

## Implementing Early Head Start-Home Visiting (EHS-HV)

### Model Overview

#### Last Updated

May 2016

#### Implementation Support

Early Head Start–Home Visiting (the home-based program option) is administered by the Office of Head Start in the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (DHHS). ACF regional offices oversee the administration of ACF programs, including Early Head Start–Home Visiting. The regional offices guide the programmatic and financial management of Early Head Start–Home Visiting in their jurisdictions and provide assistance, resources, and information to the various entities.

#### Theoretical Model

Early Head Start–Home Visiting is a comprehensive, two-generation federal initiative aimed at enhancing the development of infants and toddlers while strengthening families. The program is founded on nine principles: (1) high-quality services; (2) activities that promote healthy development and identify atypical development at the earliest stage possible; (3) positive relationships and continuity, with an emphasis on the role of the parent as the child’s first, and most important, relationship; (4) activities that offer parents a meaningful and strategic role in the program’s vision, services, and governance; (5) inclusion strategies that respect the unique developmental trajectories of young children in the context of a typical setting, including children with disabilities; (6) cultural competence that acknowledges the profound role that culture plays in early development; (7) comprehensiveness, flexibility, and responsiveness of services that allow children and families to move across various program options over time as their life situation demands; (8) transition planning; and (9) collaboration with community partnerships that allow programs to expand their services.

#### Target Population

Early Head Start–Home Visiting targets low-income pregnant women and families with children birth to age 3 years. To be eligible for Early Head Start–Home Visiting, most families must be at or below the federal poverty level. Early Head Start–Home Visiting programs must make at least 10 percent of their enrollment opportunities available to children with disabilities who are eligible for Part C services under the Individuals with Disabilities Education Act in their state. Each individual Early Head Start–Home Visiting project is allowed to develop specific program eligibility criteria, aligned with the program’s performance standards.

#### Targeted Outcomes

Early Head Start–Home Visiting aims to (1) promote healthy prenatal outcomes for pregnant women, (2) enhance the development of very young children, and (3) promote healthy family functioning.

### Model Components

Early Head Start programs include home- or center-based services, a combination of home- and center-based programs, and family child care services (services provided in family child care homes). The focus of this report is on the home-based service option. Early Head Start–Home Visiting home-based services include (1) weekly 90-minute home visits, and (2) two group socialization activities per month for parents and their children.

### Model Intensity and Length

Early Head Start–Home Visiting programs provide one home visit per week per family (with a minimum of 48 home visits per year) lasting for a minimum of 90 minutes each. They also provide a minimum of 2 group socialization activities per month for each family (with a minimum of 22 group socialization activities each year). Early Head Start–Home Visiting services are provided to eligible pregnant women and families with children from birth to 3 years of age.

### Location

Early Head Start–Home Visiting operate in all 50 states, District of Columbia, Puerto Rico.

### **Estimated Costs of Implementation**

#### Last Updated

May 2016

#### Average Cost per Family

According to the Office of Head Start, the average cost per child ranges from \$9,000 to \$12,000 [2012 dollars]. Estimates are based on costs associated with delivering comprehensive services on a year-round basis. Estimates include weekly 90-minute home visits and 22 socializations per year, as well as costs related to assessments, case management, and facilitation of referrals. In addition, cost include program structure, governance, management, supervision.

#### Purchase of Model or Operating License

There are no costs associated with operating licenses. Rather, program sites receive funding to operate Early Head Start through a federal competitive application process.

#### No information is available for

Labor Costs

Materials and Forms

Training and Technical Assistance

Infrastructure

Recruitment and Retention

# Implementing Family Spirit®

## Model Overview

Last Updated May 2016

### Implementation Support

Family Spirit was designed, implemented, and evaluated by the Johns Hopkins University Center for American Indian Health in partnership with the Navajo, White Mountain Apache, and San Carlos Apache tribal communities. The Family Spirit national office at the Johns Hopkins University Center for American Indian Health administers the program and provides implementation support. Locally, community agencies known as affiliates provide personnel support for implementing the model.

### Theoretical Model

The Family Spirit conceptual framework is based on G. R. Patterson's model that posits parenting as the critical link between parents' personal characteristics and environmental context and children's individual risks and outcomes. The Family Spirit intervention is designed to promote mothers' parenting skills, while assisting them in developing coping and problem-solving skills to overcome individual and environmental stressors.

The model also incorporates traditional tribal teachings throughout the curriculum. The program developers believe that cultural teachings are protective factors that can improve maternal and child health in American Indian communities.

### Target Population

Family Spirit serves pregnant women and families with children younger than age 3. The developer strongly recommends enrolling mothers early in pregnancy. Family Spirit was designed to be implemented in Native American communities. However, it is now also being used with non-Native populations with high maternal and child behavioral health disparities.

### Targeted Outcomes

The program aims to (1) increase parenting knowledge and skills; (2) address maternal psychosocial risk factors that could interfere with positive child-rearing (such as drug and alcohol use, depression, low education, unemployment, and intimate partner violence); (3) promote optimal physical, cognitive, and social/emotional development for children ages birth to 3 years; (4) prepare children for early school success; (5) ensure children receive recommended well-child visits and health care; (6) link families to community services to address specific needs; and (7) promote parents' and children's life skills and behavioral outcomes across the lifespan.

### Model Components

Paraprofessional health educators visit families in their homes. They try to establish a close rapport with families to facilitate delivery of the curriculum, which consists of 63 lessons within

the following six domains: prenatal care, infant care, child development, toddler care, life skills, and healthy living. The health educators also refer families to community resources to address specific needs.

#### Model Intensity and Length

The model consists of 63 lessons divided into six domains. Lessons are intended to be taught sequentially over 52 home visits. Family Spirit recommends initiating the program by at least 28 weeks of gestation and continuing until the child's third birthday. Home visits are more intensive in the prenatal and newborn stages, and diminish in frequency as children age. The program developers recommend weekly visits through the child's first 3 months, biweekly from 4 to 6 months, monthly from 7 to 22 months, and bimonthly from 23 to 36 months of age. Visits typically last 45 to 90 minutes.

#### **Estimated Costs of Implementation**

##### Last Updated

May 2016

No information is available for the following.

Average Cost per Family

Labor Costs

Purchase of Model or Operating License

Materials and Forms

Training and Technical Assistance

Infrastructure

Recruitment and Retention

## Implementing Healthy Families America (HFA)<sup>®</sup>

### Model Overview

#### Last Updated

May 2015

#### Implementation Support

Healthy Families America (HFA) is the signature program of Prevent Child Abuse America (PCA America). The HFA National Office, located in Chicago, Illinois, provides support, technical assistance, training, affiliation, state/multisite system development, and accreditation services to HFA sites.

Ten states and one large metropolitan area have affiliated as an HFA state/multisite system. These include Arizona, Florida, Indiana, Kentucky, Massachusetts, New York, Ohio, Oklahoma, Oregon, San Diego, and Virginia. State/multisite systems have a central administration or other entity providing an infrastructure of support for HFA sites in a state or geographical region. The designated central administrative entity provides HFA training for staff at all sites, facilitates implementation of the model, assists established sites in preparing for HFA accreditation, increases public awareness and advocacy, identifies potential funding streams, and evaluates services and outcomes. The HFA National Office provides support to each state/multisite system through guidance on best standards for the central administration entity. In addition, the HFA National Office offers a comprehensive accreditation process that includes the central administration and the sites it supports.

#### Theoretical Model

HFA is theoretically rooted in the belief that early, nurturing relationships are the foundation for life-long, healthy development. Building upon attachment and bio-ecological systems theories and the tenets of trauma-informed care, interactions between direct service providers and families are relationship-based; designed to promote positive parent-child relationships and healthy attachment; strengths-based; family-centered; culturally sensitive; and reflective.

#### Target Population

HFA is designed for parents facing challenges such as single parenthood; low income; childhood history of abuse and other adverse child experiences; and current or previous issues related to substance abuse, mental health issues, and/or domestic violence.

Individual HFA sites select the specific characteristics of the target population they plan to serve (such as first-time parents, parents on Medicaid, or parents within a specific geographic region); however, the HFA National Office requires that all families complete the parent survey (formerly the Kempe Family Stress Checklist), a comprehensive assessment to determine the presence of various factors associated with increased risk for child maltreatment or other adverse childhood experiences.

The HFA National Office requires that families be enrolled prenatally or within three months of birth. Once enrolled, HFA sites offer services to families until the child's third birthday, and preferably until the child's fifth birthday.

#### Targeted Outcomes

HFA aims to (1) reduce child maltreatment; (2) improve parent-child interactions and children's social-emotional well-being; (3) increase school readiness; (4) promote child physical health and development; (5) promote positive parenting; (6) promote family self-sufficiency; (7) increase access to primary care medical services and community services; and (8) decrease child injuries and emergency department use.

#### Model Components

HFA includes (1) screenings and assessments to determine families at risk for child maltreatment or other adverse childhood experiences; (2) home visiting services; and (3) routine screening for child development and maternal depression. In addition, many HFA sites offer services such as parent support groups and father involvement programs. HFA encourages local sites to implement enhancement services such as these that further address the specific needs of their communities and target populations.

#### Model Intensity and Length

HFA sites offer at least one home visit per week for the first six months after the child's birth. After the first six months, visits might be less frequent. Visit frequency is based on families' needs and progress over time. Typically, home visits last one hour.

HFA sites begin to provide services prenatally or at birth and continue through the first three to five years of life. Each local site determines—usually on the basis of available funding—if services will be extended beyond three years.

#### Location

HFA has more than 600 affiliated sites across 39 states, DC, American Samoa, and Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, the U.S. Virgin Islands, and Canada.

#### Adaptations and Enhancements

HFA sites may implement enhancements to the model, as long as those enhancements do not compromise the site's fidelity to the model as established in the HFA Best Practice Standards. For example, some sites have included clinical staff to address substance abuse and depression. Any adaptations or proposed changes that compromise the site's fidelity to the HFA model require a formal adaptation request, and any approval of such are the sole discretion of the HFA National Office and PCA America.

#### **Estimated Costs of Implementation**

##### Last Updated

May 2015

#### Average Cost per Family

According to the HFA National Office, the average cost of HFA per family per year is \$3,577 to \$4,473 [2014 dollars], depending on the number of families served. This estimate includes costs related to the personnel, nonpersonnel, model fidelity (including training), data system, and evaluation and measurement tools. Sample budgets are available from the HFA National Office.

#### Labor Costs

All labor costs including program management, supervisory, and direct services staff vary across states and regions. Information about labor costs are included in the sample budgets available from the HFA National Office.

#### Purchase of Model or Operating License

Affiliated sites are responsible for an initial application fee of \$500 plus an annual start-up fee of \$4,000 per year (in 2015) until the site is accredited, at which time the annual fee decreases and is modified based on site size. Sites pay an accreditation application fee of \$250 the year they schedule an accreditation site visit. During the accreditation process, HFA sites are responsible for the travel costs associated with a site visit of a team of at least two external, trained peer reviewers (\$2,400 in 2015).

#### Materials and Forms

The *Healthy Families America Site Development Guide* (rev. 2014), the HFA Best Practice Standards (rev. April 1, 2015), and the Affiliation Application are free and available from the HFA National Office to local communities interested in implementing the HFA model. Sample forms used for implementation are available through HFA core training.

#### Training and Technical Assistance

When bringing national trainers to a local site, training costs [2015 dollars] include (1) a certified HFA trainer fee of \$5,200 per trainer (one trainer for integrated strategies training for home visitors, and one trainer for parent survey and community outreach training), (2) a materials fee of \$40 per participant, and (3) all travel costs for the certified trainer. The maximum number of participants allowed in a home visitor training group is 16; the maximum number for an assessment parent survey training group is 12.

#### Infrastructure

The HFA National Office recognizes the importance of state or system-level infrastructure including data management, quality assurance, training and technical assistance, and evaluation, but does not specify infrastructure requirements. Such requirements and corresponding costs are determined by the local or state entities and vary accordingly.

#### Recruitment and Retention

Information on costs of recruitment is included in sample budgets available from the HFA.

## **Implementing Nurse Family Partnership (NFP)<sup>®</sup>**

### **Model Overview**

#### Last Updated

June 2011

#### Implementation Support

The Nurse Family Partnership<sup>®</sup> (NFP) is a home visiting model supported in its replication by a Colorado nonprofit organization referred to as the Nurse-Family Partnership National Service Office (NFP NSO). The NFP NSO helps states and communities implement and sustain NFP. The NFP NSO has established partnerships for the provision of consultative services in many states and major urban areas, including Colorado, Louisiana, Minnesota, North Carolina, Oklahoma, Pennsylvania, South Carolina, Texas, and New York City.

#### Theoretical Model

NFP is shaped by human attachment, human ecology, and self-efficacy theories. NFP nurse home visitors use input from parents, nursing experience, nursing practice, and a variety of model-specific resources coupled with the principles of motivational interviewing to promote low-income, first-time mothers' health during pregnancy, care of their child, and own personal growth and development. Nurse home visitors build on parents' own interests to attain the model's goals.

#### Target Population

NFP is designed for first-time, low-income mothers and their children. NFP requires a client to be enrolled in the program early in her pregnancy and to receive a first home visit no later than the end of the woman's 28th week of pregnancy. Services are available until the child is 2 years old.

#### Targeted Outcomes

NFP is designed to (1) improve prenatal health and outcomes, (2) improve child health and development, and (3) improve families' economic self-sufficiency and/or maternal life course development.

#### Model Components

NFP includes one-on-one home visits between a registered nurse educated in the NFP model and the client.

#### Model Intensity and Length

NFP nurses conduct weekly home visits for the first month after enrollment and then every other week until the baby is born. Visits are weekly for the first six weeks after the baby is born, and



then every other week until the baby is 20 months. The last four visits are monthly until the child is 2 years old. Home visits typically last 60 to 75 minutes. The visit schedule may be adjusted to meet client needs.

NFP NSO recommends that programs begin conducting visits early in the second trimester (14–16 weeks gestation) and requires programs to begin visits by the end of the 28th week of pregnancy. Clients graduate from the program when the child turns 2 years old.

#### Location

NFP programs are located in 32 states: Alabama, Arizona, California, Colorado, Delaware, Florida, Illinois, Iowa, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, Nevada, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming.

#### Adaptations and Enhancements

Adaptations or enhancements to the model are managed under the leadership of Dr. David Olds at the University of Colorado.

#### **Estimated Costs of Implementation**

##### Last Updated

June 2011

##### Average Cost per Family

NFP NSO estimates that the average cost of NFP per family per year is \$4,100 [2011 dollars]. This estimate includes costs for program materials, training, salaries for nursing staff, and access to the centralized electronic data collection and reporting system. The primary factors affecting the range in costs are nurses' salaries, which vary by geographic region and setting, and indirect costs incurred by individual agencies.

##### Labor Costs

Labor costs associated with NFP staff requirements are included in the cost per family estimation.

##### Purchase of Model or Operating License

Agencies under contract to implement NFP are granted a non-exclusive, limited right and license to use NFP proprietary property as long as agencies implement NFP as designed and in fidelity with the NFP model.

##### Materials and Forms

Agencies under contract with NFP pay separate fees for data-related materials and forms only if custom reports are requested. Data collection forms are included in the ETO and other necessary equipment and materials are detailed in the NFP Sample Implementing Agency

Budget and Narrative provided to states and communities to guide budget planning; see “Infrastructure” for estimated costs.

#### Training and Technical Assistance

Assistance, training and technical support costs are included in annual fees paid by agencies to NFP NSO. Total annual costs for an eight-nurse home visitor agency in year 1 are approximately \$102,000 and ongoing annual costs are approximately \$14,900 [2011 dollars] (subject to change). Year 1 fees include the following [in 2011 dollars]:

#### Start-up support

Effective for agencies beginning implementation before June 30, 2012, start-up support costs are approximately \$19,108.

#### Initiation and annual supervisor education

Initial education fees in year 1 are approximately \$4,452 per nurse home visitor and \$5,165 per nurse supervisor. This includes introductory education sessions at NFP, NCAST, “Partners in Parenting Education” (PIPE), and travel to NFP education. There are no tuition or registration fees to attend the annual supervisor training session in Denver, though the cost to agencies includes travel, meals, and hotel.

#### Program implementation support

Program support fees in year 1 are approximately \$8,981; annually thereafter, this fee is approximately \$6,842.

#### Nurse consultation support

Nurse consultation fees in year 1 are approximately \$14,163; annually thereafter, this cost is approximately \$8,093.

#### Infrastructure

There is a one-time set-up fee of \$3,275 for ETO. Agencies may choose whether they would like to receive monthly, quarterly, or annual ETO transmissions for \$623, \$230, or \$64 per year, respectively [2011 dollars] (subject to change).

#### Recruitment and Retention

The estimated costs for client recruitment vary by community.

# Implementing Parents as Teachers (PAT)<sup>®</sup>

## **Model Overview**

### Last Updated

April 2017

### Implementation Support

Parents as Teachers (PAT) National Center provides guidance, training, technical assistance, professional development opportunities, and a quality endorsement process for PAT affiliates. The PAT National Center also advocates at the state and national levels.

Twenty states and two countries have PAT offices. PAT state and country offices offer affiliates guidance, technical assistance, and implementation support. In addition, these offices provide oversight of the PAT affiliates in their state or country.

### Theoretical Model

The theory of change for the PAT model is that affecting parenting knowledge, attitudes, behaviors and family well-being impacts the child's developmental trajectory.

The overall PAT model is grounded in Urie Bronfenbrenner's Human Ecology Theory and Family Systems Theory. The home visits focus on three areas of emphasis—parent-child interaction, development-centered parenting, and family well-being. PAT is informed by additional theories including developmental parenting, attribution theory, and self-efficacy theory.

### Target Population

PAT affiliates select the specific characteristics and eligibility criteria of the target population they plan to serve. Such eligibility criteria might include children with special needs, families at risk for child abuse, income-based criteria, teen parents, first-time parents, immigrant families, low literate families, or parents with mental health or substance use issues.

The PAT model is designed to serve families throughout pregnancy through kindergarten entry. Families can enroll at any point along this continuum. Curriculum materials provide resources to continue services through the kindergarten year if an affiliate wants to do so.

### Targeted Outcomes

The PAT model aims to (1) increase parent knowledge of early childhood development and improve parenting practices, (2) provide early detection of developmental delays and health issues, (3) prevent child abuse and neglect, and (4) increase children's school readiness and school success.

### Model Components

The PAT model has four components that all affiliates are required to provide: (1) one-on-one personal (or home) visits, (2) group connections (or meetings), (3) health and developmental screenings for children, and (4) linkages and connections for families to needed resources.

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#### Model Intensity and Length

The PAT model requires that affiliates offer at least 12 home visits annually to families with one or no high-needs characteristics. Affiliates must offer at least 24 home visits annually to families with two or more high-needs characteristics. In some cases, visit frequency may be gradually decreased as the family transitions out and into other services. Home visits last approximately 60 minutes. The PAT model requires that affiliates offer at least 12 group connections (or meetings) annually and screen children for developmental, health, hearing, and vision problems each year.

PAT affiliates must offer services to enrolled families for at least two years. Affiliates may choose to focus services primarily on pregnant women and families with children from birth to age 3; others may offer services from pregnancy through kindergarten.

#### Location

PAT affiliates are located in all 50 states and the District of Columbia, as well as six countries internationally.

#### Adaptations and Enhancements

PAT permits affiliates to offer additional strategies (beyond the four core model components) or to make model adaptations that may be needed to best address families' needs at the local level. For example, implementation may be modified to be culturally responsive, directed to special populations, or offered in conjunction with other early childhood programs as determined by community need.

Adaptations of the PAT model are available for highly rural and/or indigenous populations such as aboriginal populations in Australia and Canada, and numerous American Indian tribes.

Examples of adaptations include:

- Elements of training
- Materials used during visits to encourage parent–child interactions (for example, use of materials in the home to create toys and games)
- Approaches that honor family and community values
- Who is included in the visits
- Pace of parenting education
- Extent to which verbal and non-verbal communication strategies are used
- Addressing needs of low literate or illiterate parents
- In New Zealand, the Ministry of Social Development's Family and Community Services adapted PAT into a program known in New Zealand as Parents as First Teachers (PAFT)\*.

The ministry contracted with community organizations to implement PAFT and managed, coordinated, and monitored the program. When developing the model, PAFT New Zealand negotiated with the PAT national office in the United States to adapt the PAT program to meet the needs of New Zealand families, including Māori and Pasifika families, indigenous populations of New Zealand and the Pacific Island nations.

PAFT (New Zealand) served families with children from birth to age 3 who were at risk of poor educational outcomes through home visits, linkages to other community services, and group meetings. The PAFT curriculum had two components: the PAT program's Born to Learn curriculum and Āhuru Mōwai. The latter was developed for the PAFT program and was based on Māori traditional beliefs and child-rearing practices. PAFT materials were available in English, Māori, and seven Pasifika languages.

### **Estimated Costs of Implementation**

#### Last Updated

April 2017

#### Average Cost per Family

On its website, the PAT National Center provides a budget toolkit for programs to estimate basic program implementation costs, from which a per-family cost can be estimated.

Factors that contribute to fluctuations in costs per family include:

- Education level and qualifications of the parent educator, which can affect salaries.
- Needs of the population served; the program requires more frequent services for families with higher needs.
- The type of agency operating the program, existing infrastructure, and overhead expenses included in the PAT budget.
- Whether services need to be provided in multiple languages, which often requires a translator.
- Whether there are additional requirements, such as staff and caseloads, associated with a particular funding source.
- The ratio of parent educators to supervisors; PAT National Center requires a minimum percent FTE per parent educator, but programs can opt to provide a higher ratio.
- Parent educators' caseloads; PAT National Center provides guidance, but programs can opt to have lower caseloads.
- Whether the implementing agency is new to PAT and therefore will incur start-up costs and may not be serving as many families per year.
- The level of educator turnover, which increases costs and also often results in family turnover. Fewer families served can increase the cost per family.
- Travel needed to reach families; more travel will reduce the overall caseload an educator can carry and still provide the desired frequency of visits.

Estimates of cost per family for twice monthly home visits (the level of intensity required for families with two or more high need characteristics) are between \$2,575 and \$6,000 per year [2016 dollars].

#### Labor Costs

Annual salaries for parent educators, supervisors, and support staff are estimated to be \$35,000, \$50,000, and \$28,000, respectively [2016 dollars]. Annual professional development fees per parent educator and supervisor are approximately \$350 [2016 dollars].

#### Purchase of Model or Operating License

All affiliates pay an initial affiliation fee of \$3,850 during their first year of operation and \$1,650 in each subsequent year [2017 dollars]. After their first year, parent educators pay \$150 to renew their certifications.

#### Materials and Forms

Curriculum materials are included in the cost of training and renewal.

#### Training and Technical Assistance

The average cost to train a parent educator is \$1,100, which includes both the three-day foundational training and the two-day model implementation training [2017 dollars]. Costs are subject to change and may vary by state. Parent educators who administer screenings may require additional training; additional costs may range from \$150 to \$600 per person [2016 dollars].

#### Infrastructure

An affiliate subscription to the PAT-recommended data system is included in the affiliation fee.

#### Recruitment and Retention

Some affiliates offer incentives to help retain families. The costs for family incentives vary by affiliate