Don't Throw Out the Baby With the Bath Water

A Novel Way of Evaluating Outcomes in the Healthy Families America Programs

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The current study examines the inherent challenges of the wide-scale implementation and replication of program models. Using the Healthy Family America (HFA) program model, the study reviews the adaptation/adoption debate and highlights the ways in which program adoption and program adaptation could coexist to facilitate successful program implementations. Specifically, 103 HFA program sites were evaluated based on their adherence to HFA's flexible program model. Although the results are mixed, the study presents a new way of addressing existing program implementation and replication issues.

Keywords: variability; program evaluation; home visitors; child abuse; neglect

The implementation of social program models produces many challenges and concerns for innovation researchers. Of particular concern is how the program model should be implemented in a new site. This question has come to be known as the adoption/adaptation debate. As a result of this debate, two discrete schools of thought have emerged: namely, the pro-fidelity and pro-adaptation schools. The pro-fidelity school advocates for implementing programs as planned, or exhibiting strict fidelity to the original model (Caslyn, Tornatzky, & Dittmar, 1977). Advocates of this school argue that changing or diluting the program will lead to a decrease in its effectiveness (Blakely et al., 1987). Similarly, Sweet and Appelbaum (2004) have posited that program fidelity through adherence to a program model or guidelines would improve program effectiveness. The opposing school, pro-adaptation, argues that some degree of modification in a program is beneficial when implementing a program model at a local site to accommodate the local population (Glaser & Backer, 1977; Larsen & Agarwala-Rogers, 1977). Each of these schools offers differing viewpoints on how best to implement a program model in a new location. Over the years, researchers have sought to reconcile these opposing viewpoints to garner the best that each school has to offer. For example, Blakely et al. (1987) offered such a position by advocating strict fidelity to the program model but encouraging program modification in the form of additions to the original program model. They argued that this would provide a compromise between the two schools of thought.

Although Blakely et al. (1987) provided one solution to the adaptation/adoption debate, there are other ways to address the issue. For example, one program model, Healthy Families America (HFA), a national multi-site home visitation program, targets families at risk for child maltreatment. There are more than 400 HFA sites around the country, serving a variety

of populations within diverse cultures. Thus, there is inherently great need for variability between these program sites. To address this inherent variability, HFA program developers built flexibility into the HFA model. Specifically, HFA is not a stagnant one size fits all program model; but rather a multi-component model that local programs are able to adapt (Gomby, 2007; Oshana, Harding, Friedman, & Holton, 2005). Although local programs may adapt the model to fit family and community needs, the integrity of the model is assured by implementing a credentialing process to certify local programs. Therefore, the goal of the current study is to test this strategy by examining the effect of local programs' adherence to the HFA model, as well as additions to the model, on the outcomes of local sites.

One Size Does Not Fit All

The HFA program model has been criticized by a number of researchers for failing to show tangible outcomes in evaluation research (Chaffin, 2004, 2005; Leventhal, 2001). We propose that it might be beneficial to reexamine the HFA programs through a different lens by reviewing issues in program implementation. Researchers have noted that when replicating programs in a new location, possible failures are inevitable because the new program does not meet the needs of the local population (Yoshikawa, Rosman, & Hsueh, 2002). As a result of these failures, program implementers often want to modify aspects of the program to facilitate success within the new population. A major consideration is that such a dilution could reduce effectiveness if modifications greatly depart from the original model. These opposing concerns exemplify the adaptation/adoption debate that researchers are working to reconcile. Several home visitation programs have attempted to address this dilemma by maintaining fidelity to certain key program elements that have been identified as necessary to facilitate program success. Within home visitation programs, these variables include the training of home visitors, the supervision of the home visitors, and the frequency of the visits, which are imperative to the success of the program (Gomby, 1999, 2007; Sweet & Appelbaum, 2004; Yoshikawa et al., 2002).

HFA and the Adaptation/Adoption Debate

Home visitation programs are a special genre of social action programs developed by a number of researchers, including David Olds and colleagues (Olds, Henderson, Tatelbaum, & Chamberlin, 1986). The home visitation program model employs individuals to visit the home and meet with the parent(s) or guardian(s) who are at risk of child maltreatment. It is important to recognize that "home visiting is not a single, uniform intervention, but rather a strategy for service delivery" (Gomby, 1999, p. 3). Therefore, various program models implement home visitation services in many ways. Specific differences among models, and sometimes even within models, include the characteristics of the home visitors, processes for identifying "at risk" families, and the time of the initiation of services. One noteworthy example of this phenomenon is illustrated in Duggan et al.'s (2000) evaluation of Hawaii's Healthy Start Program (HSP). Duggan et al. commented that local agencies implemented the same program model differently from one another, resulting in different services being delivered to families. For example, the local programs varied regarding the frequency of home visits as well as whether families were linked with certain community resources. Therefore, it should be noted that local programs derived from the same program model tend to differ from one another and that developers of a program model should consider this when designing such a model.

HFA is one of the largest home visitation program models in the country. The goal of the program model is "to promote positive parenting, to enhance child health and development, and to prevent child abuse and neglect" (HFA, 2005). Because HFA has more than 400 programs, each with a different clientele operating in different cultures, HFA is a general program model for local programs to adapt. The general model consists of a core set of elements that the local sites must follow. However, the HFA program model allows local sites flexibility regarding the way in which they implement the elements. Specifically, each program is permitted to use different entrance criteria to meet the needs of the local population. For example, some programs accept only teenage mothers, some work with first-time mothers only, and other programs accept a wide variety of clientele. In addition, each program is allowed some flexibility regarding the initiation of service; the process begins either prenatally or at the birth of the child, depending on the local program. Finally, the model does not dictate that local programs use a specific curriculum. Rather, the model simply states that the curriculum used must be appropriate for the participants. Therefore, the HFA model is not identical in all sites. Rather, local sites adapt the model to serve their unique populations and circumstances.

The unalterable core principles are referred to as the 12 critical elements. Each of the elements was developed based on careful research in the field of child abuse and neglect (see appendix). Although the HFA model developers recognized the need for flexibility among local sites, they also understood the necessity of having an intact program model based on research in the area of child maltreatment reduction. The concept of the 12 critical elements is important because these elements enable programs to maintain essential core model components while allowing for flexibility in implementation, based on the needs of various populations. To ensure the core elements were adhered to, HFA developers designed a credentialing process, based on these core components, to certify and evaluate local programs or sites and/or multi-site systems. This certification is an intense process of peer review that examines all aspects of the program. Thus, the credentialing process serves as a technique for evaluating the accuracy of the adoption of the program model to local sites.

Current Study

The goal of the current study is to examine whether the implementation of a flexible program model is a viable option for the implementation and replication of large-scale program models. To test this premise, the study focuses on the HFA model, a fixed model that allows for flexibility so that each local program can address the needs of its population.

Hypotheses

It is proposed that programs adhering to HFA's flexible program model have better program outcomes than do programs not adhering to the model. To measure outcome variables, we focused on medical indices such as the percentage of children with medical care providers and the percentage of children updated on their immunizations. In addition, although not a true indicator of program success, we also examined the dropout rate per site. Specifically, the following hypotheses are proposed, based on the selected variables:

> *Hypothesis 1:* Fidelity to the HFA model, as indicated by the HFA critical elements, will be positively related to the percentage of children with medical care providers.
> *Hypothesis 2:* Fidelity to the HFA model, as indicated the HFA critical elements, will be positively related to the percentage of children updated on their immunizations.

Hypothesis 3: Fidelity to the HFA model, as indicated by the HFA critical elements, will be negatively related to the participant dropout rate for the site.

Based on Blakely et al. (1987), it was proposed that additions to the program model, made by program sites to address the needs of the local population, would also relate to program outcomes. Three distinct types of additions to the HFA model were present across program sites. These include additional training for the staff, additional services provided to HFA families, and additional types of staff members available to program participants.

First, additional training opportunities for staff members are often provided to HFA sites by external organizations such as the Department of Children and Family Services and Public Health Departments. Training content depends on the organization providing the training opportunity. It is possible that providing staff members with additional training will influence program outcomes because these staff members are better equipped to work with the families, thus improving the program outcomes. Based on this rationale, Hypothesis 4 proposes that additions to the HFA model, in the form of additional training for staff members, will relate to program outcomes.

Hypothesis 4a: Additional training provided to site staff will be positively related to the percentage of children with medical care providers.
Hypothesis 4b: Additional training provided to site staff will be positively related to the percentage of children updated on their immunizations.
Hypothesis 4c: Additional training provided to site staff will be negatively related to the participant dropout rate for the site.

Next, we propose that additional services provided to HFA participants will relate to site outcomes. Specifically, we believe that additional services could affect the percentage of children with medical care providers and with up-to-date immunizations because this mechanism might assist and/or encourage families to make frequent doctor visits. Furthermore, families might be interested in additional services and, therefore, be more likely to remain in the program. Therefore, the fifth hypothesis proposes that additions to the model, in the form of the type of services offered, effects program outcomes.

Hypothesis 5a: Additional services provided to HFA site participants will positively relate to the percentage of children with medical care providers.
Hypothesis 5b: Additional services provided to HFA site participants will be positively related to the percentage of children updated on their immunizations.
Hypothesis 5c: Additional services provided to HFA site participants will be negatively related to the participant dropout rate for the site.

Finally, we propose that when sites offer additional types of staff, this will positively affect program outcomes. For example, it is possible that having additional staff, such as nurses, working with families will help parents to understand the importance of having medical care providers for their children and of having their children immunized on schedule. Therefore, the sixth hypothesis proposes that additional types of staff members would positively influence program outcomes.

Hypothesis 6a: Additional types of staff members available to assist HFA site participants will positively relate to the percentage of children with medical care providers.
Hypothesis 6b: Additional types of staff members available to assist HFA site participants will be positively related to the percentage of children updated on their immunizations.

> *Hypothesis 6c:* Additional types of staff members available to assist HFA site participants will be negatively related to the participant dropout rate for the site.

Method

Programs

The study sample consisted of 103 HFA programs that had undergone the credentialing process. An additional point to note is that the original sample consisted of 129 sites that had undergone site visits at the time of data collection. However, only 103 of these sites provided useable data. Eliminated sites included: 17 sites for which credentialing files were missing or incomplete, 3 sites with no identifiable credentialing process, and 6 sites that were missing outcome data.

Measures

HFA Credentialing Program Self-Assessment Tool. The independent variable, fidelity to the flexible program model, was measured using second- and third-order elements of the HFA Credentialing Program Self-Assessment Tool (Prevent Child Abuse America, 1999). The purpose of the tool was to measure the extent to which each HFA program adheres to the critical elements. The 12 broad elements contain second- and third-order items that were more specific in nature. The second- and third-order elements refer to specific, measurable aspects of a core element. For example, Element 11 states that all service providers receive intensive, didactic training specific to their role in understanding the critical elements of successful early identification and home visitation. The second- and third-order elements clarify specific information regarding what training programs are required for each position as well as time frames for training completion. To evaluate a program along each of these items, the credentialing assessors used an ordinal rating system of 1 to 3. A score of 3 indicates *outstanding performance*, a score of 2 indicates *good performance*, and a score of 1 indicates *a need for improvement*. Ratings were made during formal visits to each site by at least two trained peer reviewers (for more information on the process, see http://www.healthyfamiliesamerica.org). The data from these reviewers were used to develop a measure of program fidelity to the HFA program model. Ninety second- and third-order elements pertaining to implementation, as opposed to policy requirements, were extracted from the 140 second- and third-order elements. An item's implementation orientation was decided on by the consensus of two subject-matter experts.

In addition, we used two versions of the credentialing standards: the 1999 version and the 2003 version, a revised edition of the tool. The purpose and content of the updated HFA Credentialing Program Self-Assessment Tool were not altered. However, the wording and total number of items differ. Items were matched for the two tools for analysis. Data from 58 sites were collected using the 1999 HFA Credentialing Program Self-Assessment Tool, although data from 44 sites were collected using the 2003 version.

Outcome indices. Although it would seem logical to use an index of child abuse and neglect, the use of this variable is problematic, and researchers suggest using other outcome indices (Gomby, 1999, 2007). These include whether children have a primary care physician and the children's immunization rate. Gomby (2007) has suggested that these are critical outcome variables because reducing health-related challenges is a goal of home visitation programs. Furthermore, she notes that HFA programs offer some improvement in access to health care.

To measure these variables, we reviewed the records from each local site. Specifically, local staff members recorded the percentage of children with medical care providers and the percentage who were updated on their immunizations (excluding children who, for medical reasons, had been advised against immunization by the physician) based on the information received from the physicians. A legitimate concern was the integrity of sites' data. Therefore, all data were subject to verification by the HFA Credentialing Review Panel.

In addition to indicators of child welfare and health, participant dropout rate is high for home visitation programs and has been identified as a serious problem for HFA programs (Duggan et al., 2000; McCurdy & Daro, 2000). Home visitation programs have previously reported participant dropout rates ranging from 20% to 67% (Gomby, Culross, & Behrman, 1999). Accordingly, participant retention has become an outcome variable of interest and valuable when assessing home visitation programs. Researchers have previously examined characteristics of the participants, family support workers (FSW's), and program that impact participant retention (Daro et al., 2007; Daro, McCurdy, & Nelson, 2005; McCurdy et al., 2006), but it has not been evaluated in the context of the program model or credentialing requirements.

Participant retention is an important indicator of whether or not the program is effectively reaching individuals identified as needing services, yet it is not an indicator of whether or not the program is effectively reducing child maltreatment. Although retaining participants is not sufficient to reduce child maltreatment, it is necessary that participants receive the HFA services. Because of this, participant retention is a specified outcome of the HFA model and if a program demonstrates high fidelity to the program model, it should have higher retention rates than program sites that do not demonstrate high fidelity. We included participant retention to examine this relationship.

Annual Site Profile Update. Each year, Prevent Child Abuse America (PCAA) sends a survey to HFA sites to collect data concerning many aspects of the site's functioning and characteristics. These surveys provide information such as the site's funding information, information on participants and staff, and services offered by the sites. Data were collected using the Annual Site Profile Update in 1998, 1999, 2000, 2001, and 2003; data were not collected in 2002. The wording of surveys varied slightly by year, but similar information was solicited in each version. Response rates for the Annual Site Profile Update vary between 75% and 85%.

For the current study, the Annual Site Profile Update was used to provide information on frequent program activities, such as additional training provided to site staff, additional services provided to HFA site participants, and additional types of staff members available to assist HFA site participants. The average number of additional staff members, training opportunities, or services reported by a site during a 5-year period was used as the site's score on the corresponding variable.

Survey data regarding participant dropout rate was extracted from the Annual Site Profile Update. Data were taken from the survey information collected the year the site was under review for accreditation and the 2 following years. A participant was considered to have dropped out if he or she was not receiving service 1 year after he or she enrolled in the HFA program. The average site dropout rate during a 3-year period was used in this study to more accurately assess a site's typical participant dropout rate. Last, data regarding a number of control variables were also taken from the Annual Site Profile Update. This includes the sites' annual funding and the number of families enrolled in the local program. The local site recorded this information.

Results

Analysis

Initially, 90 second- and third-order elements were chosen from the 140 total items based on their implementation orientation, as described earlier. From these 90 items, 34 items were removed if the item showed low variance ($\sigma^2 < .40$). Fifty-six items were retained for further analysis. Exploratory factor analysis was used to interpret the underlying common factors. This analysis was constrained by the low number of programs ($N = 103$) available for this study. Because of the small sample size, missing data were replaced with the means for the items. Based on fit statistics and examination of the scree plot, four factors appeared to account for a large amount of shared variance. Maximum likelihood extraction and a promax rotation was used to analyze a four-factor model. The four factors examined accounted for 53% of the variance in the data.

The four factors identified were easily described and named. Factor 1 consisted of items that pertain to staff training and demonstration of knowledge needed for family support work; this factor was named staff training. Factor 2 consisted of items pertaining to the supervision, evaluation, and follow-up on FSW's and program functioning; this factor was named quality control. Factor 3 contained items related to the routine activities required of the FSW's; this factor was named FSW activities. Factor 4 includes items pertaining to the staff orientation prior to direct work with children and families; this factor was named staff orientation. To calculate factor scores for each program, program ratings on items were summed to form composite scores for each program on the four fidelity factors. All four factors correlated relatively highly with one another. There was not a significant difference in program ratings when the difference in credentialing tools (1998 or 2003) was taken into account ($F = .193$, $p = .662$).

Hypothesis Testing

The means, standard deviations, and intercorrelations between all study variables are reported in Table 1. It is important to note that there was a restriction of range in two of the dependent variables, participants with medical care providers and up-to-date immunizations, making it difficult to detect relationships between the independent variables and the dependent variables. Additionally, the additional staff and training were significantly correlated additional service, indicating that sites engaging in one innovation tended to engage in multiple innovations.

Hypothesis 1 states that program ratings on fidelity will correlate positively with the percentage of participants who have medical care providers. Staff orientation was the only fidelity factor that correlated significantly with the percentage of participants who had medical care providers, $r = .213$, $p < .05$. The other three correlations were not significant at $p < .05$ (see Table 1). All four fidelity factors were regressed on the percentage of participants who had primary medical care providers while controlling for the number of families enrolled at the site and the site's funding level (see Table 2). The model did not account for a significant amount of variance in the outcome variable, $R = .294$; however, staff orientation remained a significant predictor, $\beta = .313$, $p < .05$. These findings partially support Hypothesis 1.

Hypothesis 2 states that program ratings on fidelity will correlate positively with the percentage of participants who have up-to-date immunizations. All four fidelity factors correlated significantly with the percentage of participants who have up-to-date immunizations. The strength of the relationships ranged from $r = .332$, $p < .05$, for FSW activities to $r = .199$, $p < .05$, for the quality control factor. All four fidelity factors were regressed on the percentage

Table 1
Means, Standard Deviations, and Pearson Intercorrelations of Variables

Variable	M	SD	N	2	3	4	5	6	7	8	9	10
1. Staff training	21.15	7.60	94									
2. Quality control	30.60	6.91	103	.369*								
3. FSW activities	19.90	4.78	103	.416*	.424*							
4. Staff orientation	15.49	4.60	103	.679*	.512*	.414*						
5. Medical providers	96.54	10.06	103	.097	.095	.113	.213*					
6. Updated immunizations	81.93	20.26	103	.264*	.199*	.332*	.299*	.136				
7. Participant dropout rate	0.29	0.21	91	-.097	-.067	-.044	-.048	-.038	.033			
8. Additional staff	-0.24	1.11	78	-.074	.037	.087	-.044	.152	-.001	-.060		
9. Additional training	3.59	2.35	99	.019	.050	.113	.034	-.054	.029	-.236*	.376*	
10. Additional services	2.68	1.48	99	.095	.205*	.101	.113	.021	.117	-.327*	.152	.422*

Note: FSW = family support worker.
*$p < .05$.

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Table 2
Regression Analysis Controlling for Program Size and Funding

	R	R^2	B	SE
Medical providers	.294	.086		
Staff training			−.151	.238
Quality control			−.003	.237
FSW activities			.123	.331
Staff orientation			.879*	.445
Updated immunizations	.520*	.270		
Staff training			.189	.390
Quality control			.171	.382
FSW activities			1.307*	.544
Staff orientation			−.273	.729
Participant dropout rate	.219	.048		
Staff training			−.005	.005
Quality control			−.001	.005
FSW activities			−.001	.007
Staff orientation			.004	.009

Note: B represents the unstandardized regression coefficient; SE = standard error; FSW = family support worker.
*$p < .05$.

of participants who had up-to-date immunizations while controlling for the number of families enrolled at the site and the site's funding level (see Table 2). This model accounted for a significant amount of variance in the outcome variable, $R = .520$. These findings demonstrate support for Hypothesis 2. Hypothesis 3, which stated that program ratings on fidelity would correlate positively with the percentage of participants' dropout rate for the site, was not supported by these data (see Tables 1 and 2).

Hypotheses 4 through 6 concerned whether additions to the HFA model predicted program outcomes. Hypothesis 4 examined how additional training of program staff influenced outcomes. This hypothesis was partially supported. Specifically, although Hypotheses 4a and 4b were not supported, Hypothesis 4c proposed that additional training provided to site staff would be negatively related to the participant dropout for the site. This subhypothesis was supported, $r = −.236$, $p < .05$, providing partial support for Hypothesis 4. Offering additional training explained almost 13% of the variance in participant dropout rate across programs, $R^2 = .127$, after controlling for site size and funding level (see Table 3).

Hypothesis 5 examined whether additional services offered to program participants influenced program outcomes. Similarly, there was partial support for this hypothesis. Although Hypotheses 5a and 5b were not supported, Hypothesis 5c, which hypothesized a negative relationship between additional services offered and the participant dropout rate was supported, $r = −.327$, $p < .05$. Offering additional services explained almost 10% of the variance in participant dropout rate across programs, $R^2 = .098$, after controlling for the size of a program site and funding level (see Table 3). Last, Hypothesis 6 proposed that additional types of staff would relate to program outcomes. These data did not support this hypothesis (see Tables 1 and 3).

Discussion

It is clear that, to some extent, the adaptation and adoption camps are at odds with one another. Many program implementers believe it necessary to maintain adherence to the original

Table 3
Individual Regression Analyses Controlling for Program Size and Funding

	R	R²	B	SE
Medical providers				
Additional staff	.145	.021	.713	.793
Additional services	.128	1.016	.640	.943
Additional training	.166	.014	−.262	.546
Updated immunizations				
Additional staff	.411	.169	−1.236	1.351
Additional services	.432	.186	2.426	.160
Additional training	.402	.161	−.127	.934
Participant dropout rate				
Additional staff	.174	.030	−.010	.016
Additional services	.356	.127	−.054*	.018
Additional training	.313	.098	.027*	.011

Note: B represents the unstandardized regression coefficient; SE = standard error.
*$p < .05$.

program model, although other program implementers argue that flexibility is necessary when implementing a program model in a new location. An underlying tenet of this article is that both could coexist as long as program integrity remained intact. To examine the plausibility of this conjecture, the study focused on the HFA program model, an intact model requiring local programs to adhere to it, though allowing for flexibility for each local program to address the needs of its population, by providing additions to the program model. A novel evaluation technique was used to examine these propositions. A major contribution of this study was the evaluation process used to study a flexible program model within the context of the adaptation/adoption debate. The method used to study the flexible model allowed us to address the adaptation/adoption debate in a different way from previous evaluators to examine a strategy for successfully implementing and replicating large-scale program models

The study results indicate that the degree of adherence to the HFA program model was related to participant outcomes. Adherence to certain aspects, or factors, of the HFA program model predicted the percentage of children with updated immunizations and, to a lesser extent, the percentage of participants who have medical care providers. Additions to the model were also related to participant outcomes. Additional services and training were significantly related to participant dropout rate but not to the percentage of participants with updated immunizations and primary medical providers.

Limitations

An important limitation was the selection bias of sites included within this study. Although there are well more than 400 HFA sites, fewer than 150 of them have undergone the credentialing process. There are several reasons for this. First, sites may be considered HFA sites and not be visited if they are part of a state system where the whole system is credentialed. Second, new sites are expected to complete the credentialing process but are given time to fully implement the program prior to attempting credentialing. Although it would have been beneficial to include all HFA sites, unfortunately, there is no metric by which to measure sites that have not undergone this review process.

A statistical limitation was the lack of power within this study. First, there was range restriction in the dependent variables most likely because of the selection bias; sites undergoing this

process might have had better outcomes than did sites that did not go through this process. This range restriction made the nature of the relationships between the independent variables and the dependent variables difficult to detect.

Another limitation concerns the nature of the additions variables. Because the site survey did not address the specific types of program additions, it is not possible to examine which types of these additions affected program outcomes. Furthermore, since this is not a true experimental design, it is unclear as to whether these additions influenced the dependent variables or whether a third variable affected the outcomes. For example, perhaps sites that implement these additions have more innovative program directors, and therefore, the leadership of the program, as opposed to the nature of these additions is influencing program outcomes.

A final limitation concerned the selection of the dependent variables. Gomby (1999, 2007) proposed using the percentage of children with updated immunizations and with medical care providers, along with examining participant retention, as opposed to indices of child abuse and neglect. Although research supports using the former outcome variables, a selection of additional outcome variables might have been beneficial. In particular, one of the core goals of the HFA model was to strengthen families. To this end, a measure of family functioning or interaction might have been a strong additional outcome measure. Unfortunately, not all HFA sites use such measures and even among the sites using this genre of measure, not all employ the same measure or even parallel measures.

Implications and Future Research

This study provides two valuable implications for program implementation and evaluation. First, although the results presented here are not conclusive, we identified some initial evidence that fidelity to specific factors of the HFA flexible model were positively related to primary program outcomes involving children's health. In addition, innovations were related to a tangential program goal, improving participant retention. Second, we offer program evaluators a new way to examine the adaptation/adoption debate in multi-site programs. The evaluation process consisted of quantifying adherence to specific elements of the program's model, factor analyzing the quantified data for underlying latent variables, and statistically evaluating program outcomes in comparison to these variables. This evaluation technique provides a novel and efficient way to assess individual programs as well as to compare multiple programs that are based on the same flexible model.

It is clear that there are major challenges to designing successful program models and then translating these models into successful programs throughout the country. Although fidelity to a program model is needed to prevent the model from being diluted and marginalized, Daro (2005) indicated that the very nature of HFA programming requires home visitors to focus on the individual needs of the families and to remain sensitive to local community norms. She further states that for home visitors to be effective, they must address the unique needs of each family and that by strictly adhering to predetermined, national protocols, that providers might miss the opportunity to effectively assist the family. HFA is a flexible model that provides a way for local programs to exhibit fidelity to the model and still meet the unique needs of its local population.

The flexibility built in to the HFA model is not by any means unique to home visitation programs. Rather, most large-scale programs need to address the variability of local populations and still maintain program integrity. The flexible program model has the potential to achieve this end, as it advocates fidelity to the model while allowing programs to implement additions to the model. These findings support the use of the flexible model by evaluators and program implementers to address concerns with multi-site implementation and continued

successful development. Using the core elements of the program's model as a scale to measure the site's level of fidelity provides a uniform and easily accessible tool to evaluate multi-site organizations.

Evaluators should use this study as a starting point for conducting similar types of analysis. Within the home-visitation genre of programs, future evaluators should seek to reduce some of the limitations noted here through the incorporation of additional outcome variables such as family functioning and confirmed cases of child maltreatment. Future research should also investigate the impact that moderators, such as location of the sites and ethnic background of the site's participants, might have on these relationships. Additional types of program models should be examined within the adaptation/adoption flexibility framework. This could assist in understanding whether this type of flexibility is helpful for facilitating positive program outcomes across organizational genres. Finally, although some programs may require a credentialing process, other multi-site programs may not. It is important to ensure that this evaluation approach will be valid using both verified credentialing data as well as unverified site-reported data.

The primary importance of this study is the advancement of an evaluation method that could be used to efficiently measure and evaluate fidelity to a program model at a site level across multiple sites. The technique used in this study can improve and advance evaluators' ability to make site comparisons within a large, multi-site organization. In addition, basing quantitative analyses on adherence to program core elements could enable evaluators to streamline the across-site evaluation process. Evaluators will be able to uncover beneficial program additions and particular variables within the elements that are predictive of positive program outcomes rapidly, allowing for swift and targeted interventions and dissemination of information. Although the results of this study do not provide indisputable answers, they do seem to indicate that aspects of the flexible model have the potential to improve program outcomes. We believe that these results provide a strong basis for future research on the impact of the flexible model on organizational implementation, expansion, and program evaluation. The value and impact of this novel evaluation technique and the utility flexible model in multi-site organizations is an area that is wide open for future investigation.

Appendix
Critical Elements of the Healthy Families America Model

1. Services are initiated prenatally or at birth.
2. Services are voluntary; and positive, persistent outreach efforts are used to engage families initially.
3. Identification of families most in need of services because of the presence of factors associated with increased risk of child maltreatment.
4. Offer services intensively and for the long term (i.e., 3 to 5 years).
5. Services are culturally competent, and materials reflect the diversity of the population to be served.
6. Services focus on supporting the parent as well as positive parent–child interactions and child development outcomes.
7. Families are linked to a medical home. Depending on the family's needs, they are also linked to other community services.
8. Staff with limited caseloads provide services (recommended: no more than 15 of the most stressed families; no more than 25 overall).
9. Service providers are selected because of their personal characteristics (nonjudgmental, compassionate, ability to establish rapport), their willingness to work with culturally diverse populations, and their skills to do the job.

Appendix   (continued)

10. All service providers receive basic training before beginning their contact with families.
11. All service providers receive intensive, didactic training specific to their role in understanding the critical elements of successful early identification and home visitation.
12. Program staff should receive ongoing, frequent, effective supervision.

References

Blakely, C. H., Mayer, J. P., Gottschalk, R. G., Schmitt, N., Davidson, W. S., Roitjman, D. B., et al. (1987). The fidelity-adaptation debate: Implications for the implementation of public sector social programs. *American Journal of Community Psychology*, *15*, 253-268.

Caslyn, R. J., Tornatzky, L. G., & Dittmar, S. (1977). Incomplete adoption of an innovation: The case of goal attainment scaling. *Evaluation*, *4*, 127-130.

Chaffin, M. (2004). Is it time to rethink Healthy Start/Healthy Families? *Child Abuse & Neglect*, *28*, 589-595.

Chaffin, M. (2005). Response to letters. *Child Abuse & Neglect*, *29*, 241-249.

Daro, D. A. (2005). Letter to the editor: Response to Chaffin (2004). *Child Abuse & Neglect*, *29*, 237-240.

Daro, D. A., McCurdy, K., Falconnier, L., Sinje, C., Anisfeld, E., Katzev, A., et al. (2007). The role of community in facilitating service utilization. *Journal of Prevention and Intervention in the Community*, *34*, 181-204.

Daro, D. A., McCurdy, K., & Nelson, C. (2005). *Engagement and retention in voluntary new parent support programs: Final report*. New York and Baltimore, MD: W. T. Grant and Anne Casey Foundations.

Duggan, A., Windham, A., McFarlane, E., Fuddy, L., Rohde, C., Buchbinder, S., et al. (2000). Hawaii's Healthy Start Program of home visiting for at-risk families: Evaluation of family identification, family engagement, and service delivery. *Pediatrics*, *105*, 250-259.

Glaser, E. M., & Backer, T. E. (1977). Innovation redefined: Durability and local adaptation. *Evaluation*, *4*, 131-135.

Gomby, D. S. (1999). Understanding evaluations of home visitation programs. *The Future of Children: Recent Program Evaluations*, *9*, 27-43.

Gomby, D. S. (2007). The promise and limitations of home visiting: Implementing effective programs. *Child Abuse & Neglect*, *31*, 793-799.

Gomby, D. S., Culross, P. L., & Behrman, R. E. (1999). Home visiting: Recent program evaluations—Analysis and recommendations. *The Future of Children, Recent Program Evaluations*, *9*, 4-26.

Healthy Families America. (2005). *About us: Overview*. Retrieved January 27, 2005, from http://www.healthyfamiliesamerica.org

Larsen, J. K., & Agarwala-Rogers, R. (1977). Re-invention of innovation ideas: Modified? Adopted? None of the above? *Evaluation*, *4*, 136-140.

Leventhal, J. M. (2001). The prevention of child abuse and neglect: Successfully out of the blocks. *Child Abuse & Neglect*, *25*, 431-439.

McCurdy, K., & Daro, D. (2000, July). *Involvement in child abuse prevention programs: An ecological theory*. Paper presented at the Victimization of Children and Youth International Research Conference, University of New Hampshire, Durham.

McCurdy, K., Daro, D., Anisfeld, E., Katzev, A., Keim, A., LeCroy, C., et al. (2006). Understanding maternal intentions to engage in home visiting programs. *Children and Youth Services Review*, *28*, 1195-1218.

Olds, D. L., Henderson, C. R., Tatelbaum, R., & Chamberlin, R. (1986). Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Journal of the American Medical Association*, *78*, 65-78.

Oshana, D., Harding, K., Friedman, L., & Holton, J. (2005). Rethinking healthy families: A continuous responsibility. *Child Abuse & Neglect*, *29*, 219-228.

Prevent Child Abuse America. (1999). *Healthy Families America Credentialing Self-Assessment Tool*. Chicago: Author.

Sweet, M. A., & Appelbaum, M. I. (2004). Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children. *Child Development*, *75*, 1435-1456.

Yoshikawa, H., Rosman, E. A., & Hsueh, J. (2002). Resolving paradoxical criteria for the expansion and replication of early childhood care and education programs. *Early Childhood Research Quarterly*, *17*, 3-27.