



2016 Family Home Visiting Program
Report to the
Rhode Island General Assembly



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Section 1: Overview

Families are children’s first teachers. Promoting healthy physical, social, and emotional development within the family context is essential to ensure that children have the ability to reach their full potential. The first five years of life is a time of rapid growth and change when the architecture of the developing brain is most susceptible to both positive and negative influences of relationships and experiences. Significant disadvantages in the circumstances of young children can undermine their development, limit their future economic and social mobility, and threaten the vitality, productivity, and sustainability of an entire country.¹

Research shows that there is a negative impact on brain development when young children do not have consistent, supportive relationships with caregivers and are exposed to “toxic stress” which is associated with extreme poverty, family chaos, chronic neglect and/or abuse, severe maternal depression, parental substance abuse, or repeated exposure to violence at home or in the communities. Persistently elevated levels of stress hormones in young children can lead to permanent changes in brain structure and lifelong impairments in learning behavior and health. ^{2, 3}

Many Rhode Island families face challenges that impact their ability to guide the development of their children during the critical early years of life. Children and families in communities experiencing economic, social, and environmental disadvantages are disproportionately affected by stressors such as poverty and adverse experiences in early childhood, leading to the continuation of health disparities in later life.

Family Home Visiting services have been shown to effectively support high-risk, vulnerable families; improve outcomes for children and their families; and address the factors that lead to health disparities. Family Home Visiting is a voluntary, home-based service ideally delivered prenatally through the early years of a child's life. The Family Home Visiting Program provides families with the necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn. It provides social, emotional, health, and parenting support to families. The programs provide information about resources and connect families to resources that are appropriate. This report summarizes outcomes from the Family Home Visiting programs that the Rhode Island Department of Health (RIDOH) administered in FY2016.

¹ Center on the Developing Child at Harvard University (2016). From Best Practices Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families.

² Shonkoff, J. P., Garner, A. S., & the Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care and Section on Developmental and Behavioral Pediatrics. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, 129(1), e232-e246.

³ *The science of early childhood development: Closing the gap between what we know and what we do.* (2007). Cambridge, MA: Harvard University, Center on the Developing Child.

Section 2: Need for Family Home Visiting

Health, as defined by the World Health Organization, is “a state of complete physical, social, and mental well-being and not merely the absence of disease or infirmity.”⁴ Health is created in the community through social, economic, and environmental factors as well as individual behaviors and biology. When groups face serious social, economic, and environmental disadvantages such as structural racism and a widespread lack of economic and educational opportunities, health inequities, which lead to health disparities, result.⁵ Family Home Visiting services are a proven, early strategy to address the factors that contribute to health disparities. National research has demonstrated that family home visiting programs improve prenatal health, reduce childhood injuries, reduce subsequent pregnancies, improve school readiness, increase intervals between births, and increase employment. Family home visiting services provided to high-risk families have also demonstrated significant impact on reducing child emergency room visits and the number of months a family needs economic support.

The need for Family Home Visiting services in Rhode Island is supported by the following state statistics:

Indicators for poor outcomes

	Child Poverty	Births to Teens	Low maternal education	Low Birth Weight	Child Maltreatment	Incarcerated Parents	Domestic Violence
<i>Rhode Island</i>	24.8%	18.6 per 1000 births	11%	7.5%	13.8 per 1000 children	12.8 per 1000 children	35%

Sources: Rhode Island Kids Count Factbook, 2013; Rhode Island Department of Labor and Training, 2013; Rhode Island Department of Health, 2012

Indicator Definitions:

- **Poverty** – Children younger than age 6 living below the federal poverty level (2010-2014)
- **Teen Birth** – Births to women ages 15 to 19 (2010-2014)
- **Low Maternal Education** – Births to mothers with less than a high school diploma (2015)
- **Low Birth Weight** – Infants born weighing less than five and a half pounds (2010-2014)
- **Child Maltreatment** – Victims of child abuse and neglect
- **Incarcerated Parents** – Children with one or more incarcerated parents (2015)
- **Domestic Violence** – Reported domestic violence incidents where children were present (2014)

It is evident that Rhode Island’s high rates of child poverty, births to teens, and births to mothers who have not completed high school put children at risk for poor outcomes. In addition, the high rates of children who are maltreated, children who have an incarcerated parent, and children who witness domestic violence must be addressed. Family home visiting is one strategy within a system of early childhood services to address these problems.

⁴ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946 by the representatives of 61 states (Official Records of the World Health Organization, no 2 p.100) and entered into force on April 7, 1948

⁵ Minnesota Department of Health, 2015. Advancing Health Equity in Minnesota

Providing services to pregnant and parenting teens is a priority for Rhode Island's family home visiting programs because of the increased risk for poor outcomes experienced by children of teen parents. The earliest risks for children of teen parents are increased risk for infant mortality or low birth weight. Children of teen parents are also at increased risk for developmental delays, child maltreatment, and placement in foster care.⁶ During pregnancy or immediately following the birth of the child is a critical time period to intervene in both the young mother's and the child's life. Evidence-based family home visiting is an effective intervention that not only directly improves outcomes but can also provide connections to other community supports such as quality child care, maternal mental health supports, Early Intervention, special education, and other services that will have a positive impact on the child's developmental trajectory as well as the family constellation.

Section 3: What is Family Home Visiting?

Family Home Visiting is a voluntary, evidence-based set of programs that can be delivered prenatally through the early years of a child's life. The earlier these services begin (prenatally) the greater the likelihood that they will positively impact outcomes. By electing to participate in family home visiting programs, families receive help and support from health, social service, and child development professionals. Through regular, planned home visits, parents learn how to improve their family's health and how to provide better opportunities for their children. Home visits may include:

- Supporting preventive health and prenatal practices;
- Assisting parents on how best to feed and care for their babies;
- Supporting parents and caregivers in understanding child development milestones and behaviors;
- Promoting parents' and caregivers' use of praise and other positive parenting techniques, and;
- Working with parents and caregivers to set goals for the future, continue their education, and find employment and quality child care solutions.

Depending on the goals identified by a family which are based on assessments, a family may work with a home visitor for up to five years. Through regular family home visits, parents and caregivers learn how to improve their family's health and provide prepare their children for success in school.

Description of Our Programs

In 2010, federal legislation established the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program to expand and improve state-administered family home visiting programs for at-risk families with young children. This program is administered at the federal level by the Health Resources and Services Administration (HRSA) and the Maternal Child Health Bureau (MHB). MIECHV program emphasizes evidence-based programs, providing most of the federal funding to support rigorously evaluated programs for which there is well-documented evidence of success. These programs have proven to be an effective strategy

for strengthening families, as well as being cost effective over time. Research shows the programs can lead to reduced healthcare costs, reduced need for remedial education, and increased family self-sufficiency.⁷ RIDOH has successfully administered evidence-based family home visiting programs since 2010. In the past six years, three family home visiting programs have been established utilizing a variety of approaches to meet the unique need of communities. Rhode Island uses MIECHV federal funding to support implementation of evidence-based models: Healthy Families America, Nurse-Family Partnership® and Parents as Teachers. Prioritized populations, as designated by HRSA/MCHB include:

- Low-income eligible families;
- Eligible families that include a pregnant woman who is younger than age 21;
- Eligible families that have a history of child abuse or neglect or have had interactions with child welfare services;
- Eligible families that have a history of substance abuse or need substance abuse treatment;
- Eligible families that have users of tobacco products in the home;
- Eligible families that have children with low student achievement;
- Eligible families with children who have developmental delays or disabilities; and
- Eligible families that include individuals who are serving or formerly served in the Armed Forces, including families that have members of the Armed Forces who have had multiple deployments outside of the United States.

In order to achieve improved outcomes for children, evidence-based family home visiting programs must follow national program guidelines, use professional staff trained in the model, be implemented in the appropriate timeframes, and be implemented with fidelity.⁸

MIECHV services help families connect to necessary services, such as healthcare or community resources, and monitor child development/behavior and progress on developmental milestones. Under the MIECHV program, Rhode Island is accountable for meeting legislatively-mandated benchmarks in six areas: (1) improved maternal and newborn health; (2) prevention of child injuries, child abuse, neglect or maltreatment, and reduction of emergency department visits; (3) improvement in school readiness; (4) reduction in crime or domestic violence; (5) improvements in family economic security; and (6) improved coordination and referrals for other community resources and support.

⁷ Sarah Avellar et al., *Home Visiting Evidence of Effectiveness Review: Executive Summary*, Washington, D.C. U.S. Department of Health and Human Services, Office of Policy, Research and Evaluation, September 2013, http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2013.pdf#exec_summary.

⁸ Howard, K.S. & Brooks-Gunn, J. (2009) The role of home-visiting programs in preventing child abuse and neglect. *The Future of Children*, 19(2), 119-146

Evidence Based Home Visiting Models

Following are descriptions of the evidence-based family home visiting models implemented by the Rhode Island Family Visiting Program through contracts with community-based organizations. RIDOH works with community organizations and partners to determine which model(s) best meet the needs of their communities. These evidence-based family home visiting models meet the U.S. Department of Health and Human Services criteria for evidence of effectiveness and are supported by RIDOH. Currently, RIDOH funds 12 local implementing agencies (LIAs) across the State.

1. Healthy Families America (HFA)

Healthy Families America (HFA) is designed to work with families who are at-risk for adverse childhood experiences, including child maltreatment. It is the most appropriate model for families who may have histories of trauma, intimate partner violence, and mental health and/or substance abuse issues. HFA services begin prenatally or immediately following the birth of a baby and are offered voluntarily, intensively for an extended period of time (three to five years after the birth of the baby).

Goals of the HFA program include:

- Build and sustain community partnerships to systematically engage families in home visiting services prenatally or at birth.
- Cultivate and strengthen nurturing parent-child relationships.
- Promote healthy childhood growth and development.
- Enhance family functioning by reducing risk and building protective factors.

2. Nurse-Family Partnership

Nurse-Family Partnership® (NFP) helps improve the lives of vulnerable mothers who are pregnant with their first child. Each mother served by NFP is partnered with a registered nurse early in her pregnancy and receives regular nurse home visits that continue through her child's second birthday. Research has shown that every dollar invested in NFP yields a range of \$2.88 to \$5.70 in return.⁹

The NFP program seeks to improve:

- Pregnancy outcomes by helping women engage in good preventive health practices, including prenatal care from healthcare providers, improving diets, and reducing use of cigarettes, alcohol, and illegal substances;
- Child health and development by helping parents provide responsible, competent care; and
- Economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education, and find work.

3. Parents as Teachers (PAT)

PAT focuses on a family-centered and strength-based approach. The model promotes developmental-centered parenting, parent-child interaction, and family well-being to support healthy families and help children get ready for school. Parent Educators visit families prenatally until children are four years old.

The PAT program seeks to:

- Promote optimal early development, learning, and health for children.
- Increase parent knowledge of early childhood development and parenting practices.
- Increase children's school readiness and school success.

Section 4: Program Statistics

There were 1,645 adult clients served in Family Home Visiting programs statewide in FY2016, according to data reported to RIDOH. Of the 1,645 served, 16% (258) were pregnant women, 17% (284) were pregnant women who delivered during the reporting period, and 67% (1,103) were parents and caregivers of young children. HFA served 1,056 families, NFP served 258 families and PAT served 331 families during this time. Additionally, 1,415 infants and children were served in FY2016.

Among participants who were still active at the time of this report, the average length of program participation ranged from 13 months to three years. Among those who were served during FY2016 but were no longer active at the time of this report, the average length of program participation was 10 months. Average program duration was the longest within HFA, followed by PAT and NFP, which is expected because HFA and PAT are both programs that serve families for a longer period of time than the NFP.

In FY2016, of the clients served in the program, 476 (28%) reported less than a high school diploma or GED, 240 (15%) were younger than age 20 at time of enrollment, and 1,017 (61%) reported being single. The majority of participants, 1,266 (77%), lived in one of the four core cities of Providence, Pawtucket, Central Falls or Woonsocket.

Figure 1. Maternal, Infant, and Early Childhood Home Visiting Caregivers Served by State Fiscal Year, Rhode Island, 2012 – 2016

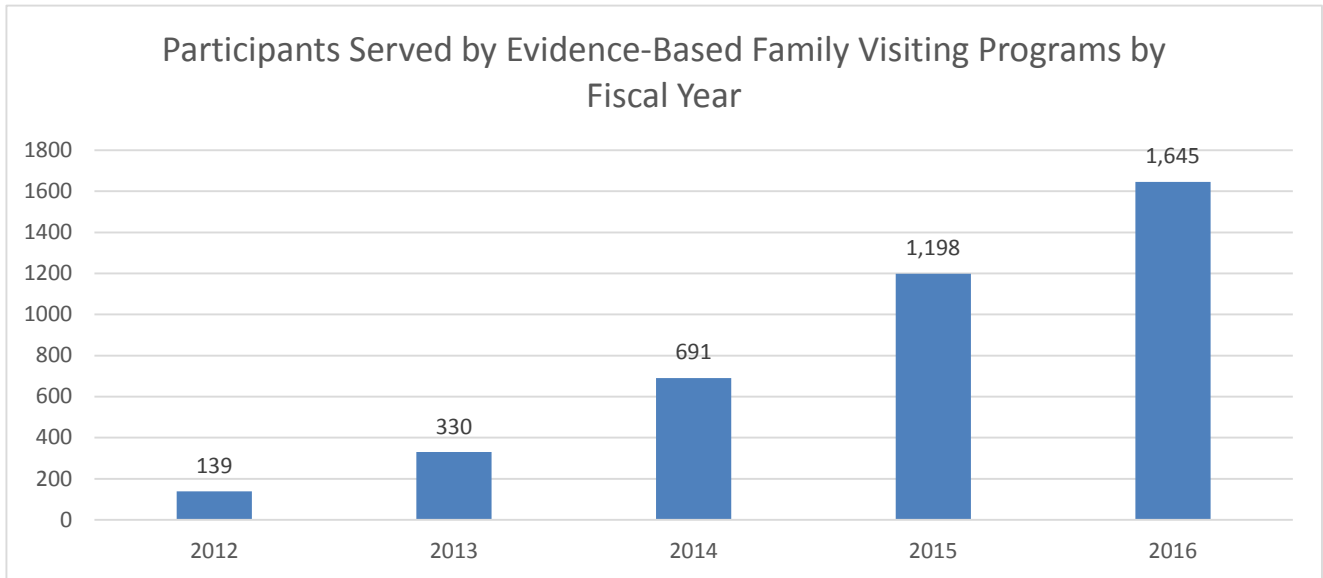
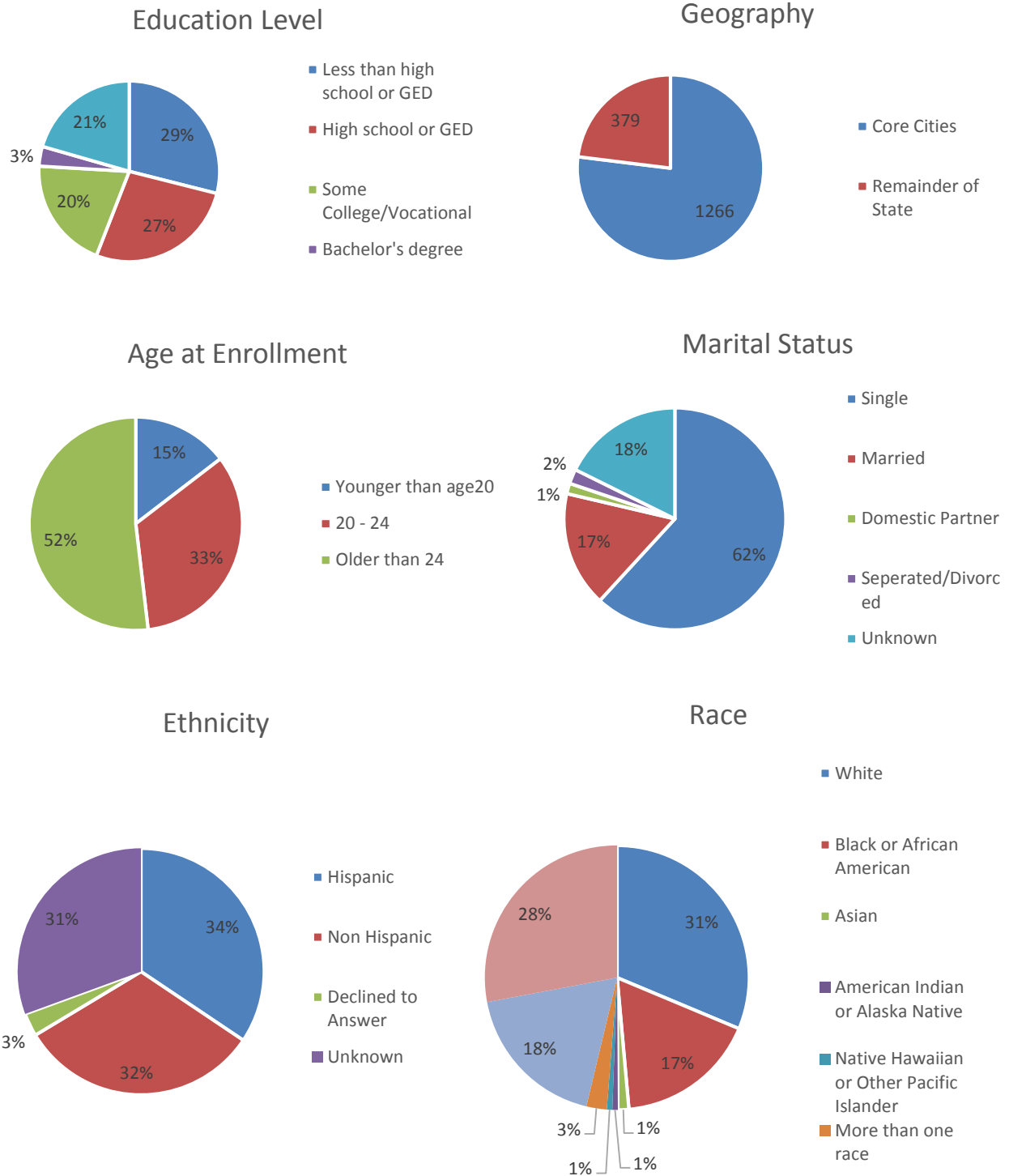


Figure 2: Characteristics of program participants



Community Collaboration and Impact

Community development and systems-building activities are integral components of efforts to ensure an early childhood system of care that is comprehensive, coordinated, and responsive to family needs. The Family Home Visiting Programs strengthen early childhood systems of care by collaborating with community service providers to coordinate services and integrate service delivery; building and coordinating data systems; developing centralized intake systems; and providing professional development and training to family home visiting staff and, in some cases, the broader early childhood workforce.

In Rhode Island, communication and collaboration between state leadership and community partners is critical to support a comprehensive system of services and supports to meet family needs. In 2011, an Interdepartmental Management Team was formed. This team is comprised of partners from several state agencies including: Executive Office of Health and Human Services-Early Intervention, Head Start Collaboration Office, Department of Children Youth and Families, Department of Education, and Department of Human Services-Temporary Assistance for Needy Families. This team works on interagency efforts such as integrating program standards, developing shared policies and procedures across programs, supporting recruitment of families, aligning referral and discharge processes, reviewing data, and addressing specific systems barriers that are raised within communities and at Local Implementing Agencies. Family Home Visiting staff also participate on advisory bodies including the Early Intervention Interagency Coordinating Council and Rhode Island's Early Learning Council and the Successful Start Steering Committee. This ensures that family home visiting is embedded in the early childhood system and that initiatives are integrated with shared vision and planning. Maternal, Infant and Early Childhood Home Visiting staff work directly with the early childhood staff at Rhode Island's child welfare agency to support and coordinate referrals to family home visiting for families involved in the child welfare system and Early Intervention. Both state and community partners use information and data to make decisions about systems and coordination. This process supports collective impact and results in more cohesive system of supports for families at multiple levels of infrastructure.

Local Implementation Teams (LI Teams) were created to support implementation of evidence-based family home visiting at the community level. These LI Teams are community-based and multi-disciplinary and include early childhood providers from child care, healthcare, social supports, and other programs. The teams provide an infrastructure which supports coordination and implementation of the family home visiting programs with a collective impact approach to service delivery and policy alignment. These teams also provide the infrastructure for ongoing assessment of unmet needs. Teams meet bi-weekly to coordinate referrals, outreach and engagement, policy and program development, and data collection. LI Teams integrate and align with the work of RIDOH's Health Equity Zones. Community level information from the LI Teams is shared with state leadership so that coordinated responses can be developed to any barriers or issues, an essential component of early childhood system building. Rhode Island also implemented the Home Visiting Network which includes all home-visiting providers in Rhode Island, including Early

Intervention and Early Head Start. This network provides a learning community and peer-to-peer support for family home visitors.

Family Visiting Benchmarks

The Health Resources and Service Administration (HRSA) federal family home visiting Program grantees are mandated to report on their program's performance annually. Each state must collect and report data on program implementation and performance for the families who are enrolled and participating in federally funded programs across the state. In October 2016, Rhode Island will submit its fifth year of benchmark data reflecting the initial set of 39 locally-refined measures that span the six benchmark areas, including: improvements in maternal, newborn, and child health; prevention of child injuries, child abuse, neglect or maltreatment, and reductions of emergency room visits; improvements in school readiness and child academic achievement; reductions in crime or domestic violence; improvements in family economic self-sufficiency; and improvements in the coordination and referrals for other community resources and supports. In October 2016, the performance reporting requirements for Federal Family Home Visiting grantees will be revised. With this change, states will be shifting from reporting measures which are specific to Rhode Island and designed to be unique to communities, to 19 measures which are nationally aligned. This shift was designed to simplify, standardize, and strengthen the performance measurement system. To meet these goals, HRSA engaged in a year-long process that included federal family home visiting grantees, federal partners, home visiting model developers, and other stakeholders to revise the performance measurement system. Effective October 1, 2016, Rhode Island Local Implementing Agencies will report on modified data collection forms which have been updated to reflect the new measures. The benchmark report due October 31, 2017, will reflect data collected from October 1, 2016 to September 30, 2017. Family Home Visiting benchmark data in its fourth year (October 1, 2015- September 30, 2016), demonstrated improvement and/or consistency on the majority of measures. A few examples include:

- Increase in the percentage of pregnant women who received the recommended number of prenatal care visits from program entry to the delivery of the child from 53% in 2013 to 69% in 2015;
- Increase in the percentage of caregivers who are provided education on child and home safety from 94% in 2012 to 98% in 2015;
- Increase in the percentage of families with the identified presence of domestic violence with a safety plan in place up to 100% in both 2014 and 2015;
- Consistently high rates of insurance coverage for children enrolled in the program.

Looking forward, the new, updated measures promise to be more readily understandable by colleagues and collaborators less familiar with the intricacies of the family home visiting programs. Each of these measures, along with how each is collected and calculated, is described in Rhode Island's Family Home Visiting Benchmark Plan, which will be posted on RIDOH's website. Benchmark data collection and reporting is more than just a federal mandate, benchmark data collection and review supports: common process and outcome

measures across programs and models; performance monitoring; quality improvement efforts; and tells the family visiting story.

Data for selected outcomes under each of the six current Family Home Visiting Benchmark Plan areas are shown on the following pages. The reporting period for the benchmark data is October 1 through September 30. Data are shown for reporting years 2012, 2013, 2014, and 2015. Analysis was restricted to clients in long-term, public health family home visiting programs, who were active during the reporting period, had at least three completed visits prior to the end of the reporting period, and were eligible for each of the respective measures. The increase in the number of clients included in each measure reflects the growth of the family visiting program from 2012 through 2015.

Improved Maternal and Newborn Health

Performance Measure: Percentage of pregnant women enrolled in the program that received an “adequate” or “adequate plus” number of prenatal care visits from entry into the program to delivery of child	2012	2013	2014	2015
Percent	0	53%	63%	69%
Numerator	0	8	98	128
Denominator	3	15	155	185

Prenatal care can help prevent complications and inform women about important steps they can take to protect their infant and ensure a healthy pregnancy. With regular prenatal care, women can reduce the risks of pregnancy; manage existing conditions, such as high blood pressure and diabetes; and reduce the infants risk for complications.

How Family Home Visiting helps

Family home visitors work with clients to support healthy pregnancies by recognizing and reducing risk factors and by promoting prenatal healthcare, healthy diet, exercise, stress management and ongoing well-woman healthcare. Family home visitors also assess and promote positive infant and toddler healthy development and work with parents and community resources and providers to obtain supportive services. One of the measures that family home visitors take to improve maternal and newborn health is to screen for postpartum depression and refer mothers to relevant services. They also encourage caregivers to take their children to well-child visits and assist them in enrolling in health insurance.

Child Injuries, Child Abuse, Neglect or Maltreatment, and Reduction of Emergency Department Visits

Performance Measure: Percentage of mothers/caregivers provided information and/or trained on specific topics such as safe sleep, shaken baby syndrome, passenger safety, etc. while enrolled	2012	2013	2014	2015
Percent	94%	86%	90%	98%
Numerator	94	270	537	984
Denominator	100	315	597	1009

A history of adverse experiences in childhood, including exposure to violence and maltreatment, is associated with health risk behaviors such as smoking, alcohol and drug use, and risky sexual behavior, as well as obesity, diabetes, sexually transmitted diseases, attempted suicide, and other health problems later in life.

How Family Home Visiting helps

Family home visitors help prevent child injuries by providing information on hazards in the home environment, as well as coaching caregivers in positive parenting practices. Family home visitors support caregivers to identify safety concerns in the home that may put the infant or toddler at risk for an unintentional injury, such as unsafe sleep environments. Family home visitors also work with parents to support positive parent-child interaction, safety planning in high-risk situations, and appropriate navigation of the healthcare system.

Improvements in School Readiness and Achievement

Performance Measure: Parent knowledge of child development and their child's developmental progress.	2012	2013	2014	2015
Percent		100%	88%	94%
Numerator	NA	6	14	59
Denominator	NA	6	16	63

A parent is a child's first, and most important, teacher. The strength of this first relationship significantly influences a child's ability to form and maintain subsequent healthy relationships. The quality of these first relationships greatly affects other aspects of a child's development. Positive social and emotional development in a very young child lays the foundation for lifelong physical health, mental health, and the capacity to learn.

How Family Home Visiting helps

Family home visitors screen young children using standardized screening tools and discuss the results with parents to help them understand their child’s developmental progress. Family home visitors also utilize standardized assessment tools to measure the quality of parent-child interaction. These assessments are then used to employ specific interventions that assist caregivers in enhancing their relationship with their infant/child. Family home visitors work with caregivers to envision how they want to care for their child and promote the caregivers’ ability to accurately read and respond to infant cues in order to promote infant trust and attachment, language skills, behavioral regulation, and emotional, physical and cognitive development.

Reduction in Domestic Violence

Performance Measure: Percent of families enrolled in the program identified with a presence of domestic violence that have a safety plan completed.	2012	2013	2014	2015
Percent	62%	29%	100%	100%
Numerator	8	2	6	14
Denominator	13	7	6	14

Domestic violence has a demonstrable, long-term impact on the adult victim as well as on children who witness violence. Intimate partner violence (IPV) costs the United States \$8.3 billion per year, including direct medical and mental healthcare costs and indirect costs from lost lives and lost work productivity. In addition to death or physical injury, interpersonal violence victims often experience adverse health outcomes due to chronic stress.

How Family Home Visiting helps

Family home visiting programs in Rhode Island screen mothers and pregnant women for domestic violence using screening tools and make appropriate referrals to domestic violence services. In addition to screening women for domestic violence, family home visitors offer support and education regarding healthy relationships and assist in the completion of safety plans for domestic violence to help the mother strategize how to keep her and her children safe. In collaboration with the client, the family home visitor promotes engaging other appropriate individuals in the client’s family and social networks, promoting healthy relationships and nurturance and care for the child.

Family Economic Self-Sufficiency

Performance Measure: Percentage of mothers and index children who obtain and/ or maintain health insurance within three months of program enrollment.	2012	2013	2014	2015
Percent	93%	81%	95%	95%
Numerator	152	98	212	365
Denominator	163	121	223	384

Poverty has multiple, long-term effects on children’s health and ability to learn because it limits a family’s access to resources and causes increased stress related to economic insecurity. Insurance coverage is another measure of progress toward self-sufficiency. As stated by the Kaiser Commission on Medicaid and The Uninsured, lack of health insurance compromises the health of individuals because they are less likely to receive preventive care, more likely to be hospitalized for avoidable health problems, less likely to receive timely diagnoses, and more likely to delay needed treatment. In addition, lack of insurance also affects the financial well-being of families by increasing family exposure and vulnerability to the high cost of healthcare and out-of-pocket costs.¹⁰

How Family Home Visiting helps

Family home visitors assist clients in setting personal goals for the future, including goals related to employment and education. Family home visitors help their clients to seek out jobs, complete educational programs, and enroll in health insurance by linking them to resources and helping to overcome barriers. Family home visitors help the client envision how she would like life to be for herself and her child and promote pregnancy planning, education, and employment as a means of accomplishing the client’s goals. Family home visitors engage in a therapeutic relationship with the client, focused on promoting the client’s abilities and behavior change to protect and promote her own health and well-being and that of her child.

Continuous Quality Improvement and Evaluation

RIDOH continues to remain firmly focused and committed to collecting data to examine process and outcome measures related to its programs including Family Visiting services. The importance of measuring program impact has grown in the last decade and is one of the cornerstones of program implementation among family home visiting programs in all sectors, both private and public. The overarching vision for Continuous Quality Improvement (CQI) for MIECHV in Rhode Island is for RIDOH’s Family Visiting Program staff and local implementing agencies to participate in ongoing CQI training and implementation; and in doing so form a strong culture of CQI throughout Rhode Island family home visiting. By identifying and aligning common outcomes and measures, family home visiting programs use data to continuously improve and document the effectiveness of these services.

Since 2013, Rhode Island has been engaged in a thorough evaluation of the local MIECHV program implementation. The Rhode Island MIECHV evaluation is being conducted through a contract between RIDOH and Bradley Hospital, which was selected to conduct the evaluation through a competitive bidding process. Data, collected through both qualitative and quantitative methods, will provide a rich understanding of the systems in place in Rhode Island that support children and families, and the impact of family home visiting on some of Rhode Island's most vulnerable families.

The MIECHV evaluation, which is ongoing and evolving, has built on the evaluation plan developed in the initial federal funding in 2011 and has been expanded through two additional periods of funding. Evaluation activities across the three time frames include continuation of evaluation questions pertaining to different time periods, and new questions added as the program and evaluation evolved. The most recent application expanded to include the implementation and evaluation of Mental Health Consultation (MHC).

The evaluation addresses fundamental questions regarding the implementation and expansion of MIECHV using multiple approaches, with data coming from diverse sources. It examines characteristics and status of the children and families during their participation in the home visiting programs, characteristics of family home visitors, features of the implementation agencies, attributes of the state-level administration of MIECHV, and elements of the relationship networks among these participants and systems. The initial evaluation included the domains of systems change, program fidelity, child/family outcomes, family engagement, and cost analysis. Additional domains added during the expansion phases of the evaluation include workforce development and transition planning.

Overall the evaluation aims to address these basic questions:

- Do children and families do well?
- How does implementation affect family progress?
- How do family visiting agencies support implementation?
- How does Rhode Island MIECHV support agencies, family visitors, and family progress?

The following table outlines the research plan with questions and methods for each evaluation domain:













Evaluation Domains	QUESTIONS	METHODS
SYSTEMS CHANGE	How does Family Visiting fit into the early childhood system of care in Rhode Island? What organizational capacities are needed for successful implementation?	<ul style="list-style-type: none"> - Analysis of group process - Key informant interviews - Administrative data
FIDELITY	Are programs implemented according to model standards?	<ul style="list-style-type: none"> - Model-required measures - MIECHV benchmarks
CHILD AND FAMILY OUTCOMES	<p>How are children and families benefiting from family visiting? Sub-studies focused on HFA, Motivational Interviewing+, Mental Health Consultation</p> <p><u>Active:</u> 1) HFA comparison study 2) MI+ study (family engagement)</p> <p><u>Pending:</u> 1) Mental Health Consultation</p>	
PARENT ENGAGEMENT	<p>What are parents' experiences with the referral and intake process?</p> <p>What family, agency, and provider characteristics promote parent engagement?</p>	<ul style="list-style-type: none"> - Key informant interviews - Self reports (parents, family visitors) - Benchmark data
COST ANALYSIS	How much does it cost to implement family visiting in Rhode Island?	<ul style="list-style-type: none"> - Administrative and outcome data - Time tracking and literature benchmarks
WORKFORCE DEVELOPMENT	What trainings and activities are available to providers, and how are they being utilized?	<ul style="list-style-type: none"> - Administrative data - Engagement and satisfaction measures - Key informant interviews
TRANSITION PLANNING	How is transition planning implemented and what services are in place for families at program exit?	<ul style="list-style-type: none"> - Transition planning documents - Key informant interviews - Administrative data

Section 5: Conclusion

In less than five years, the Family Home Visiting Program has grown from one evidence-based program with the capacity to serve 100 families in four cities to a comprehensive, coordinated system with the capacity to serve more than 1,000 families statewide. With federal funding to support direct services to families, ongoing professional development to the family home visiting workforce, and the development of coordinated early childhood system, thousands of families have seen improved outcomes in child health, maternal health, physical and social emotional development, and readiness for school. Families are healthier, safer, and more economically self-sufficient. In addition, the family home visiting workforce and its capacity has grown, and community partnerships have increased. Rich in evidence that the programs meet family needs and outcomes, the family home visiting program has provided families a solid foundation and puts Rhode Island in a strong position to expand family home visiting to the many additional families that would benefit from the supportive services.

Section 6: Appendix

2017 Family Visiting Legislatively Mandated Benchmarks

-  **Breastfeeding:** Percent of infants (among mothers who enrolled in home visiting prenatally) who were breastfed any amount at six months of age.
-  **Depression Screening:** Percent of primary caregivers enrolled in home visiting who are screened for depression using a validated tool within three months of enrollment (for those not enrolled prenatally) or within three months of delivery (for those enrolled prenatally).
-  **Safe Sleep:** Percent of infants enrolled in home visiting that are always placed to sleep on their backs, without bed-sharing, and without soft bedding.
-  **Developmental Screening:** Percent of children enrolled in home visiting with a timely screen for developmental delays, using a validated parent-completed tool.
-  **Preterm Birth:** Percent of infants who are born preterm following program enrollment.
-  **Well-Child Visit:** Percent of children enrolled in home visiting who received the last recommended visit based on the American Academy of Pediatrics.
-  **Postpartum Care:** Percent of mothers enrolled in home visiting prenatally, within 30 days after delivery, who received a postpartum visit with a healthcare provider within eight weeks (56 days) of delivery.
-  **Tobacco Cessation Referrals Enrollment:** Percent of primary caregivers enrolled in home visiting who report using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling services within three months of enrollment.
-  **Child Injury:** Rate of injury-related visits to the emergency room since enrollment among children enrolled in home visiting.
-  **Child Maltreatment:** Percent of children enrolled in home visiting with at least one investigated case of maltreatment following enrollment within the reporting period.
-  **Parent-Child Interaction:** Percent of primary caregivers enrolled in home visiting who receive an observation of caregiver-child interaction by the home visitor using a validated tool.
-  **Early Language and Literacy Activities:** Percent of children enrolled in home visiting with a family member who reported that during a typical week she/he read, told stories, and or sang songs with child every day.