Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) Formula Grant Evaluation

Final Report to the Massachusetts Department of Public Health: **Evaluation Summary**

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Prepared by researchers from Tufts Interdisciplinary Evaluation Research at Tufts University (TIER) and the UMass Donahue Institute's Applied Research and Program Evaluation Group (UMDI)

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Newborn and early childhood home visiting – a two-generation approach to providing support to families with young children – has garnered increasing public attention over the past 30 years. Long supported by state and local governments, as well as private dollars, home visiting first received major federal funding in 2010, through an amended provision within the Affordable Care Act (Public Law 111-148) entitled the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. This amendment to Title V of the Social Security Act funds states, tribes, and territories to implement home visiting services in at-risk communities. Jointly administered by the Health Resources and Services Administration and the Administration for Children and Families, MIECHV programming exists now in 893 counties in all 50 states, the District of Columbia, 25 tribes, and five U.S territories.

Administered by the Massachusetts Department of Public Health (MDPH), the MIECHV program in Massachusetts (MA MIECHV), delivers home visiting services via four models [Early Head Start (EHS), Healthy Families America (HFA), Healthy Families Massachusetts (HFM), and Parents as Teachers (PAT)], in 17 communities across the Commonwealth. These home visiting programs, housed in local implementing agencies (LIAs), aim to help pregnant and parenting families across 6 domains (including: maternal health, child health, school readiness, prevention of child maltreatment, family economic self-sufficiency, reduction in crime or domestic violence, and service coordination), either directly or by connecting families to resources and supports in their communities.

Evaluation Design

The MA MIECHV evaluation was designed to build on earlier evaluation work conducted during fiscal year (FY) 2012 to FY 2017 by from UMDI and TIER. These earlier evaluation phases focused on understanding the local contexts in which MA MIECHV programs operate at the community level, using qualitative methods and administrative program data to better understand the ways in which MA MIECHV programs facilitate families' engagement in community services.

For this current iteration of the evaluation, we aimed to deepen our understanding of how MA MIECHV programs fit into early childhood community systems of care, from the perspectives of home visitors as well as participants. An additional point of focus was to explore factors related to non-fiscal sustainability efforts, adding breadth and depth to these perspectives through solicitation of feedback from community stakeholders via survey. Finally, to understand the flow of participants into MA MIECHV from other community programs, we explored the influence of referral source on program eligibility and engagement. For this quantitative research component, we generated two hypotheses, based on earlier phases of our research: 1) Welcome Family, a short-term nurse home visiting program for new parents and their newborn infants, and meant to function in MA MIECHV as a "child find"[1] program, would positively influence engagement; and 2) referrals from the DCF, the child welfare agency in MA, would negatively influence engagement. We hope that findings from this evaluation will better position MDPH to engage in practices that ensure the long-term sustainability of home visiting programs by revealing the ways that they are part of local systems of care and, as such, are perceived by stakeholders as an indispensable resource in their communities.

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[1] "Child find" refers to the mandate written into the Individuals with Disabilities Education Act requiring states to identify all children, ages birth to 21, who have disabilities. MDPH describes the Welcome Family program as having the potential to function as an Early Intervention child-find; this could take the form of a direct referral to EI, but could also be interpreted more loosely, as a referral into another evidence-based home visiting program that does regular child development screenings as part of its programming.

Evaluation Questions

1. How do participants characterize their own "systems of care" in terms of usability and efficacy, and how does home visiting fit in to these systems?
2. To what extent is MA MIECHV perceived by stakeholders at multiple levels as being embedded in the early childhood system of care? To what extent, if at all, has it moved from "initiative" to "institution"? What strategies can MA MIECHV employ to move from one-time initiative to institutionalization?
3. To what extent is referral source (specifically, Welcome Family and DCF) related to families' eligibility for, and engagement with, home visiting?

To address the first and second research questions, we collected data from home visitors, program participants, and community service providers in three MA MIECHV communities—Fall River, Springfield, and Berkshire County. For the third question, we analyzed program data from a census sample of home visiting participants in all communities, and, for the Welcome Family analyses only, the three communities with the longest-running Welcome Family programs—Boston, Fall River, and Springfield.

Major Findings

Question 1: Early Childhood System of Care

Throughout this report, we use the term "system of care" and its various corollaries. "System of care" is the more general term, whereas "community system of care" is used to denote the level at which we are focusing (i.e., the community), and "early childhood system of care" denotes the target population (i.e., families with young children). An early childhood system of care can be defined and described in different ways, depending on the purposes and priorities in question. For the current purposes, we define it as:

> A coordinated network of community-based services and supports that is organized to meet the concrete, social, and emotional needs of young children and their families. Families and early childhood professionals within public and private organizations at the community level work in partnership so services and supports are readily accessible, effective, strengths-based, and address the cultural and linguistic needs of young children and their families.[2]

Participants describe their own systems of care as large and complex, reporting an average of 17 different current service providers (range = 7-42). The service areas participants most commonly mentioned being involved with were *early care and education/early intervention*; *economic/nutritional/material support*; and *medical*. Importantly, half of participants indicated some kind of involvement with DCF. The majority of providers in almost every service area were rated positively by participants, particularly in the areas of family support, maternal health, and adult

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[2] Adapted from the Nebraska Department of Health and Human Services' *Community Early Childhood System of Care (ECSOC) Self-Assessment* (http://dhhs.ne.gov/publichealth/Documents/System%20of%20Care-Final.pdf)

education programs. Negative ratings, and ambivalent ones, were largely concentrated in the areas of DCF, housing, and behavioral health.

To ask how home visiting fits into this community system of care takes into account two realities about the home visiting programs that are the focus of this evaluation. First, home visiting programs provide a direct service to families, like other programs within the system of care. They also help families access and navigate the system of care. Although these programs are not case management programs by design, home visitors report that over half their time (53%) is spent on case management and service coordination activities, rather than parenting education and support, which is the primary focus of the program. Beyond providing contact information, helping participants make calls, and following up on referrals, home visitors often mitigate barriers associated with transportation, logistical conflicts, or with emotional or psychological challenges related to service engagement (e.g., history of not trusting professionals), leading to fewer missed appointments and a greater engagement with services.

Both participants and home visitors alike describe the benefits participants receive as much broader than merely system navigation and resource access, identifying the home visitor-participant relationship as the core of the program, with some participants indicating this as the only model of a healthy relationship in their lives. The home visitor was described as providing guidance and praise as participants navigated both parenting and getting their needs met through the system of care. This relationship facilitates a sense of empowerment for participants, and an ability to be self-sufficient, which is a key aim of home visiting.

Question 2: Issues of Sustainability

Fiscal sustainability issues are important to understand, and payment mechanisms for home visiting services are being explored both in Massachusetts and around the country. But fiscal sustainability is only one part of the solution. Here, we focus on the ways home visiting programs have, or can, become so integral to the communities in which they operate that they are seen as an indispensable part of an early childhood system of care. The Home Visiting Applied Research Collaborative (HARC), which was established as part of MIECHV to articulate a national home visiting research agenda, refers to the embeddedness of home visiting programs within a system of care as a critical aspect of "institutionalization." Once institutionalized, the home visiting program would be known and valued on multiple levels and recognized as the go-to service of its type. This is the type of "sustainability" that is explored in this report—the type that renders home visiting politically and logistically difficult to disentangle from the larger systems in which it sits.

The first threshold to be met when considering matters of institutionalization is whether the program is valued by participants. Participants and home visitors alike spoke eloquently and poignantly about what makes these programs special and important for participants, with many participants expressing the multiple ways in which their home visitors have changed their lives for the better. Participants and home visitors described the factors that they believe lead to program success, including the ability to meet with participants in a natural home setting, home visitors' system of care expertise, home visiting program staff who genuinely care about the program, the importance of co-location with partner programs/organizations, and the program's positive regard within the community.

For a home visiting program to become institutionalized within a community system of care, relevant stakeholders need to know about it, understand it, and value it. Whereas most community service providers surveyed indicated having heard of home visiting in general, and HFM in particular, less than one third of respondents had heard of the MA MIECHV initiative, or the PAT and Welcome Family programs in their community. These findings suggest that there is significant room for improvement in

terms of community embeddedness and institutionalism, highlighting the importance of MDPH more deliberately facilitating system-building and collaboration efforts on the ground.

Question 3. Referral Source and MA MIECHV Engagement

We tested the hypothesis that Welcome Family would have a positive relation, and DCF a negative one, to the likelihood that families would be eligible for, and engage with, the home visiting programs to which they were referred by these two entities. Both models yielded results that confirmed these hypotheses, though findings were largely concentrated in the earlier stages of program engagement—namely eligibility. Referrals made through Welcome Family were more likely to be eligible (i.e., appropriate referrals) than those made from almost any other referral source. And while only a few comparisons reached statistical significance, the opposite was largely true for the DCF referrals in relation to referrals made from other types of programs. Furthermore, when we compared total referrals in non-Welcome Family communities with those in Welcome Family communities, families in the three Welcome Family communities, on the whole, were more likely to be eligible for services than their counterparts. If we view the relative eligibility of participants as a proxy for community providers' knowledge about the MA MIECHV programs—about who the home visiting programs are *for*—Welcome Family emerges as well-positioned to continue its child-finding role, as well as to continue building partnerships with HFM and the other MA MIECHV home visiting programs, as well as strengthen their outreach and recruitment potential with other community providers.

Study Limitations

A number of limitations should be kept in mind when reviewing evaluation findings. First, the communities focused on were not selected for their generalizability to the Commonwealth as a whole, but rather as case studies used to understand the issues explored herein. Second, participants self-selected for participation in focus groups, and the participant sample likely skews positively due to this selection bias. Similarly, community service providers who responded to the survey may have been more likely to be familiar with home visiting than those who did not respond. Finally, we were only able to include HFM programs in the referral source analyses, which precludes extrapolating findings to the other models.

Key Implications

Several implications, at both the policy and programmatic levels, can be offered. First, it would be prudent to codify and support the informal connections and partnerships that home visitors have built with community providers, to more deliberately network MA MIECHV with other programs within a community system of care, and to raise awareness about the role of home visiting in general. Findings suggest that, with some exceptions, stakeholders agree our Commonwealth provides a significant amount of resources and services for families in need, but strategic alignment could be improved. Interagency collaboration not only helps to organize available resources and remove barriers to accessing services, but helps to create a community infrastructure that is both continuous and complementary. Care to incentivize the work involved on the ground is of utmost importance, as is ensuring that appropriate partners are engaged at all levels. The evaluation observed significant overlap

between MA MIECHV families and those involved with DCF, suggesting the latter in particular to be a crucial partner to MA MIECHV.

Relatedly, while it is important to promote and/or require interagency collaboration, it is also important to *build capacity* for such collaboration, in order to have a useful and sustainable impact. MDPH can facilitate capacity building in a number of different ways, beginning with creating a long-term vision for systems coordination among MA MIECHV programs, and providing oversight and guidance to help programs move toward that vision. The success of Welcome Family in bringing eligible referrals to HFM programs suggests the critical role that home visiting programs can play in supporting other home visiting programs. Convening a coalition of home visiting practitioners who can work collaboratively toward articulating a common vision about how families should move in and out of support programs, may lead to a shared commitment to providing seamless support services to families. Having this kind of unified, collective home visiting presence in communities may also help other community stakeholders to see home visiting programs as inextricably linked to community systems of care – as being institutionalized – which significantly enables sustainability efforts.

Finally, home visitors wear a number of different hats and act in numerous capacities for participants. These findings complicate the notion of "precision home visiting,"[3] an empirical framework that attempts to identify components that are effective for particular populations. Precision home visiting eschews the notion that home visiting is a "be-all" program and is partly a response to the legitimate concerns that home visiting can become diluted and/or overtaken by addressing social service needs, rather than engagement in parenting education and support. However, simply because a program might become narrower in their focus on parenting does not mean that concrete needs are eliminated, and they will still need to be addressed. Partnering with another organization to provide co-located case management or resource referral services is one possible solution.

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[3] Retrieved from https://www.hvresearch.org/introduction-to-precision-home-visiting/

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Administered by the Massachusetts Department of Public Health (MDPH), the MIECHV program in Massachusetts (MA MIECHV), delivers home visiting services via four models [Early Head Start (EHS), Healthy Families America (HFA), Healthy Families Massachusetts (HFM), and Parents as Teachers (PAT)], in 17 communities across the Commonwealth. These home visiting programs, housed in local implementing agencies (LIAs), aim to help pregnant and parenting families across 6 domains (including: maternal health, child health, school readiness, prevention of child maltreatment, family economic self-sufficiency, reduction in crime or domestic violence, and service coordination), either directly or by connecting families to resources and supports in their communities.

UMDI and TIER teams collaborated to design a mixed-methods evaluation aimed at examining MA MIECHV's relative embeddedness in community systems of care from multiple perspectives: programs that refer participants to MA MIECHV, home visitors, programs to which MA MIECHV participants are referred, and the families themselves. We aligned our work to complement the activities of the Sustainability Team, an outside consultant-led committee primarily looking at funding models and mechanisms for home visiting services in Massachusetts. The evaluation comprised quantitative analyses of extant program data, and a more focused case study approach in three MA MIECHV communities.

The purpose of this evaluation was to broaden and deepen the understanding of the early childhood systems of care in which MA MIECHV programs are embedded. Building on research that was conducted by the evaluators in previous evaluation phases (see below), this iteration of the work engaged families directly. The perspectives of program participants aid us in understanding more fully how families experience home visiting within the context of their unique needs, the available resources in their community, and the early childhood systems of care in which they are embedded. An additional point of focus was to explore factors related to non-fiscal sustainability efforts, adding breadth and depth to these perspectives through the use of program data and solicitation of feedback from community stakeholders via survey. Specific purposes of the evaluation include the following:

- Leverage and build on the previous evaluations conducted by UMDI and TIER to generate a more holistic understanding of the ways that MA MIECHV can become increasingly embedded in an early childhood system of care, thereby maximizing efforts toward sustainability.
- Provide formative feedback regarding the impact of enhanced recruitment and referral practices on family utilization of home visiting services.
- Document multiple perspectives on each community's early childhood system of care, how home visiting fits within that system, and how families are moved through the system.
- Give voice to the experiences of program participants, provide an opportunity for families to describe their experiences, and utilize these data to inform sustainability efforts over time.

Findings from this evaluation will better position MDPH to engage in practices that ensure the long-term sustainability of home visiting programs by revealing the ways that they are part of local systems of care and are perceived by stakeholders as an indispensable resource in their communities.

Previous Evaluation Work

Both UMDI, whose previous work was completed in December 2015, and TIER, whose work was completed in December 2016, have studied the community contexts in which local MA MIECHV programs operate. UMDI assessed community capacity to support families with young children at the broader community and initiative levels, while TIER has been assessing community service systems through the lens of locally-implemented MA MIECHV programs.

UMDI's previous evaluation work progressed through each of three phases. In the first phase, all MA MIECHV communities were included. In the second and third phases, subsets of eight and four communities were included respectively. TIER's previous evaluation work focused on four communities throughout the evaluation period (See Table 1).

Table 1. Focus Communities in Previous Evaluations

Focus Communities	UMDI			TIER
	Phase I	Phase II	Phase III	
Berkshire County*	X	X		X
Boston	X	X		
Brockton	X			
Chelsea	X	X		
Everett	X			
Fall River	X			X
Fitchburg	X			
Holyoke	X			X
Lawrence	X			
Lowell	X	X	X	
Lynn	X			
New Bedford	X	X	X	
Revere	X			
Southbridge	X	X		
Springfield	X	X	X	
Worcester	X	X	X	X

*Note: Berkshire County includes both Pittsfield and North Adams. For UMDI's Phase II, only North Adams was a focus community.

UMDI Study of Community Capacity

The UMDI evaluation consisted of three phases. During Phase I, UMDI used information gathered from key stakeholders in selected MHVI communities to develop an operational definition of community capacity to support child and family well-being and to build a foundation for measuring capacity in those communities.

During Phase II, this definition was utilized to assess the capacity of eight MHVI communities, including identifying general trends in community capacity and generating individual community profiles. These profiles documented community demographic information and availability of resources in key areas, assessed components of capacity in each community, and explored strengths and challenges regarding capacity to support child development and family well-being.

In Phase III, UMDI explored the intersecting roles of three key state initiatives focused on creating, strengthening, and making accessible an early childhood system of care: MHVI, Coordinated Family and Community Engagement grantees (CFCE), and Birth to Third Grade Strategy Alignment grantees (B3). Funded through the Massachusetts Department of Early Education and Care (EEC), CFCE grantees are tasked with reaching out to all families with young children to provide education and support, identifying children at risk of developmental delays and assisting their families in accessing necessary resources, and providing support to early education and care providers. In addition to these direct services, CFCE councils work to promote the importance of early childhood growth and development and kindergarten readiness at the community level. Additionally, they partner with key community stakeholders to create or support community-level initiatives and special events focused on the needs of families with young children. Also funded and administered by EEC, the B3 grantees are charged with improving early elementary school teaching and learning, improving early childhood education through public/private collaboration, and providing support services through community partnerships. These three entities (MHVI, CFCE, and B3) were identified because they are grant-funded initiatives that are encouraged to collaborate with each other and with other community providers and stakeholders to create and sustain a community system of care for children and families. Key findings from the UMDI evaluation are as follows:

- *Phase I—Definition of community capacity:* "The interaction of human capital, organizational resources, and social capital existing within a given community that can be leveraged within the community to support child development and improve or maintain the well-being of children and families."
- *Phase II—Community capacity measurement:* The eight communities (see Table 1), each diverse in terms of population density, racial composition, income, funding, and resources, were markedly different in their capacity to serve families with young children. While this variability precluded universal cross-community recommendations about how best to strengthen capacity, overarching themes were identified, including the importance of a backbone organization, comprehensive data systems, and family and resident engagement and leadership. Recommendations were made regarding state department strategies to support capacity at the community level.
- *Phase III—Intersection of roles of MA MIECHV, CFCE, and B3:* Data suggest the three initiatives have less operational overlap than intended by their respective funders. While the relationships among the three varied across the four different communities, in general it appeared that MA MIECHV programs, when recognized at all by the other two entities, were perceived as direct service providers only, rather than key system players at the administrative or initiative level.

TIER Study of MA MIECHV Integration into Community Systems of Care

Focusing on four communities (see Table 1), TIER used a mixed methods approach to examine the relative integration of home visiting into community-level systems of care, the types of connections MHVI programs have with other community organizations, and the extent to which these inter-organizational relationships appeared to be reflected in home visitors' referral patterns. Using program data derived from the programs' management information systems (MIS), TIER documented the full range of home visitor behaviors involved in service coordination, including behaviors intended to connect participants to services and maintain their engagement once connected. Activities were coded using a multi-level scheme capturing all stages of home visitor's facilitation of participants' linkages to community services, including pre-referral activities (e.g., suggesting a service), referrals (i.e., the initial action taken to link a participant to a service), referral follow-up activities (e.g., assistance completing applications), service connection, service disconnection, post-connection activities (e.g., satisfaction check-ins), and post-disconnection activities (e.g., attempts to re-engage). Codes also characterized the primary goal of each discussion (i.e., to connect a participant to a service ["linking mode"], or support an existing connection ["maintaining mode"]). We identified a hierarchy of home visitor behavior codes, based on the intensity of time and effort required from home visitors in providing each type of support, including low-level support (check-ins), moderate support (encouragement/suggestions/advice; emotional support/cheerleading; information provision), and advanced support (instrumental support; interagency case review).

Additionally, TIER used social network analysis in each of the evaluation sites to examine, through a survey administered to every organization providing services to families in each of the four communities, the formal/informal network of organizations in which each LIA is embedded, focusing on the density, trust, and levels of collaborations among programs in each network.

Key findings from the referrals study revealed that home visitors discussed an average of 30 different programs with each participant, and overall, only 21% of referrals resulted in service connection. This rate varied, with some (e.g., housing) requiring much more intensive home visitor support and yielding far fewer connections. Home visitors also worked to keep participants engaged once they were connected to a service, often discovering challenges in need of attention through monitoring activities. Findings from this study confirmed the inextricability with which home visitors are embedded in community systems of care. They not only are providing essential direct services to participants, but also are working behind the scenes as conduits between participants and this system, facilitating access to services by informing participants about the existence and functions of the services, interpreting complicated policies, imparting skills that can be used to pursue needed services in the future, and providing emotional support throughout.

Results from the social network analyses suggested that each of the four communities TIER studied had fairly dense networks of community providers. Based on indegree centrality scores (the total number of incoming connections each program has), the Department of Children and Families (DCF), consistently emerged as the most prominent member in three of the networks, and the Department of Transitional Assistance emerged as most prominent in one. On one level, it is not surprising that DCF emerged as a "leader" in three of four communities, given their concentrated power and comparatively large funding streams. But given that this survey was administered to all programs serving children and families in a given catchment area, the majority of which provided universal, prevention-focused services (e.g., family centers, child care programs, hospitals, libraries, public schools), it is sobering that the program

serving a relatively small subpopulation in need of substantive intervention emerges as being the most central in these systems of care. . MHVI programs across communities were fairly well embedded in their respective systems, and emerged for the most part in the middle of the pack in terms of network prominence.

Summary of Preliminary Evaluation Findings and Implications for Next Steps

While the two evaluations described above were unique in their orientation and methodologies, there was one empirical question that implicitly framed both: To what extent has MA MIECHV become embedded in, and considered vital to, comprehensive early childhood systems of care? Initial findings highlight how complicated the answer to this question is. On the one hand, as shown by the TIER study, home visitors are adept at navigating local systems of care, suggesting that at a grassroots, service-provision level MA MIECHV is inextricably embedded in local systems of care. On the other hand, as suggested by the UMDI study, these day-to-day program operations on the ground do not appear to be in alignment with the state- and community-level expectations and explicit requirements in the areas of collaboration and inter-agency coordination. Indeed, key players in the early childhood systems (e.g. community recreation departments, municipal leadership, etc.) often had little to no understanding of the role of MA MIECHV in an early childhood systems, or sometimes even of home visiting in general.

What does this mean for MA MIECHV in terms of its long-term sustainability? As defined HARC, which was established by HRSA to articulate a national home visiting research agenda, "sustainability" can be understood as "the extent to which an intervention delivers benefits over time, that is, the transition from a one-time initiative to institutionalization…" This definition of sustainability includes the following operational indicators: "Maintenance of home visiting's initial benefits, its institutionalization, and home visiting capacity building in a setting or community." MDPH has demonstrated that MA MIECHV delivers benefits over time (programs have consistently made progress in all six of the benchmark areas set forth in the federal MIECHV legislation) and is now redoubling its efforts around institutionalization and community capacity building. Specifically, MDPH has been focusing on innovative ways (e.g., using Welcome Family as a child-find activity in certain communities) to broaden and educate outreach and referral networks, making more explicit the role that MA MIECHV plays in local systems of care. MA MIECHV hopes to ensure its long-term sustainability by establishing itself as a highly-recognized key player in the early childhood systems of care—both as a provider of direct services to families with young children and as a key entry point for those families into the wider systems of care. Both points are in alignment with the program's theory of change which purports that through the implementation of EBHV and supporting sustainable community systems of care the program will contribute to improving health and developmental outcomes for vulnerable families.

Current Evaluation

Building upon these respective studies, UMDI and TIER collaborated to design a mixed-methods evaluation aimed at examining MHVI's relative embeddedness in community systems of care from multiple perspectives: programs that refer participants to LIAs, LIA service providers, programs to which MHVI participants are referred, and families themselves. Because issues of long-term sustainability are being addressed, we aligned our work to complement the activities of the Sustainability Team, an

outside consultant-led committee primarily looking at funding models and mechanisms for home visiting services in Massachusetts.

To ensure that the evaluation answered questions that were both timely and serve national as well as state and local interests, we drew upon HARC's Home Visiting Research Agenda to frame this evaluation, focusing on the following three home visiting research priorities: 1) Research to promote family engagement in home visiting (Priority 7); 2) Research to promote coordination with other services for families (Priority 8); and 3) Sustainment of home visiting (Priority 9). Below are the key evaluation questions, organized and contextualized by Research Priority.

Question 1. How do participants characterize their own "systems of care" in terms of usability and efficacy, and how does home visiting fit in to these systems? (Research Priority 8). HARC advises, "The benefits of coordination and referral to specialty services in general are assumed but lack empirical study… Research is needed to guide the field toward optimal ways for home visitors and other providers to work together in assessing, prioritizing, and addressing family needs." The community systems of care in which MHVI programs operate are characterized by resources that are not available in correct proportions to meet community need, confusing eligibility requirements, and long waitlists. There is much to be learned by asking participants how they view their own particular "systems" of care against these community backdrops, and what role they perceive MHVI as playing in these systems

Question 2. To what extent is MHVI perceived by stakeholders at multiple levels as being embedded in the early childhood system of care? To what extent, if at all, has it moved from "initiative" to "institution"? What strategies can MHVI employ to move from one-time initiative to institutionalization? (Research Priority 9). We were interested specifically in investigating what HARC describes as "the extent to which an intervention delivers benefits over time, that is, the transition from a one-time initiative to institutionalization." Among the factors HARC mentions as salient to this transition are "sustained organizational or community attention to the issues addressed by home visiting; and system-level efforts to expand and replicate home visiting and promote its coordination with other services." We addressed this evaluation question via focus groups and a community stakeholder survey

Question 3. To what extent is referral source (specifically, Welcome Family and DCF) related to families' eligibility for, and engagement with, home visiting? (Research Priority 7). As observed by HARC, "Home visiting cannot improve outcomes if it does not reach families who could benefit and cannot retain or engage enough families to deliver benefit…" For this new grant period, MHVI leveraged the Welcome Family universal short-term home visiting program for its child-find potential, training nurses to refer families to the appropriate home visiting programs in that catchment area. We used program data to test the hypothesis that this approach theory increased the number of eligible referrals that were made to home visiting programs.

Evaluation Methods

The evaluation included: secondary analysis of extant program data; focus groups with home visitors and program participants; and an online survey to other community service providers in each of the evaluation communities. Each of these methods is described below, beginning with a short description of the evaluation sites. See Table 5, at the end of this section, for timeline of evaluation activities.

Evaluation Sites

The current evaluation focuses on three MA MIECHV communities—Fall River, Springfield, and Berkshire County--to address the first and second research questions, and all MA MIECHV communities for the third research question (with a focus on the three communities with the longest-running Welcome Family programs—Boston, Fall River, and Springfield—for the analyses of Welcome Family as a referral source). (See Table 2 for evaluation focus communities and Table 3 for years program has been in existence in each of the case study communities).

Table 2. Focus Communities in Current Evaluation

Focus Communities	UMDI			TIER	Current Evaluation (UMDI/TIER)	
	Phase I	Phase II	Phase III		Q1 & Q2	Q3 (HFM only)
Berkshire County	X	X		X	X	X
Boston	X	X				X
Brockton	X					X
Chelsea	X	X				X
Everett	X					X
Fall River	X			X	X	X
Fitchburg	X					X
Holyoke	X			X		X
Lawrence	X					X
Lowell	X	X	X			X
Lynn	X					X
New Bedford	X	X	X			X
Revere	X					X
Southbridge	X	X				X
Springfield	X	X	X		X	X
Worcester	X	X	X	X		X

Table 3. Years Program Has Been in Existence in Each Case Study Community

MA MIECHV Community	Model	Years Enrolling Families							
		before FY12	FY12	FY13	FY14	FY15	FY16	FY17	FY18
Berkshire County	HFM								
	PAT								
Fall River	HFM								
	PAT								

MA MIECHV Community	Model	Years Enrolling Families							
		before FY12	FY12	FY13	FY14	FY15	FY16	FY17	FY18
	WF								
Springfield	HFM								
	PAT								
	WF								

Provider Focus Groups

Focus groups with home visitors explored provider perspectives on how home visiting fits into the local system of care. Seven focus groups were conducted with providers. Three focus groups were held in Springfield (13 home visitors in total), three in Fall River (11 home visitors in total), and one in Pittsfield (12 home visitors in total) (for more information on participants, see Section VII.1.A.).

Data collection methods

At the beginning of the focus groups, home visitors completed a brief survey that asked about their background and experience in home visiting, the length of time they had lived and worked in their community, and the activities of their workday. Focus groups were then guided by a semi-structured interview protocol that asked participants questions about themselves, their home visiting program, and their community; the early childhood system of care in their community; and issues of home visiting program sustainability. Focus groups were primarily led by one researcher while the other took detailed notes. Focus groups were conducted at the home visiting program organization's meeting space and lasted from 90 to 120 minutes. (See Appendix A for protocol).

Analytic methods

The brief provider survey was analyzed via descriptive statistics. Detailed focus group notes were used as data, which were coded thematically by one researcher and then discussed with the second researcher (who also took detailed notes during the focus group) to refine and triangulate the analysis.

Participant Focus Groups

Participant focus groups were conducted to learn more about participants' own systems of care and the role they see their home visitors as playing within those systems. Participants were invited to attend by program staff and selected for their interest in discussing their experiences with home visiting. Two focus groups were held in Springfield (6 families in total), one was held in Fall River (7 families), and two were held in Berkshire County (7 families in total). (for more information about focus group participants, see Section VII.1.B.).

Data collection methods

The purpose of the participant focus groups was to elicit each participant's understanding of their personal systems of care and the role that their home visitor plays in that system. Focus groups first proceeded through a series of brief introductory questions and then we guided participants through an activity where they mapped the services they receive, their interconnectedness, and the role home visiting plays in these personal networks. Introductory questions included the following:

- Your name/age, partner's name/age, children's names/ages
- Where you live, with whom, and for how long

- What do you like about your community?
- What do you dislike about your community?

After a brief conversation about the community, participants were guided through a multi-step network-mapping activity, using flip-chart paper, poster paper, post-its, and stickers. The activity included the following steps:

- As a group, brainstorm services/resources in the community that participants might use or access (e.g., food stamps, education support, childcare, job training, mental health care, etc.), which we recorded on a flip chart in the front of the room.
- Write every service they are involved with on individual post-it notes, which they place on their own poster paper.
- Use color-coded stickers to indicate their overall feelings about each service—green for mostly positive, red for mostly negative, and yellow for neutral. We encouraged participants to "go with their gut" for this part, prompting them to think about things like how much of a hassle it was to access the services, what kind of interactions they've had with the caseworker, whether they get timely call-backs, etc. (They are told that they can put more than one star on a service to indicate strong feelings, and also can put more than one color on a service to indicate mixed feelings).
- Add a purple sticker to every service that their home visitor has helped them with in any way (e.g., referring them, helping them to access the service, helping them troubleshoot problems, etc.).
- Draw lines between service providers that, as far as they know, communicate with each other about the participant's case.

Figure 1. Network Map Example

- Draw a pie chart to indicate how much time they spend talking about their service needs with their home visitor and how much time they spend talking about parenting and child development.

Upon activity completion (see Figure 1 for network map example), we engaged the participants in a discussion about what their service networks looked like and then asked them to talk more generally about the role that their home visitor has played in each of their lives. (See Appendix B for protocol).

Analytic methods

The same protocol for analysis of the qualitative content of the provider focus groups was used for the participant focus groups. To analyze the network maps, we created datasets that included the full array of services, categorized by service area (e.g., behavioral health, housing, etc.; see Table 4). For each participant, the color-coded ascriptions of valence to each service were quantified as very positive (more than one green sticker), positive (one green sticker), neutral (any number of yellow stickers), negative (one red sticker), and very negative (more than one red sticker). Descriptive statistics were conducted at the service and participant levels, on service areas, valence, and home visitor assistance/involvement.

Table 4. Service Areas

Service Area	Examples
Adult Education/ Employment	GED, ESL, connections to jobs and job training
Arts/Recreation/ Cultural/ Spiritual	Dance, sports, exercise, YMCA, parks, libraries, museums, churches
Behavioral Health/ Disability Services	Therapy, counseling, DMH, programs for youth and adults with disabilities
Child Protective Services	DCF and programs that only work with DCF-Involved Children
Courts/Juvenile Justice/ Legal Services	Family and probate court, juvenile justice, DYS, child custody, legal services, probation
Domestic Violence	DV shelters, other programs for women experiencing violence
Early Childhood Education/ Early Intervention	Child care centers, family care centers, preschools, Early Intervention programs, Head Start
Economic/Food/Material	DTA, SSI, SNAP, Fuel assistance, goodwill, free gifts, Christmas funds, Salvation Army, furniture, diapers, Cradles to Crayons
Family Support/Home Visiting	Home visiting programs, family centers, parent-child play groups
Housing	Teen living programs, housing authority, shelters, emergency/temporary housing, vouchers, Section 8
Maternal Health	Ob/Gyn, midwives, lactation consultants, post-partum medical care, labor and delivery classes
Medical	Primary care, specialists, dentists, hospitals/clinics, visiting nurse, pediatricians
Multi-service	Category for large agencies with no specific service or program (e.g., New England Farm Workers' Council, Catholic Social Services)
Police	Police, ICE
Post-Secondary	Community college, 2- and 4-year colleges
School Age	After school, tutoring (beyond 5), youth programs
Secondary Education	High school diploma granting institution
Substance Use	Addiction and recovery services
Municipal/Transportation	Driver's license, immigration matters, Public transportation, cab vouchers

Stakeholder Survey

We created an online survey for community service providers to explore how MA MIECHV programs appear to fit into the local community systems of care. The Community Stakeholder Survey asked respondents about their awareness of home visiting in their community, their perception of its importance and ability to meet unmet needs, the degree to which they interact with home visiting programs professionally, and their awareness/perceptions of each individual MA MIECHV home visiting program (i.e., PAT, HFM, and Welcome Family). Questions also touched on the benefits of home visiting, how it fits into the community system of care, and the importance of maintaining such a resource. In total, there were 50 items on the survey. However, actual survey length varied based on the community in which the survey was administered and the respondent's knowledge about home visiting programs in their area. Pittsfield providers were asked only about HFM and PAT programs (there is no Welcome Family program in Pittsfield), whereas the Springfield and Fall River surveys included a section on Welcome Family. A respondent who indicated no familiarity with home visiting or any of the specific MA MIECHV programs would have only seven items to respond to, whereas a respondent in Springfield and Fall River who had heard of all three MA MIECHV programs in their area would be asked to respond to all 50 items.

Data collection methods

For each community, the evaluation team constructed a list of directors or staff of programs that 1) provided direct services to at least one segment of MA MIECHV's target population (pregnant women, children 0-5, or families) who resided in the catchment area, and 2) were a nonprofit, medical, or behavioral health provider, or government service provider. To identify programs for inclusion, TIER staff reviewed publicly available organizational information and findings from earlier evaluation phases (i.e., home visitor focus groups, and referral data for each catchment area). In total, 393 programs were identified across the three communities. An email with a request to participate in the survey was sent to each identified stakeholder, with reminder emails sent two weeks and then four weeks after the survey launch date. During this period attempts were also made to find new contact information for bounced-back emails. Respondents were sent a $5 Dunkin Donuts gift card upon survey completion and were entered into a raffle for a $100 Amazon gift card. (See Appendix C for survey).

Analytic methods

Survey responses were downloaded from Qualtrics, a Web-based survey tool, to Excel and then into SPSS v.24 for coding and cleaning. To increase our ability to detect differences in survey responses by site, we recoded all scaled responses to dichotomous variables (e.g., Items with a 4-point Likert scale (from *strongly disagree* to *strongly agree*) recoded as follows: *Strongly agree*, s*omewhat* agree = "Endorsed"; *somewhat disagree*, *strongly disagree* = "Did not endorse"). Frequencies were run for each item, aggregated by model and site. Chi-squares were used to detect differences by site.

Program Data Analysis

For the third research question, we used program data from HFM's PDS, a web-based management information system that home visitors use to document participant demographics, screenings and service utilization information.

Data collection methods

We focused on data entered in the PDS during FY16-FY18. The final analytic sample for the first set of models (influence of Welcome Family on family engagement) included only participants enrolled in HFM programs in MA MIECHV communities that also had a Welcome Family program--Boston, Fall River, and Springfield. The final analytic sample for the second set of models (influence of referral source on family engagement, with DCF as the predictor of interest) included all participants enrolled in HFM programs. The third set of analyses, which explored whether, overall, families referred to programs in the Welcome Family communities were more likely than families referred in the non-Welcome Family communities to be eligible for the program, included all participants.

Analytic methods

Participants with any referrals prior to FY15 start were excluded from the sample, as were participants with more than one enrollment between FY15 and FY18, with one exception: when participants had two referral dates within one month of each other, the participant was retained and the latter referral record was used. We used the following outcome variables to assess family engagement: number of days between referral and first contact eligibility for program; acceptance of program; receipt at least one home visit; number of days between referral and first home visit; duration in program; and total home visits. To create the independent variable, we recoded and collapsed the referral source program names (recorded as both drop-downs and text fields in the PDS) into eight categories: DCF; Early Care and Education/Early Intervention; Economic/Food/Housing/Material Support; Education/Job Training;

Family Support/Home Visiting; Friend/Relative/Self; Medical/Behavioral Health/Insurance; and Welcome Family.

We used regressions to test the influence of referral source on family engagement. In the first set of models, the sample was subsetted to the three communities offering Welcome Family, Boston, Fall River, and Springfield, and we examined associations between Welcome Family as a referral source (vs. other referral sources) and each of the family engagement outcomes. The second set of models, which excluded Welcome Family as a referral source, and used DCF as the omitted reference category, incorporated Huber White robust standard errors to account for clustering of participants within program catchment area. Ordinary Least Squares (OLS) regression was used for continuous outcomes, logistic regression for binary outcomes, and negative binomial regression for the number of home visits, which is a count outcome. Regression adjusted means (continuous, count outcomes) and probabilities (binary outcomes) were computed for each outcome by referral source. Finally, we ran chi square analyses to test the differences in family eligibility between Welcome Family and non-Welcome Family MA MIECHV communities.

Table 5. Timeline of Evaluation Activities

Evaluation Activity	FY16		FY17				FY18			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Finalize work plan	X									
Create site visit protocol and plan		X								
Site visits to Fall River, Springfield, and Pittsfield		X								
Develop focus group (FG) protocols		X	X							
Recruit for and conduct provider focus groups				X	X					
Recruit for and conduct participant focus groups						X	X			
Develop web-based survey of community stakeholders							X	X		
Launch sustainability surveys								X		
Data coding, analysis, and report-writing								X	X	X

Evaluation Results

Sample Description

Four participant groups form the evaluation sample, from the communities specified above: 1) home visitors, 2) home visiting program participants, 3) community service providers, and 4) census sample of HFM participants active between 10/1/2015 and 9/30/18, Each of these is described below.

Home Visitors (Berkshire County, Fall River, Springfield)

In total, 36 home visitors attended seven focus groups, almost all women (n = 34). In Springfield, 13 home visitors participated (9 HFM, 2 PAT, and 2 Welcome Family); in Fall River, 11 (7 HFM, 2 PAT, and 2 Welcome Family), and in Pittsfield, 12 (10 HFM, 2 PAT). All home visitors affiliated with the program were asked by program directors to participate, and in no case did a home visitor request not to

participate. A significant majority of home visitors (82%) resided in the same community that the program serves, and 92% indicated having lived there for their entire lives. The average length of time home visitors lived in their community was 37 years. Home visitors had worked in the community an average of 17 years and had worked in home visiting an average of 6 years.

Program Participants (Berkshire County, Fall River, Springfield)

In total, 20 home visiting program participants participated in focus groups across the three communities. In Springfield, 7 families participated (4 HFM, 3 PAT), in Fall River, 7 (all HFM), and in Berkshire County, 6 (3 HFM, 3 PAT). The mean age of participants was 24.6 years (range = 16–61 years), and the majority (19) were female. On average, participants were enrolled in the program for 17.3 months (range = 2–48 months).

Community Service Providers (Berkshire County, Fall River, Springfield)

As mentioned earlier, 391 eligible programs across the three program communities were identified. Of the 391 email invitations sent to service providers requesting survey participation, 112 emails either bounced back, were delivered to someone who no longer worked there, or went to a program that no longer existed. Of the 279 surveys that appeared to be successfully delivered, 124 (44%) providers completed the survey. There were no significant differences in completion rates by community or type of service provider

HFM Participants

Between 10/1/15 and 9/30/18, there were 3938 first-time referrals into HFM programs across the MA MIECHV communities, and 1337 in the three Welcome Family communities. For the full sample of referrals, average age at enrollment was 20.14 (SD=3.75), and 62% were 21 years and under. Most participants (87%) were female. Almost half (48.7) of participants identified as Hispanic. Of those who self-reported a race, 18% were Black, 49% White, 2% Asian, 21% were multi-racial, and 14% chose some other race. There were no differences in demographics between the full sample and the Welcome Family sample subset.

Results by Evaluation Question

Early Childhood Systems of Care

Research Question 1: How do participants characterize their own "systems of care" in terms of usability and efficacy, and how does home visiting fit in to these systems?

Throughout this report, we use the term "system of care" and its various corollaries. "System of care" is the more general term, whereas "community system of care" is used to denote the level at which we are focusing (i.e., the community), and "early childhood system of care" denotes the target population (i.e., families with young children). An early childhood system of care can be defined and described in different ways, depending on the purposes and priorities in question. For the current purposes, we define it as:

> A coordinated network of community-based services and supports that is organized to meet the concrete, social, and emotional needs of young children and their families. Families and early childhood professionals within public and private organizations at the community level work in partnership so services and

supports are readily accessible, effective, strengths-based, and address the cultural and linguistic needs of young children and their families.[4]

This definition was adopted because it most closely aligned with the ways UMDI and TIER's previous and current research conceptualizes the term "early childhood system of care" after reviewing definitions presented by various jurisdictions around the country. However, we added the term "concrete" to the definition, which slightly alters the original, but is in keeping with previous iterations of the current evaluation.

The early childhood system of care encompasses several important elements, such as a commitment to supporting families with young children, advocacy for relevant programming, mechanisms to identify families in need, appropriate collaboration and communication, and community buy-in to the importance of programming that benefits families with young children. The previous phases of our evaluations focused on understanding community capacity to support families from the perspectives of municipal stakeholders, and using administrative program data to track the ways in which home visiting programs interface with local service systems. For this iteration of our research, we sought a more "insider" perspective, eliciting the lived experiences of families and providers who navigate these systems every day.

Participants' systems of care

Analysis of the mapping exercise conducted as part of the participant focus group was illuminating for understanding the complexity and sheer vastness of participants' own systems of care. Here we present findings for 16 of the 20 focus group participants (2 Springfield maps and 2 Fall River maps lacked sufficient detail for analysis).

Participants' involvement with service providers, by service area

On average, participants reported connection to 17 different service providers (range = 7–42) across an average of six service areas (range = 6–14). As shown in Figure 2, all of the participants were connected to at least one service provider in the areas of *Early Care & Education / Early Intervention (ECE/EI)*; e.g., child care), *Economic/Food/Material* (e.g., TANF, WIC), and *Medical* (e.g., primary care, pediatrician, specialist).

Significantly, 50% of participants indicated that child protective services (DCF) were part of their system of care. This involvement could be a result of the participant's own childhood experiences of abuse or neglect (currently or in the past) or concerns around abuse or neglect within the participant's current parenting. DCF was often described as both positive ("they got me services," e.g. childcare) or negative ("they never helped me when I was a kid").

When providers were asked about agencies or programs in the community that had the most power, DCF was most often identified. Although DCF cannot mandate participation in a particular program (i.e., according to statutory requirements, MA MIECHV programs are voluntary), home visitors and participants alike described the ways that participation in various programs was a condition either of maintaining custody of children or of reunification with their children. Such practices make DCF a crucial player in an early childhood system of care.

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[4] Adapted from the Nebraska Department of Health and Human Services' *Community Early Childhood System of Care (ECSOC) Self-Assessment* (http://dhhs.ne.gov/publichealth/Documents/System%20of%20Care-Final.pdf)

Figure 2. Percent of Participants Connected to at Least One Service Provider, by Service Area (n=16)*
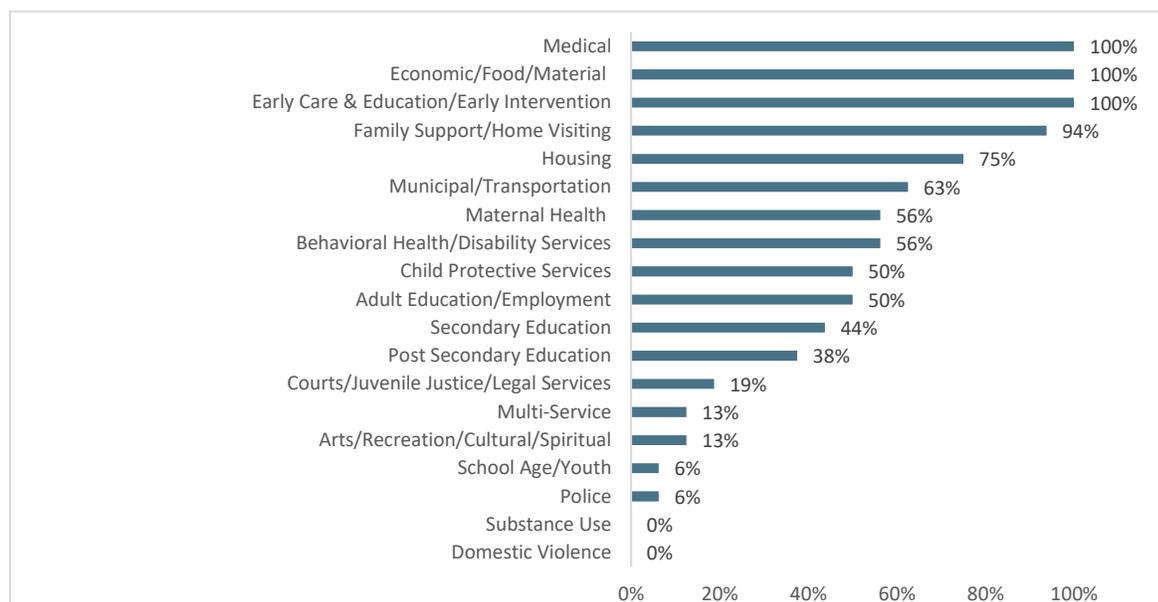
*Note: Although all participants had engagement in home visiting services, one participant did not indicate this on his/her map. We present the data as reported by participants.

Satisfaction with system of care

Participants were asked to rate their experiences with each of the providers in their networks using a color-coded star system. Ratings were then coded as positive, negative, or a combination of both.

Table 6 shows participants' ratings of providers in service areas with ten or more providers, excluding the neutral ratings. The majority of providers in almost every service area were rated quite positively by participants (e.g., family support/home visiting, maternal health, and adult education). Negative ratings were largely concentrated in child protective services, housing, and behavioral health.

Table 6. Rating of Services, by Service Area

Service Area	Total Services Rated	Rated as Positive Only		Rated as Negative Only		Rated as Both Positive and Negative	
		n	%	n	%	n	%
Adult Education/Employment	9	8	89%	1	11%	0	0%
Behavioral Health/Disability Services	12	8	67%	4	33%	0	0%
Child Protective Services	8	1	13%	3	38%	4	50%
Early Childhood Education/Early Intervention	20	15	75%	4	20%	1	5%
Economic/Food/Material	37	32	86%	4	11%	1	3%
Family Support/Home Visiting	25	25	100%	0	0%	0	0%
Housing	6	3	50%	2	33%	1	17%
Maternal Health	11	10	91%	1	9%	0	0%
Medical	42	33	79%	7	17%	2	5%
Total	170	135	72%	26	19%	9	9%

Figure 3 shows the same data graphically, which makes it easier to see those service areas in which participants have both positive and negative feelings about their providers. For example, a housing subsidy might be extremely helpful once a participant is able to access it, and so she might rate it as very positive. But she might also consider the effort and time that securing the slot took and so might also rate it as very negative. Notably, participants expressed the most ambivalence about their connection with Child Protective Services; this service provider was often rated as positive because of

Figure 3. Ratings by Participants, Selected Service Areas

their ability to connect participants to services, but as negative because participants experienced their presence in their lives as intrusive, scary, or unwanted or associated the services with a challenging period of their lives (e.g., being removed from their parents, or being at risk of having their own child removed from their care due to safety risks).

The role of home visiting

To ask how home visiting fits into a community system of care takes into account two realities about the home visiting programs that are the focus of this evaluation. First, home visiting programs provide a direct service to families, just like other programs within the system of care. But additionally, they also help families access and navigate the system of care. Although these programs are not case management programs by design, home visitors report that over half their time (53%) is spent on case management and service coordination activities, rather than parenting education and support. Home visitors explain an interesting duality here. On the one hand, parents cannot fully participate in a parenting education and support curriculum if their basic needs are not met. On the other hand, home visitors also eloquently talk about holding a space to focus on parenting and children in the midst of the chronic chaos participants often inhabit. This duality necessitates that home visitors walk a thin line between ensuring that participants are able to access the supports they need while also focusing as much as possible on supporting parenting. According to home visitors who could share service coordination activities with a third-party partner, balancing those two disparate but integrally connected activities was made significantly easier when they were able to delegate resource connection activities. This partnership will be discussed in greater detail in the next section.
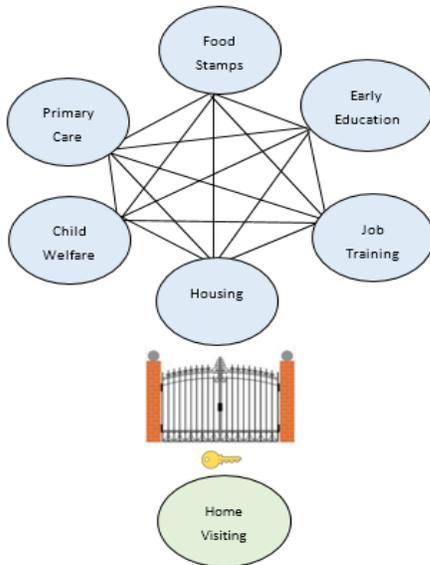
Because of this simultaneous dual focus (parenting support and case management) in home visiting, the role that home visiting programs play in an early childhood system of care is complicated. During focus groups, home visitors in particular described how they conceptualized the system of care, both verbally and pictorially. Here we provide some examples.
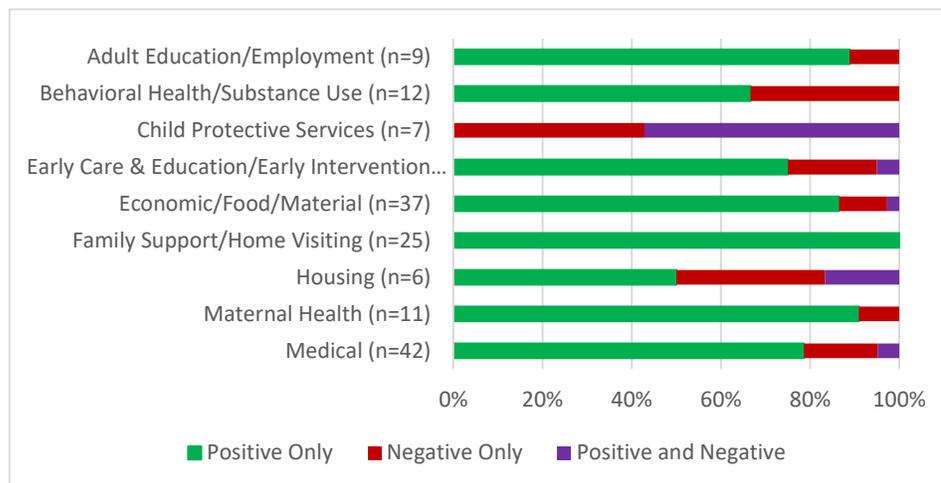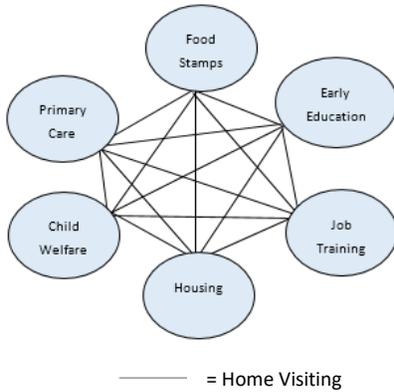
Home visiting is the connector between services; it creates the web

Home visiting is an anchor within the system; home visiting knows about all the other programs, even if those programs don't know about home visiting

Home visiting is a point of entry into the system, somewhat outside of it
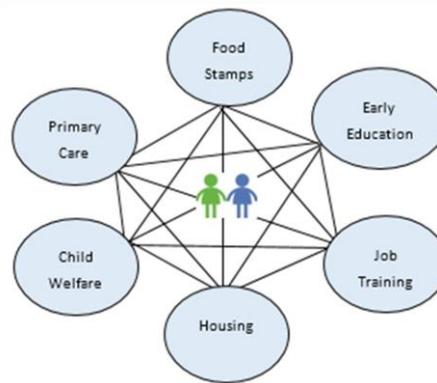
Home visiting is a partner to individuals and families navigating the system; it supports them and makes sure they do not fall through the cracks

Home visiting plays all these roles within the system of care, depending on the kind of support being providing to participants. But, undeniably, home visiting is an integral part of a system of care for these participants, so intrinsically embedded within it that one can easily argue that the way these participants access and navigate the system would inevitably change without their participation in a home visiting program. Home visiting is not a case management program by design, and in many ways the sorts of resource connecting done within the home-visiting capacity are very different than those done strictly within case management. Yet, home visitors work toward helping participants be self-sufficient and, as such, do as little of the logistical work as possible while still ensuring that participants are connected and engaged. The goal is to teach self-sufficiency and increase capacity, not simply to access resources on behalf of the participant.

The extent to which home visitors need to help participants access services seems somewhat dependent on the program. PAT home visitors described engaging in significantly more parenting-related education than resource connection when compared to HFM home visitors. We offer two possible explanations for this difference. First, eligibility criteria differ based on the program model. PAT participants can be any

age—and most tend to be somewhat older, have longer histories of parenting, and have had more opportunities to already be connected to the system of care that supports them. Indeed, the majority of PAT focus group participants indicated that they were graduates of HFM programs, where the majority of their connections to services had already been made. By comparison, HFM participants are younger, first-time parents who are new to community systems of care and need more support accessing needed services. Additionally, the PAT model is slightly more prescriptive about the curriculum to be delivered at every visit than the HFM model; this may allow HFM home visitors more flexibility, and space during visits for service coordination activities, when compared with PAT home visitors.

Table 7 shows the number and percentages of participants who reported having their home visitor facilitate the connection to a service in some way. For example, nine participants reported being connected to at least one maternal health provider. Of these nine, only one participant (11%) reported that the home visitor played a role in facilitating a connection. Conversely, 94% of the 16 participants connected to at least one economic support program said that their home visitor had facilitated at least one of those connections. As seen in Table 7, all participants (n=16) reported that their home visitor helped connect them to at least one service (Range = 1–15), suggesting that home visitors are crucial resources to help participants access needed services. Participants described home visitors' facilitating activities as going beyond merely a referral, or even a supported referral (where the provider helps the client make a call and schedule an appointment). Home visitors removed barriers associated with transportation, with logistical conflicts, or with emotional or psychological challenges.

Table 7. Home Visitor-Facilitated Connections to Services

Service Area	Participants with at least one provider in service area	Participants with at least one provider with which home visitor facilitated connection	
	n	*n*	*%*
Family Support/Home Visiting	15	15	100%
Economic/Food/Material	16	15	94%
Medical	16	15	94%
Early Care & Education/Early Intervention	16	10	63%
Behavioral Health/Disability Services	9	5	56%
Municipal/Transportation	10	5	50%
Housing	12	5	42%
Courts/Juvenile Justice/Legal Services	3	1	33%
Post-Secondary Education	6	2	33%
Secondary Education	7	2	29%
Child Protective Services	8	2	25%
Adult Education/Employment	8	1	13%
Maternal Health	9	1	11%
Arts/Recreation/Cultural/Spiritual	2	0	0%
Multi-Service	2	0	0%
Police	1	0	0%
School Age/Youth	1	0	0%
Domestic Violence	0	0	N/A
Substance Use	0	0	N/A

Although home visitors reported spending more than half (53%) of their time on case management and resource connection, MA MIECHV programs in Berkshire County have a within-agency program

partnership that supports the home visiting program by assuming much of the service coordination role home visitors would otherwise have primary responsibility for. This partnership, with the Family Center of Northern Berkshire County, seems to help home visitors be better able to focus on parenting support and education by taking some of the case management burden from them. Co-location within the building appears to enhance this benefit. One home visitor explained, "If there is something they need, I just send them right downstairs to [Family Center staff], and she will help them get whatever they need." Home visitors explained that such a partnership makes it significantly easier for them to engage in parenting support and education, not because the concrete needs are not there, but because they are able to delegate some of the tasks involved in meeting those needs. When asked about this cross-program partnership, participants described it working very well and assumed that the two programs were actually one and the same. Because staff from the Family Center also conduct home visits to facilitate resource connections, some participants assumed they had a "main" home visitor and a "secondary" home visitor from the same program. When these cross-program partnerships work well, they can appear quite seamless to participants.

The role of the home visitor

Although home visitors' primary responsibility is not case management and service coordination, they are in a uniquely qualified position to engage in such work. As described previously, home visitors tend to have similar backgrounds as participants. The majority (82%) live in the community in which they work, and most have lived there all their lives. They also openly discussed their own experiences navigating community systems of care and learning how to access needed services for themselves and their families. These home visitors are experts in this area through both personal and professional experience. Not only do they have intimate knowledge of the community system of care, they often know staff at other programs by name, and they might even have personal relationships with them.

However, participants and home visitors alike are clear in their perspective that the benefits that participants receive from these programs are much broader than access to support and services (parenting and beyond). These benefits very clearly begin with the relationship between the participant and the home visitor. This relationship is often stable, reliable, and consistent. Participants described a long-standing relationship (roughly a year and a half on average) with their home visitor, which was sometimes the only model of a healthy relationship in their lives. The home visitor was described as providing guidance and praise as participants navigated both parenting and getting their needs met through the system of care. This relationship facilitates a sense of empowerment for participants, and an ability to be self-sufficient, which is a key aim of home visiting.

Home visitors often described their relationships with participants as one of a de-facto parent. They often described their job as "raising" this participant. Home visitors often have similar backgrounds as participants but are older and more experienced. One home visitor explained, "I learned how to do these things, and now I can teach you [the participant], and then you can teach your kids." This sort of skill-building, educating, and parenting mentorship is what healthy parenting of older/adult children might look like. Home visitors reported that participants look to them for many kinds of support, including in areas that clearly fall outside the scope of home visiting services. For instance, one home visitor noted that, "One participant called me up on a weekend and asked me for a ride to the airport."

Participants, however, were extremely disinclined to describe their relationship with home visitors as similar to the relationship between a parent and child. A repeating theme described by participants of their own experiences was that parents tend not to be supportive or helpful, and many have been blatantly abusive. Rather than see them as a parent, then, participants tended to describe their home visitors as being more like a non-parental relative or a friend—someone with whom they can have a trusting relationship - but is more supportive and responsible than the relatives and friends participants

are used to. As one participant said, "she is like an older sister, but a *helpful* older sister." Another participant said, "she's like a friend, but a friend who doesn't party."

Interestingly, home visitors universally denied experiencing their relationships with participants as friendships, and were visibly uncomfortable with that characterization. This is likely because home visitors in both models are trained to assume professional postures with their clients, maintaining personal boundaries to the extent that they can. Despite these discrepancies in perspectives about professional distance, it is clear from both participants and home visitors that a close relationship is core to both parties' experience of the program.

Issues of Sustainability

Research Question: To what extent is MA MIECHV perceived by stakeholders at multiple levels as being embedded in the early childhood system of care? To what extent, if at all, has it moved from "initiative" to "institution"? What strategies can MA MIECHV employ to move from one-time initiative to institutionalization?

As described above, a strong early childhood system of care is key to ensuring that all families with young children get access to the services and supports they need to thrive. Home visiting services are a crucial component to ensuring that the system of care meets families' needs, can be navigated by families, and operates as smoothly as it can. Home visiting stabilizes the system of care for many participants, ensuring it does not fall apart by removing access barriers (e.g., knowledge about resources, transportation, emotional challenges, childcare, etc.) that could otherwise result in participants being terminated from, or quitting, a needed service or support. For example, some participants have lost access to needed mental health treatment because too many appointments were missed, causing the provider to terminate services. Because it is our contention that home visiting services are crucial to participants, both because they stabilize a system of care and also because they themselves constitute crucial services within the system, attention is now turned to exploring issues of sustainability.

When providers were asked during focus groups, "what makes community programs successful?" and "why do some programs last while others end?" many providers were quick to point out that "programs come and go at the whim of funders." Fiscal sustainability issues are important to understand, and payment mechanisms for home visiting services are being explored, both in Massachusetts and around the country. But fiscal sustainability is only one part of the solution. Here, we focus on the ways home visiting programs have, or can, become so integral to the communities in which they operate, so as to be seen as an indispensable part of an early childhood system of care. The HARC included guidelines focused on understanding issues of sustainability in their Home Visiting Research Agenda[5]. They state:

> Home visiting sustainment is likely to be linked to how well programs are implemented, how well they are aligned with community goals and interests, and how well they coordinate with other resources in a system of care. Even if a program is well aligned with community interests, changes in public policies or key leadership may disrupt or threaten years of implementation effort; little is known about how such disruptions can be negotiated or mitigated … [R]esearch can elucidate the decision-making process of stakeholders to understand how they access and weigh evidence in decisions regarding continued investment in home visiting. It is likely that system, organization, and

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[5] http://www.hvresearch.org/wp-content/uploads/2018/01/home_visiting_research_agenda_2013_10_29_final.pdf.

individual-level factors have independent and interactive effects on home visiting sustainability (p. 25).

HARC refers to the embeddedness of home visiting within a system of care as "institutionalization," which is a term we borrow. Institutionalization makes home visiting politically and logistically difficult to disentangle from the larger systems in which it sits. Once institutionalized, the home visiting program would be seen and accepted as effective, known and valued on multiple levels, and recognized as the go-to service for pregnant and parenting families in need of global parenting support. When "sustainability" is discussed in this section, this is the type of sustainability that is referred to; it is not simply a matter of ensuring payment for services.

Perspectives on factors that facilitate program success

Both participants and providers alike spoke at length about what makes these home visiting programs important to them and their communities. Many participants were eloquent, and quite poignant, when discussing what the home visiting program has done for them. Participants voiced overwhelming appreciation for services, with most saying things such as, "I don't know where I'd be without my home visitor" or "I would be on the streets, probably wouldn't have my kids without this program," It is important to keep in mind that participants self-selected, and their perspectives on the program may therefore be skewed positive. Nevertheless, these experiences are quite real for them, and it is clear that these home visiting programs are making a positive impact for participants and their children. Previous evaluation work conducted by TIER confirms that these participants' positive experiences are not unique; findings from TIER's randomized, controlled trial of HFM, a home visiting program for first time young parents under the age of 21, for instance, suggest that home visiting has a positive impact on multiple domains, including parenting stress, depression, risky behaviors, and education.[6]

Participants and home visitors added depth to these findings, describing the aspects of these programs that they see as crucial to their success and benefit for participants. For the most part, these accounts focused primarily on the unique ability of home visitors to meet with parents in a natural home environment. At a most basic level, this ability eliminates barriers around transportation and the amount of time it can take parents with young children to get to an office setting. But home visitors and participants alike were able to describe other significant benefits. Home visitors can see participants' living environments, which gives them a better sense of the family's needs and strengths. Second, participants reported being more comfortable in their home environments than they would be in an office setting, so perhaps they are more open to receiving support and education. Relatedly, the parenting education they receive can be practiced in vivo, in the same setting their parenting routinely takes place, which can make the learning process more powerful. Meeting participants where they are, both psychologically and physically, was described as the most important facilitator of program success for the participants.

But successful programs come and go within the community, and to understand how to sustain a successful program, one needs to look beyond outcomes. Although home visitors were quick to point out fiscal issues in determining what community programs and services are sustainable, they were also able to point to program factors they have seen make some community programs stand out from others, and last over time. First, they described staff at these programs as knowing and understanding the complex system of care within the community and having personal and professional relationships

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[6] Jacobs, F., Easterbrooks, M.A., Goldberg, J., Mistry, J., Bumgarner, E., Raskin, M., …Fauth, R. (2015). Helping young families: Results of a randomized controlled trial of a home visiting program for adolescent parents. *American Journal of Public Health, 106,* 342-349.

with staff from other community agencies and programs. By and large, this complex system relies on personal communication within the context of personal relationships between staff from different programs and agencies. Previous research conducted by TIER[7] suggests that home visitors do play this kind of role in their communities; they know how to negotiate this complex web of interconnected services, largely based on who they know at various agencies.

Second, both participants and home visitors described the importance of having staff who care about the program, the participants, and the community. Here, too, home visitors embody this description. Even home visitors who were relatively new to their positions (e.g., PAT home visitors in Springfield and Fall River) expressed deep investment in the program, extrapolating from their own personal and professional experiences with other similar services. They also spoke with great conviction about the important work they do with, and on behalf of, participants, in whose success they are extremely invested. Lastly, home visitors are part of these communities in a personal way, and they have a deep investment in ensuring that their communities are healthy and safe for all residents.

The third factor is specific to home visiting programs: the importance of co-location and partnership with programs that support participants in concrete ways. Although home visitors are extremely skilled and adept at helping participants navigate a system of care, if these tasks are the entirety of their activities, then they are not actually doing their job. Home visitors keenly described the importance of being able to delegate some responsibility for concrete support to another program or service. The benefits of this are three-fold. First, it allows the home visitor to focus on the service they are charged with delivering: parenting education and support. Second, a specialized resource program has the capacity to be more streamlined in its approach to helping participants secure services, thus being more efficient. Third, and especially important from a sustainability perspective, partner programs and agencies become interdependent and thus have a stronger chance of survival because they are seen as good collaborators.

Lastly, home visitors talked about successful programs being seen as "indispensable." In other words, the program is so important to the community, and so many people in the community see it as a go-to service, that removing it from the community is relatively unthinkable. Home visitors talked about the importance of "good marketing," ensuring the community is knowledgeable and invested in the service provided by the program. Indeed, this is exactly what HARC articulates in its research agenda, particularly focusing on the ways programs are aligned with community need and are perceived to be "institutionalized." This is where we turn our attention next.

Stakeholder perspectives on home visiting

For a home visiting program to become institutionalized within a community system of care necessitates that relevant stakeholders know about it, understand it, and value it. As previously described, to assess the perspective of stakeholders, an online survey was completed by 124 stakeholders from the three target communities. Survey findings in this section are presented first for all respondents, then, when appropriate, by model, and, finally, by community. Chi-squares were used to test for differences by community; only significant differences are presented here. Accompanying graphs are only presented when there are significant differences.

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[7] Goldberg, J., Winestone, J., Fauth, R., Colón, M., & Mingo, M.V. (2018). Getting to the warm hand-off: A study of home visitor referral activities. *Maternal and Child Health Journal*, *22* (Suppl 1): 22-32. DOI: 10.1007/s10995-018-2529-7.

Familiarity with home visiting

Whereas most (58.9%) of the 124 respondents indicated having heard of home visiting in general, and the HFM program in particular (58.1%), less than one third of respondents had heard of MA MIECHV (31.5%) and the PAT program (29.8%), and less than a quarter of respondents in Springfield and Fall River (the two communities with a Welcome Family program) reported having heard of Welcome Family (22.7%). The fact that community providers are most familiar with HFM is not surprising, given that HFM has been in these communities, in the same agencies, for almost 20 years. By contrast, MA MIECHV, which started in 2012, is relatively new, as are the PAT and Welcome Family programs that were implemented as part of MA MIECHV.

In general, familiarity with these programs did not vary greatly by community (see Figure 4), with the exception of PAT; a higher percentage of respondents in Berkshire County (44%), where the PAT program was started in 2012, were more likely to have heard of the PAT program in their area when compared to respondents in Springfield (18%), where PAT was rolled out toward the end of 2016, [χ2(2, N=124)=8.93, p<.05].

Figure 4. Proportion of Respondents Who Indicated Familiarity with MA MIECHV, Home Visiting in General, HFM, PAT, and Welcome Family, by Community
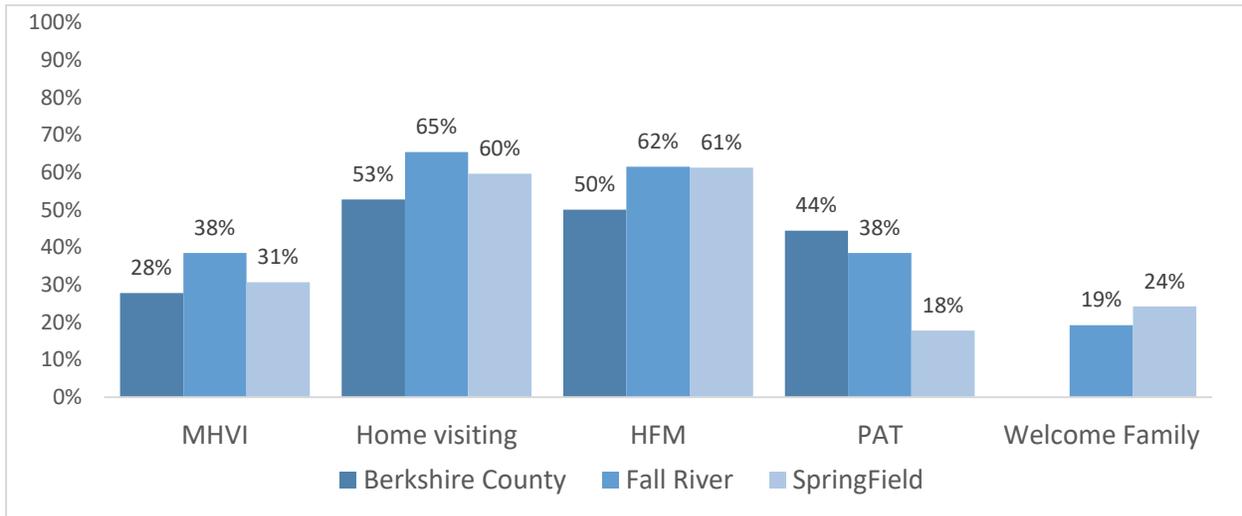
Understanding of models

Respondents who endorsed familiarity with specific MA MIECHV models in their respective communities were asked to indicate whether they understood the program's eligibility requirements, knew what services were offered, and felt they could accurately explain the program to a prospective family. Across the communities and models, most respondents reported understanding the MA MIECHV programs' eligibility requirements (57.5%) and services offered (63.5%), with a slightly lower proportion (50.8%) indicating that they would feel comfortable explaining the models to a prospective family.

These rates look similar when broken down by model, as seen in Table 8, with slightly higher percentages of participants expressing knowledge about HFM (63.0%) and Welcome Family (58.3%) than PAT (50.5%).

Table 8. Knowledge about MA MIECHV Models, by Model

Item	HFM (n-72)		PAT (n=37)		Welcome Family (n=20)	
	n	%	n	%	n	%
Knows eligibility requirements	46	63.9%	18	48.6%	12	60.0%
Understands services offered	53	73.6%	21	56.8%	12	60.0%
Could accurately explain services to prospective family	37	51.4	17	45.9%	11	55.0%
Means		63.0%		50.5%		58.3%

When compared by community (see Figure 5), statistical differences emerged for responses pertaining to HFM and Welcome Family. When compared to Springfield providers, a higher proportion of Berkshire County and Fall River providers indicated that they understood HFM eligibility requirements [$\chi2(2$, N=72)=9.54, p<.01]. Similarly, a lower proportion of Springfield providers, as compared to those in Fall River, indicated knowing Welcome Family eligibility requirements $\chi2(1$, N=20)=4.44, p<.05] and service offerings [$\chi2(1$, N=20)=4.44, p<.05]. These results are not surprising, given the fact that Welcome Family was implemented in Fall River three years earlier (2013) than in Springfield (2016).

Figure 5. Knowledge about HFM and Welcome Family, by Community
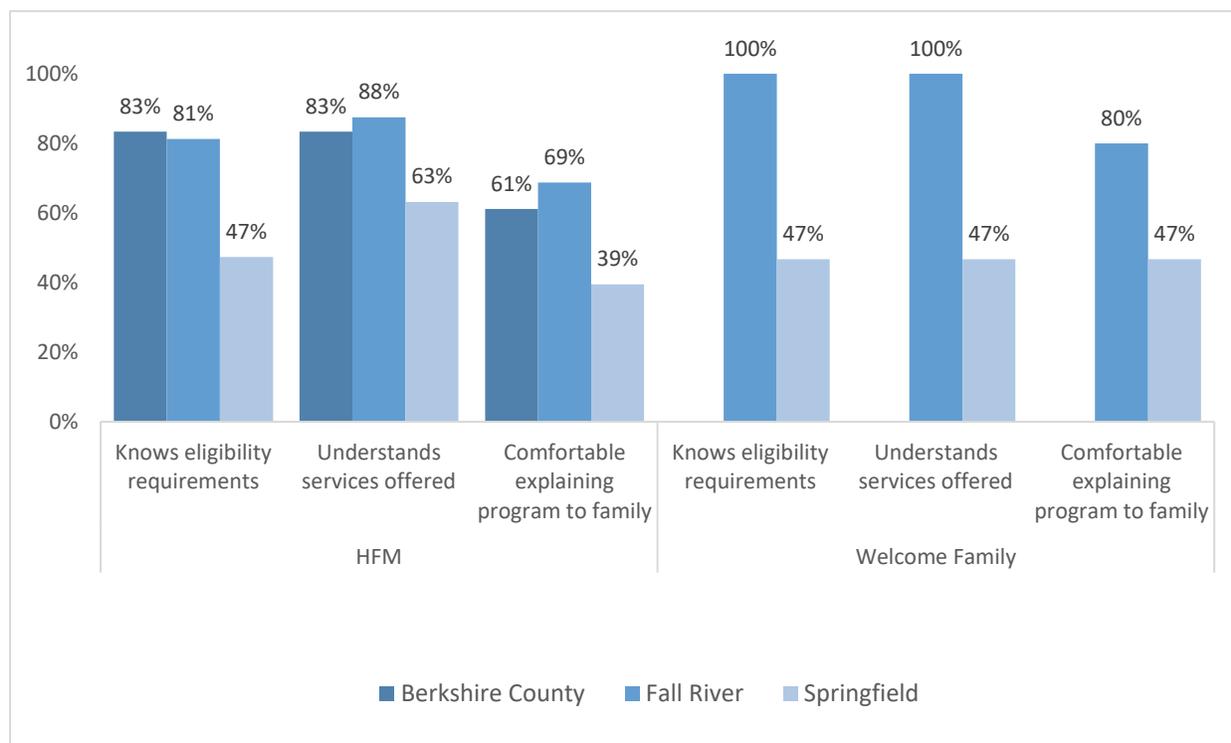

Contact with MA MIECHV programs

Overall, 6% of respondents who had knowledge of each model reported that staff from their program had contact with staff from a MA MIECHV program at least once in the past year. When compared by model, a higher proportion of respondents indicated contact with staff from an HFM program (80.6%) than with PAT (51.4%) and Welcome Family (55.0%). Again, given the length of time HFM programs have existed in these communities when compared with the other two models, this difference is not surprising.

When compared by community (see Figure 6), differences emerge only for HFM; a smaller proportion of providers in Springfield reported having had contact with HFM staff than in Berkshire County and Fall River [χ2(2, n=72)=7.57, p<.05].

Figure 6. Contact with MA MIECHV Programs in Past Year, by Community
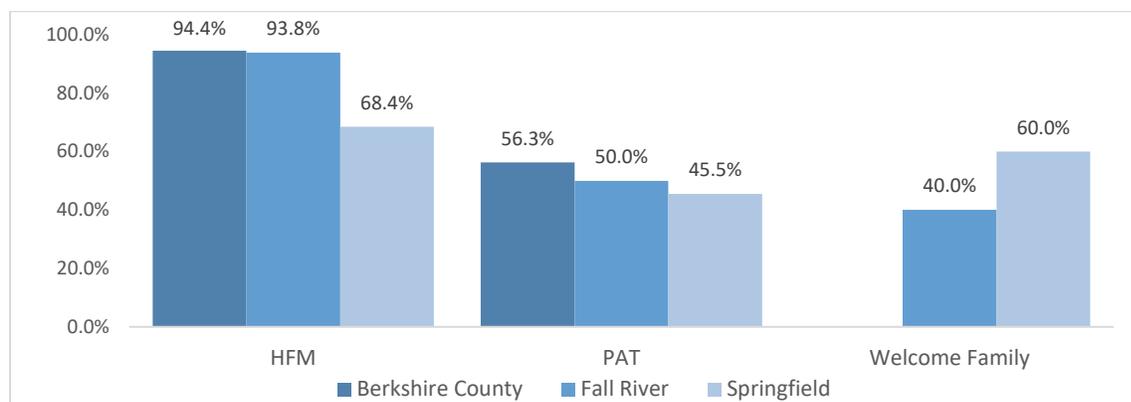
Collaborative activities

Across sites and models, a fairly low proportion of respondents reported participating in collaborative activities with their local MA MIECHV program in the past year: only 21% said that staff from their programs had participated in a joint training, 32% had shared space or materials, and 21% had co-sponsored an event. Almost half (47%) said they had shared information about their respective programs with the MA MIECHV program, and 33% reported sharing information about specific families. Finally, 15% reported participating in an MA MIECHV program's Advisory Board, and 35% reported participating in some other kind of joint meeting with representatives from the MA MIECHV program. As Table 9 shows, rates are similar when broken down by the MA MIECHV models about which respondents were reporting.

Table 9. Collaborative Activities in the Past Year, by MA MIECHV Model

Item	HFM (n=72)		PAT (n=37)		Welcome Family (n=20)	
	n	%	n	%	n	%
Participated in joint staff training	17	23.6%	7	18.9%	3	19.2%
Shared space/materials	27	37.5%	12	32.4%	2	26.6%
Co-sponsored event	18	25.0%	8	21.6%	1	17.2%
Shared information about programs	42	58.3%	14	37.8%	7	43.7%
Shared information about families	28	38.9%	11	29.7%	5	31.2%
Participated in an Advisory Board mtg	15	20.8%	4	10.8%	1	12.2%
Participated in joint meeting (not Advisory Board)	30	41.7%	12	32.4%	4	31.4%
Means		35.1%		26.3%		25.9%

There were no statistical differences between communities (see Figure 7) on collaborations with PAT and Welcome Family programs. However, community differences in responses to questions about HFM emerged for every collaboration indicator except for co-sponsorship of an event and participation in an Advisory Board meeting. For each of these measures, respondents in Berkshire County were more likely, and those in Springfield less likely, to have engaged in the following: joint staff meeting [χ2(2, N=118)=15,67, *p*<.01]; shared space/material [χ2(2, N=72)=13.65, *p*<.01]; shared information about

programming [χ^2(2, N=72)=8.75, p<.05]; shared information about families [χ^2(2, N=72)=13.66, p<.01]; and participated in a joint meeting other than an Advisory Board meeting [χ^2(2, N=72)=9.22, p<.01]. Fall River respondents were also less likely to have endorsed participating in a joint staff training than respondents in Berkshire County.

Figure 7. Collaboration with HFM, by Community
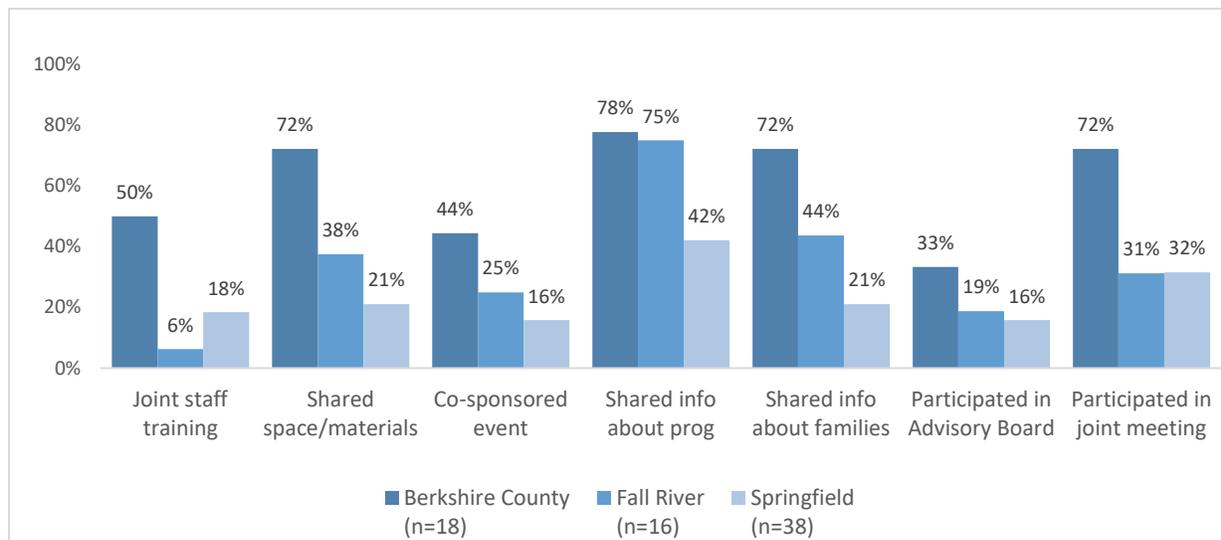
Appreciation for models

We asked providers whether they felt that each of the MA MIECHV programs in their community filled an important service need and whether they believed that families who participated would benefit from the program. Of those community service providers that were familiar with the home visiting models, the majority agreed that each model met an important service need in their respective communities (82%) and would benefit the families that enrolled (83%). See Table 10 for answers broken down by MA MIECHV model. There were no significant differences by site.

Table 10. Appreciation for MA MIECHV Model, by Model

Item	HFM (n-72)		PAT (n=37)		Welcome Family (n=20)	
	n	%	n	%	n	%
Program fills important service need	68	94.1%	25	67.6%	17	85.0%
Families will benefit from program	67	93.1%	26	70.3%	17	85.0%
Means		93.8%		68.9%		85.0%

Relationship with MA MIECHV Programs

A series of questions designed to elicit a sense of the types of relationships providers had with each of the MA MIECHV programs in their communities were asked, including questions about whether the interactions they had with MA MIECHV programs were mostly positive and whether they perceived the program as competing with theirs for funding, or for families, as well as the extent to which they felt their program would benefit from a closer working relationship with the MA MIECHV program. Finally, respondents were asked whether they agreed with the following statement for each of the models: "[MA MIECHV program] seeks out opportunities to work with different service areas and sectors in [Community]."

Across communities and models, about half of respondents (49.6%) indicated their interactions with the MA MIECHV program had been mostly positive, and the majority of providers did *not* see the MA MIECHV programs as being in competition with their program for funding (85.5%) or families (86.4%). Furthermore, 60.5% agreed that their program would benefit from a closer relationship with the MA MIECHV program in question. Only one third (33.8%) saw the MA MIECHV programs in their communities as seeking out opportunities to work across sectors. As can be seen in Table 11, these proportions are consistent across models.

Table 11. Relationships with MA MIECHV Programs

Item	HFM (n-72)		PAT (n=37)		Welcome Family (n=20)	
	n	%	n	%	n	%
Interactions mostly positive	38	52.8%	17	45.9%	10	50.0%
Program not competing for families	56	77.8%	31	83.8%	19	95.0%
Program not competing for funding	58	80.6%	31	83.8%	19	95.0%
Would benefit from closer relationship with program	43	59.7%	21	56.8%	13	65.0%
Program seeks out opportunities to work with different service areas and sectors	28	38.9%	12	32.4%	6	30.0%
Means		61.9%		60.5%		67.0%

When compared by site (see Figure 8), some differences emerge, concentrated, again, in providers' responses about HFM. A greater percentage of Berkshire providers, and a slightly lower percentage of Springfield providers, agreed that their interactions with the HFM program in their area were mostly positive [$\chi2(2, N=72)=6.04, p<.05$] and that the HFM program in their area seeks out cross-sector, cross-service type collaborations [$\chi2(2, N=72)=9.7, p<.01$]. When compared to the other two communities, proportionately fewer providers in Fall River agreed that the HFM program there was not competing for families [$\chi2(2, N=72)=12.45, p<.01$].

Figure 8. Relationship with HFM, by Community
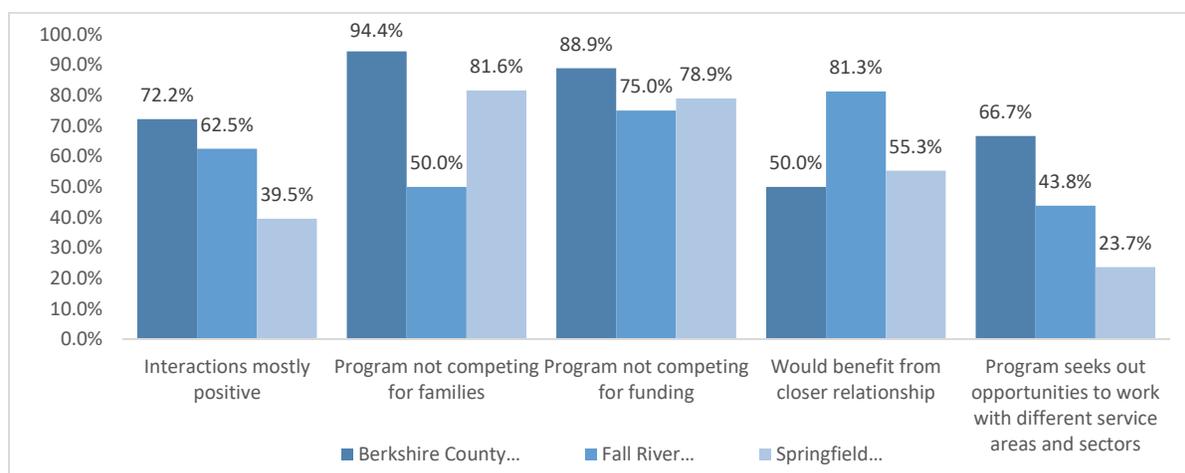
Referrals

For each MA MIECHV program, respondents were asked whether their program had referred families to that program in the past year and whether their program had received referrals from the MA MIECHV program. Less than one third of respondents indicated that their program had made referrals in the past

year to a MA MIECHV program (29.5%) or received referrals from a MA MIECHV program (30.1%); these rates were similar across MA MIECHV models (see Table 12).

Table 12. Referrals, by MA MIECHV Model

Item	HFM (n-72)		PAT (n=37)		Welcome Family (n=20)	
	n	%	n	%	n	%
Respondent's program referred families to MA MIECHV program	26	36.1%	12	32.4%	4	20.0%
Respondent's program received referrals from MA MIECHV program	26	36.1%	9	24.3%	6	30.0%
Means		36.1%		28.4%		25.0%

Community level differences (see Figure 9) emerged for answers about the HFM program only. When compared by site, a higher percentage of Berkshire County providers than of providers in Fall River and Springfield reported both making referrals to ($[\chi^2(2, N=72)=10.22, p<.01]$) and receiving referrals from ($[\chi^2(2, N=72)=9.99, p<.01]$) the HFM program in their area.

Figure 9. Referrals to and from HFM, by Community
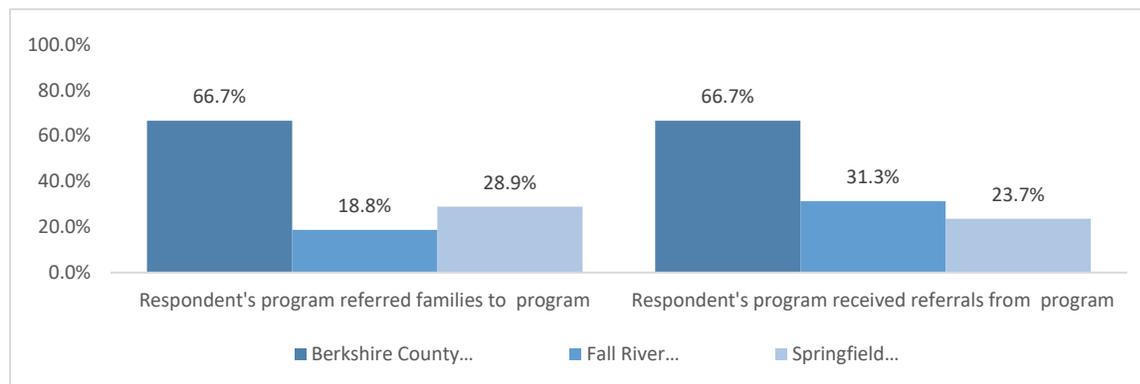
Summary of survey findings

The primary purpose of surveying stakeholders within the community was to understand their perspectives on the extent to which MA MIECHV programs are embedded within the community system of care. Taken together, findings suggest that in some ways—particularly in Berkshire County—stakeholders see MA MIECHV programs as an important component of the system of care, but they stop short of suggesting that programs, on the whole, are successfully embedded. Findings do suggest that there is significant room for improvement and highlight the importance of MDPH more deliberately facilitating system building efforts on the ground. These efforts can focus on increasing visibility of the work the initiative is doing across the state and can facilitate more collaboration between LIAs and other local community service providers. These findings echo UMDI's previous findings suggesting that MA MIECHV programs do not factor heavily within community coalitions and networks, aside from representing a local resource for families. Due to the focus on direct service delivery, there has thus far been less programmatic emphasis on playing an active role in community-wide initiatives, and/or to raise the profile of MA MIECHV—both the local MA MIECHV programs and the state level initiative--as a go-to resource in community systems of care.

Although all programs in each community have room for greater embeddedness, it is clear that HFM is more established than the other programs. This finding is reasonable given HFM's long-standing tenure in each community. Relatedly, PAT in Berkshire County is much better known, understood, and

appreciated than the PAT programs in Fall River and Springfield. Again, such a finding is expected, as PAT has been providing services in Berkshire County much longer than it has in both Springfield and Fall River, where both programs were newly contracted at the beginning of the current evaluation period. It is encouraging, however, that community longevity seems correlated with knowledge and appreciation of the program. With some effort focused on raising the profile and value of these programs in the community, newer programs have the prospect of more quickly catching up to their longer-standing peers.

It is also the case that HFM has been able to successfully brand itself and achieve name recognition, in part due to sustained and targeted marketing/advocacy efforts by program administrators. As a state agency, MDPH has a significant platform from which to coordinate similar marketing efforts for MA MIECHV at various levels. Although not able to participate in legislative advocacy work, MDPH is well positioned to raise awareness throughout the Commonwealth about the role MA MIECHV can play in an early childhood system of care and its potential benefits to families with young children.

Findings also suggest that some communities simply report better collaboration, mutual referrals, and general positive feelings about home visiting. In particular, Berkshire County respondents report greater on-the-ground collaboration than respondents in Springfield. These findings also echo those of previous evaluation work in these communities and are supported by focus group data from the current evaluation. There is a culture of cooperation and mutual respect in Berkshire County that facilitates such positive regard, facilitated by the fact that there are fewer providers in general in this part of the state, so the collaborative process is somewhat simplified. It is outside the scope of the current evaluation to explore the factors that enable such a culture, but it is clear that stakeholders both within and outside of MA MIECHV programs feel similarly about the Berkshire County systems of care.

Interestingly, while we had expected to find a similar community culture based on previous work evaluators had conducted in Fall River, the current survey findings did not support those. The current survey results *did* support previous findings regarding the challenges that Springfield programs face in terms of collaboration, cooperation, and mutual respect.

Referral Source and MA MIECHV Engagement

Research Question 3: To what extent is referral source (specifically, Welcome Family and DCF) related to families' eligibility for, and engagement with, home visiting?

In their proposed national home visiting research agenda, HARC observed, "Home visiting cannot improve outcomes if it does not reach families who could benefit and cannot retain or engage enough families to deliver benefit…" During this grant period, MDPH exploited their Welcome Family universal short-term home visit program for its child-find potential, explicitly training nurses to refer families to the appropriate home visiting programs in that catchment area. Their hope was that these enhanced outreach and recruitment attempts would increase the number of appropriate referrals (i.e., "families for whom a particular program is a good fit") that are made to the home visiting programs in these catchment areas. The first set of analyses we ran tested that hypothesis, using regressions to detect differential influences on family engagement outcomes by referral source, with Welcome Family as the reference category. Based on emerging findings from the other two research questions about the seemingly uneasy relationship both home visitors and home visiting participants express having with DCF, we added a second hypothesis to this question: we posited that referrals made into home visiting by DCF would be negatively associated with family engagement. For this set of analyses, we expanded the sample to include all HFM participants in MA MIECHV communities, including the communities with Welcome Family, but excluding that particular referral source for the analyses. Findings from these two models are presented below, beginning with descriptives.

Program descriptives

Table 13 shows the distribution of referral source categories, first for HFM participants enrolled in programs in the communities that also have a Welcome Family program, and then for the full HFM sample across all communities. The majority of referrals in both samples were made from programs providing medical and behavioral health care and support. In the full sample, the second most common category was informal referral sources (via self, friend, or relative), while in the Welcome Family communities, the second most common were referrals from that program.

Table 13. Distribution of Referral Sources Among HFM Participants Enrolled FY16-FY18, for the Communities with a Welcome Family Program at the Time, and for all Communities

Referral Source Service Area	HFM participants in Boston, Fall River, Springfield		HFM Participants in All MA MIECHV communities	
	n	%	n	%
Medical//Behavioral Health	402	33.2	908	37.7
DCF	107	8.8	290	12.0
Early Care & Education/Early Intervention	14	1.2	35	1.5
Economic/Food/Housing/Material	73	6.0	311	12.9
Education/Job Training	32	2.6	177	7.3
Informal (friend, relative, self)	265	21.9	589	24.4
Family Support/Home Visiting	43	3.6	101	4.2
Welcome Family	274	22.6	N/A	N/A
Total	1210	100%	2411	100%

Note: Referral sources categorized as unknown or other were set to missing.

Figure 10 shows, for the full sample, the flow of participants from the point of referral through eligibility, acceptance, receipt of first visit, and duration in program. The average number of days between the referral and first contact date was 10.3 (SD=19.3) and the average number of days between referral and first home visit was 17.5 (SD=19.).

Figure 10. Flow of Participants from Point of Referral into Program
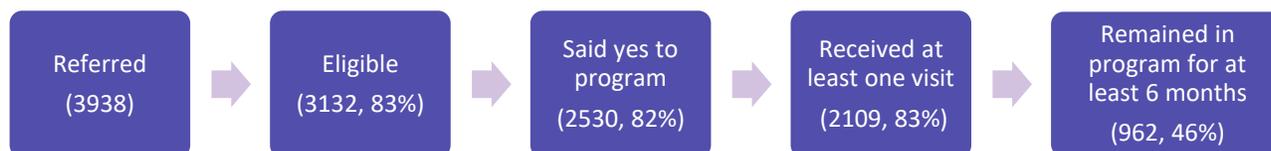
Associations between Welcome Family referral and family engagement

The first set of models we ran examined the extent to which Welcome Family as a referral source appeared to influence family engagement, when compared with the other referral source categories. These analyses included only HFM participants in Boston, Fall River, and Springfield.   Results of the regressions indicate that participants who are referred through Welcome Family:

- Have fewer days between referral and first contact than ECE referrals (B =10.23; SE=5.22; p<.05), but more days than self-referrals (B =-5.77; SE=1.76; p<.01).
- Are more likely to be eligible for the program than participants referred informally (odds =.07; p<.01), by a medical provider (odds =.17; p<.01), by DCF (odds =.14; p<.01), by a program

providing economic/material assistance (odds =.18; p<.01), or by another family support or home visiting program (odds =.07; p<.01)

- Are more likely to receive at least one home visit than participants referred by an ECE program (odds =.18; p<.05)
- Are more likely to stay enrolled for at least 6 months than participants referred by another family support/home visiting program (odds =.25; p<.05)

Expecting that there may be more positive associations between the outcomes and the longer running Welcome Family programs (Boston and Fall River), and/or the Welcome Family program co-located with the HFM program (Fall River), we tested for differences by community, but no differences emerged. There are also were no differential effects by demographic characteristics.

Associations between DCF referral and family engagement

The second set of models we ran examined the effects of referral source on engagement in all MA MIECHV communities, excluding Welcome Family as a referral source, using DCF as the reference category. Results of the regressions indicate that participants who are referred through DCF:

- Have more days between referral and first contact than participants who are referred informally (by a friend, or self-refer) (B =-4.40; SE=1.22; p<.01)
- Are less likely to be eligible for the program than participants referred informally (odds =.71; p<.05), by a medical provider (odds =1.49; p<.01), or by an education/job training program (odds =3.13; p<.01).
- Are less likely to accept the offer of services than participants referred by an education/job training program (odds =2.38; p<.01).
- Are less likely to receive at least one home visit than participants referred informally (odds =1.90; p<.05)
- Are less likely to stay enrolled for at least 6 months than participants referred by an education/job training program (odds =1.6; p<.05).

Finally, we used chi squares analyses to examine whether there was an overall difference in eligibility between referrals to HFM programs in communities with Welcome Family, and those without. Results suggest a modest overall effect, with 85.8% eligible referrals to programs in Welcome Family communities, compared to 81.4% eligibility in non-Welcome Family communities (χ2(2, N=3372)=11.67, p<.01).

Summary of program data analysis

We tested the hypothesis that Welcome Family would have a positive relation, and DCF a negative one, to the likelihood that families would be eligible for, and engage with, the home visiting programs to which they were referred by these two entities. Both models yielded results that confirmed these hypotheses, though findings were largely concentrated in the earlier stages of program engagement—namely eligibility. Referrals made through Welcome Family were more likely to be eligible (i.e., appropriate referrals) than those made from almost any other referral source. And while only a few comparisons reached statistical significance, the opposite was largely true for the DCF referrals in relation to referrals made from other types of programs. Furthermore, when we compared total referrals in non-Welcome Family communities with those in Welcome Family communities, families in the three Welcome Family communities, on the whole, were more likely to be eligible for services than their counterparts. If we view the relative eligibility of participants as a proxy for community providers' knowledge about the MA MIECHV programs—about who the home visiting programs are *for*—Welcome Family emerges as well-positioned to continue its child-finding role, as well as to continue building partnerships with HFM and the other MA MIECHV home visiting programs to strengthen their outreach

and recruitment potential with other community providers. And DCF, once again, emerges as an entity that shares many participants with MA MIECHV, but appears to come up a bit short in terms of its knowledge about the program, and how best to engage with it.

Discussion of Results

The results of the current evaluation have significant implications for efforts to sustain home visiting over the long term. These implications are reviewed here. Additional conclusions, implications, and recommendations at both the program and policy level are offered in a later section.

First and foremost, results indicate that home visiting is a valued and important service to participants, who describe receiving various amounts of support and education. Many participants offered heartfelt and poignant descriptions about the extent to which the program has changed their lives for the better. Their home visitors act in a variety of roles and provide holistic support to these participants. The relationship component of the program is hugely important and is sometimes the only stable and healthy relationship in participants' lives. Whether such a responsibility *should* fall on the home visitor is a different topic, one we take up in more detail later, but the reality is that at this point in time, home visitors play a central role in these participants' lives. Home visitors seem to value this role and see it as part of their professional responsibility. But it is clear they also have personal investment in their communities and the well-being of the participants with whom they work. The ability of home visitors to play so many roles for participants is due, in part, to home visitors' personal and professional experience in the community. Home visitors should be valuable knowledge bases and resources for program administrators and funders as sustainability efforts continue to be refined and undertaken. They have a nuanced understanding of complex community systems and relationships and are in a unique position to advise the process of institutionalization.

Second, results suggest that home visiting is known and appreciated by the community but there is quite a bit of room for improvement. Community buy-in is a key element of any sustainability plan, and simply knowing a program exists is not a strong enough foundation for a community to invest in it (e.g., refer families to, advocate for, etc.). Additionally, although stakeholder survey respondents were asked if they are aware of program elements, such as services provided and inclusion criteria, this knowledge was not tested, and respondents might actually be unfamiliar with important program characteristics. For example, a respondent may assume that home visiting programs serve primarily a case management and resource connection need if they only interact with the program in that capacity. On the other hand, they might understand that home visiting provides parent education and support but might not know about other wrap-around supports the program currently provides.

At least one provider discussed the possibility of engaging in more "marketing" to educate the community about what home visiting, both in general and at the specific model level, does and why it is important to participants. Although the business term "marketing" might not make sense in this context, thinking in terms of practices around community networking and awareness raising would be fruitful. There are a number of important roles the home visiting programs play within a community system of care that benefit other programs. For example, programs get referrals from home visiting programs, which is a boost to them. Previous research suggests home visitors play an important role in addressing both concrete and emotional barriers to accessing and remaining engaged in services. Addressing these barriers helps ensure participants get more out of services and not fall through the cracks.[8] Additionally, based on participants' and home visitors' reports, it is apparent that the work of

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[8] See Goldberg, et al., 2018

home visitors likely eases the burden on other social service programs (e.g., mental health providers) working with parents in need. Although home visitors are not mental health providers or other social welfare professionals by training, they are another set of eyes—particularly within the home—and are well-poised to communicate about participants' needs and strengths with other service providers within the system of care. Additionally, they help lessen the stress associated with both parenting and concrete needs that participants experience, which can have a marked impact on mental health issues. Communicating such messaging clearly to stakeholders would facilitate buy-in and institutionalization.

A plan to engage in that kind of awareness raising and networking would also, perhaps, elevate MA MIECHV programs' roles as collaborative, cross-sector partners in the community, an assessment that survey respondents were fairly lukewarm about. A similar finding was observed in UMDI's previous work, and often this disconnect is attributed to the fact that MA MIECHV's mission is primarily one of service provision, at least on the ground within the community, and is less focused on building community initiatives or coalitions. That said, it behooves program administrators to take these findings as seriously as their interests in promoting sustainability. Although the focus here is on non-fiscal sustainability efforts, when stakeholders feel that a program is a good partner for them, that program is more likely to be seen as an indispensable part of a community system of care, and funding cuts to the program are seen as increasingly politically difficult.

EVALUATION SUCCESSES and Challenges

Successes that Resulted from the Evaluation

We define evaluations as "successful" if they do what they set out to do and if their results are useful for involved stakeholders. Indeed, we were able to answer the research questions regarding systems of care and sustainability proposed in the evaluation plan, and to use findings from previous iterations of this evaluation work to triangulate the findings here. This triangulation allowed for confirmation of working theories about how programs engage in service coordination and the relative embeddedness of home visiting programs in community systems of care. Additionally, results of this evaluation allow for implications and recommendations that we believe can inform and positively benefit sustainability efforts and help these important programs to become institutionalized within the community systems of care.

Challenges Encountered in Conducting Evaluation and Deviations from Approved Evaluation Plan

To achieve the successes described above, numerous challenges were overcome throughout the course of the evaluation. Perhaps most notably, we had initially proposed to examine differences between programs with child-find practices and those without. The two communities we initially targeted were to serve as case-study comparisons: Fall River, with Welcome Family serving as a child-find program, and Springfield, with Welcome Family *and*, by way of comparison, a centralized intake system serving three collaborative programs (HFM, PAT, and an Early Head Start program) housed within three separate agencies. Shortly after the evaluation proposal was accepted, a new round of funding was announced that changed the landscape of the home visiting programs in Springfield significantly. Rather than three home visiting programs across three different agencies with a centralized intake system, two programs within the same agency were funded. Although this was the community's choice in terms of how to

restructure programming, it eliminated the centralized intake aspect of the community's MA MIECHV offerings. The loss of the centralized intake program necessitated that we think differently about how to compare communities and entry points into home visiting programs. Rather than focus on the differences between child-find and non child-find communities, then, as originally planned, we reframed as follows: we expanded that research question, including a focus on how referral sources in general influenced eligibility and engagement; and 2) added a more explicit set of analyses that examined the differential effects of two referral sources in particular--Welcome Family and DCF.

A second challenge was related to slow start-up of the PAT programs in Springfield and Fall River. Initially, the focus for questions two and three was to be on only Springfield (with Welcome Family and centralized intake) and Fall River (with Welcome Family but no centralized intake). Within these two communities, two home visiting programs in addition to Welcome Family were targeted: HFM and PAT. Early during the data collection period, however, it became apparent that the PAT program in both Fall River and Springfield was too new for either its home visitors or participants to be in a position to lend perspectives to the evaluation. PAT home visitors in both communities either had no families on their caseload or had just begun to enroll families at the time of data collection. Relatedly, PAT families were too new to the program to be able to speak with the researchers about their experiences in a meaningful way. Therefore, researchers decided to include a third community with long-standing PAT and HFM programs: Berkshire County.

We postponed focus groups with both providers and participants in the hopes that several more months would allow those programs to be up and running enough for those focus groups to add rich data to our evaluation. Unfortunately, we were never able to conduct a PAT participant focus group in Fall River, and the one in Springfield did not add the richness of data we were hoping for. Similarly, although PAT providers were able to share their personal experiences about their communities, and their professional experiences from previous work, their limited experiences within the PAT program (some had yet to have a case at the time of data collection) greatly limited the depth of information they were able to provide about how PAT, specifically (rather than home visiting in general), fits into a system of care. To address this challenge, we added a third community with a well-established PAT program to the evaluation: Berkshire County. Although this addition proved to be a fruitful and important source of data, it nevertheless stretched our resources and necessitated that we adapt our evaluation plan considerably.

Finally, there were two methodological deviations from the plan: a change in the proposed focus group protocol used with families, and a change to the survey implementation plan. As for the focus group, we originally had planned to implement a protocol very similar to the one we used with providers; a brief survey and then guided discussion. Based on feedback we received during the pilot of our participant focus group protocol, however, we realized that the information we were seeking from the young mothers—both in the quantitative survey and from our focus group questions—would be much more effectively elicited through the interactive activity described below. The change to our survey implementation plan was a result of the addition of the third community to our sample. We originally proposed the conduct a social network analysis (SNA) survey in addition to the community stakeholder survey. When we added the third focus community, however, we needed to cut elsewhere from our budget, and the SNA survey (which is very time-consuming to administer and analyze) was an obvious place to cut, given that it would have been slightly redundant with the community stakeholder survey.

Implications and Recommendations

Considered with previous iterations of this evaluation work, it is clear that the work of home visitors is inextricably tied into community systems of care. Home visiting programs are both one of many resources within a community system of care, and they also facilitate the functionality of the system of care for families in a variety of ways. They help families navigate it successfully, they facilitate connections between and among other programs, and they stabilize families enough to engage effectively in the services they need. This stabilization is a function both of the service home visiting provides and the relationship participants experience with their home visitor. This relationship is described as, among other things, one of a teacher, mentor, role model, coach, cheerleader, and general support. Home visitors wear many hats in their role, and the entirety of their work is to help participants get what they need to parent successfully and help their family thrive. In these ways, home visiting is clearly embedded within the system of care.

But this embeddedness is somewhat unidirectional. That is, home visitors and participants expressed the important role of home visiting in the community system of care, but community stakeholders on the whole are somewhat less cognizant of this important role. Although many voiced an awareness of home visiting programs, their actual level of awareness/depth of understanding is unclear, and there is definite room for improvement.

Finally, our research findings over the last six years suggest that, with some exceptions, there is a significant amount of resources and services for families in need in Massachusetts. However, strategic alignment and coordination is missing. This is true both within communities, and between public health programming and other human service domains at the state level. Taken together, these findings have implications for programs and policies at the community and state levels that can strengthen the community system of care, strengthen MA MIECHV, and facilitate program sustainability (see MDPH, 2016, for Integrated Evaluation findings).

Role of Home Visitors Within a Community System of Care

Efforts to network MA MIECHV with other programs within a community system of care, and to raise awareness about the role of home visiting, seem prudent to undertake. This is particularly true in communities, such as Springfield, where there is less awareness about MA MIECHV programs, and for programs that are newer to the community, such as PAT in Fall River and Springfield. Such efforts would facilitate movement toward stakeholders seeing home visiting programs as inextricably linked to community systems of care—as being institutionalized. That kind of positioning of home visiting significantly enables sustainability efforts, as community stakeholders would strive to prevent losing such an integral service. Additionally, moves to cut or discontinue funding for such a program would be seen as politically difficult. This is not to say, however, that systems building and "marketing" efforts should supersede the important on-the-ground connections that home visitors work to make every day. These personal connections are not only of enormous benefit to participants, but also help to embed and institutionalize the home visiting program within the community system of care in and of themselves. Although funding is ultimately what enables a program to exist, the community, political, and programmatic context in which the funding occurs has enormous implications for ongoing sustainability and program embeddedness.

Findings from the current evaluation describe home visiting programs that are of enormous benefit to participants, wide in scope, and more flexible and responsive to participant need than was initially

expected by researchers. Home visitors wear a number of different hats and act in numerous capacities for participants. Whether or not these multiple roles are appropriate is an important question. What is clear, however, is that these findings complicate the notion of "precision home visiting," which seems to be an upcoming directive for home visiting programs. The HARC describes precision home visiting as, "home visiting that differentiates what works, for whom, and in what contexts to achieve specific outcomes. It focuses on the components of home visiting services rather than on complex models of home visiting that are administered uniformly."[9] Not only does precision home visiting attempt to identify components that are effective for particular populations, it eschews the notion that home visiting is a be-all program, including case management, screening, and referral for service needs. In other words, it is a response to the legitimate concerns that home visiting has become diluted and/or overtaken by addressing social service needs, rather than engagement in parenting education and support. The reality, however, is that all social and concrete needs affect a participant's ability to parent effectively. However, if a home visiting program is overwhelmed by a participant's social and concrete needs, it is at risk of morphing into a case management program.

However, simply because programs might become narrower in their focus on parenting does not mean that concrete needs are eliminated. The challenges families have will remain, as will the challenges to effectively engage them in parenting support when their immediate needs are not met. One obvious solution to this problem is to devolve responsibility for case management. This could either happen, as was done in Berkshire County, with a program partner (whether co-located or not), or a dedicated case manager within the same program. There are obviously benefits and drawbacks for each of these options. Regarding the former option, we did observe that the inter-agency program collaboration appeared to work so well that participants did not distinguish between the two programs. On the other hand, it is possible that having service coordination primarily fall to someone other than the home visitor may detract from the home visitor's understandings of participants needs and challenges with regard to social and concrete resources. In this sense, having a case manager as part of the home visiting team would seem preferable. However, the feasibility of this option is obviously dictated by both budget constraints and model fidelity requirements. Furthermore, it remains an empirical question whether devolving some of those responsibilities potentially diminishes the role that home visitors play in these participants' lives. Further evaluation of these options is warranted in order to understand which might better suit each home visiting program and its participants.

Role of the Department of Children and Families

Given its multi-faceted nature and the number of community partners with which MA MIECHV participants and home visitors routinely engage, partnerships and collaborations are of utmost importance to maintain program viability and sustainability. Home visitors themselves have a solid understanding of the complex web of relationships between and among community programs (and their staff) and navigate these on a daily basis to help meet the needs of their participants. Some of these partnerships are mandated by joint funding opportunities, whereas others have developed organically as a result of mutually beneficial referrals. But evaluation results suggest that one critical entity remains difficult to engage on the ground, is seen by both program participants and home visitors as having a significant amount of power, and was present in the lives of a majority of program participants: DCF.

DCF and MA MIECHV overlap significantly in that their primary mission is to strengthen families. However, DCF has the authority to remove children from their home, and such authority makes them an

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[9] http://www.hvresearch.org/precision-home-visiting/.

often-feared programmatic entity. On the other hand, DCF also has the ability to connect participants to resources to which they might not otherwise have as easy access (e.g., childcare vouchers), so the benefits participants also receive from having DCF involved in their family's life are undeniable. Additionally, DCF is seen by the majority of home visitors as not being a good team player within a system of care, and having a more punitive rather that collaborative role. Given the significant role DCF is playing in the lives of so many families served by MA MIECHV, it seems important to strengthen and make more robust the partnership between DCF and MDPH. This state-level leadership, if engaged in effectively by both Departments, will help pave the way for increased collaboration between DCF staff and home visitors, which would not only benefit program participants, but could also help institutionalize MA MIECHV within a system of care.

Strategic Alignment, Coordination, and Long-Term Vision

Although findings generally suggest that stakeholders agree the Commonwealth provides a significant amount of resources and services for families in need, strategic alignment and coordination can be improved. Such alignment and coordination is almost always engendered by mandate, typically tied to funding. A community can only be successful in supporting families when there is a coordinated and collaborative infrastructure of agencies and coalitions focused on getting families the support they need. Interagency collaboration not only organizes available resources and removes barriers to accessing services, but it also creates a community infrastructure that is both continuous and complementary.

While it is important to promote and/or require interagency collaboration, such practices are only possible with the right infrastructures and capacity in place (e.g., funding, staff time, shared vision & data). Developing a thorough understanding of factors that facilitate or hinder the creation and maintenance of these infrastructures and practices is a critical first step, and may be a fruitful focus for future evaluation efforts.

A sustainable method of funding to build and strengthen a system of care needs to have a long-term vision as well as oversight and guidance in order to lend legitimacy and leadership to the process. Community systems of care can only be strengthened and sustained by input and guidance from an entity with a larger-picture perspective, such as MDPH. MA MIECHV hopes to ensure its long-term sustainability by establishing itself as a highly-recognized key player in the early childhood systems of care—both as a provider of direct services to families with young children and as a key entry point for those families into the wider systems of care. A vision of the type of role home visiting programs can and should play within a system of care (e.g., a resource, an anchor, a point of entry, etc.) can help MDPH put in place the sorts of mandates that help create and strengthen MA MIECHV's ideal role in that system of care. This is true both at community levels (where, as per earlier reporting, program links and coordination might better be thought of as "mini systems), and at the state level.

Relatedly, MDPH can facilitate capacity building in a number of different ways, beginning with creating a long-term vision for systems coordination among the MA MIECHV programs themselves, and providing oversight and guidance to help programs move toward that vision. The success of Welcome Family in bringing eligible referrals to HFM programs suggests the critical role that home visiting programs can play in supporting other home visiting programs. We recommend convening coalitions of home visiting practitioners—either at the state or municipal levels, who can work collaboratively toward articulating a common vision about how families should move in and out of support programs, and a shared commitment to providing seamless family support services to families. Having this kind of unified, collective home visiting presence in communities may facilitate movement toward stakeholders seeing

home visiting programs as inextricably linked to community systems of care – as being institutionalized – which significantly enables sustainability efforts.

Incentivize Activities That Facilitate Institutionalization

In order for MA MIECHV to continue moving toward sustainability within a system of care, to be so valued it becomes institutionalized, activities that facilitate such movement need to be incentivized. But the work involved should not be considered an extracurricular activity; it should be written into job descriptions, accounted for in working hours, and compensated monetarily. Reports from previous phases of the current evaluation discussed the fact that MA MIECHV programs tend not to take an active role in establishing collaborations or participating as part of community-wide initiatives. Indeed, findings from the current survey of community providers indicate that only one third (33.8%) saw the MA MIECHV programs in their communities as seeking out opportunities to work across sectors. These collaborations are not only critical to well-functioning systems of care, but they position programs in leadership roles within the community. Additionally, over time, they become seen by other programs within a system of care as more than just a programmatic resource for families, but as a legitimate player in moving forward an agenda related to families with young children. But these collaborations and leadership activities take time and resources to cultivate and maintain. MA MIECHV programs would be better poised to engage in these sorts of activities if they perceived some benefit to their program and the families they served. Helping programs understand the importance of activities that facilitate program institutionalization is an important step in helping home visiting programs ultimately become more visible and respected.

Appendix A: Provider Focus Group Protocol

Introduction:

- Introduce yourselves, your organization, and your role.
- Have been researching MHVI-related issues for several years.
- Working to understand the role of home visiting programs in community systems of care.
- Conducting focus groups with all staff of all MHVI programs in both Fall River and Springfield.
- We're not here to evaluate you or your work; we already know you do great work. We're here because you are experts in this work and in this community, and you're helping us to understand.
- We'd like to audio record our session. Only

Rules:

- There are no right or wrong answers
- Information you provide will be kept confidential, but might be identifiable by nature of the small number of people involved.
- We do not inform your supervisor or anyone else in this agency about what was said during this focus group.
- Any questions before we begin?

_____

You and Your Program

- Can you tell us a little about this program and your role within it?

The Families Served

- How do families find their way to this program? From where, and how, are they referred?
- What are families looking for or asking for when they enroll?
- What do families get from this program?

The Community

- What do you see as the strengths of this community?
  - What are the families like in this community?
- What are the most significant problems affecting families in your community? [flipchart]
  - What are the biggest unmet needs for young children and families?
- What resources are available in their community to address these issues? [flipchart]
- What are the barriers (if any) to accessing these resources? [flipchart]

Early Childhood System of Care & Referral Systems

- What comes to mind when you hear the term "early childhood system of care"?
- Do you feel that you/your organization is part of a system of care? What role does it play?
- What role should MHVI play in a system of care?
- What coalitions or partnerships focused on supporting families exist in this community? To what extent are you involved in those?
- Do you have a good sense of where to refer families for:
  - Academic support
  - Behavioral/mental health
  - Child care
  - Clothes
  - Domestic violence
  - Early Intervention
  - Financial assistance
  - Food assistance
  - Fuel assistance
  - Furniture
  - Housing assistance
  - Parent education
  - Primary and pediatric care
  - Recreational activities
  - Social support groups
  - Substance abuse
- When families are referred, what do you think are their chances of getting served?
- How well do you feel local agencies work together to support families?
- To what extent do you collaborate or interact with programs other than social service programs (examples might include medical providers, educational settings, etc.)
- Tell me about the relationship between this program and _____ (PAT/WF/HF).
- Off of the top of your head, without thinking too much – In this community, which organization/agency has the most power?

Looking to the future

- [Have participants look at the list of problems, resources and barriers on the flipchart] What actions, programs, or strategies do you think would make the biggest difference in your community for families?
  - What solutions would help solve the problems and reduce/remove the barriers listed?
- What other initiatives or programs that aim to support children and families have been successful in this community? What made them successful?
- What programs have failed? What do you think made them fail?
- To what extent do you think it's important that MHVI programs and services remain available in this community?
- What do you think state agencies can do to ensure MHVI is sustainable over the long term?
- Is there anything else we haven't asked you that is important for us to know?

Appendix B. Parent Focus Group Protocol

Hello! Thanks for joining us today. My name is [name] and this is [name]. We are researchers from Tufts University working on a project with the Massachusetts Maternal, Infant, and Early Childhood Home Visiting program to find out more about the families and services in [community].

Before we begin, we have a bit of paperwork. I wanted to go through the consent form with you. The form provides more information about the study, what we're going to do today, and what we will do with the information you provide after today. Just a reminder that you are under no obligation to participate or answer questions you would rather not respond to. We will be audio-recording this session, so if you do not want to be recorded, we will have to dismiss you from the group. You have the right to decide that you no longer want to participate at any time. Take some time to read the form and let me know if you have any questions. If after reading, you decide you would like to participate in this focus group and you agree to be recorded, please sign the last page and give it to one of us. If after reading, you decide you would *not* like to participate, you are free to leave.

[Time for reading and signing of consents]

Let me give you a few quick ground rules for the group. First, everyone's opinion is important and it's okay to disagree with each other or with me. We are very interested in hearing about all points of view. It's okay to talk to each other and not just to me. Since our time is limited I may need to ask you to stop and change topics from time to time. Any other rules we should follow?

Now that we have everyone's consent forms, we will begin the group with an ice-breaker to get the conversations started.

Ice Breaker

Let's go around and state your first name, how long you have lived in this community, and the ages of your children. Then tell us something about you that people might not know. A hidden talent or secret dream?

Now we have some more questions for you. First, we will start with questions about your community. Next we will ask about your experiences with programs, which do you use and why? Finally, we will ask about your experiences with the home visiting program and get some feedback. Any questions before we begin?

Community

- What do you see as the strengths of this community?
- What do you see as the weaknesses of this community?

Network Mapping Activity: *This exercise involves each participant creating his or her own service network map using flip chart paper, pens, post-it notes, and stickers The point of the activity is for each participant to generate a map of which services she has used/is using in her community, how those services are connected with one another, and the various roles her home visitor plays vis a vis her connection to these services.*

1. We're going to do an activity that involves your mapping out all of the services that you are involved with. Let's start by brainstorming a list of all the services that exist in this community. (Start list on flipchart that includes all the possible services *(e.g., WIC, housing authority, food stamps, etc.—continue adding to this list throughout the activity, as participants think of other services they are involved with).*

2. Now think of the community services you are involved with. Write each of them down on a separate post-it note and put those post-its on your paper.

3. Next step is to mark how you feel about each service. You each have a sheet of stickers—the green stickers mean you feel positive about the service, the yellow stickers mean you feel neutral about the service, and the red stickers mean you feel negative about the service. Put a star on each of the post-its that tells us how you feel about the service. You can put more than one star to show a strong feeling. And you can also put more than one color on a post-it if you have mixed feelings. Just go with your gut on this one.

4. Now think about the role your home visitor has played, if any, in each of these services. Has your home visitor helped you in any way with the service? This could mean s/he referred you, or made phone calls to the provider on your behalf, or helped you troubleshoot something. If your home visitor played a role in your use of this service, put a purple star on that post-it.

5. Now think about whether, as far as you know, any of these service providers on your paper talk to each other, or share information with each other, about your particular case. If you think they do, draw a line between those providers—for instance, if you know your home visitor has talked to your DCF worker about your case, you would draw a line between the home visitor post-it and the DCF post-it. You may have to rearrange post-its to make it easier to draw the lines.

6. Draw a circle on your paper (*or a separate piece of paper if there is no room*). Let's say this circle represents a typical visit with your home visitor. Think about how much time you spend talking about your service needs, and how much time you spend talking about parenting and child development, and other parenting-related stuff. Draw a line that cuts the circle into how much time you spend talking about services and how much time you spend on parenting. This is not an exact science—again, just go with your gut!)

Discussion about Activity

- What community programs or services do you use?
  - How did you find out about those?
  - What did you like about them?
  - How long did you use those programs?
  - Why did you stop?
- What do you see as Home Visiting's role in your wider system of care?
  - Which of these services did your home visitor refer you to?
  - Has your home visitor helped you stay connected with services you are involved in?

Appendix C. Community Stakeholder Survey

1. Let's begin! What is the name of your program (or agency)?

_____

2. What is your job title?

_____

3. How many years have you been in this job? (numbers only please)_____

4. Consider the other organizations in the [Community] area with which your program most frequently collaborates (e.g., refer families to each other, co-sponsor events, etc.). Now consider what types of services those organizations provide. Using the click and drag feature, please drag the service types of the programs with which you most frequently collaborate into the box on the right, ranking them in order of how often you interface with each program (you can choose as many or as few service types as you want)

Adult basic education

Behavioral health

Child care

Child protection

Domestic violence

Early Intervention

Economic/ material assistance

Education

Food/ nutrition

Health insurance

Home visiting

Housing

Legal aid/probation

Medical

Parent/family support

Police

Substance abuse

Job training

5. Had you heard of the Massachusetts Home Visiting Initiative (MHVI) before reading the introduction to this survey?

☐ Yes
☐ No

1. General questions about home visiting in your community

The next few questions ask you about home visiting in your community. In case you are not familiar with home visiting, here is a brief description:

Home visiting is a home-based family support model for families with young children. Parents receive education and support around child development and parenting, help accessing needed resources and social support, and screenings and assessments for other needs. Services can range from one or two visits to several years of weekly visits, depending on the home visiting model and/or families' need.

6. Are you aware of any home visiting programs serving pregnant and parenting families in your community?

- ☐ Yes
- ☐ No

*If **yes**, proceed to question 7a. If **no** skip to question 7b.*

7a. Please indicate how strongly you agree with the following statements about the home visiting program(s) in your community:*.*

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Not sure
Although I'm aware of home visiting programs in [Community], I am unclear about what they do.					
Home visiting fills an important service need for pregnant and parenting families.					
My program has referred families to home visiting program(s).					
My program has received referrals from home visiting program(s).					
There currently are not enough home visiting programs in [Community] to meet the needs of pregnant and parenting families. *If **strongly agree** or **somewhat agree**, proceed to question 7a1. If **strongly disagree** or **somewhat disagree** skip to question 7a2.*					

7a1. You agreed with the statement that there is currently not enough home visiting in [Community]. Below are some statements that expand upon that--please check all that apply.

- ☐ Existing home visiting program(s) do not have enough staff capacity to enroll all eligible families.
- ☐ The eligibility criteria in existing home visiting program(s) are too restrictive (i.e., exclude certain populations).

☐   Families have language needs that existing home visiting program(s) can't meet.

☐   Not enough people know about home visiting.

☐   Existing home visiting program(s) do not have sufficient expertise to serve certain populations who need the service.

7a2. You disagreed with the statement that there is currently not enough home visiting in [Community]. Below are some statements that expand upon that--please check all that apply.

☐   I don't see home visiting as filling a service need.

☐   There are other services more in need of funding.

☐   There are already enough home visiting programs around.

☐   As far as I know, all the families that need home visiting services can get them.

☐   I don't see the value of home-based services.

*(If **no** to question 6).*

7b. Please indicate how strongly you agree with the following statements about the home visiting program(s) in your community:

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Not sure
Home visiting would fill an important service need for pregnant and parenting families.					
My program would refer families to home visiting if there were programs available.					
Home visiting programs would be a good referral source for my program.					
My program would be strengthened by collaboration with a home visiting program.					

2A. Questions about specific home visiting programs in [Community]: HFM

A.1. Have you heard of the Healthy Families Massachusetts program (HFM) at [Agency] in [Community]?

☐   Yes

☐   No

*If **yes**, proceed to question A2. If **no**, skip to question B1.*

A.2. Please indicate how strongly you agree with the following statements about the HFM program.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
I understand HFM's eligibility requirements.				
I know what types of services HFM offers				
I could accurately explain the HFM program to a family.				
My program would be strengthened by collaboration with a home visiting program.				
Families who enroll in HFM will benefit from the program.				
Families who are referred to HFM are able to enroll in a timely fashion.				
HFM fills a necessary service need in [Community].				

3. In the past year, approximately how often did staff from your program have contact with staff from HFM?

- ☐ Never
- ☐ Once a year or less
- ☐ About once a quarter
- ☐ About once a month
- ☐ Every week
- ☐ Every day

A.4. In the past year, how often has your program worked with the HFM program on the following activities?

	Not at all	Once	2 or 3 times	More than 3 times	Don't know
Participated in joint staff training					
Shared space or materials with HFM					
Shared information about your respective programs					
Shared information about families with each other					
Participated in HFM advisory board meeting					
Participated in a joint meeting (other than advisory board meeting)					
Co-sponsored or co-facilitated an activity or event					
Some other activity					

A.5. Check all that have been true in the past year.

☐ My program and HFM have applied for a grant together

☐ My program and HFM have worked together on programming

☐ My program and HFM have shared funding

☐ My program has had some kind of formal agreement in place with HFM (e.g., memorandum of understanding)

☐ Representatives from my program and from HFM have participated in the same task force, coalition or initiative

☐ My program and HFM have participated in the same centralized or coordinated intake process

☐ My program and HFM have had some other form of ongoing collaboration or partnership (please specify)

A.6. Please indicate how strongly you agree with the following statements about the HFM program.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	No opinion
My program's interactions with HFM are mostly positive					
My program is competing with HFM for families					
My program is competing with HFM for funding					
My program would benefit from a closer working relationship with HFM					

A.7. In the past year, has your program referred any families to HFM?

☐ Yes

☐ No

☐ Don't know

If yes, proceed to question A7a. If no, skip to question A8.

A7a. Approximately how many families did your program refer to HFM in the past year?

☐ 1-5

☐ 6-10

☐ 11-15

☐ More than 15

☐ Don't know

A7b. When your program refers a family to HFM, how often does someone from HFM let your program know whether or not the referred family got into the program?

☐ All the time

☐ Most of the time

☐ Some of the time

☐ Hardly ever
☐ Never

A.8. In the past year, has HFM referred any families to your program?

☐ Yes
☐ No
☐ Don't know

*If **yes**, proceed to question A8a. If **no**, skip to question A9.*

A8a. Approximately how many families HFM refer to your program in the past year?

☐ 1-5
☐ 6-10
☐ 11-15
☐ More than 15
☐ Don't know

A8b. When HFM refers a family to your program, how often does someone from your program let HFJM know whether or not the referred family received your program service?

☐ All the time
☐ Most of the time
☐ Some of the time
☐ Hardly ever
☐ Never

A9. How much do you agree with this statement?: "HFM seeks out opportunities to work with different service areas and sectors in [Community]."

☐ Strongly agree
☐ Somewhat agree
☐ Somewhat disagree
☐ Strongly disagree
☐ No opinion

2B. Questions about specific home visiting programs in [Community]: PAT

B.1. Have you heard of the Parents as Teachers program at [Agency] in [Community]?

☐ Yes
☐ No

If **yes***, proceed to question* ***B****2. If* **no***, skip to question C1.*

B.2. Please indicate how strongly you agree with the following statements about the PAT program.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
I understand PAT's eligibility requirements.				
I know what types of services PAT offers				
I could accurately explain the PAT program to a family.				
My program would be strengthened by collaboration with a home visiting program.				
Families who enroll in PAT will benefit from the program.				
Families who are referred to PAT are able to enroll in a timely fashion.				
PAT fills a necessary service need in [Community].				

B.3. In the past year, approximately how often did staff from your program have contact with staff from PAT?

- ☐ Never
- ☐ Once a year or less
- ☐ About once a quarter
- ☐ About once a month
- ☐ Every week
- ☐ Every day

B.4. In the past year, how often has your program worked with the PAT program on the following activities?

	Not at all	Once	2 or 3 times	More than 3 times	Don't know
Participated in joint staff training					
Shared space or materials with PAT					
Shared information about your respective programs					
Shared information about families with each other					
Participated in PAT advisory board meeting					

Participated in a joint meeting (other than advisory board meeting)					
Co-sponsored or co-facilitated an activity or event					
Some other activity					

B.5. Check all that have been true in the past year.

- ☐ My program and PAT have applied for a grant together
- ☐ My program and PAT have worked together on programming
- ☐ My program and PAT have shared funding
- ☐ My program has had some kind of formal agreement in place with PAT (e.g., memorandum of understanding)
- ☐ Representatives from my program and from PAT have participated in the same task force, coalition or initiative
- ☐ My program and PAT have participated in the same centralized or coordinated intake process
- ☐ My program and PAT have had some other form of ongoing collaboration or partnership (please specify)

B.6. Please indicate how strongly you agree with the following statements about the PAT program.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	No opinion
My program's interactions with PAT are mostly positive					
My program is competing with PAT for families					
My program is competing with PAT for funding					
My program would benefit from a closer working relationship with PAT					

B.7. In the past year, has your program referred any families to PAT?

- ☐ Yes
- ☐ No
- ☐ Don't know

If yes, proceed to question B7a. If no, skip to question B8.

B7a. Approximately how many families did your program refer to PAT in the past year?

☐   1-5
☐   6-10
☐   11-15
☐   More than 15
☐   Don't know

B7b. When your program refers a family to PAT, how often does someone from PAT let your program know whether or not the referred family got into the program?

☐   All the time
☐   Most of the time
☐   Some of the time
☐   Hardly ever
☐   Never

B.8. In the past year, has PAT referred any families to your program?

☐   Yes
☐   No
☐   Don't know

If yes, proceed to question B8a. If no, skip to question B9.

B8a. Approximately how many families PAT refer to your program in the past year?

☐   1-5
☐   6-10
☐   11-15
☐   More than 15
☐   Don't know

B8b. When PAT refers a family to your program, how often does someone from your program let HFJM know whether or not the referred family received your program service?

☐   All the time
☐   Most of the time
☐   Some of the time
☐   Hardly ever
☐   Never

B9. How much do you agree with this statement?: "PAT seeks out opportunities to work with different service areas and sectors in [Community]."

☐   Strongly agree
☐   Somewhat agree
☐   Somewhat disagree

☐   Strongly disagree
☐   No opinion

2C. Questions about specific home visiting programs in [Community]: Welcome Family

C.1. Have you heard of the Welcome Family program at [Agency] in [Community]?

☐   Yes
☐   No

*If **yes**, proceed to question **C2**. If **no**, skip to question 8.*

C.2. Please indicate how strongly you agree with the following statements about the Welcome Family program.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
I understand Welcome Family's eligibility requirements.				
I know what types of services Welcome Family offers				
I could accurately explain the Welcome Family program to a family.				
My program would be strengthened by collaboration with a home visiting program.				
Families who enroll in Welcome Family will benefit from the program.				
Welcome Family fills a necessary service need in [Community].				

C.3. In the past year, approximately how often did staff from your program have contact with staff from Welcome Family?

☐   Never
☐   Once a year or less
☐   About once a quarter
☐   About once a month
☐   Every week
☐   Every day

C.4. In the past year, how often has your program worked with the Welcome Family program on the following activities?

	Not at all	Once	2 or 3 times	More than 3 times	Don't know

Participated in joint staff training					
Shared space or materials with Welcome Family					
Shared information about your respective programs					
Shared information about families with each other					
Participated in Welcome Family advisory board meeting					
Participated in a joint meeting (other than advisory board meeting)					
Co-sponsored or co-facilitated an activity or event					
Some other activity					

C.5. Check all that have been true in the past year.

- ☐ My program and Welcome Family have applied for a grant together
- ☐ My program and Welcome Family have worked together on programming
- ☐ My program and Welcome Family have shared funding
- ☐ My program has had some kind of formal agreement in place with Welcome Family (e.g., memorandum of understanding)
- ☐ Representatives from my program and from Welcome Family have participated in the same task force, coalition or initiative
- ☐ My program and Welcome Family have participated in the same centralized or coordinated intake process
- ☐ My program and Welcome Family have had some other form of ongoing collaboration or partnership (please specify)

C.6. Please indicate how strongly you agree with the following statements about Welcome Family.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	No opinion
My program's interactions with Welcome Family are mostly positive					
My program is competing with Welcome Family for families					
My program is competing with Welcome Family for funding					
My program would benefit from a closer working relationship with Welcome Family					

C.7. In the past year, has your program referred any families to Welcome Family?

- ☐ Yes
- ☐ No
- ☐ Don't know

*If **yes**, proceed to question C7a. If **no**, skip to question C8.*

C7a. Approximately how many families did your program refer to Welcome Family in the past year?

- ☐ 1-5
- ☐ 6-10
- ☐ 11-15
- ☐ More than 15
- ☐ Don't know

C7b. When your program refers a family to Welcome Family, how often does someone from Welcome Family let your program know whether or not the referred family got into the program?

- ☐ All the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Hardly ever
- ☐ Never

C.8. In the past year, has Welcome Family referred any families to your program?

- ☐ Yes
- ☐ No
- ☐ Don't know

*If **yes**, proceed to question C8a. If **no**, skip to question C9.*

C8a. Approximately how many families Welcome Family refer to your program in the past year?

- ☐ 1-5
- ☐ 6-10
- ☐ 11-15
- ☐ More than 15
- ☐ Don't know

C8b. When Welcome Family refers a family to your program, how often does someone from your program let HFJM know whether or not the referred family received your program service?

- ☐ All the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Hardly ever
- ☐ Never

C9. How much do you agree with this statement?: "Welcome Family seeks out opportunities to work with different service areas and sectors in [Community]."

- ☐ Strongly agree
- ☐ Somewhat agree

☐   Somewhat disagree
☐   Strongly disagree
☐   No opinion

3. Final questions about home visiting in [Community]

8. Do you know of any other home visiting programs for families with young children in the [Community] area?

☐   Yes
☐   No

*If **yes**, proceed to question 8a. If **no**, skip to question 9.*

8a. What home visiting programs have you heard of?
_____

Thank you!!