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Research Report

Process Evaluation of the New Mexico Maternal, Infant, and Early Childhood Home Visiting Competitive Development Grant

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Preface

For years, New Mexico has ranked poorly on a variety of child well-being measures. To better promote child well-being, the state has pursued home visiting programs for delivering services to families. These efforts have included securing a federal competitive demonstration grant from the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program to improve the lives of children and families in high-need communities by building capacity to implement home visiting programs.

This report describes and evaluates the New Mexico Home Visiting Competitive Development Grant (HVCDG). The State of New Mexico undertook the HVCDG as part of a contract from the federal MIECHV program, which is jointly administered by the Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF), and was established as part of the Patient Protection and Affordable Care Act of 2010 (ACA). The development HVCDG evaluated here was awarded to the State of New Mexico in the first round of the MIECHV competitive development grant awards.

The State of New Mexico contracted with the RAND Corporation to evaluate the HVCDG. The evaluation design was approved by HRSA and ACF. RAND also created a manual for using its Getting To Outcomes® approach, which is designed to help home visiting practitioners plan, implement, and self-evaluate their programs. It is available at http://www.rand.org/pubs/tools/TL114.html

This work will be of particular interest to those in New Mexico most involved with early childhood issues, as well as more generally to policymakers and child- and family-service organizations. This research was conducted in RAND Health and RAND Labor and Population, divisions of the RAND Corporation. For more information on RAND Health, contact: Jeffrey Wasserman, Director, RAND Health, 1776 Main Street, P.O. Box 2138, Santa Monica, CA 90407-2138, (310) 393-0411, or visit the RAND Health homepage at: www.rand.org/health. For more information on RAND Labor and Population, contact Krishna Kumar, Director, RAND Labor and Population, 1776 Main Street, P.O. Box 2138, Santa Monica, CA 90407-2138, (310) 393-0411, or visit the Labor and Population homepage at http://www.rand.org/labor.

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Executive Summary

New Mexico's children have ranked near the bottom or last in the annual KIDS COUNT state-by-state rankings of child well-being for over a decade (New Mexico Voices for Children, 2014), prompting interest in strategies that could improve child outcomes in the state. One strategy shown to be effective in improving child well-being is home visiting programs, which, according to the State of New Mexico's Children, Youth and Families Department (CYFD), deliver "informational, educational, developmental, referral/linkage, screening/evaluation, and other direct intervention and support services for families" (CYFD, undated, pg. 5). The State recognizes the promise of home visiting, but also that community organizations need additional assistance to implement them well—not just funding. To help improve implementation of home visiting programs, the New Mexico CYFD secured a federal competitive demonstration grant from the Maternal, Infant, and Early Childhood Home Visiting program. The resulting Home Visiting Competitive Development Grant (HVCDG) sought to improve the lives of children and families in a select group of high-need communities by building capacity—i.e., the knowledge and skills needed to complete key tasks that make programs successful—for home visiting program implementation through the Getting To Outcomes® (GTO) framework and ECHO® (Extension for Community Healthcare Outcomes) distance-learning approach. The GTO framework promotes community capacity for high-quality programming by specifying ten steps community practitioners should take and providing implementation support to complete those steps. ECHO involves specialists providing training and technical assistance via distance technology to community practitioners in rural areas to improve the quality of services for complex diseases.

The State asked the RAND Corporation, a codeveloper of GTO, to:

- develop a GTO manual specifically tailored to home visiting
- provide consultation (called "supervision" in GTO projects) to a local subcontractor (called the GTO facilitation team) on facilitating the use of GTO in the participating communities, and
- evaluate whether the HVCDG project improved community capacity and child and family outcomes.

The State also subcontracted with the Center for Development and Disability at the University of New Mexico (CDD UNM) to adapt its ECHO telehealth approach to provide training and technical assistance (T/TA) to the home visiting programs in the participating communities (Luna, Quay, & McKinley counties, and the South Valley neighborhood of Albuquerque).

The State modified the HVCDG's timeline, sites, and scope significantly from the original proposal. First, the HVCDG started eight months late (in May 2012) because of state contracting delays. CYFD requested an extension from MIECHV; however, RAND had completed a large amount of the data collection before the State received the extension. Hence, this report covers the period of the originally planned activities, from September 2011 through November 15, 2013. Second, the HVCDG deleted its planned fifth community site (Grant County) when a more recent needs assessment showed less severe needs there, and replaced it with a "state level" unit of activity. Third, the State believed that additional improvements in other early childhood services were needed to maximize the value of investments in home visiting. Finally, the state shifted the GTO intervention from supporting the newly funded home visiting programs as originally planned to the community coalitions. As a result of these changes, HVCDG adopted the following objectives:

1. help sites form effective early childhood coalitions (facilitated by the GTO facilitation team)
2. enhance the continuum of services needed to successfully support families
3. improve the infrastructure of the sites to deliver home visiting.

Methods

RAND conducted a process evaluation to assess: coalition development and activities, change in the continuum of early child care and related services, capacity of the home visiting programs, and use of GTO and ECHO (a planned outcome evaluation was eliminated after the change in scope). We developed a research question for each HVCDG objective, and added a fourth research question to evaluate how the HVCDG used GTO and ECHO (see Table S.1). To answer the four research questions, we reviewed documents, interviewed stakeholders, rated the quality of the coalitions' plans, and analyzed data from the newly started home visiting service programs.

Document Review

To evaluate GTO utilization, we reviewed documents from the GTO consultation and facilitation teams. We also used documents from the coalitions to document their fidelity to the GTO framework using the GTO Activity Monitoring Tool that lists all of the subtasks prescribed in GTO's ten steps. We also determined the number of coalition meetings held, the meeting content, and the number and diversity of participants. Finally, we reviewed the T/TA tracking data maintained by CDD UNM for measuring ECHO implementation.

Table S.1. Overview of Research Questions and Methods

Research Questions	Measure/ Data Collection Tool	Sources	Data collection Time points
1. Did the four participating communities form early childhood coalitions and begin to implement requisite activities?	• Document abstraction (e.g., coalition meeting minutes) • Interviews with community stakeholders • Plan Quality Index • Kansas University community coalition building tool	• Coalition documents • Coalition members • Community Action Plans	Beginning of community organizing; Fall 2013
2. To what extent did the project utilize GTO and ECHO distance learning to support the work of the coalitions and home visiting programs?	• Document abstraction (e.g., coalition meeting minutes, ECHO T/TA database, GTO facilitation tracking log); • Interviews with community stakeholders, GTO consultation team and GTO facilitators, ECHO T/TA provider	• Coalitions, GTO facilitators, and ECHO T/TA provider • Coalition members, GTO consultation team and GTO facilitators, ECHO T/TA provider	Fall 2013
3. Did the participating communities enhance the continuum of services they need to support families?	• Document abstraction (e.g., GTO facilitation tracking log) • Interviews with community stakeholders, state-level stakeholders; GTO facilitators, ECHO T/TA provider • Continuum of services list	• GTO facilitators, and ECHO T/TA provider • Coalition members, GTO facilitators, ECHO T/TA provider, state level stakeholders	Beginning of community organizing; Fall 2013
4. Did the participating communities improve their infrastructure for home visiting services?	• Home visiting administrative data • GTO Capacity Interview	• Home visiting programs • Home visiting program leaders	Fall 2013

Interviews

We interviewed both the GTO facilitation team and the CDD UNM T/TA provider as a data source to document GTO and ECHO utilization. We also interviewed three to four community stakeholders from each site about HVCDG support (using GTO and ECHO), carrying out coalition-building activities, and the perceived change over about a year's time in the availability and helpfulness of the continuum of services to support families. We conducted additional interviews with stakeholders familiar with state early childhood policies regarding changes that may have occurred as a result of the HVCDG. Finally, we interviewed home visiting staff using the "GTO Capacity Interview" protocol, documenting the extent to which the program staff carried out key activities that previous studies have shown are associated with high quality programming (Livet and Wandersman, 2005).

Plan Quality Index

We rated the quality of the plans produced by the four community coalitions using the Plan Quality Index developed by Butterfoss, Goodman, et al. (1996). This instrument rates planning activities that GTO prescribes.

Home Visiting Service Delivery

As one indicator of how well each site established a new home visiting infrastructure, we analyzed data on the number of home visitors hired; families served; home visits made; and current families enrolled for the two communities that had started home visiting programs within the evaluation time period.

Findings

Research Question 1. Did the four participating communities form early childhood coalitions and begin to implement requisite coalition activities?

Although most coalition members were satisfied with their involvement and planned to stay involved, the coalitions did not carry out most activities needed to establish a strong structure during the 18-month evaluation period. Documents and interviews show that Quay, Luna, and McKinley county coalitions conducted most needs assessment and planning activities. However, the low Plan Quality Index ratings of all the coalitions suggest those actions did not result in high-quality plans (a key midstream product for the community coalitions). South Valley, whose coalition was mostly represented by a single organization, carried out far fewer coalition activities. None of the community sites engaged in any significant evaluation and quality improvement activities. Stakeholders across the communities noted that a lack of funding or other resources could undermine their coalitions' sustainability.

Research Question 2. To what extent did the project utilize GTO and ECHO distance learning to support the work of the coalitions and home visiting programs?

GTO was not well implemented with the four community coalitions. The GTO facilitation team made use of much less GTO training and consultation offered by RAND than is typical in GTO projects (Chinman, Hunter, et al., 2008; Acosta, et al., 2013). Program documents and interviews suggest that the GTO facilitation team did not fully implement GTO in the participating sites. While the GTO facilitation team presented the concept of the GTO framework to Luna and Quay county coalitions, they did not train any coalition members in GTO—and the GTO facilitation team carried out what actions were taken, instead of empowering the coalitions to take the lead in completing the GTO tasks. (Active participation is a key way to build capacity in the GTO framework.) The RAND team did not have administrative authority over the GTO facilitation team typical in GTO projects, and could only provide feedback to the team and the State. The State, which did have authority, did not hold the GTO facilitation team accountable—i.e., ask them to change their actions and implement GTO with fidelity the model.

Accordingly, the coalitions conducted few GTO activities in 18 months, although coalitions in other GTO projects have completed almost all the prescribed GTO

activities in half that time. This may be because the coalitions in other GTO or similar projects were better resourced. Although the coalitions in HVCDG had similar amounts of facilitation support as other GTO projects as measured by the level of effort of the GTO facilitation team, they had no resources to apply to the management of the coalition itself (all members were voluntary). The activities that the coalitions completed most often were conducting needs assessments and developing goals and concrete benchmarks. But there was little evidence that the communities significantly engaged in the other activities related to the GTO steps during the HVCDG, and none of ten steps were addressed completely.

In contrast, specific activities carried out by the CDD UNM T/TA provider—a mix of didactic training, case consultations, and general Q&A for home visiting staff—appears to match that of past ECHO projects. The T/TA provider used a combination of onsite meetings and distance communications to help train home visiting program staff in Luna and Quay counties and provided T/TA to improve the delivery of their home visiting services. The level of contact between the T/TA provider and the two home visiting programs—3.5 times per month in Luna and 3.0 times per month in Quay—was close to the weekly contact prescribed by the ECHO model.

Research Question 3. Did the sites enhance the continuum of services they need to support families?

Community stakeholders reported no improvement in the continuum of services. Community respondents also reported that the continuum of services is inadequate to serve families and several key services lack funding. Community stakeholders said the lack of awareness or understanding of available services can pose a barrier to accessing existing services, and coordination across services is needed. In fact, many community stakeholders indicated that the main value of the HVCDG was to promote awareness of community services related to young children. Also, HVCDG's plan called for the GTO facilitation team to engage in state-level discussions to create policies that would improve the continuum of services across the state (i.e., the state was the fifth "site"). However, the GTO facilitation team engaged in very few meetings with state-level officials and stakeholders. State-level interview respondents said there was a need for state-level discussions and that more meetings would have been helpful.

Research Question 4. Did the sites improve their infrastructure for home visiting services?

Infrastructure is defined as the degree to which program staff are able carry out the many tasks known to be associated with effective programs, and these are prescribed by the GTO framework (Livet and Wandersman, 2005). We assessed the infrastructure of the home visiting programs by documenting the amount of services delivered and via ratings of responses from home visiting program leaders to the GTO Capacity Interview. Only two sites started home visiting services during the evaluation period

(Luna, Quay), so those were the only programs interviewed and monitored. Staff from the Luna County program were rated as having moderate capacity, showing particular strengths in how they developed program goals and objectives, chose and planned the home visiting program, and steps it took to sustain services. Quay County was rated lower across all GTO domains, but did show some capacity for program planning. Both programs were rated low in their capacity to perform program evaluation and continuous quality improvement. Luna County met its enrollment target, Quay County did not. Interviewees there suggested that administrative delays by their fiscal agent contributed to the delayed program start.

Conclusions

The coalitions' weak structure and lack of resources and accountability limited their planning and impact on the continuum of services. The coalitions that were started by the GTO facilitation team did not possess sufficient resources, strong leadership, formalized structures, or a membership that actively participated in the requisite activities of coalition formation and implementation. Research on coalitions shows that weak organizational structure limits effectiveness (Zakocs and Edwards, 2006). This was, in large part, because HVCDG funding, except for the GTO facilitation team's time, was not available to support a more formalized infrastructure of the coalitions, but was instead intended to support home visiting programming. The members of the coalitions were participating on donated time. Given this, there was no management and staffing support to build the accountability needed for successful progress through the GTO steps. The Community Action Plan did not specify any budget information associated with the planned objectives. Finally, there was no strong accountability for the work of the coalitions. Although the GTO facilitation team worked with the coalitions, it did not have authority to hold the coalitions accountable for their work, and the coalitions had no benchmarks they were responsible to meet.

GTO was not implemented according to design. Applying GTO to home visiting was an innovation of the HVCDG, but did not occur because the GTO framework was applied only to the coalitions and not well implemented. This was because the GTO facilitation team participated in less training, consultation, and tracking than in past GTO projects; did not conduct GTO training with coalition member or home visiting staff, and did not empower the coalition members to take on any of the GTO-related tasks, an important feature that promotes capacity building. The GTO tasks that were completed—mostly elements of needs and resources assessments (GTO Step 1) and setting community goals and objectives (Step 2)—were largely done by the GTO facilitation team and shared with the coalition for their input.

The sites made little progress through the GTO steps due to loose organization along with a lack of staff support, budget, and other inputs, including few supports from the GTO facilitators. After two years, the GTO facilitation team, along with the members from the coalitions,

did engage in some elements of the early GTO steps, but did not complete these or subsequent steps that related to home visiting. In past GTO projects that involved coalitions and programs with stronger organizational structures, and more GTO consultation, training and facilitation, practitioners were able to complete most or all of the ten steps in nine months or less (Chinman, Tremain, et al., 2009; Chinman, Acosta, et al., forthcoming). Although there was sufficient staffing available for GTO facilitation, the lack of management and support for individuals' participation in the coalitions remains an important barrier for the HVCD grant.

The coalitions, home visiting programs, and GTO facilitation lacked accountability. The coalitions, the home visiting programs, and the GTO facilitation team had few deliverables linked to a timeline that could ensure adequate progress. For example, the proposed timeline was to establish home visiting programs in the select communities within the first year of the award. Although this did not occur, there are other interim benchmarks that could have been established to monitor progress, allow feedback, and create an opportunity for midcourse corrections. Benchmarks alone do not guarantee accountability, but the lack of benchmarks makes accountability unlikely. The facilitation team did not carry out GTO according to its design during the evaluation period and the State did not hold them accountable.

The distance-learning T/TA was delivered mostly according to the ECHO model, but delays in HVCDG meant that a full pilot test of ECHO for home visiting was not completed. The T/TA provider for the HVCDG has been providing services (training, case consultations, Q&A sessions) that align with past ECHO demonstrations (Colleran et al., 2012; Arora, Thornton, et al., 2011). Yet the delays in implementation meant the HVCDG did not yield data for judging ECHO's impact on home visiting outcomes, preventing the pilot test of the use of ECHO.

Revisiting the project logic model demonstrates significant challenges to overcome. Reviewing the HVCDG project logic model (Figure 2.1 in Chapter Two) demonstrates how the lack of certain activities (state level meetings, effective community organizing, and GTO training and facilitation) made it more difficult to achieve downstream outputs (e.g., increased capacity), short-term outcomes (strong coalitions, detailed community plans), and medium outcomes (enhanced continuum of services), which in turn will make it more difficult to achieve the long term outcomes of improved early childhood outcomes.

Limitations

The current evaluation has limitations that should be noted. First, it was beyond the scope of this evaluation to conduct a census of available services, and the use of key leaders as interviewees may have led to certain services being overlooked. Second, as stated in the Introduction, we did not evaluate the outcomes of children and families served by the newly created home visiting services as outlined in the proposal because

no home visits had been delivered by the end of the first year of the project. Third, we had to rely on documentation about coalition and other community activities provided by the GTO facilitation team and CDD UNM T/TA provider. In some cases, this information is incomplete or missing (e.g., meeting minutes), and it is difficult to independently verify the accuracy of the information. We augment with interview notes where we can, but this is not always possible. Finally, RAND's role as both the provider of GTO supports (written material, training, T/TA) and the project evaluator may appear to compromise the independence of the evaluation. However, we took several steps to bolster the independence of the evaluation, including the use of different staff for data collection and GTO consultation; using multiple data collection staff to improve reliability, and adopting GTO implementation criteria from previous GTO research studies.

Policy Recommendations

We provide specific recommendations that can improve the HVCDG but are also applicable to similar projects planning to use coalitions and GTO.

Support Coalitions With Funding and Accountability

The coalitions in the HVCDG need more support—i.e., funding, paid staffing, and GTO facilitation—to better execute plans and manage the coalition (i.e., develop concrete roles for all participants, set benchmarks and timelines for accomplishing key tasks, and conduct outreach to expand the membership). Providing more support should also be accompanied with greater accountability, such as benchmarks for completing planned work. Future funding should be accompanied by requirements to document interim steps.

Implement GTO As It Was Designed

The effect that GTO may have on building home visiting program capacity can only be examined by actually providing GTO training and support to home visiting program staff. There may still be sufficient time and resources in the HVCDG to use GTO with home visiting programs as well as the coalitions.

Increase Accountability Across All HVCDG Project Activities

More accountability is needed in many aspects of the HVCDG to monitor interim steps and make changes. The State should: set performance benchmarks for the GTO facilitation team, the community coalitions, and the home visiting programs; monitor their activities; and establish consequences for both good and poor performance.

Acknowledgements

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This report was peer reviewed according to RAND's Standard for High-Quality Research and Analysis (available at: http://www.rand.org/standards.html). We appreciate insightful reviews from Joie Acosta and Debra Strong.

Abbreviations

ACA	Patient Protection and Affordable Care Act of 2010
ACF	Administration for Children and Families
CDD UNM	Center for Development and Disability at the University of New Mexico
CYFD	[State of New Mexico] Children, Youth and Families Department
ECHO	Extension for Community Healthcare Outcomes
ELAC	Early Learning Advisory Council
FQHC	Federally qualified health center
FIT	[State of New Mexico Department of Health, Developmental Disabilities Supports Division] Family Infant Toddler Program
FTE	full-time equivalent
GTO	Getting To Outcomes
HRSA	Health Resources and Services Administration
HVCDG	New Mexico Home Visiting Competitive Development Grant
INA	Infrastructure Needs Assessment
LANL	Los Alamos National Laboratory
MIECHV	Maternal, Infant, and Early Childhood Home Visiting Program
NFP	Nurse Family Partnership
OB/GYN	obstetrician/gynecologist
PCA	Partnership for Community Action
PAT	Parents as Teachers
QCHC	Quay County Health Council
REC6	Regional Educational Cooperative 6
RFP	request for proposal
TA	technical assistance
T/TA	training and technical assistance
WIC	[Special Supplemental Nutrition Program for] Women, Infants, and Children

1. Introduction

New Mexico's standings in the annual KIDS COUNT state-by-state rankings of child well-being indicators dropped from 49th in 2012 to 50th in 2013 (New Mexico Voices for Children, 2014). New Mexico has not ranked higher than 40th in the KIDS COUNT rankings since they commenced in 1990 (Annie E. Casey Foundation, 2014). These outcomes have led legislators and foundations to promote more expenditures for children's well-being.

One strategy that has been shown to improve child well-being is home visits by health, social service, and other trained providers. Rigorous evaluations show that home visiting can produce favorable and statistically significant impacts in a spectrum of outcome domains for children and families (Avellar et al., 2013). As a result, public and private expenditures devoted to home visiting in New Mexico have grown.

Among these efforts, the State of New Mexico sought a Home Visiting Competitive Development Grant (HVCDG) from the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, administered jointly by the Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF), and established as part of the Patient Protection and Affordable Care Act of 2010 (ACA). The MIECHV program represents the first time that the federal government has allocated recurring funding specifically for home visiting programs. The New Mexico grant was awarded in one of the first rounds of MIECHV competitive development grant awards.

The New Mexico HVCDG seeks to improve the lives of children and families in four pilot communities as well as across the state by building capacity—i.e., the knowledge and skills needed to complete key tasks that make programs successful (Acosta et al., 2013; Chinman, Acosta, et al., 2012)—for implementing home visiting programs. Each site received grant funds to start home visiting programming. Each site was asked to develop a coalition—a collaboration among various early childhood stakeholders—to support the new programming and further improve the continuum of available early childhood services. To support the new home visiting programs and coalitions, the state selected two models that have successfully built capacity in other service areas but had not been applied to home visiting programs. These are Getting To Outcomes® (GTO), a framework that seeks to improve program implementation, and ECHO® (Extension for Community Healthcare Outcomes), a distance-learning approach to improving health. The objectives of the HVCDG were to

1. help the sites form effective early childhood coalitions in support of home visitation programs
2. enhance the continuum of services at the sites to successfully support families

3. improve the infrastructure of the sites to provide home visiting.

More resources are just one component of improving outcomes for children. If those resources are not used well, then outcomes are unlikely to change. Therefore, we conducted a process evaluation to assess how well the sites established the coalitions, used GTO and ECHO, and improved the continuum of services needed to support families. In particular, the evaluation sought to answer four research questions:

1. Did the four participating communities form early childhood coalitions and begin to implement requisite coalition activities?
2. To what extent did the communities use GTO and ECHO to support the work of the coalitions and home visiting programs?
3. Did the sites enhance the continuum of services they need to support families?
4. Did the sites improve their infrastructure for home visiting services?

We will go into more detail regarding the HVCDG and its evaluation (as required by the MIECHV development grant projects; see Health Resources and Services Administration, 2011). First, we describe home visiting in the state at the start of the project. We then discuss the motivation and some background for the HVCDG.

Home Visiting in New Mexico

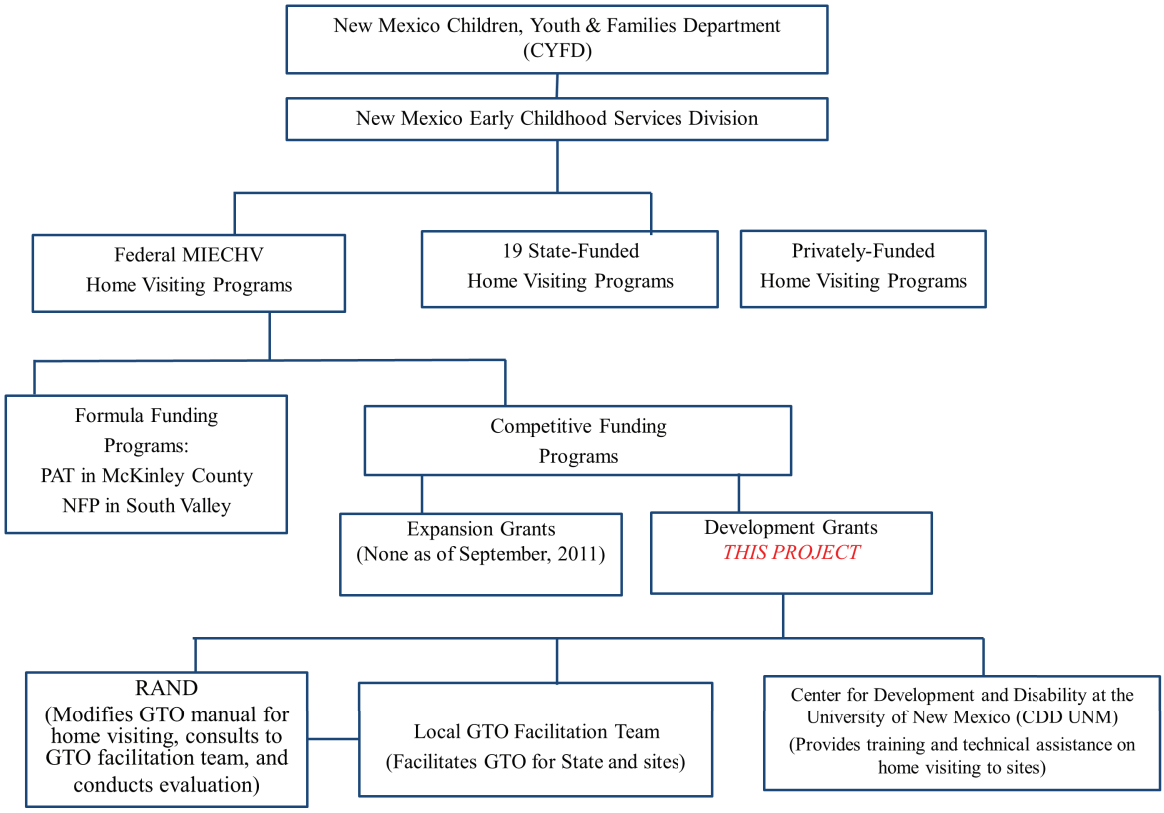
Home visiting in the state has grown dramatically in the last five years. According to the State of New Mexico's Children, Youth and Families Department (CYFD), in addition to federal funding, the State has increased its own funding for such programs from $98,000 in 2008 (the first year New Mexico spent general funds on home visiting) to $8.1 million in fiscal year 2014 (CYFD, 2013). In fiscal 2013, state funds supported 19 home visiting programs to serve a caseload of 930 families. These funds supported a variety of home visiting models, the most common being the First Born® Program, which provides visits to first-time parents until their child reaches three years of age. Private funding has supplemented such efforts; for example, St. Joseph's Community Health Foundation supports one of the nation's largest home visiting programs—a First Born Program site. This program began in South Albuquerque but has expanded to the entire metro area, serving more than 400 families. The W.K. Kellogg Foundation has also helped launch a First Born Program in McKinley and San Juan counties able to serve about 200 families.

MIECHV further increased funding for home visiting programs through two types of grants: formula grants and competitive grants. The formula grants are allocated to states in proportion to the number of young children in a state, and require a state proposal but are not competitive. MIECHV formula grants support two evidence-based home visiting programs in New Mexico: a Nurse Family Partnership (NFP) site in the South Valley neighborhood of Albuquerque and a Parents as Teachers (PAT) site in McKinley County.

The HVCDG was part of the MIECHV competitive grant program that seeks to help states expand or enhance evidence-based home visiting programming. New Mexico did not have any expansion grants at the time of this program, and this was New Mexico's first development grant. (More information on the MIECHV program can be found at the HRSA "Maternal, Infant, and Early Childhood Home Visiting" web page, listed in the References.)

In New Mexico, the CYFD administers the federal MIECHV program as well as home visiting programs funded by the state legislature. Figure 1.1 shows the organization of these. Within the CYFD, the New Mexico Early Childhood Services Division is responsible for state and federal home visiting programs. The federal home visiting program manager was the principal investigator of the HVCDG and reported to the deputy director who oversees the Early Childhood Services Division.

Figure 1.1. Administration of Home Visiting Programs in New Mexico, as of September 2011



The State currently supports federally and State-funded home visiting programs with a training and technical assistance (T/TA) program delivered by the Center for Development and Disability at the University of New Mexico (CDD UNM). (More

information about this program can be found at the CDD UNM "Home Visiting Training" web page, listed in the References.) The CYFD emphasizes implementation support in its proposal to the MIECHV for HVCDG (available at the CYFD "Affordable Care Act—Maternal, Infant and Early Childhood Home Visiting Program"web page listed in the References) for resources to support implementation:

> . . . many of the most needful communities in the state have little or no capacity to implement an evidence-based home visiting program. Rather than just "throw money at a problem" and then wonder why nothing changed, **New Mexico will develop an innovative and respectful process that allows communities to build the capacity to implement and sustain successful evidence-based home visiting programs.** To accomplish this, we will pilot test the use of two evidence-based [implementation-support] models that have never been tested for use when implementing evidence-based home visiting programs. (Page 1, emphasis added)

The need for such support has been documented by implementation science, which highlights several reasons why a program's prior success does not automatically translate to success in a new setting (Schoenwald and Hoagwood, 2001). First, new practices are not always adopted even when they are known to improve outcomes (Ennett et al., 2003). Second, individual and organizational levels that affect the degree to which new practices are adopted and implemented also need attention. For example, a number of studies have shown that factors at both the individual levels (e.g., training, skills, efficacy, involvement in decisionmaking) and the organizational levels (e.g., size, business climate, financial resources, active support for evidence-based practices among staff and administrators) have been related to implementation quality (Ennett et al., 2003; McCormick, Steckler, and McLeroy, 1995; Parcel et al., 1989; Rohrbach, D'Onofrio, et al., 1996; Rohrbach, Graham, and Hansen, 1993; Steckler, 1992). In turn, implementation quality influences the outcomes achieved for program participants across a range of disciplines and services (Dane and Schneider, 1998; Durlak and DuPre, 2008; Dusenbury et al., 2005; Fixsen, Naoom, et al., 2005; Berkel et al., 2011). This literature suggests that beyond such strategies as disseminating manuals, active strategies are needed at both the organizational and individual levels to encourage implementation with high quality. Passive approaches, such as training, do not result in change by themselves, as attendees often experience barriers to incorporating newly learned information into their work (Cividin and Ottoson, 1997; Ottoson, 1997). More comprehensive approaches are needed, such as using external facilitators to partner with local staff to tailor implementation to the local context (Rosenheck and Dennis, 2001). In sum, outcomes are only achieved when programs that work are adopted and implemented well, as specified by Fixsen et al. (2013):

Evidence-based programs x Effective implementation = Improved outcomes

Many communities with the greatest need for home visiting lack the capacity to implement evidence-based programs well and do not reach the same outcomes demonstrated by program developers. Hence, New Mexico sought to promote capacity for strong implementation by choosing two implementation support models: GTO, an implementation support framework, and ECHO, a distance-learning approach to improve health. We describe both of these in more detail.

Background on the New Mexico HVCDG

GTO

The State selected the GTO framework, which rigorous evaluations have indicated improve the capacity of individual practitioners to successfully implement evidence-based health and human services (Chinman, Hunter, et al., 2008; Acosta et al., 2013; Chinman, Tremain, et al., 2009). GTO first specifies ten steps (or sets of activities, see Table 1.1) that program staff should take, each associated with obtaining positive results across many different program types (Livet and Wandersman, 2005). GTO then provides active guidance and support to help practitioners complete those steps. "Capacity" is defined as the knowledge and skills needed to complete key tasks that make programs successful and that are specified in the ten steps of GTO: The first six steps involve planning activities (needs assessment, goal setting, choosing programs, ensuring appropriate capacity, ensuring a good fit, and planning program details). The next two steps are process and outcome evaluation (Steps 7 and 8 in Table 1.1). The last two steps involve using data to improve and sustain programs (Steps 9 and 10 in Table 1.1). GTO manuals, face-to-face training, and onsite technical assistance (or TA) build capacity to complete each step. Consistent with social cognitive theories of behavioral change (Ajzen and Fishbein, 1977; Bandura, 2004; Fishbein and Ajzen, 1975), exposure to GTO (e.g., from manuals and training) leads to stronger knowledge and skills in performing GTO-related activities (capacity). This in turn can lead to enhanced performance of more GTO-related behaviors (i.e., the tasks specified in the ten steps), which supports successful program implementation (Durlak and DuPre, 2008). Important to GTO's capacity-building is allowing practitioners to be more than passive learners, giving them the opportunity to carry out for themselves the various programming tasks GTO specifies. Practitioners are given guidance (training) and tools (from the manuals) to carry out these tasks, and then TA providers offer ongoing feedback about what is needed for improvement (Kitson, Harvey, and McCormack, 1998; Rycroft-Malone et al., 2002; Stetler et al., 2006).

The GTO framework is grounded in implementation theory. For example, a recent randomized trial showed how GTO operationalizes the Consolidated Framework for Implementation Research (CFIR) to ensure that all the major domains influencing implementation are considered (Acosta et al., 2013; Damschroder et al., 2009). For

example, the GTO framework specifically targets the CFIR domain of "implementation process" at both the individual and program level so that program implementation more closely aligns with empirically based, high-quality processes.

Table 1.1. GTO Steps (Guided by Key Questions)

1. What are the needs to address? GTO Step 1 provides information about conducting a community needs assessment to help inform program planning.
2. What are the goals and objectives? GTO Step 2 has worksheets for creating measurable goals and objectives from the needs identified in Step 1.
3. Which evidence-based programs can be useful in reaching the goals? GTO Step 3 offers an overview of evidence-based programming and how to select a program to address the goals outlined in Step 2.
4. What actions need to be taken so the selected program fits the community context? GTO Step 4 prompts readers to reduce duplication and facilitate collaboration with other programs.
5. What capacity is needed for the program? GTO Step 5 prompts readers to ensure there is sufficient organizational capacity to conduct the selected program.
6. What is the plan for this program? GTO Step 6 assists with planning the selected program.
7. How will implementation be assessed? GTO Step 7 assists with conducting a program process evaluation.
8. How well did the program work? GTO Step 8 assists with conducting a program outcome evaluation.
9. How will continuous quality improvement strategies be incorporated? GTO Step 9 prompts practitioners to reassess the questions in Steps 1–8 after completing the program as a means for improvement.
10. If the program is successful, how will it be sustained? GTO Step 10 presents several ideas to consider when attempting to sustain an effective program.

SOURCE: Chinman, Acosta, et al., forthcoming.

There are GTO manuals available in seven service areas—home visiting (created as part of this project), substance abuse prevention (Chinman, Imm, and Wandersman, 2004), underage drinking prevention (Imm, et al., 2007), teen pregnancy prevention (Lesesne et al., 2007), homelessness (Hannah et al., 2011), positive youth development (Fisher et al., 2006), and a manual that focuses on using GTO for systems-level change (Levison-Johnson, Dewey, and Wandersman, 2009). In each manual, the general ten-step approach is maintained, but tailored to each service area. For example, the needs assessment chapter in each manual discusses relevant data sources that are pertinent to each service area. The evidence-based program chapter discusses the evidence base specific to each service area. The outcome evaluation chapter discusses outcome measures specific to each service area. In addition, there is a GTO manual that is specifically devoted to Step 10, sustainability (Johnson et al., 2009), and the National Institutes of Health is supporting work underway to develop a manual for Step 9, continuous quality improvement. The manuals for each topic are published and distributed in hard copy and PDF files for download. Sixteen states have used GTO; in 2012, the Substance Abuse and Mental Health Services Administration made GTO materials available for use in more than 1,500 town hall meetings across the United States to address underage-drinking prevention.

GTO has improved the capacity (i.e., knowledge and skills about quality program implementation) of individual practitioners and the performance of key program tasks

in both quasi-experimental trials (Chinman, Hunter, et al., 2008) and randomized-controlled trials (Acosta et al., 2013; Chinman, Tremain, et al., 2009). In these studies, practitioners implemented most or all of the ten steps in nine months or less. Congruent with social cognitive theories of behavioral change (Ajzen and Fishbein, 1977; Bandura, 2004; Fishbein and Ajzen, 1974; Fishbein and Ajzen, 1975), the efficacy and behaviors related to the activities targeted by GTO's ten steps (i.e., "capacity" at the individual level), was related to how well programming is carried out at the program level (Chinman, Acosta, et al., 2012), in turn affecting outcomes.

The State subcontracted with the RAND Corporation, a codeveloper of GTO with University of South Carolina, to engage in three tasks on this project:

- develop a GTO manual specifically tailored to home visiting
- provide support (called "supervision" in GTO projects) to a local subcontractor on how to facilitate the use of GTO in the demonstration communities (called the GTO facilitation team)
- evaluate the project to assess whether it improved community capacity and whether it improved child and family outcomes.

ECHO

The State also subcontracted with CDD UNM to adapt its ECHO telehealth approach to provide T/TA to the home visiting programs in the demonstration site communities. ECHO uses telemedicine and distance learning to improve patient care by building the capacity of primary health care providers in underserved rural areas to manage complex health problems. By helping primary health care providers offer more comprehensive care for complicated disorders, such as hepatitis C, ECHO aims to reduce specialist referrals, which can increase wait times, cost, and fragmentation of care (Arora, Thornton, et al., 2007).

In ECHO, specialists use teleconferencing and videoconferencing; Internet-based assessment tools; online presentations; and telephone, fax, and e-mail communications to help primary care providers in rural areas use best practices. These distance technologies enable specialists and primary care providers to co-manage patients, increasing the capacity of rural clinicians to provide better treatment.

ECHO participants must, at a minimum, have access to the Internet and telephone service (including a fax machine and a speaker phone), and the ability to view word processing documents and presentations. Videoconferencing capability enhances interaction between the partners and specialists and requires broadband access and a video camera. After completing orientation and training, participating clinicians present and discuss their patients during weekly two-hour telemedicine clinics. The clinics use a standardized, case-based format that includes discussion of treatment complications and psychiatric, medical, and substance abuse issues. During

these clinics, clinicians collaborate with specialists in a variety of subspecialties, as well as with other clinicians.

ECHO enhances the skills of community providers through: (1) longitudinal co-management of patients with specialists, (2) shared case-management decisionmaking with other primary care providers, and (3) short didactic presentations on relevant topics. In multiple studies, this approach has helped deliver quality specialty care to patients in rural areas in a cost-efficient manner (Arora, Geppert, et al., 2007; Arora, Thornton, et al., 2011).

The State envisioned CDD UNM using ECHO to support home visiting programs. CDD UNM has provided professional development and technical assistance to the State-funded home visiting sites on topics such as reflective supervision, trauma-informed services, and mandatory reporting.

Site Selection

The State named five demonstration communities in the proposal and also stated that the project would improve statewide capacity to deliver and support home visiting programs. The same subcontractor responsible for facilitating the community use of GTO would execute the statewide work as well. The proposal named five communities among the ten highest-need counties,[1] as identified in the State's home visiting needs assessment submitted as part of the MIECHV formula grant requirements (CYFD, undated). These were Quay County, Luna County, Grant County, McKinley County and the South Valley/South Central neighborhood of Albuquerque. When a subsequent rating showed South Valley ranked 11th and Grant County 14th (State of New Mexico, undated), and the State became concerned about the difficulty of managing five community sites, it replaced the Grant County site with a "state level" unit of activity.

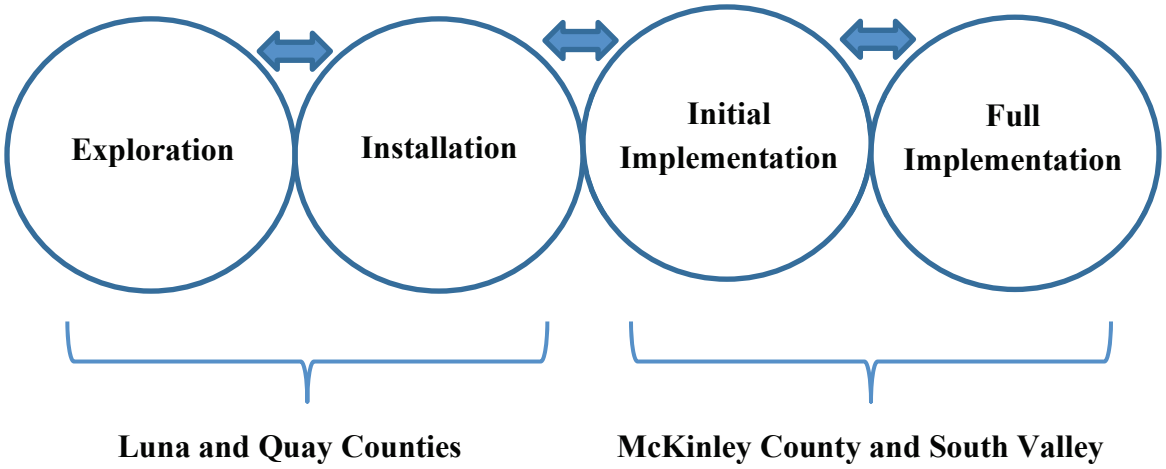
In addition to community need, existing community resources are often a secondary criterion for selecting locations for services (Kilburn and Maloney, 2010). While the State selected four sites that all demonstrated high need, the sites exhibited disparate levels of community resources. Two of the selected communities (South Valley area of Albuquerque and McKinley County) had previously completed lengthy strategic planning processes led by professional planning consultants and subsequently initiated home visiting services. More specifically, the St. Joseph's Community Health Foundation had undertaken a strategic planning exercise in 2010 prior to providing First Born home visiting services in the South Valley neighborhood. The State was also operating a Nurse Family Partnership site in the South Valley as part of its federal formula grant funding. In McKinley County, the W.K. Kellogg Foundation had convened a community coalition in 2011–2012 to engage in a strategic planning process to determine investments that led to the development of a First Born Program site there.

[1] The State considers the South Valley/South Central neighborhood of Albuquerque to be equivalent to a County in these analyses.

The State was also operating a Parents as Teachers program in McKinley County as part of its federal formula grant. In other words, while South Valley and McKinley County are routinely among the highest-need areas on child outcomes, they had also recently incorporated State-operated programs supported by federal funds as well as well-funded, private, home visiting programs. In the end, the State selected sites with disparate existing home visiting resources. Two sites (Luna and Quay counties) had no home visiting program in operation; two others (South Valley and McKinley County) had rich existing home visiting programming.

We use the Fixsen et al. (2013) model to describe how the sites were in different stages in their implementation of home visiting, shown in Figure 1.2. This project engaged with Luna and Quay counties, which were in the exploration/installation phases, and McKinley County and South Valley, which were in the initial to full implementation phases.

Figure 1.2. Stages of the Implementation Process



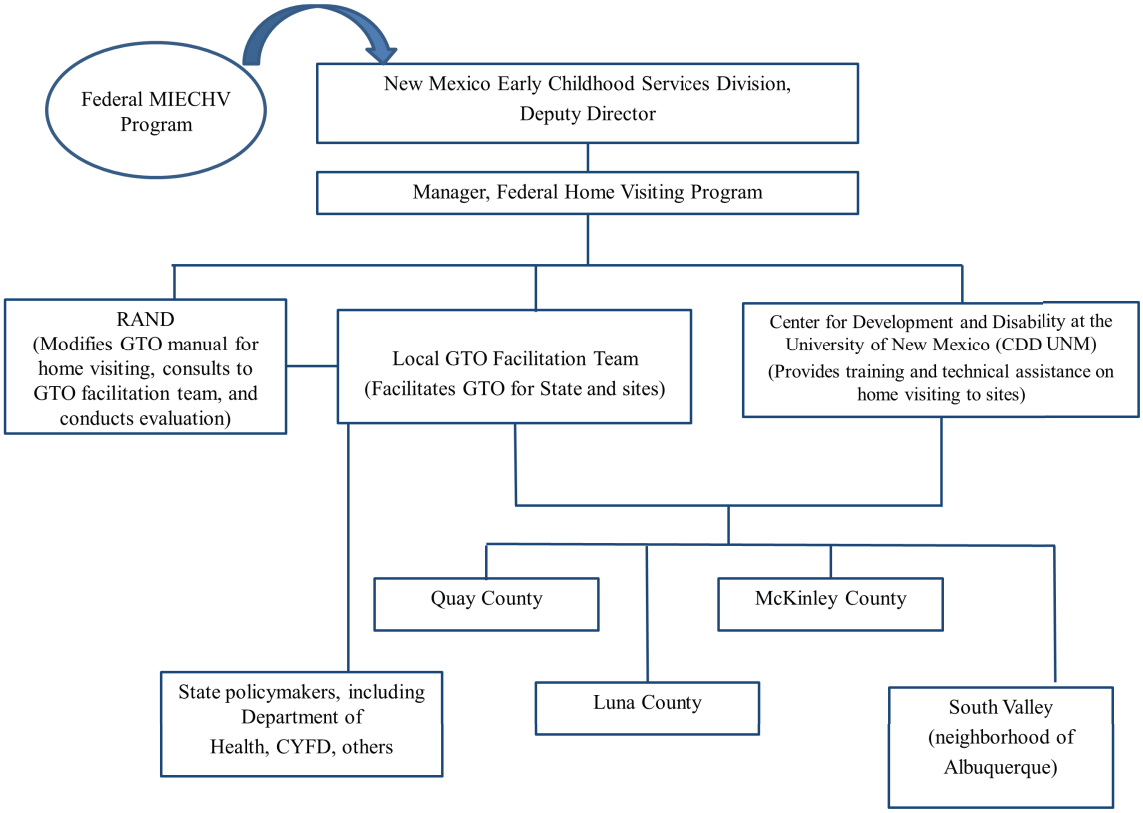
NOTE: Reproduced from Fixsen et al. (2013), p. 2.
Exploration: identifying the need for change, creating readiness to make necessary changes, gathering information about potential solutions, learning what is required to implement the innovation, assembling champions and stakeholders, and deciding whether to proceed with the innovation.
Installation: gathering the resources needed to implement the innovation with fidelity and establishing the infrastructure and training required.
Initial implementation: first use of the innovation in the local community and learning how to deliver the innovation with fidelity.
Full implementation: skillful use of the innovation and integration into the local community.

Early Steps

Figure 1.3 provides an overview of the HVCDG structure. There were several delays and changes made to the HVCDG project goals and activities at the start and throughout the course of the work. To reflect the ongoing changes to the project workplan, RAND resubmitted its evaluation plan more than six times to the federal

sponsor for approval over a 13-month period. In this section, we highlight some of the most substantial changes.

Figure 1.3. Structure of the HVCDG



NOTE: The Federal Home Visiting Manager at CYFD oversees this project and reports to the Early Childhood Services Director. The three subcontractors to the State are RAND, the local contractor who facilitates GTO, and CDD UNM. The local facilitation team provides GTO, and CDD UNM provides ECHO to the four geographic sites and the "state level" site. RAND supports the GTO facilitation team in New Mexico but does not work with the sites directly.

Although the State won federal funding in September 2011 with a specified set of subcontractors, RAND and the other subcontractors were required to bid for the work under the State's contracting rules, and did not receive an approved subcontract until May 2012, at which time the project work commenced. Due to these delays in the state contract process, the proposed timeline of 24 months had to adjust to approximately 18 months.

The funded work began with a kickoff meeting in late May 2012 including the RAND GTO and evaluation specialists, the local organization responsible for GTO

facilitation, and the CDD UNM T/TA group responsible for providing ECHO support. At the meeting, significant changes in scope and focus were made from the work originally proposed. The State believed that to properly support nascent home visiting services, they needed to develop early childhood coalitions, which would bring together people with the expertise to identify gaps and develop additional strategies to aid children and families. Thus, by the end of the kickoff meeting, the State had articulated the revised project objectives as

1. assisting the selected communities in forming effective early childhood coalitions
2. enhancing the continuum of services that the communities need to successfully support families
3. improve the infrastructure of the communities to deliver home visiting.

About six months later, the GTO facilitator stated it would not work directly with newly funded home visiting programs to use the GTO approach. Instead, they would organize local stakeholders into coalitions for improving services for families, and then facilitate the use of GTO within those coalitions to accomplish this goal.

The GTO facilitator initially envisioned that two state-level work groups would be assembled to contribute to the state-level work—a smaller one comprising primarily state officials and a larger one including a wide spectrum of stakeholders from the public and private sector. In the end, only the smaller state-level group convened once.

The original evaluation plan included a process evaluation to assess GTO implementation and achievement of capacity-building goals. Based on the State's original plan that the home visiting programs would become operational in the first year, the evaluation was designed to measure changes over time in program capacity. Because only two of the four communities had operational home visiting programs in the last six months of the evaluation period, the evaluation only includes a one-time (post) assessment of capacity.

Additionally, the original evaluation plan included an outcomes evaluation using existing state administrative data to assess whether the HVCDG improved family and community outcomes. Because no home visiting program had delivered services by the fifteenth month of the project, it was infeasible to conduct the outcome evaluation within the project timeframe, so we removed the bulk of it from the evaluation plan, with only some elements preserved (i.e., examination of number of families served).

Finally, upon agreement by the state and the federal team overseeing the HVCDG, RAND made major enhancements to the process evaluation in order to account for the expansion of the work to build community coalitions, enhance the continuum of early child care and related services, and to build statewide supports.

The revised project workplan included several primary activities:

- The GTO facilitation team would begin convening community coalitions in the selected communities, and then they would begin the GTO planning steps.

- As part of these steps, the community would select a home visiting model and identify a fiscal agent who could receive a grant from the State for home visiting.
- The State would issue a request for proposals (RFP) for home visiting, applicants from the community would apply, and the State would select a contractor.
- The local community would initiate the selected program (e.g., secure space, hire staff) with T/TA from CDD UNM.
- The local home visiting program would deliver services while continuing to receive T/TA from CDD UNM on home visiting.
- With support from the GTO facilitation team, the community coalitions continue to meet in order to create a "community action plan" designed to outline how they would improve the continuum of services available for families of young children.
- Throughout this process, the RAND team would provide guidance, or consultation, on GTO delivery to the GTO facilitation team.
- The GTO facilitation team would also undertake state-level systems change and capacity development over the course of the project.

Background of Community Coalitions and Action Planning

Although there are several conceptualizations of coalitions (Allensworth and Patton, 1990; Boissevain, 1974; Butterfoss, Goodman, and Wandersman, 1993; Stevenson, Pearce, and Porter, 1985), most state that coalitions are interorganizational, cooperative affiliations that bring people and groups together for a common purpose. The main strengths of the community coalition are its ability to marshal large numbers of individuals and to demonstrate broad community support, reduce duplication of efforts, address multiple issues at once, and provide a forum for sharing different perspectives on how to solve community problems. Community coalitions can be appropriate locations for tackling complicated problems because they are public health promotion mechanisms that simultaneously intervene on multiple levels (individual, organizational, policy) and sectors (parents, youth, criminal justice, education) that are needed to have a real impact on community health status (Butterfoss, Goodman, and Wandersman, 1993).

Community-based coalitions have had positive outcomes with reducing substance abuse among youth (Hingson et al., 1996) and teen pregnancy (Galano and Huntington, 1997), increasing immunization rates (Butterfoss, Morrow, et al., 1998), and preventing arson (Maciak et al., 1998). Communities that Care, which provides significant financial and implementation support to coalitions that then initiate evidence-based drug prevention programs, has helped reduce drug use—and the use of its planning system improved program implementation (Brown, Feinberg, and Greenberg, 2010). Nevertheless, other reviews and cross-site evaluations show that many community–led efforts have not affected outcomes. Kreuter, Lezin, and Young (2000) found only six

studies that documented impacts on health status or systems change among 68 published coalition evaluations. The cross-site evaluation of the Center for Substance Abuse Prevention's Community Partnerships reported that only eight of 24 communities had statistically significant lower use rates for alcohol and other drugs than evident in comparison communities (Center for Substance Abuse Prevention, 2000; Yin et al., 1997). The relationship between coalition functioning and implementation and outcomes has also been unclear (Zakocs and Edwards, 2006), in part because studies have lacked rigor or used widely different measures. Given these previous results, as well as the compressed timeline for our work, we chose to focus our evaluation on concrete, important tasks and activities the coalitions may or may not have taken. One of these key tasks is developing a community plan. Plans are important intermediate outcomes of coalition work, and their quality can determine how well a coalition proceeds in carrying out its programming.

Home Visiting Model Selection

The MIECHV program had identified more than a dozen home visiting programs as "evidence-based" (Avellar et al., 2013). The State required that communities select from three specific evidence-based programs on the MIECHV list: Early Head Start, NFP, and Parents as Teachers, or from the "promising" First Born Program that was already being delivered in the State. Program staff believed that peer learning and cost efficiencies would occur if multiple sites in the state used the same program model.

Over the evaluation project period, the State issued RFPs for home visiting service provision in three communities: Luna County, for which $450,000 was to be offered; Quay County, for $250,000; and South Valley, for $350,000. The availability of the large amounts of funds may have contributed to the communities choosing PAT over the other possible program models. This is because PAT has the widest eligibility criteria, serving children from prenatal through age 5, and does not focus solely on high-risk children. Using the PAT program would therefore maximize potential numbers of families served among the small number of children in these communities. Not enough families would have been eligible with the NFP or First Born models to spend the complete budget allocated for direct services in each community.

HVCDG Budget and Resources

The evaluation covers activities from September 2011 through November 15, 2013. The original end date for the HVCDG was September 2013, and it was originally anticipated that RAND would complete the evaluation after other grant work had ceased. Data collection for the final follow-up time period commenced in the summer of 2013 in keeping with the fall 2013 project end date. By the time the State obtained an extension of the HVCDG to September 2014, RAND had completed a large amount of the final follow-up data collection and did not have enough resources to extend the evaluation to the new project end date of 2014.

The total HVCDG funding was originally slated to be $1,102,339.00 in the first year (September 30, 2011 to September 29, 2012) and $1,544,563.00 in the second year (September 30, 2012 to September 29, 2013). State officials reported that they had spent about $1.2 million by November 15, 2013, the end period of this report. In the middle of 2013, uncertainties related to the continuance of the Affordable Care Act, as well as the federal government shutdown and budget crises, made it unclear whether the entire MIECHV program would continue past September 2013. At the same time, the Luna County, Quay County, and South Valley sites were launching their home visiting programs. In order to assure future funding for these sites, at the beginning of the State fiscal year (July 1, 2013), CYFD allocated state general funds to support the sites for a year. This implied that this HVCDG no longer needed to include direct home visiting services in its budget.

When it was resolved that MIECHV and the HVCDG would continue, an extension moved the end date to September 30, 2014. This extension included a statement of work that was renegotiated with the federal sponsor to cover work totaling the amount of the second-year funding listed above: $1,544,563.00. Given that home visiting services in the three sites starting new programs were now covered by State general funds, the new scope of work did not include direct services; rather, it focused on expanding professional development and home visiting infrastructure–building activities. No funding for GTO assistance from RAND or extension of the RAND evaluation was part of the extension work plan. Therefore, the activities being undertaken in the final year of the HVCDG are not included within the scope of this evaluation report.

Rather than providing specific budget amounts, we provide information about the units of labor and other direct costs to facilitate replication. This approach is often superior to providing dollar amounts when reporting cost information, because it more easily translates across time and locations for those interested in replicating the work (Kilburn, 2012). We report approximate resources used by the different groups involved in this project in Table 1.2. The amounts are approximate due to the State "braiding" funding, or combining multiple funding sources to support activities as described earlier. These are resources devoted to the capacity-building activities of the project, and only include resources used by HVCDG participants other than the home visiting programs themselves. Note that this also does not include resources used to produce the GTO manual for home visiting.

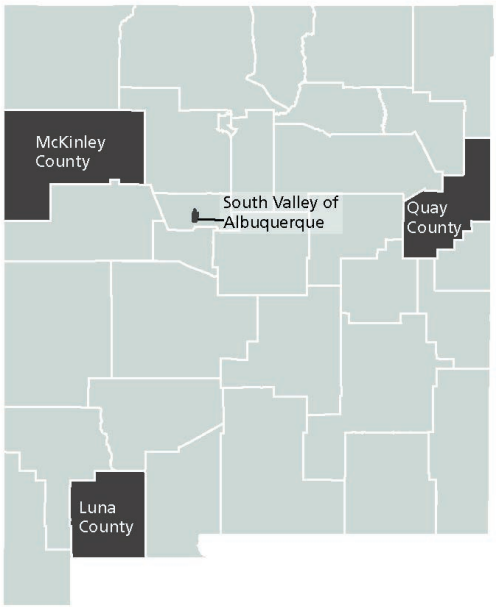
Table 1.2. Resources Used to Deliver Project Capacity-Building Intervention

Resource Category	Quantity
CYFD administration of grant (includes time of manager, Federal Home Visiting program)	Half time of manager
RAND GTO consultation	One-quarter time of senior GTO staff member, plus 10 percent time for research assistant and 10 percent time for second staff member familiar with home visiting
Subcontract to local GTO facilitator	Full-time project associate, an average of half time of senior associate, a quarter of additional staff person, $1,000 monthly stipends for local community organizer to coordinate coalition meetings in each site, travel costs and other direct costs, such as facilities and supplies
Subcontract to CDD UNM for provision of professional development and technical assistance, some via distance learning approach	Half-time TA provider, partial time of senior manager, travel costs, and other direct costs

Site Descriptions

We now describe the HVCDG sites, including the "State" as a fifth site (Figure 1.4). New Mexico is the fifth largest state geographically, yet has only two million residents. Half of the state's residents live in Albuquerque; for many of the rest, services such as medical care or preschool are a very long drive away.

Figure 1.4. Map of New Mexico and Sites Participating in the HVCDG



Quay County

Both the state home visiting needs assessment and the investment zone needs assessment rank Quay County as the highest-need county in the state. It routinely ranks among the top three counties in the state for infant mortality, child abuse rates, domestic violence rates, and school dropout rates. Quay is a sparsely populated county whose population peaked a century ago and whose primary industry is agriculture. Most residents live in Tucumcari, where there is a regional hospital. Tucumcari is about two hours from Amarillo, Texas, the nearest city. Table 1.3 summarizes some demographic characteristics of the county and other evaluation sites.

Luna County

Luna County is generally second to Quay County in needs assessment rankings. It typically posts the highest unemployment rate in the state, and is generally in the top two counties for teen births and poverty rates. Deming, its county seat, is home to a small hospital and is located about an hour's drive from Las Cruces, N.M., and an hour and a half's drive to El Paso, Texas. A home visiting program supported by a health center in Las Cruces served about 35 families in the county, but had lost funding and ceased operations by the time this project commenced.

Table 1.3. Site Characteristics

Characteristic	Quay County	Luna County	McKinley County	South Valley	Statewide
Population (est. 2013)	8,662	24,659	73,308	~33,000	2,085,287
Population density per square mile	3.2	8.5	13.1	n/a	17.0
2012 births	120	419	1,239	n/a	26,992
Original service goal (additional families)	40	40	60	60	n/a

NOTE: Population and population density for counties and state from U.S. Census Bureau, undated; 2011 births from New Mexico Department of Health, 2012.
n/a = not available.

McKinley County

In contrast to the rest of the state, which is predominantly Hispanic and white, McKinley County is about three-quarters Native American and home to a large Navajo community. McKinley County tops New Mexico counties in preterm births and infant deaths, and is usually first in the state in alcohol-related auto accidents and other alcohol problems. About two-thirds of county residents live in Gallup, where there is a regional hospital and an Indian Health Services hospital. Gallup, a two-hour drive from Albuquerque, is home to one of the two home visiting programs supported by the state's formula MIECHV funding. Gallup-McKinley County Schools was funded to

deliver Parents as Teachers to 80 families at the beginning of this project. There are also eight Bureau of Indian Education schools in the county delivering Family and Child Education, a variant of Parents as Teachers adapted for tribal populations, to roughly 200 children (Bell et al., 2013). The county is also the site of a new First Born Program, described earlier, that is funded to serve 120 families at a time.

South Valley

The "South Valley" of Albuquerque is a vaguely defined set of neighborhoods in the southern part of the Albuquerque metro area. Various projects aiming to serve the "South Valley" have at various times used census tracks, ZIP codes, school catchment areas, or other boundaries to establish eligibility for South Valley residents. The proposal projected that about 33,000 individuals live in this area. This neighborhood includes several predominantly immigrant communities, as well as longtime Hispanic residents. Education levels here are among the lowest in the state, as are levels of prenatal care. There are not reliable estimates of the numbers of babies born to residents of this area, but it includes the highest concentration of births in Bernalillo County, which had 8,385 births in 2011. The original proposal for this project anticipated serving an additional 60 families with home visiting as part of the project. A 2011 analysis of home visiting in the county (Varela and Licht, 2011) found approximately 720 funded home visiting slots in the county at that time, including an NFP site to serve 50 families in the South Valley. The St. Joseph's Community Health First Born site also prioritizes residents in the South Valley. A Bernalillo County Home Visiting Network has been convening stakeholders and engaging in strategic planning related to home visiting for the county. One of its accomplishments has been the development of a common intake and referral form for ten of the programs operating in the county.

State-Level Work

As discussed earlier, CYFD stated that state-level capacity development replaced Grant County as the fifth "site" when the project commenced. However, the original proposal included state-level work as part of the plan. For example, the proposal included the following tasks: establish state work group, facilitate dialogue about fiscal leveraging and integration, and create a catalog of available resources and funding/service definitions. We have described the role of CYFD extensively, but other state departments also undertake related early childhood activities. For example, the State Department of Health operates the early intervention home visiting services for therapeutic treatment of children with diagnosed disabilities or developmental delays. The project goal of enhancing the continuum of early childhood services that support home visiting, and the short-term outcome of developing a state-level plan that improved home visiting infrastructure and supports (see logic model in Figure 2.1, as discussed in the next chapter), clearly require that CYFD collaborate with the Department of Health, and potentially other state departments, such as the Public

Education Department. Also relevant to the state work is the "Home Visiting Accountability Act," which the state legislature passed in 2013 and requires CYFD to establish data collection standards for home visiting and to report data to the legislature and the public regarding the state's home visiting inputs and outcomes. In 2014, CYFD will develop procedures for adhering with the requirements (New Mexico Department of Health, 2012) of this act.

Outline of This Report

Chapter Two provides details on the evaluation methods. Chapter Three presents the findings of the evaluation, and Chapter Four offers conclusions and policy recommendations. The appendixes include detailed data for each county, forms we used for the evaluation, and other supporting material.

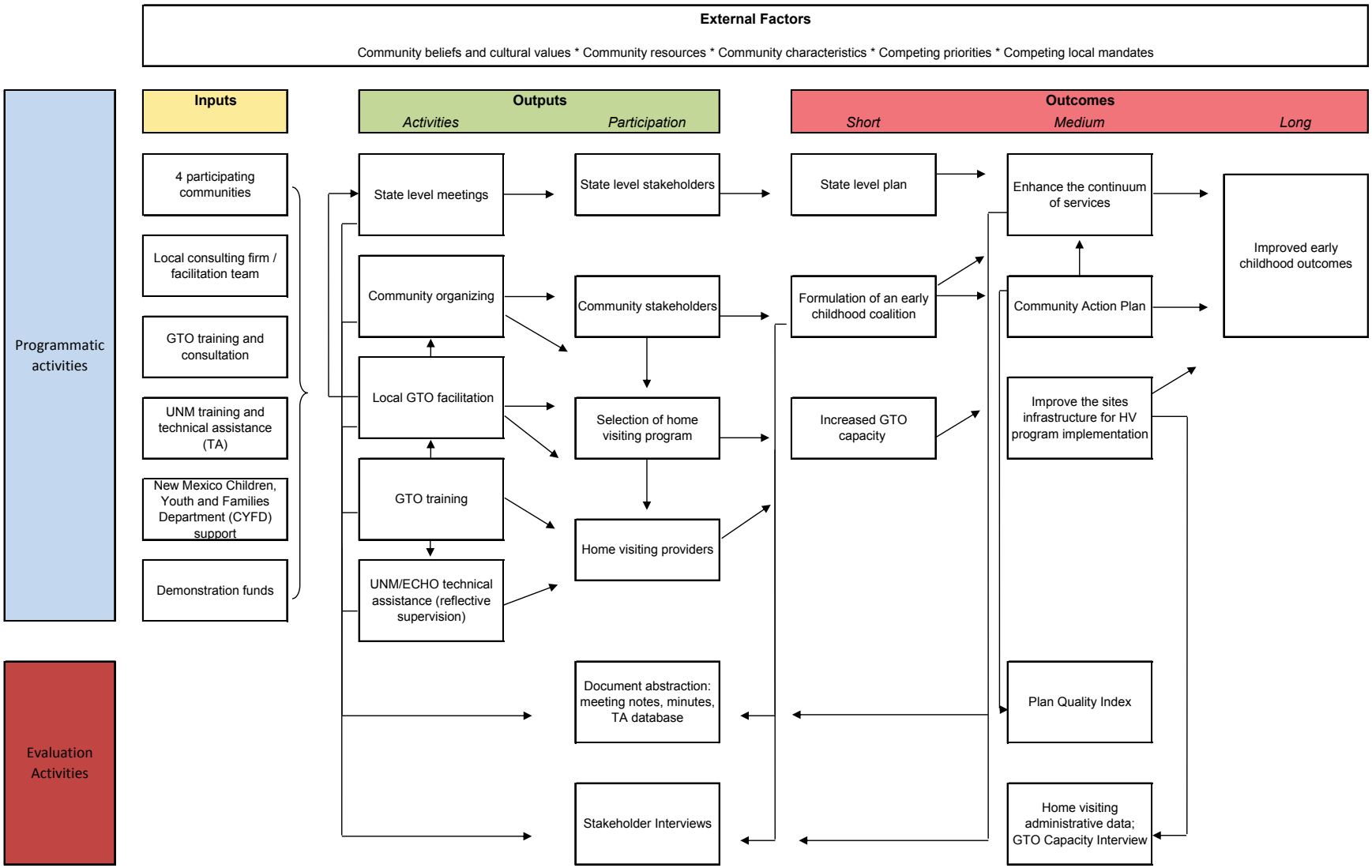
2. Methods

This project sought to deliver GTO/ECHO supports that improve community capacity *under the theory that it would lead to improved family outcomes*. Figure 2.1 is a logic model showing the inputs into the HVCDG that include the participating communities, the state-contracted GTO facilitation team, GTO training and consultation from RAND, CDD UNM T/TA services, CYFD support, and project funding to support direct services along with the associated evaluation activities.

Both activities and participation were considered important outputs, and took place at multiple levels, including the state, local communities, individual organizations, and home visiting providers. Activities (and corresponding participation) included state-level meetings (with state-level stakeholders), community organizing (community stakeholders), GTO training and facilitation (intended to aid in the selection of an evidence-based home visiting program and build capacity among home visiting providers), and TA on carrying out home visiting services (intended to build capacity for home visiting service delivery). After the sites selected and installed home visiting programs, the programs themselves were considered important contributors to achieving the outcomes. The HVCDG activities were expected to generate three short-term outcomes, as shown in the logic model:

- develop a state-level plan that improved home visiting services
- form early childhood coalitions in the four selected communities
- increase individual and organizational capacity to implement home visiting successfully at the state and local levels through GTO training and utilization.

Figure 2.1. HVCDG Logic Model



These short-term outcomes in turn were to produce three medium-term outcomes: a community action plan developed by each site's coalition, an enhanced continuum of early childhood services and supports at the state and local levels, and improved infrastructure for delivering home visiting in the demonstration sites. The logic model stipulated that these activities and short- and medium-term outcomes would, in turn, improve outcomes for children in the state. The purpose of this evaluation is to assess whether the intervention implemented in New Mexico increased the capacity of participating communities and the state as a whole to reach three objectives:

1. help sites form effective early childhood coalitions
2. enhance the continuum of services the sites need to successfully support families
3. improve the infrastructure of the selected communities to deliver home visiting.

The HVCDG intended to use the GTO framework and ECHO distance-learning technology to achieve these objectives. Reflecting this purpose, RAND conducted a process evaluation to examine the use of the GTO and ECHO distance-learning approaches and the degree to which the project achieved the three stated objectives.

As shown in Table 2.1, we evaluated GTO and ECHO distance-learning utilization by reviewing documents from the GTO consultation team, the GTO facilitation team and the CDD UNM T/TA provider; tracked their facilitation and T/TA activities; and interviewed them about their work in each site. The document review provided information about the extent of GTO training and facilitation. We also posed questions about GTO and ECHO distance learning to stakeholders in each of the four communities to gather their perspectives on utilization.

To assess the formation of coalitions, we conducted a series of interviews with community stakeholders in each participating community about their coalition work. We also reviewed documents that these coalitions produced, and we rated the quality of their community action plans using a standardized instrument called the Plan Quality Index.

To assess the project's second objective, regarding the enhancement of the continuum of services to support families, we asked these same community stakeholders before the start of the intervention and again 18 months later about the continuum of services in their communities. We also conducted interviews with individuals who, because of their statewide role in early childhood services, answered questions about the range of early childhood programs and gaps in services from a statewide policy perspective.

To assess the sites' infrastructure for home visiting services, we collected data at the end of the evaluation period about the number of families served and the number of home visits conducted at the two sites with operational home visiting programs funded through this grant (Luna and Quay counties). We also rated, through a structured

interview, these two programs' capacity for performing key tasks important to the success of any human service program using the GTO Capacity Interview.

Where possible, the evaluation incorporated systematic methods to gather and synthesize information. We used or modified existing measurement tools and we had more than one rater independently document activities to reduce bias in the interpretation of the results. Whenever feasible, we also attempted to validate information by comparing across different stakeholders/participants and different data sources (e.g., meetings notes compared with stakeholder interviews compared with ratings of community action plans). For example, we collected information about GTO facilitation from the consultation team, the GTO facilitation team, and community stakeholders, and we collected information about community activities from both the GTO facilitation team and from several community stakeholders, so a variety of perspectives about the project and its implementation over time were used.

Research Questions and Corresponding Methods

Table 2.1 shows the four research questions we developed and corresponding methods.

Table 2.1. Overview of Research Questions and Methods

Research Questions	Measure/ Data Collection Tool	Sources	Data Collection Time Points
1. Did the four participating communities form early childhood coalitions and begin to implement requisite activities?	• Document abstraction (e.g., coalition meeting minutes) • Interviews with community stakeholders • Plan Quality Index • Kansas University community coalition building tool	• Coalition documents • Coalition members • Community action plans	Beginning of community organizing; Fall 2013
2. To what extent did the project utilize GTO and ECHO distance learning to support the work of the coalitions and home visiting programs?	• Document abstraction (e.g., coalition meeting minutes, ECHO T/TA database, GTO facilitation tracking log); • Interviews with community stakeholders, GTO consultation team and GTO facilitators, ECHO T/TA provider	• Coalitions, GTO facilitators, and ECHO T/TA provider • Coalition members, GTO consultation team and GTO facilitators, ECHO T/TA provider	Fall 2013
3. Did the participating communities enhance the continuum of services they need to support families?	• Document abstraction (e.g., GTO facilitation tracking log) • Interviews with community stakeholders, state-level stakeholders; GTO facilitators, ECHO T/TA provider • Continuum of services list	• GTO facilitators, and ECHO T/TA provider • Coalition members, GTO facilitators, ECHO T/TA provider, state level stakeholders	Beginning of community organizing; Fall 2013
4. Did the participating communities improve their infrastructure for home visiting services?	• Home visiting administrative data • GTO Capacity Interview	• Home visiting programs • Home visiting program leaders	Fall 2013

We provide an overview of the methods used to address each research question. This evaluation was reviewed and approved by RAND Human Subjects Protection Committee, which is responsible for ensuring the ethical treatment of individuals who are participants in RAND projects through observation, intervention, interaction or use of data about them.

Research Question 1. Did the four participating communities form early childhood coalitions and begin to implement requisite coalition activities?

Successful community coalitions typically progress through stages of development (Butterfoss, 2007; Butterfoss, Goodman, and Wandersman, 1993; Florin, Mitchell, and Stevenson, 1989;): formation, implementation, maintenance, and institutionalization. The first two stages describe the four community coalitions in the HVCDG.

The formation stage is characterized by receiving funding, hiring staff, forming committees, and training volunteers. The implementation stage involves forming more issue-specific subcommittees, conducting needs assessments to better understand the problem to be addressed in the community, and writing a comprehensive plan to address the identified needs. The maintenance and institutionalization stages occur when coalitions carry out their plans and document impacts.

For coalitions to succeed, they must progress through the formation and implementation stages, meaning they must complete the activities associated with that stage. During the evaluation period, we did not observe any site's progress beyond the implementation stage. Thus, the evaluation team focused on assessing those two stages. We collected data through meeting notes and minutes, interviews with key stakeholders in the communities, and an assessment of the community action plans of each site provided by the GTO facilitation team.

Meeting Notes and Minutes

The evaluation team reviewed community meeting documentation as provided by the facilitation team (as we will discuss further) to determine the number of meetings held in each community, the meeting content, and the number and diversity of participants. We monitored this information over time to determine the frequency of coalition meetings and to calculate participation rates by different community sectors regarding early childhood services. Collecting this data provided a picture of the effort put forth by each coalition, its membership, and its activities.

Community Stakeholder Interviews

We used resources from the Kansas University Work Group for Community Health and Development (Puddy, Fawcett, and Francisco, 2002) to develop an interview protocol with questions related to successful coalition building—e.g., "has your community: (a) examined early childhood outcomes; and (b) developed action plans to address community needs?" We selected the Kansas group's tool after we had reviewed

the literature on community coalitions and were unable to locate a measure that specifically assessed coalition building; that is, the phase in which a coalition is being formed. Most of the measures in the area of coalition effectiveness assumed that a coalition was already formed and therefore were inappropriate for our project needs. Our tool is innovative in that it assesses the formulation of the coalition, rather than solely focusing on its functioning, maintenance, and effectiveness, as prior instruments have done.

We conducted two sets of interviews, one in the first year of the project period to document the community activities regarding early childhood before the project, and one in late 2013 to document the coalition activities through the demonstration period. In each set, the evaluation team interviewed three to four community stakeholders at each participating site. For each coalition-building activity specified in the Kansas tool, we asked stakeholders if the community had, as part of a coalition or other planning group, engaged in any of the activities, either in the year before the HVCDG meetings began or since they were initiated (at the second interview). If participants noted that their community had completed the activity, we asked them to describe who completed it and how it was completed so that we could consider whether it had been accomplished as a result of this project or had been recently been conducted by another group.

These interviews followed a "key leader" approach, using certain community stakeholders as bellwethers of community services (e.g., Sosale et al., 1999). Key leaders are not chosen randomly, but purposely—based on their role or status that affords them specialized knowledge compared to other community members. They are chosen because they are considered knowledgeable about the issues being researched (Kumar, Stern, and Anderson, 1993). As such, we selected stakeholders to interview (with input from the CYFD and the GTO facilitation team) with the goal of involving relevant individuals from both health care and early education sectors that had already been identified in the community and were participating in the early coalition building activities. We also sought to interview the local community organizers hired by the GTO facilitation team in each community.

We conducted the interviews by phone, digitally recording them, and developed field notes that were confirmed by the lead interviewer. Two members of the evaluation team reviewed the digitally recorded sessions and field notes. Each member independently developed themes for open-ended responses related to coalition activities. The evaluation team members then shared their assessments with one another, discussed any discrepancies, and developed a written qualitative summary that described community stakeholder perceptions about coalition activities. We also synthesized responses from the community stakeholders at each site to document whether the coalitions performed certain activities specified in the Kansas University-based protocol. The evaluation team members corroborated the interview responses by reviewing meeting documents shared by the GTO facilitation team.

Community Action Plans

To objectively evaluate the quality of the plans produced by the four community coalitions in this project, we used the Plan Quality Index developed by Butterfoss, Goodman, et al. (1996). The Plan Quality Index uses planning criteria from several sources (Chavis et al., 1987; Florin Mitchell, and Stevenson, 1993; Franchak and Norton, 1984; Kroutil and Eng, 1989; Nelson, 1986; Steckler, Dawson, and Herndon, 1980), including input from evaluation and community planning experts. The measure is designed so that raters review planning documents and make ratings on the quality across a number of domains, or "components," that comprise a quality plan. Plan components include:

- the presence of a needs assessment
- clear, measurable, and logically linked goals, objectives (concrete statements of what will should change, in who, by when, and by how much), and activities
- clear specification of activity targets
- designation of responsibility for each task
- description of activity integration
- a specific timeline
- budget
- an evaluation plan

All the components of the Plan Quality Index evaluate activities prescribed by GTO (e.g., concrete objectives, workplan, evaluation plan). Thus, it is a good fit for the HVCDG. Nevertheless, we made some modifications to the component wording to make it more specific to the HVCDG. For example, the item, "Objectives and activities are logically related to statewide prevention priorities as reflected in a statewide plan or planning process" was replaced with, "Was the plan logically developed?" The ratings range from 0 (none of the plan component is adequate) to 5 (81–100 percent of the plan component is adequate). We averaged components to a total score, which is also interpreted using the same 0–5 scoring range. In a past project, in which two raters reviewed 16 community coalition plans, the Plan Quality Index was found to be reliable (interrater reliability = .73) and valid (Butterfoss, Goodman, et al., 1996). The Plan Quality Index is in Appendix B.

In fall 2013, the GTO facilitation team provided the evaluation team with community action plans for each of the four participating communities that summarized the community needs, goals, objectives, program activities, persons responsible for carrying out the activities, timelines, and outcomes to be achieved. Two evaluation team members independently reviewed and scored the plan documents for each site using the scoring rubric above.

Research Question 2. To what extent did the project utilize GTO and ECHO distance learning to support the work of the coalitions and home visiting programs?

GTO Utilization

GTO's framework contains three implementation supports: (1) written materials, (2) training, and (3) facilitation (often called technical assistance) provided to users to build capacity—or the knowledge and skills—among community practitioners to proceed through a series of tasks, or steps, associated with high quality programming. For GTO to have an impact—to build capacity—the three supports must be delivered and practitioners must progress through the GTO steps. In past GTO projects (e.g., Acosta et al., 2013), facilitators (those providing assistance directly to practitioners) received ongoing consultation during the project from GTO experts in order to ensure fidelity to the GTO approach. To examine fidelity to GTO, we collected and analyzed documents provided by the GTO facilitation and GTO consultation teams and interviewed the facilitation team members using a structured interview used in past GTO projects (Acosta et al., 2013).

GTO Document Abstraction

We asked the GTO facilitation team to complete a tracking log to document each instance of facilitation they conducted with the sites. The log has entries for the date of the activity, staff members involved, the relation of the activity to project objectives (i.e., coalition building, continuum of care, home visiting infrastructure), and a brief description of the activity.

We used the GTO Activity Monitoring Tool, developed as part of previous GTO research studies (Chinman et al., 2008) (see Appendix A), to code the facilitation team's activities. The coding guide divides each GTO step into several distinct subtasks. For example, Step 1 comprises seven subtasks, including an assessment of needs and resources for a selected target area. We documented the number, type, and timing of the GTO tasks.

The GTO facilitation team submitted the tracking log about once monthly to a secure website. The facilitation team also shared with the evaluation team all documents they produced during the project. These included:

- meeting agenda, attendance, and minutes
- handouts or other materials distributed during meetings
- community action plan documents
- needs assessment reports
- any other documents that were developed by the facilitation team as part of this project

The GTO facilitation team uploaded these materials to a secure website that both the facilitation and evaluation team accessed. The abstraction involved locating and reviewing these documents and tracking logs on the website.

Finally, we abstracted documents using the information shared by the GTO consultation team regarding training, consultation, and facilitation from May 2012 through September 2013. We reviewed emails sent between the GTO consultation and facilitation team along with meeting notes from the GTO consultation sessions to document the level of GTO training and consultation provided to the facilitation team.

Using the GTO Activity Monitoring Tool, two members of the evaluation team reviewed each entry in the facilitation team's tracking log and related submitted materials to determine which GTO steps were addressed with the four participating communities. The evaluation team also reviewed the GTO consultation emails and meeting notes to document the amount and type of GTO training and consultation provided during the project. We compared this information to the facilitation team's tracking log of GTO training and consultation to ensure information was consistent across participants.

GTO Facilitation Team Interview

RAND conducted a semistructured interview with the GTO facilitation team. The interview consisted of open-ended questions about the facilitation team's perceptions about incorporating GTO in their work with the four communities. More specifically, there were questions about

- the extent to which GTO was used (e.g., if the facilitation team used the GTO materials in the community meetings or conducted any GTO trainings)
- whether GTO was appropriate for this project
- the benefits and challenges to using GTO

The evaluation team conducted the semistructured interview with the GTO facilitation team in December 2013. We collected the interview data and analyzed it as previously described—i.e., two members of the evaluation team reviewed the digitally recorded sessions and field notes. Each member independently assessed the degree to which the GTO facilitation team reported using the GTO materials, provided any GTO training, and perceived benefits and challenges of using GTO. Evaluation team members then shared their assessments with one another, discussed any discrepancies, and developed a written qualitative summary that described GTO use reported by the facilitation team.

Community Stakeholder Interviews

The evaluation team conducted semistructured interviews by phone with community stakeholders in fall 2013. These second-year interviews asked two open-

ended questions about the community stakeholders' perceptions on how GTO was incorporated into the HVCDG in each of the four communities. More specifically, we asked three to four stakeholders in each community whether the framework was introduced by the GTO facilitation team, if there was any expectation of using GTO in their community planning work, whether they received any GTO training, and the extent to which they used and liked GTO. The data was collected and analyzed as previously described.

T/TA and ECHO Distance Learning Utilization

To assess the extent to which the HVCDG used ECHO distance learning to train program staff with the home visiting programs, we collected and analyzed data about T/TA provided by CDD UNM and interviewed the T/TA provider.

CDD UNM manages a database that captures the type and amount of T/TA support provided to home visiting programs across New Mexico. The database was developed prior to this project and is used by CDD UNM to monitor the T/TA it provides to state-funded home visiting services. For each T/TA session, the database records

- date of activity
- activity title or "headline," description, and type (e.g., capacity building)
- method (i.e., facilitation of a meeting, onsite activity, participation at a meeting, support by email/telephone, telehealth [i.e., use of distance technology as part of meeting])
- participating county and city
- duration (in hours); number of participants
- "emphasis" (coded "Education" or "other")

CDD UNM provided a copy of any entries into their database in relation to the home visiting initiatives in the four selected communities that took place during the evaluation period. The evaluation team reviewed the database entries to determine the amount and type of T/TA provided. We also examined whether the T/TA was provided onsite, by email/telephone, or using the proposed distance technology (i.e., telehealth) approach. We organized the entries by participating sites and evaluated the number of instances.

CDD UNM T/TA Interview

The evaluation team conducted the semistructured interview with the CDD UNM T/TA provider in November 2013, using a similar procedure as previously described. The semistructured interview consisted of open-ended questions about

- T/TA activities performed
- the time period these activities were performed
- the frequency of T/TA contacts

- whether ECHO distance communication strategies were implemented and what topics they covered with whom
- challenges providing T/TA to the participating sites
- the level of effort and resources expended on the T/TA efforts.

A member of the evaluation team reviewed the digitally recorded sessions and field notes and assessed responses to each of the qualitative questions regarding type of T/TA provided, as well as facilitators of and barriers to training. The reviewer created a spreadsheet that detailed the T/TA provided at each site, sorted by type as well as by reported facilitators and barriers. The reviewer then shared this worksheet with another member of the evaluation team who reviewed it and checked it for accuracy against abstracted information.

Research Question 3. Did the participating communities enhance the continuum of services they need to support families?

The CYFD believed that, in addition to home visiting programming, a variety of medical, educational, and recreational services (often called a "continuum") needed to be in place for children and families to thrive. Additionally, in order for home visiting programs to achieve some of their objectives, such as referring families to needed services or helping families meet basic needs, communities need resources that support these objectives. A key reason CYFD chose to add coalition development in the four communities, over and above the home visiting services, was that convening people with the expertise to identify gaps and develop appropriate strategies that were grounded in the local context would help enhance the continuum of services available to children and families—which, in turn, would facilitate the achievement of home visiting objectives. Therefore, the evaluation team assessed the continuum services to support families and its changes over time, by conducting interviewers with key stakeholders in each of the four participating sites (see Appendix C for the continuum).

Community Stakeholder Interviews

We asked questions about the continuum of services to the same community stakeholders previously described. We interviewed in the first year of the project and again in late 2013 to detect changes over time. In the first interview, we asked community stakeholders about the presence of a variety of services in each community, perceptions of access to these services for families, engagement of continuum service providers in the early childhood coalition, and plans to address barriers or gaps in access to these services. In the second interviews, we asked stakeholders whether there were any changes in the continuum of services since project inception and if any of those changes could be attributable to HVCDG. The evaluation team formulated the 'continuum' of these services based on guidelines from several home visiting programs (i.e., NFP, PAT, First Born Program), New Mexico state documentation (CYFD, 2011),

with input from the state project officer and GTO facilitation team during the first quarter of the HVCDG (see Appendix C).

Responses from the community stakeholders at each site were synthesized to assess whether there was agreement on the presence of services and how well they served families in the community. Two members of the evaluation team independently assessed the degree to which the responses showed that the community group had services present.

State-Level Stakeholder Interviews

Using the similar key leader approach as previously described, we conducted interviews with three stakeholders who represented different community sectors and were familiar with state-level policies related to early childhood, in order to examine whether changes at the state level had occurred as a result of this project. The team also asked the same questions of three community stakeholders with awareness of state activities. Given the small number of interviews conducted and the need to protect their confidentiality, we are unable to provide more details about the stakeholder roles and responsibilities.

The semistructured interview protocol assessed changes in stakeholder knowledge and awareness since the project was launched of the full range of early childhood services that are available and asked about where the gaps lie. The interview also consisted of open-ended questions about the stakeholder perception about state-level fiscal leveraging, cross-agency integration, and any progress as the result of this project. We used a retrospective pre-post approach (Moore and Tananis, 2009) for interview questions that examined changes over time in knowledge or awareness of early childhood services. This approach is commonly used for assessing changes in knowledge or awareness over a short period of time during which a response-shift bias is likely to occur—i.e., when a respondent is likely to overestimate an effect at baseline compared to a more accurate rating made after intervention, potentially masking a true pre-post intervention effect (Aiken and West, 1990). We conducted these interviews in late 2013 and analyzed them in a similar manner as previously described.

Meeting Notes and Minutes

The evaluation team reviewed the GTO facilitation team's activity tracking log that documented each instance of state-level meeting activity and all materials provided for any state-level meetings to determine the number of meetings held at the state level (not including meetings solely related to communicating project activities to CYFD), who the facilitation team met with, and the general meeting topic.

Research Question 4. Did the participating communities improve their infrastructure for home visiting services?

Home visiting infrastructure is defined in this HVCDG as the degree to which programs are able carry out the many tasks known to be associated with effective programs as prescribed by the GTO framework (Livet and Wandersman, 2005). Thus, this research question assessed the degree to which these programs had carried out these tasks. Although not explicitly "infrastructure," we also collected data on the amount of home visiting services provided as an indicator of how well these communities established a viable home visiting program. To address this research question, we intended to conduct structured interviews with the project-related home visiting program staff in all the participating communities. GTO facilitation-team meeting notes, however, showed that only two communities had begun home visiting services during the evaluation period (at least by fall 2013). We also received data directly from the CDD UNM T/TA provider about home visiting program activity.

Home Visiting Administrative Data

In Luna and Quay counties (which had launched programs within the first two years of the HVCDG), the CDD UNM T/TA facilitator gave the evaluation team data on home visiting services through November 2013, including the number of home visitors hired; families served; home visits made; and current families enrolled. We compared these data with the initial target enrollments.

Home Visiting Program Staff Interviews

We interviewed key home visiting program staff in Luna and Quay counties, the two communities that had initiated a project-related program. The interview protocol (i.e., "GTO Capacity Interview") was designed to assess staff's capacity in performing GTO tasks essential to these programs and services. This instrument assesses infrastructure because it documents the extent to which the program staff carry out key program activities and thus is an indicator of capacity demonstrated by those staff. The protocol had been developed and used in previous GTO research and was adapted for home visiting for this project. The interview asks detailed questions about the actions taken by all staff in the program in the areas of the ten GTO steps. We made ratings at the program level because programs operate as a unit. The GTO Capacity Interview has a rating for each of the ten steps of the GTO model, averaging to a total score. Each step is assigned one of seven possible ratings, described with specific behaviors, ranging from "highly faithful" (=7) to "highly divergent" (=1) from ideal program practice. For example, the highest rating for Step 6 (Planning) is, "Use planning tool to make links from goals and objectives and to implementation and ongoing management and monitoring." The lowest rating is, "Regularly does activities that were not planned and have questionable relationship to the goals and objectives." In a prior GTO project

(Chinman, Hunter, et al., 2008), the total score was found to be sensitive to change and the average interrater reliability across the elements was .74 (reliability ranged from .65–.96 across 14 elements).

A senior field RAND interviewer previously trained in the implementation and scoring of responses from the GTO capacity interview protocol, conducted the interviews by phone in January and February 2014, digitally recording them and creating field notes. The interviewer then rated each program on its capacity for GTO components. The evaluation team also reviewed the program responses about use of distance learning and T/TA received.

3. Findings

Research Question 1: Did the four participating communities form early childhood coalitions and begin to implement requisite coalition activities?

Each community undertook activities related to the formation and implementation of a coalition centered on early childhood issues. Details about coalition development and activities in each of the four communities from April 2012 through November 15, 2013, are available in Appendixes D through G. While the coalitions were positively received in their communities, their progress varied across sites, as did the quality of their plans. Future viability of the coalitions was uncertain due to the anticipated lack of continued funding and staff to support their work after the HVCDG ends.

Coalition Planning Activities

New Mexico required each site to establish a coalition, and required each coalition to develop a plan for implementing early childhood services that would supplement the newly started home visiting programs. However, the State did not establish any other benchmarks for the coalitions to meet regarding any other aspect of their work. For example, the State did not ask the coalitions to turn in their plans or require any other deliverable. Table 3.1 displays a matrix of coalition activities organized by the four communities in relation to the Kansas University-based interview protocol we used. For ease of reporting, we assigned a green, yellow, or red color code to each activity by site. Green cells denote that our documentation review (i.e., interviews, meeting materials) consistently showed the presence of the activity. Yellow cells denote that there was some indication the activity was present, but it was inconsistent or unclear by review of the project documentation. Red cells denote that the documentation consistently showed the communities did not yet engage in specific activities through the HVCDG.

As Table 3.1 shows, each community site undertook the majority of steps to examine their community's current needs and resources. For the later stages of planning activities, though, three communities did not take steps to refine and revise their action plans during the evaluation timeframe. The Luna County coalition did make changes to its Community Action Plan based on progress and feedback from stakeholders. Although Quay, Luna, and McKinley counties undertook most of the steps, Quay and Luna counties did not involve key cultural and ethnic groups in planning and McKinley County did not involve key community officials. South Valley did not involve key cultural and ethnic groups or key sector representatives and never held regular meetings. None of the sites developed a vision or mission statement in initial planning. Quay, Luna, and McKinley counties did all of the other initial and advanced planning steps but South Valley did not begin any. Most of the activities conducted in South

Valley were carried out by one organization, calling into question whether there was a coalition present there. Additional planning activity details are in Appendices D–G.

Table 3.1. Community Planning Activities Conducted May 2012 through November 2013

Activity	Quay County	Luna County	McKinley County	South Valley
A. Examined community's current needs and resources				
1. Listened to community: talked one-on-one, or used public forums or focus groups to record info on: the problem or goal, barriers and resistance to addressing the concern, resources for change, recommended alternatives and solutions				
2. Examined early childhood outcomes in community (e.g., preterm births, low birth weights, school readiness)				
3. Identified a potential target population from within the target area to target a home visiting program (e.g., adolescent mothers, mothers below poverty line, families without health insurance)				
4. Compiled baseline data for the target population and a comparison population (if available)				
5. Articulated the causes and underlying risk factors within your target area showing the factors most likely contributing to poor early childhood outcomes (e.g., lack of a prenatal care)				
6. Documented existing programs and resources for promoting child wellbeing				
7. Determined how many children and families existing programs are serving				
8. Determined whether services/programs are meeting community needs; addressed ways services can be more effective				
9. Assessed whether there are current efforts already underway to promote child wellbeing; if so, determined who was involved and how effective the effort was				
10. Determined if there were past initiatives and why and how the efforts ended				
B. Community capacity-building planning group formed				
11. Contact with key community officials to participate in planning group				
12. Contact with key community grassroots leaders to participate in planning group				
13. Contact with key sector representatives (health, education, law enforcement, labor) to participate in planning group				
14. Contact with key ethnic/cultural groups to participate in planning group				
15. Formulated a plan for working together				
16. Formed planning group that consists of diverse group community stakeholders—held first meeting				
17. Regular meetings (monthly) with key planning group				

Table 3.1—Cont.

Activity	Quay County	Luna County	McKinley County	South Valley
C. Initial and advanced planning				
18. Developed a community vision statement				
19. Developed a mission for the coalition				
20. Developed specific measurable results for coalition initiative (could be key behavioral outcomes, related community-level outcomes or key aspects of the process), have specified levels of change and dates of when they will occur				
21. Developed objectives for promoting child well-being				
22. Developed strategies to achieve objectives and results				
23. Developed community action plans that describe how strategies will be implemented to attain objectives (what actions will be taken by whom, and by what time, plus resources needed and available, potential barriers and communication plan)—documented (written)				
24. Identified target populations for change (all children or high-risk children)				
25. Identified agents of change (who will be in position to contribute to solution)				
26. Identified community sectors to be involved in action (e.g., health, religious, government, education, business, media)				
D. Action planning				
27. Linked change objectives to community sectors (i.e., identified which sectors will be involved in addressing which objectives)				
28. Modeled link between behavioral change and improved outcomes from planned changes				
29. Identified major action steps for each change (what will occur, in what quantity, by whom and by when; including resources and barriers and communication plan)				
E. Refining and revising community action plan				
30. Monitored and documented progress on community or systems change efforts by group to see if community action plan is working or needs to be revised				
31. Reviewed and made changes in community action plan based on progress to date and feedback from stakeholders				
32. Celebrated successes				
33. Made efforts to maintain successes (sustainability planning)				

SOURCE: Puddy, Fawcett, Francisco (2002), coalition meeting documentation, and interviews with community stakeholders.
NOTES: green = group engaged in activity; yellow = unclear from available information if group engaged in activity; red = group did not engage in activity.

Quality of Community Action Plans

The community action plans reviewed by the evaluation team were submitted by the GTO facilitation team in fall 2013. Table 3.2 shows the ratings for each of the communities on the different action plan components. Component 2 was not able to be rated because the goals were specified *a priori* by the larger CYFD state goals for early childhood, thus it was not able to be derived from desired outcomes as prescribed by

the Plan Quality Index. Ratings are made on a scale from 0–5, with 5 indicating the best quality. Overall, the ratings suggest the four coalitions' plans were of moderate to low quality. Luna and Quay counties had stronger plans (average of 3.0), while the plans from South Valley and McKinley County were less developed. Interrater reliability across all 56 Plan Quality Index ratings was .90, which is high. To complement the plan ratings, we describe in Appendixes D through G the strengths and challenges of each site's plan.

Table 3.2. Community Action Plan Quality Consensus Ratings

	Ratings by Community			
Plan Component	**Quay**	**Luna**	**McKinley**	**South Valley**
1. Needs assessment is comprehensive.	3	3	3	2
2. Goal(s) adequately reflect desired outcomes to problems/needs identified in needs assessment.	Not applicable			
3. At least one relevant objective is stated for each goal.	4	5	4	4
4. Specific, feasible activities are provided for each objective.	2	2	1	0
5. The plan is logically developed (i.e., priorities identified in needs assessment lead to goals, which lead to objectives, which lead to activities, which lead to resource requirements).	5	4	4	4
6. Activities are measurable, so as to facilitate evaluation.	3	3	2	3
7. Are specific priority populations identified for each activity?	5	5	4	4
8. A timeline is provided for each activity.	1	3	1	0
9. The agency/group/individual who will coordinate each activity is identified.	5	5	4	5
10. Sources of coordination/collaboration among community agencies and groups are identified.	5	5	4	5
11. New preventive activities are coordinated with existing community programs/activities	5	5	4	5
12. The combined activities form a comprehensive, multilevel community-wide intervention.	4	3	3	2
13. A budget that outlines sources of funding and expenses for activities is provided.	0	0	0	0
14. The plan is feasible given the human resources and budget.	0	0	0	0
15. The evaluation plan is clear and comprehensive.	0	2	0	0
Total Score, Average	**3.0**	**3.2**	**2.4**	**2.4**

SOURCE: Authors' calculations using adapted Plan Quality Index (Butterfoss, Goodman, and Wandersman, 1995; Butterfoss, 1996).
NOTES: Scoring: 0 = None of the component is adequate; 1 = Approximately less than 20 percent of the component is adequate; 2 = Approximately 20–40 percent of the component is adequate; 3 = Approximately 41–60 percent of the component is adequate; 4 = Approximately 61–80 percent of the component is adequate; 5 = Approximately 81–100 percent of the component is adequate.

As shown in Table 3.2, there is some variation across plans, but they share many similarities. All the plans present a logical framework in which strategies and activities address specified goals and objectives, which were developed logically from collected

needs assessment data. Target populations, persons responsible for the strategies, and anticipated community collaborators are generally specified. However, all the plans represent an early stage of planning as many key details are not in place. Luna and Quay counties have more details specified, and in some instances have already started implementing some activities, but most plans do not have key parts, such as timelines, budgets, and evaluation plans. In several cases, the strategies in the plans are stated intentions to carry out a certain program. All areas in the planning documents (target audience, lead organization/person, collaborative partners, role of partners, benchmarks/dates, and outcomes) need more detail. Although these documents could be used in communities to generate discussions, more details will be needed to move the intentions specified into actual services and programs.

Summary of Early Childhood Coalition Efforts

Overall, the coalitions formed in the communities were positively received by most community stakeholders. While the groups made varying levels of progress in terms of coalition activities, the majority of stakeholders found some value in the work. Most often, stakeholders expressed appreciation that the work brought together diverse groups of stakeholders and raised awareness in the communities about early childhood issues. All community stakeholders expressed a desire to continue the work, and in the case of some communities, stated plans to continue. However, stakeholders across the communities noted that a lack of funding or other resources could undermine their coalitions' sustainability.

Quay, Luna, and McKinley counties had preexisting health councils that provided a venue from which the GTO facilitation team could establish a coalition focused on early childhood. Additionally, in McKinley County, a preexisting early childhood group served as a venue to reach stakeholders and to discuss the HVCDG-relevant issues. In South Valley, a similar collaboration with a health council was not established.

The data from the Tables 3.1 and 3.2 highlight the differences between whether key coalition activities were conducted at all, and whether these activities then resulted in a high-quality plan, which is a key midstream product for community coalitions. Table 3.1 shows that each coalition undertook a number of community planning activities, especially in the earlier stages. Yet the quality of the community action plan component related to these activities, as noted in Table 3.2, varied widely. For example, though stakeholders stated that each coalition undertook most of the steps in identifying needs and resources, the needs assessments in the community action plans were rated as moderate to low quality, because in many cases they did not contain any data, or they contained data that were not tied to specific objectives. In another case, Table 3.1 shows that only Luna County made changes to its action plan based on data and feedback, suggesting that it conducted some evaluation activities. However, Table 3.2 notes that the quality of its evaluation plan was rated as a 2 because of its lack of specificity. In sum, although coalitions conducted many activities (established by stakeholder reports

or documents), it does not guarantee that those activities were conducted in a high-quality manner, as reflected by the community action plan ratings.

Research Question 2: To what extent did the project utilize GTO and ECHO distance learning to support the work of the coalitions and home visiting programs?

A key part of "utilizing GTO" is the degree to which those charged with facilitating its use among community practitioners receive training and consultation themselves. Therefore, we first describe the GTO training and consultation that RAND provided. Then we describe the GTO facilitation team's use of GTO. We follow with an examination of the use of ECHO distance learning among home visiting programs.

GTO Training

The consultation team provided two onsite GTO trainings during the project. The first training was provided in May 2012 to four members of the GTO facilitation team and the state project officer. At the training, the participants were provided with extensive materials including past GTO manuals, brief GTO overviews, and worksheets for use in GTO facilitation. The second training was provided in January 2013 to five staff members of CDD UNM, one member of the facilitation team, and the state project officer. The attendees received similar materials as provided in the first training and a draft of the GTO for Home Visiting manual (The manual was still in preparation at that time and therefore not formally ready for public distribution). To facilitate learning, RAND sent "read-ahead" documents prior to the trainings including GTO journal articles that described how GTO had been used in previous projects, including consultation and community trainings.

GTO Consultation

Previous research shows that one-day trainings are not sufficient for achieving adequate fidelity for complex interventions such as GTO, and ongoing consultation is needed (Cividin and Ottoson, 1997; Ottoson, 1997). Therefore, the GTO framework includes ongoing consultation between newly trained GTO facilitators and the RAND GTO team to ensure adequate support and fidelity to the GTO approach consistent with other implementation support models (Henggeler et al., 2008; Miller et al., 2004). Previous uses of GTO have used a weekly consultation meeting between the RAND GTO team and local GTO facilitation team (Chinman, Acosta, et al., 2012). This consultation has typically been by phone as the GTO consultants and facilitators have been in different locations.

RAND provided GTO consultation to the GTO facilitation team fairly consistently throughout the project period through monthly conference calls and two in-person

onsite visits, although this was at a lower level than is typical for GTO projects, because the GTO facilitation team did not believe greater contact was needed. During these calls, the consultant provided guidance on how to use GTO with the coalitions. In between calls, the GTO consultant provided resources to help guide and support GTO use and capacity building. The consultant also provided detailed feedback on tools that the GTO facilitation team created, on goals and objectives that the GTO facilitation team developed with the coalitions, and early drafts of the community action plans. The consultant gave to the GTO facilitation team several of the existing GTO manuals accompanied by guidance on using them to support the community activities. Moreover, the assessment tools around the three project objectives (i.e., coalition building guide, continuum of care, assessment of home visiting infrastructure capacity) were shared early to help guide the facilitation activities.

Summary: GTO Training and Consultation

The training and consultation was inconsistent in several ways with GTO fidelity, the guidance of the GTO consultants, and previous GTO projects (for a detailed explanation of GTO supports, see Chinman, Acosta, et al., 2012). First, past trainings have typically lasted six to eight hours, while the initial training for this project was less than half that. Second, other GTO projects have had more frequent consultation meetings (i.e., weekly rather than monthly). Third, previous GTO projects have benefited from having the facilitators share proposed meeting agendas and other materials they develop to work with the communities in advance of the community meetings, but the GTO facilitation team did not share meeting agendas and other materials for this project in advance with the GTO consultation team nor with individuals invited to the community meetings. Fourth, in all other GTO projects, the GTO facilitators had a contract from RAND, while in this project the GTO facilitation team had a contract from the State of New Mexico. When RAND employs the GTO facilitators, it has line authority to ask for improvements if the adherence to GTO fidelity is low. In this case, RAND could only suggest changes and report to the State on the low level of GTO fidelity. However, the State did not ask the GTO facilitation team to make any changes in how they were implementing GTO and thus did not hold them accountable for maintaining fidelity to the GTO framework.

GTO Facilitation

Program documents and interviews suggest that the facilitation team did not fully implement GTO in the participating sites. Data from the GTO Monitoring Tool shows that the coalition in Luna County addressed 42 percent of the subtasks across all ten GTO steps. Quay County addressed 28 percent, McKinley County addressed 32 percent, and South Valley address 12 percent. In particular, based on the GTO facilitation meeting documentation, elements of GTO Step 1 (needs and resource assessments) were addressed, in part, in the four participating communities. In the community meetings,

the coalitions discussed the selection of a home visiting program and provider, as well as fiscal agencies to deliver it, that incorporated some elements from GTO Steps 3 (choosing evidence based programs), 4 (determining fit of new programs) and 5 (ensuring sufficient capacity to adopt a new program). Two documents finalized in mid- to late 2013 from Luna, Quay and McKinley counties demonstrated incorporation of elements of Step 2 (developing community goals and objectives) and the community action plans that were submitted near the end of the evaluation period demonstrated some elements of GTO Step 6 (planning). South Valley completed the goals and objectives documentation (GTO Step 2), but not the more detailed parts of the community action plans. In Luna and Quay counties (where home visiting programs had been initiated during the project period) and McKinley County (where programs already existed), there was discussion in the last two meetings about some process evaluation elements (i.e., number of referrals, services delivered), as specified in GTO Step 7. There was little evidence that the communities significantly engaged in the other activities related to outcome evaluation (GTO Step 8), quality improvement (GTO Step 9), or planning for sustainability (GTO Step 10) during the project period. Moreover, none of ten steps were addressed comprehensively as specified in the GTO approach (i.e., completing all elements of a GTO Step).

Data from the interviews show that the GTO facilitation team presented the concept of the GTO framework to the Luna and Quay County coalitions during early meetings to guide their work. However, it is not clear whether the GTO facilitation team presented the GTO framework in McKinley County and it appears they did not mention it to the South Valley coalition. The GTO facilitation team reported it did not offer any training in GTO, explaining that providing a formal GTO training was "too complicated." The GTO facilitation team also reported that the GTO approach was not used "in an intentional manner" with the coalitions throughout the project period. Similarly, when asked about GTO's use in planning broadly, community stakeholders defined it narrowly as working on goals and objectives (GTO Step 2).

Use of ECHO Distance Learning Activities

In general, the activities of the CDD UNM T/TA provider are consistent with the ECHO model in that the T/TA provider used a combination of onsite meetings and distance communications meetings to help train home visiting program staff in Luna and Quay counties (the two sites that started home visiting during the evaluation timeframe) and provided TA to improve the delivery of their home visiting services. Also, the specific T/TA activities—a mix of didactic training, case consultations, and general Q&A driven by home visiting staff—appear to match what has been done in past ECHO projects. For example, T/TA activities focused on completing an Infrastructure Needs Assessment to identify program strengths and gaps in policies and procedures, providing reflective supervision, and offering training and assistance on multiple topics ranging from staff hiring to use of screening tools. Finally, the level of

contact between the T/TA provider and the two home visiting programs was close to the weekly contact prescribed by the ECHO model. In Luna, the average contact was about three and a half times per month and in Quay, it was three times per month during the evaluation timeframe. The T/TA provider attended regular community meetings in each site and communicated with sites via email and telephone in between in-person or distance technology meetings.

The T/TA provider reported that it considers good practice to begin with in-person meetings for relationship-building purposes. This means being willing and able to travel to remote parts of the state, then progressing to the use of distance technology for meetings after ensuring that program staff are comfortable, the technology can meet confidentiality requirements, and the communities have adequate technology support. This represents a small adaptation, as ECHO projects have started the weekly distance learning portion of the approach immediately after initial face to face training.

Generally, the two communities using distance technology adapted to it well, according to the T/TA provider. Some issues with rural connections and privacy concerns were noted; a move to use ZOOM technology (high-definition, distance-meeting software that requires a license) is anticipated to address several of these. It appears that the T/TA provider was instrumental in troubleshooting issues and tailoring the type of technology used to fit community capacity. Being onsite in the community periodically seems to help the T/TA provider understand the community context and how it might affect the T/TA needed. Moreover, the provider seems to have expertise and national recognition in this area, as evidenced by presenting in a national webinar on using distance learning to support home visiting. Finally, the provider has been contracted to develop a Distance Technology Manual for the sites with which she works, which would provide guidance and simple instructions about the use of distance communication formats for T/TA delivery. The manual was in development as of November 15, 2013.

The T/TA provider did not carry out this work in McKinley County and South Valley in this evaluation's timeframe because those sites had not yet started delivering services. Additional details for each site are provided in Appendixes D through G.

Research Question 3: Did the participating communities enhance the continuum of services they need to support families?

In interviews, community stakeholders reported no improvement in the continuum of services. In general, each community reported some services in

- health and medical services, such as local hospitals, early intervention, or mental health providers
- early care and education, such as child care

- parent supports and services, such as parenting classes or adult education providers
- basic needs services, such as Women, Infants, and Children (WIC), food bank, or housing programs
- family safety and legal services, such as domestic violence shelter or juvenile justice organizations

Appendixes D through G present further details of stakeholders' perceptions in each community regarding services that are available and lacking, how well services address the needs of families in their communities, and the steps needed to address service gaps in the future. We discuss the GTO facilitation team's efforts to engage state-level stakeholders in discussions on enhancing service systems.

State-Level Efforts

During this evaluation's timeframe, the GTO facilitators held few state-level discussions. State-level stakeholders interviewed about this work stated that no improvements in the overall system of services were attributable to the HVCDG. We describe the activities of the GTO facilitator as reported in their documentation and through an interview. We also present perceptions of state-level stakeholders who were interviewed about HVCDG activities.

Facilitation Team Meetings with State Stakeholders

Part of the GTO facilitation team's responsibility was to assemble and support a state-level workgroup focusing on fiscal leveraging and integration for family services. The GTO facilitation team convened a single meeting of a state-level workgroup in October 2012. In that meeting, the GTO facilitation team provided an overview of their activities and the GTO process; reviewed data on early childhood risk factors, needs, and resources in the four communities; and reviewed logic model frameworks and the role of home visiting programs. Thirteen persons attended, representing the Brindle Foundation, CYFD (three attendees), Department of Health Family Infant Toddler Program (two attendees), the local GTO facilitation team (three attendees), the Los Alamos National Laboratory Foundation First Born Program, RAND and CDD UNM (two attendees). The GTO facilitation team sought but could not find an opportunity for a representative from the Department of Human Services to participate.

The GTO facilitation team did not convene the workgroup again during the evaluation time period. Participants did intend to have follow-up workgroup meetings and expressed appreciation for learning about the HVCDG and interest in continuing the advisory work with additional stakeholder partners included. Although this meeting focused on information-sharing about the HVCDG, respondents suggested they would have liked future meetings to include opportunities for input and discussions of how home visiting implementation affects strategies to address the

identified community needs. It is unclear why the GTO facilitation team did not hold further meetings. Interview responses suggest that CYFD staff told the GTO facilitator that further meetings of this type would not be productive at that time. The GTO facilitation team acknowledged that it has not succeeded yet in efficiently engaging the state-level group, and thus does not have policy recommendations to make.

In addition to this workgroup meeting, the GTO facilitation team conducted small group or individual meetings with several stakeholders between July 2012 and November 15, 2013. Primary groups it sought to engage included the New Mexico Department of Health, CYFD staff connected to the HVCDG, a state-level advisory group for the project, and New Mexico foundations, including Los Alamos National Laboratory and Brindle Foundations. The GTO facilitation team chose these particular groups for their potential resources and infrastructure to support a system of services, with a particular focus on effectively allocating public health resources. The GTO facilitation team has long-standing relationships with many of these stakeholders, which they believe facilitate this grant's efforts.

Early in the grant period, July 2012, the GTO facilitation team met with representatives from CYFD and the Early Childhood Development Partnership—a public-private partnership that focuses on creating public awareness of the need to improve early childhood investments—to discuss the possibility of convening the Partnership to assist in identifying possible primary care providers and partners. The purpose would be to collaborate on delivering health care services through the state, with a focus on rural areas and under- or unserved communities such as Quay County. No project documentation showed further activity related to this group.

In September 2013, the GTO facilitation team met with staff from the New Mexico Early Childhood Alliance, a statewide membership organization for early childhood professionals, to discuss services and supports available for child care providers. Meeting notes suggest that the GTO facilitation team discussed whether the Alliance or other resources are available for communities such as South Valley that are seeking to improve child care capacity.

In September 2013 the GTO facilitation team also met with a representative from the Department of Health Breastfeeding Support Services to discuss resources available for communities. The Luna County coalition had identified this as a gap in services, and it succeeded in getting an open WIC Breastfeeding Peer Counselor position transferred to Deming by the Department of Health.

The GTO facilitation team stated it was premature to hold discussions on fiscal leveraging or cross-agency integration at the state level during the evaluation timeframe, and that is why they did not initiate that type of dialogue. As the team noted, it focused on leveraging at the local level, and on how state agencies could help make local projects more successful. Thus, it is not surprising that the state-level stakeholders we interviewed did not note any changes in state-level dialogues related to leveraging or integration as a result of this project.

In November 2013, the GTO facilitation team developed a strategic plan to address state-level concerns for home visiting and the early childhood services continuum as part of this project. This plan outlines the framing for future state-level work, identifies relevant state agencies and other key stakeholders that control resource allocation and policy decisions, and suggests areas in which future recommendations are likely to focus. It is unclear with whom the GTO facilitation team shared this document.

As part of this project, the GTO facilitation team also conducted numerous meetings with CYFD staff to discuss the HVCDG efforts at the state and community level. Topics of meetings with CYFD primarily focused on specific facilitation team efforts and questions around home visiting implementation, developing a continuous quality improvement tool for future use with home visiting programs, obtaining state child care data for community use, and discussing state home visiting data collection.

State-Level Stakeholder Perceptions of Continuum of Services

We evaluated the degree to which the HVCDG actually enhanced the knowledge of several stakeholders at the state level regarding the full range of, and gaps in, available early childhood services, which was intended to be influenced by state-level meetings according to the HVCDG logic model. All respondents stated little to no change in their knowledge or awareness of the range of early childhood programs, gaps in early childhood services, state funding for early childhood services across communities, and state-level policy barriers and facilitators related to early childhood service implementation as a result of this project. One respondent attributed some increase in knowledge about the early childhood issues within certain individual communities to the information provided by the GTO facilitation team.

In addition, community respondents reported that the current continuum of services is inadequate to serve families, and it lacks funding. This was evident even in Luna County, where respondents perceived several of their services served families' needs well, unlike the other three participating communities. Across the participating communities, the lack of awareness or understanding of available services evidenced by the interviewees (a proxy for community members) is an important problem for accessing existing services, and a need is perceived for coordination across services.

Several respondents stated that they believed that the work at the community level conducted by the GTO facilitation team likely contributed to local knowledge and awareness changes related to early childhood services, but not as much at the state level beyond CYFD. Community plans to address these identified shortcomings seem to focus on these bigger issues. Respondents expressed the view that there is a need for fiscal leveraging efforts in the state, but few such efforts are underway in New Mexico. Likewise, respondents perceived there are some cross-agency integration efforts in the state to improve specific services, but there was more discussion than action. Two state-level groups were identified as possible entities to work on these broader issues: the New Mexico Early Learning Advisory Council, a governor-appointed advisory council

on statewide early childhood education and care; and the Children's Cabinet, comprising top state leaders and department secretaries with the purpose of making recommendations to assist New Mexico's children.

The GTO facilitation team noted that the leadership of other State agencies that serve youth may be a barrier to engaging state-level stakeholders in a dialogue about early childhood services. The team noted that it may be difficult to determine if any future changes will show whether knowledge of state-level services has changed, or if political changes allowed staff to act more on issues of which they were already aware.

In order to provide a roadmap for future state-level engagement, we also asked the state-level respondents to note who they believed were the appropriate stakeholders to involve in state-level discussions of early childhood service delivery. In addition to the Early Learning Advisory Council (ELAC), the Children's Cabinet, and the four agencies that are typically involved—CYFD, Department of Health, Public Education Department, and Human Services Department—they mentioned the following:

- community-level stakeholders, including early childhood providers who work first-hand with rural communities and those who receive direct benefits
- people outside the government, such as the private sector
- champions of early childhood issues
- agencies that may be perceived as atypical, such as Department of Public Safety, Corrections Department, and military
- faith-based organizations
- early intervention experts
- tribes
- Association of City Governments
- Legislative Finance Committee
- Legislative Education Study Committee
- key legislators and cabinet secretaries

Research Question 4: Did the participating communities improve their infrastructure for home visiting services?

Home Visiting Services Provided

Table 3.3 summarizes home visiting services across sites, while Appendixes D through G provide further detail on services by site.

Luna and Quay counties began implementing the PAT home visiting program, which was perceived positively by the community. Luna County met its enrollment target. Quay County did not, which may be attributable to delays in getting the program started during the evaluation period. The South Valley site selected the PAT

program early on, but it had neither hired staff nor begun implementation by the end of our evaluation period. The fourth community (McKinley County) chose a different approach and sought to divide the grant money between two home visiting programs already serving the community for use to collaborate on outreach for high-need family recruitment and referrals into home visiting programs. Only one of the two programs in that community had signed a contract with CYFD during the evaluation period, which may explain why successful collaboration and additional recruitment efforts were not evident during our evaluation timeframe. This is likely related to the delay in the second contract. Outreach specialists were not hired by either home visiting program; however, a job description was created in collaboration and a common referral form was agreed upon for use by both home visiting programs during the evaluation period.

Table 3.3. Home Visiting Services Across Sites as of November 15, 2013

Region	Families served (#)	Families currently enrolled (#)	Home visits conducted (#)	Home visitors on staff (#)	Date services began
Luna County	160	81	1,934	5	3/1/13
Quay County	25	25	139	3	7/15/13
McKinley County	N/A	N/A	N/A	N/A	N/A
South Valley	N/A	N/A	N/A	N/A	N/A

SOURCE: CDD UNM.
NOTES: McKinley County and South Valley did not begin home visiting services as part of this project during the evaluation timeframe.

Capacity for Completing Tasks Prescribed by GTO

In addition to the actual home visiting services delivered, the HVCDG aimed to build the capacity of the home visiting program staff to carry out high-quality programming. According to the GTO approach, there are a range of tasks that must be implemented with quality in order for programs to achieve outcomes. For example, home visiting staff with high capacity would conduct a thorough needs assessment, use that information to develop goals and concrete objectives for the family outcomes, and work with their community coalition to identify an evidence-based program that is logically linked to achieving those goals and objectives. This staff would then ensure the chosen program was a good fit and that it had all the needed expertise and resources to implement it, conduct thorough planning and evaluation, carry out quality improvement based on process and outcome data, and work to sustain effective elements of the program over time. These steps align with implementing home visiting (or any evidence-based program) because they have been shown to be associated with

obtaining positive results across many different types of programs (Livet and Wandersman, 2005).

Only two communities, Luna and Quay, started home visiting programs during the evaluation timeframe. Therefore, we only interviewed staff from these two programs to rate their capacity. As noted earlier, we rated the ten steps in the interview (see Table 3.4). Regarding Luna County, the results from the interview showed that the program staff had developed clear goals that had a strong link to the activities of the PAT program they chose to implement. The Luna home visiting program staff had also planned well (e.g., developed policies and procedures; completed several planning tasks for recruitment, timelines, and assigning tasks to individual staff). The program staff had also started to apply for additional funding to sustain the program. However, Luna program staff scored weaker on reviewing its capacity to carry out PAT and carrying out quality improvement activities based on data. For example, although data are reviewed in monthly meetings, there was no evidence that any improvements were attempted despite the presence of various implementation challenges stated by the Luna staff.

Table 3.4. Capacity Scores for Home Visiting Programs

GTO Step	Luna	Quay
1. Assessing needs and resources	3.0	3.0
2. Defining goals and objectives (G&O)	5.0	3.0
3. Choosing and developing evidence-based programs	5.0	1.0
4. Ensuring program fit	3.0	3.0
5. Ensuring capacity to carry out programs	2.0	3.0
6. Planning	5.0	4.0
7. Conducting process evaluation	4.5	3.0
8. Conducting outcomes evaluation	3.5	2.0
9. Conducting Continuous Quality Improvement	2.5	1.0
10. Initiating sustainability activities	5.0	1.0
TOTAL AVERAGE	**3.9**	**2.4**

NOTE: Response choices range from 1 (highly divergent from ideal practice) to 7 (highly faithful to ideal practice).

In contrast, Quay's program staff evidenced lower scores on the GTO Capacity Interview. Although the program showed moderate capacity in planning, the program staff demonstrated much lower capacity in choosing evidence-based programs, conducting continuous quality improvement, or taking steps to sustain the programming after the funding ends. For example, it does not seem that PAT was chosen because it met a need identified by families (as compared to another evidence-based home visiting program). Also, the Quay County home visiting program staff

reported not having reviewed data, although it could be because they have started more recently, compared to the Luna program.

Luna County showed particular strengths in how it developed program goals and objectives, as well as how it chose and planned the PAT program; the program staff also report taking steps to sustain their services. Quay County, perhaps because it started more recently, achieved lower capacity ratings across all GTO domains, but did show some capacity for planning. Scores by program staff on evaluation and continuous quality improvement were relatively low, which was not due only to starting services recently. Staff from these two programs did have an opportunity to carry out process and outcome evaluation and quality improvement activities on services they had already delivered.

4. Conclusions and Policy Recommendations

Conclusions

The goal of the HVCDG in New Mexico was to improve the lives of children and families in a select group of high-need communities, as well as across the state, by building capacity for implementing home visiting programming through the GTO and ECHO approaches. The State, along with the selected sites, has experienced a number of contracting and administrative delays. When continued MIECHV funding was uncertain, the State funded the second year from its general budget, so that almost half the funds from the original MIECHV grant that were initially allocated for direct services were repurposed for home visiting infrastructure development.

The evaluation we conducted shows that, after two years, a small amount of progress has been made on the project's three objectives: forming effective early childhood coalitions, enhancing the continuum of services to support families, and improving the infrastructure of the home visiting programming. According to the documents, ratings of community action plans, and interviews, the coalitions have not completed many activities important to their mission—suggesting they are still early in their development despite having 18 months to carry out their work. Moreover, stakeholders reported no change in the continuum of services. After two years of grant funding, the HVCDG has started home visiting programs in two of the four selected communities. There has been modest development in the infrastructure of these two home visiting programs, as evidenced by their limited capacity to plan, implement, improve, and sustain home visiting. Despite the shift of GTO from the home visiting programs to the coalitions, the GTO facilitation team carried out very little GTO with the coalitions.

ECHO, the distance T/TA provided by CDD UNM, was mostly implemented according to past ECHO demonstrations in two of the four communities that were able to launch home visiting programs during the evaluation period. But this project does not constitute a "pilot test" of ECHO in home visiting as initially planned, in large part because project delays made an outcome evaluation inappropriate.

Next, we summarize contributors to these results and make recommendations for improvements.

The coalitions' weak structure and lack of resources and accountability limited their planning and impact on the continuum of services. Research on community coalitions (Zakocs and Edwards, 2006) has identified key characteristics that predict their success in implementing programs and achieving outcomes. These include the presence of a formalized structure (e.g., paid staff, by-laws, mission statements, formalized roles), strong leadership, group cohesion, and active participation from a diverse membership.

However, coalitions in the past typically have had difficulty developing these qualities, and therefore have had an uneven track record in starting high-quality prevention and intervention programs across a wide range of behavioral health domains according to reviews of many several evaluations of coalition effectiveness (e.g., Wandersman and Florin, 2003). We found the coalitions in this project have experienced similar challenges. Overall, according to the interviews and documents, the coalitions that were started by the GTO facilitation team did not develop formalized structures or a membership that participated in formation and implementation activities, which was evident in their inability to carry out important planning tasks. The coalitions were able to review needs assessment data and develop goals and objectives, but this work took considerably longer than it did in previous GTO projects, and the coalitions were much less able to carry out planning tasks beyond some elements of the early GTO steps.

The lack of progress resulted in part because HVCDG funding was not available to support a more formalized structure of the coalitions, but went to home visiting programming (per the design of the proposal). The members of the coalitions donated their time. The future plans they proposed appear to also rely on donated time from the members and their host organizations as the community action plan did not specify any budget information associated with the planned objectives. Given this, there was no management and staffing support to build the accountability needed for successful progress through the GTO steps.

Finally, there was not strong accountability for the work of the coalitions. Although the GTO facilitation team worked with the coalitions, it did not have authority to hold the coalitions accountable for their work and it was unclear what benchmarks the coalitions were responsible to meet.

It is possible that these factors contributed to the lack of changes in the continuum of services at the community and state levels during the timeframe of the evaluation. Individuals join coalitions for multiple reasons, only some of which (e.g., networking, build job skills, social contact) correspond to the mission of the coalition (Chinman and Wandersman, 1999). Several stakeholders mentioned that the coalitions were useful in that they brought stakeholders together and raised awareness about service availability and gaps. Yet after the coalitions chose a particular home visiting program and a fiscal agent to house it, they were also supposed to enhance the continuum of services for early childhood. While raising awareness and networking is an important step in tackling problems facing children and families, in most cases it is not sufficient to affect service availability or outcomes. Although many studies have demonstrated this (as reviewed by Wandersman and Florin, 2003), Goodman et al. (1996, pg. 37) summarizes this point:

> For instance, many alcohol, tobacco and other drug coalitions that we evaluate employ "Red Ribbon" campaigns, in which members mobilize *en masse* and place red ribbons on highway overpasses and other visible places in communities. The campaign is meant to be a visible reminder of

> the dangers of substance abuse and driving. Such campaigns seem particularly appropriate during the initial mobilization stage to raise community awareness, but they are not likely to be effective in producing sustainable changes in community health status indicators, such as the number of alcohol-related traffic fatalities. For health status change to occur, the coalition must add strategies that coordinate among agencies, provide intensive prevention programs and services, and implement and monitor policies that promote and reinforce healthy environments.

GTO was not implemented according to design. An innovative feature of the HVCDG was to test the application of the GTO framework to home visiting programs. This did not occur; GTO was applied to the newly formed early childhood coalitions but not the home visiting programs. In addition, the GTO framework must be implemented with fidelity to build capacity within community organizations to carry out high-quality programming (Acosta et al., 2013). In this project, GTO was not implemented with the coalitions with fidelity.

The underutilization of GTO was manifest in three ways. First, the team charged with facilitating GTO at the sites participated in less training, consultation (monthly or less), and tracking (e.g., did not record time spent) than those in past GTO projects. Facilitation, where outside staff with experience in GTO build the capacity of community practitioners to use the GTO supports (sometimes called technical assistance), is one of the critical parts of the GTO framework (Acosta et al., 2013; Chinman, Acosta, et al., 2013; Chinman, Hunter, et al., 2008; Chinman, Tremain, et al., 2009). Past GTO studies have shown that GTO facilitators themselves often need support from GTO consultants (Chinman, Acosta, et al., 2012). Consultation helps the facilitators by providing guidance in areas that may be outside their expertise and troubleshooting difficult problems. Also, in previous GTO projects, facilitators complete tracking forms documenting the amount and content of their work, which are then reviewed by the consultants. Past GTO projects have shown that such support has been associated with improvements in capacity and program performance (Acosta et al., 2013; Chinman, Acosta, et al., 2013; Chinman, Hunter, et al., 2008). Fewer opportunities to review the facilitation work and provide consultation made it more difficult to support the GTO facilitation team, and the coalitions with which they worked.

Second, the GTO facilitation team did not conduct GTO training with any coalition member or home visiting staff. Moreover, they distributed few GTO materials (i.e., GTO worksheets) to coalition members and none to home visiting program staff. Training community practitioners is a key aspect of the GTO framework because it introduces practitioners to the GTO model, concepts, and tools. Use of these has been shown to improve capacity to deliver quality programming (Hunter, Paddock, et al., 2009). Without the training or access to tools, the coalition members had little understanding of the GTO framework. When interviewed, many commented that they had not heard of GTO in the context of the HVCDG or that it was something for which the GTO facilitation team was solely responsible.

Third, the GTO facilitators did not empower the coalition members to take on any of the planning tasks. The GTO framework is theorized to lead to improvements in program staff capacity to implement with quality by active participation in the GTO activities, along with the training, written tools, and facilitators' coaching. The GTO tasks that were completed—mostly elements of needs and resources assessments (GTO Step 1) and setting community goals and objectives (Step 2)—were largely done by the GTO facilitation team and shared with the coalition for their input. Thus, it is unclear if community coalitions experienced any significant gains in capacity.

The sites made little progress through the GTO steps due to loose organization along with a lack of staff support, budget, and other inputs, including few supports from the GTO facilitators. The GTO model is a roadmap—or a listing of key activities that must be completed—to successfully carry out a program. After the two-year evaluation period, the GTO facilitation team, along with the practitioners from the coalitions, did engage in some elements of the early GTO steps (needs and resource assessments, developing goals and objectives, choosing programs), but did not complete these or the other GTO steps related to enhancing the continuum of services. In comparison, other GTO projects conducted in a variety of content domains and settings implemented most or all of the ten steps in nine months or less (Chinman, Tremain, et al., 2009; Chinman, Acosta, et al., forthcoming). Compared to the HVCDG, those other GTO projects involved coalitions (or programs) with stronger organizational structures and more GTO consultation, training and facilitation.

Although coalition resources were low, resources for GTO facilitation staffing in the HVCDG—about 1.75 full-time equivalents (FTEs)—were in line with or greater than the amount of resources in past projects. For example, GTO facilitation was associated with significant gains in capacity using a ratio of about 1.0 FTE GTO facilitator to eight to 15 programs (Chinman, Hunter, et al., 2008; Acosta et al., 2013). Although there seemed to be enough resources to provide GTO facilitation, it did not occur. However, it should be noted that resources for GTO facilitation are not equivalent to resources to support coalition operations and the lack of such management and staffing support remains an important barrier for the coalitions formed by the HVCDG.

The coalitions, home visiting programs, and GTO facilitation lacked accountability. The coalitions, the home visiting programs, and the GTO facilitation team had few deliverables linked to a timeline that could ensure adequate progress. For example, the proposed timeline was to establish home visiting programs in the select communities within the first year of the award. Although this did not occur, there are other interim benchmarks that could have been established to monitor progress, allow for feedback, and create an opportunity for midcourse corrections. Although benchmarks alone do not guarantee accountability (consequences associated with benchmarks must also be in place), the lack of benchmarks makes accountability unlikely. Additionally, the GTO facilitation team did not carry out GTO according to its design to the communities and

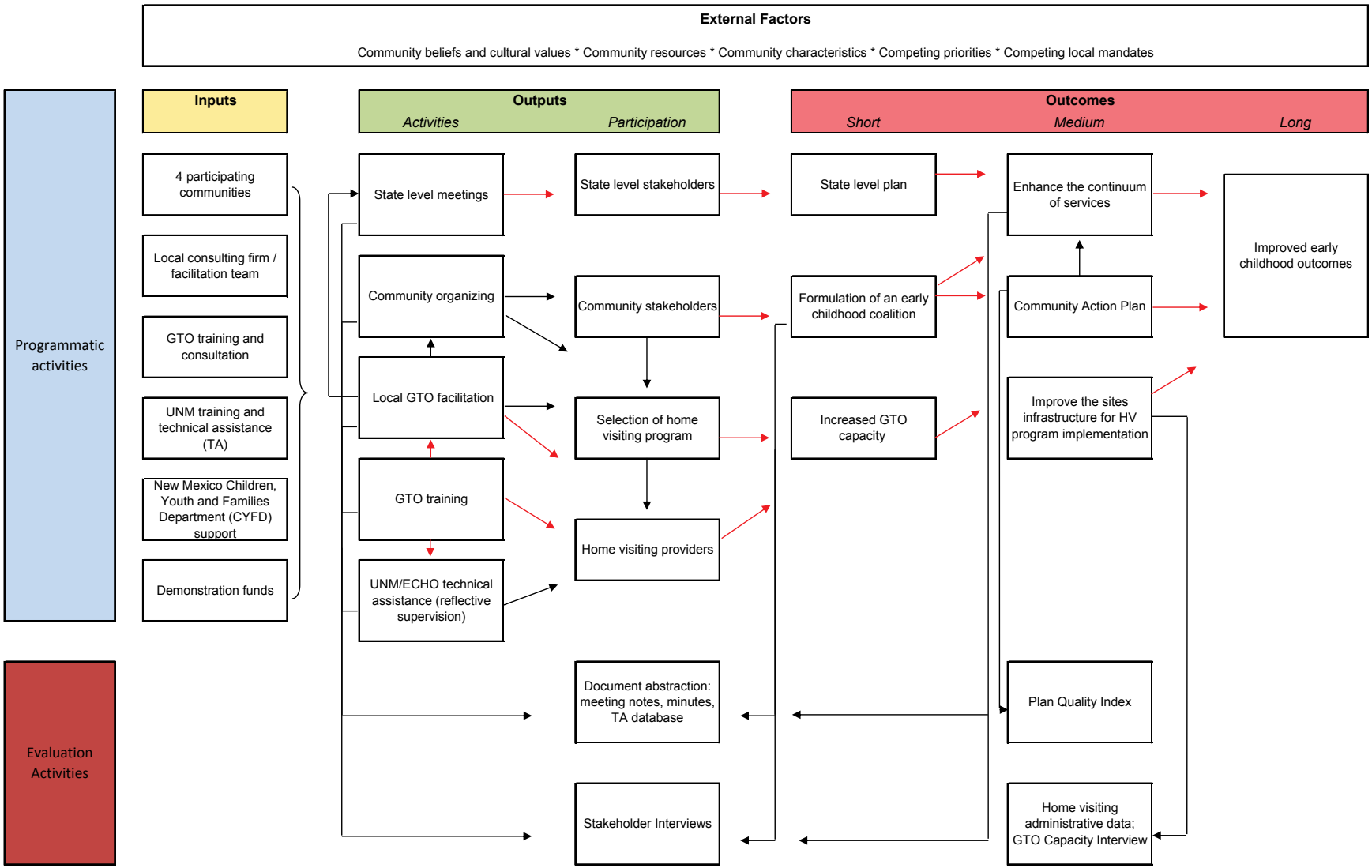
home visiting programs during the evaluation period and the State did not hold them accountable.

Although it does not constitute a "pilot test" as stated in the proposal, the distance learning T/TA was delivered mostly according to the ECHO model. The T/TA provider for this project has been providing services (training, case consultations, Q&A sessions) that are mostly in line with past ECHO demonstrations (Colleran et al., 2012; Arora, Thornton, et al., 2011). For example, Luna County had about three and a half T/TA contacts per month, and Quay County had three. Although the overall level of contact is slightly less than ECHO's weekly rate, after a slower start-up, both sites were receiving weekly contact. Further, both sites began using ZOOM technology, which provides more interpersonal feeling than other technologies and is recommended by ECHO.

The intention to pilot test the use of ECHO in a new content area, home visiting, was not achieved because delays in project activities made an outcome evaluation inappropriate. Therefore, this project did not yield data for judging ECHO's impact on home visiting outcomes. Another project that includes an evaluation of its impact on home visiting outcomes is still needed.

Revisiting the project logic model demonstrates significant challenges to overcome. Reviewing the project logic model demonstrates how the lack of certain activities made it more difficult to achieve specified outputs and outcomes. This made it difficult not only to achieve the three stated objectives—early childhood coalition formation (a short-term outcome), enhanced continuum of services, and improved home visiting program infrastructure (medium-term outcomes)—but also makes it unlikely the HVCDG can achieve long-term improvements in early childhood outcomes. In Figure 4.1, the red arrows indicate underdeveloped links in the HVCDG during the evaluation timeframe. More specifically, there were very few state-level meetings, making it more difficult to affect the continuum of services at a state-policy level. There were no GTO trainings and few GTO facilitation activities provided to the coalitions or the home visiting programs. Therefore, there was little capacity built among either group. The lack of capacity and the loosely organized nature of the coalitions made it more difficult to enhance the continuum of services in the communities. The lack of capacity among home visiting programs calls into question their ability to carry out the programming with quality over time (e.g., be able to plan, conduct evaluation, use data to make improvements).

Figure 4.1. HVCDG Logic Model Revised to Demonstrate Challenges



Limitations

The current evaluation has limitations that should be noted. One limitation is the use of a key leader approach to document impact on the continuum of care of early childhood services. Conducting a complete census of the availability of the many services in communities would be a preferred approach, but was beyond the scope of this evaluation. Although the use of key leaders is appropriate to document the availability and quality of community services (e.g., Sosale et al., 1999), it is possible that certain services were overlooked. Second, as stated in Chapter One, we did not evaluate the outcomes of children and families served by the newly created home visiting services. The HVCDG was delayed to such an extent that it would have been premature to do so. In addition to GTO not being well implemented, the lack of an outcome evaluation was another reason why the goal of conducting a pilot test applying GTO and ECHO to home visiting was not realized. Third, we had to rely on documentation about coalition and other community activities provided by the facilitation team and CDD UNM T/TA provider. In some cases, this information is incomplete or missing (e.g., meeting minutes), and it is difficult to independently verify the accuracy of the information. We augment with interview notes where we can, but this is not always possible. Finally, RAND's role as both the provider of GTO supports (written material, training, TA) and the project evaluator may appear to compromise the independence of the evaluation. We attempted to bolster the independence of the evaluation by having different staff engage in data collection and analysis than provided the GTO support. To improve reliability, we employed multiple staff to look for evidence of using the various GTO steps. Also, the specific expectations for use of GTO have been developed through several research projects. Critiques about the use of GTO therefore comes from specific research, which shows those who did not make use of the GTO supports did not experience the same level of gains in capacity.

Policy Recommendations

Despite delays, important progress has been made and resources remain to implement remaining HVCDG components as intended. Community stakeholders have been convened, and many have a favorable view of HVCDG contributions. The state is giving a sizable amount of general funding to home visiting programs, and there are still significant resources remaining in the MIECHV grant. The GTO facilitation team and the T/TA provider have the opportunity to provide ongoing support to the home visiting programs and coalitions. Below we provide specific recommendations that can maximize this foundation for the HVCDG, but are also applicable to similar projects attempting to use coalitions and GTO.

Support Coalitions With Funding and Accountability

Previous rigorous research has shown that a level of support as low as one full-time staff person and a budget of just $75,000 per year can lead to the creation of well-structured coalitions able to choose evidence-based programs, implement them well, and achieve outcomes all in less time than has elapsed in the HVCDG so far (Hawkins, Catalano, et al., 2008; Hawkins, Oesterle, et al., 2009). The coalitions in the HVCDG might have achieved similar results had they received more support—i.e., funding, paid staffing, and facilitation in the GTO framework. It is probably unrealistic to expect these groups to enhance the continuum of services in their counties solely relying on volunteers and donated time. Additional support would allow the coalitions to better carry out the plans that were made and hire paid staff to oversee the implementation as well as to manage the coalition itself (i.e., develop concrete roles for all participants, set benchmarks and timelines for accomplishing key tasks, conduct outreach to expand the membership). Providing more support should also be accompanied with greater accountability. GTO has also been used as a grant and reporting mechanism (Hannah, Ray, et al., 2010), whereby applicants use the ten steps to convey how they will carry out their work. The State could then award planning grants to build capacity, as well as monitor various interim steps these grants must accomplish through use of the reporting requirements related to the ten GTO steps. A coalition with a stronger organizational structure and funding may also be able to retain members who voiced concern about the viability of the coalitions going forward.

Implement GTO as It Was Designed

GTO can be adapted to a variety of contexts, but the adaptations made in the HVCDG undermined its potential effectiveness. Not providing GTO training to community coalitions to use GTO is too much of a change from the original model to expect outcomes seen in previous GTO projects. Further, GTO was not used at all with the home visiting programs.

There may, however, still be sufficient time (at the time this report was presented to the State) and resources in the HVCDG to use GTO with both coalitions and home visiting programs. The GTO home visiting manual is available at no cost from the RAND website (Mattox, 2013). Trainings could be provided to both coalition and home visiting program staff. GTO implementation support needs to follow the model used in past projects (written materials and training, followed by ongoing facilitation that is well supervised and monitored). The state could help ensure accountability and fidelity to the GTO model. If more resources are provided to the coalitions, GTO could strengthen their loose organizational structure and help the home visiting programs in areas where they were weak, such as evaluation and quality improvement.

Finally, using GTO with the organizations carrying out home visiting could strengthen their programming. Doing so was in the original plan for the HVCDG, but

was not implemented when the focus of GTO shifted to the coalitions. Although the ECHO distance learning T/TA provided by CDD UNM to the two active home visiting programs was considered helpful, the capacity of those programs to carry out many operational tasks (i.e., planning, evaluation, quality improvement) was found to be limited, and using GTO has been shown to improve such capacities. Further, using GTO may have provided a mechanism to enhance the accountability of the home visiting programs.

Increase Accountability Across All Project Activities

In past GTO projects, GTO consultants provided guidance to the GTO facilitators, but also served as organizational consultants for GTO facilitators. That did not occur in the HVCDG, where the GTO consultants from RAND and the GTO facilitation team were both subcontractors to the State. Therefore, the consultants could make suggestions about implementing GTO, but did not have organizational authority to enforce those suggestions. That authority rests with the State. The evaluation team provided feedback to the State several times about the underutilization of GTO. However, the State did not appear to hold the GTO facilitation team accountable for enhancing their use of GTO. Future projects should build in more accountability, not only by providing more GTO consultation and training but also by ensuring that adequate progress through the GTO steps is occurring, perhaps by requiring documentation of GTO activity forms at monthly or quarterly intervals.

More accountability may also be needed with the home visiting services, given their implementation challenges. For example, future grants and contracts could hold organizations accountable for various implementation milestones (e.g., choice of fiscal agent, hiring, training) in addition to service delivery targets.

Finally, more accountability is needed for the coalitions. The project set a goal of enhancing the continuum of services but did not establish any clear set of benchmarks or timelines for the coalitions to govern their activities. Communities That Care, in addition to sufficient support, had an extensive set of benchmarks and timelines that showed the coalitions exactly what needed to be accomplished, and when. Although enhancing the continuum of services for early childhood is more complex than implementing one program, benchmarks could still be established to guide the coalitions and provide accountability.

Therefore, going forward for the remaining time in the HVCDG, the onus would be on the State to provide feedback to the GTO facilitation team, the coalitions, and the home visiting programs to meet the demands of the project.

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Appendix A: The GTO Activity Monitoring Tool

Getting To Outcomes Steps	Activity *(Check all that apply)*
1. Conducting needs and resources assessment	___a. Selected a target area in which to do a needs assessment. ___b. Examined problem behavior rates in selected target area (e.g., preterm births).Identified a potential target population from within the selected area whose behavior should be of focus (e.g., teenagers at Valley High). ___c. Compiled baseline data for the target population and a comparison population (if available). ___d. Articulated the causes and underlying risk factors within your selected area showing the factors most likely contributing to the problem. ___e. Assessed the risk and protective factors of participants in the selected area. ___f. Conducted a resource or asset assessment. ___g. Other, specify:
2. Specifying goals, objectives, target population	___a. Developed program goal(s) that are clearly stated. ___b. Developed program goal(s) that are realistic and measurable. ___c. Defined the target population(s). ___d. Developed objectives (e.g., desired outcomes) that are linked to program goals. ___e. Specified the amount of change expected in the desired outcomes. ___f. Specified by when the desired outcomes are expected to occur. ___g. Decided how the desired outcomes will be measured. ___h. Obtained access to the information needed to measure the goals and desired outcomes. ___i. Other, specify:
3. Choosing evidence-based programming (Best Practice)	___a. Examined what science-based sources/resources are available to address problem area. ___b. Determined how the results of the science-based/best practice program fit with goals and objectives defined in Step 2. ___c. Determined if the results of the science-based/best practice program are applicable to target population (e.g., same age, similar characteristics). ___d. Included the evidence-based principles of effectiveness if adapting a science-based program or developing a best practice program. ___e. Constructed a logic model for program to foster clarity of purpose, buy-in from stakeholders, and a rationale for program selection. ___f. Other, specify:

4. Ensuring program Fit	___a. Conducted an assessment of local programs addressing similar needs. ___b. Determined how program will fit with existing programs offered to the same target population. ___c. Determined how program will fit with existing programs offered to address similar needs. ___d. Determined how program will fit with existing programs to meet larger community goals. ___e. Examined how the program will fit within specific agency/organizational structure. ___f. Other, specify:
5. Ensuring capacity to carry out programs	Have taken steps to ensure that . . . ___a. Leaders understand and support the program. ___b. Staff have appropriate credentials and experience, and a strong commitment to the program. ___c. There are adequate numbers of staff. ___d. Staff member roles are defined. ___e. There are adequate technical resources. ___f. There is adequate funding to implement the program as planned. ___g. Other, specify
6. Planning programs (Plan)	___a. Identified specific activities linked to the goals and objectives outlined in Step 2. ___b. Created a realistic timeline for completing each activity. ___c. Identified those who will be responsible for each activity. ___d. Developed a budget that outlines the funding required for each activity. ___e. Identified facilities/locations for each activity. ___f. Identified resources needed for each activity. ___g. Other, specify:
7. Conducting process evaluation	___a. For each activity, tracked dates actually completed. ___b. For each activity, tracked actual duration. ___c. For each activity, tracked actual attendance. ___d. For each activity, tracked adequacy of resources. ___e. For each activity, tracked adequacy of location. ___f. For each activity, debriefed (What should be repeated/done differently). ___g. Measured program characteristics. ___h. Measured participant characteristics. ___i. Measured satisfaction. ___j. Measured fidelity. ___k. Other, specify:

8. Conducting outcome evaluation	___a. Decided what you want to assess based on the goals and objectives in Step 2. ___b. Selected an evaluation design to fit your program. ___c. Chose methods for measurement. ___d. Decided who you will assess. ___e. Determined when you will conduct the assessment. ___f. Gathered the data. ___g. Analyzed the data. ___h. Interpreted the data. ___i. Other, specify:
9. Using evaluation data to improve program	Answered these questions and made plans based on the answers: ___a. Have the needs of the target group/resources in the community changed? ___b. Have the goals/desired outcomes/target population changed? ___c. Have the resources available to address the identified needs changed? ___d. Are new and improved science-based/best-practice technologies available? ___e. Does the program continue to fit with the agency (both philosophically and logistically) and your community? ___f. How well did you plan? What suggestions are there for improvement? ___g. How well was the program implemented? How well did you follow the plan you created? What were the main conclusions from the process evaluation? ___h. How well did the program reach its outcomes? What were the main conclusions from the outcome evaluation? ___i. Cultural Competence: How well were cultural factors considered in the above questions? ___j. Other, specify:
10. Sustaining successful programs	___a. Started discussions with community members about sustaining the program. ___b. Ensured that the needs of the community are driving the program. ___c. Developed a consensus-building process to reach a compromise for addressing different stakeholder (community, funder, technical experts) needs. ___d. Began an assessment of the community's local resources to identify potential "homes" for the program. ___e. Considered options (e.g., scaled-down version of the program) to discuss with those who may sustain the program. ___f. Determined whether the program can be integrated with other programs. ___g. Adapted the goals of the program to the local population needs. ___h. Adapted the program to the mission and activities of the host organization. ___i. Courted a respected program champion. ___j. Obtained endorsements from the top of the organization. ___k. Other, specify:

Appendix B: The Plan Quality Index (PQI)

Coalition: _____ Rater: _____ Date: _____ Score: ____

COMPONENTS OF ACTION PLAN	Rating (% adequate)						
	0	1-20	21-40	41-60	61-80	81-100	Score 0-5
1. Needs assessment is comprehensive.							
2. Goal(s) adequately reflect desired outcomes to problems/needs identified in needs assessment.							
3. At least one relevant objective is stated for each goal.							
4. Specific, feasible activities are provided for each objective.							
5. The plan is logically developed (i.e., priorities identified in needs assessment lead to goals, which lead to objectives, which lead to activities, which lead to resource requirements).							
6. Objectives and activities are measurable, so as to facilitate evaluation.							
7. Are specific priority populations identified for each activity?							
8. A timeline is provided for each activity.							
9. The agency/group/individual who will coordinate each activity is identified.							
10. Sources of coordination/collaboration among community agencies and groups are identified.							
11. New preventive activities are coordinated with existing community programs/activities.							
12. The combined activities form a comprehensive, multilevel community-wide intervention.							
13. A budget that outlines sources of funding and expenses for activities is provided.							
14. The plan is feasible, given the human resources and budget.							
15. The evaluation plan is clear and comprehensive.							
SOURCES: Butterfoss, Goodman and Wandersman (1995); Butterfoss (1996). NOTES: Scoring: 0 = None of the component is adequate; 1 = Approximately less than 20 percent of the component is adequate; 2 = Approximately 20–40 percent of the component is adequate; 3 = Approximately 41–60 percent of the component is adequate; 4 = Approximately 61–80 percent of the component is adequate; 5 = Approximately 81–100 percent of the component is adequate.							

Appendix C: Continuum of Care Draft List

CONTINUUM OF CARE DRAFT LIST FOR DISCUSSION

Updated August 24, 2012

This is a first draft of resources that a community would ideally have in place to support home visiting. This list came from four sources:

- First Born® Program Replication Guide (2009) (Chapter 7: Building Community Capacity)
- NFP website: did not add anything to First Born list (was pretty vague)
- PAT website: also did not add anything (even more vague)
- List created at team kickoff meeting from "Pyramid and Lattice" lists.

The top three are suggested because they are the primary evidence-based or promising home visiting programs the state is funding (based on federal home visiting evidence standards). Additional programs are presented at the bottom, and then the team suggested some others that were also added. This document reflects the conversation on August 22, 2012.

REVISED LIST

Minimum Community Resources to Support Families with Young Children

Medical

- Local hospitals or medical centers
- OB/GYN physicians
- Pediatricians
- Behavioral health/mental health providers
- Locations with birthing centers, such as hospitals or midwifery centers
- Early intervention services/Family Infant Toddler (FIT) program (Individuals with Disabilities Education Act Part C early intervention—required federal program for children 0-3 with disabilities)

Early Care and Education

- Child care, Head Start, Early Head Start (center-based version), other prekindergarten

Parent Supports and Services

- Local schools—public and private, elementary and secondary (high school teens may be moms)
- Substance abuse treatment services

Basic Needs

- Local income support agency and workers
- WIC

Family Safety

- Local domestic violence shelter, counselors
- Local CYFD caseworkers
- Justice organizations—juvenile justice, local sheriff, etc.

Additional Resources to Support Families with Young Children

Medical

- Family practice physicians
- Midwives
- Family planning organizations
- Federally qualified health centers (FQHCs), Indian health services, other clinics
- Local public health department, local mental health agency
- YMCA or other fitness or health promotion organizations (sometimes have pregnancy yoga, "baby and me" swim classes, etc.)

Parent Supports and Services

- Other home visitation programs (e.g.—mandated child protective services, Early Head Start home-based version, etc.)
- Parenting classes in area
- Families First (state case manager program for at-risk families—get about 1–3 home visits to sign up for health insurance, remind family of well-child visits, etc.)
- Local General Educational Development/higher education/adult education/English as a second language providers (community colleges, etc.—lots of moms in home visiting want to continue their education)
- Local employment office

Basic Needs

- Organizations providing baby care items (car seats, diapers, etc.)
- Food bank or other food programs
- Housing programs, electricity subsidies, or other basic needs programs
- Transportation solutions

Early Care and Education

- Child care resource and referral agency
- Libraries (often have story time/book clubs)
- Other potential sources of books and learning materials

Other

- Foundations

Appendix D: Luna County Site Summary

This appendix presents a compilation of information to describe HVCDG activities in Luna County during the evaluation timeframe. We begin with an overview of key activities in tabular form. The next sections describe the formation, sustainment, and activities of the coalition, followed by a description of the continuum of services available in the community. Then we discuss the T/TA activities provided to the selected home visiting program. We follow with a timeline of key activities and a description of the coalition meeting attendance. We conclude with a summary section of evaluation findings by research question.

We relied on multiple data sources for this summary. Information about coalition activities and meeting participants comes from a review of documents provided by the facilitation team, including meeting notes, sign-in sheets, and other materials. We also gained information from interviews with the facilitation team and community stakeholders. Information on the continuum of services was gathered through interviews with several community stakeholders and a review of coalition meeting notes. T/TA information was provided by the T/TA provider in the form of CDD UNM database entries, an annual report by CDD UNM on HVCDG activities, and an interview and other correspondence with the T/TA provider. Information on home visiting program implementation was supplied by the T/TA provider and the state project officer.

Table D.1 below provides an overview of coalition efforts and home visiting program implementation.

Table D.1. Overview of Key Activities April 2012 through November 15, 2013

Organization	Description
Coalition	
Stakeholders participating	• Nonprofit serving individuals and families • State health department • County government agency • Regional university • FQHC • Nonprofit serving disabled (FIT provider) • School district • Service provider for parents with young children • State children and families department • Supports for pregnant and parenting teens • Foundation supporting early literacy • Technical assistance provider • Child care center/entity • City government agency • Home visiting program • Program supporting childhood obesity prevention • Public assistance program
Coalition meetings	• 13 coalition meetings (of which one was a two-day meeting) • Four Home Visiting Advisory Committee meetings • Five child care workgroup meetings
Meeting materials	Modified GTO tools: • Goals and objectives worksheet • Activities plan Other Materials: • County ranks on risk factors • Description of home visiting programs • Strategic planning documents • Logic model • Home visiting provider RFP draft and score sheets • Home visiting goals list • Luna County potential home visiting referral sources • Work plan document • Luna County Resource Directory • Community prioritization tool • Common Referral Form • Child care survey • Child care provider list
Coalition goals and objectives	(1) Children are born healthy (2) Children are healthy, safe, and nurtured (3) Children are ready to enter school
Home Visiting Program	
Home visiting target population	Teen parents, first-time parents, and single parents
Home visiting program model selected	PAT
Home visiting fiscal agency	County of Luna
Home visiting program provider agency	Luna County Healthy Start Program
Date Home visiting services began	March 1, 2013
Home visiting program services implementation (as of 11/15/13)	Five home visitors 81 families currently enrolled 160 families served 1,934 home visits

SOURCES: Coalition meeting documentation, minutes and sign-in sheets; T/TA provider documentation.

Formation and Sustainment of Early Childhood Coalition

Prior to the HVCDG award, there was no early childhood coalition in Luna County. Previous community coalitions and groups have met about other related health topics in Luna, notably the Luna County Health Council led by the county government. The Health Council comprises different subgroups that focus on community health topics, such as teen pregnancy. Although the Health Council meets once a month, one of the Health Council members we interviewed stated there was no regular time for this meeting and the action plans do not always happen.

Coalition Development

The facilitation team began the coalition-building process by working with the Luna County community coordinator they contracted with to help build and sustain the local coalition focusing on early childhood. (In each site, the GTO facilitation team contracted with an individual or organization to serve as a community organizer who provided some local support for coordination of, and stakeholder involvement in, coalition meetings. A monthly stipend was provided to this organizer during the HVCDG time period.) The facilitation team introduced the community coordinator to the HVCDG and asked her to help set up meetings in Luna County in July 2012. In the early stages, the community coordinator helped coordinate meetings in mid-August 2012 between the facilitation team and a range of early childhood service providers (including health department staff, university staff, and child care directors) to discuss goals, needs, and interest in a home visiting program. After the first round of meetings with the providers, the facilitation team asked and the community coordinator accepted the position as local HVCDG community organizer for Luna County. The first coalition meeting was held in August 2012.

In December 2012, the facilitation team and the coalition first discussed the need for a Home Visiting Advisory Committee, which would include members from the FQHC and from nonprofits serving individuals and families. The coalition and the facilitation team determined the Home Visiting Advisory Committee structure and role, and the committee held its first meeting in late February 2013, where members discussed status of staff hires and the logistics of recruiting or referring clients.

In summer 2013, Home Visiting Advisory Committee members established a formal agreement to meet monthly (the PAT national office requires committee members to convene at least quarterly). It appears that a transition in committee membership occurred in autumn 2013, though it is unclear from available documentation why this happened. They had not reconvened the group as of November 15, 2013.

In addition to the full coalition, a workgroup was also formed to allow more focus on the key issue of child care that was identified in the scope of larger continuum of care. This child care workgroup is focusing exclusively on issues that are prevalent in Luna County. In particular, it is focusing on both formal and informal child care

services and providers, and it aims to list early childhood services that community members can put effort into implementing over the next few years. The child care workgroup held its first meeting in late March 2013.

Coalition Functioning

The coalition meetings have been well attended, with five to 10 participating organizations at each meeting (Table D.4). On average, there were eight organizations present at each meeting. The most consistent attendees are a nonprofit organization serving individuals and families, the State health department, a county government agency, and a regional university. At each coalition meeting, a variety of groups attended, including local home visiting programs, city and county government, and child care providers. Interviewed stakeholders stated that in the past, individual programs conducted needs assessments to serve their functions, but that a community-level assessment to identify existing gaps and resources had not been conducted until this HVCDG. Luna interview respondents identified bringing together a diverse group of stakeholders, helping the community identify goals and outcomes, and increasing awareness of early childhood issues as the main value of the HVCDG. One barrier for coalitions in Luna is lack of coordination regarding the funding process for new projects. The facilitation team has created a proposal process to overcome this barrier in a way that at least one stakeholder feels is a fair process.

Luna County interview respondents noted that the facilitation team helped keep the coalition focused on its goals, used a systematic process, and provided an outside, unbiased perspective. Respondents acknowledged, however, that additional stakeholders, such as local schools, could be involved.

Interview respondents either said the coalition would continue or that they hoped it would, and that the coalition's work was valuable and members were committed, making it more likely to sustain. They also stated that sustaining the coalition depends on available funding and upcoming changes in community elected officials.

Coalition Activities

The coalition engaged in a number of activities from August 2012 to November 2013. Next, we discuss the activities that were undertaken in this community organized by the ten-step GTO model.

Step 1: Conducting Needs and Resource Assessments

The coalition frequently conducted resource assessments and assessed community needs and barriers between August 2012 and September 2013. The coalition identified that the target population for the home visiting program in their community would be teen mothers, first-time parents, and single parents. The facilitation team also assisted with asset mapping and compiled a list of community resources and additional needs.

Step 2: Specifying Goals, Objectives and Target Population

Over several meetings between September 2012 and October 2013, the coalition discussed their interest in (1) increasing prenatal services for teens, and (2) reducing teen school dropouts. Each specified goal was aligned with a home visiting program objective as well as a larger community objective. The coalition identified goals, objectives, and target populations using a modified version of the GTO goals and objectives worksheet, which specifies the amount of change expected in desired outcomes, how quickly desired outcomes are expected to occur, and data sources to be used in measuring outcomes. The coalition began reviewing logic models that contained an indicator for an outcome (e.g., infant mortality rates for poor birth outcomes), intervening variables (e.g., birth context, maternal factors) and contributing factors (e.g., preterm birth and short birth spacing) developed by the facilitation team in November 2012.

Step 3: Choosing Evidence-Based Programming (Best Practices)

Over the course of two meetings, the coalition selected a home visiting program to implement in Luna County. In October 2012, the coalition listened to and considered home visiting presentations from PAT and the First Born Program. The coalition then discussed pros and cons of each of the two evidence-based home visiting programs. In October 2012, the coalition voted to use the PAT model, although there were also some strong proponents for the First Born model.

Steps 4 and 5: Ensuring Program Fit and Ensuring Capacity

The facilitation team collaborated with the State health department to discuss practical issues related to selecting a fiscal agency and a program agency. At the coalition meeting in September 2012, the facilitation team and the coalition worked together and determined Luna County to be the most appropriate fiscal agent. In addition, the coalition discussed potential program providers and the facilitation team developed an RFP process for interested program delivery agencies. The facilitation team also invited coalition members to participate in reviewing responses to the RFP from potential PAT providers, and five coalition members participated in that process.

Over subsequent meetings, the coalition often discussed adaptation of the PAT curriculum to meet the needs in their community, consistent with Step 4. For example, they discussed incorporating literacy work into the selected home visiting program (PAT). The coalition also identified specific activities linked to goals and objectives. Some changes, such as adding breastfeeding lessons and early literacy, corresponded to expressed community needs. There was also much discussion about how to recruit the target populations, consistent with Step 5.

Between February and May 2013, the home visiting program was staffed, a Home Visiting Advisory Committee was formed, and many technical resources (i.e., distance communication, staff trainings, proposals, memoranda of understanding) were

completed. As of November 2013, efforts were underway to incorporate reading curriculum into home visiting programs, and the Home Visiting Advisory Committee was planning to reconvene.

Step 6: Planning Programs

The coalition completed some elements of Step 6 between May and November 2013. The facilitation team and the coalition identified specific strategies and activities linked to goals and objectives, created deadlines for completing some of those activities, and identified those responsible for each activity in their community Action Plan drafted November 2013.

Step 7: Conducting a Process Evaluation

The coalition completed some elements of Step 7 starting in March 2013. The parent educator reported to the Home Visiting Advisory Committee that the new curriculum was "very successful," indicating her satisfaction with using it.

In addition, the Home Visiting Advisory Committee monitored home visiting activities and family participation, when these activities occurred, and duration (e.g., how long a family participated in home visiting). This monitoring occurred between May and August 2013.

Status of Continuum of Services as of Fall 2013

Luna County has several community resources. The information in Table D.2 is based on interviews and meeting notes. We have more information for some sectors than others depending on the source of information. For example, we may have details about some categories, whereas we only know of the existence of others.

Table D.2. Luna County Community Services

Sector	Services
Medical	
Local hospitals or medical centers	• One FQHC • Neonatal intensive care units in Albuquerque and El Paso • Hospital
OB/GYN physician(s)	• Hospital • Two stand-alone OB/GYNs
Pediatrician(s)	• Five providers
Behavioral health/mental health providers	• Sliding scale behavioral health services • FQHC • Family and marriage counseling entity • One private for-profit entity provides counseling
Locations with birthing centers, such as hospitals or midwifery centers	• Hospital (OB/GYN, labor and delivery, pediatrics)
Early intervention services	• Nonprofit serving disabled individuals provides early intervention services for ages 0–3, including in-home services (FIT provider)
Early Care and Education	
Child care, Head Start, Early Head Start (center-based version), other prekindergarten	• A statewide organization providing child development services, Head Start, Early Head Start, preschool, and private child care • Multiple child care centers and home-based child care providers • Preschools, of which one serves developmentally delayed children
Home visitation programs	• PAT, which came into the community as a result of this HVCDG • FQHC that offers home visiting services
Parent Supports and Services	
Local schools—public and private, elementary and secondary	• A charter school that focuses on returning high school dropouts and parents • One literacy foundation • School district • Educational supports for pregnant and parenting teens
Substance abuse treatment services	• Sliding-scale behavioral health services
Basic Needs	
Local income support agency and workers	• Supports for the developmentally disabled • State human services department
WIC	• State human services department
Family Safety	
Local domestic violence shelter, domestic violence counselors	• Nonprofit providing sexual assault recovery services
Local CYFD caseworkers	• Limited resources
Justice organizations—juvenile justice, local sheriff, etc.	• Limited resources

SOURCES: Coalition meeting documentation and interviews with community stakeholders.

In meetings, the coalition identified the need for more early childhood providers. Although early childhood education is available at the local university, few graduates continue in this field. For most early childhood services, the reach of the services, rather than quality of care, is noted as the primary gap. Losses in funding and restrictions on

population served mean that families who would benefit from these services are not receiving them. Also, two child care providers shut down in summer 2013.

Luna County interview respondents stated that barriers to receiving community services included a lack of awareness of services and the culture of the community (including language barriers, fears related to immigrant status, and beliefs about services). Additionally, they identified the school board as a barrier and generally wanted to involve schools more in providing services. Respondents noted multiple methods of increasing awareness about the existence of services as next steps for the community, including word of mouth, public service announcements, media, and social workers.

T/TA for Home Visiting Program

In Luna County, the T/TA provider provided training and technical assistance and attended various coalition meetings between February and November 2013. During the year, the T/TA provider attended four of the eight coalition meetings held, two of the four Home Visiting Advisory Committee meetings, and one of five child care workgroup meetings. The provider also referenced 28 instances of onsite or distance technology T/TA between February and November 2013. The T/TA was provided to the home visiting program manager and other program staff.

The T/TA provider initiated T/TA onsite in February 2013 with general introductions and discussion about program start-up. The program staff received training on the PAT theory of change and reflective supervision in March. In April, the T/TA provider introduced the Infrastructure Needs Assessment (INA) tool to learn more about the technical strengths, needs, and capacities of the home visiting program. The INA was reviewed regularly in subsequent meetings. The T/TA provider, in coordination with the home visiting program staff, developed a training plan using the INA results and trained home visiting program staff in reflective supervision; positive guidance/discipline; boundaries, ethics and safety for home visitors; hiring and training of staff; how to address secondary trauma that staff may experience; maintaining fidelity to the PAT home visiting model; caseloads and recruitment plans; use of screening tools, such as the Ages and Stages Questionnaire or depression scales by home visitors; and understanding how to make referrals to specialists based on screening results and what resources are available. The T/TA provider also discussed program policies, parallel processing, and professional development plans for staff, as well as using cell phones as tools for parents to communicate with the program (i.e., confirm appointments).

Timeline of Events

Table D.3 presents coalition and home visiting program milestones from April 2012 through November 15, 2013.

Coalition Meeting Attendance

A variety of individuals representing different organizations attended at least one coalition meeting during this timeframe. Table D.4 shows stakeholder attendance listed by the type of organization or entity the stakeholder represented. We note the organization that the attendee signed in under, although we recognize that some attendees may be representing different parts of a single umbrella organization (e.g., a home visiting program operated by a larger organization). If at least one person from an entity was present for a given meeting, then the general entity as a whole is counted as present at that meeting. The list is ordered with the entities present at the largest number of meetings at the top, noting the total number of meetings attended as well as the number of representatives from that entity attending across all meetings.

Table D.3. Timeline of Coalition and Home Visiting Events, April 2012 through November 2013

Description	Date
Coalition Meetings	
Meeting 1 of community coalition (Day One)	8/16/12
Meeting 1 of community coalition (Day Two)	8/17/12
Meeting 2 of community coalition	9/13/12
Meeting 3 of community coalition	10/18/12
Meeting 4 of community coalition	11/29/12
Meeting 5 of community coalition	12/20/12
Meeting 6 of community coalition	1/22/13
Meeting 1 of Home Visiting Advisory Committee	2/28/13
Meeting 7 of community coalition	2/28/13
Meeting 8 of community coalition	3/28/13
Meeting 2 of Home Visiting Advisory Committee	3/28/13
Meeting 1 of child care workgroup	3/29/13
Meeting 9 of community coalition	5/1/13
Meeting 3 of Home Visiting Advisory Committee	5/1/13
Meeting 2 of child care workgroup	5/2/13
Meeting 10 of community coalition	8/6/13
Meeting 4 of Home Visiting Advisory Committee	8/6/13
Meeting 3 of child care workgroup	8/7/13
Meeting 11 of community coalition	9/4/13
Meeting 12 of community coalition	10/2/13
Meeting 4 of child care workgroup	10/3/13
Meeting 13 of community coalition	11/6/13
Meeting 5 of child care workgroup	11/7/13
Coalition and Home Visiting Program Milestones	
Local community organizer begins	By Sept. 2012
Home visiting program selected	10/18/2012
State contracts with local home visiting fiscal agent	12/19/2013
Home visiting program manager hired	1/9/2013
Home Visiting Advisory Committee begins	2/28/2013
Home visiting program begins	3/1/2013
Submitted coalition's community action plan	11/15/2013

Table D.3.—Cont.

Description	Date
Onsite and Distance Technology T/TA Meetings with Home Visiting Program Staff	
Onsite meeting 1	2/28/13
Onsite meeting 2	3/13/13
Distance meeting 1	3/19/13
Onsite meeting 3	4/12/13
Distance meeting 2	4/16/13
Onsite meeting 4	5/6/13
Distance meeting 3	5/14/13
Distance meeting 4	5/28/13
Distance meeting 5	6/5/13
Distance meeting 6	6/19/13
Distance meeting 7	6/25/13
Distance meeting 8	7/2/13
Onsite meeting 5 (also included distance technology)	7/8/13
Distance meeting 9	7/9/13
Distance meeting 10	7/16/13
Distance meeting 11	7/25/13
Distance meeting 12	7/29/13
Onsite meeting 6	8/6/13
Distance meeting 13	8/23/13
Distance meeting 14	8/27/13
Onsite meeting 7	9/4/13
Distance meeting 15	9/12/13
Distance meeting 16	9/17/13
Onsite meeting 8	10/3/13
Onsite meeting 9	10/17/13
Distance meeting 17	10/23/13
Distance meeting 18	11/5/13
Distance meeting 19	11/12/13

SOURCES: Meeting and other documentation provided by the facilitation team and T/TA provider.

Table D.4. Stakeholders' Coalition Meeting Attendance

Organization	# People in Each Entity Attending at Least One Mtg	Total Mtgs Present	2012				2013							
			8/16–8/17	10/18	11/29	12/20	1/22	2/28	3/28	5/1	8/6	9/4	10/2	11/6
Nonprofit serving individuals and families	7	12	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
State health department	1	12	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
County government agency (provides home visiting services)	2	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Regional university	3	11	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
FQHC (provides home visiting services)	4	8	✓	✓		✓		✓			✓	✓	✓	✓
Nonprofit serving disabled (FIT provider)	1	9	✓	✓	✓		✓	✓	✓		✓	✓		✓
School district	1	6	✓	✓	✓		✓	✓	✓					
Service provider for parents with young children	3	6					✓	✓		✓		✓	✓	✓
State children and families department	1	4			✓		✓	✓		✓				
Supports for pregnant and parenting teens	1	4		✓			✓	✓		✓				
Foundation supporting early literacy	1	3										✓	✓	✓
Technical assistance provider	1	3									✓	✓	✓	
Child care center/entity	2	1	✓											
City government agency	1	1		✓										
Home visiting program	1	1		✓										
Program supporting childhood obesity prevention	1	1	✓											
Public assistance program	1	1		✓										

SOURCES: Meeting sign-in sheets and minutes detailing attendance.
NOTE: An additional meeting was held on 9/13/12, but attendance data are not available.

Site-Specific Evaluation Results

Research Question 1: Did the four participating communities form early childhood coalitions and begin to implement requisite coalition activities?

Coalition Formation and Implementation

Respondents stated that there was a Luna County Health Council prior to this HVCDG in which they participated, but there was no coalition group specific to early childhood. Respondents also said that, through this HVCDG, either the GTO facilitation team or CYFD staff contacted stakeholders and asked them to be involved in the new coalition. The Luna County coalition is composed of a variety of stakeholders who have had some involvement in early childhood issues.

The facilitation team led a total of 13 coalition meetings between August 2012 and November 2013 (see Table D.3). Regular attendees to these meetings included representatives from the parent supports and services, health and medical, state government, early care and education, and county government sectors. By September 2012, the GTO facilitation team contracted with a community organizer who helped enlist stakeholders to join the coalition. The GTO facilitation team met with coalition members twice in August and September 2012, including a two-day meeting in August, to discuss the community goals, needs, and interest in a home visiting program. The coalition then met three additional times between October 2012 and January 2013 to review different home visiting models, clarify goals for the home visiting program, provide updates on the process to select a home visiting program provider among three proposals, create a structure for the Home Visiting Advisory Committee, and discuss client recruitment and coordination across early childhood providers. The coalition selected PAT as its home visiting program in October 2012 and met eight additional times between February and November 2013. During these meetings, the coalition reviewed the facilitator-created work plan, further developed goals and objectives, identified data sources to measure those goals, and confirmed program resources. The Home Visiting Advisory Committee, formed as a requirement of implementing PAT, first met in February 2013 and met four times between February and August 2013, following the regular coalition meeting times. In addition, a child care subcommittee from the coalition met five times between March and November 2013.

One Luna respondent stated that the coalition would continue, and three other respondents expressed the hope it would continue because it is perceived to do valuable work and the group is committed. Respondents stated that sustaining the coalition would be contingent on funding and changes in elected officials in the county.

Coalition Planning Activities

Respondents in Luna County noted the GTO facilitation team brought together a diverse group of stakeholders, helped the community identify goals and outcomes, increased awareness, and provided information to stakeholders. Respondents also stated that the GTO facilitation team used a systematic process that helped keep the coalition focused on its goals. Additionally, two respondents noted that the team provided an unbiased and objective outside perspective. Respondents also recommended that additional stakeholders be involved in the coalition, particularly the local schools.

Quality of Community Action Plan

Strengths

The Luna County plan had several details that represent a significant amount of work already completed and future planning. The stated objectives are generally clear and well specified. There are logical links among needs, objectives, goals, strategies, and measures. The Luna County plan has already leveraged new resources (e.g., additional substance abuse screenings at Ben Archer Health Center, a new nurse practitioner funded by the Department of Health that will conduct family planning and sexually transmitted disease testing in Deming, and new breastfeeding workshops). Activities that are planned seem integrated into the community from the start, given that it is mostly partners in the coalition who are taking on the activities. The literacy work is notable for how it has progressed from needs assessment and planning to producing several activities. Some activities have a good amount of details (e.g., breastfeeding support), usually associated with events that have occurred in the past.

Challenges

The amount of details presented in the plan could be improved. For example, in the needs assessment section, sometimes actual data are presented; other times, only the data source is listed, not what the data state (e.g., "Chasnoff Chances data; Community-identified issue; Screening tools used by home visitors"). Other times the needs assessment section of the plan was missing information. The section on concerns, barriers, capacity, and strengths had good information, but it is not clear where that information came from or how the work would be accomplished. For example, under Strategy 2, "increase availability of condoms", had five different partners associated with it. One statement about the role of partners ("Identify locations, ideal times and partners for distribution to best meet teen needs") does not specify which partner is supposed to do these activities. The activities themselves are vague. "Conduct immunization campaign" does not have many accompanying details. There is also little information available about evaluation of the planned activities. For example, although measures are specified for most, but not all, major activities, the process of how the measures will be administered is missing in most cases. No budget or any other type of

resource (i.e., facilities, equipment) is discussed, but it appears that all the work is intended to be in-kind donations from partner organizations. A great deal of shorthand and several abbreviations are used, which is appropriate for those familiar with the process, but the document might be unclear for outside stakeholders or those who are new to the coalition.

Research Question 2: To what extent did the project utilize GTO and ECHO distance learning to support the work of the coalitions and home visiting programs?

GTO Facilitation Abstract

During the evaluation timeframe, the coalition examined county-level data on rates and rankings across the state on several early childhood indicators (e.g., preterm births), outlining the need for home visiting, a component of GTO Step 1 (i.e., conducting a needs and resource assessment). In the coalition meetings, the risk factors associated with the indicators were discussed (e.g., teenage pregnancies contributing to preterm birth rates)—another element of GTO Step 1. The group compiled a list of early child care providers during the initial meetings, contributing to a resource assessment—reflecting a third element of GTO Step 1. In autumn 2012, the facilitation team assisted the community in selecting a home visiting program as well as the fiscal and program agencies to deliver it, which incorporated elements of GTO Steps 3, 4, and 5. In 2013, the coalition started forming goals and objectives for the community, consistent with GTO Step 2. Starting in March 2013, home visiting staff started to report on home visiting activities to the advisory committee, consistent with GTO Step 7 (i.e., process evaluation). A community action plan that incorporated elements of GTO Step 6 (i.e., Planning) was presented and discussed with the coalition members in October 2013.

Community Stakeholder Interviews

All the stakeholders agreed that the GTO facilitation team introduced the GTO framework. Some of the stakeholders mentioned that GTO was discussed early on, consistent with the GTO facilitation team reports. One stakeholder elaborated that they discussed all the different risk factors as part of GTO. One stakeholder stated that they discussed objectives "over and over" and how to accomplish the goals the coalition agreed upon. In response to a question about using GTO in the community planning work, one stakeholder said that they "we're getting there and maybe we need a little more help."

ECHO Distance Learning Activities

Luna County was the first site among the four to initiate home visiting, so Luna County home visiting staff were the first to receive T/TA support. Table D.3 provides a chronological overview of the onsite and distance T/TA meetings from February through November 15, 2013. The T/TA provider began with onsite visits to establish a

relationship with staff, and then they began to meet more frequently using distance communications. Based on information from the T/TA database, the Luna County site received nine onsite visits by the T/TA provider and engaged in 19 distance-learning meetings.

The T/TA provider participated in the initial meeting of the Luna County Home Visiting Advisory Committee in late February 2012, where discussion topics included the timeline for delivery of services, implementation of PAT as the program model, and a review of dosage and frequency of services. The onsite visits began in March 2013 with training on the theory of change for the PAT home visiting program model. (According to the T/TA provider, this program model was different than the Healthy Start model that staff had previous experience with.)

In the second onsite meeting in March, the T/TA provider developed and administered two tools— INA and Technology Infrastructure Self-Assessment—to assist the home visiting staff in assessing T/TA needs and distance-technology capacity. According to the T/TA provider, the INA tool sections follow the standards in the CYFD home visiting service manual and are intended to identify program strengths and gaps in policies and procedures. INA sections include

1. eligibility, recruitment, and participation
2. culturally competent service delivery
3. relationship-based practices
4. family goal setting
5. curriculum and service delivery approach
6. program management systems
7. staff qualifications
8. community engagement
9. data management.

The Technology Infrastructure Self-Assessment focuses on technology and equipment needed for videoconferencing and staff self-assessment of their personal capacity to use technology. Based on information from the T/TA database and provider interview, these tools helped identify priorities for future work, and the tools were referred back to periodically. The T/TA provider stated that, while there is a guiding framework for the T/TA sessions, it is also the case that other high-priority issues sometimes come up in a given week and support is provided to address that need.

The distance technology used was initially Skype and then Adobe Connect via the Internet. The T/TA provider and home visiting program staff interviewed noted that Skype had several technical problems, such as cutting off unexpectedly, that interfered with its effective use. It was also not felt by program staff to be safe for use with documents. A larger issue in the community, as noted by both the T/TA provider and program staff, is a need for better Internet service in the county outside the Deming area. By November 2013, they began using a new web-based distance communication

platform, ZOOM, which the T/TA provider noted provides easier accessibility for sites and is HIPAA compliant and encrypted. It is also provided by CDD UNM at no cost to sites, and home visiting program staff stated that ZOOM was much better than Skype and was like "being face to face" with CDD UNM staff.

As noted in the T/TA database, annual report, and provider interview—and supported by interviews with program staff—T/TA engagements with the program often focused on reflective supervision for program managers, which was a key goal of the T/TA provider's scope of work for this HVCDG (CDD UNM, undated-b). The T/TA provider noted that other topics covered were a combination of provider-initiated content based on perceived program needs and the home visiting program manager's request for specific information, based on issues arising in the moment. Topics included hiring and training of staff, how to address secondary trauma that staff may experience, recognizing boundaries and ethics during home visits, maintaining fidelity to the PAT home visiting model, caseloads and recruitment plans, use of screening tools such as the Ages and Stages Questionnaire or depression scales by home visitors, and understanding how to make referrals to specialists depending on screening results and what resources were available. Additionally, the T/TA provider observed several home visits and reflected with home visitors on what went well and what tools and support would be most helpful. The T/TA provider reported meeting in October 2013 with the entire home visiting program staff to discuss the accomplishments to date and prepare for the next funding cycle.

The T/TA provider also provided support to the Luna County Home Visiting Advisory Committee and attended several other community meetings related to early childhood services, including four coalition meetings. The T/TA provider considered this to be important for community relationship-building, which in turn helped facilitate the provider's work with the home visiting program. Additionally, in between meetings as noted in the T/TA database, the provider maintained regular contact with home visiting staff through email exchanges and phone conversations to support follow-up steps to the INA and to address specific questions or issues brought forward by site staff (e.g., helping the staff develop a code of ethics document). Home visiting program staff noted that T/TA helped them successfully implement home visiting services and that they would recommend it to other communities. The program staff believes they could call on the T/TA provider any time to get assistance.

Research Question 3: Did the sites enhance the continuum of services they need to support families?

Luna County respondents reported that they perceived specific medical, early childhood education, and parent supports in the community generally served the needs of families somewhat well or very well. Due to conflicting responses from the respondents, it was less clear how well families were served by services for basic needs

and family safety, although WIC and food programs were thought to serve family needs well, whereas housing programs were not thought to serve families well.

When asked generally, respondents answered that they perceived a lack of awareness of services by families in the community. The culture of the community was reported as the largest barrier to services. Cultural issues included language barriers, a desire for greater illegal immigration enforcement, and the belief among parents that their children are better off at home than receiving services with other children enrolled in Head Start. Most respondents felt that greater involvement of the public schools was an important step toward improving early childhood outcomes. Respondents suggested that a next step to address these barriers could be through publicity about services, both to increase awareness of the existence of services and to demonstrate the services' importance. Respondents identified word of mouth, public service announcements, and media as the strongest ways to increase knowledge of services, along with social worker advocacy.

Research Question 4: Did the sites improve their infrastructure for home visiting services?

The community decided in October 2012 to implement the PAT home visiting model, and subsequently chose the County of Luna as the fiscal agent for the program. The contract agreement between CYFD and the County of Luna had an official start date of December 19, 2012. The County announced an RFP for a community provider for PAT, and Luna County Healthy Start was selected from among three submissions as the provider in December 2012.

The initial scope of work stated that the PAT program would serve 75 families by September 30, 2013. As shown in Table 3.1 in Chapter Three, the PAT program had been offering services for 8.5 months and had served 160 families by November 15, 2013, and had 81 families currently enrolled at that time. Thus they met their targeted enrollment for this HVCDG. They had five home visitors on staff and had provided 1,934 home visits. Based on stakeholder interviews, the community believes this PAT program is adding needed capacity for home visiting services.

According to the T/TA provider, recruitment in Luna County is ongoing due to the mobility of the immigrant families being served. For example, mothers may deliver their babies in Luna County, stay for a few months, and then return to Mexico. This provides some explanation for the large number of families served compared with the number currently enrolled, and it suggests that some families are not receiving many home visits. The T/TA provider also noted that the program's recruitment targets teen mothers and first-time mothers.

Appendix E: Quay County Site Summary

This appendix presents a compilation of information to describe HVCDG activities in Quay County during the evaluation timeframe. We begin with an overview of key activities in tabular form. The next sections describe the formation, sustainment, and activities of the coalition, followed by a description of the continuum of services available in the community. We then discuss the T/TA activities provided to the selected home visiting program, and follow that with a timeline of key activities and a description of the coalition meeting attendance. We conclude with a summary section of evaluation findings by research question.

We relied on multiple data sources for this summary. Information about coalition activities and meeting participants comes from a review of documents provided by the facilitation team, including meeting notes, sign-in sheets, and other materials. We also gained information from interviews with the facilitation team and community stakeholders. Information on the continuum of services was gathered through interviews with several community stakeholders and a review of coalition meeting notes. T/TA information was provided by the provider in the form of CDD UNM database entries, an annual report by CDD UNM on HVCDG activities, and an interview and other correspondence with the provider. Information on home visiting program implementation was supplied by the T/TA provider and the state project officer.

Table E.1 provides an overview of coalition efforts and home visiting program implementation.

Table E.1. Overview of Key Activities April 2012 through November 15, 2013

Organization	Description
Coalition	
Stakeholders participating	• FIT program • University extension program • Critical care medical facility • FQHC • Community health council • State health department • Community member • State children and families department • Community college • Nonprofit serving disabled individuals • State education agency • Nonprofit serving local businesses • Technical assistance provider • Home visiting program • Public early child care education center • State workforce department • Telecommunication company • County public safety department • City government agency • County government agency • School district • Community health center • County alcohol treatment center • County medical clinic • Nonprofit focused on business development • Public assistance program
Coalition meetings	• One set of introductory meetings • 15 coalition meetings • Four workgroup meetings (prenatal and teen pregnancy) • Six HVCDG updates during Quay County Health Council meetings
Meeting materials	Modified GTO tools: • Goals and objectives worksheet • Community strategic planning tool Other Materials: • County ranks on risk factors • Description of home visiting programs • Strategic planning steps worksheet • Logic model • Quay County asset mapping • Home visiting provider RFP draft • Home visiting goals list • Quay County potential home visiting referral sources • Work plan document • Quay County Resource Directory • Community prioritization tool • Community strategic planning worksheet
Coalition goals and objectives	Observable reduction in top three childhood risk factors (infant mortality, preterm births, low birth weights)

Table E.1.—Cont.

Organization	Description
Home Visiting Program	
Home visiting target population	Pregnant teens, teen parents, first-time mothers
Home visiting program model selected	PAT
Home visiting fiscal agency	Regional Educational Cooperative 6 (REC6)
Home visiting program provider agency	Presbyterian Medical Services
Date home visiting services began	7/15/2013
Home visiting program services implementation (as of 11/15/13)	Three home visitors 25 families currently enrolled 25 families served 139 home visits

SOURCES: Coalition meeting documentation, including minutes and sign-in sheets, and T/TA provider documentation.

Formation and Sustainment of Early Childhood Coalition

Prior to the HVCDG award, there was no early childhood coalition in Quay County. Although the Quay County Health Council (QCHC) was initially founded as a maternal and child health council more than 20 years ago, it has since become focused on addressing a broad range of health issues. The core executive committee is elected annually and the Council overall represents a wide variety of interests, including hospitals, public health, public assistance (food/nutrition/early childhood) programs, local law enforcement, and others. Funding cuts and changes over the years have resulted in reductions in size and scope.

Coalition Development

In spring 2012, the facilitation team began the coalition-building process, working with the contracted community coordinator to help build and sustain a local coalition focusing on early childhood. The facilitation team introduced the HVCDG and discussed community risk factors, resources, and needs with the community coordinator. The community coordinator helped organize a series of introductory meetings with the facilitation team, Quay County's community leaders, and key stakeholders. The 22 attendees represented business leaders, government agencies, and service organizations. At these introductory meetings, the group also identified many service providers in the area. The first coalition meeting was held in June 2012.

In autumn 2012, the facilitation team introduced the idea of a Home Visiting Advisory Committee as a subcommittee of the health council to ensure the community would continue to be heard once the implementing agency and fiscal agency started the home visiting program in 2013. The Home Visiting Advisory Committee held its first meeting in late July 2013.

In September 2013, the coalition branched out into two workgroups, in addition to the Home Visiting Advisory Committee, to allow more focus on the two key issues that

they identified in the scope of larger continuum of care. The Prenatal Care Workgroup is examining perceived causes of lack of prenatal care in Quay County and is brainstorming ways to alleviate the issue. The Teen Pregnancy Workgroup aims to decrease teen birth rates by 25 percent by 2016. As of November 2013, the Teen Pregnancy Workgroup was reviewing teen pregnancy statistics in Quay County.

Coalition Functioning

The facilitation team led one set of introductory meetings and 15 coalition meetings from April 2012 through November 15, 2013. In most cases, the coalition met monthly. The facilitation team also led six meetings with QCHC between April and September 2012 to discuss the home visiting program. In addition, the facilitation team attended Health Council meetings throughout the HVCDG to update the Council on the progress of the coalition.

The coalition meetings have been well attended, with eight to 14 participating organizations at each meeting (Table E.4). On average, there were 11 organizations present at each meeting. The most consistent attendees are a FIT provider (therapy and counseling), an FQHC, a critical care medical facility, and a university's extension program. At each coalition meeting, a variety of groups attended, including local medical centers, the community college, and early intervention services.

Quay County interview respondents expressed positive feelings about the coalition's activities and process. They stated the process was systematic and helped the coalition proceed through identifying risk factors, outcomes, and strategies. Respondents noted that the coalition might not have gotten as far in its work without the facilitation and that the same process could be used to identify gaps in other community services. Interview respondents also said the facilitation team helped identify community needs and provided important information and data.

All stakeholders interviewed stated the coalition would be sustained into the next year. While it was less likely to meet in person, respondents noted that they planned to meet using teleconferencing or by telephone. They also said the coalition would not continue without funding or other resources, but wanted to be self-sustaining because there is a need for such work.

Coalition Activities

The coalition engaged in a number of activities from May 2012 to November 2013. Next, we discuss the activities that were undertaken in this community organized by the ten-step GTO model.

Step 1: Conducting Needs and Resource Assessments

The coalition frequently reviewed the county's risk factors and relative rankings between May 2012 and September 2013. Using this information, the coalition identified

that the target population for the home visiting program in their community would be first-time mothers, and pregnant and parenting teens. The facilitation team created handouts documenting information gathered in the meetings, referred to as "Quay Logic Model—Environmental" and "Quay Logic Model—Birth Factors," highlighted indicators, intervening variables, contributing factors, and strategies to address intervening variables.

The coalition also compiled a list of resources (i.e., child care providers) in the area. The resource list, referred to as "asset mapping," was updated several times over the course of the meetings held between May 2012 and August 2012. The facilitation team also assisted with a cumulative list of community resources and additional needs. The coalition continued to update and examine community resources throughout 2012 and 2013; notably, those entities that can serve as referrals for or from the home visiting program. More recently, the coalition has looked into capacities and clientele of the child care service providers that they have identified. A key need identified in the planning meetings is the lack of transportation to medical services. The coalition assessed that the home visiting program may help alleviate this issue, since parent educators are allowed to provide transportation to their clients.

According to the stakeholders interviewed, Quay County has been involved previously in surveying community members, conducting data-driven assessments, and identifying health priorities, but this is the first time the County has conducted a comprehensive community-level assessment specific to early childhood.

Step 2: Specifying Goals, Objectives and Target Population

The facilitation team and the coalition frequently updated and refined their measures, goals, and objectives in response to changes in the state of the home visiting program and larger continuum of care circumstances between September 2012 and October 2013. The coalition discussed short-term and long-term success, with a long-term focus on increasing kindergarten readiness in young children and reducing substance use during pregnancy, along with addressing infant mortality, preterm births, and low birth weights. Each specified goal was aligned with a home visiting program objective, as well as a larger community objective. In deciding which objectives to focus on, the facilitation team used a prioritization tool that gave objectives a ranked priority based on coalition member votes. The coalition discussed specific (measurable) objectives and potential sources of data four times over the course of the meetings held between June 2013 and October 2013, and assigned activities and responsible parties to each objective as specified in their documentation shared in October 2013.

Step 3: Choosing evidence-based programming (best practices)

Over the course of four meetings, the coalition selected a home visiting program to implement in Quay County. In July 2012, the coalition discussed the three home visiting programs available: First Born Program, PAT, and NFP. The group then discussed

desired qualities and characteristics of an evidence-based home visiting program, fiscal agent, and implementing agent. A representative from PAT provided additional information on their home visiting model. In September 2012, the coalition decided on PAT, their target population, and short- and long-term goals. The target population was refined in October 2012 and finalized in March 2013.

Steps 4 and 5: Ensuring Program Fit and Ensuring Capacity

The facilitation team worked with the coalition on the desired characteristics of the home visiting program's implementing and fiscal agencies and met with the Health Council to discuss practical issues related to selecting a fiscal agency and a program agency. Throughout September 2012, the Health Council led the process of identifying potential agents, and the Executive Committee selected Mesalands Community College as the fiscal agent one month later. Mesalands agreed to be the fiscal agent and began negotiations—but administrative changes led to Mesalands no longer being able to serve as the fiscal agent, and REC6 became the new fiscal agent in November 2012. Presbyterian Medical Services became the new program agent in March 2013.

To ensure that the program would reach its enrollment goals, the facilitation team and the coalition used their developed resource directory to target referral providers, and discussed strategies for recruiting and retaining clients in the home visiting program.

A Home Visiting Advisory Committee formed with participants from the QCHC to help support and advise the home visiting program staff. The home visiting program identified that they will serve families with children from birth to age 3 and hired staff in April 2013.

The facilitation team and the coalition also assessed video conferencing and other technical capacities in October 2013. Interviewed stakeholders stated there are plans to hold some meetings via videoconferencing.

Step 6: Planning Programs

The coalition completed some elements of Step 6. The facilitation team developed a work plan with stakeholders in January 2013 that listed tasks for establishing the home visiting program. In August 2013, the coalition concentrated on what activities could be done in the short term and long term for its first goal. During meetings held in September and October 2013, members identified responsible parties for fulfilling some of the activities and objectives in the goals/objective worksheet and in the Activity Plan.

Step 7: Conducting a Process Evaluation

The coalition did one element of Step 7 starting in August 2013, when it discussed the number of referred clients enrolled in PAT (13 out of 17), and the number of teen parents that home visiting staff were aware of that were being served (two out of 13). In October 2013, the coalition mentioned the number of referred clients enrolled in PAT was 26 out of 42, including six teenagers. In this meeting, the coalition also discussed the status of the home visiting program's services, staffing, and funding. Planning group members involved in the home visiting program listed barriers faced by families

enrolled in the home visiting program (i.e., no phone service, instable housing, mothers in abusive relationships).

Status of Continuum of Services as of Fall 2013

Quay County has several community resources, mostly in Tucumcari. The information in Table E.2 is based on interviews and meeting notes. We have more information for some sectors than others, depending on the source of information. For example, we may have details about some categories, whereas we only know of the existence of others.

Table E.2. Quay County Community Services

Sector	Services
Medical	
Local hospitals or medical centers	• Public health office—two nurses and one traveling nurse practitioner • Family health center (provides primary care) • Critical care medical facility (25 beds) • Two FQHCs—one at a medical center providing primary care, and another at a family practice (family medicine)
OB/GYN physician(s)	• One practitioner providing prenatal care to women with low-risk pregnancies without regard to insurance/Medicaid reimbursements
Pediatrician(s)	• No pediatric specialists • Family nurse practitioner at family health center • Medical case management services for children
Behavioral health/mental health providers	• Limited – one provider serving five counties • Community mental health provider • One private for-profit entity with two counselors provide counseling
Locations with birthing centers, such as hospitals or midwifery centers	• None. One stakeholder stated that women will go to Clovis in the neighboring county (80 miles and 1.5 hour drive) to deliver.
Early intervention services	• Two FIT providers for children ages 0–3 serving children with developmental delays and identified risks • Developmental disabilities waiver program
Early Care and Education	
Child care, Head Start, Early Head Start (center-based version), other prekindergarten	• Preschools including Head Start, Early Head Start, and independent • Operating at maximum capacity and no space or workforce for expansion • Child care is a large problem for teen moms
Home visitation programs	• PAT, which came into the community as a result of this HVCDG
Parent Supports and Services	
Local schools—public and private, elementary and secondary	• Limited support in schools • One alternative high school, but much like homeschooling
Substance abuse treatment services	• Limited
Other	• A Catholic fraternal benefits organization provides basic necessities for first-time parents • Two Medicaid transportation providers
Basic Needs	
Local income support agency and workers	• State human services department—Tucumcari
WIC	• Yes, but understaffed due to budget cuts
Other	• Religious organization provides food bank and basic necessities • A Catholic public charity organization provides utility assistance
Family Safety	
Local domestic violence shelter, domestic violence counselors	• Yes
Local CYFD caseworkers	• CYFD Protective Services
Justice organizations—juvenile justice, local sheriff, etc.	• Local detention center

SOURCES: Coalition meeting documentation and interviews with community stakeholders.

In meetings, the coalition identified several needs and barriers related to early childhood issues, including child care, OB/GYN services, and lack of supportive services in schools. Other needs and barriers related to early childhood issues that interviewees identified are a lack of health care services, especially specialty services, as the main gap in services in Quay. They also noted a lack of awareness of services and a lack of transportation as barriers to receiving services. Respondents stated that there were specific plans with UNM to address the shortage of doctors in the area, and that they are asking the facilitation team if there are grants set aside specifically for rural communities.

Coalition stakeholders revealed that there are currently no OB/GYN or prenatal services within the community. Although there is a family health center, they have been unsuccessful at attracting an OB/GYN. One major contributing factor that was identified relates to the Medicaid bundled payment for prenatal services that only the delivery doctor receives. Because there is no birthing service at the small Tucumcari hospital, many women deliver in Clovis, and there is little incentive for an OB/GYN to practice at the family health center or at the critical access center in town. As of May 2013, there was one practitioner providing prenatal care to women with low-risk pregnancies without regard to insurance/Medicaid reimbursements.

In addition, there are limited child care providers in the area. Meeting documents note that this is the result of a combination of factors, such as frequent turnover of staff (50 percent annually), cost-prohibitive tuition costs for early childhood education, and difficulty sustaining proper licenses.

Quay County ranks high in teen births; however, the school system is limited in what it provides in both prevention and support. Key stakeholders said the schools lacked sufficient counseling services and did not offer day care for teen moms (GRADS program). The coalition was speaking with community members to figure out how to provide family planning.

T/TA for Home Visiting Program

The T/TA provider in Quay County attended various coalition meetings between January 2013 and November 2013, including six of the ten coalition meetings held in 2013. The provider also listed nine instances of onsite or distance technology T/TA between July 2013 and October 2013. T/TA was provided to the home visiting program manager and other program staff.

The T/TA provider initiated contact in May 2013 with general introductions. Two months later, CDD UNM introduced the INA tool to learn more about the technical strengths, needs, and capacities of the home visiting program. The INA was reviewed regularly in subsequent meetings. The T/TA provider coordinated with the home visiting program staff in developing a training plan using the results from the INA. The T/TA provider trained home visiting program staff in reflective supervision; hiring and

training of staff; positive guidance and discipline; boundaries, ethics, and safety for home visitors; increasing workload and time management for home visiting staff; recruitment targets; use of assessment and screening tools by home visitors; program support for literacy and its relation to school readiness outcome; and policies for waitlists for families.

During that summer, the T/TA provider also checked in with the home visiting program about finishing PAT's national requirements, discussed the status of the Home Visiting Advisory Committee, and paid particular attention to the program manager's needs to ensure that program passes CYFD standards.

Timeline of Events

Table E.3 presents coalition and home visiting program milestones from April 2012 through November 15, 2013.

Table E.3. Timeline of Coalition and Home Visiting Events, April 2012 through November 2013

Description	Date
Coalition Meetings	
Meeting 1 of QCHC	4/24/2012
Meeting 2 of QCHC	5/10/2012
Meeting 3 of QCHC	5/22/2012
Meeting 1 of community coalition	6/18/2012
Meeting 4 of QCHC	6/26/2012
Meeting 2 of community coalition	7/17/2012
Meeting 5 of QCHC	7/24/2012
Meeting 3 of community coalition	8/29/2012
Meeting 4 of community coalition	9/18/2012
Meeting 6 of QCHC	9/25/2012
Meeting 5 of community coalition	10/25/2012
Meeting 6 of community coalition	12/11/2012
Meeting 7 of community coalition	1/29/2013
Meeting 8 of community coalition	3/5/2013
Meeting 9 of community coalition	4/2/2013
Meeting 10 of community coalition	5/17/2013
Meeting 11 of community coalition	6/18/2013
Meeting 1 of Home Visiting Advisory Committee	7/25/2013
Meeting 12 of community coalition	7/30/2013
Meeting 13 of community coalition	8/28/2013
Meeting 1 of Prenatal Care Workgroup	9/13/2013
Meeting 14 of community coalition	9/18/2013
Meeting 2 of Home Visiting Advisory Committee	9/26/2013
Meeting 2 of Prenatal Care Workgroup	10/3/2013
Meeting 1 of Teen Pregnancy Workgroup	10/4/2013
Meeting 15 of community coalition	10/22/2013
Meeting 3 of Prenatal Care Workgroup	11/5/2013
Coalition and Home Visiting Program Milestones	
Local community organizer begins	4/13/2012
Home visiting intervention program selected	By Sept 2012
State contracts with local home visiting provider	1/30/2013
Home visiting program manager hired	By May 2013
Home visiting intervention begins	7/15/2013
Home Visiting Advisory Committee begins	7/25/2013
Submitted coalition's community action plan	11/15/2013
Onsite and Distance Technology T/TA Meetings with Home Visiting Program Staff	
Onsite meeting 1	7/30/2013
Onsite meeting 2	8/28/2013
Distance meeting 1	9/13/2013
Distance meeting 2	9/17/2013
Onsite meeting 3	9/26/2013
Distance meeting 3	10/4/2013
Distance meeting 4	10/11/2013
Distance meeting 5	10/24/2013
Distance meeting 6	10/31/2013

SOURCES: Meeting and other documentation provided by the facilitation team and T/TA provider.

Coalition Meeting Attendance

A variety of individuals representing different organizations attended at least one coalition meeting during this timeframe. Table E.4 shows stakeholder attendance listed by the type of organization or entity the stakeholder represented. We note the organization that the attendee signed in under, although we recognize that some attendees may be representing different parts of a single umbrella organization (e.g., a home visiting program operated by a larger organization). If at least one person from an entity was present for a given meeting, then the general entity as a whole is counted as present at that meeting. The list is ordered with the entities present at the largest number of meetings listed at the top, noting the total number of meetings attended as well as the number of representatives from that entity attending across all meetings.

Table E.4. Stakeholders' Coalition Meeting Attendance

Organization	# People in Each Entity Attending at Least One Mtg	Total Mtgs Present	2012					2013								
			6/18	7/17	8/29	9/18	12/11	1/29	3/5	4/2	5/17	6/18	7/30	8/28	9/18	10/22
FIT program (1)	4	14	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
University extension program	1	13	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Critical care medical facility	3	12	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓
FQHC (provides home visiting services)	5	13	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Community health council	1	12	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
State health department	3	12	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Community member	2	10	✓	✓	✓			✓	✓		✓	✓	✓	✓	✓	
State children and families department	6	10	✓	✓	✓	✓	✓	✓	✓		✓			✓		✓
Community college	5	10	✓	✓	✓		✓	✓	✓	✓	✓		✓		✓	
FIT program (2)	5	9	✓	✓	✓	✓	✓	✓	✓	✓					✓	
State education agency	3	6		✓	✓		✓				✓		✓	✓		
Nonprofit serving local businesses	1	7			✓		✓	✓	✓			✓	✓		✓	
Technical assistance provider	2	7	✓					✓		✓	✓	✓	✓	✓		
(Indeterminable)	4	5					✓			✓	✓			✓		✓
Home visiting program	2	5			✓								✓	✓	✓	✓
Public early child care education center	4	3	✓	✓	✓											
State workforce department	1	3	✓		✓	✓										
Telecommunication company	1	3		✓			✓		✓							
County public safety department	1	3	✓	✓	✓											
City government agency	2	1													✓	
County government agency	2	1											✓			
School district	2	2							✓						✓	

Table E.4.—Cont.

Organization	# People in Each Entity Attending at Least One Mtg	Total Mtgs Present	2012					2013								
			6/18	7/17	8/29	9/18	12/11	1/29	3/5	4/2	5/17	6/18	7/30	8/28	9/18	10/22
Community health center	1	1													✓	
County alcohol treatment center	1	1		✓												
County medical clinic	1	1														✓
Nonprofit focused on business development	1	0														
Public assistance program	1	1										✓				

SOURCES: Meeting sign-in sheets and minutes detailing attendance.
NOTES: An additional meeting was held on 10/25/12, but attendance data are not available.

Site-Specific Evaluation Results

Research Question 1: Did the four participating communities form early childhood coalitions and begin to implement requisite coalition activities?

Coalition Formation and Implementation

The GTO facilitation team formed an early childhood coalition in Quay County drawn from representatives of the existing QCHC (sometimes also referred to as Quay County Maternal Child and Community Health in documents). The QCHC includes a variety of stakeholders that address a broad range of health issues. Thus the new coalition focused more specifically on early childhood issues than the existing Health Council had. The two groups worked in collaboration with each other.

The GTO facilitation team held 15 coalition meetings with a diverse group of community stakeholders (see Table D.3). Those who attended frequently included representatives from health and medical, parent supports and services, state government, basic needs, early care and education, family safety, and legal support services sectors. The GTO facilitation team worked with a representative of the QCHC to identify stakeholders for the coalition and contracted with her to serve as the HVCDG's community organizer beginning in April 2012. The GTO facilitation team began the HVCDG by holding a series of introductory meetings in April 2012 attended by a variety of community stakeholders, where the goals of the home visiting program were introduced and stakeholder input was received. In addition to the 15 GTO facilitator-led coalition meetings, there were six additional meetings of the QCHC between April and September 2012 that helped develop the work of the coalition in its early stages. Between May and September 2012, HVCDG meeting efforts focused on asking stakeholders to identify community needs and assets, develop strategies to address poor birth outcomes and family environment, and review a variety of home visiting models.

The coalition decided by September 2012 to implement PAT as the home visiting program. The subsequent coalition meetings held between September 2012 and October 2013 included efforts to work out details of the home visiting program, such as establishing a fiscal agent to administer the program, selecting a provider from among an unknown number of proposals to implement the program, and developing a work plan with stakeholders. A subset of QCHC members formed a Home Visiting Advisory Committee (a requirement of PAT,) designed to review data from the home visiting program and make recommendations for improvement. The Home Visiting Advisory Committee held its first meeting in July 2013 (PAT also requires that these committees meet at least quarterly), and focused on planning for the home visiting program. A second Home Visiting Advisory Committee meeting took place in September 2013, though it is not clear from documents whether the GTO facilitation team was involved

in that meeting. A subset of coalition members also held three meetings of The Prenatal Care Workgroup and one meeting of the Teen Pregnancy Workgroup between September and November 2013.

All stakeholder interview respondents stated the coalition would be sustained into the next year. They said the coalition was likely to meet less frequently in person, with plans to meet online or over the phone to supplement in-person meetings. Respondents said the coalition should sustain itself because there is still a need for such work, but that it would not sustain without funding and other resources.

Coalition Planning Activities

Respondents in Quay County were very positive about the GTO facilitation team's approach. They said the team used a systematic process and helped keep the coalition on track through the process of identifying risk factors, outcomes, and strategies. One respondent suggested that the coalition might not have gotten as far without such facilitation. Respondents also noted that the GTO facilitation team helped the coalition identify community needs and provide stakeholders with important information, including data about risk factors. One respondent noted that the coalition would use the same process to help identify and address gaps in other community services.

Quality of Community Action Plan

Strengths

The needs assessment included concrete data elements for most domains, although some data sources were distal to the actual domain. For example, the reading and math proficiency of area third-graders is mentioned in several places under the goal "children are ready to enter school." Other data or indicators besides proficiency scores may shed more direct light on school readiness. All goals have at least one objective to operationalize the goals. The objectives are generally well specified, meaning they specify what will change, in whom, by when, and how much. The objectives also relate well to the stated goals and to the activities that are mentioned, indicating a logical progression from needs, to goals and objectives, to activities. Collaborative partners are mentioned for most activities. Activities are targeted to a mix of institutional levels (home visiting program enrollees, child development centers) and community levels (all parents, all teens in Quay County). The activities that are mentioned are well coordinated with existing community programs.

Challenges

In some cases, although the objectives are specified, the domain being targeted is unclear. For example, parents' "literacy activities" with their children are specified as a target for improvement, but "literacy activities" is not well defined. There is a significant lack of details about the activities mentioned. Several activities are not

interventions, but intentions to form workgroups to collect more needs assessment data. For example:

- Form a workgroup to research access and barriers to prenatal care services in Quay County to determine additional needs.
- Form teen pregnancy prevention workgroup to research resources, stats, activities to support teen pregnancy prevention.
- Form workgroup to develop outreach strategies.

Other activities are intentions to develop a program, expand services, or develop a media campaign:

- Work with Medicaid-funded transport companies to allow exceptions for pregnant women traveling with children.
- Initiate Cuidate (a teen pregnancy prevention program).
- Collaborate with local organizations to develop family reading/literacy activities.
- Develop media campaign to educate women to importance of prenatal care/availability of local prenatal care/dangers of substance abuse/dangers of child abuse.

However, in all instances, very few details are provided about how these initiatives would be operated. For example, almost no tasks are listed beyond the initial intent to form a workgroup, develop a program, or run a media campaign. There were few detailed timelines or task deadlines provided. No budget or evaluation plan was specified.

Research Question 2: To what extent did the project utilize GTO and ECHO distance learning to support the work of the coalitions and home visiting programs?

GTO Facilitation Abstract

Similar to the activities documented in Luna County, the coalition reviewed county-level data on rates and rankings across the state on several early childhood indicators (e.g., low birth weights), providing a rationale for home visiting, a component of GTO Step 1. Continued review of data occurred through the HVCDG period, with discussion of the New Mexico Youth Risk and Resilience data from the local high schools in autumn 2013. In August 2012, the GTO facilitation team assisted the community in selecting a home visiting program, incorporating elements of GTO Step 3. The fiscal and program agencies to deliver the service were confirmed by early 2013, which incorporated elements of GTO Steps 4 and 5. Similar to Luna County, goals and objectives for the community were developed in 2013, consistent with GTO Step 2. In August and September 2013, discussion of process evaluation elements (GTO Step 7)

regarding the home visiting program (i.e., number of families referred, number of those that are teens) was mentioned. A community action plan that incorporated elements of Step 6 (i.e., Planning) was presented and discussed with the coalition members in October 2013.

Community Stakeholder Interviews

Two of the three stakeholders interviewed recalled GTO being introduced early in one meeting in combination with why Quay County was chosen to participate in the HVCDG. Another stakeholder mentioned the team's role as a facilitator but did not recall mention of a specific framework. The stakeholder that recalled GTO being introduced early on agreed that they expected to use GTO in the community planning work.

ECHO Distance Learning Activities

Quay County home visiting staff began discussions with the T/TA provider in May 2013 and focused on start-up plans. This was followed by the initial T/TA meeting onsite in July 2013 to introduce the provider to staff in the new home visiting program and to complete the INA tool described in Appendix D, which was used similarly as in Luna County. The T/TA provider noted that the Quay County home visiting staff had a background in home visiting that was consistent with the PAT model, so they did not receive the initial training on the theory of change for PAT that the staff in Luna County received.

Table E.3 provides a chronological overview of the onsite and distance T/TA meetings from July through November 15, 2013. As in Luna County, the T/TA provider began with onsite visits to establish a relationship with staff, after which meetings were more frequently held using distance communications. Based on information from the T/TA database and annual report, the Quay County site received three onsite visits by the T/TA provider to support the new home visiting program and engaged in six distance-learning meetings during this time period.

The T/TA distance technology was Adobe Connect via the Internet. Counter to Luna County's experience, the T/TA provider stated that Quay's home visiting organization did not experience technical difficulties and already had technology capacity and support; for example, quickly being able to use videoconferencing for meetings. Home visiting program staff noted that they only needed to add web cameras to use the technology, but that the distance learning also saved travel time and costs. However, it was mentioned that using distance communications such as videoconferencing is not the same as being able to see someone in person. The T/TA did not begin using ZOOM technology during the evaluation timeframe.

As noted in the T/TA database, annual report, and provider interview—and supported by interviews with program staff—T/TA engagements with the program focused on reflective supervision for program managers, and other topics were based

on perceived program needs and requests for specific information. Topics included hiring and training of staff; positive guidance and discipline; boundaries, ethics, and safety for home visitors (the same training as in Luna County); increasing workload and time management for home visiting staff; recruitment targets; use of assessment and screening tools by home visitors; program support for literacy and its relation to the school readiness outcome; and waitlist policies for families.

In addition to meetings, the T/TA provider maintained contact with home visiting staff through email exchanges and phone conversations as needed to support follow-up steps to the INA, as noted in the database. However, specific topics for these exchanges were not documented in the database information. As home visiting program staff noted, the T/TA provided through this HVCDG helped the program successfully implement home visiting services, although whether it would be recommended to other communities would be based on the organizational needs in that community.

The T/TA provider also offered support to the Quay County Home Visiting Advisory Committee established as part of this HVCDG and participated in several community meetings related to early childhood services or home visiting to build community relationships, as in Luna County. The T/TA provider also attended six coalition meetings between January and August 2013. Several of these community and coalition meetings occurred before T/TA was initiated with the home visiting program, which helped the provider learn about community stakeholders and the home visiting context before providing services.

Research Question 3: Did the sites enhance the continuum of services they need to support families?

Respondents in Quay County stated that they perceived early intervention services, local public health offices, and local schools served community families' needs somewhat or very well. However, they felt the following services did not serve families well: local hospital or medical center that provides anything beyond basic services, behavioral health or mental health providers, family practice physicians, child care, and substance abuse treatment. We received mixed answers or insufficient information to gauge other services present in the community, especially in the areas of basic needs and family safety.

When asked generally about gaps and barriers to services, respondents noted that the lack of health care services is a particular gap, including a lack of specialty services and doctors. They also identified a lack of awareness of services and a lack of transportation to access services. The perceived next steps in the community as noted by respondents are to address medical service shortages and increase access to child care and prenatal care. Two respondents specifically noted a plan to work with UNM to help provide more medical services.

Research Question 4: Did the sites improve their infrastructure for home visiting services?

The community decided by September 2012 to implement the PAT home visiting model, and subsequently chose REC6 as the fiscal agent for the program in November 2012 (Mesalands community college, initially selected as the fiscal agent, had to withdraw and REC6 was chosen after that). The CYFD and REC6 contract agreement's start date was January 30, 2013. REC6 announced an RFP for a community provider for PAT, and Presbyterian Medical Services, an FQHC, was selected as the provider in March 2013. PAT began serving families on July 15, 2013.

The initial scope of work stated that the PAT program would serve 40 families by September 30, 2013. Delays in initiation meant the program started only two and a half months prior to the initial contract's end period. As shown in Table 3.1 in Chapter Three, the PAT program had been offering services for four months and had served 25 families by November 15, 2013, with 25 families currently enrolled. Thus, they did not meet their original targeted enrollment for this HVCDG. They had three home visitors on staff and had provided 139 home visits. According to the T/TA provider, this program is actively recruiting and is well supported by the community. Based on stakeholder interviews, respondents concur and feel that the PAT program serving families is one of the main values of this HVCDG for the community. Respondents also expressed some frustration with the delays in the beginning to get the contracts signed, hire staff, and start to serve families. They wanted home visiting services to have started sooner, and suggested shortening the process from program selection to starting services as a way this HVCDG could be improved if replicated.

Appendix F: McKinley County Site Summary

This appendix presents a compilation of information to describe HVCDG activities in McKinley County during the evaluation timeframe. We begin with an overview of key activities in tabular form. The next sections describe the formation, sustainment, and activities of the coalition, followed by a description of the continuum of services available in the community. Then we discuss the T/TA provided to the selected home visiting program. We follow with a timeline of key activities and a description of the coalition meeting attendance. We conclude with a summary section of evaluation findings by research question.

We relied on multiple data sources for this summary. Information about coalition activities and meeting participants comes from a review of documents provided by the facilitation team, including meeting notes, sign-in sheets, and other materials. We also gained information from interviews with the facilitation team and community stakeholders. Information on the continuum of services was gathered through interviews with several community stakeholders and a review of coalition meeting notes. Information on home visiting program implementation was supplied by the T/TA provider and the state project officer.

Table F.1 provides an overview of coalition efforts and home visiting program implementation.

Table F.1. Overview of Key Activities April 2012 through November 15, 2013

Organization	Description
Coalition	
Stakeholders participating	• FIT provider • FIT provider serving tribal areas • State children and families department • Coalition focused on childhood obesity • Home visiting program • Tribal medical center for teens • Tribal medical center • Public charity organization focused on education • Affordable housing developer • State health department • Technical assistance provider • Public early child care education center • Public school • Marketing and public relations agency • Infant health advocacy organization • Medical school
Coalition meetings	• One two-day introductory meeting • Ten coalition meetings
Meeting materials	Modified GTO tools: • Goals and objectives worksheet • Activities plan Other Materials: • Description of home visiting programs • Work plan document • Implementation proposal re: home visiting funding • Resource list/directory • Outreach specialist job recruitment
Coalition goals and objectives (priorities)	1. Behavioral health 2. High-quality child care (includes early learning and developing literacy) 3. School readiness 4. Domestic violence 5. Gestational diabetes 6. Teen pregnancy
Home Visiting Program	
Home visiting target population	Very high-risk communities, as determined from population data
Home visiting program model selected	PAT and First Born Program to collaborate on outreach to high-need families
Home visiting fiscal agency	County of McKinley for First Born Program
Home visiting program provider agency	Los Alamos National Laboratory (LANL) Foundation for First Born Program
Date home visiting services began	7/19/2013 for First Born Program
Home visiting program services implementation (as of 11/15/13)	Not applicable

SOURCES: Coalition meeting documentation, including minutes and sign-in sheets, and T/TA provider documentation.

Formation and Sustainment of Early Childhood Coalition

Prior to the HVCDG award, there was no coalition that worked exclusively on the broad system of early childhood services in McKinley County, although there was a preexisting early childhood group convened by the LANL Foundation with funding from the W.K. Kellogg Foundation to support the development of their home visiting services in McKinley County. Additionally, there were three preexisting coalitions that broadly worked on health issues. The Healthy Environments and Health Living Council had been in the community for two years; the McKinley County Health Alliance, at least ten years; and the Healthy Environments, Active Lifestyle coalition, two to three years.

Coalition Development

In spring 2012, the facilitation team began the coalition-building process by contacting the LANL Foundation, which was then leading the First Born Program's stakeholders' group. The facilitation team introduced the HVCDG and discussed potential collaborations. The preexisting group invited the facilitation team to join efforts that were already underway to establish the First Born Program. By October 2012, the facilitation team contacted the coalition focused on childhood obesity and discussed collaboration with the existing PAT home visiting program. Although unclear from documentation and interviews, it appears the facilitation team joined with the preexisting early childhood group for coalition meetings starting at the end of 2012, and included stakeholders who had not been part of the original group. Stakeholders then met as part of this modified coalition and began focusing on early childhood services in the community, in addition to home visiting services.

Coalition Functioning

The facilitation team led one introductory meeting and ten coalition meetings from May 2012 through November 15, 2013. In most cases, the coalition met monthly.

The coalition meetings have been well attended, with five to 11 participating organizations at each meeting (Table F.4). On average, there were eight organizations present at each meeting. The most consistent attendees were representatives of the two FIT providers, the State children and families department, a coalition focused on childhood obesity, a home visiting program, and two tribal medical centers.

There was no general consensus among McKinley County interview respondents regarding benefits of, or areas to improve, the HVCDG. Respondents identified different main values of the HVCDG, including bringing stakeholders together and identifying gaps in services. They also expressed different areas of improvement needed, including ensuring all stakeholders are on the same page and ensuring continued involvement among stakeholders.

McKinley County respondents noted the coalition would be sustained, contingent on funding and having a coordinator to organize the effort. One stakeholder mentioned that the coalition already committed to sustain until at least 2015, because some of its identified objectives run through that year.

Coalition Activities

The coalition engaged in a number of activities from November 2012 to November 2013. Next, we discuss the activities that were undertaken in this community organized by the ten-step GTO model.

Step 1: Conducting Needs and Resource Assessments

The coalition reviewed population data for planning how to prioritize target areas, identified and examined risk factors, and compiled a list of resources (providers) in the area between November 2012 and July 2013. It discussed community gaps and needs, notably in transportation and mental health services. The resource list, referred to as "McKinley Resources" was updated a couple of times over the course of the meetings.

Step 2: Specifying Goals, Objectives and Target Population

The facilitation team and the coalition frequently updated and refined their measures, goals, and objectives between August 2013 and October 2013. The coalition developed priorities for goals and objectives upon reviewing risk factors, and decided to prioritize behavioral health, high-quality child care, school readiness, domestic violence, gestational diabetes, and teen pregnancy. The facilitation team then developed a first draft of goals and objectives based on community-identified priorities using a modified GTO goals and objectives worksheet. This worksheet specifies the amount of change expected in desired outcomes, the deadline by which desired outcomes are expected to occur, and data sources to be used in measuring outcomes. Each goal has an associated home visiting objective as well as a larger community objective. The facilitation team updated goals, objectives, and corresponding activities based on community feedback.

Step 3: Choosing Evidence-Based Programming (Best Practices)

Over the course of two meetings, the coalition selected a collaborative home visiting intervention focus in McKinley County. In November 2012, the coalition discussed the three home visiting programs available: First Born Program, PAT, and NFP. The coalition decided both the First Born Program and PAT were the best fit for the community, because they were the most cost-effective and these two programs could collaborate on referrals. The coalition considered that the First Born Program was already implemented and running for six months (as of December 2012), and PAT had been successful with teen parents.

Steps 4 and 5: Ensuring Program Fit and Ensuring Capacity

The facilitation team collaborated with the coalition on using a common referral form for the two home visiting models, and in developing a referral system for home visiting programs. Coalition members expressed a desire to ensure programs did not conflict with each other. In October 2013, the First Born Program director submitted a report indicating there are plans to collaborate with PAT and other organizations as needed (i.e., foundations to buy books and share with families), and that the First Born Program is in the process of planning trust-building activities aimed toward parents, interested women, and interested stakeholders. In November 2013, the facilitation team attempted to contact the lead educator of the PAT program to help determine which literacy support items may be most appropriate for high school dropout teen mothers enrolled in PAT.

The facilitation team collaborated with the coalition and developed a job description for hiring an outreach/recruiting specialist for this HVCDG. The facilitation team helped the two programs agree to a proposal to divide additional CYFD grant funding available for McKinley County and began looking into whether an outreach specialist would be able to track referrals and home visiting data in the State's home visiting referral database. The facilitation team and the coalition assessed capacity for some technical items, such as motivational trainings and video conferencing, and developed technical items, such as memoranda of understanding and the common referral form. The LANL Foundation became the program agent for the First Born Program in July 2013, but no similar contract arrangement for PAT was made during the evaluation timeframe. As of November 15, 2013, no outreach specialist had been hired by either home visiting program.

Step 6: Planning Programs

The coalition completed some elements of Step 6 in October 2013. The facilitation team and the coalition specified activities for some of the strategies in the community action plan, began to formulate strategies for the prioritized goals and objectives, and identified responsible parties for some of the objectives.

Step 7: Conducting a Process Evaluation

The coalition completed two elements of Step 7. In August 2013, the facilitation team announced to the planning group that PAT served 80 families at a coalition meeting. Also in August 2013, the facilitation team spoke with a database specialist at UNM about the ability to track home visiting referrals, and the outreach specialist's ability to add data into the State's home visiting referral database. The First Born Program report stated a total number of referrals received since January 1, 2013, and the number of referrals the First Born Program made to PAT.

Status of Continuum of Services as of Fall 2013

McKinley County has several community resources, mostly located in Gallup. The information in Table F.2 is based on interviews and meeting notes. We have more information for some sectors than others depending on the source of information. For example, we may have details about some categories, whereas we only know of the existence of others.

Table F.2. McKinley County Community Services

Sector	Services
Medical	
Local hospitals or medical centers	• Three tribal health centers, one of which exclusively serves ages 11 to 21 • Teen health center • Children's medical services (case management, medical services, diagnostic work) • Nonprofit health care network (intensive care unit, surgery, cardiology, lab)
OB/GYN physician(s)	• Tribal health services (provides routine OB services)
Pediatrician(s)	• Tribal medical center (employs ten pediatricians) • Tribal health services (employs two pediatricians; provides pediatric services from birth to age 18) • Tribal community health center (pediatrics) • Nonprofit health care network (well-baby care)
Behavioral health/mental health providers	• Six entities and one individual providing mental health services
Locations with birthing centers, such as hospitals or midwifery centers	• Nonprofit health care network (labor and delivery)
Early intervention services	• Two FIT providers serving children ages 0-3
Early Care and Education	
Child care, Head Start, Early Head Start (center-based version), other prekindergarten	• 19 Head Start centers, all serving ages 3 to 4 • Three preschool centers, serving ages 3 to 4
Home visitation programs	• First Born Program • PAT
Parent Supports and Services	
Local schools—public and private, elementary and secondary	• Eight schools providing literacy and early learning • Tribal education department programs: home-based services for children ages 0 to 2; center-based services for children ages 3 to 4. Program also has adult education teacher
Substance abuse treatment services	• Nonprofit health care network that provides 30-day outpatient, treatment, medication management, intensive outpatient available for substance abuse treatment
Basic Needs	
Local income support agency and workers	• Have these available, but with reduced funding and reduced staff
WIC	• County public health department. Two tribes have their own WIC office.
Other	• Nonprofit affordable housing developer to build low-income housing • Foundation provides heating and electricity subsidies; occasionally provides rent subsidies
Family Safety	
Local domestic violence shelter, domestic violence counselors	• Entity providing services to battered women and their families • Program providing domestic violence services in tribal area
Local CYFD caseworkers	• State children and families department's child protective services
Justice organizations—juvenile justice, local sheriff, etc.	• An early intervention team that handles child abuse in tribal areas

SOURCES: Coalition meeting documentation and interviews with community stakeholders.

Coalition members stated that the reported rate for child abuse is low, but they believe that there are reporting issues and that child abuse rates are actually higher.

There are also noted jurisdictional issues between state and tribal governments when it comes to child abuse.

McKinley County interview respondents identified people living in isolated, rural communities and the lack of transportation to services in the community as a key barrier to services. Respondents identified different efforts that were underway to address barriers to services, including focusing on outcomes, carrying out a community plan, and bringing services to more isolated tribal areas.

Training and Technical Assistance (T/TA) for Home Visiting Program

No T/TA has been conducted in McKinley County by the end of the evaluation timeframe.

Timeline of Events

Table F.3 presents coalition and home visiting program milestones from April 2012 through November 15, 2013.

Table F.3. Timeline of Coalition and Home Visiting Events, April 2012 through November 2013

Description	Date
Coalition Meetings	
Introductory Meeting (LANL Foundation Home Visiting Planning Session)	5/3/12–5/4/12
Meeting 1 of community coalition	11/13/2012
Meeting 2 of community coalition	12/13/2012
Meeting 3 of community coalition	1/28/2013
Meeting 4 of community coalition	3/22/2013
Meeting 5 of community coalition	4/18/2013
Meeting 6 of community coalition	5/23/2013
Meeting 7 of community coalition	7/23/2013
Meeting 8 of community coalition	8/15/2013
Meeting 9 of community coalition	9/20/2013
Meeting 10 of community coalition	10/25/2013
Coalition and Home Visiting Program Milestones	
Local community organizer begins	1/9/2013
Home visiting intervention selected—collaboration between two existing home visiting programs	1/28/2013
State contracts with local home visiting fiscal agent for supporting First Born Program	7/19/2013
Home visiting collaboration planning begins	7/19/2013
Submitted coalition's community action plan	11/15/2013
Outreach specialist hired	Not completed by evaluation end date
Home Visiting Advisory Committee begins	Not applicable

SOURCES: Meeting and other documentation provided by the facilitation team and T/TA provider.

Coalition Meeting Attendance

A variety of individuals representing different organizations attended at least one coalition meeting during this timeframe. Table F.4 shows stakeholder attendance listed by the type of organization or entity the stakeholder represented. We note the organization that the attendee signed in under, although we recognize that some attendees may be representing different parts of a single umbrella organization (e.g., a home visiting program operated by a larger organization). If at least one person from an entity was present for a given meeting, then the general entity as a whole is counted as present at that meeting. The list is ordered with the entities present at the largest number of meetings listed at the top, noting the total number of meetings attended as well as the number of representatives from that entity attending across all meetings.

Table F.4.
Stakeholders' Coalition Meeting Attendance

Organization	# People in Each Entity Attending at Least One Mtg	Total Mtgs Present	2012		2013							
			11/13	12/13	1/28	3/22	4/18	5/23	7/23	8/15	9/20	10/25
FIT provider	3	9	✓	✓		✓	✓	✓	✓	✓	✓	✓
FIT provider serving tribal areas	1	8	✓	✓	✓		✓	✓	✓	✓	✓	
Public school system (provides home visiting services)	3	8	✓	✓	✓	✓	✓		✓	✓	✓	
State children and families department	2	7		✓	✓	✓	✓	✓	✓		✓	
Coalition focused on childhood obesity	1	7	✓	✓	✓				✓	✓	✓	✓
Tribal medical center for teens	1	7	✓		✓	✓	✓		✓	✓	✓	
Tribal medical center	2	7	✓		✓	✓	✓	✓		✓		✓
Public charity organization focused on education (provides home visiting services)	4	6	✓		✓	✓	✓			✓	✓	
Affordable housing developer	1	5		✓	✓		✓	✓			✓	
State health department	1	5		✓	✓		✓			✓		✓
Technical assistance provider	2	4			✓		✓	✓	✓			
Public early child care education center	1	1		✓								
Marketing and public relations agency	3	3		✓				✓			✓	
Infant health advocacy organization	1	1										✓
Medical school	1	1					✓					

SOURCES: Meeting sign-in sheets and minutes detailing attendance.

Site-Specific Evaluation Results

Research Question 1: Did the four participating communities form early childhood coalitions and begin to implement requisite coalition activities?

Coalition Formation and Implementation

McKinley County respondents identified more with a preexisting early childhood group convened by the LANL Foundation with funding from the W.K. Kellogg Foundation to support the development of home visiting services in the county than they did with the new coalition led by the GTO facilitation team. One respondent expressed the view that the new coalition worked with the existing early childhood group to avoid duplicating efforts. One stakeholder noted that the facilitation team did help identify additional stakeholders to involve in the coalition work that had not been involved in the preexisting early childhood group.

Between November 2012 and October 2013 (see Table F.3), the GTO facilitation team participated in ten meetings that were scheduled concurrently with the preexisting early childhood group convened by the Los Alamos National Laboratory Foundation, broadening their scope to include the early childhood issues central to this HVCDG. Regular attendees to those ten meetings included representatives from the health/medical, parent supports and services, and state government sectors. The GTO facilitation team contracted with the community organizer in January 2013. During the ten meetings, the coalition reviewed community risk factors, discussed possible evidence-based home visiting models to establish or expand, decided on specifics for the home visiting program, developed a referral system for home visiting programs and a list of community resources, and reviewed program goals and objectives. The existing First Born Program and PAT were selected in December 2012 to divide the available HVCDG funds, and in January 2013, the coalition agreed that the two programs would collaborate on outreach and recruitment of high-need families in the county. Subsequently, a fiscal agent and program provider were contracted with by the State to enhance recruitment and referrals for the First Born Program beginning in July 2013, but no similar contract was established with a PAT provider during the evaluation timeframe.

All respondents in McKinley County stated that the coalition would continue. Stakeholders noted that sustaining the coalition would be contingent on funding and having a coordinator. One stakeholder noted that some of the objectives the coalition developed in its community action plan go through 2015, so they had already made an implicit commitment to continue to meet at least until then.

Coalition Planning Activities

McKinley County respondents had varying beliefs about the coalition's work. Although the coalition was mostly a continuation of a preexisting group, some valued that a few new stakeholders were brought in. Others mentioned identifying gaps in services and the focus on home visiting services as the main value. Respondents also noted that improvements could be made by making certain that stakeholders are all on the same page and by promoting sustained involvement among stakeholders.

Quality of Community Action Plan

Strengths

Some needs assessment data is concrete (i.e., numbers of adolescent births, domestic violence rates, infant deaths) and the use of state rankings is useful. The concerns and strengths are usually presented and have good information to guide planning. All goals are operationalized by at least one objective. The objectives are generally well specified and relate well to the activities that are mentioned, indicating a logical progression from needs, to goals and objectives, to activities. The activities themselves are moderately measurable. Many at least specify what the activity is, who is responsible for carrying it out, and who will receive it. There was moderate specificity in the target populations mentioned. In most cases, a general priority population was specified ("pregnant women" or "McKinley Co. teens/adolescents"). In some cases, the plan included more specificity, indicating a more targeted group ("Parents enrolled in PAT"), and in a few cases a very specific group was mentioned ("Home visitors with parents indicating/reporting substance use"). Lead agencies or parties responsible for the activities are specified for most activities. Collaborative partners, including the Department of Health and other community agencies, are mentioned for most activities. Activities are targeted to a mix of levels, including individual (individual parents, home visiting program enrollees), institutional (home visiting providers), and community (all parents, all teens in McKinley). The activities that are mentioned are well coordinated with existing community programs and resources.

Challenges

For some needs assessment data, only the names of data sources are listed, but no data is actually presented (e.g., "CYFD home visiting database referral data", "Community-identified concern"). For other parts of the plan, no needs assessment data is presented. In some cases, although the objectives are specified, the domain being targeted is unclear. For example (and similar to Quay County), "literacy activities" on the part of area parents are specified as a target for improvement, but "literacy activities" is not well defined (and there is a note in the plan document stating that

more clarity is needed for this activity). Several activities that are listed appear to be what the home visiting programs are already doing. For example:

- providing early literacy activities to families—"Home visiting curricula support this work with parents"
- improve parenting skills—"Home visiting programs focus on developing, supporting parental skills, education."

Other activities are intentions to develop outreach:

- develop media campaign to educate teens on the importance of birth control availability; pregnant woman on the dangers of substance abuse.

And still other activities are intentions to develop a program or expand services:

- safety for pregnant women
- screenings for behavioral health issues
- nutrition classes.

However, in all instances, very few details are provided about how these initiatives would be run or implemented. Almost no tasks are listed beyond the initial intent to conduct these activities. Only a third of the activities mention what role the listed collaborators would play. No significant timelines are presented. There was one instance in which a date is mentioned ("DoH [Department of Health] to conduct training by Fall 2015"). No budget or evaluated plans are specified.

Research Question 2: To what extent did the project utilize GTO and ECHO distance learning to support the work of the coalitions and home visiting programs?

GTO Facilitation Abstract

Like the other communities, the coalition's first meetings focused on reviewing county-level data on rates and rankings across the state on several early childhood indicators, providing a rationale for home visiting, an element of GTO Step 1. Successive meetings continued to focus on additional needs and resources data. For example, a resource list that contained information about service provision and capacity (an element of GTO Step 1) was disseminated by the facilitation team at the May 2013 meeting to get stakeholder input on accuracy. School ranking information and information regarding home visiting referrals from CYFD were presented by the facilitation team in summer 2013. Unlike the other sites, the community planning in McKinley County was different because two home visiting programs already operated there and this HVCDG work involved attempting to collaborate on conducting outreach to increase recruitment and participation rates. Planning for an outreach specialist to service both home visiting programs was started in January 2013. The coalition discussed referral rates in August 2013, an element of GTO Step 7. Similar to the other

sites and consistent with GTO Step 2, a goals and objectives worksheet was discussed in August 2013. Incorporating elements of GTO Step 6 (i.e., planning), a community action plan was presented and discussed in October 2013.

Community Stakeholder Interviews

All three respondents said they had heard of GTO and two agreed there was an expectation to use it in the community planning process. When the stakeholders responded about using the GTO framework, they mentioned having planning documents to establish goals and objectives for their community.

ECHO Distance Learning Activities

The focus in McKinley County differs from the other three communities, because the grant is supporting home visiting outreach and recruitment efforts of the privately funded First Born Program, in collaboration with the MIECHV formula-funded PAT, rather than initiating new home visiting services. The T/TA provider did not supply much specific T/TA as part of this HVCDG during the evaluation timeframe because the community had not developed a formal collaboration plan or begun the outreach and recruitment efforts fully.

According to T/TA database notes and information about other home visiting efforts, the T/TA provider participated in five community meetings related to early childhood services and home visiting as part of ongoing work in the community between April and July 2013. Two of those meetings appear related to this HVCDG. In January 2013, the T/TA provider attended the McKinley County Home Visiting Development Initiative meeting, which is part of this HVCDG's coalition work, where they reached consensus to begin development of a collaboration between PAT and the First Born Program for this HVCDG. In April 2013, the provider attended the community coalition meeting that included community partners interested in supporting collaborative home visiting efforts. Finally, one community stakeholder respondent noted that the T/TA provider at one point provided an example of a home visiting referral form the collaboration could use, although that form was ultimately rewritten by the coalition group.

Relevant to future distance-learning efforts in this community, the T/TA provider noted that it was discovered during this HVCDG that the school district, which houses the PAT program, has a firewall that prevents using Skype or Adobe Connect. The provider also noted that in-person meetings seemed to work better than videoconferencing in this community, due to cultural concerns around having images captured on video. The lesson noted was that T/TA providers will need to ask sensitive questions about this potential barrier to using distance technology that includes video and have cultural competency related to tribal issues in general.

Research Question 3: Did the sites enhance the continuum of services they need to support families?

Overall, McKinley County respondents stated they did not feel that many of the services in the community served families' needs well. Respondents provided mixed answers on whether or not home visitation programs, adult education, local employment office, or local income support agencies served the community well.

Respondents identified the lack of transportation to services as a key barrier. They noted that many people live in rural, isolated communities or on reservations that are not close to services. They also noted a variety of efforts underway to address barriers to service, and reported that the perceived next steps are to largely focus on continuing the process the community has started (e.g., focusing on outcomes, implementing a community plan through the coalition's work and other forums). While one respondent noted efforts to bring services to isolated areas on the reservations, respondents overall were not aware of any plans to deal with the lack of transportation.

Research Question 4: Did the sites improve their infrastructure for home visiting services?

The McKinley County community chose a different home visiting intervention strategy than the other three counties. It had an existing PAT program and an emerging First Born Program providing home visiting services. But stakeholders recognized the need to serve more high-need families. After community dialogue, stakeholders agreed in January 2013 to divide the grant funding between the two entities providing PAT and First Born Program services and to collaborate on outreach to and recruitment of high-need families. The State initiated a contract with McKinley County effective July 19, 2013, in support of the LANL Foundation to provide First Born Program outreach and recruitment in collaboration with PAT through September 2014. Although there were notes referencing plans to initiate a contract with Gallup-McKinley County Schools in support of the PAT program to also collaborate in outreach and recruitment efforts, no contract with CYFD was created as of November 2013 through this HVCDG.

As of November 15, 2013, little progress had been made on these collaborative efforts, according to available documentation and interview responses. According to coalition meeting notes, the community had developed a common referral form across home visiting programs in the County in autumn 2013 and was discussing coordinating recruitment and referral services between the First Born Program and PAT. A job description for an outreach specialist was drafted, as mentioned in coalition meeting notes, but neither home visiting program had hired an outreach specialist by November 2013.

Appendix G: South Valley Site Summary

This appendix presents a compilation of information to describe HVCDG activities in South Valley during the evaluation timeframe. We begin with an overview of key activities in tabular form. The next sections describe the formation, sustainment, and activities of the coalition, followed by a description of the continuum of services available in the community. We then discuss T/TA provided to the selected home visiting program. We follow with a timeline of key activities and a description of the coalition meeting attendance. We conclude with a summary section of evaluation findings by research question.

We note that, in order to provide consistency in information presentation across the summaries of HVCDG sites, we include information on coalition activities for South Valley. However, the community meetings that the state-contracted facilitation team engaged in were not coalitions with diverse stakeholders meeting regularly as noted in the other sites, but were primarily focused on planning meetings with staff or representatives of one specific stakeholder, Partnership for Community Action, an advocacy and leadership organization in South Valley. Thus, when we use the term coalition in this Appendix, we are referencing these community planning meetings.

We relied on multiple data sources for this summary. Information about coalition activities and meeting participants comes from a review of documents provided by the facilitation team, including meeting notes, sign-in sheets, and other materials. We also gained information from interviews with the facilitation team and community stakeholders. Information on the continuum of services was gathered through interviews with several community stakeholders and a review of coalition meeting notes. Information on home visiting program implementation was supplied by the T/TA provider and the state project officer.

Table G.1 provides an overview of coalition efforts and home visiting program implementation.

Table G.1. Overview of Key Activities April 2012 through November 15, 2013

Organization	Description
Coalition	
Stakeholders participating	• Advocacy and leadership organization • State health department • Technical assistance provider • State children and families department • Organization focused on health needs of young children • Community members • Home visiting program
Coalition meetings	• Five meetings with advocacy and leadership organization staff • Two meetings with advocacy and leadership organization's parent leaders • Two community-wide meetings
Meeting materials	Other Materials: • County ranks on risk factors • Description of home visiting programs
Coalition goals and objectives	Children are ready for school
Home Visiting Program	
Home visiting target population	None specified
Home visiting program model selected	PAT
Home visiting fiscal agency	UNM
Home visiting program provider agency	UNM
Date home visiting services began	Not completed by evaluation end date
Home visiting program services implementation (as of 11/15/13)	0 home visitors 0 families currently enrolled 0 of families served 0 of home visits

SOURCES: Coalition meeting documentation, including minutes and sign-in sheets, and T/TA provider documentation.

Formation and Sustainment of Early Childhood Coalition

Prior to the HVCDG award, there was no early childhood coalition focused on the South Valley, but there were two related collaborations in the vicinity. Stakeholders in Bernalillo County formed a "Pregnancy to Three" task force in 2007 that transitioned into an NFP community advisory group, which began serving families in 2011/2012. The Early Childhood Accountability Partnership started in 2010 with a broad focus on school readiness. This group meets quarterly, with smaller organizing teems meeting one or two times a month. It has drafted a concept paper using a collective impact framework and is working on developing a governance infrastructure, as well as goals and indicators.

Coalition Development

The facilitation team began their coalition-building process by meeting with a County-level home visiting workgroup and with staff from the Partnership for Community Action (PCA). At the first planning meeting, the facilitation team introduced the goals of the home visiting program to PCA, an organization focused on parent empowerment. PCA agreed to partner with the facilitation team as the contracted local community organizer based on their interest and current work on early childhood needs. The initial agreement was issued in August 2012, and a signed agreement was reached in September 2012.

Coalition Functioning

Overall, meetings in the South Valley were mostly limited to the facilitation team and PCA staff. PCA helped organize and facilitate a meeting with the community in September 2012 and a focus group in October 2012. Between July and November 2012, the facilitation team held monthly meetings, but then only held three more meetings between December 2012 and November 2013. Aside from PCA staff, other meeting attendees included community members (all parents from PCA's Parent Leader Group) and community members at large.

South Valley interview respondents expressed a variety of beliefs about the HVCDG's main value and areas for improvement. Respondents noted benefits of the HVCDG that included bringing community members together, increasing awareness about early childhood issues, providing funds, and giving community members an opportunity to plan. Respondents also stated that additional stakeholders in the community should be involved, and had mixed opinions about the coalition's sustainability. These opinions ranged from expecting the coalition to sustain to having no expectations about the coalition's work or sustainment.

Coalition Activities

The coalition engaged in a number of activities from May 2012 to November 2013. Next, we discuss the activities that were undertaken in this community organized by the ten-step GTO model.

Step 1: Conducting Needs and Resource Assessments

The coalition reviewed the county's risk factors and relative rankings and looked at community assets, needs, and barriers (including language barriers) in November 2012. The facilitation team identified groups working on early childhood services in South Valley and compiled a list of area child care providers.

Step 2: Specifying Goals, Objectives and Target Population

Through the focus groups and community meetings, the coalition discussed broad goals and general target populations, but it has not defined specific (measurable) objectives or short- or long-term goals.

Step 3: Choosing Evidence-Based Programming (Best Practices)

Over the course of one meeting, the coalition selected a home visiting program to implement in South Valley. In September 2012, the coalition comprising PAT staff and parents from the PCA leadership group discussed the three home visiting programs available: First Born Program, PAT, and NFP, deciding PAT was the best fit for the community.

Steps 4 and 5: Ensuring Program Fit and Ensuring Capacity

The facilitation team collaborated with the coalition about the desired characteristics of the implementing and fiscal agencies, and in September 2012 met with CDD UNM to discuss the feasibility of CDD UNM serving as a fiscal agency and a program agency. In subsequent meetings, the facilitation team and the coalition discussed home visiting program hiring needs, talked about collaboration in delivering home visiting services in South Valley, and mentioned the need for collaborating with other early childhood groups in the area. There was difficulty with hiring home visiting staff for the PAT program, and the coalition discussed parents being hired as home visitors. As of November 15, 2013, CDD UNM was looking for office space for the home visiting program.

Status of Continuum of Services as of Fall 2013

Bernalillo County and Albuquerque have several community resources for South Valley residents. The information in Table G.2 is based on interviews and meeting notes. We have more information for some sectors than others depending on the source of information. For example, we may have details about some categories, whereas we only know of the existence of others. For example, we may have details about some categories, but only know of the existence of others.

Table G.2. South Valley Community Services

Sector	Services
Medical	
Local hospitals or medical centers	• Three hospitals • Family medical office that provides primary care, urgent care, women's health care, prenatal care, acupuncture, massages, and substance abuse services • Community health care center that provides medical, dental, behavioral health, and WIC services • Health care center providing medical services, behavioral health services and maternal child health services
OB/GYN physician(s)	• State university hospital's maternal child health services • Community health care center that provides medical, dental, behavioral health, and WIC services
Pediatrician(s)	• Pediatricians
Behavioral health/mental health providers	• Nonprofit specializing in youth development
Locations with birthing centers, such as hospitals or midwifery centers	• Community health workers association is creating a group of midwives • Midwives
Early intervention services	• FIT providers serving children ages 0–3
Other	• Nonprofit specializing in reproductive health services and advocacy • County health department
Early Care and Education	
Child care, Head Start, Early Head Start (center-based version), other prekindergarten	• Head Start* • Child care, although not much licensed child care*
Home visitation programs	• Four home visiting programs that were in (or serving) the area prior to this HVCDG
Other	• Social workers who work with low-income adults, including parents of young children, with unmet needs in the County
Parent Supports and Services	
Local schools—public and private, elementary and secondary	• Special high school for teen moms • Community college*
Substance abuse treatment services	• Nonprofit specializing in youth development • Family medical office that provides primary care, urgent care, women's health care, prenatal care, acupuncture, massages, and substance abuse services • School-based services
Other	• Teen pregnancy coalition • Nonprofit organization advocating for young women of color • Advocacy and leadership organization • Community schools for community engagement
Basic Needs	
Local income support agency and workers	• Agency office for WIC, TANF, Medicaid* • County child care subsidy office
WIC	• Yes, but understaffed due to budget cuts

Table G.2.—Cont.

Sector	Services
Family Safety	
Local domestic violence shelter, domestic violence counselors	• Nearby provider does not disclose location
Local CYFD caseworkers	• County level
Justice organizations—juvenile justice, local sheriff, etc.	• County sheriffs • City police • Restorative justice focused on just one school in South Valley (pretty small)
Other	• Local grassroots organization that emphasizes drawing from cultural roots and violence prevention

SOURCES: Coalition meeting documentation and interviews with community stakeholders.
NOTE: South Valley-specific resources are indicated with an (*).

The interviewed stakeholders stated that a systematic assessment of the South Valley community resources had not been completed, but noted the importance of finding out what the community already has in order to identify gaps. Although many services are available in Albuquerque and Bernalillo County, South Valley residents may not be accessing them. Transportation was also identified as a limiting factor, particularly for young families who may have trouble using public transportation with small children.

Although the community resources had not been systematically studied, interviewed stakeholders noted that child care could be improved. First, there is the perception that child care providers are not high quality. Many child care providers are not licensed. Licensed programs such as Head Start have low capacity and serve only a fraction of families. Second, there is a perception there is little financial assistance for child care, especially for those at the edge of the cutoff for assistance. As a result, child care is often unaffordable, which also makes low-quality child care or family care more appealing.

One stakeholder noted that home visiting is relatively unknown in the South Valley community. There are no waiting lists for the current home visiting programs, even though there is a need for such services. Stakeholders stated a need to better understand parent preferences and priorities regarding early childhood to develop a successful home visiting program.

South Valley interview respondents stated a lack of services overall and a lack of awareness of existing services. Additionally, they noted a lack of funding for services and a lack of transportation to services. Respondents stated that isolated efforts exist to address barriers to services, but no coordinated efforts are in place.

T/TA for Home Visiting Program

No T/TA had been conducted in South Valley by the end of the evaluation timeframe, as no home visiting staff had yet been hired.

Timeline of Events

Table G.3 presents coalition and home visiting program milestones from April 2012 through November 15, 2013.

Coalition Meeting Attendance

Individuals representing different organizations attended at least one coalition meeting during this timeframe. Table G.4 shows stakeholder attendance listed by the type of organization or entity the stakeholder represented. We note the organization that the attendee signed in under, although we recognize that some attendees may be representing different parts of a single umbrella organization. If at least one person from an entity was present for a given meeting, then the general entity as a whole is counted as present at that meeting. The list is ordered with the entities present at the largest number of meetings listed at the top, noting the total number of meetings attended as well as the number of representatives from that entity attending across all meetings.

Table G.3. Timeline of Coalition and Home Visiting Events, April 2012 through November 2013

Description	Date
Coalition Meetings	
Meeting 1 of PCA staff	7/30/2012
Meeting 2 of PCA staff	8/13/2012
Meeting 3 of PCA staff	9/4/2012
Meeting 1 PCA's Parent Leader Group	9/20/2012
Community focus group	10/9/2012
Community stakeholder meeting	11/20/2012
Meeting 4 of PCA staff	4/26/2013
Meeting 2 PCA's Parent Leader Group	5/30/2013
Meeting 5 of PCA staff	10/10/2013
Coalition and Home Visiting Program Milestones	
Local community organizer begins	9/4/2012
Home visiting program selected	9/20/2012
State contracts with local home visiting fiscal agent	2/28/2013
Home visiting program manager hired	Not completed by evaluation end date
Home Visiting Advisory Committee begins	Not completed by evaluation end date
Submitted coalition's community action plan (partial)	11/15/2013

SOURCES: Meeting and other documentation provided by the facilitation team.

Table G.4. Stakeholders' Coalition Meeting Attendance

Organization	# People in Each Entity Attending at Least One Mtg	Total Mtgs Present	2012						2013	
			7/30	8/13	9/4	9/20	10/9	11/20	4/26	10/10
Advocacy and leadership organization and/or parent group	21	8	✓	✓	✓	✓	✓	✓	✓	✓
State health department	1	1						✓		
Technical assistance provider	5	1						✓		
State children and families department	1	1						✓		
Organization focused on health needs of young children	3	1						✓		
Community members	42	1					✓			
Home visiting program	1	1						✓		

SOURCES: Meeting sign-in sheets and minutes detailing attendance.
NOTE: An additional meeting of the advocacy organization's parents' group was held on 5/30/13, but attendance data are not available.

Site-Specific Evaluation Results

Research Question 1: Did the four participating communities form early childhood coalitions and begin to implement requisite coalition activities?

Coalition Formation and Implementation

As noted by the community stakeholder respondents, much of the "coalition" work in South Valley was with PCA, a nonprofit advocacy organization serving Albuquerque residents that describes its mission as supporting children and families to achieve self-sufficiency. When asked about their involvement in the coalition, respondents were not familiar with the coalition, were more active in the early stages of coalition conversations, or were involved only in a limited way. PCA staff was hired as the community organizer by the GTO facilitation team in September 2012.

The facilitation team held nine meetings between July 2012 and November 2013 (see Table G.3). The majority of these meetings (five of them) included the GTO facilitation team and PCA staff and focused on HVCDG efforts to invest in the community. In a September 2012 meeting of the PCA Parent Leader Group, a number of parents attended and discussed which of three home visiting models to implement in South Valley. At that meeting, the attendees agreed on the PAT model. The GTO facilitation team then held a focus group of more than 40 community participants in October 2012 to discuss the perceived needs of community families and the focus for a home visiting program. In a community stakeholder meeting convened in November 2012, a variety of other stakeholders met to discuss the process for the HVCDG and to review South Valley risk factors. A second meeting of the PCA Parent Leader Group met in May 2013 to discuss the necessary requirements for parents to be hired as home visitors, as well as the home visiting and child care needs in the community.

Respondents in South Valley had mixed opinions about the sustainability of the coalition. One respondent expected the coalition to be sustained. Another thought it would continue, but didn't know under which configuration. A third did not expect it to continue.

Coalition Planning Activities

There was no consensus among South Valley respondents in terms of the main value of the coalition and HVCDG, nor in terms of areas of improvement. Different respondents mentioned various benefits of the HVCDG, including increasing awareness and providing information about early childhood issues, providing additional funds for early childhood work, and providing a chance for some stakeholders to sit down and plan. Different respondents also said additional stakeholders and community members should be involved.

Quality of Community Action Plan

Strengths

The underlying logic of this plan was sound. This site intends to develop a "Parent Cooperative" that would train registered and informal child care providers and PAT staff to carry out literacy activities with youth and families that both groups are serving. The priorities identified in the needs assessment were well linked to the sites' goals, objectives, activities, and resource requirements. Target populations for the program were specified along with the agency/group/individual who will coordinate each activity. The plan identified sources of coordination/collaboration among community agencies and how the new literacy activities would be coordinated with existing community programs/activities (i.e., child care providers and PAT staff).

Challenges

South Valley's plan, while having certain strengths, is much less developed than the other counties (despite having a similar score to McKinley). The Community Strategic Planning document was not submitted, which is the tool primarily used for expanding the details of the implementation. As a result, although a basic outline of a program is reflected in the plan, there are almost no operational details. No details are presented on the scope of implementation (e.g., how much would be implemented), timeline, budget, or evaluation plan.

Research Question 2: To what extent did the project utilize GTO and ECHO distance learning to support the work of the coalitions and home visiting programs?

GTO Facilitation Abstract

Like the other communities, the coalition reviewed county-level data on rates and rankings across the state on several early childhood indicators, providing a rationale for home visiting, an element of GTO Step 1. In September 2012, a parent focus group was conducted that discussed the needs of the community, consistent with GTO Step 1. At the September 2012 community meeting, the coalition selected a home visiting program, incorporating elements of GTO Step 3. In May 2013, the coalition continued to work on specifying the needs in the community. At the September 2012 meeting, the coalition discussed elements of GTO Steps 4 and 5 in terms of the determining a program and fiscal agencies, and program staffing needs. A goals and objectives document that incorporates elements of GTO Step 2 was presented and discussed in October 2013.

Community Stakeholder Interviews

None of the three stakeholders interviewed from the South Valley were able to recall GTO being mentioned as part of the work in the community. All three had heard of GTO through different mechanisms, but two did not know that it had any relation to this HVCDG. The third respondent had heard about a GTO training but did not think they needed to be included in it.

The South Valley community did not initiate their home visiting program within this evaluation's timeframe, but the T/TA provider stated in an interview conducted in December 2013 that future efforts in that community will follow a similar model as in Luna and Quay counties. For example, they will start with the INA tool to assess the program strengths and weaknesses and engage in reflective supervision training. The T/TA provider database information did note that T/TA regarding staff hiring was provided in July 2013 via email to PCA, the HVCDG's community organizer for South Valley. Additionally, between January and July 2013, the T/TA provider attended two Bernalillo County Home Visiting Workgroup meetings to develop the capacity for networking among Bernalillo County home visiting programs and meet stakeholders, and one South Valley home visiting initiative meeting with Partnership for Community Action representatives.

Research Question 3: Did the sites enhance the continuum of services they need to support families?

In South Valley, we had insufficient information to determine how well families' needs are served by specific areas of the continuum of services. However, community stakeholders stated there is a lack of services in general, as well as a lack of awareness of services. Related to that, respondents noted a lack of funding for services and a lack of transportation to get to services in the community or nearby. One respondent emphasized that there is no coordinated effort among organizations or community activities to address these barriers to services. Other respondents mentioned a number of isolated efforts and projects that could help address the lack of services, especially those related to early childhood services and health care. Despite the efforts to create a coalition in South Valley, a perceived next step was to focus on increasing funding and awareness of services and to create a coalition around these efforts.

Research Question 4: Did the sites improve their infrastructure for home visiting services?

The community, as represented by the PCA and its parents' group, decided in September 2012 to implement the PAT home visiting model and subsequently chose CDD UNM as both the fiscal agent for the program and the provider of PAT services. The CYFD and CDD UNM contract agreement's official start date was February 28, 2013.

The initial scope of work stated that the PAT program would serve 65 families by September 30, 2013. However, the scope of work was revised in June 2013 to serve 80 families by September 2014. In November 15, 2013, the program still had not hired staff or initiated any services. Based on interview responses, the perception is that administrative delays on the part of CDD UNM have led to the greatly delayed start.