the factors that facilitate or impede the successful implementation of home visiting programs.

The report from the first year of implementation was submitted to HHSC in September 2013. The goal of that report was to highlight 1) early variation in the implementation of the home visiting programs; 2) the development of the ECCS and the use of the EDI and TECCS; 3) the development of a referral, matching and intake system; and 4) efforts to increase father engagement in home visiting. For each element, CFRP assessed variation in 1) the motivations and capacities to participate in THV; 2) infrastructures and staffing before and after implementing THV; 3) experiences with communication, trainings, and technical assistance during implementation; 4) experiences with marketing, outreach, and recruitment of families into the home visiting programs; 5) service utilization; 6) retention of families in the home visiting programs; and 7) experiences with THV-related data collection, analysis, and use.

An interim second-year report was submitted to HHSC in March 2014. This report presented preliminary analyses of variation in service delivery across the THV programs over approximately 18 months of implementation. Though the data suggested that THV is successfully targeting and serving the high-risk Texan families required by MIECHV, large amounts of missing data and overall poor data quality greatly interfered with the ability to draw valid conclusions about recruitment, dosage, and retention.

Now that the THV communities have completed or are nearing the completion of the second year of implementation and with far less missing data, it is possible to build upon the first-year and interim second-year reports with a careful examination of variation in service delivery across the THV programs. The present report focuses primarily on the first research aim and includes analyses of both service delivery and progress made toward the federally-defined benchmarks.

IMPLEMENTATION IS KEY TO PROGRAM SUCCESS

Home visiting programs have rapidly expanded across the country as an evidence-based policy choice for supporting families with young children. Selecting an evidence-based model, however, is not a guarantee of effectiveness. Implementation is a key determinant of whether or not children and families benefit from home visiting programs.[3] Careful monitoring of whether the program implementation adheres to the program's original design and purpose (i.e., model fidelity) is critical to ensuring that the program yields the range of outcomes observed in the randomized controlled trials.[4] Programs that are well-designed, but poorly implemented will not produce their intended effects.[5,6]

Home visiting program standards and content are often modified during implementation to fit local participants' needs, organizational capacity, and the community context.[7] Whether these model modifications strengthen the program's effects or reduce the likelihood of achieving the impact found in the RCTs is uncertain and may depend on numerous factors. This report focuses on assessing the variation in multiple aspects of service delivery including reaching the target population, recruitment, dosage, and retention. Each aspect of service delivery examined in this report is presented in greater detail below.

RECRUITMENT

One of the keys to successful implementation of evidence-based home visiting programs is the capacity to recruit, enroll, and retain participants from the model's target population. Each of the 23 home visiting programs is funded to hire a specific number of home visitors. The maximum number of families (or children, in the case of HIPPY) that each home visitor can serve varies depending on the program models' requirements. According to the most recent estimates (July 2014), THV is only at approximately two-thirds service capacity across the state. This is due, in part, to the difficulty of recruiting high-risk families into the programs, which is further complicated by the program models' age and income eligibility requirements. We present analyses of cumulative and current THV enrollment data across program models and the THV communities along with current enrollment as a proportion of funded capacity.

Home visiting programs rely on various referral sources to recruit participants. Analyses of referral source data from the THV data system identified the most common referral sources. These data are largely missing, so conclusions about common referral sources relied on analyses of interviews with and reports from program managers, home visiting coordinators,

and home visitors. These interviews highlighted various strategies home visiting programs use to recruit families and the many challenges associated with recruiting their target populations.

SERVING THE TARGET POPULATION

Each of the four home visiting program models included in THV have specific income and/or age eligibility requirements for families, though the stringency of these requirements varies from program to program. Regardless of the extent to which the program models vary in defining and targeting "at-risk" families, one of the core components of the MIECHV legislation is that states receiving MIECHV funding give priority to serving high-risk populations.[a] The MIECHV legislatively-identified priority populations include, among others, low-income families, pregnant teenagers, families with a history of child abuse or neglect, families with a history of substance abuse, and military families. Analyses of data from the THV data system examined important demographic characteristics of the families, guardians, and children participating in THV.

DOSAGE AND PROGRAM DELIVERY

One of the most common ways to assess whether or not a program was implemented with fidelity is the extent to which the program provided participants with the required amount of the program or dosage.[8] If home visitors do not conduct all of the expected visits with families (dosage), then they cannot deliver all of the services and program curricula, which will limit the extent to which families can benefit from the programs.

Generally, dosage refers to the amount of an intervention participants receive and can be measured in a variety of ways including the number of visits provided, weeks of enrollment, and the percentage of participants who received the intended service dosage (as required by the evidence-based model being implemented). Each of the program models serving families in THV has a different intended dosage. Analyses of home visit completion data from the THV data system examine the percentage of families that received 100 percent, 80 percent and 60 percent of the intended dosage for the program they participated in across the 4 home visiting program model and across the 23 home visiting programs. Analyses of parent meeting reports, which are submitted monthly by the 3 programs that include group socialization activities as a part of their model, show the number of attendees and the proportion of meeting topics that were related to meeting the federal benchmarks, involving fathers, or primarily social events.

Each home visiting program model has a particular set of goals for its families and delivering the curriculum content is key to achieving those goals. Analyses of data from the THV data system examine the percentage of families across the 4 program models that received the specific services required by MIECHV to show improvement in the 6 benchmark areas. Services included screening for parents' cigarette use, receiving information on birth spacing, screening for

[a] Social Security Act, Title V, Section 511(d) (4).

maternal depressive symptoms, receiving information on injury prevention, screening children for developmental and learning delays using the Ages and Stages Questionnaire (ASQ), screening for domestic violence, and providing referrals to available resources in the community for any identified family need.

Analyses of interviews with and reports from home visitors provided additional insight into the many barriers (e.g., frequent no-shows and cancellations, high levels of need) that make it difficult for families to receive the full dosage and content of their home visiting program.

RETENTION

The longer families stay in a program, the greater the dosage of home visiting services that families receive, which should ultimately lead to improved outcomes in maternal and child health, school readiness and achievement, and family economic self-sufficiency, as well as reductions in domestic violence and child injury and abuse. Although families may benefit from initiating participation in the home visiting programs, families must maintain enrollment to accrue full program benefits.

As a model of early intervention (relative to center-based or school-based early education) home visiting programs are advantageous because bringing the intervention into the home allows for greater family involvement, personalized services, and individual attention, which may all increase program retention rates.[9] Furthermore, by delivering services in the home, these programs can target families who may be difficult to reach. In general, home visiting programs do target hard-to-reach or high-risk families, particularly those who are low-income. Those factors that make families hard-to-reach or high-risk, however, are the same factors that make it difficult for families to stay in the program. The families targeted by home visiting programs often have needs beyond those that can be served by home visiting programs or have barriers (e.g., housing instability, multiple jobs) that make it difficult to remain committed to and engaged in the program.

Analyses of data from the THV data system examined the percentage of families (by program model) who completed the program, did not complete the program (and are no longer enrolled), and the percentage of families for whom program completion is unknown. Analyses of interviews with and reports from home visiting program coordinators and home visitors provided data on strategies used to retain families and common reasons why families leave the program.

FAMILY AND CHILD OUTCOMES

As noted earlier, HRSA required THV to develop benchmarks that focus on 6 predetermined outcome domains. HHSC and the 4 program models worked together to develop 35 process and outcome measures to show improvement in the six federal benchmark areas. Preliminary analyses of available data show progress to date on demonstrating improvement in each benchmark area. Data collection is still ongoing and data quality issues, though they continue to

markedly improve, remain. These factors do not permit a more thorough analysis of the benchmark outcomes at this time. As the data quality improves, these measures will be examined in greater detail.

The Present Report

Following a detailed description of the methodology for the analyses in this report in Chapter 2, which highlights lingering concerns about data accuracy and missing data, we present descriptive analyses of variation in each recruitment, family characteristics, dosage, program delivery, and retention in Chapters 3 through 6. Chapter 7 presents preliminary analyses of family outcomes in THV. Conclusions and next steps are presented in Chapter 8.

CHAPTER 2: ANALYTIC METHOD

Data Sources

TEXAS HOME VISITING BENCHMARK DATA SYSTEM

The primary source of quantitative data for the present report is the Texas Home Visiting (THV) data system, which includes demographic, enrollment, and benchmark information. Each home visiting program participating in THV collects demographic information on participating families along with data on each of the 6 federally-established benchmarks, consisting of child and maternal health, child injuries and emergency room visits, school readiness and achievement, domestic violence, family economic self-sufficiency, and referrals for other community resources and supports. Each program is responsible for logging this information in addition to family enrollment, visit, and exit data into their respective data systems—3 of the 4 home visiting program models use different data systems to input their data (PAT and EHS-HV use VisitTracker; NFP and HIPPY use separate versions of Efforts to Outcomes [ETO], though, in the next few months HIPPY is transitioning to VisitTracker). The data from each data system are imported into the THV data system, from which CFRP can securely access the data.

The THV data system was launched in spring 2013 to meet federal (HRSA) grant data reporting requirements. In July 2013, reports from the data system indicated large amounts of missing information on families for all home visiting programs in the THV communities. CFRP, Cooper Consulting (the developer of the THV data system), HHSC, the state program model leads, as well as program leads and home visiting program coordinators in the THV communities worked to resolve many of the missing data issues. Nonetheless, several issues with missing data persist and are presented in greater detail below.

This report includes analyses of data collected from the initiation of THV in August 2011 through August 2014, but primarily highlights implementation activities during the second year of serving families—September 2013-August 2014. Analyses of quantitative data were conducted using Stata 12.

MONTHLY REPORTS AND INTERVIEWS

The primary sources of qualitative data are the monthly reports submitted by the program leads and the NFP Nurse Supervisors in each community, and the interviews conducted over the phone and in person with the program leads, home visiting program coordinators, and home visitors in each community. Analyses for the present report were limited to data collected through reports and interviews dating from September 2013 through August 2014.

CFRP researchers reviewed a total of 141 monthly and quarterly reports and 34 interviews (Table 2). The monthly reports and interviews were coded using MAXQDA software. Examples of the coding themes and sub-categories are presented in Table 3.

Table 2. Qualitative Data Sources for Present Report

Community	Monthly and Quarterly Reports	Interviews	Total # of Data Sources
Cherokee/ Anderson	• 9 Monthly Reports • 3 Quarterly Reports	• Conference Call with Program Lead, ECCS/EDI/Matching System Coordinator, PAT Coordinator, & HIPPY Coordinator • Site visit interviews: o HIPPY Coordinator & Home Educators o PAT Coordinator & Parent Educators	15
Dallas	• 9 Monthly Reports • 3 Quarterly Reports	• Conference call with Program Lead, ECCS Coordinator, EDI Coordinator, HIPPY Coordinator, PAT Coordinators, Matching System Coordinator • Site visit interviews: o ECCS o HIPPY Coordinator o Lumin: EHS/PAT Director, PAT Coordinator & Parent Educator o ChildCare Group: PAT Coordinator o Family Compass: PAT Executive Director	18
Ector/Midland	• 10 Monthly Reports • 7 NFP Monthly Reports • 3 Quarterly Reports • 1 NFP Quarterly Report	• Conference Calls: o Program Lead, ECCS/EDI Coordinator, NFP Nurse Supervisor, PAT Coordinator, HIPPY Coordinator o NFP Nurse Supervisor & Nurse Home Visitors o Program Leads • Site-visit interviews: o ECCS Coordinator o PAT Coordinator & Parent Educators o HIPPY Coordinator & Home Educators	27
Gregg	• 10 Monthly Reports • 7 NFP Monthly Reports • 3 Quarterly Reports • 3 NFP Quarterly Reports	• Conference call with Program Leads • Site-visit interviews: o Program Lead o PAT Coordinator & Parent Educators o HIPPY Coordinator & Home Educators o NFP Nurse Supervisor & Nurse Home Visitors	28
Hidalgo/Willacy	• 10 Monthly Reports • 8 NFP Monthly Reports • 3 Quarterly Reports • 3 NFP Quarterly Reports	• Conference call with Program Lead and Program Manager (ECCS & Matching System Coordinators), EDI Coordinator, PAT Coordinator, & HIPPY Coordinator • Site-visit interviews: o HIPPY Coordinator & Home Educators o NFP Coordinator, Nurse Home Visitors, & Administrative Assistant o PAT Coordinator, Program Lead, & Parent Educators	28

Community	Monthly and Quarterly Reports	Interviews	Total # of Data Sources
Nueces/San Patricio	• 10 Monthly Reports • 9 NFP Monthly Reports • 3 Quarterly Reports • 3 NFP Quarterly Reports	• Conference call with Program Lead, ECI Project Director, Matching Coordinator • Site-visit interviews: o PAT Coordinator & Parent Educators o HIPPY Coordinator & Home Educators o EHS-HV Coordinator & Home Visitors o NFP Nurse Supervisor & Nurse Home Visitors	30
Potter/Amarillo	• 10 Monthly Reports • 8 NFP Monthly Reports • 3 Quarterly Reports • 3 NFP Quarterly Reports	• Conference Call o Program Lead, ECCS Coordinator, PAT Coordinator, HIPPY Coordinator, EHS-HV Coordinator, & NFP Nurse Supervisor o NFP Nurse Supervisor • Site-visit interviews: o NFP Nurse Home Visitors o EHS-HV Coordinator & Home Visitor o HIPPY Coordinator & Home Educators	29
TOTAL	**107 Monthly Reports 34 Quarterly Reports**	**34 Interviews**	**175**

Table 3. Coding Methodology for Qualitative Data

Coding Theme	Sub-Categories
Home Visiting	Model Fidelity, Sustainability, Family Characteristics, Recruitment (Sources, Strategies), Program Delivery (Home Visits, Parent Meetings/Group Socializations, Referrals), Staffing (Training, Turnover), Retention, Program Outcomes
ECCS	Membership, Relationship to Home Visiting, Activities, Benefits for Members, Sustainability
EDI	Implementing EDI, Using EDI, Sustainability
Father Participation	Attitudes toward Engaging Fathers, Strategies for Engaging Fathers, Barriers to Engaging Fathers, Community-Level Activities, Types/Forms of Father Participation, Consequences of Father Participation
Matching System	Relationship to Home Visiting, Structure, Sustainability
Requests for Support	Data, UCLA/UWW, Program Models, Technical Assistance, HHSC

Analytic Sample

As noted earlier, the quantitative analyses used all available data from the initiation of THV in August 2011 through August 2014. Qualitative analyses, in contrast, were limited to monthly reports and interviews conducted between September 2013 and August 2014.

For the descriptive analyses, the analytic sample was restricted to include only those families who, as of August 20, 2014, **had been enrolled in THV for at least 1 month and for whom at least 1 home visit had been recorded**. These restrictions were used to improve the quality of the data because the 23 home visiting programs vary in whether families are considered enrolled after they complete enrollment forms or when the first visit is completed. The programs also vary in the length of time families must be enrolled before data are entered into the data system. There are approximately 185 families in the THV data system for whom there were no associated home visits recorded and 408 families who had been enrolled for less than one month. Thus, a total of 593 families were excluded from the analytic sample.

This report presents data on 2,915 families, 2,884 guardians (there are 31 families for whom guardian records are missing), and 3,356 children (including children who were not yet born when their pregnant mothers enrolled), all of whom had been enrolled for at least 1 month and had at least 1 home visit recorded by August 20, 2014.

Missing Data

CFRP has identified a number of data quality issues in the THV data system. These issues, particularly regarding systematic missing data, have improved significantly, but continue to persist. The issues that remain, however, diminish the ability to be fully confident in the accuracy of the results presented throughout this report and the extent to which conclusions drawn from this report apply to home visiting programs more generally.

There are numerous data quality concerns with respect to demographic data in the THV data system. These issues are noted throughout the report, but a summary of the issues is presented here:

- Child and guardian race are entered differently across program models. ETO (used by NFP and HIPPY) includes Hispanic as an option for ethnicity, but not for race. In contrast, VisitTracker (used by PAT and EHS-HV) asks for race and ethnicity separately, but some PAT and EHS-HV sites include Hispanic as an option for both race and ethnicity. This resulted in a high proportion of individuals who were Hispanic being recoded as “more than one category selected” for race.
- In addition to data quality issues with race, large amounts of data are missing for other important family demographic characteristics including income-to-need ratios (nearly 25%), health insurance (approximately 16% of parent/guardian health insurance data and 11% of child health insurance data), military status (20%), and receipt of public assistance benefits (15%).

- The majority (60%) of referral (into THV) source data is missing. There are 8 home visiting programs (all 5 NFP and 3 HIPPY programs) for which there are no data on referral sources. Additionally, because the referral field is a write-in, some of the values for referral source are more easily interpreted than others.
- Most of the families in the THV data system who have termination dates do not have an associated program completion status. Of the 1,245 families with termination dates (as of August 2014), more than 850 families (nearly 70%) are missing information for program completion. That is, for close to 70 percent of exited families, it is impossible to determine whether a family was exited from the program because they completed the program or because they dropped out.

CHAPTER 3: HOW MANY FAMILIES DOES THV SERVE?

Background

One of the keys to successful implementation of evidence-based home visiting programs is the capacity to recruit, enroll, and retain participants from the model's target population. Recruiting families into home visiting programs is difficult because the overall target population served by home visitors has a number of risk factors that make them hard to reach and the program models have various age and income eligibility requirements that restrict which families can be enrolled in a particular program.

Family Enrollment in THV

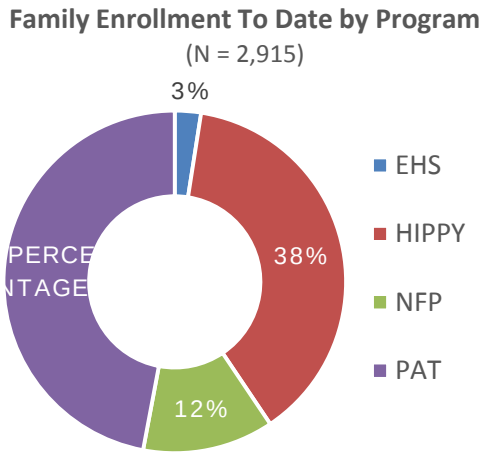
To date, THV has enrolled 2,915 families and in August 2014, is serving 1,670 families. Table 4 presents the number of enrolled families, guardians, and children by program model and overall.

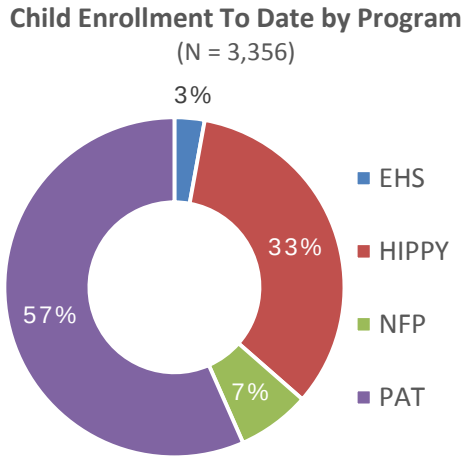
Table 4. THV Family, Guardian, and Child Enrollment

	Families Ever Enrolled	Families Currently Enrolled	Guardians Ever Enrolled	Guardians Currently Enrolled	Children Ever Enrolled	Children Currently Enrolled
EHS-HV	72	40	72	40	96	57
HIPPY	1,111	616	1,080	588	1,127	600
NFP	361	328	361	328	233	223
PAT	1,371	686	1,371	686	1,900	926
TOTAL	**2,915**	**1,670**	**2,884**	**1,642**	**3,356**	**1,806**

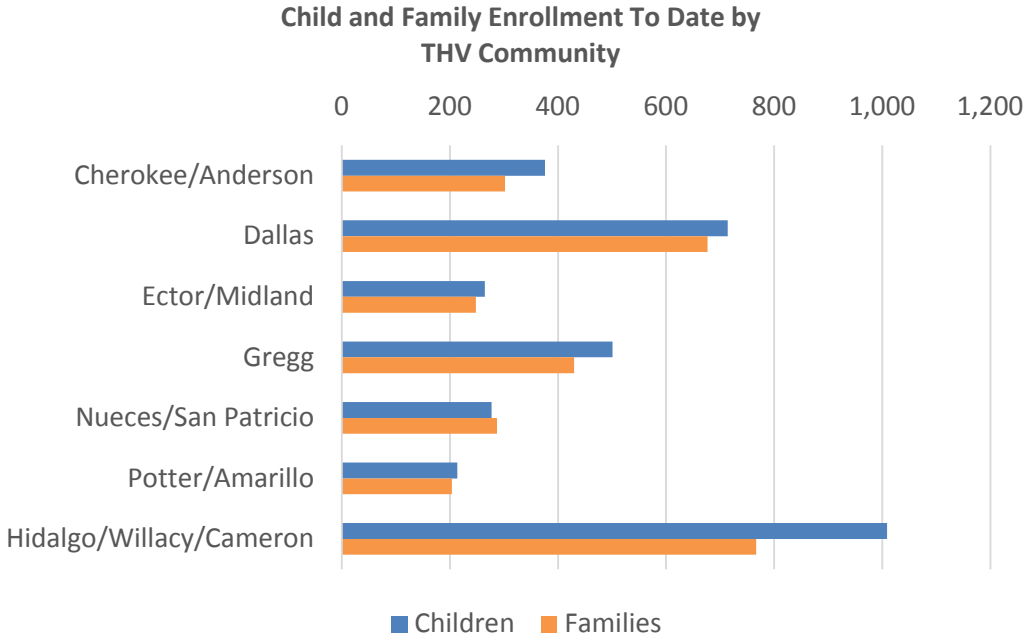
Note: "Enrolled" includes only those who were enrolled for longer than 1 month and who had completed at least 1 home visit; "Currently Enrolled" refers to enrollment as of August 20, 2014

PAT and HIPPY are the largest programs—having served a combined 85 percent of families and 90 percent of children to date. They are currently serving a combined 78 percent of families and 84 percent of children.





The programs in the Dallas and Hidalgo/Willacy/Cameron communities are the largest—having served a combined 1,444 families and 1,727 children. The programs are currently serving a combined 761 families and 850 children.



PROGRAM CAPACITY

The number of families each of the 23 THV programs can serve depends on the number of home visitor positions funded by HHSC. The maximum number of families that can be served by any one home visitor varies according to the recommended standards of each home visiting program model. The recommended standards for caseloads per home visitor across the program models are presented in Table 5.

Table 5. Recommended Standards for Caseloads

Program Model	Recommended Standard Caseload per Home Visitor
EHS-HV[10]	12
HIPPY[11]	25 (10-15 for part-time)
NFP[12]	25
PAT[13]	24

As shown in Table 6, THV is operating at approximately two-thirds service capacity across the state. The evaluation of the Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment (EBHV)[14]—a cooperative agreement between the Children's Bureau within the Administration for Children and Families at the U.S. Department of Health and Human Services and 17 organizations in 15 states to support the implementation of home visiting programs—highlighted similar challenges with maintaining capacity at funded enrollment levels. More than half of home visitors in the EBHV evaluation carried caseloads below capacity even though most of the programs had been operating for at least 2 years by the end of the evaluation. In EBHV, operating below capacity was primarily attributed to the lengthy period of time that new home visitors need to build caseloads as well as the challenge of establishing reliable participant referral systems to ensure a steady flow of potential enrollees.

One of the recommendations provided in the EBHV evaluation is that capacity may need to be redefined from a fixed number (based on the number of families that can be served based on the number of funded home visitor positions) to a more fluid assessment driven by the length of time home visitors have been in their positions and the specific needs of families. Capacity in the table below is based on the current number of budgeted home visitor positions, but it may be more accurately defined by the current number of home visitors on staff (which, because of staff turnover, may be less than the number of budgeted staff positions) or as the EBHV evaluation suggests, based on the length of time the home visitor has been employed and the specific needs of the families.

Table 6 presents the number of currently enrolled families and children for each of the 23 THV programs along with the maximum number of families and children (the capacity) each program is currently budgeted to serve. The extent to which the 23 programs are at or near capacity varies widely. The NFP programs are generally at lower capacity than the other

programs, which is likely due, at least in part, to the particularly slow start-up process associated with launching an NFP program and the strict eligibility requirements for NFP.

Table 6. THV Current Enrollment (August 2014) and Capacity by Program

		Families Currently Enrolled	Children Currently Enrolled	Budgeted Capacity (Families)*	% Capacity
EHS-HV	Nueces	16	18	20	80%
	Potter	15	26	24	63%
HIPPY**	Cherokee	0	0	150	0%
	Dallas	238	255	255	100%
	Ector	39	43	88	49%
	Gregg	91	95	150	63%
	Hidalgo/Willacy	0	0	180	0%
	Nueces	63	67	144	47%
	Potter	35	36	120	30%
NFP	Ector	63	44	100	63%
	Gregg	111	81	125	89%
	Hidalgo/Willacy	121	91	150	81%
	Nueces	118	66	150	79%
	Potter	87	47	125	70%
PAT	Cherokee	124	166	140	89%
	Dallas (CCG)	90	108	90	100%
	Dallas (FC)	34	37	52	65%
	Dallas (EDCS)	36	38	58	62%
	Ector	72	84	75	96%
	Gregg	98	147	120	82%
	Hidalgo/Willacy	218	311	235	93%
	Nueces	57	72	60	95%
	Potter	19	27	35	54%
TOTAL		1,745	1,859	2,646	66%

These enrollment and capacity data come from August 2014 Monthly Reports, which differ slightly from the enrollment data that come from the THV Data System

**Capacity refers to the number of families, except for HIPPY, which calculates capacity in terms of children*

***HIPPY programs do not serve families in the summer, but vary on how they report enrollment during summer*

Recruitment and Referrals into THV

A review of monthly reports by program leads and coordinators and interviews with program coordinators and home visitors provided insight into recruitment strategies, referral sources, and the time-intensive, but critical effort put forth to enroll families into THV. The home visiting programs within a community partner for recruitment events and refer to each other, but each program primarily prioritizes enrolling families in their individual program.

CHALLENGES DEVELOPING A MATCHING AND REFERRAL SYSTEM

Though each community[b] was contractually required to develop a referral and matching system, the degree to which an actual matching "system" has been developed varies considerably across the 7 communities. Most often, the programs have a coordinator (either a designated coordinator or the program lead) in charge of attending community events and providing outreach to spread the word about THV and refer families to the appropriate program. The matching coordinator typically operates alongside or in conjunction with the individual recruitment efforts of each home visiting program.

The development of the matching system in each community was intended to coincide with the development of a THV "brand." That is, families would be first recruited into the Texas Home Visiting Program and then, depending on eligibility requirements and interest, would be directed toward a specific home visiting program through the matching system. Over the course of the evaluation, several challenges to developing a successful matching system have been highlighted. One difficulty, often cited early on when each program was rapidly trying to build their caseloads, was that because home visiting programs were trying to recruit in the same community, recruitment felt like a "competition" for families instead of the collaborative efforts intended by the matching system. This "competition" has decreased considerably now that many programs are near capacity and several have waitlists.

Another barrier to developing a successful matching system was rigid program eligibility requirements. Staff from all of the NFP programs continue to note that the strict eligibility requirements of NFP limit the program's ability to benefit from the matching system. In some communities, a home visiting program is restricted to serving a specific population in that community (e.g., EHS-HV in Potter serves a Chin refugee population, PAT in Potter can only serve families in a specific ISD, several of the programs in Dallas serve specific neighborhoods). Thus, a family may be eligible for the program based on the model's standards, but not be eligible based on local eligibility criteria. Many programs reported receiving referrals for families through the matching system only to find out that they were not eligible for that specific program, and had to turn the families away.

[b] All THV communities except for Potter County, which did not apply for competitive grant funding, received competitive funding and were required to develop the three interventions, including the matching and referral system.

Additionally, some programs reported that the participants who were referred to the program through the matching system were not always reliable or engaged when enrolled in the program. Staff from these programs felt that more reliable and engaged recruits could be found through individual programs' own recruitment efforts. Program staff noted that being able to explain the specific curriculum and expectations of their individual program rather than the benefits of home visiting programs more broadly was critical to recruiting reliable participants.

IMPROVEMENT IN RECRUITMENT EFFORTS FROM YEAR ONE

Many of the home visitors and program coordinators noted that recruitment efforts in the second year of implementation have been more successful than in the first year. This is, in part, because most program staff have been implementing the program for a year and have a much better understanding of the program curriculum and exactly what the program requires of and provides for families. This year of experience has meant that home visiting program coordinators and home visitors are better able to accurately explain the program to potential families and clearly communicate the benefits of participating in the program when trying to recruit and enroll new families.

Additionally, because they have been operating longer, programs have been able to build up greater trust and positive reputations in communities, leading to more recruitment by word of mouth from families who have participated in the program. Communities' increased trust in programs also helped combat some programs' struggles with branding and stigma, particularly in distinguishing themselves from Child Protective Services (CPS). In response to these issues, some programs changed the names of program elements (e.g., First Five Permian Basin in Ector/Midland) or were careful to stress that their program was designed to support parents by providing them with resources and information, not to correct their current parenting behavior.

REFERRAL SOURCES

The most commonly cited referral sources in monthly reports and in interviews continue to be word of mouth and WIC offices. Word-of-mouth referrals from existing clients are a growing and primary referral source. As one program staff member noted, the families being recruited by families who have participated in the program "stick" better.

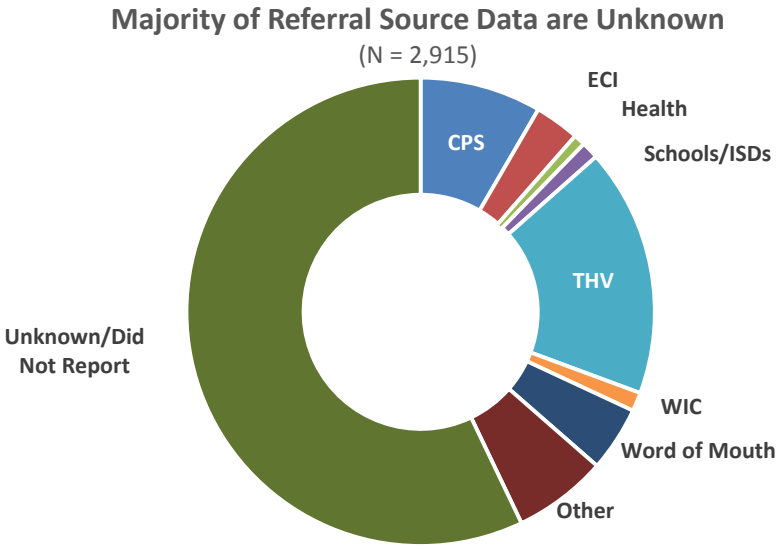
Though some of the programs have been able to establish and benefit from a relationship with the local WIC office in their community, the ability for the home visiting programs to rely on their local WIC clinics for referrals varies across the communities. In Dallas, one of the organizations implementing the PAT program reported that they were not allowed to recruit through their local WIC clinic without a signed MOU, which has been submitted to HHSC and is awaiting approval. In Nueces, the WIC clinic would only provide its clients with brochures for the home visiting programs if they were provided alongside brochures for other resources. The WIC clinic in Nueces refused to refer clients to the home visiting programs specifically. In

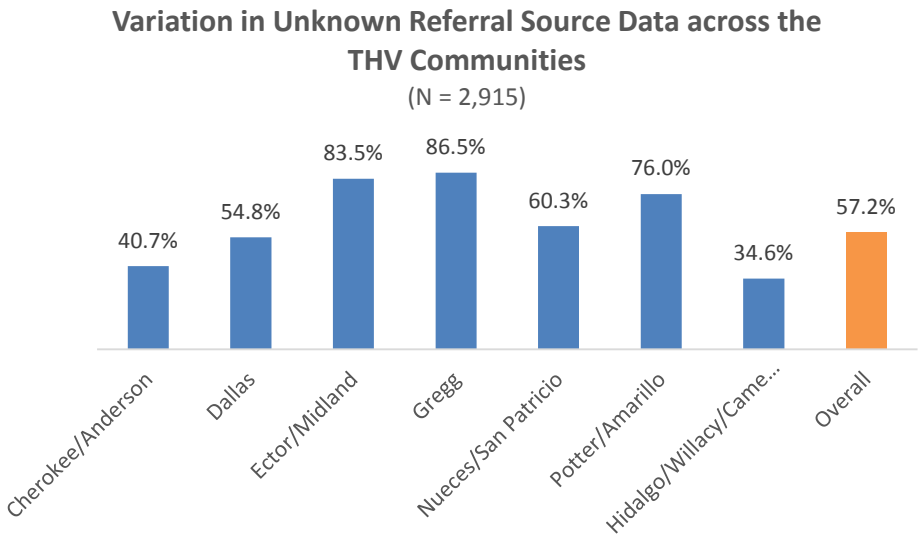
contrast, the WIC clinics in other communities (e.g. Ector and Hidalgo/Willacy) were reported to be valuable referral sources for the home visiting programs.

Beyond that, home visiting programs report obtaining referrals from schools (particularly those that serve pregnant mothers), ECI, child care centers, preschools, community organizations and events (e.g., libraries, health fairs, and health clinics), CPS, and other agencies and organizations that serve young children. A strategy that many of the home visiting programs have adopted is to host educational events for target populations who may be more difficult to reach. These events include health presentations at schools and parent meetings for teens. By establishing a relationship with potential participants, the programs hope to enroll individuals who are more committed to participating.

In contrast to the qualitative data from interviews and reports, the data on referral sources from the THV data system are far less informative. This, in part, reflects that home visitors can write in the referral source, which results in an unwieldy list of referral sources. It also reflects the large amount of missing referral source data.

Referrals from THV include referrals made through the local matching system and more informal referrals between THV programs. The "other" category includes sources such as local women's centers and juvenile services and other sources for which the category was unclear (e.g., 145 referrals come from a source called, "Entity"). Overall, nearly 60 percent (57.2%) of the referral source data are missing. Across program models, this ranges from 18.1 percent (EHS-HV) to 86.1 percent (HIPPY). Across the THV communities, the percentage of missing referral source data ranges from 34.6 percent in Hidalgo/Willacy/Cameron to 86.5 percent in Gregg.





Summary

Recruiting high-risk families into THV remains a challenge for all programs, though less of a challenge than recruitment during the first year of serving families. Many programs reported being surprised at how challenging it has been to enroll families into their programs despite the high level of need. The development of a coordinated matching and referral system along with a THV brand was intended to help programs with that challenge, but the pressure for individual programs to meet their capacity numbers and program eligibility requirements limit the extent to which a matching system can effectively help programs with recruitment challenges. Most programs find referrals independently, many of which come through word of mouth, WIC and health care providers, and the local schools.

CHAPTER 4: WHO IS THV SERVING?

Background

Each of the 4 home visiting program models participating in THV have specific income and/or age eligibility requirements for families. The stringency of these requirements, however, varies across the programs (Table 7). Some programs use a specific income threshold to target at-risk families (e.g., NFP and EHS-HV), others are more flexible in their definition of at-risk (e.g., PAT) and others serve families regardless of their level of risk (e.g., HIPPY).

Table 7. Eligibility Requirements for Enrollment in Texas Home Visiting Program

	EHS-HV	HIPPY	NFP	PAT
Income	At or below the federal poverty level	N/A	At or below 185 percent of the federal poverty level	N/A
Child Age	Throughout pregnancy and through age 3	Children aged 3 or 4 at the beginning of the year before they start school	Enrolled before the end of the 28th week of pregnancy through age 2	Throughout pregnancy and through kindergarten entry
First Birth	N/A	N/A	Have no previous live births	N/A
Other Eligibility Requirements	N/A	Might include: did not graduate from high school or have only limited formal education, limited English proficiency, limited financial resources, or other risk factors.	Texas resident (a requirement for Texas NFP specifically)	Might include: Children with special needs, families at risk for child abuse, income-based criteria, teen parents, first-time parents, immigrant families, low literate families, or parents with mental health or substance abuse issues.
Notes	Each individual EHS is allowed to develop specific program eligibility criteria, aligned with the program's performance standards.	N/A	N/A	PAT affiliate programs select the specific characteristics and eligibility criteria of the target population they plan to serve.

Regardless of the extent to which the program models vary in defining and targeting "at-risk" families, all families participating in THV are considered at-risk or of high need because they

reside in one of the THV communities, which were identified as high-need areas in a statewide needs assessment conducted by HHSC. The factors contributing to a high-need designation are described in greater detail in each of the community profiles (Appendix A) and are presented in a table in Appendix C.

As shown in Appendix C, compared to the state average, overall, the THV communities have higher levels of total poverty, a greater percentage of children in poverty, a greater percentage of uninsured children, higher levels of adults with no high school diploma or GED, higher levels of unemployment, and a greater percentage of children living with a single parent. Among the THV communities, Cherokee, Hidalgo, Willacy, and Cameron counties have the highest levels of child poverty, ranging from more than one-third to almost half of children living in families with incomes below the federal poverty line.

One of the core components of the MIECHV legislation is that states receiving MIECHV funding give priority to providing services to high-risk populations.[15] The MIECHV legislatively identified priority populations include:

1. Eligible families who reside in communities in need of such services, as identified in the statewide needs assessment
2. Low-income eligible families
3. Eligible families who are pregnant women who have not attained age 21
4. Eligible families that have a history of child abuse or neglect or have had interactions with child welfare services
5. Eligible families that have a history of substance abuse or need substance abuse treatment
6. Eligible families that have users of tobacco in the home
7. Eligible families that are or have children with low student achievement
8. Eligible families with children with developmental delays or disabilities
9. Eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States

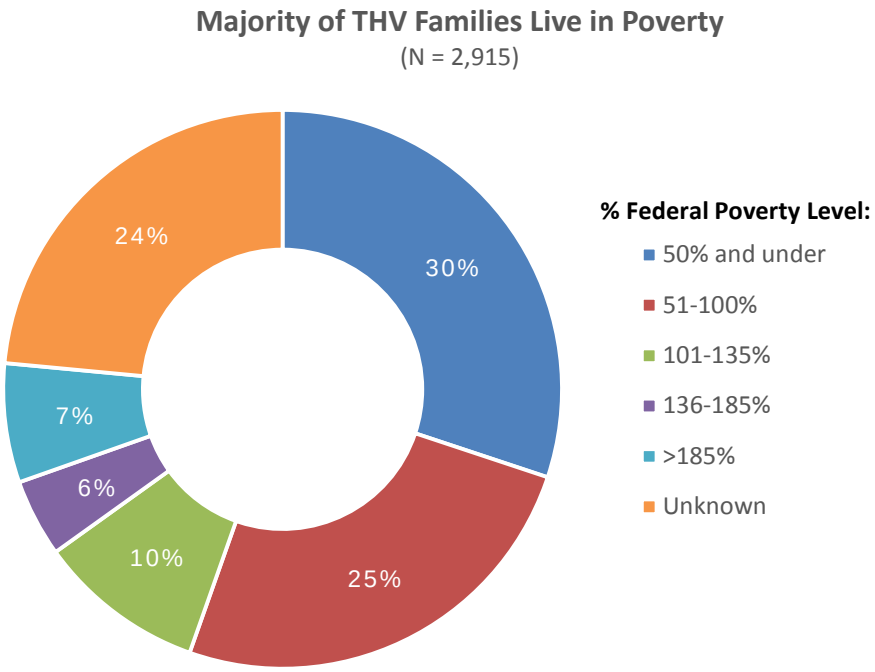
Given the high-risk populations that some of the home visiting programs already target and the high-risk populations that each of the programs participating in THV is required to serve, who are the families being served by THV? The demographic characteristics are either presented at the family, guardian, or child level and are presented for all THV families overall, and then by program model.

Demographic Characteristics of THV Families

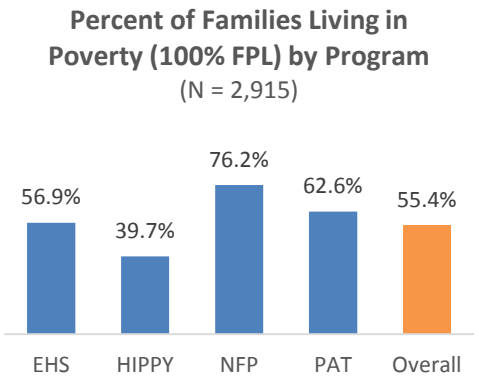
Most of the demographic data in the THV data system are reported at the guardian or child level, but important characteristics including poverty status, household language, and military status are reported at the family level and displayed below. Most THV families live in poverty and report English being the primary language in their household, but very few THV families include an individual serving in the military.

POVERTY STATUS

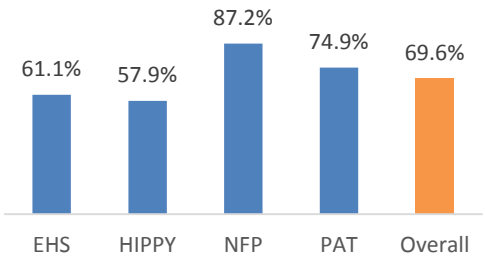
More than two-thirds of THV families (69.6%) had incomes at or below 185 percent of the Federal Poverty Line (FPL) and over half had incomes below 100 percent of the FPL at the time of enrollment. Approximately a quarter of the overall poverty status data are missing, with almost half of the missing data coming from HIPPY families.



NFP is serving the poorest of the THV families—more than three-quarters of NFP families to date are poor (at or below 100% FPL) and nearly 90 percent are low-income. In contrast, only 40 percent of HIPPY families are poor and almost 60 percent are low-income.



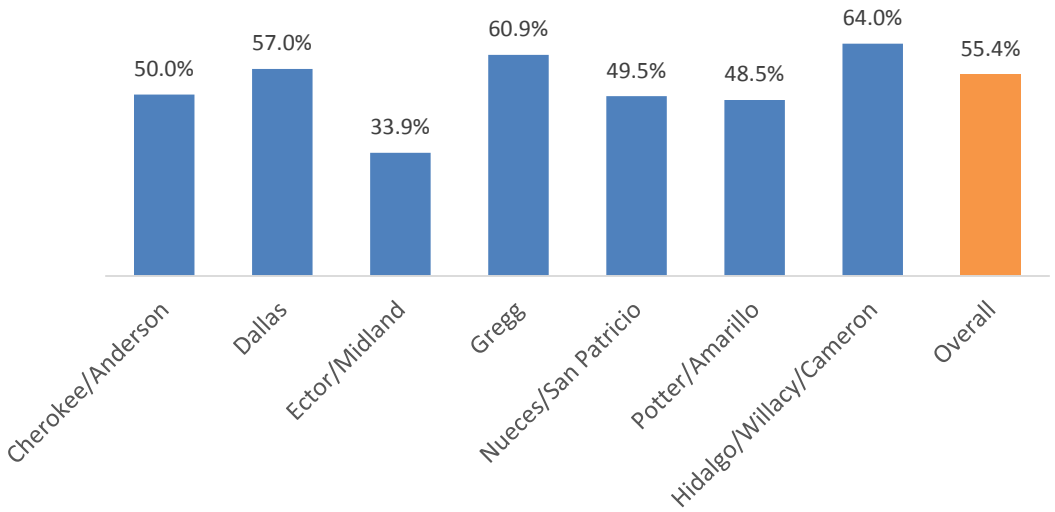
Percent of Families Living in Poverty (100% FPL) by Program
(N = 2,915)



Percent Low-Income Famlies (<185% FPL) by Program
(N = 2,915)

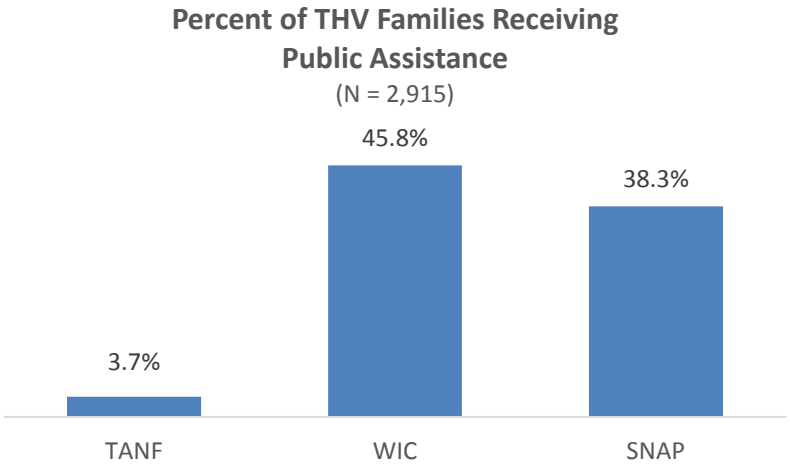
In general, at least half of the THV families served in each of the seven THV communities to date were poor. Ector is the one exception—only about one-third of THV families in Ector have been poor. The recent oil boom in Midland and Odessa has resulted in population surges as well as an increase in median family income, but also has driven up the cost of living.[16] In contrast, nearly two-thirds of THV families in Hidalgo/Willacy/Cameron to date are poor.

Percent of Families Living in Poverty (100% FPL) by THV Community
(N = 2,915)

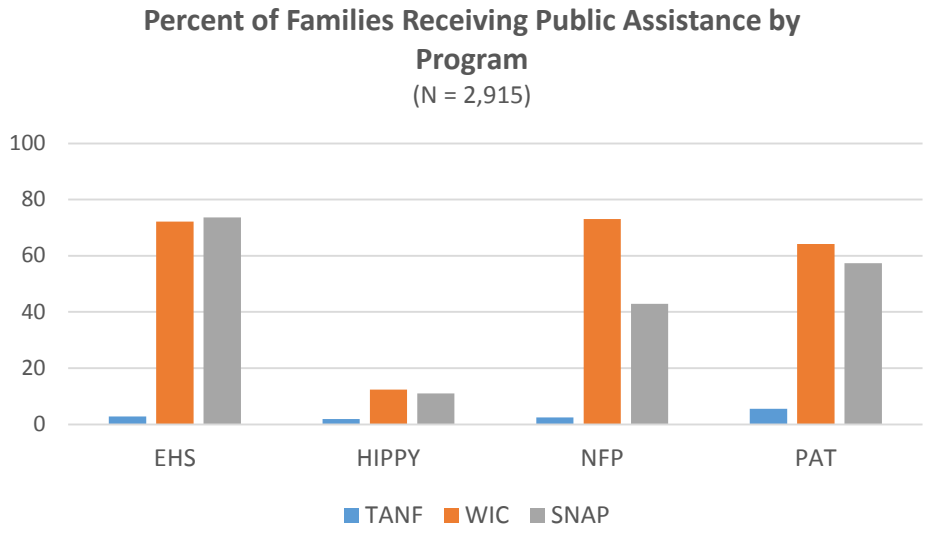


PUBLIC ASSISTANCE BENEFITS

At enrollment, THV families are far less likely to receive TANF than SNAP or WIC. Approximately 4 percent of THV families receive TANF. In contrast, more than a third (38.3%) and nearly half (45.8%) of THV families receive SNAP and WIC, respectively.

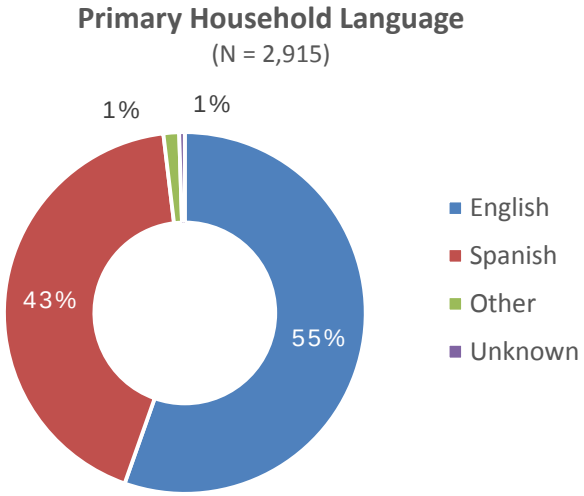


Receipt of public assistance varies by program model. To date, very few HIPPY families are receiving any form of public assistance. Nearly three-fourths of EHS-HV families have received WIC and SNAP. A similar proportion of NFP mothers have received WIC.

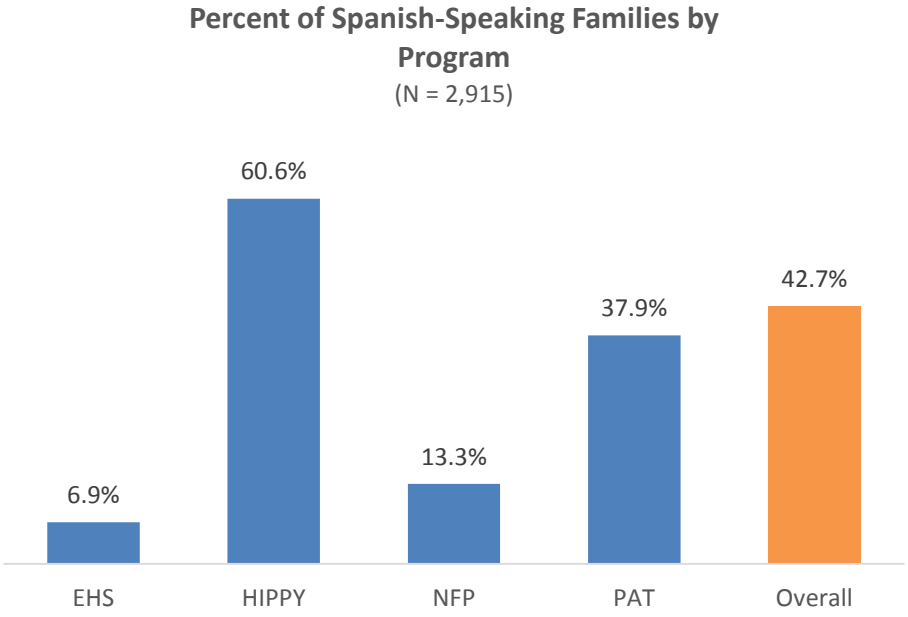


PRIMARY HOUSEHOLD LANGUAGE

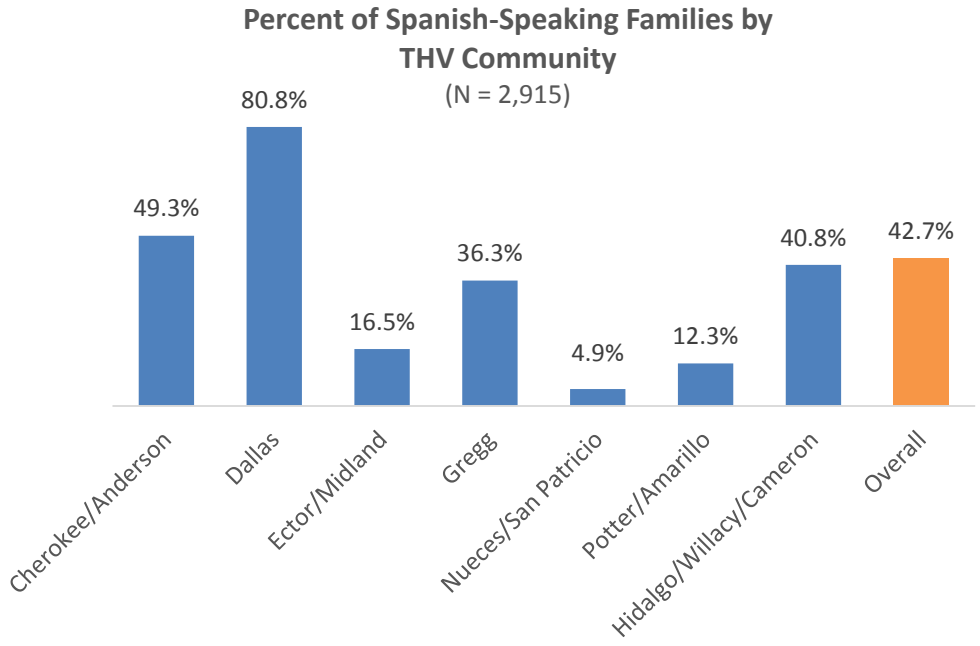
Overall, 55 percent of THV families speak English and 43 percent of families speak Spanish, but this varies widely by program model and THV community.



The majority of families served to date by EHS-HV, NFP, and PAT report English as their primary language. In contrast, Spanish speakers constitute the majority of HIPPY families served to date (60.6%).



Spanish-speaking families make up the majority of THV families in Dallas (80.8%) and nearly half of THV families in Cherokee/Anderson (49.3%), but make up less than 20 percent of THV families ever served in Ector/Midland, Nueces/San Patricio, and Potter/Amarillo.



MILITARY FAMILIES

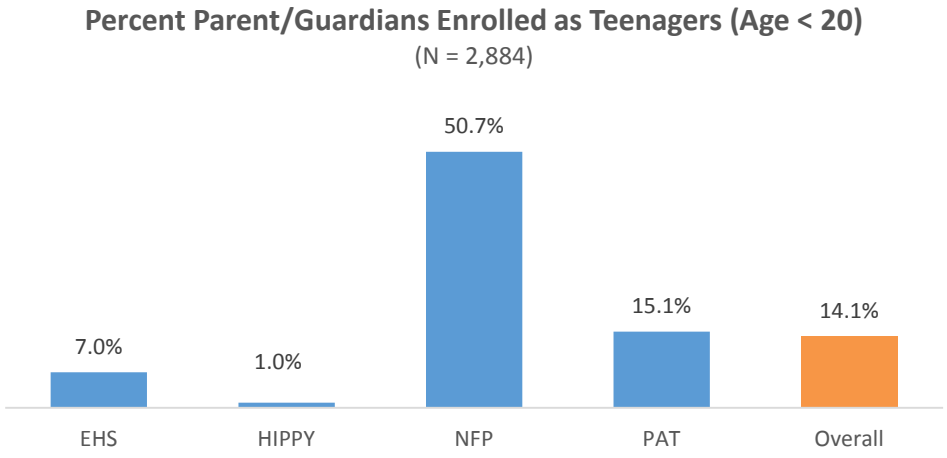
Very few military families are being served by THV. Only 1.5 percent of families in THV report having a member of their family in the armed forces. The military populations in the THV communities are small (Appendix D), so it is not surprising that THV is serving so few military families. Still, 1.5 percent may be an underestimate of the true proportion of THV military families as a fifth of information about the military status of THV families is unknown and more than half of the data for HIPPY families (54.4%) are unknown.

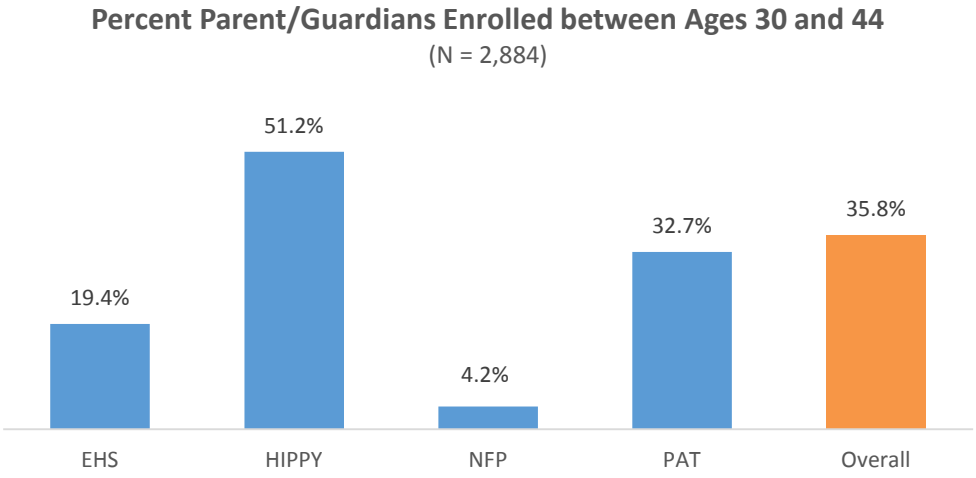
Demographic Characteristics of THV Guardians

The demographic data analyzed at the guardian level include gender, age at enrollment, race/ethnicity, education level, and health insurance status. The available data suggest that in general, THV is serving young, Hispanic females; many of whom are married and have earned at least a high school diploma.

AGE AND GENDER

The vast majority of THV primary guardians are female (97.6%) and most were under the age of 30 (59.7%) when they enrolled in the program. Age at enrollment varies widely by program model. More than 50 percent of NFP mothers enrolled as teenagers (between ages 10 and 19) compared to less than 1 percent of HIPPY parents. In contrast, over half (51.2%) of HIPPY parents enrolled between the ages of 30 and 44.

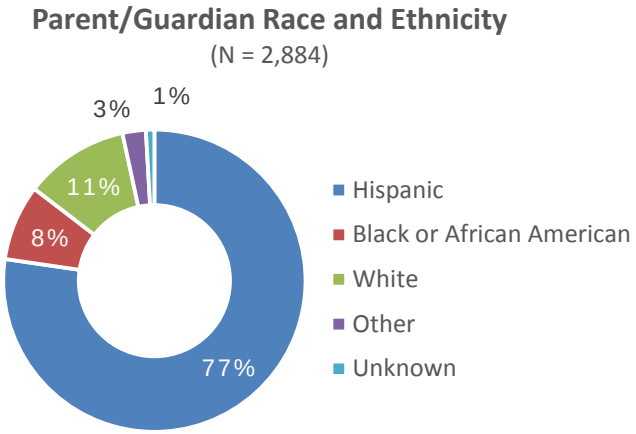


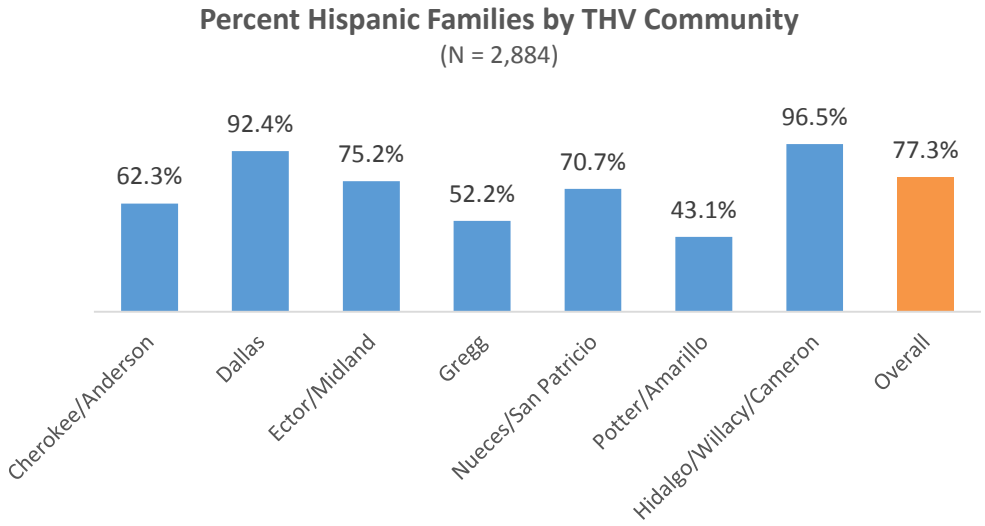


RACE/ETHNICITY

Race and ethnicity are reported differently across the program models, which resulted in a high proportion of individuals enrolled in PAT and EHS-HV who are Hispanic being coded as "more than one category selected" for race. These data were recoded such that race and ethnicity were combined and guardians were classified as White, Black/African American, Hispanic, other (which includes American Indian, Alaskan Native, Asian, Native Hawaiian or other Pacific Islander, or more than one category), or unknown (the data are missing).

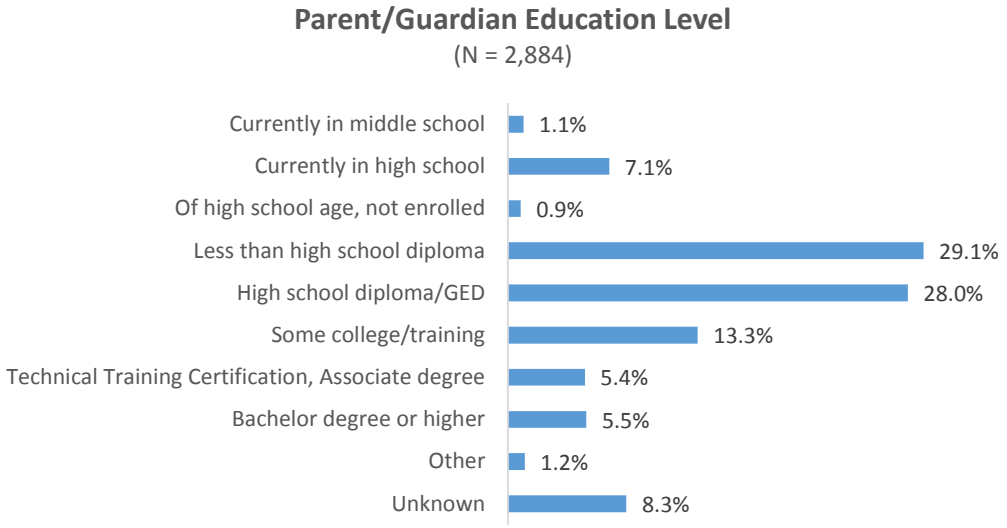
More than three-quarters of parents are Hispanic (77.3%), though this varies somewhat across communities. More than 90 percent of the families ever served in the Dallas and Hidalgo/Willacy/Cameron are Hispanic and fewer than half of the families served in Potter/Amarillo are Hispanic.



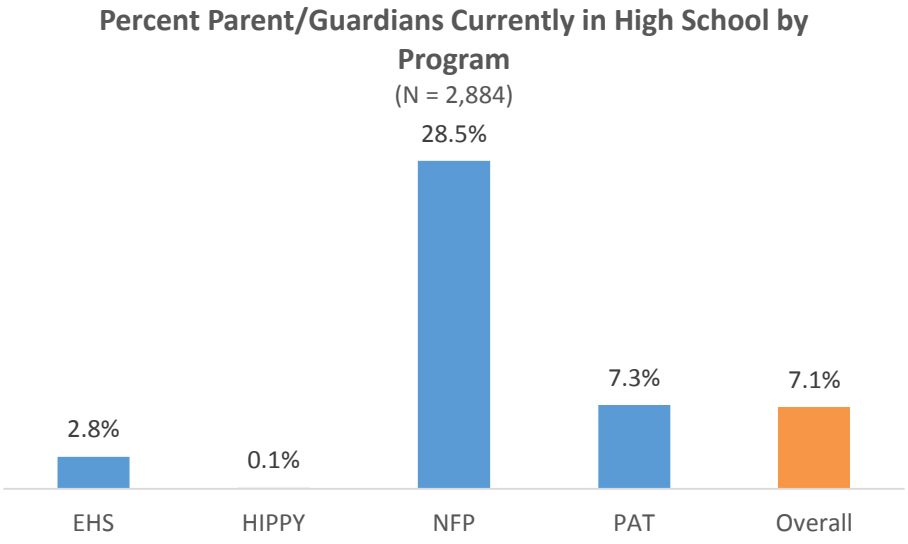


EDUCATION LEVEL

More than a quarter (29.1%) of THV families are high school dropouts, but slightly more than a quarter (28.0%) of THV parents have their high school diploma or GED, and another quarter (24.2%) have at least some college or training.

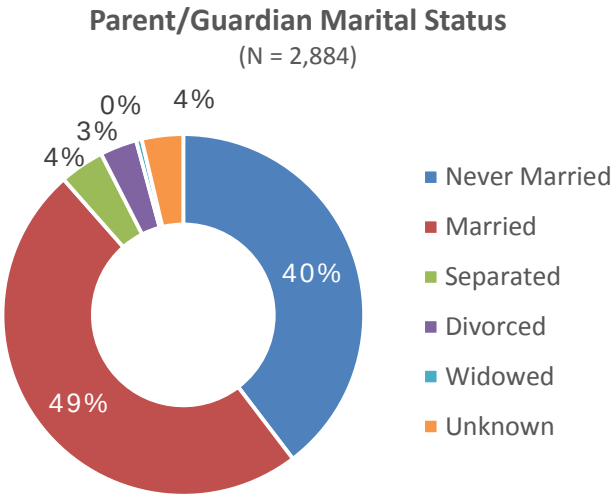


Although, overall, only 7 percent of THV parent/guardians to date were currently in high school when enrolled in THV, more than a quarter of NFP mothers (28.5%) were high school students when participating in the program.

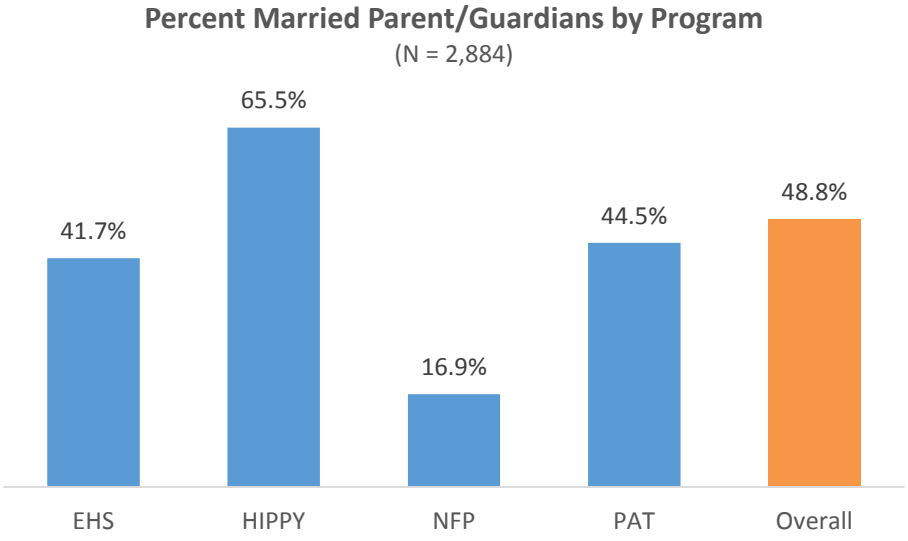


MARITAL STATUS

Nearly half of THV parents are currently married (48.8%) and another 40 percent have never been married.

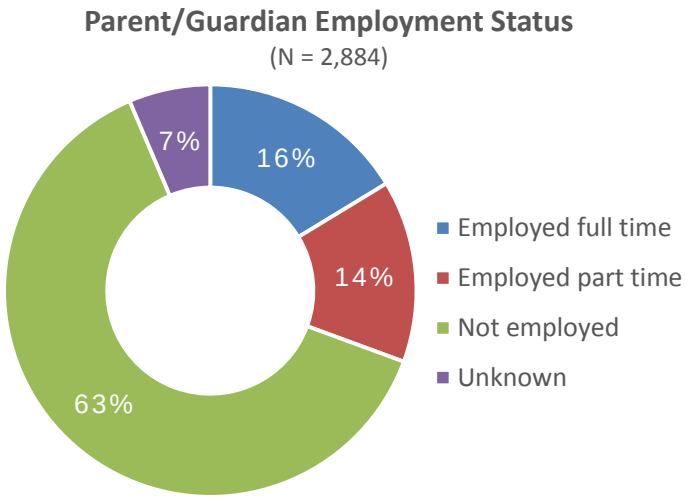


Marital status varies across the programs—almost two-thirds of families served by HIPPY (65.5%) to date were married at enrollment compared to less than one-fifth of mothers served by NFP (16.9%).

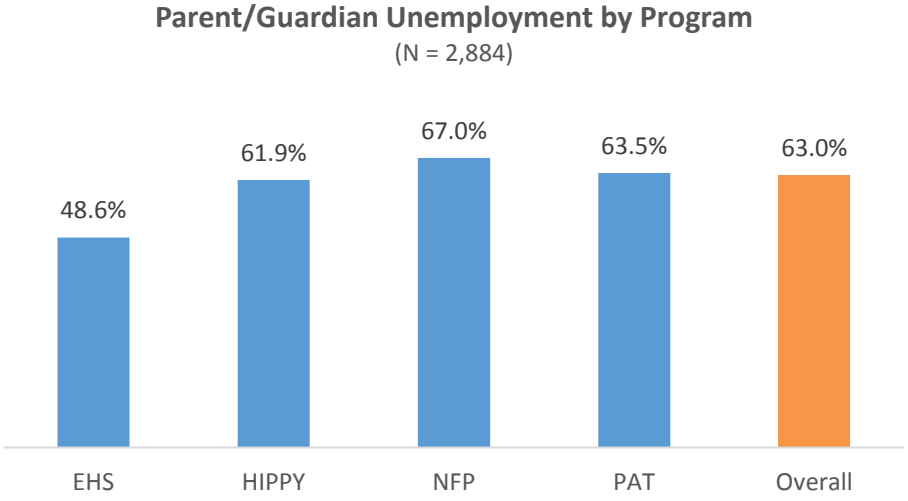


EMPLOYMENT STATUS

The majority (63.0%) of THV parents are unemployed. Of those who are employed, similar proportions are employed full time (16%) and part time (14%).

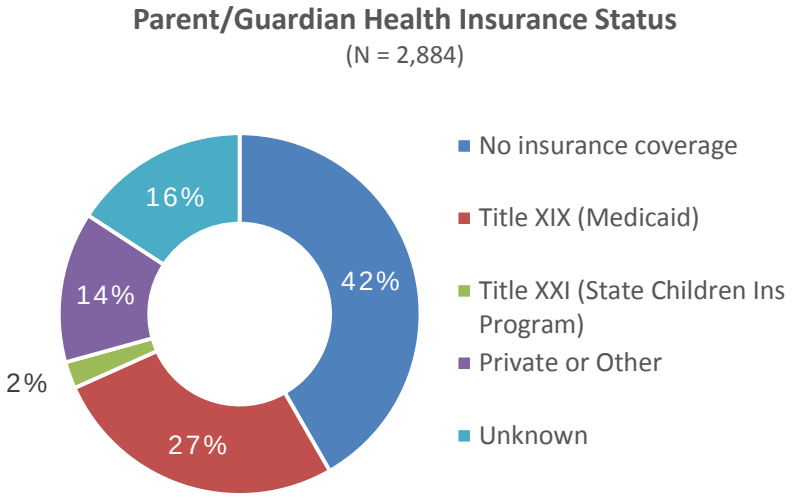


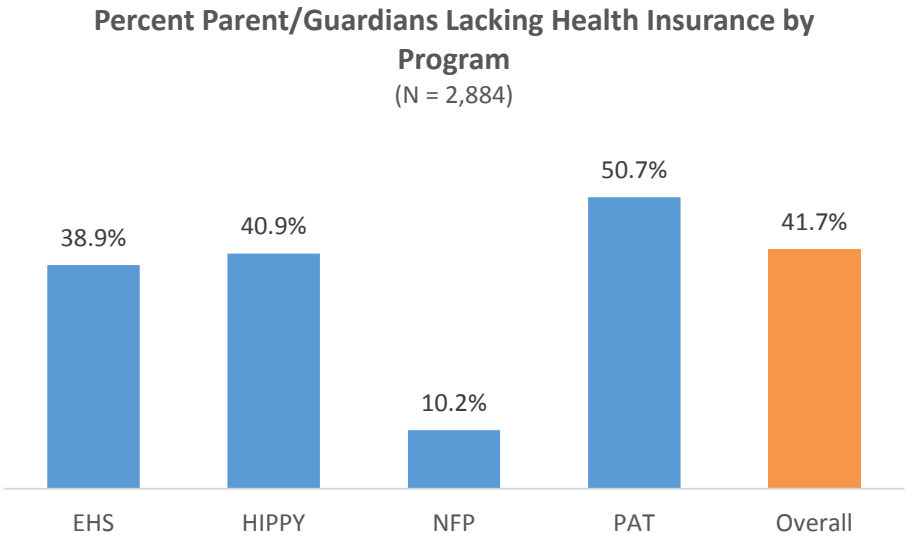
Employment status among THV parents varies by program, but not by community. EHS-HV has the lowest percentage of families not working (48.6%) and NFP has the highest (67.0%), which reflects the mostly-teenage population served by NFP, many of whom are still in high school. The lower rate of unemployment among EHS-HV families may, in part, reflect that EHS-HV is missing the highest proportion of employment status data (15.3%). There is little variation across communities—the percent of parents unemployed ranges from 53.6 percent (Cherokee/Anderson) to 67.8 percent (Dallas).



HEALTH INSURANCE STATUS

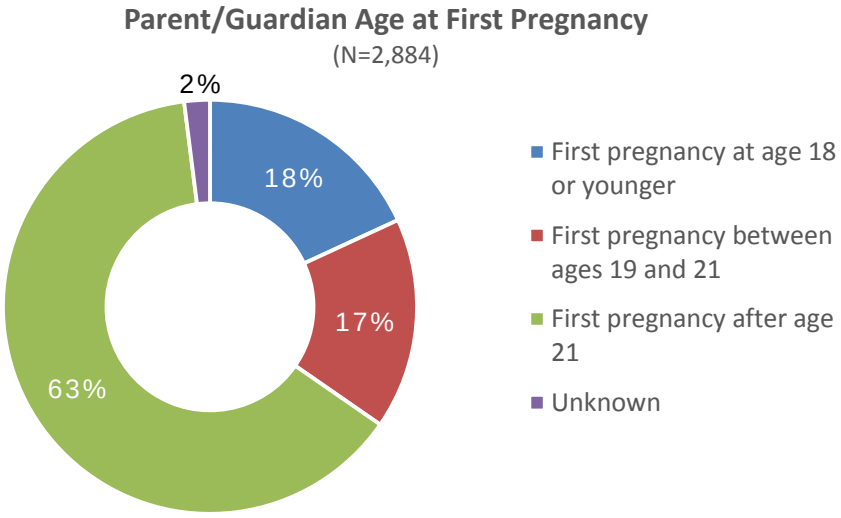
Approximately 40 percent of THV parents lack health insurance, but the NFP program has the lowest percentage of uninsured parents of all programs. More than 80 percent of NFP mothers report being insured through Medicaid, presumably because they are pregnant. Poor mothers are eligible for Medicaid during their pregnancy, but only remain eligible for two months (60 days) postpartum.[17]



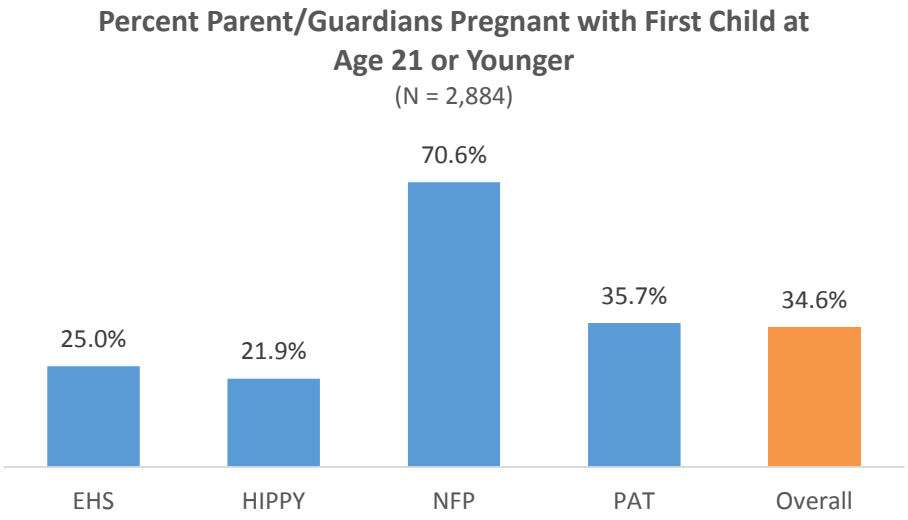


AGE AT FIRST PREGNANCY

Overall, nearly 20 percent (18.1%) of THV mothers were age 18 or younger at the time of their first pregnancy, and another almost 17 percent became pregnant with their first child between ages 19 and 21 (16.5%).



Almost three-fourths (70.6%) of mothers enrolled in NFP became pregnant with their first child before age 21, compared to 25.0 percent, 21.9 percent, and 35.7 percent of mothers for EHS-HV, HIPPY, and PAT, respectively.

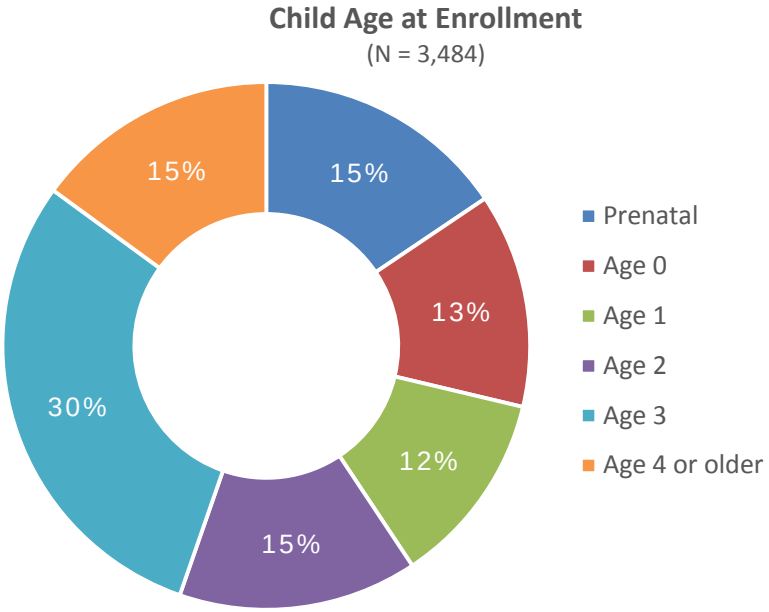


Demographic Characteristics of THV Children

The demographic data analyzed at the child level included the child's age at enrollment (three of the four THV programs—EHS-HV, NFP, and PAT enroll families while mothers are still pregnant), the child's race/ethnicity, the family structure in which they are currently living, and their health insurance status. For race/ethnicity and insurance coverage the analyses were limited to born children only, whereas for age and family status, analyses included both unborn and born children. The available data suggest that most THV children were age three or younger at enrollment, are Hispanic, and have health insurance. Equal proportions of children are living in married and unmarried families.

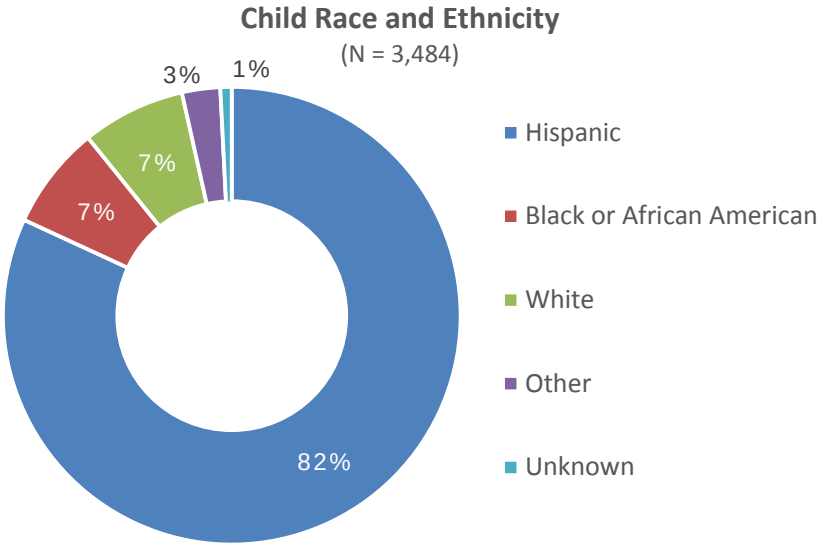
AGE AT ENROLLMENT

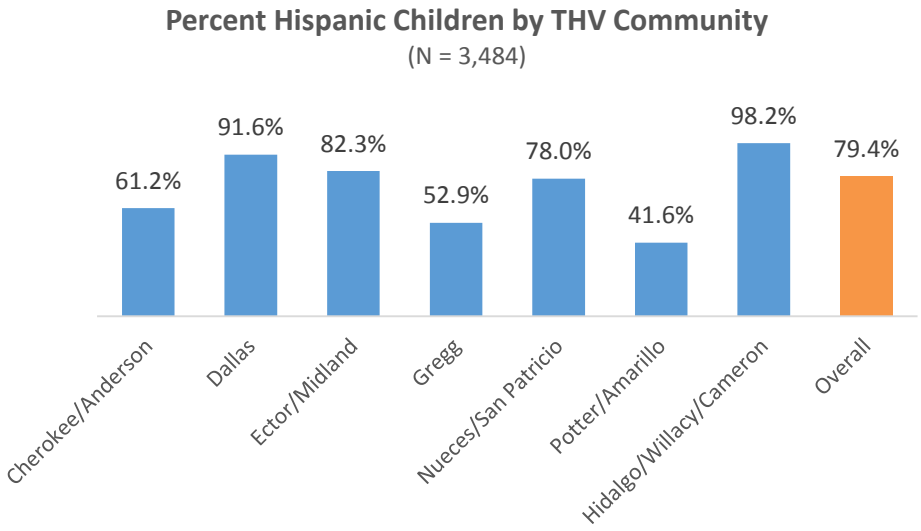
Nearly 85 percent (84.7%) of THV children are age 3 or younger when their families enroll. Close to 30 percent (28.6%) of children were enrolled prior to their first birthday (including those enrolled prior to their birth). Another quarter (26.5%) were enrolled at ages 1 or 2 and 29.6 percent were enrolled at age 3.



RACE/ETHNICITY

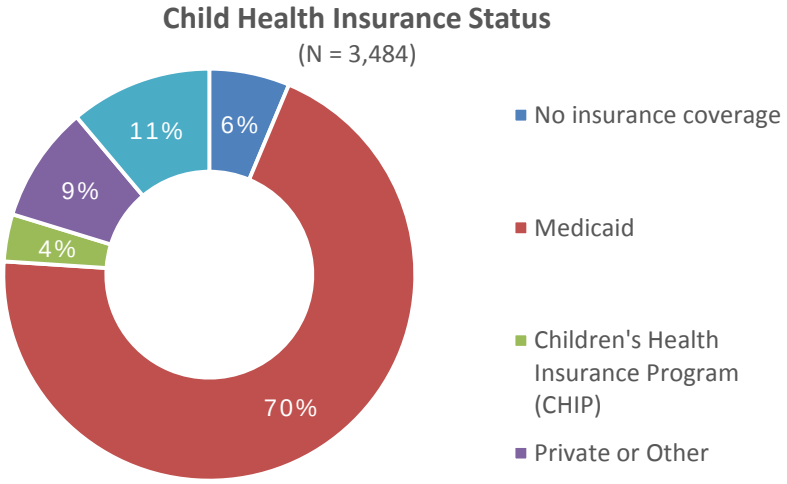
The majority (79.4%) of children are Hispanic, but this varies somewhat by THV community. Almost all (98.2%) of the children being served by THV in Hidalgo/Willacy/Cameron are Hispanic. Both Dallas and Ector counties are serving higher than average proportions of Hispanic children (91.6% and 82.3%, respectively).



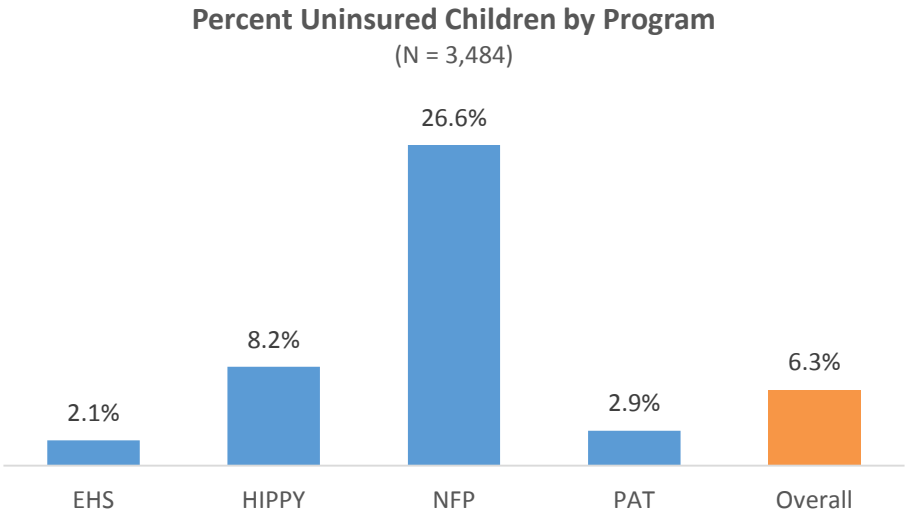


HEALTH INSURANCE STATUS

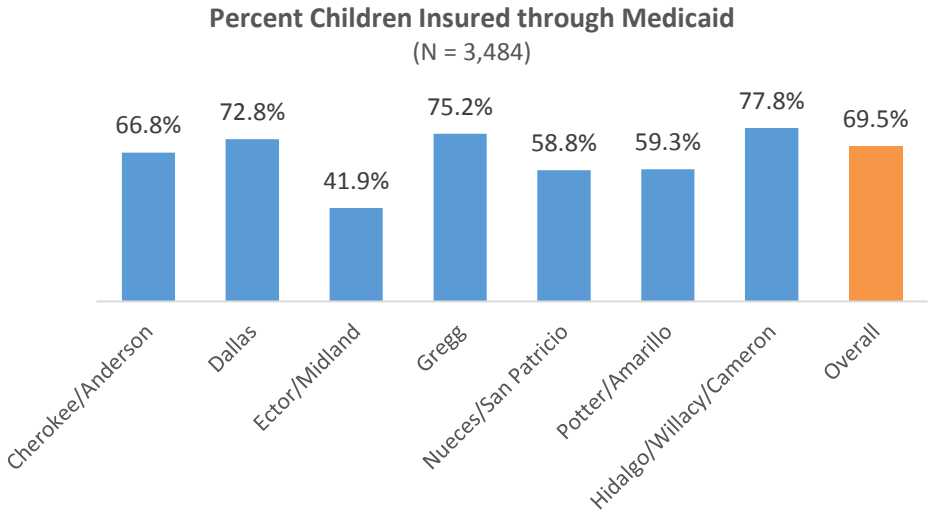
Fortunately, very few children enrolled in THV are uninsured (6.3%), which is nearly half of the percentage of Texas children that were uninsured in 2012 (13.1%). Approximately three-fourths of children are insured through Medicaid (69.5%) or CHIP (3.7%). More than 10 percent of information is missing for children's health insurance status, which means these estimates may be an underestimate.



NFP has the highest proportion of uninsured (born) children (26.6%), which is strange given that NFP has the lowest proportion of uninsured mothers (10.2%) compared to the other programs. This could reflect a programmatic challenge of enrolling NFP infants in Medicaid or CHIP. Alternatively, these estimates may be biased by missing data. NFP is not missing any data on children's health insurance, but the other programs are missing between 10 and 17 percent of this information. Rates of uninsured children may be high in the other programs as well, but the missing data are skewing the estimates.

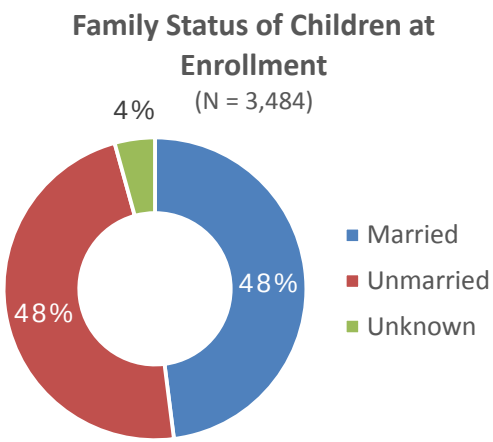


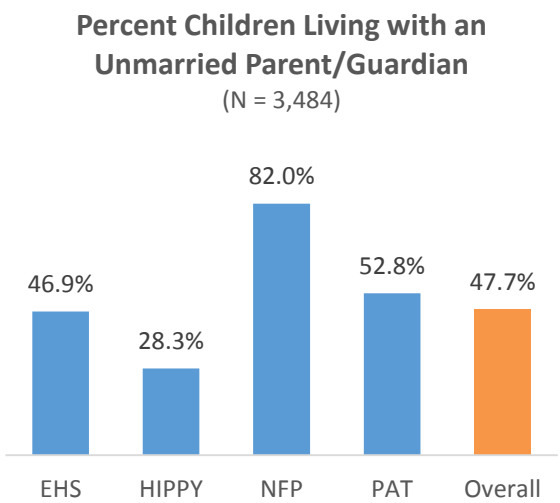
Rates of uninsured children are vary across the THV communities, ranging from 2.7 percent in Hidalgo/Willacy/Cameron to 11.7 percent in Ector/Midland. The percentage of children insured through Medicaid also varies substantially across the THV communities, ranging from 41.9 percent in Ector/Midland to 77.8 percent in Hidalgo/Willacy/Cameron.



FAMILY STATUS

Nearly identical proportions of children are living in married (48.0%) and unmarried (47.7%) families. Family status varies widely by program model. NFP is serving children largely living with unmarried parents (82.0%) and HIPPY is serving children mostly living with married parents (62.3%). There is some variation across communities as well—nearly 60 percent of children live with unmarried parents in Hidalgo/Willacy/Cameron and Nueces/San Patricio, whereas nearly 60 percent of children live with married parents in Cherokee and Potter/Amarillo.





Summary

Overall, the available data suggest that THV continues to serve the high-risk Texan families that were targeted by MIECHV. The majority of families being served by THV are low-income, with a significant proportion of families living in poverty and almost a third living in extreme poverty (below 50% FPL). Overall, most of the guardians enrolled in THV are young, Hispanic females; though the characteristics of families in THV vary by program model. The available data suggest that the majority of NFP enrollees are teenagers and unmarried whereas the majority of HIPPY enrollees are older—between the ages of 30 and 44—and married. The majority of THV parent/guardians do not work, which may be conducive to their participation in the program. These same risk factors—being poor or low-income, a teenage parent, young, and single—that characterize so many THV families and make them eligible for participation in the programs also make it difficult for the programs to serve and retain them. These challenges are highlighted in the following chapters.

CHAPTER 5: WHAT DOES THV PROVIDE FAMILIES?

Background

Careful monitoring of whether the programs are implemented and delivered with fidelity enables policy makers, program operators, and evaluators to clearly link practice to participant outcomes.[18] One of the most common ways to assess whether or not a program is implemented with fidelity is the extent to which the replication effort provided participants with the recommended level of service, or dosage.[19] Generally, dosage refers to the amount of an intervention and can be measured in a variety of ways including the number of visits provided, weeks of enrollment, and the percentage of participants who received the intended service dosage (as required by the evidence-based model being implemented).

Beyond dosage, assessing the extent to which programs are delivering the content of the curriculum is another key element of implementation. Each home visiting program model has a particular set of goals for its families and delivering the curriculum content is key to achieving those goals. Generally, the home visiting program models share the objective of supporting families with young children, particularly high-need families, in order to promote children's early development. Because the programs differ in the period of children's development during which they target their intervention, the programs' specific goals vary somewhat. NFP, for example, which targets first-time pregnant mothers, focuses on improving pregnancy outcomes and both maternal and child health. In contrast, HIPPY, which targets preschool-aged children, focuses primarily on school readiness by empowering parents to prepare their children for success in school.

Dosage and program delivery are inextricably intertwined. Home visiting programs are delivered to families during home visits. If home visitors do not conduct all of the expected visits with families, then they cannot deliver all of the services and program curricula, which will limit the extent to which families can benefit from the programs.

Dosage in THV

Home visiting program coordinators and home visitors across the THV programs noted in both their monthly reports and in interviews the many obstacles to providing participants with 100 percent of the intended dosage. Frequent cancellations due to illness, holidays, and school breaks, or no-shows were cited as one of the greatest challenges to serving families. Despite most programs being flexible, willing to reschedule, and calling or texting to confirm appointments, home visitors noted that often families just didn't show up or were unresponsive to phone calls and texts. Several programs noted that families that were higher need or experienced more difficult situations had a harder time staying on track with homework and visits, as well as remaining in the program, which may affect dosage. Additionally, even when families reengaged with the program, many feel overwhelmed due to

falling behind. This was particularly common in the HIPPY program, where families who have fallen behind have to receive multiple weeks of curricula at once to catch up.

Interviews with home visitors also revealed that many home visitors have contact with families outside the formal interactions, or dosage, required by the curriculum. Families often have the cell phone numbers of their home visitors and call or text when help is needed. Home visitors also reported spending hours outside of the visit establishing connections and finding resources for their families, suggesting that even if families are not receiving 100 percent of the intended dosage as prescribed by the home visiting program model, they are likely receiving assistance in other ways that are not captured by the THV data system.

Table 8 displays the expectations for full dosage (100% of recommended visits) according to the home visiting program models being implemented in THV. As shown in the table, the expectations for full dosage vary by program model. NFP requires program participants to receive a complicated series of both prenatal and post-natal visits to meet the expectations for full dosage, while HIPPY requires weekly visits but only for 30 weeks, and PAT requires monthly visits (twice-monthly if the family is deemed high-risk, which is the case for almost all THV families) for full dosage. The expected dosages for each program were translated into the number of visits a family should receive over one year and over 6 months of participation in the program.

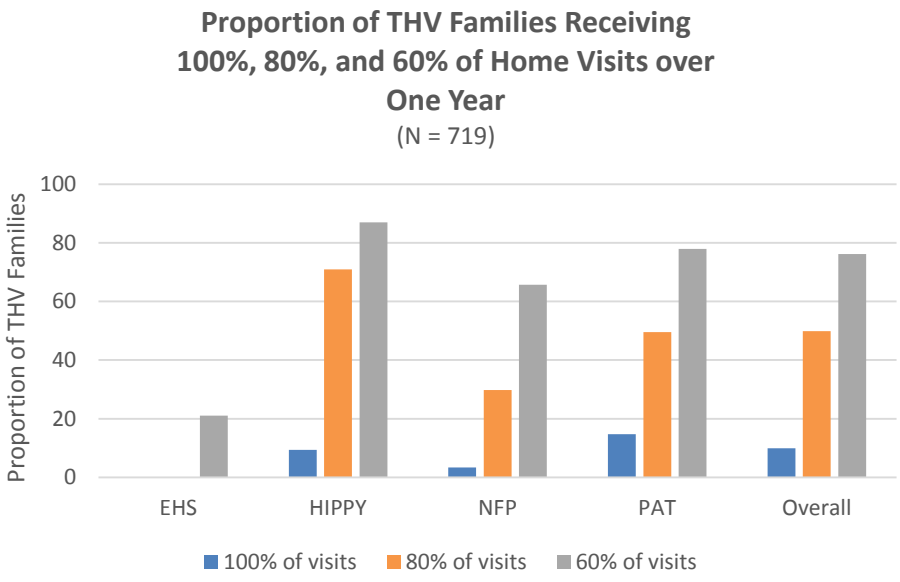
Table 8. Expected Average Participant Dosages

	Duration	Dosage	# of Visits Expected / Year	# of Visits Expected / 6 months
EHS-HV	Pregnancy - Age 3	Weekly 90-minute home visits & twice-monthly group socializations[20]	52	26
HIPPY	Age 3 (or Age 4) - Age 5	Weekly home visits for 30 weeks & twice-monthly group meetings[21]	30	15
NFP	Pregnancy (before 28 weeks) – 24 months	Weekly for first 4 visits, every other week until birth, weekly from birth-6 weeks, every other week from 6 weeks-21 months, monthly until 24 months[22]	30	18
PAT	Pregnancy – Age 5 (Families are expected to participate for 2 years)	Monthly visits or twice-monthly visits for families with 2 or more risk factors[23] *(The majority of THV PAT programs visit their families twice monthly)*	24	12

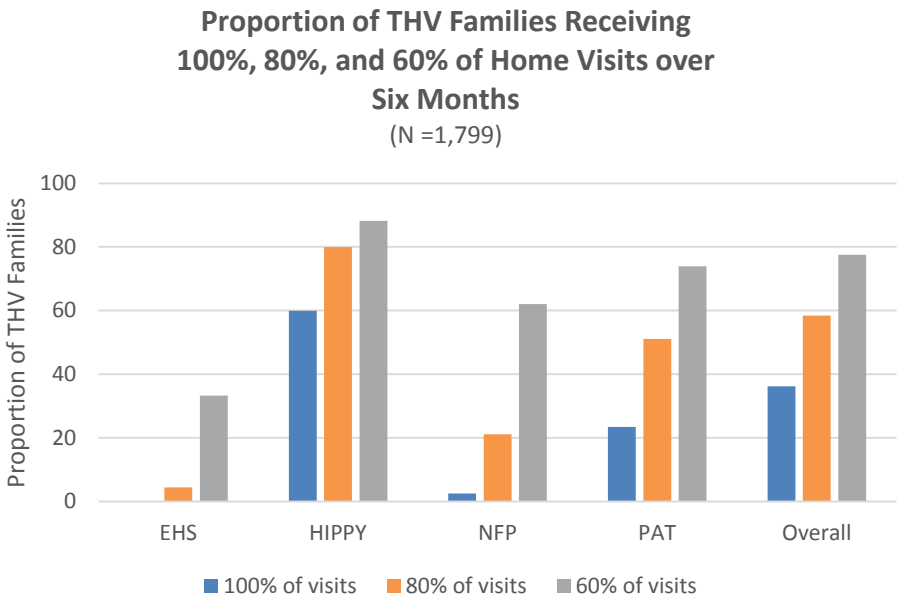
NUMBER OF VISITS

The number of visits a family should receive over a year and over six months of participation in their home visiting program were calculated based on the model expectations for average participant dosages (Table 8). For ease of interpretation, analyses of the proportion of THV families receiving 100, 80, and 60 percent of the visits they should receive over a year of participation were restricted to the first year of enrollment for families who had been enrolled for at least one year (719 families). Analyses of the proportion of THV families receiving 100, 80, and 60 percent of visits over six months of participation were restricted to the first six months of enrollment for families who had been enrolled for at least six months (1,799 families).

Overall, less than 10 percent of THV families have received 100 percent of the home visits they should have had over a year and nearly 80 percent (76.2%) have received 60 percent of their home visits. The HIPPY program has the highest proportion of families receiving 60 and 80 percent of their home visits, but the PAT program has the highest proportion of families (14.7%) receiving 100 percent of their visits. Most, but probably not all, THV families in the PAT program receive twice-monthly visits because of their level of risk. Still we assumed twice-monthly visits for all families in PAT. Thus, 14.7 percent of families receiving 100 percent of their twice-monthly visits is a conservative estimate.



In contrast, when dosage is restricted to the first six months of enrollment, the percentage of families receiving 100 percent of their home visits is much higher. Overall, more than one-third of THV families have received 100 percent of their home visits over their first 6 months. Similar to the one-year estimates, the HIPPY program has the highest proportion of families receiving 60 and 80 percent of their home visits, but this time, also 100 percent of their visits.



SUMMARY

The greater likelihood of THV families, both overall and across home visiting programs, to receive 100 percent of their home visits over their first six months compared to their first year of enrollment most likely reflects declining family engagement in the program over time—an issue that home visitors and program coordinators have elaborated on in interviews. Even though close to 80 percent of THV families receive 60 percent of their visits (either over their first year or over their first six months), it is unclear whether receiving slightly more than half of the intended program will benefit families to the same extent that receiving the full program would.

Program Delivery in THV

Each home visiting program follows a model-specific curriculum to provide families with the information, tools, and support to promote child and family well-being. In addition to model-specific curricula, each of the programs participating in THV are required to deliver specific services in order to show progress toward meeting the MIECHV benchmarks. These services may overlap with services already provided by the model-specific curricula or be additional components delivered to meet the MIECHV requirements.

Interviews with home visiting coordinators and home visitors provided insight into the many barriers home visitors face in not only completing all of the required visits, but also delivering the required services and information when visits do occur. Many home visitors noted that they show up prepared for a particular visit, but often the families would have other more urgent needs that day or just need someone to talk with, and the planned curriculum for that visit is not delivered. Home visitors often feel that addressing families' immediate and basic needs (e.g., housing, utilities, and food) and crises is an important part of their job, even if it sometimes makes it difficult to deliver curriculum as planned. The relationship that develops between the home visitor and a family is essential to keeping families in the program, and is also the only form of support that many families feel they have.

Home visitors reported having to be resourceful to incorporate as many elements of the intended visit as possible into the conversations they have with the families. Several home visitors explained that they would do the curriculum first and then would turn to the specific needs of the mother afterwards. Many felt this was an effective strategy in completing the required elements of the visit (e.g., screenings) and also providing support for families' immediate needs. However, if the intended curriculum was not delivered during a particular visit, home visitors would often return for an additional visit or double-up on visits to ensure the curriculum is delivered, though this interfered with a home visitor's ability to serve all of the families on their caseload.

In addition to providing information on curriculum delivered during visits and process benchmarks, monthly reports and interviews with program leads, coordinators, and home visitors also shed light on the content of parent meetings and extracurricular activities. Parent meetings provided by programs covered a wide range of topics, including literacy, home and child safety, healthy relationships (including domestic violence), time management, arts (e.g., music, movement, crafts), father involvement, and health. Health topics themselves covered a wide range of issues, including fitness, nutrition, safe sex and pregnancy prevention (including birth control and AIDS awareness), emotional health (including self-esteem, stress, and anxiety management), health care reform, and brain development. Special holidays like Mother's Day and Father's Day were also celebrated with families and special activities included trips to museums, parks, and the petting zoo. A few programs reported increased attendance at parent meetings, particularly at events that involved food and fun. A few programs noted an increase in attendance by fathers at these events.

Home visitors also mentioned several extracurricular activities that went beyond the given curriculum of a program. These activities included working with families on public benefits, donations of toys and food for families, and even a scholarship program. Several programs mentioned an emphasis on literacy and reported providing books to families, often in conjunction with outside partners.

RECEIPT OF SCREENINGS AND INFORMATION

Data from the THV data system on the percent of families in THV who have received the required screenings and information were analyzed. The particular population of program participants for whom services and information are required varies for each program element—that is, the total eligible population (the denominator) varies for each program element. For example, information on birth spacing must be provided at least once and within 6 months postpartum, but only to mothers who give birth while enrolled in the program—a small number of women relative to the total. In contrast, a much larger population—all primary caregivers who have been enrolled for at least 3 months - must be screened for cigarette use. Table 9 displays the number of THV participants who should have received each program element across the program models.

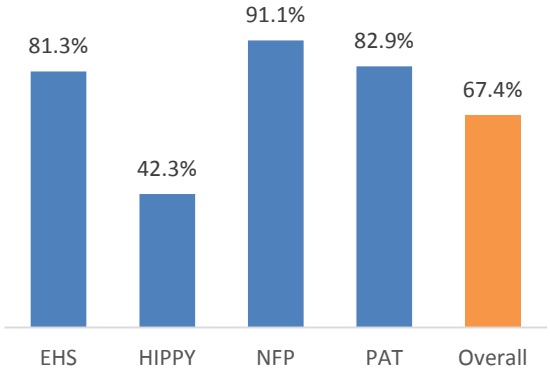
Table 9. Number of THV Participants Included in Analyses of Each Program Element

	EHS-HV	HIPPY	NFP	PAT	Total
Cigarette Screening	64	1,004	338	1,053	2,459
Birth Spacing	9	N/A	194	80	283
Depression Screening	25	N/A	338	442	805
Injury Prevention	48	858	194	639	1,739
ASQ Screening	69	855	194	906	2,024
Domestic Violence Screening	20	230	182	299	731
Referrals	11	163	174	202	550

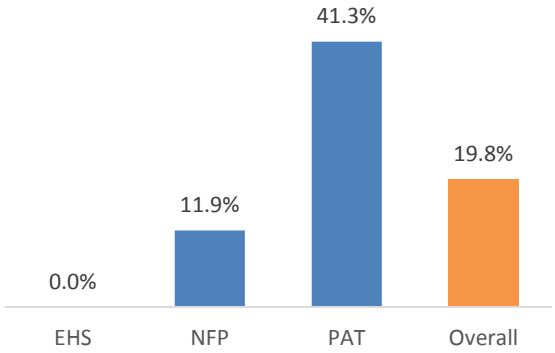
Whether families actually receive the information and services they are supposed to varies across the program elements. Overall, two-thirds of THV families have been screened for cigarette use, received at least one Ages and Stages Questionnaire (ASQ) screening, been screened for domestic violence and almost three-quarters have received at least one referral for an identified need. Less than half of mothers have been screened for prenatal or postnatal depression or provided with information on injury prevention and less than a fifth have received birth-spacing information.

This stands in contrast to much of the information collected in the monthly reports and through interviews. For example, many programs mention that the ASQ screenings or screenings for cigarette use, depression, and domestic violence are all conducted within the required time frame. The same programs also described the challenges of balancing required screenings and curriculum delivery with addressing families' needs in addition to problems with dosage (e.g., cancellations and no shows). Differences between reports from home visiting program staff and the data in the THV system may also reflect ongoing issues and errors in the data system.

Percent of Mothers Screened for Cigarette Use at least once within 3 Months of Enrollment

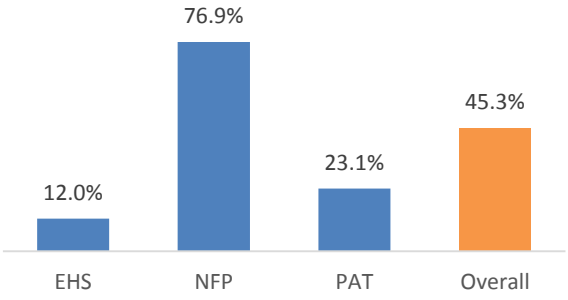


Percent of Mothers who Received Birth-Spacing Information at least once within 6 Months Postpartum



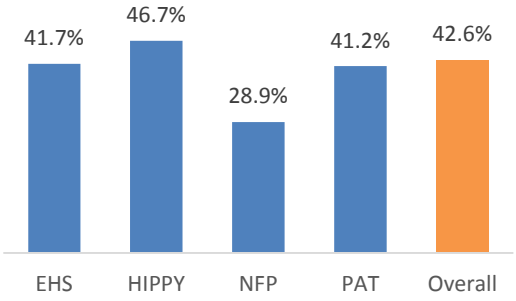
Note. HIPPY is excluded from this measure

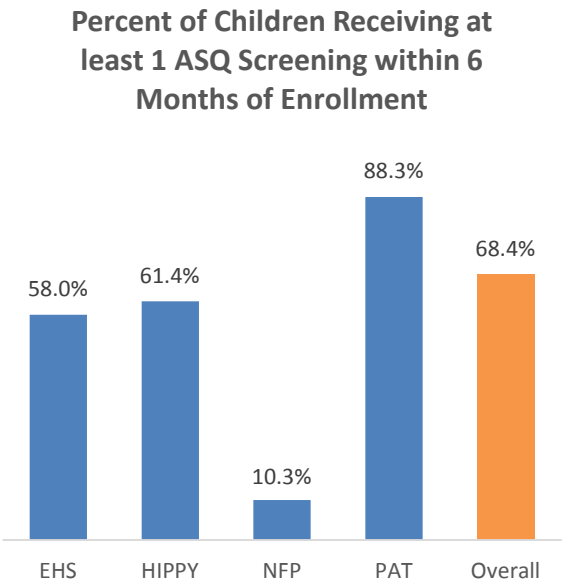
Percent of Mothers Screened for Prenatal/Postpartum Depression within 3 months of Enrollment

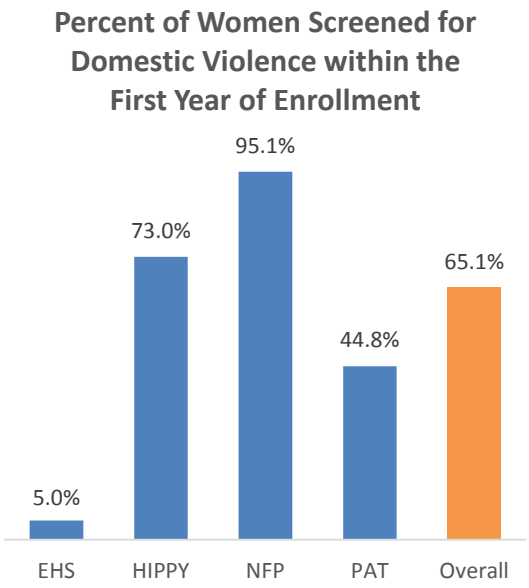


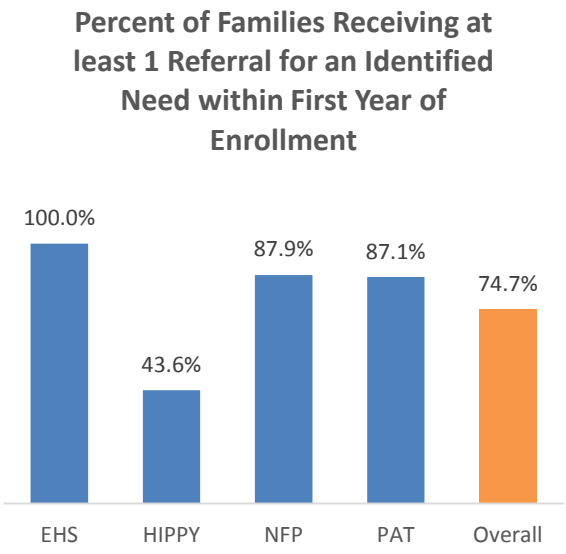
Note. HIPPY is excluded from this measure

Percent of Families Provided Information on Injury Prevention at least once within 6 months of Enrollment




Percent of Children Receiving at least 1 ASQ Screening within 6 Months of Enrollment
58.0%
61.4%
10.3%
88.3%
68.4%
EHS
HIPPY
NFP
PAT
Overall


Percent of Women Screened for Domestic Violence within the First Year of Enrollment
5.0%
73.0%
95.1%
44.8%
65.1%
EHS
HIPPY
NFP
PAT
Overall


Percent of Families Receiving at least 1 Referral for an Identified Need within First Year of Enrollment
100.0%
43.6%
87.9%
87.1%
74.7%
EHS
HIPPY
NFP
PAT
Overall

MODEL FIDELITY

The extent to which THV will be able to show improvement in the federal benchmarks depends largely on families receiving the information and services associated with their program model's curriculum. Observations from our visits to each of the communities made it clear that there is seemingly little attention being paid to model fidelity and that there are few, if any, oversight mechanisms in place. The program lead in each community is contractually obligated to monitor model fidelity for each of the programs being implemented in their community, but the extent to which this is occurring or should be occurring, given the level of subcontracting to direct service providers, is unclear. The lack of access to the THV Data System makes it difficult for the program leads to be able to accurately monitor program fidelity, and makes it almost impossible when the delivery of the home visiting program is subcontracted to other partners.

Neither HHSC nor the program model leads are providing the program leads the level of guidance and support on model fidelity they require to monitor fidelity. If model fidelity is not being carefully monitored, it will be nearly impossible to adequately examine how the programs were implemented. Moving forward, HHSC should either get assurance from the program models that the programs are being implemented with fidelity or get a measure of the degree to which the programs are or are not being implemented with fidelity.

PARENT MEETING/GROUP SOCIALIZATION ATTENDANCE

Three of the four THV program models—EHS-HV, HIPPY, and PAT host monthly group meetings for the parents enrolled in their program. Attendance at these monthly meetings provides an important opportunity for social interaction among parents of similarly aged children and allows the program models an additional opportunity to educate parents. Table 10 shows how many THV parents attended parent meetings or group socializations and the content or focus of the meetings.

There is wide variation across programs with regard to how much parent meeting data are available. For some programs, there is more than a year's worth of data, but for others, only a few months of data are available. In general, the available data suggest that the programs are using the parent meetings largely as an opportunity to provide parents with information related to the benchmarks.

Table 10. Parent Meeting Attendance to Date

Community	Program	# of Parent Forms	Total # of Parents Attendees	Avg. # of Parent Attendees	Topic					
					# Social	% Social	# FF	% Father Focus	# Benchmark	% Benchmark
Cherokee	HIPPY	13	146	11	1	8%	1	8%	11	85%
	PAT	13	132	10	1	8%	1	8%	11	85%
	TOTAL	**25**	**278**	**11**	**2**	**8%**	**2**	**8%**	**22**	**88%**
Dallas	HIPPY	1	10	10	0	0%	0	0%	1	100%
	PAT (CCG)	18	351	20	9	50%	0	0%	9	50%
	PAT (Lumin)	13	138	11	3	23%	2	15%	8	62%
	PAT (FC)	2	32	16	2	100%	0	0%	0	0%
	TOTAL	**35**	**531**	**15**	**14**	**40%**	**2**	**6%**	**18**	**51%**
Ector	HIPPY	12	323	27	0	0%	1	8%	11	92%
	PAT	14	292	21	1	7%	0	0%	13	93%
	TOTAL	**26**	**615**	**24**	**1**	**4%**	**1**	**4%**	**24**	**92%**
Gregg	HIPPY	16	370	23	3	19%	0	0%	13	81%
	PAT	17	167	10	2	12%	0	0%	15	88%
	TOTAL	33	537	16	5	15%	0	0%	28	85%
Hidalgo/Willacy	HIPPY	1	1	1	0	0%	0	0%	1	100%
	PAT	6	61	10	1	17%	1	17%	4	67%
	TOTAL	**7**	**62**	9	1	14%	**1**	14%	**5**	71%
Nueces	EHS-HV	41	199	5	6	15%	2	5%	33	80%
	HIPPY	21	388	18	3	14%	1	5%	17	81%
	PAT	7	53	8	0	0%	1	14%	6	86%
	TOTAL	**70**	**640**	9	9	13%	**4**	6%	**56**	80%
Potter	EHS-HV	53	392	7	6	11%	1	2%	46	87%
	HIPPY	7	78	11	1	14%	1	14%	5	71%
	PAT	30	204	7	6	20%	0	0%	24	80%
	TOTAL	**60**	**674**	11	**13**	22%	**2**	3%	**75**	125%
Overall	EHS-HV	94	591	6	12	13%	3	3%	79	84%
	HIPPY	71	1316	19	8	11%	4	6%	59	83%
	PAT	120	1430	12	25	21%	5	4%	90	75%
	TOTAL	**285**	**3337**	12	**45**	16%	**12**	4%	**228**	80%

SUMMARY

Not only is there variation in the information and screenings that THV families have received across program elements—THV families are much more likely to have received a referral for an identified need, been screened for cigarette use and domestic violence, and have a child who has received at least one ASQ screening than they are to have received information on birth spacing or injury prevention, or be screened for depression—there is variation across the program models. Variation across the program models is not unexpected given the different populations targeted by each model and their varying goals. NFP has the highest percentage of mothers who have received prenatal/postnatal depression screenings, but the lowest percentage of children who have received an ASQ screening. In contrast, HIPPY and PAT have the highest percentages of children receiving ASQ screenings, reflective of having school readiness as a primary program goal.

The THV programs use parent meetings and group socializations as an additional opportunity to provide parents with information or services related to the benchmarks. Given the difficulties that home visitors describe delivering the program curriculum in the midst of unpredictable family needs and crises, as well as having to work around cancellations and no shows, parent meetings are an important tool for programs to ensure families are receiving the services and information they are supposed to.

All of the THV programs still struggle to meet the program model expectations for service delivery with regard to both dosage and program content. The primary barriers to providing families with the full dosage of the program are the characteristics of the high-risk and high-need families they are serving. The very characteristics that make these families in need of and eligible for the program make them difficult to reach and serve. The primary barrier to delivering program content is dosage – not being able to meet with families to serve them.

CHAPTER 6: HOW LONG DO FAMILIES STAY IN THV?

Background

Retaining families in home visiting programs is essential for improving child and family outcomes, but because home visiting programs target high-need families who have multiple stressors in their lives, keeping them engaged in the program can be particularly difficult. Theoretically, the longer families stay in a home visiting program, the greater the dosage of home visiting services those families receive. Although families may benefit from initiating participation in the home visiting programs, research shows that families who remain in home visiting programs for longer periods of time, and thus have greater opportunity to receive home visits, demonstrate more positive outcomes compared to families who leave the programs prior to program completion.[24]

Attrition in THV

Qualitative data collected through interviews and from monthly reports provided important insight into the reasons why families leave a program prior to completion and the great lengths to which programs try to keep families in the program. The home visiting programs cited the time commitment required by the programs, school breaks or holidays, moving or relocation, children going to preschool, and parents returning to either school or work as the primary reasons that families leave. Teenage parents and families referred by CPS were identified as particularly hard to engage and retain in home visiting programs across THV.

Home visitors reported that families struggle with time commitments for a variety of reasons, including a misunderstanding of or lack of preparedness for program requirements, difficulty balancing the program with extracurricular activities of the family and other children, or difficulty balancing the program with the family's other needs. Many of the home visiting programs noted an important tension between the goals of the program and retention: promoting families' economic self-sufficiency (helping them train for and find a job, assisting them with going back to school or obtaining a GED), which is a primary goal of the programs, is also associated with families leaving the program due to lack of time. Several programs also noted that changes in staffing (due to turnover and/or staff leave) sometimes lead to families exiting the programs or falling behind.

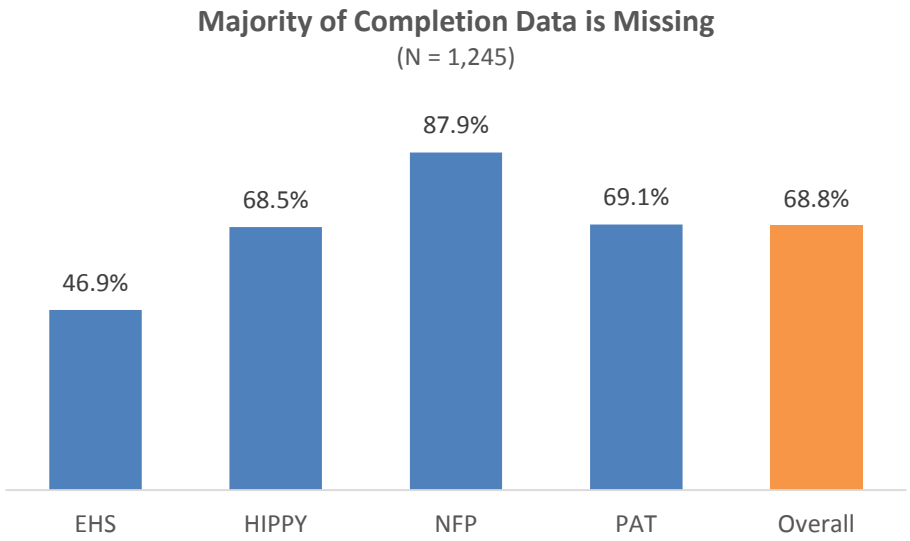
The relationship between the home visitor and the family was frequently cited as one of the primary ways home visitors keep families engaged. Through the relationship and trust the home visitors establish with their clients, home visitors become a source of emotional support and a resource for referrals on which the clients depend. Most home visitors said their clients cited the home visitor-client relationship as the part of the program they valued the most. Currently, no data on the home visitor-client relationship is being collected. Moving forward, such data may be particularly important to understanding if the relationship a home visitor established with his or her client is a core component of the program—a part of the program

that is critical for producing outcomes. CFRP will collect some data on the home visitor-client relationship through the Father Participation and Retention Evaluation (FPRE), but collecting this data on a regular basis would provide HHSC with valuable information.

Many home visitors reported that being explicit about the program expectations and requirements with families at the beginning of the program was helpful in retaining families, because families "knew what they were getting themselves into" when they enrolled. Home visitors also reported the importance of ensuring that families saw tangible benefits of their continued participation in the program. All of the home visitors reported being persistent with families who were on the verge of dropping out – with frequent calls, texts, and mailings to keep families engaged. Several programs also noted that families referred by word of mouth through other families and Spanish-speaking families were more likely to remain in the program than other families.

In addition to the flexible scheduling and repeated attempts to contact families, many home visiting programs used creative strategies to keep families engaged. Some programs monitored the engagement of their families through client satisfaction surveys. Other programs reported strategies such as offering incentives for reaching milestones in the programs, connecting with families at parent meetings, using social media to contact families (e.g., for teen parents or clients whose phone numbers change often), and trying to match families and home visitors with complementary personalities.

The qualitative information about attrition in THV provided much more insight than did the data from the THV data system. Analyses of attrition data from the THV system show an alarmingly high amount of missing data. The data show that for the 1,245 families who have left the program to date, information about completion status—whether the family exited the program because they completed the program or they dropped out of the program prior to completion is unknown for nearly 70 percent of families. Across the program models, the amount of missing completion data ranges from 46.9 percent (EHS-HV) to 87.9 percent (NFP). This amount of missing data makes it impossible to draw any substantive conclusions about how long families stay in THV. Understanding the factors related to the length of time families stay in the program is the focus of the Father Participation and Retention Evaluation (FPRE). This evaluation work will require complete data on family attrition and should be a primary focus of HHSC's efforts to improve data quality in the THV data system.



Summary

Though interviews and reports from the home visiting program coordinators and home visitors show the challenges associated with keeping families engaged and retaining them in the program, there is very little quantitative data available on retention in THV. Almost 70 percent of data on whether families exited a program because they completed the program or because they dropped out are missing. Improving the quality of data on retention is a critical area of improvement moving forward for both Continuous Quality Improvement (CQI) and future evaluation efforts focused on retention.

CHAPTER 7: HOW ARE FAMILIES BENEFITING FROM THV?

Background

Home visiting programs are a unique model of early childhood intervention in that by supporting parents' abilities to support their children's development they target parenting rather than the child. This theory of change—influencing children indirectly through direct intervention with parents—is supported by decades of empirical evidence. Healthy pregnancies and positive parenting in early childhood predict fewer behavioral problems, better academic performance, and stronger socio-emotional competencies.[25,26]

Over the last four decades, several home visiting programs have undergone rigorous tests of their effectiveness. Many programs have been evaluated with randomized controlled trials (RCTs), an evaluation method that has been recognized by the National Academies as providing "the highest level of confidence" in program efficacy or failure.[27] Although participation in home visiting programs has been linked to improvements in maternal and child health, parenting attitudes and behaviors; better cognitive and social-emotional outcomes for children; and a lower incidence of child abuse and maltreatment, reviews and meta-analyses of home visiting evaluations consistently find that the results are mixed, and when positive, tend to be modest at best.[28,29,30,31]

A summary of the evidence base for the 4 home visiting programs participating in THV is presented in Table 11. A "favorable" effect means there was at least one statistically significant impact on the outcome measure in a direction that is beneficial for children and parents. A program model that has no statistically significant impact on an outcome in one study ("no effect"), but a favorable impact on the same outcome in a different study is still labeled favorable. The sizes of favorable effects are modest, generally ranging from -0.25 to 0.25.

THV is required to show improvement in the 6 federally-defined benchmark areas and the purpose of this chapter is to present preliminary data on select benchmark outcomes for families participating in THV. The qualitative data collected through interviews and monthly reports are presented first, followed by data from the THV data system on maternal and child health outcomes and referrals for services due to identified developmental needs. At this time, the data are presented as overall estimates for THV, rather than by program model or community because the quality of the data are not yet reliable enough to present more granular analyses.

Table 11. Summary of RCT Effects for THV Program Models by Benchmark

	EHS-HV	HIPPY	NFP	PAT
Maternal and Newborn Health	No Effect	Not Measured	Favorable	No Effect
Prevention of Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	Not Measured	Not Measured	Favorable	Favorable
Improvement in School Readiness and Achievement	Favorable	Favorable	Favorable	Favorable
Reduction in Crime or Domestic Violence	Not Measured	Not Measured	Favorable	Not Measured
Improvements in Family Economic Self-Sufficiency	Favorable	Not Measured	Favorable	Favorable
Improvements in the Coordination and Referrals for Other Community Resources and Supports	Favorable	Not Measured	No Effect	Not Measured

Child and Family Outcomes in THV: The Qualitative Story

MATERNAL AND NEWBORN HEALTH

The maternal and newborn health benchmark includes prenatal healthcare, cigarette screening and cessation programs for mothers, birth spacing, screening for depressive symptoms, breastfeeding, well-child visits, and health insurance for mothers and children. Several programs reported passing additional information on to mothers about child development and encouraging mothers to be proactive about their health and their children's health. One NFP program reported that home visitors are being trained specifically to assist families with applications for public benefits. Several programs also mention visible improvements in breastfeeding, well-child visits, and the number of children with insurance at birth, as well as seeing mothers keep up with immunization requirements, maintain birth control plans, and have fewer subsequent pregnancies.

CHILD INJURIES, CHILD ABUSE, NEGLECT OR MALTREATMENT

The child injuries, child abuse, neglect, or maltreatment benchmark seeks to reduce emergency room visits for mothers and children, child injuries requiring medical treatment, suspected and substantiated cases of child maltreatment, and the number of first-time victims of child maltreatment. Many programs reported providing families with information aimed at preventing child maltreatment or increasing child safety. For example, sites provided education on preventative measures, information on spotting child maltreatment from other caregivers and training on child safety and injury prevention (covering topics such as travel safety, water

safety, safe sleeping techniques, etc.). Several home visiting programs also worked directly with families with a CPS case. However, many programs noted that these families are difficult to keep engaged in the program, particularly after their CPS case closes.

SCHOOL READINESS AND ACHIEVEMENT

The school readiness and achievement benchmark covers a range of topics, including, but not limited to: reading by primary caregivers; knowledge of child development; increase in quality of the parent-child relationship; parent well-being; and child cognitive, social, emotional, and physical development. Based on information provided in monthly reports and site interviews, school readiness appears to be a benchmark of high priority to program coordinators and home visitors. Program staff also reported that parents of toddlers and preschool-aged children saw preparing their children for school as the primary reason for participating in the program. Most often, programs cited completing developmental screenings to ensure that children are on track in terms of their development as one step toward meeting this benchmark. If children were identified as having delays, home visitors reported referring families to appropriate services. Additionally, many programs reported providing or lending books to families, encouraging parents to read to their children, sharing age appropriate activities, and informing parents about connections between these activities for their children now and school readiness as their child prepares to start school. One community stated that schools noted improved academic performance and increased parent involvement among home visiting program participants.

DOMESTIC VIOLENCE

The domestic violence benchmark covers domestic violence screenings, referrals, and the creation of safety plans. Many programs mentioned conducting screenings in their monthly reports and interviews, although there was little mention of cases of domestic violence and making the required referrals. However, home visitors reported providing information to mothers, particularly those who may be at risk of experiencing domestic violence, on important phone numbers and safe places to go. For those at risk, home visitors discussed keeping information in a safe place away from a potential abuser or reported not leaving information out of fear it would be discovered. When families were at risk of violence, home visitors reported making safety plans.

FAMILY ECONOMIC SELF-SUFFICIENCY

The family economic self-sufficiency benchmark targets increasing average monthly household income, the average number of hours participants are working or in school, and the percentage of parents and children with health insurance. Many programs report linking parents with services that will assist in job training, job searching, and/or increasing their education. Many programs help parents define goals for themselves and then provide encouragement as parents continue to work toward achieving their goals. Several programs utilized connections to other organizations in the community, used parent meetings as a time to distribute useful information, and one program even reported providing planners to parents to help them

organize and track appointments. It is worth noting that several home visitors felt that family economic self-sufficiency was an important part of their job and encouraged families to pursue education and work opportunities. However, parents' participation in work or school often limited their availability for the program and made participation difficult, creating a tension between program objectives.

COORDINATION AND REFERRALS FOR OTHER RESOURCES AND SUPPORT

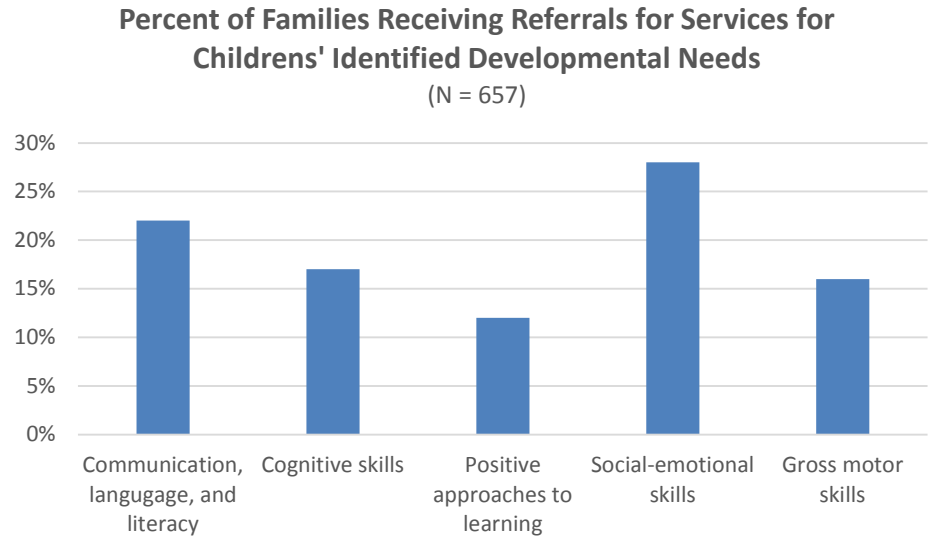
This benchmark focuses on identifying families in need of services, making the appropriate connections to resources, and verifying completed referrals. Additionally, this benchmark aims to measure sites' formal connections with social service agencies and the number of agencies the program coordinator maintains contact with. Although some programs report conducting specific needs assessments, much of the information found in monthly reports and site interviews suggested that home visitors assess families' needs at each meeting with the families such that referrals and connections to other resources for support occur on a fairly continuous basis. Monthly reports and interviews suggest that while community coalitions can provide access to resources for home visiting programs, many of the connections that programs make to other organizations in the community are made due to the outreach efforts of program coordinators and staff. Programs report making referrals to a range of services. Examples of commonly cited referrals include: mental and physical health services, job training and placement, education services, public benefits (e.g., Medicaid, food stamps/SNAP, WIC), and food banks, among others.

Home visitors and program coordinators reported that many connections to resources were made by program staff. Some programs have access to 211 or 411 tools that allow them to see what types of resources are available in the community. Additionally, several programs reported making a community resource binder, which can be an accessible tool for home visitors to utilize. At least one program reported working to make their referral coordination easier by building on existing 411 services to centralize resources and be more efficient. However, home visitors also report continued problems with referrals that stand in the way of progress on this benchmark. Some program sites mention problems with a lack of available resources (especially those that are bilingual), which can be exacerbated in communities with a high demand for services (especially when there are wait lists). While some programs do not identify the quantity of resources as a problem, they do cite quality issues. Home visitors also reported that it can be difficult to get some families to follow up with referrals, to get other families to ask for services that are needed (due to fear of stigma or being reported to CPS), or families may have transportation issues that make it difficult to access resources through referrals.

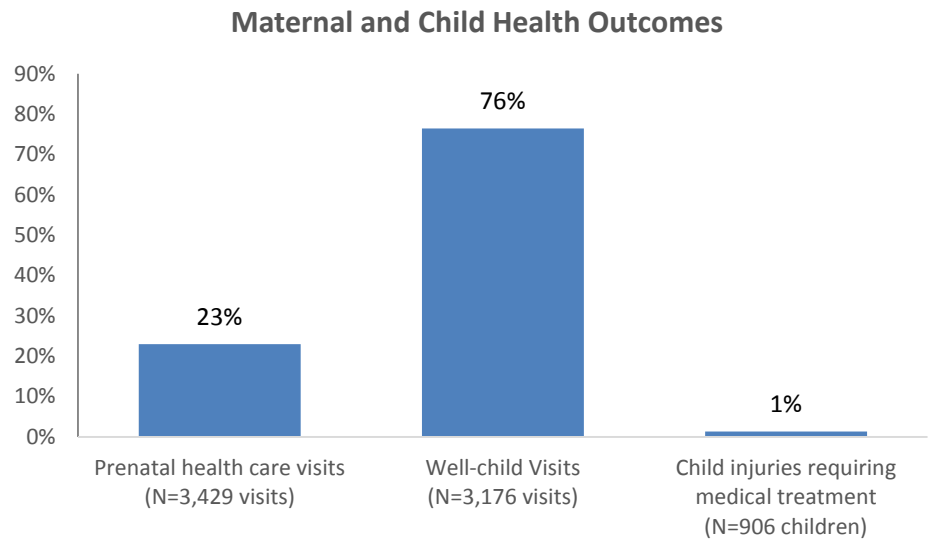
Child and Family Outcomes: The Quantitative Story

The quality of the data in the THV data system do not currently allow for detailed analyses of the progress made by THV toward the benchmark outcomes. Instead, we present preliminary data on child and maternal health outcomes and children's developmental screenings for THV, overall. As the data improve, a more thorough examination will be possible.

Overall, 657 THV children (out of 3,484 children) have been identified with developmental needs through screenings they received as a result of their participation in their home visiting program. Of those children, 150 received a referral for services within three months of the need being identified. The percent of children receiving referrals for services for identified developmental needs range from 12 percent (positive approaches to learning) to almost 30 percent (social-emotional skills) across developmental domains.



Overall, THV mothers are attending about a quarter (23%) of prenatal health care visits during their pregnancy (HIPPY mothers are excluded from this benchmark outcome). Compared to prenatal care visits, THV parents do much better at taking their children to well-child visits—THV children attended 76 percent of recommended well-child visits during their first year in the program. Additionally, approximately 1 percent of THV children have experienced injuries requiring medical treatment during their first year in the program.



Summary

At this point, the qualitative data collected from home visiting program staff provide a more detailed perspective on the progress THV has made to date on the benchmark outcomes and how THV families are benefitting in each of those areas than the quantitative data. Data from the THV data system suggest that families are in fact benefiting from their participation, but the extent to which they are benefiting varies and whether or not it will be sizeable enough to be visible at the community level remains to be seen. In addition to the benchmark outcomes, THV families are likely benefitting in other, unmeasured ways. Several programs reported seeing increased parent empowerment and mother independence. Other programs noted that they saw parents better able to make outside appointments and follow plans they have set (e.g., WIC appointments, birth control plans, breastfeeding goals, etc.). Program coordinators also felt that they were able to be a support to mothers by providing companionship and inspiring confidence building and bringing joy and laughter in the home.

CHAPTER 8: CONCLUSION AND FUTURE DIRECTIONS

This report brought together two important data sources—data from the THV system that has undergone several months of data quality checks and rich qualitative data collected through months of interviews with home visiting program staff and reports submitted by program leads in each community—to answer several important questions about how THV is being implemented across the state. Being "evidence-based" does not, however, ensure that home visiting programs can be effectively translated into community practice or that they will be effective at producing the amount of change expected of them—implementation is a key determinant of whether or not children and families benefit from home visiting programs.[32]

Careful monitoring of whether the program implementation adheres to the program's original design and purpose (i.e., model fidelity) is critical to ensuring that the program yields the range of outcomes observed in the randomized controlled trials. The overall purpose of this report was to examine how THV is being implemented through analyses of:

1. How does THV recruit families into the program and how many families have been served to date?
2. Who is THV serving and how do they compare to the target populations?
3. What does THV provide families and how much of the program do families receive?
4. How long do families stay in THV?
5. How are families benefiting from THV?

THV is successfully enrolling the high-risk and high-need Texan families the program was intended to serve—most have incomes below the federal poverty line and almost a third live in extreme poverty (below 50% FPL). The same risk factors that make families eligible to participate in THV make them hard to serve and retain in the programs. Each of the THV communities struggles with meeting its target capacities, providing the program to families, and retaining families in the program. The often-chaotic nature of the lives of THV families results in frequent cancellations and rescheduling, which make it difficult to fully deliver the program content and often results in families dropping out of the program prior to completion.
Even still, home visiting programs are overcoming these challenge to ensure their families are benefiting from participation and the data suggest families are in fact benefiting both in measurable and unmeasurable ways.

Persistent concerns with missing data were highlighted throughout this report. The vast majority of referral source data and retention data are missing – making it impossible to draw substantive conclusions about how families make their way into THV and how many leave.

Moving forward, CFRP will focus on highlighting explanations for the variation in implementation presented throughout this report. To the greatest extent possible, future analyses will aim to link variation in implementation described in the present report with variation in the following:

1. Program model differences (e.g., goals, target population, service intensity, etc.);
2. Community differences (e.g., population demographics, available resources, etc.);
3. The motivations and capacities to participate in THV;
4. Infrastructures and staffing before and after implementing THV;
5. Experiences with communication, trainings, and technical assistance during implementation;
6. Experiences with marketing, outreach, and recruitment of families into the home visiting programs; and
7. The THV elements including the ECCS and EDI, matching system, and father engagement.

There is little existing research on the impacts of home visiting programs at scale and virtually no evidence on how to achieve quality on-the-ground implementation. The present examination of how THV is being implemented across the state provides important insight into the challenges of on-the-ground implementation and also provides a necessary context to interpret how much families benefit from THV. Almost 3,000 families have participated in THV to date and with expansion sites coming on board, even more families will have the chance to participate and benefit. Understanding how THV has been implemented for these families will inform future implementation efforts such that the likelihood that families and children will benefit from participation will only increase.

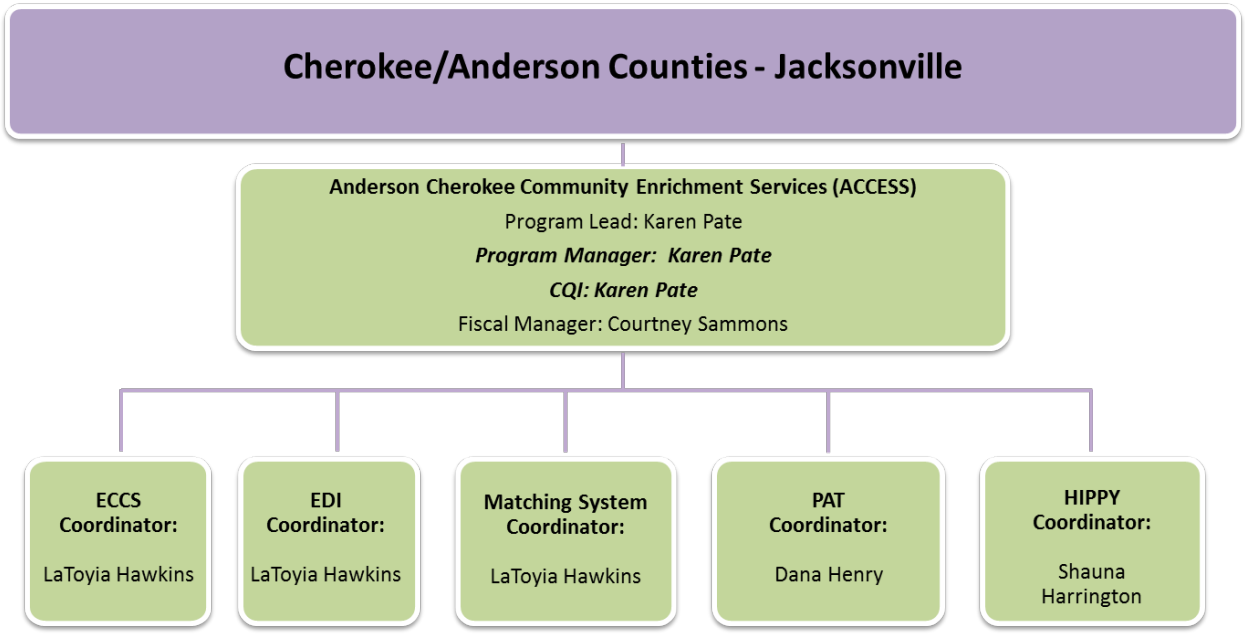
APPENDICES

Appendix A: Community Profiles

In this appendix, we provide community profiles of the 7 THV communities. The profiles include an organizational chart showing the organization of the primary and subcontractors implementing THV, a brief description of the community, a description of the contracting agencies, and a status update of where the communities stand on each of the THV elements: development of the ECCS, the EDI process, the matching system, father engagement, and continuous quality improvement.

CHEROKEE AND ANDERSON COUNTIES

Figure 1: Cherokee and Anderson Counties Organizational Chart



Community Description

Cherokee County is a rural county in east Texas with a population of approximately 50,878 people (estimated for 2013).[33] Jacksonville is the largest city in the county, with a population of approximately 14,713 people, but many individuals in Cherokee County live in rural areas.[34] In Cherokee County, approximately 26.7 percent of the population lives below 100 percent of the federal poverty level and an estimated 38.3 percent of children live in poverty.[35]

Anderson County is a rural county in east Texas just west of Cherokee County with a population of approximately 57,938.[36] Palestine is the largest city in Anderson County with a population of approximately 18,617 people, but like Cherokee County, much of the population lives in rural areas.[37] Approximately 22.5 percent of the population in Anderson County lives below 100

percent of the federal poverty level and an estimated 27.8 percent of children in the county live in poverty.[38]

Both counties have higher rates of births to teen mothers than the Texas average: 16.6 percent in Cherokee and 12.9 percent in Anderson compared to the state average of 10.7 percent.[39] Cherokee county has a higher rate of infant mortality (6.9 per 1000 births) than the state average (5.8 per 1000 births).[40] The rates of women who smoke during pregnancy in Cherokee County (12%) and Anderson County (14.5%) are higher the state average (4.4%), and the rate of birth spacing of less than 18 months in Cherokee County (8.3%) is higher than the state average (6.3%).[41] Prior to THV, Anderson and Cherokee counties did not have any home visiting programs.

Contracting Organizations

Anderson Cherokee Community Enrichment Services (ACCESS) is the only contractor for THV in Cherokee County. ACCESS is implementing all of the THV elements, including the PAT and HIPPY programs, the ECCS, EDI, and the matching system. ACCESS is a publicly funded Community Mental Health and Mental Retardation Center that serves individuals with mental illness, developmental disabilities, or substance abuse, and serves at-risk youth. Prior to THV, ACCESS did not have experience delivering early childhood services. ACCESS applied to implement all of the THV elements because there was a lack of other direct service organizations in Cherokee County with the capacity to implement the different grant elements.

Early Childhood Comprehensive System (ECCS)

ACCESS joined Partners in Health, an existing coalition in Cherokee County that serves as the Cherokee County ECCS. The coalition meets monthly and includes representatives from non-profit organizations that serve families and children, local school districts, the police department, county probation and local health service providers.

ACCESS members have been attending monthly TECCS conference calls and other trainings provided by UCLA/United Way Worldwide. The 3 THV program coordinators attended the TECCS conference at the end of July 2014. ACCESS has focused recent efforts on the development of a Community Needs Assessment that the ECCS and Jacksonville ISD distributed in August and September. The assessment will identify gaps in services and will inform the ECCS strategic planning process.

Early Development Instrument (EDI)

Cherokee County implemented the EDI in Bullard ISD, Jacksonville ISD (JISD), and Wells ISD during the 2012-2013 school year. ACCESS and the 3 participating school districts received the EDI results in August 2013 and analyzed the results from the 2012-2013 school year. The JISD staff participated in the HHSC Community Engagement & CQI Technical Assistance site visit in April 2014 to understand how the EDI data can inform JISD initiatives to improve school readiness. JISD decided to initiate a second round of the EDI in May 2014 to validate the EDI data and to inform the ACCESS strategic plan.

JISD was the only school district that chose to implement the EDI during the 2013-2014 school year. Data collection was completed during the last week of the 2013-2014 school year. Results are still pending as of July 2014. ACCESS is working to encourage additional school districts to participate in completing the EDI.

Matching System

ACCESS is responsible for organizing the Cherokee County Home Visiting Matching System. ACCESS uses the matching system to refer families to home visiting programs and to other community-based services as needed. The HIPPY and PAT home visiting coordinators use the same Universal Referral form when they are recruiting families. The home visiting coordinators refer families to the matching system coordinator for placement in home visiting programs, and for referrals to other services. Staff members follow up on all referrals to ensure the referral was successful.

The matching coordinators participated in a May 2014 training provided by HHSC on marketing and outreach plans and participate in monthly conference calls. ACCESS is also working to expand the local resource directory that matching coordinators use for referrals.

Father Engagement

Cherokee County received father engagement training during FY 2012-2013 and developed an action plan for engaging fathers during FY 2013-2014.

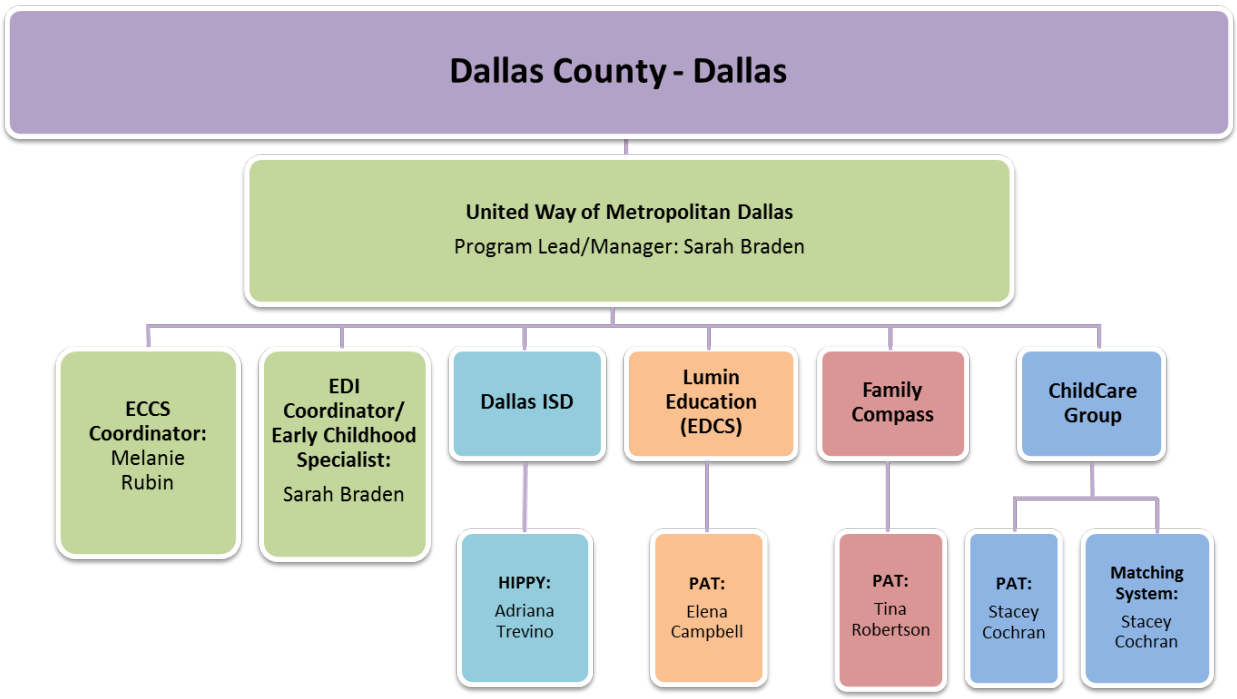
Home visiting programs reported that more fathers have been attending the Parent Group Connection meetings. Home visitors are encouraging fathers to participate in the curriculum with their children and participating mothers have reported that fathers who are not present during the home visit are participating in reading with their children and are engaging in some of the activities. Additionally, ACCESS staff reached out to other organizations in the community to elicit assistance in engaging fathers.

Continuous Quality Improvement (CQI)

ACCESS members attended CQI training and the coalition is beginning to implement CQI activities. Staff are prioritizing benchmarks based on current performance data and have developed a schedule for reporting to stakeholders. The advisory committee completed a SWOT analysis and determined that it would be important to engage the local community in identifying gaps in the early childhood care system. The committee developed and administered a Community Needs Assessment in August and September of 2014; ACCESS anticipates that data will be helpful in informing CQI activities.

DALLAS COUNTY

Figure 2: Dallas County Organizational Chart



Description of Community

Dallas County is located in northeast Texas within the Dallas-Fort Worth metropolitan area. The county has a population of approximately 2,480,331 people (estimated for 2013), making it the largest THV community. [42] Approximately 1.26 million residents live in the city of Dallas.[43] Home visiting programs have operated in Dallas County for several decades, and all of the five MIECHV home visiting program sites in the county are expansion sites.

In Dallas County, approximately 19.3 percent of the population lives below 100 percent of the federal poverty level, and an estimated 29 percent of children live in poverty.[44] According to the state needs assessment, Dallas County is above average on rates of preterm births, low birth weight births, and births to teen mothers. Dallas County has a higher rate of infant mortality (6.5 per 1000 births) than the state average (5.8 per 1000 births).[45]

Contracting Organizations

United Way of Metropolitan Dallas (UWMD) is the primary contractor for Dallas County. UWMD is a nonprofit organization serving Dallas, Rockwall, Collin, and southern Denton counties that specializes in awarding and monitoring grants to nonprofit agencies across the region. In 2011, UWMD awarded over $24 million in grants to 120 separate programs. As a fiscal agent for numerous programs over the years, UWMD has experience managing funds, including government funds. UWMD also participates in early childhood intervention programs in Dallas as a member of the Zero to Five Funders Collaborative.

Because UWMD is a fiscal agency that specializes in monitoring grants, UWMD chose to subcontract all home visiting services and the positions of matching coordinator and ECCS Coordinator. UWMD subcontracted the ECCS Coordinator position to a policy consultant who has a strong reputation in the community and prior experience bringing together early childhood community stakeholders.

There are 4 different subcontracting organizations managing the 4 THV home visiting programs in Dallas. Dallas ISD (DISD) is a public school district that has provided the HIPPY program since 1988. East Dallas Community Schools (EDCS), now Lumin Education, is a nonprofit agency that operates the Head Start Center in one of the poorest neighborhoods (Bachman Lake) in Dallas County, and was implementing PAT prior to THV. EDCS has implemented PAT since 1993, and was serving 230 families on three campuses prior to THV. EDCS serves children ages 3 to 5 through PAT.

Family Compass is a nonprofit agency that focuses on child abuse prevention. Family Compass operates a PAT program that also meets the standards to qualify as a Healthy Families program, and serves only teen parents. ChildCareGroup (CCG) is a nonprofit agency that provides child care and educational services including a child care resource program in the community. CCG also has operated PAT in the Pleasant Grove community since 2007 and expanded this PAT program as part of THV.

Early Childhood Comprehensive System (ECCS)

Dallas County subcontracted a policy consultant to coordinate the ECCS, which includes members of the steering committee and THV providers. In addition to the THV primary and subcontractors, the committee includes representatives from the education and health service sectors. The ECCS is implementing the current strategic plan and adjusts the plan based on feedback from partners. The ECCS consultant and UWMD staff have participated in bimonthly calls with UCLA and HHSC, as well as TECCS monthly site calls. Additionally, UWMD staff have held and participated in several community meetings with an aim to align efforts with early childhood partners and develop consistent messaging for public awareness campaigns.

The ECCS consultant has expressed concern about the sustainability of funding for THV in Dallas, and is conducting research to identify sustainable funding sources. UWMD and the ECCS consultant continue to work on identifying and engaging other partners in the coalition.

Early Developmental Instrument (EDI)

Dallas County implemented the EDI in DISD during the 2012-2013 school year and again during the 2013-2014 school year. UWMD conducted trainings for the teachers of the 19 DISD elementary schools and 2 charter schools in January and February of 2014 and collected over 1600 EDI surveys for the 2013-2014 school year. UMWD staff also conducted EDI neighborhood mapping sessions, though the team experienced challenges with asset mapping due to mapping a larger geographic area in 2014 compared with the previous year. The 2013-2014 EDI data

collection activities are now complete and the 2014 Dallas County Community Profile should be available in August 2014. UWMD participated in monthly EDI and TECCS conference calls with UCLA and UWW, and staff have been working on system improvement strategies. UWMD secured funding to implement EDI for the 2014-2015 school year; staff are currently searching for a partner to provide mapping services for the 2014-2015 school year.

Matching System

CCG is the subcontracting organization responsible for organizing the Dallas County Home Visiting Matching System. Parents can access referrals to home visiting programs in Dallas through the CCG website (www.childcaregroup.org/parents), and by contacting the CCG by phone (214-631-CARE). As of June 2014, advertisements for the matching system are running on 20 DART buses for a total of 16 weeks. CCG also attends community events to market THV and the matching system. CCG is experiencing some challenges in locating bilingual home visiting programs for clients on the matching system wait list. The team is working to expand the tool to include additional community resources.

Father Engagement

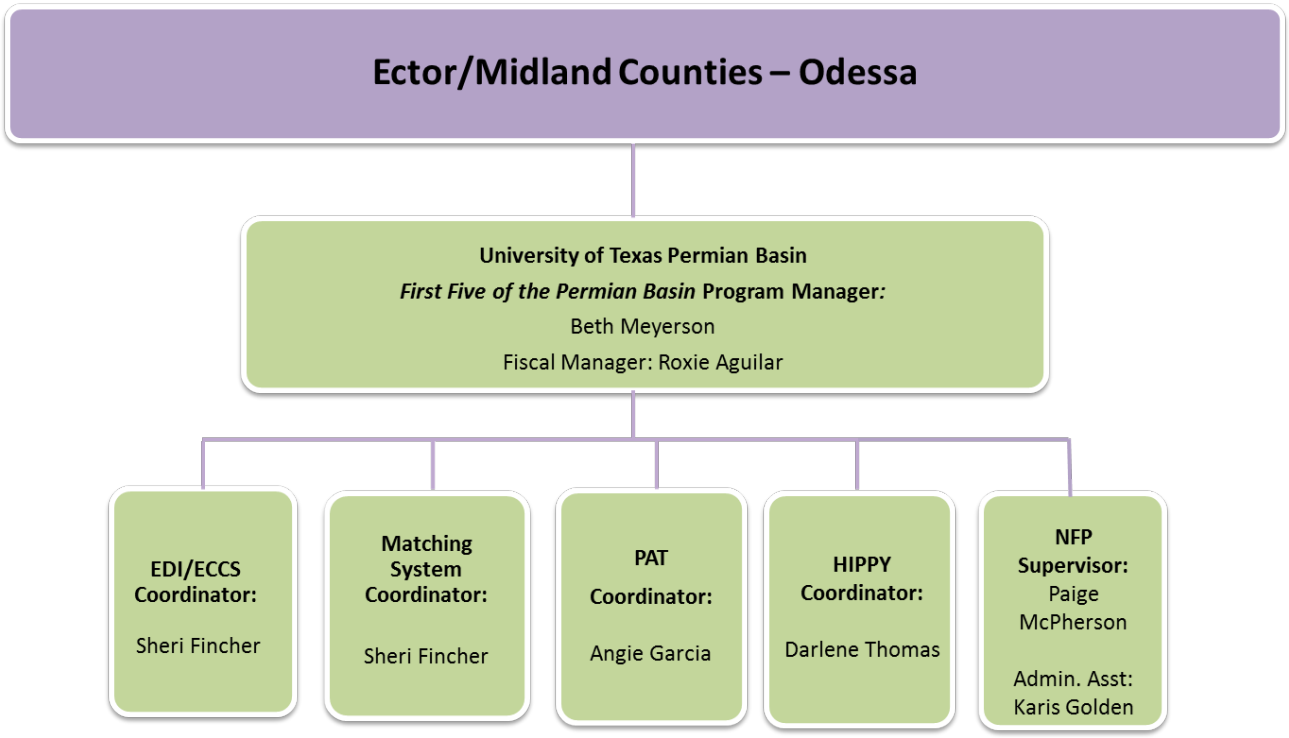
Dallas County received Father Engagement Training, and the county is developing an action plan for engaging fathers during FY 2013-2014. Each of the 4 subcontractors has begun encouraging father participation in home visiting services and at social events. Lumin Education has a successful Fatherhood Initiative program and reports that several fathers are attending weekly Monday night meetings. CCG reported an increase in father participation during home visiting sessions and at Group Connections. Family Compass is encouraging home visitors to discuss father participation with mothers and have requested that school partners engage fathers in the initial home visiting discussions with mothers. DISD encourages fathers to participate in home visits, field trips, and group meetings. DISD honored 86 fathers for active participation in HIPPY at an end-of-the-year ceremony.

Continuous Quality Improvement (CQI)

UWMD and the ECCS consultant have aligned efforts between the Learning Systems project with UCLA and the CQI project with HHSC. UWMD/ECCS created a process for subcontractors to test strategies that will help to improve the family experience with THV. Subcontractors defined and tested a peer recruitment strategy in May and reported the results at a June meeting with UWMD/ECCS. The next steps on the CQI/Learning Systems agenda are to adapt the peer recruitment strategy to fit each subcontractor's target population and to identify a new strategy to test for the next cycle.

ECTOR AND MIDLAND COUNTIES

Figure 3: Ector and Midland Counties Organizational Chart



Community Description

Ector County is located in the Permian Basin region of West Texas. The major urban area in the county is Odessa, and the rest of Ector County is rural. The county has a population of approximately 149,378 people (estimated for 2013).[46] Approximately 14.5 percent of people in Ector County live below 100 percent of the federal poverty line and 21.1 percent of children live in poverty.[47]

Midland County is located just to the east of Ector County in West Texas with an approximate population of 151,468 (estimated for 2013).[48] Approximately 9.8 percent of people in Midland County live below 100 percent of the federal poverty line and 16.3 percent of children live in poverty.[49]

Ector and Midland counties are in the midst of an oil boom, which has greatly increased housing prices and inflated wages. Ector County is higher than the state average in low-weight births (9.1% in Ector County compared with 8.3% statewide) and Midland County has a higher rate of infant mortality (8.8 per 1000 births) than the state average (5.8 per 1000 births).[50] Ector and Midland counties have higher rates of births to teenage women (16.3% in Ector County and 13.1% in Midland County compared with 10.7% statewide).[51] Ector County and Midland County are also above the state average in subsequent births within 18 months and women who smoke

during pregnancy.[52] Prior to THV, Odessa had no home visiting services, but did have several referral systems in place through 2-1-1 and MOUs across agencies.

Contracting Organizations

The University of Texas—Permian Basin (UTPB) is the primary contractor in Ector County, and the School of Education manages the contract. UTPB has maintained a presence in Ector County since 1969 and works closely with the school districts, business leaders, and community organizations.

UTPB provides three THV home visiting services: HIPPY, NFP, and PAT. UTPB originally chose to manage the PAT program internally and subcontract with Greater Opportunities of the Permian Basin (GOPB), a nonprofit agency, to provide the HIPPY program and Star Care Health Services (Star Care), a private health care agency, to provide NFP. Both GOPB and Star Care decided to stop implementing the home visiting programs—UTPB now manages all 3 programs internally under the name, First Five Permian Basin.

Early Childhood Comprehensive System (ECCS)

UTPB coordinates the local ECCS in Ector County. UTPB hired a coordinator to develop the ECCS and lead the community through the TECCS process, but the EDI Coordinator, also hired by UTPB, assumed the responsibilities and duties of the ECCS Coordinator in November 2012. The name of the ECCS was simplified to the Early Childhood Coalition (ECC).

More than 35 social services agencies and educational leaders take part in the ECC, all of whom have attended at least 1 meeting. A core group of 10 to 12 agencies attends meetings regularly, with an average of 25 to 30 individuals in attendance at each meeting. Meetings occur monthly and the ECC stakeholders are directly involved in the strategic planning process, as well as the planning for a fatherhood engagement initiative in Ector and Midland counties.

The ECC is currently developing an Early Childhood Strategic Plan with a focus on 5 areas: better maternal/infant health, a reduction in domestic violence and child abuse, increased school readiness, family economic self-sufficiency, and collaboration among agencies and service providers to create a better early childhood system.

Early Development Instrument (EDI)

For the 2012-2013 school year, UCLA and HHSC worked with UTPB to pilot administering the EDI to 4 and 5-year-old children enrolled in Head Start. UTPB was the first organization in the country to do this. Head Start completed approximately 500 surveys of children enrolled in the local Head Start Academy. UTPB plans to follow up on the readiness of these children in 2014.

Ector County Independent School District (ECISD) did not participate in the EDI for the 2012-2013 school year, but did agree to participate for the 2013-2014 school year. Kindergarten teachers collected 2,154 surveys in April and May 2014. The data will be available in November 2014.

Matching System

UTPB is responsible for organizing the Ector County Home Visiting Matching System. UTPB replaced the title matching coordinator with "Early Childhood Resource and Referral Coordinator" (ECRR) to make the role more understandable to the general public. In February 2013, the ECRR relocated from the Community Outreach Center operated by ECISD to UTPB, which has helped increase the number of referrals generated.

Ector County realized the need for a "one-stop" call center for any issue related to services for families with young children (not just those specific to home visiting). Ector County is marketing the Early Childhood Resource and Referral phone number, 432-552-4025 (for ages 0 to 5) through a Spanish/English First Five Permian Basin brochure, on Facebook, and through event attendance and networking. The ECRR has also developed a notebook of local resources for staff to use for referring families. UTPB recently updated the matching system with a more functional record-keeping system to better track referrals and follow-up.

Both the PAT and HIPPY programs in Ector County have waiting lists. The ECC and UTPB are currently working on plans to engage families on the home visiting waiting list. The County is experiencing challenges in managing the waiting list and keeping waiting families engaged.

Father Engagement

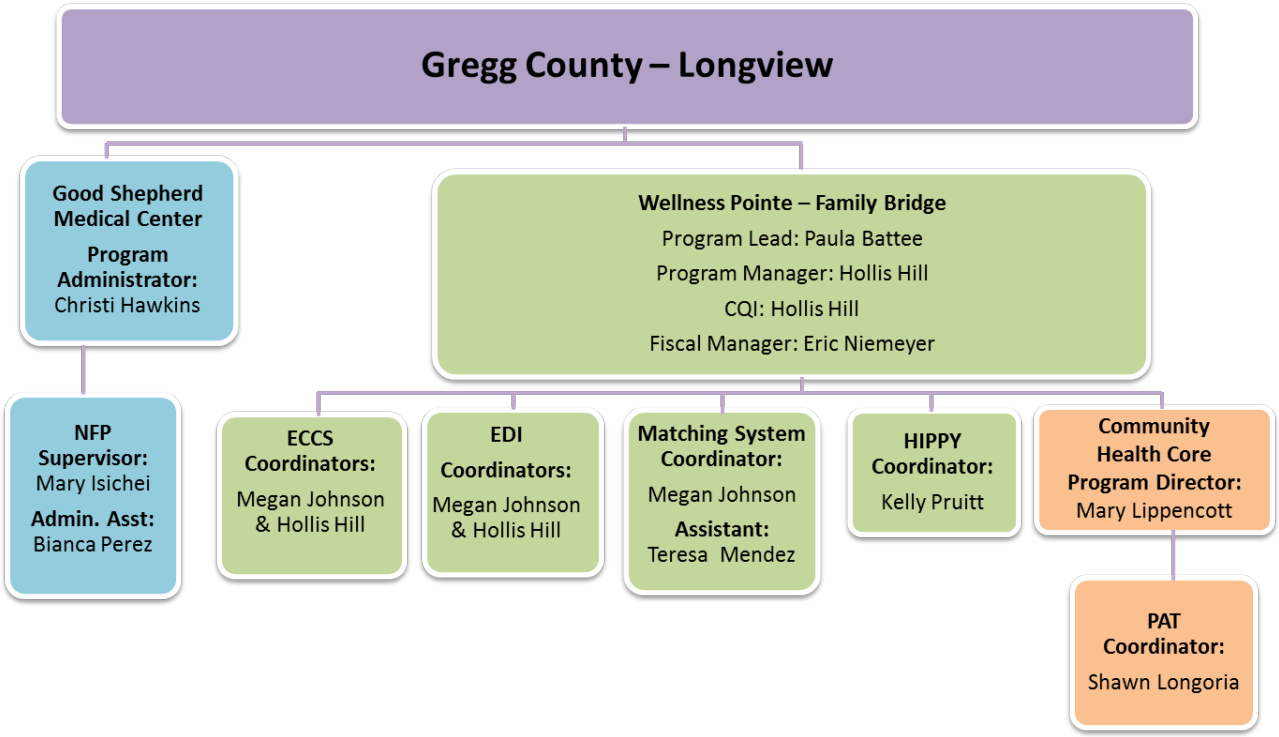
Ector County has developed a plan to engage fathers for FY 2013-2014. Both the PAT and HIPPY programs have reported an increasing number of fathers attending the parent meetings. Additionally, home visitors in all three programs work flexible shifts in order to encourage participation by both parents. The county recently received tentative approval for HOPES funding, which would allow the ECC to hire a full-time Father Engagement Coordinator. The coordinator would meet with fathers in all 3 home visiting programs.

Continuous Quality Improvement (CQI)

The ECC formed a CQI committee that includes the home visiting coordinators and the coordinator of a teen parenting program. The ECC and the CQI committee conducted three community conversations in 2013 and used this data to develop a CQI project focused on recruitment and retention of teen parents for FY 2013-2014. The CQI committee developed and implemented a strategy in January 2014 that was not successful. The committee is developing a new strategy for FY 2014-2015 that will include a Health Fair in October 2014 for students in the Pregnant and Parenting Teen program, the teen fathers, and students' family members.

GREGG COUNTY

Figure 4: Gregg County Organizational Chart



Community Description

Gregg County is located in east Texas, and has a population of approximately 123,024 people (estimated for 2013). [53] Longview is the largest city in Gregg County, with a population of approximately 81,443.[54] In Gregg County, approximately 18.8 percent of individuals live below 100 percent of the federal poverty line and approximately 27.9 percent of children live in poverty.[55]

Gregg County has more preterm births (17.9%) than the state average (12.2%), more births to teenage mothers (14.8% in Gregg County compared to 10.7% statewide), and a higher rate of infant mortality (10.8 per 1000 births compared to 5.8 per 1000 births). Gregg County also has a higher incidence of child abuse (15.9 victims per 1000 children) compared to the state average (9.3 victims per 1000 children).[56] The percentage of women who smoke while pregnant (11.7%) is higher in Gregg County compared to the state average (4.4%).[57] Prior to THV, Gregg County did not have any home visiting programs.

Contracting Organizations

Wellness Pointe is the primary contractor for THV in Gregg County. Wellness Pointe implements the HIPPY program, and manages the ECCS, EDI and matching system. Wellness Pointe is a nonprofit health service provider, and the only Federally Qualified Health Center in Gregg County. Wellness Pointe subcontracts the PAT program to Community Health Core, which is the

mental health and intellectual disability governing authority in Gregg County. Good Shepherd Medical Center, a non-profit community hospital, is the NFP provider in Gregg County.

Early Childhood Comprehensive System (ECCS)

Wellness Pointe formed the Family Bridge Coalition in January 2012 as the Gregg County ECCS. The coalition includes representatives from non-profit organizations and the local business community in Gregg County. Information about the Family Bridge Coalition can be accessed at: www.myfamilybridge.org/about.html. Wellness Pointe continues to identify and recruit new partners to the Family Bridge Coalition. The coalition appointed a subcommittee to develop a strategic planning framework for using data from EDI reports and information from community conversations to improve THV in Gregg County. The coalition has also formed a subcommittee to investigate sustainability strategies of experienced sites and to develop a plan for the sustainability of the Gregg County THV program. Family Bridge Coalition meets monthly to go over actionable items and subcommittee issues.

Early Development Instrument (EDI)

Gregg County implemented the EDI in Longview ISD during the 2012-2013 school year. Wellness Pointe and Longview ISD received the EDI results in August 2013. The coalition approved an EDI data flyer outlining community strengths and improvement areas from the 2012-2013 EDI and began distributing it in the communities in April. In the 2013-2014 school year 2 new schools districts, Pine Tree ISD and Spring Hill ISD, implemented the EDI with 100 percent participation. UCLA will provide the results for the 2013-2014 school year. After Wellness Pointe receives the EDI report, they will meet with school district officials to encourage their participation in addressing any areas of vulnerability revealed by the data.

Matching System

Wellness Pointe is responsible for organizing the Gregg County Home Visiting Matching System. Family Bridge Coalition developed a universal screening and consent form to provide referral information for the three THV home visiting programs in Gregg County. Partners can access the form on the Family Bridge website (www.myfamilybridge.org/enroll-now). The Family Bridge Coalition website also links to Infoline, a community referral and information service hosted by United Way that connects families and individuals to social services in Gregg County (www.longviewunitedway.org/infoline-gregg-county). The coalition has appointed 1 staff member to act as administrator over the matching system and to develop the matching system further. Currently, all referrals to THV programs in Gregg County go through this administrator. The coalition is working to make available access to a blog where programs can post updates and upcoming events.

Father Engagement

Gregg County received father engagement training during FY 2012-2013, and conducted a survey of home visitors about father engagement during summer 2012. Gregg County is in the process of implementing an action plan for engaging fathers during FY 2013-2014. Wellness Pointe staff filled the Father Engagement Specialist position, established a Father Engagement

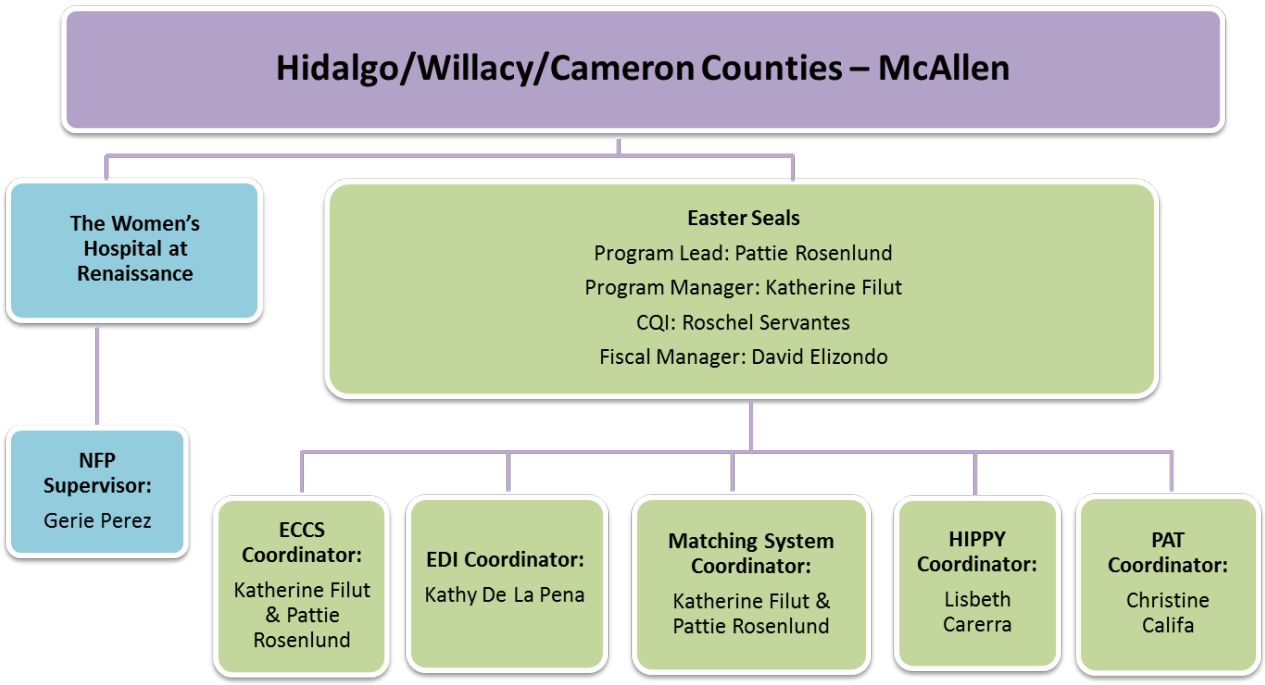
mentor group, recruited and trained 12 men to become mentors, and developed the first father engagement program. Home visitors delivered letters and forms to THV participating families to encourage father participation and gather data about fathers in the programs.

Continuous Quality Improvement (CQI)

The Family Bridge Coalition appointed a CQI subcommittee to develop and implement a CQI plan with a focus on family engagement. In May, home visitors tested a peer recruitment strategy and presented the results at the Coalition meeting in June. The subcommittee is currently running a CQI project to determine why families remain in home visiting programs; Gregg County THV programs will use the results from this project to improve family retention.

HIDALGO, WILLACY, AND CAMERON COUNTIES

Figure 5: Hidalgo, Willacy, and Cameron Counties Organizational Chart



Community Description

Hidalgo County is a large county on the border with Mexico that has densely populated urban centers and some rural areas. The largest city in Hidalgo County is McAllen. Hidalgo County has a population of 815,996 (estimated for 2013).[58] In Hidalgo County, 34.2 percent of individuals live below 100 percent of the federal poverty line and 45.7 percent of children lived in poverty.[59]

Willacy County is a large rural county with a population of approximately 21,921 that borders Hidalgo County.[60] The poverty rates in Willacy County are similar to those in Hidalgo; 38.6 percent of the total population lives below 100 percent of the federal poverty line, and 45.9 percent of children live in poverty.[61] Willacy County could not support THV on its own because of its size, which led HHSC to jointly fund services in Willacy County and Hidalgo County.

Cameron County is the southernmost county in Texas, east of Hidalgo County with a population of 417,276 people.[62] The poverty rates in Cameron County are similar to those in Hidalgo and Willacy counties; 35.5 percent of individuals live below 100 percent of the federal poverty line and 48.2 percent of children live in in poverty.[63] Additionally, many families in Cameron County live in colonias, which are residential areas along the Texas-Mexico border that lack basic living necessities such as potable water, sewer systems, electricity, paved roads, and safe housing.[64]

Hidalgo, Willacy, and Cameron counties have poverty rates that are higher than the statewide average. Each county's rates of births to teens, preterm births, and child maltreatment cases

are also higher than the state average.[65] Prior to THV, McAllen had home visiting programs, including three PAT sites, but no systems in place for screening, identifying, and referring families to home visiting services. Additionally, there was limited cross-program collaboration. The United Way of Southern Cameron County (UWSCC) implemented two cycles of the EDI in Cameron County prior to Cameron County joining MIECHV; the results of the data collection indicated a need for early childhood system services.

Contracting Organizations

Easter Seals of the Rio Grande Valley is the primary contractor for Hidalgo, Willacy, and Cameron counties. Easter Seals is a nonprofit agency that primarily provides services to children and adults with special needs or disabilities. Easter Seals' Hidalgo County activities are based out of their McAllen office. Easter Seals also has an office in Harlingen, the largest city in Cameron County. The PAT and NFP home visitors working in Willacy County are based in the Harlingen office.

Easter Seals is overseeing all THV elements internally including, the ECCS, the EDI, the matching system, and HIPPY and PAT programs. The PAT program at Easter Seals is an expansion program; Easter Seals has implemented the PAT program since 2008. Easter Seals began the HIPPY program as part of THV.

The Women's Hospital at Renaissance is the NFP contractor for THVP. The Women's Hospital at Renaissance is a well-known physician-owned hospital with experience providing community services in Hidalgo County and the Rio Grande Valley.

Early Childhood Comprehensive System (ECCS)

Easter Seals joined 2 existing coalitions of service providers and social service agencies to form an ECCS. The ECCS includes a Leadership Council, a Make the First Five Count Committee (MTFFC), and supporting work circles.

The Leadership Council acts as the governing body of the ECCS and reflects on recommendations made by work groups. The MTFFC is the main work group and reports to the Leadership Council; this group has been meeting frequently to finalize the Community Strategic Plan. The MTFFC carries out plans of action decided by the ECCS, and oversees the supporting work circles. The supporting work circles focus on specific areas, such as the EDI and other specific needs in the community.

Local community partners taking part in the MTFFC include HHSC, Texas Health Steps, Child Protective Services, NFP, Workforce Solutions, AVANCE, Children's Defense Fund, Valley Association for Independent Living, Counseling Services, Head Start, United Way, Buckner Children and Family Services and ISDs participating in the EDI. The MTFFC is currently working to build a Data Dashboard; the team has administered the first Data Dashboard Community Organizations survey and analyzed the results. The Leadership Council and the MTFFC Coalition are meeting regularly to identify specific population change areas for the community and how

the ECCS can align with efforts that agencies are already making to ensure the greatest impact. The team will meet in August to finalize the MTFFC Strategic and Sustainability plan.

Early Development Instrument (EDI)

All 4 of the school districts in Willacy County and the largest school district (McAllen ISD) in Hidalgo County administered the EDI for the 2012-2013 school year. Easter Seals RGV presented the results of the 2012-2013 EDI to stakeholder groups, school administrators, the MTFFC, and the Leadership Council. ECCS established working committees to focus on parental engagement in home visiting programs and data analysis and collection based on the 2012-2013 EDI results.

The EDI Coordinator administered the 2013-2014 EDI project in 5 Hidalgo County school districts, including La Villa ISD, Donna ISD, Monte Alto ISD, Mercedes ISD, and Weslaco ISD. Teachers completed 3,043 EDI surveys in Hidalgo County and staff completed 2 mapping activities. The EDI Coordinator and Easter Seals RGV staff gave presentations on the 2013-2014 EDI data to several community groups, school districts, the MTFFC, and the Leadership Council. The data team and the EDI Coordinator identified a number of families that are highly vulnerable in 2 or more developmental domains based on the neighborhood mapping EDI results; THV programs are making specific efforts to engage these families.

Matching System

Easter Seals formalized an informal matching system originally developed in October 2012. The position of matching coordinator is shared among 3 members of the Easter Seals team including the THV program lead and program manager. The group created a decision tree for referrals to ECI, PAT, NFP, and other home visiting services in the area including AVANCE. THV programs maintain an agency resource guide that the Matching Systems Coordinator uses to identify new partners and make referrals.

Easter Seals recently created a revised Universal Matching System Referral form for use by partner organizations, business, and doctors' offices. The Matching Systems Coordinator uses the submitted forms to determine family eligibility and program fit. ECCS has requested the development of a counter referral form to confirm whether the referred family is receiving services.

Father Engagement

Hidalgo, Willacy, and Cameron counties are in the beginning stages of implementing an action plan for engaging fathers. THV service providers attended 2 father engagement trainings in April and June 2014: the NFI Father Friendly Check-Up Training and the Strong Fathers Strong Families Father Engagement Summit. ECCS plans to follow up with THV providers who attended the trainings to confirm that the providers are moving forward with a plan to engage fathers. Additionally, ECCS partnered with MenCare.org to provide manuals to home visitors on engaging fathers. ECCS hosted a Father Reading Night in June to encourage families to connect

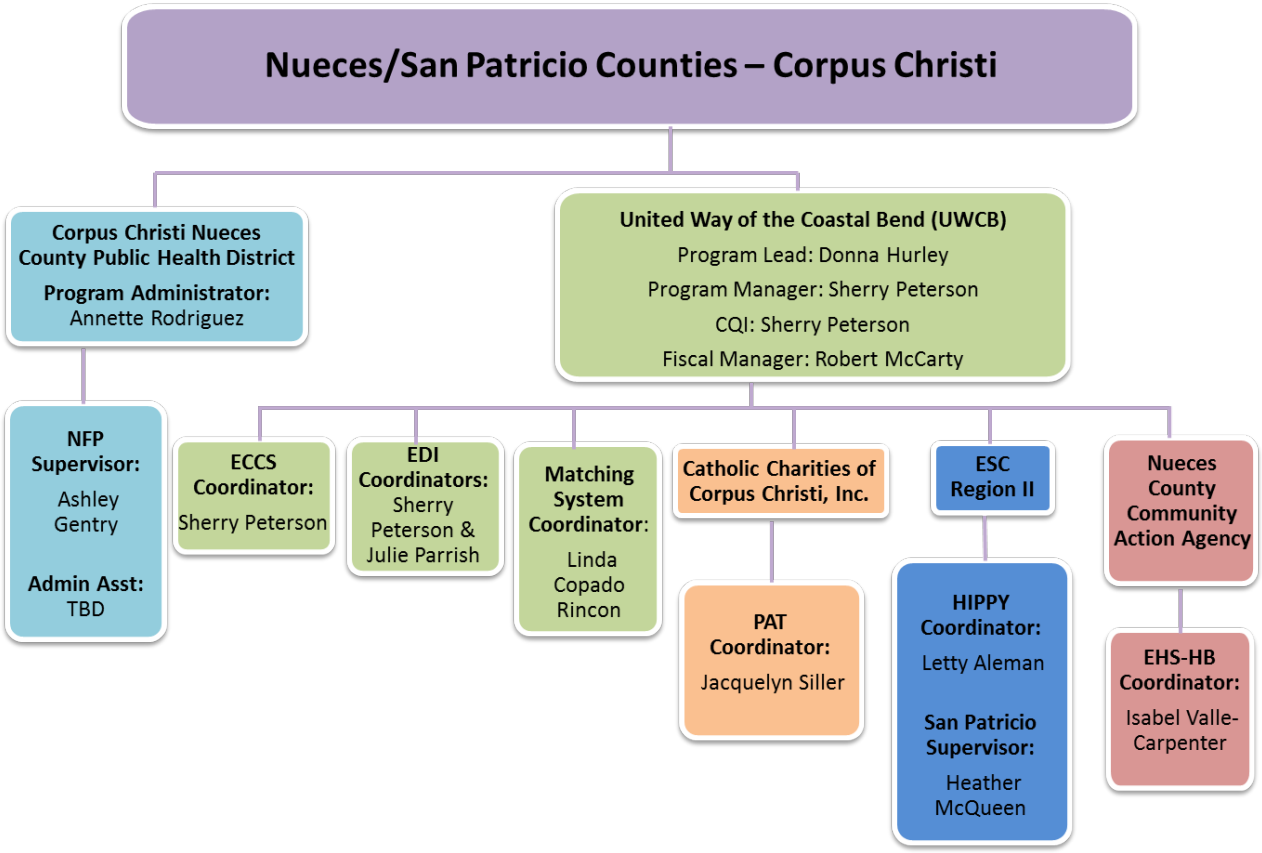
through reading and play. As of June 2014, 20 fathers were participating consistently in home visits.

Continuous Quality Improvement (CQI)

The ECCS appointed a THV CQI committee that includes the PAT, HIPPY, and NFP Program Coordinators, the THV Program Director, the Data Compliance Monitor, and one home visitor from each program. The CQI committee reviews the Quality Assurance Report monthly for project trends on quality indicators and identifies improvement strategies. The committee presents the strategies during the monthly Medical Advisory Committee for feedback and THVs implement and test the strategies on a monthly basis using the PDCA cycle. The committee is currently focusing on improving outcomes in 2 areas: family attrition and family group connection participation.

NUECES AND SAN PATRICIO COUNTES

Figure 6: Nueces and San Patricio Counties Organizational Chart



Community Description

Nueces County is located in southeast Texas on the Gulf of Mexico and has a population of approximately 352,107 people (estimated for 2013).[66] Corpus Christi is the largest city in Nueces County, with a population of approximately 316,381, but there are also several small towns, rural areas, and colonias in the county.[67] In Nueces County, 17.5 percent of individuals live below 100 percent of the federal poverty line and 25.9 percent of children live in poverty.[68]

San Patricio County is located just north of Nueces County in southeast Texas on the Gulf of Mexico and has a population of approximately 66,137.[69] The poverty rates in San Patricio County are similar to those of Nueces County; 16.5 percent of individuals live below 100 percent of the federal poverty line and 25.5 percent of children live in poverty.[70]

Both Nueces and San Patricio counties have higher rates of preterm births, births to teens, and child maltreatment than the state average.[71] Prior to THV, home visiting and parenting services in Nueces and San Patricio counties were limited.[72]

Contracting Organizations

The United Way of the Coastal Bend (UWCB) is the primary contractor for THV in Nueces and San Patricio counties, and manages the ECCS, EDI and matching system. UWCB is a non-profit organization that promotes education, health, and income opportunities. UWCB subcontracted the PAT, EHS-HV, and HIPPY programs to other organizations in Nueces County. Nueces County Community Action Agency (NCCAA), an established direct service provider, expanded their existing EHS-HV program to include a home-based option. Catholic Charities of Corpus Christi (CCCC), a direct service provider with experience in home visiting for a health program, is implementing the PAT program. Education Service Center, Region II (ESC2) is implementing the HIPPY program. Corpus Christi Nueces County Public Health District (CCNCPHD) is the NFP provider in Nueces County. The contractors will hire local San Patricio County staff to provide services to San Patricio County families.

Early Childhood Comprehensive System (ECCS)

UWCB created a new coalition, Success by Six, to serve as the Nueces and San Patricio counties ECCS. The Success by Six Coalition includes representatives from the nonprofit, government, and business sectors in the county. The Coalition is developing a full ECCS strategic plan that should be complete by October 2014; the strategic plan will include an action plan with the Coalition's specific activities and tasks. Several members of the ECCS attended the TECCS Conference in July.

Early Development Instrument (EDI)

Nueces County implemented the EDI in Corpus Christi Independent School District (CCISD) during the 2012-2013 school year. UWCB and CCISD received their initial EDI results in August 2013, and are analyzing the results from the 2012-2013 school year. Three additional school districts, CCISD, West Oso ISD, and Flour Bluff ISD, completed the EDI for the 2013-2014 school year. The ECCS analyzed the EDI Community Profile data and decided to focus recruitment on the 6 neighborhoods with the highest levels of vulnerability, children in poverty, non-English speaking within the home, and free and reduced lunch population. The ECCS is also using the EDI data to inform the ECCS Strategic Plan.

Matching System

UWCB is the organization responsible for organizing the Nueces and San Patricio counties' Home Visiting Matching System. The matching coordinator refers families to the most appropriate home visiting program, but home visiting programs also recruit families that are not referred through the matching system. UWCB has provided a referral form online. Parents can apply to enroll in a home visiting program using the referral form on the UWCB website (www.uwcb.org/Nueces_County_Home_Visiting_Program.cfm).

The matching coordinator contacts the family within 3 business days of receiving the referral form and schedules a one-on-one interview by phone or in person to determine the appropriate program for the family. The matching coordinator emails the referral information

to the home visiting program within two business days of the interview. The matching coordinator then follows up with the program within 5 business days and the family within 7 business days to ensure contact was made.

Father Engagement

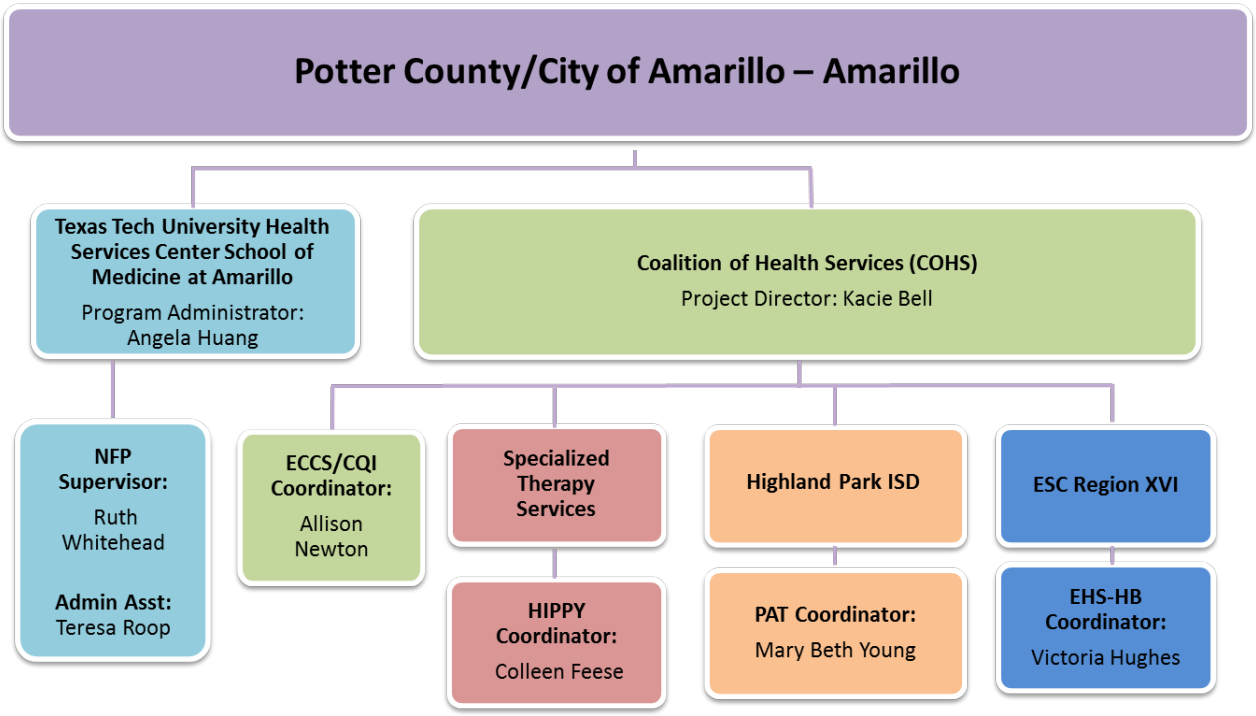
UWCB and THV staff attended a Father Engagement training session led by the OAG in April. Home visiting staff attended the first Fatherhood Summit in March 2014 and additional staff attended a second Fatherhood Summit in May 2014. UWCB held a Fathers Reading Every Day (FRED) kickoff party in May to encourage fathers to read to their children. Participating fathers attended a FRED Celebration Event in June. UWCB program staff attended a National Fatherhood Initiative teleconference in June to review and improve the current Fatherhood Strategic Plan.

Continuous Quality Improvement (CQI)

The Coastal Bend ECCS formed a CQI subcommittee in 2013. The CQI team meets monthly and has begun to develop a project plan. The team has reviewed THV outreach and recruitment processes and identified these processes as areas that may need improvement.

POTTER COUNTY

Figure 7: Potter County Organizational Chart



Community Description

Potter County is located in the Texas Panhandle. The largest city in Potter County is Amarillo, which spans across Potter and Randall counties. Potter County has a population of approximately 121,661 people (estimated for 2013).[73] In Potter County, 23.4 percent of individuals live below 100 percent of the federal poverty line and 32.2 percent of children live in poverty.[74]

Potter County has higher rates of low birth weight babies, births to teenagers, rates of infant mortality, and rates of child maltreatment than the statewide average.[75] Potter County is above the state average in the percentage of women who smoke while pregnant (11% in Potter County compared to 4.4% statewide) and is above the state average in subsequent births within 18 months (8.7% compared to 6.3% statewide).[76] Prior to THV, Potter County had a variety of home visiting services, though not enough to meet demand. There were no systems in place for screening, identifying, and referring families for home visiting services.

Contracting Organizations

Coalition of Health Services (COHS) is the primary contractor for Potter County. COHS is a nonprofit organization that seeks to provide better health care in the Texas Panhandle through its support of health initiatives. The agency has experience with subcontracting services; it was fiscal agent for numerous programs in the area, including Title V, Primary Health Care and

Breast and Cervical Cancer Services, Uniting Parents, 2 Care for Kids, Amarillo Area Breast Health Coalition, and Robert Wood Johnson/Teen Pregnancy Prevention project.

Potter County has each of the 4 home visiting programs associated with THV: EHS-HV, HIPPY, NFP, and PAT. COHS subcontracted with Highland Park Independent School District (HPISD) to provide the PAT program, Specialized Therapy Services (STS) to provide the HIPPY program, and Region 16 Education Service Center (ESC16) to provide the EHS-HV program.

HPISD is a small school district located on the outskirts of Amarillo in Potter County. STS is a private organization that provides speech, physical, and occupational therapy along with educational and behavioral services. ESC16 is the regional education service center for the surrounding area and has an existing EHS-HV program. THV funding was used to expand the existing program to target refugee populations in Potter County.

Texas Tech University Health Science Center, a public education institution, is the NFP contractor in Potter County. The NFP administrator at Texas Tech noted that she had been involved with efforts to bring the NFP program to Potter County for 3 years without success, and THV was an opportunity for Texas Tech to gain approval as an NFP site.

Early Childhood Comprehensive System (ECCS)

Potter County holds coalition meetings every 6 weeks. Because Potter County chose not to participate in the competitive grant, they did not receive technical assistance for their ECCS from United Way Worldwide. Instead, Potter County received assistance from the community specialist at HHSC.

COHS hired an ECCS/CQI Coordinator in December 2012. Potter County refers to their ECCS as the "Stakeholder Group." Meetings occur every 6 weeks and members include Texas Refugee Services, Child Protective Services, 2-1-1, faith-based youth workers, child care and the local food bank. Recruitment of new members is on-going, but maintaining original membership is also a goal. Both the ECCS/CQI Coordinator and the Project Director serve on a number of other community coalitions and boards in order to establish and maintain collaboration among community stakeholders. Potter County has held 6 Community Conversations, including 1 in Spanish and 1 with the Stakeholder Group as of June 2014. The ECCS also held 3 peacekeeping circles that included all of the home visitors, home visitor supervisors, and the Stakeholder Group. The group is currently working on completing a strategic plan.

Early Development Instrument (EDI)

Potter County chose not to participate in the competitive grant because of community resistance to the EDI and, therefore, the county is not formally implementing the 3 competitive grant interventions. Over the first year of THV, Potter County implemented 2 of the 3 interventions: the matching system and father engagement. In the second year, Potter County successfully implemented the EDI in Highland Park ISD for the 2013-2014 school year. Potter County hired an EDI coordinator in November 2013 to facilitate the EDI implementation.

Matching System

Potter County has no formal matching system, but relies on contacts at various agencies and organizations, a referral form, and assistance from 2-1-1. Home visitors have a community resource binder on hand to help refer families to local services and programs. Potter County also participates in the state matching phone calls for technical assistance.

Father Engagement

Each of the home visiting program coordinators and home visiting staff completed the father engagement strategy training. Potter County incorporated the results from the Father-Friendly Check-Up™ assessment into an action plan to increase father involvement in each of the THV programs. The first father engagement event took place in November 2013 with five fathers in attendance. Potter County reports that fathers are participating in home visits and are attending group meetings. Potter County has hosted several additional father engagement activities, including 1 in July 2014.

Continuous Quality Improvement (CQI)

Potter County appointed a CQI team in December 2012. The team identified father engagement as the priority improvement area for Potter County THV. The CQI team set goals for father engagement and THV programs are working to accomplish greater father engagement to reach these goals. The CQI plans to document successful CQI policies and practices.

Appendix B: Evaluation Data Sources

The data used to conduct this mixed-method evaluation come from a variety of sources. The primary source of quantitative data is the Texas Home Visiting data system, which includes demographic, enrollment, and benchmark information. Qualitative data come from various THV documentation and materials, observations of THV-related activities, monthly and quarterly reports, and interviews. HHSC, the 4 state home visiting program model leads, the 7 community contractors, and all of the 23 home visiting programs were and continue to be extremely helpful in providing information, meeting with the CFRP evaluation team for interviews, and allowing CFRP to observe their coalition meetings and conduct focus groups in their respective communities. The ease of access to the program stakeholders and documents substantially enhances the quality of the evaluation.

TEXAS HOME VISITING DATA SYSTEM

Each home visiting program participating in THV collects demographic information on participating families along with data on each of the 6 federally-established benchmarks, which include child and maternal health, child injuries and emergency room visits, school readiness and achievement, domestic violence, family economic self-sufficiency, and referrals for other community resources and supports. Each home visiting program is responsible for logging this information in addition to family enrollment, visit, and exit data into their respective data systems. The data from each of the home visiting programs data systems is imported into a central system (the THV data system), from which CFRP can securely access the data. The demographic and benchmark data will be the primary source of data for assessing variation in the components of service delivery.

OBSERVATIONS OF THV-RELATED ACTIVITIES

HHSC and the communities participate in numerous conference calls, technical assistance meetings, trainings, and coalition activities. CFRP observes these activities either in person or over the phone and take extensive notes. The researchers analyze and code notes from the observations on an ongoing basis, and continually update our findings.

CFRP regularly observes ongoing monthly THV conference calls organized by HHSC. To date, CFRP observes and participates in monthly state contractor conference calls, which provide a forum for HHSC staff, state-level contractors, and state program model leads to share updates on THV related progress. CFRP observes monthly conference calls to discuss progress on developing the matching systems. These calls involve staff from HHSC and the community matching coordinators. Additionally, CFRP observes monthly conference calls to discuss updates related to the ECCS, EDI, and the TECCS process. Attendees include HHSC staff, the state contractors for the EDI and TECCS process, and the EDI and ECCS Coordinators from each community.

Members of the CFRP evaluation team also observe conferences and trainings that include the contractors, the subcontractors, or the home visiting state program model leads within each community. CFRP attends TECCS/EDI conferences and trainings on father engagement provided

by the OAG and the National Father Initiative. Finally, CFRP observes all webinars provided to community contractors by HHSC or state-level contractors.[c]

MONTHLY AND QUARTERLY COMMUNITY REPORTS

HHSC requires the program manager in each of the 7 communities to submit monthly reports on behalf of each of the THV home visiting program models in their respective communities.[d] The monthly reports provide updates regarding staffing, the number of participants enrolled in each home visiting program model, and the program models' maximum caseloads at that point in time. Program managers also report their communities' major accomplishments, plans for the upcoming months, resource constraints, and any critical issues that require the attention of the HHSC program staff. NFP programs submit a separate monthly report to the program managers.

In addition to the monthly reports, HHSC requires program managers to submit quarterly reports to obtain additional information about the communities' progress toward THV goals. The quarterly reports provide documentation on staffing and infrastructure, the communities' major accomplishments and challenges for the quarter, the communities' goals and objectives, the number of MOUs established, and recent communications with local social service agencies during the quarter. Program managers also provide specific updates on their activities with regard to the home visiting programs, THV related trainings, Continuous Quality Improvement (CQI), the EDI and TECCS process, the matching system, and benchmark data collection.

INTERVIEWS AND COMMUNITY VISITS

CFRP has conducted semi-structured, open-ended interviews (over the phone or in person) with individuals from HHSC, state program model leads, community-level program managers or primary contractors, and community-level home visiting program coordinators and home visitors. The purpose of the interviews is to hear from THV participants about their experiences implementing THV. Questions are both broad (e.g., How are things going for your community?) and more specific (e.g., Can you provide an update on where you are in implementing the matching system in your community?). Participants typically provide a brief update on each element of THV and any MIECHV related deliverables (e.g., sustainability plan), including successes and challenges they have experienced.

CFRP has conducted 2 rounds of site visits to each of the THV communities—the first round occurred throughout the fall of 2012 and the second round occurred throughout the fall of 2013 and early winter of 2014. During each site visit, CFRP meets with THV staff, including

[c] On occasion, CFRP also has observed monthly conference calls held by state program model leads for NFP and PAT (HIPPY and EHS-HV do not hold monthly conference calls). Some of these calls are closed to observations. In these instances, CFRP receives meeting notes in lieu of observing the calls.

[d] NFP submits a separate monthly and quarterly report to the program manager. CFRP reviews NFP's reports in addition to the community monthly and quarterly reports from the program managers.

home visitors. The timing of these visits usually correspond to a local coalition meeting or father engagement training that CFRP will also observe. A third round of site visits is planned for late fall 2014 and early winter 2015.

Appendix C: County-Level Demographic Characteristics of THV Communities

Demographic Characteristics and Risk Factors of Texas Counties Participating in THV

County	Total Poverty %	Child Poverty %	Race/ethnicity %				Uninsured Children %	No HS/ GED %	Un-employment %	Children with Single Parent %
			White	Hispanic	Black	Other				
Anderson	22.5	27.8	60.2	16.9	20.7	2.1	14.5	21.6	7.2	35.2
Cameron	35.5	48.2	10.1	88.5	0.4	1.0	14.1	37.0	10.1	33.4
Cherokee	26.7	38.3	61.8	21.7	14.4	2.1	14.5	24.0	7.5	34.6
Dallas	19.3	29.0	31.7	39.0	22.2	7.1	13.5	22.9	6.7	35.2
Ector	14.5	21.1	37.3	56.4	4.1	2.2	15.9	26.7	4.0	35.2
Gregg	18.8	27.9	59.6	17.5	19.7	3.1	12.5	18.4	5.5	36.0
Hidalgo	34.2	45.7	7.3	91.0	0.4	1.2	16.4	38.8	10.8	30.4
Midland	9.8	16.3	50.0	41.1	6.1	2.9	14.3	17.9	3.3	29.5
Nueces	17.5	25.9	31.4	62.0	3.6	3.0	9.4	21.0	5.8	39.8
Potter	23.4	32.2	47.1	36.7	9.8	6.4	13.5	23.9	5.2	41.4
San Patricio	16.5	25.5	40.8	55.4	1.6	2.2	12.1	22.4	7.5	33.9
Willacy	38.6	45.9	9.6	87.4	1.9	1.0	14.2	39.3	13.8	35.2
All THV Counties (Average)	**23.1**	**32.0**	**37.2**	**51.1**	**8.7**	**2.9**	**13.7**	**26.2**	**7.3**	**35.0**
Texas	**17.9**	**25.8**	**45.4**	**37.6**	**11.5**	**5.4**	**13.1**	**19.3**	**6.3**	**30.4**

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Appendix D: Active-Duty Military and Military Family Populations in THV Communities

Estimates of the number of children living in military families in the THV communities based on the percentage of children on TRICARE, a health insurance program for the U.S. Military and their dependents provide a conservative estimate of the number of children in military families in the THV communities.

Active-Duty Military and Military Family Populations in THV Communities

County	Active-Duty Military Population (2012- 5 year estimate)	Total Population over 18 (2012)	Proportion Texas Population Over 18 Active-Duty Military (5-year)	Children in Military Families (2012)	Child (0-17) Population (2012)	Proportion
Anderson	30	46,811	0.1%	35	11,371	0.3%
Cameron	385	281,254	0.1%	903	134,193	0.7%
Cherokee	0	37,977	0.0%	112	13,147	0.9%
Dallas	1,274	1,788,066	0.1%	4,453	661,347	0.7%
Ector	14	102,313	0.0%	485	40,654	1.2%
Gregg	29	91,246	0.0%	254	30,952	0.8%
Hidalgo	393	530,506	0.1%	2,023	272,327	0.7%
Midland	47	106,348	0.0%	440	38,614	1.1%
Nueces	2,255	258,988	0.9%	3,725	88,073	4.2%
Potter	101	88,461	0.1%	327	33,802	1.0%
San Patricio	430	47,210	0.9%	559	17,797	3.1%
Willacy	0	16,388	0.0%	29	5,795	0.5%
Texas Total	**105,827**	**19,074,989**	**0.6%**	**184,798**	**6,917,706**	**2.7%**

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