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THE INFLUENCE OF THE MATERNAL INFANT HEALTH OUTREACH PROGRAM ON CHILD
DEVELOPMENT: THROUGH THE EYES OF MOMS AND HOME VISITORS

A dissertation submitted to
the Graduate College of
Marshall University
In partial fulfillment of
the requirements for the degree of
Doctor of Education
in
Curriculum and Instruction

by

Debra L. Lockwood

Approved by

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Marshall University
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DEDICATION

This dissertation is dedicated to the participants of the Maternal Infant Health Outreach Worker Program. Thank you for sharing your life stories with us.

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ABSTRACT

The Influence of the Maternal Health Outreach Program on Child Development: Through the Eyes of Moms and Home Visitors

MIHOW, the Maternal Infant Health Outreach Worker Program, is a parent-to-parent home visitation program that aims to enhance early childhood development in economically disadvantaged and geographically isolated families with children from birth to three. This qualitative case study conducted in two rural Appalachian counties examined the perceptions and experiences of moms and home visitors regarding the influence MIHOW has on child development. Findings were interpreted in relation to extant literature on the prevention of developmental delays. Five themes emerged from the data. The first theme related to the developmental checklists and screening materials and moms' understanding of how the checklists related to monthly growth and development. The second theme related to how moms characterize home visitors as "like a friend," and the nature of peer relationships between home visitors and moms. The third theme was related to the frequency, consistency, and scheduling of home visits. The fourth theme related to concerns associated with lack of transportation and how this created a barrier for moms connecting with community resources. A lack of attention to social-emotional development was the fifth theme. The findings provide evidence that the program is helpful to parents in preventing, identifying, and treating developmental delays related to cognitive, physical, and communication. The program was not as effective with moms in preventing delays related to social-emotional.

Chapter 1: Introduction

The task of caring for infants and young children is monumental, even for individuals with plentiful resources. The stress involved in caring for young children can be especially overwhelming for individuals in poverty and low socio-economic settings, with few resources, and those suffering with addiction issues (Peacock, Konrad, Watson, Nickel, & Muhajarine, 2013). Since brain development is so important in the first few years, the developmental gap between children from socio-economic disadvantaged homes and those from more affluent families begins to show between ages two and three (Chandler, 2013). The size of gaps could be small or just significant enough to be considered developmental delays. These early differences in developmental outcomes can lead to intergenerational cycles of inequality (Norbert, 2011). The early identification of developmental delays can benefit families and children by getting them the assistance they need (National Center on Birth Defects and Developmental Delays, Centers for Disease Control and Prevention, 2013). The results of early interventions suggest that intervening with the child and family can reduce problems (Manning, Homel, & Smith, 2010). Early intervention is identified to be beneficial to young children with developmental delays because the earlier the intervention the greater the developmental gain (Shin, Nhan, Lee, Crittenden, Flory, & Hong, 2009).

According to the State of New Jersey Department of Human Services Office for Prevention of Developmental Delays, whereas many developmental delays are not preventable, some can be reduced through improved attention to maternal and child health issues (State of New Jersey Department of Human Services Office for Prevention of Developmental Delays, 2008). The use of early developmental prevention programs is mentioned in several studies as

having a positive influence on child development. Specific improvements were noted in areas related to health, education, behavior, and crime (Manning, Homel, & Smith, 2010). According to Shin, Nhan, Lee, Crittenden, Flory and Hong (2009), the earlier these interventions occur the greater the gains for the child.

Home visitation is featured in many programs that attempt to prevent or reduce developmental delays (Manning, Homel, & Smith, 2010; Shin, Nhan, Lee, Crittenden, Flory, & Hong, 2009; Rickards, Walstaab, Wright-Rossi, Simpson, Reddihough, 2008). It is a way to improve the health and development of the mother and the child (Tandon, et al. 2008). “Home visitation is among the most high-profile, widely disseminated preventative interventions for pregnant and newly delivered women” (Tandon, Parillo, Mercer, Keefer, & Duggan, 2008, p.118). A goal of home visitation programs is to provide social support services to which individuals with young children might not have access (Peacock et al. 2013; Lee, Mitchell-Herzfeld, Lowenfels, Greene, Dorabawila, & DuMont, 2009). With increased federal funding for home visitation programs in recent years, the need to know that programs are operating efficiently and effectively has grown (Krysik & Lecroy, 2012).

The Maternal Infant Health Outreach Worker (MIHOW) is a national home visitation program that serves “economically disadvantaged and geographically and/or socially isolated families with children birth to age three” (MIHOW Program: Vanderbilt University Medical Center, 2013, para.1). The program is designed to improve the health and child development among these families. The main components of the program are home visits, case management, parent education, modeling positive parent-child interactions, health and developmental screening, information and referral, and peer support groups. The MIHOW

program in West Virginia targets families, in two low socio-economic and rural areas, who have difficulty accessing resources.

Although there are many home visitation programs in existence, there is a lot that we do not know about their influence on factors related to child development (Harden, Chazan-Cohen, Raikes, & Vogel, 2012; Peacock, Lonrad, Watson, Nickel, & Muhajarine, 2013). There is uneven and inconsistent outcome documentation, and a lack of information about *how* home visitation accomplishes the outcomes that *are* documented. Given the large financial investment in home visitation on both the national and local levels, further understanding of home visitation and how it influences moms, families, and children is important. This multi-site case study focused on the moms' and home visitors' perceptions and experiences regarding the influence MIHOW had on child development and parenting.

Conceptual Framework

A conceptual framework for research delineates the most important things that will be studied (Maxwell, 2013). The conceptual framework is based on the concepts, assumptions, expectations, beliefs, and theories which help to support one's research. In this study, home visitation and moms' and home visitors' experiences with the program and perceptions of its influence on child development were explored.

The key concepts in the study are home visitation and child development. Home visitation is a method of service delivery that offers hope for pregnant women and young moms who have few support networks in and outside of the home (Lee, Mitchell-Herzfeld, Lowenfels, Greene, Dorabawila, & DuMont, 2009). Historically, home visitation programs have focused on

poor moms and those at an economic disadvantage with the goal being to help those most in need.

An understanding of normative and atypical child development is essential in providing parenting interventions (Guerra, Graham, & Tolan, 2011). Mcdevitt and Ormrod (2013) define child development in relation to the “study of persistent, cumulative, and progressive changes in the physical, cognitive, and social-emotional development of children and adolescents” (p. 4). I used Mcdevitt and Ormrod’s definition of child development for my study. In this definition of child development, language is considered under cognitive.

I conducted this study knowing that many of the West Virginia MIHOW young children, moms, and home visitors live in rural, isolated areas, and assuming that some of the children have developmental delays, some which are not diagnosed. Based on prior experiences and current research with school-aged students having exceptional learning needs, I knew that many students having developmental delays come from impoverished homes with few resources and inconsistent parenting methods. Many of these children also come from single-family homes. According to Domian, Baggett, Carta, Mitchell, and Larson (2010), such children endure stress, marginalization, and have learning difficulties.

This study of the MIHOW moms and home visitors was conducted based on my involvement with MIHOW evaluation research. I interviewed moms and home visitors who participated in the MIHOW program in two communities in rural West Virginia. The MIHOW moms and home visitors were accessible to me because of the current MIHOW program evaluation, although access to the participants was difficult because many of them moved around frequently, changed phone numbers, and did not always answer their phones. Also,

there was difficulty accessing moms because increased numbers of women work outside of the home (Spatig, Carlson, Lockwood, & Wellman, 2013).

My beliefs about home visitation provided a personal background for this study. I completed several home visits during clinical field experiences for my master's degree in preschool special education. I went into two diverse, yet similarly problematic, homes with home visitors to provide early intervention home-based services. The experience of going into the homes of two families in need was eye-opening for a 27 year old from a middle-class background. During the first clinical part of the home-based field experience, I went into the home of a family living in an urban housing project in Huntington, West Virginia. I also traveled with another home visitor during a visit to a rural home in southern Ohio where there were many family members living in one small trailer with minimal resources.

The purpose of these home visits during graduate school was to observe how the early intervention process addressed various areas of child development with the assistance of a teacher working with the parent during home-based intervention. These beliefs and prior experiences generated my interest in this topic of study.

Theory is described "as a set of concepts and ideas and the proposed relationships among these, a structure that is intended to capture or model something about the world" (Maxwell, 2013, p.48). It is a way of explaining what is going on with a phenomenon and how one understands it. This study was guided by the theory of phenomenology in the sense that the investigator sought to understand how the phenomena "presents themselves in the lived experiences of the individual" (Pinar, Reynolds, Slattery, & Taubman, 2008, p. 405). In other words, the theory of phenomenology helped me understand how the moms and home visitors

perceived and understood the MIHOW program, especially in relation to child development. I conducted interpretive research based on the notion that the world is socially constructed and ever-changing (Glesne, 2011).

Related Literature

The literature about home visitation and child development was divided into research focused on home visitation program outcomes and research focused on home visitation program processes. Although I separated the research into these two categories for organizational purposes, it was clear that the two categories were not mutually exclusive and that elements in one category influenced those in the other. The first category included studies exploring visitation outcomes for the mother and family, and outcomes for the children. The processes category included studies focused on how programs were being implemented for whom and in what ways. Process studies were subdivided into those pertaining to programming and those pertaining to participants. Programming literature was subdivided into program content and delivery and service dosage. Literature focused on participants was subdivided into the characteristics of the home visitor and mother, and the relationships between them.

Program Outcomes

The home visitation outcomes section of the literature is divided into outcomes for the mother and family, and outcomes for the children. The outcomes for the mother and family pertain to the home environment, maternal depression, and learning. Outcomes for the child are divided into health, cognitive development, and social-emotional behaviors.

Moms and Families. The outcomes for many families that participate in home visitation programs are associated with improvements in the home environment (Katz, Jarrett, El-Mohandes, Schneider, McNeely-Johnson, & Kiely, 2011; Domian, Baggett, Carta, Mitchell, & Larson, 2010; Azzi-Lessing, 2011). Research on the home environment is related to key issues associated with social support, stimulation, and smoking. The social support networks created through participation in home visitation programs improve the home environment by reducing the stresses for moms associated with child maltreatment (Katz, Jarrett, El-Mohandes, Schneider, McNeely-Johnson, & Kiely, 2011). A second improvement in the home environment is related to stimulation to encourage child development. The lack of environmental stimulation correlates with a reduction in cognitive skills and academic achievement later in childhood. Kemp., Harris., McMahan., Matthey., Vimpani., Anderson., Schmied., Aslam., and Zapart (2011) noted that home visitation improved the home environment through stimulation that increased as parents became more responsive to the child's needs. Additionally, a third improvement in the home environment is related to the reduction of smoking. Azzi-Lessing (2011) noted that moms identified as moderate to heavy smokers reduced their smoking during home visits made by the Nurse Family Partnership.

In addition to improvements in the child's home environment, a second outcome of home visitation for the mother and family is a decrease in maternal depression. Maternal depression has been linked to parents' inability to meet their own emotional needs and the developmental needs of their child (Ammerman, Shenk, Teeters, Noll, Putnam, & Ginkel, 2011; Domian, Baggett, Carta, Mitchell, & Larson, 2010; Price & Filipic, 2013). The literature on home visitation and depression identified inconsistent outcomes for the mother. Some studies noted

that home visitation had little influence on depression (Harden, Chazan-Cohen, Raikes, & Vogel, 2012; Leis, Mendelson, Perry, & Tandon, 2011). On the other hand, several studies identified depression as an area that was influenced positively by home visitation (Azzi-Lessing, 2011; Tandon, Parillo, Mercer, Keefer, & Duggan, 2008; Ferguson & Vanderpool, 2013; Ammerman, et al., 2011; Shaw, Wong, Kaczorowski, & The McMaster University Postpartum Research Group, 2006). Parenting methods and social support networks were two examples of methods identified to reduce maternal depression for moms (Harden, et al. 2012; Ammerman, et al., 2012; Katz, et al., 2011).

The knowledge about child development and parenting gained through participation in a home visitation program is another outcome for moms. Moms' knowledge of pregnancy and health related topics increased as a result of home visitation programs (Tough, Johnston, Siever, Jorgenson, Slocombe, Lane, & Clarke, 2006; Tandon, Parillo, Mercer, Keefer, & Dugan, 2008;). Moms participating in a home visitation program learned about infant and school-aged child development, and there was no difference in learning between moms of different ages (Hammond-Ratzlaff & Fulton, 2001). Low-income moms at-risk for family dysfunction showed improvements in parenting knowledge with the support of postpartum support interventions (Shaw, et al., 2006).

Children. There are fewer studies related to the influence of home visitation on child development that focus specifically on the child. The majority of the studies are related to the influence of home visitation on the mother or the family with little focus on child outcomes (Harden, Chazan-Cohen, Raikes, & Vogel, 2012). The key child outcomes reported in the home visitation literature pertain to health, cognitive development, and social-emotional behaviors.

There were no recent studies found on home visitation literature related to physical development.

Several publications noted an association between home visitation and improved health outcomes related to the birth weight of the baby (Peacock, Konrad, Watson, Nickel, & Muhajarine, 2013; Lee, Mitchell -Herzfeld, Lowenfels, Greene, Dorabawila, & DuMont, 2009). Moms who received home visitation were less likely than those in the control group to deliver low birth weight babies (Peacock, Konrad, Watson, Nickel, & Muhajarine, 2013). The earlier the moms received the home visits and the numbers of home visits were associated with a reduction in the number of low birth weight babies (Peacock et al., 2013 & Lee et al., 2009).

Improved cognition was reported in a number of publications about home visitation outcomes for children (Peacock, et al., 2013; Katz, et al., 2011). Early Head Start documented improvement in cognitive and academic outcomes for children (Harden, Chazan-Cohen, Raikes, & Vogel, 2012). Peacock et al. (2013) found little improvement in language, but cited improvements in cognition and a reduction in problem behaviors. The literature is not clear as to why language gains are inconsistent and does not demonstrate the same gains as cognition after home visitation. Language and cognition are identified separately in the literature as factors related to child development.

The improved social-emotional functioning of the child was also identified in the literature as an outcome of home visitation (Harden, Chazan-Cohen, Raikes, & Vogel, 2012; Manning, Homel, & Smith, 2010). The children were impacted positively in social-emotional functioning, whereas the parents developed better parenting skills. For example, there was a reduction of behavior problems for pre-kindergarten children who participated in home

visitation. Harden et al. concluded that the improved social-emotional functioning was due to improved parent-child interactions. Manning, Homel, and Smith (2010) identified smaller improvements in outcomes related to social-emotional development in a meta-analysis of early developmental prevention programs focused on deviance and social participation. These are the only two studies related directly to children's social-emotional development as an outcome of home visitation. There were no studies that related directly to improvements in physical development.

Program Processes

The processes involved in home visitation are as important as the outcomes (Price & Cohen-Filipic, 2013). The following section describes research pertaining to how home visitation programs were implemented, who participated in them, and in what ways. The program processes related literature is divided into programming and participants. The programming literature is related to program content and delivery. Participant focused literature is related to the home visitors' and moms' characteristics, and the relationships between participants.

Programming. Home visitation and center-based programs are both methods to deliver services designed to improve outcomes for the family (Harden, Chazan,-Cohen, Raikes, & Vogel, 2012). Home visitation effectiveness is influenced by program content and delivery. Some of the literature related to program content and delivery is descriptive, especially the literature related to home visitation curriculum. Program content and delivery are issues mentioned in the home visitation literature. Dosage and contextual factors are sub-categories related to the delivery of home visitation. Dosage relates to the number of home visits a family receives.

Program content is a focus in home visitation literature. Many current models of home visitation programs use curriculum based on the child's monthly and yearly development (Woolfolk & Unger, 2009; Katz, McNeely, Johnson, & Kiely, 2011; Spatig, Carlson, Lockwood, & Wellman, 2013). Vanderbilt University developed the MIHOW curriculum which is focused on monthly age-appropriate objectives. Their curriculum is related to "attachment, discipline, cognitive development, and emotional health" (MIHOW Program, 2013, para.3). Azzi-Lessing (2011) notes that curricula and home visits vary based on the individual needs of the family.

Program delivery relates to the dosage of home visits. Program delivery literature identifies issues related to curriculum implementation and whether differences in program models have an influence on when and with what intensity services are implemented (Zolnoski, Stacks, Kohl-Hanlon and Dykehouse, 2012). The key findings related to program implementation and delivery of services focused on the dosage of home visits (Russell, Britner, & Woolard, 2007; Zolnoski, Stacks, Kohl-Hanlon, & Dykehouse, 2012; Ogbuana, Jones, McTigue, Baker, Heim, Baek, & Smith, 2009; Azzi-Lessing, 2011). The home visits must occur often enough and over an extended period of time in order to benefit the mom and child. Azzi-Lessing (2011) calls for more research about frequency, duration, and intensity of home visits. Although we know that consistent home visits produce better results for participants, the home visits are often inconsistent and infrequent (Zolnoski, Stacks, Kohl-Hanlon, & Dykehouse, 2012; Ogbuana, Jones, McTigue, Baker, Heim, Baek, & Smith, 2009; Azzi-Lessing, 2011).

Additionally, program delivery is influenced by contextual factors (Matone, O'Reilly, Luan, Localio, & Rubin, 2012; Azzi-Lessing, 2011). Home visitation delivery is influenced by laws and public policies, availability of critical resources, and the characteristics of the communities

that families live in (Azzi-Lessing, 2011). Contextual information about the community was also identified in several studies to be important in defining program goals and services. Programs that use process evaluation can benefit from considering how contextual information matters in a community (Matone, O'Reilly, Luan, Localio, & Rubin, 2012). The ability to understand contextual information in a community is necessary for the delivery of site specific programs and services. In addition to discussions about child development using curriculum handouts and assisting with basic needs, home visitation programs often focus on making community connections (Zolnoski, Stacks, Kohl-Hanlon, & Dykehouse, 2012; Spatig, Carlson, Lockwood, & Wellman, 2013).

Participants. The characteristics of participants in home visitation programs have been found to be related to program engagement and effectiveness. The relationships among participants are useful for understanding why some moms engage more successfully in home visitation programs with their home visitors than others. The key topics related to participants focus on the characteristics of home visitors and moms, and the relationships between them.

Home visitors can be divided into two main categories—professionals with degrees and paraprofessionals without degrees. Those with professional degrees are nurses, social workers, and early childhood professionals (Murphy, Cupples, Percy, Halliday, & Stewart 2008; Mills, Schmied, Taylor, Dahlen, Schuiringa, & Hudson, 2012). Paraprofessionals are lay individuals, often members of a local community without a professional degree (Azzi-Lessing, 2011; Nelson, Tandon, Duggan, Serwint, 2009). A number of studies compare the effectiveness of service providers with and without degrees and their influence on parent and child outcomes of home visitation (Murphy, et al., 2008; Mills, Schimied, Taylor, Dahlen, Schuiringa, & Hudson, 2008;

Gaffney & Altieri, 2001). Some studies report moms felt more comfortable having home visits with lay professionals from within the community, whereas other studies found moms preferred home visitors with professional degrees because of their expert knowledge.

Another way home visitors have been characterized is through the eyes of moms. Several studies described moms' positive perceptions of their home visitors. Moms described effective home visitors using descriptors associated with trust (Kirkpatrick, Barlow, Stewart-Brown, & Davis, 2007; Jack, DiCenso, & Lohfeld, 2005; Brookes, Summers, Thornburg, Ispa, & Lane, 2006). Similarly, in an article by Rossiter, Fowler, McMahon & Knowalenko (2012), participants described personal qualities of their home visitors related to empathy, warmth, and the ability to nurture friendship. According to Brookes, Summers, Thornburg, Ispa, and Lane (2006), participant moms described the most important home visitors characteristics as "conscientious, consistent, and persistent" (p.38). In contrast, an older study by Knott and Latter (1999) describes moms' negative perceptions of home visitors. This was hypothesized to be because of misunderstandings about participant roles. The moms described the home visitors as judgmental and concerned only with the child outcomes of home visitation.

The characteristics of moms have also been the focus of home visitation research. Brookes, Summers, Thornburg, Ispa, and Lane (2006) found that parents who are successful in home visitation programs were those who were focused on the welfare of the child. In contrast, unsuccessful parents were more focused on themselves than on the child. Further, both unsuccessful and successful parent engagement in home visitation programs has been linked to low-income status and susceptibility to risk factors associated with maternal depression, substance abuse, and violence (Azzi-Lessing, 2011). In one study of home visitation,

participating moms were described as vulnerable (Kirkpatrick, Barlow, Stewart-Brown, & Davis, 2007). The vulnerable women found that the relationships with their home visitors gave them the confidence to deal with their own problems more effectively.

The relationship between the mother and home visitor, and the influence this relationship has on program outcomes, were addressed in several studies. One feature of successful mother and home visitor relationships is emotional connectedness between the two. A connected relationship between the mother and home visitor has been identified as essential for success in home visitation programs (Woolfolk & Unger, 2009; Jack, DiCenso, & Lohfeld, 2005; Kirkpatrick, Barlow, Stewart-Brown, & Davis, 2007; Plews, Bryar, & Closs, 2004). Although there are several studies about these relationships, according to Peacock, Konrad, Watson, Nickel, and Muhajarine (2013) there is a gap in the literature regarding the benefits of an effective relationship between the family and paraprofessional. Peacock et al. (2013) noted that further study of this relationship using qualitative research methods could provide a deeper understanding of the benefits of home visitation for families. Several articles identified the relationships that the home visitor established with the family and family members as benefits of the home visits (Brookes, Summers, Thornburg, Ispa, Lane, 2006; Kirkpatrick, Barlow, Stewart-Brown, Davis, 2007). The relationship between the home visitor and child was identified in one article which described an “emotional connection” that the child shared with the home visitor (Woolfolk & Unger, 2009). This was the only article that was found that mentioned the influence of the home visitor and child relationship on outcomes associated with the child.

Summary of the Literature

The home visitation literature is divided into two categories, one related to program outcomes and one related to program processes. Many studies looked at the outcomes of home visitation for the mother and family because most home visitation programs directly targeted the moms as a way to influence the children. Key issues identified in the literature associated with outcomes for the mother and family are related to improvements in the home environment, reduction of maternal depression, and parental learning about pre- and post-natal development. The key outcomes related specifically to the child include positive developmental outcomes related to higher birth weight in babies, improved cognition, and fewer problematic social behaviors. Some studies reported minimal improvement in language and inconsistent improvement in other factors associated with child development.

The literature about program processes is divided into two categories: one related to programming and one related to participants. The programming literature includes research focused on program content and delivery. The content of many home visitation programs is based on month-to-month and yearly developmental milestones. Program delivery is influenced by contextual factors and service dosage. Service dosage, in particular the frequency, duration, and intensity of home visits, is the key factor identified in program delivery literature. It is believed to influence the effectiveness of home visitation programs.

The participant focused literature includes research on participant characteristics and research on the relationships between participants. The key findings relate to mom and home visitor characteristics and how their characteristics influenced program effectiveness. There is a call for further research about the quality and benefits of the relationships between families

and home visitors. Further understanding of participants' perceptions of relationships with home visitors and how home visitation programs worked with families could help us to understand their perceived influence on child development and prevention of developmental delays. Knowing more about how participants experience and perceive home visitation is critical because developmental delays could be prevented through good maternal and child care practices (State of New Jersey Department of Human Services Office for Prevention of Developmental Delays, 2008).

Problem Statement

Because we know that developmental gaps between children from low socio-economic homes and those from more affluent homes appear around ages two or three, prevention and early identification are critical (Chandler, 2013). Home visitation programs offer a promising, timely approach to the prevention and early treatment of developmental delays for the child. Although we know that home visitation programs are efforts to reduce inequalities related to low socio-economic factors, what we did not know was how the mom participants and home visitors experienced these programs, how they perceived their relationships with each other, and how they perceived program and process outcomes. Peacock, Konrad, Watson, Nickel, and Muhajarine (2013) identified a gap in the literature regarding the benefits of an effective relationship between the family and paraprofessional home visitors. Peacock et al. (2013) concluded that further study of the relationship using qualitative research methods could provide a deeper understanding of the benefits of home visitation for families. Since home visitation programs have increased in the past few decades and appear to have several positive family and child outcomes, a deeper understanding of what makes programs effective was vital.

Likewise, Harden, Chazan-Cohen, Raikes, and Vogel (2012) concluded that future research should investigate “the mechanisms by which home-based programs impact child and family development” (p. 450). Most of the research on home visitation and child development focused on the outcomes of home visitation for the mother and family, but few studies have focused on moms’ and home visitors’ lived experiences of the programs. This study sought to fill the gap regarding how moms and home visitors perceived and experienced home visitation programs, especially their relationships with each other. It also sought to understand how moms and home visitors perceived the MIHOW program’s influence on child development related to the areas of physical, cognitive, and social-emotional functioning and communication.

Research Questions

1. How do moms and home visitors perceive and experience the MIHOW home visitation program?
 - Curriculum
 - Visits
 - Other services
 - Relationships

2. How do moms and home visitors perceive the MIHOW program’s influence on child development?
 - Physical
 - Cognitive
 - Social-emotional
 - Communication

Purpose of the Study

The purpose of this study was to contribute to research on home visitation, specifically by gaining knowledge about how MIHOW home visitation programs were experienced and perceived by the moms and home visitors. It aimed to understand what influence, if any, home visitation had on child development as seen through the eyes of the moms and home visitors. Finally, the aim was to use the findings to learn more about the potential of home visitation programs to prevent developmental delays.

Significance of the Study

Home visitation programs have a real chance at providing benefits for parents and children during the early years (Harden, Chazan-Cohen, Raikes, & Vogel, 2012). This study contributes to existing literature about the experiences of home visitation programs for moms, staff, and children. It is in line with the current call by President Obama for universal preschool and a major investment in home visitation (Chandler, 2013). According to Chandler, home visitation is a method to dissolve the achievement gap between the rich and poor.

Methods

The research was conducted using qualitative methods based on process theory which “tends to see the world in terms of people, situations, events, and the processes that connect these; explanation is based on an analysis of how some situations and events influence others” (Maxwell, 2013, p. 29). This qualitative case study used phenomenology as a theoretical framework (Pinar, Reynolds, Slattery, & Taubman, 2008). Phenomenology is used to determine how things are perceived through lived experiences (Pinar, et al. 2008). I used interviews to

determine how the moms and home visitors perceived and understood the MIHOW home visitation program and its influence on child development.

The study included semi-structured, ethnographic interviews with moms and home visitors from two MIHOW locations in rural West Virginia. Each mother was interviewed at least three times. The inclusion of one or two participant observations enhanced my understanding of home visitation and how it was experienced by program participants. Any written documents that were relevant to the research questions were also included.

The analysis consisted of coding data and identifying themes and patterns. Bogdan and Biklen (2007) describe the data analysis process as “working with the data, organizing them, breaking them into manageable units, coding them, synthesizing them, and searching for patterns” (p.159). The final step consisted of data interpretation. I interpreted the data in relation to other documented literature about home visitation and child development.

Strengths and Limitations

A strength of this study was that I had access to moms and home visitors participating in the MIHOW program. I was already acquainted with some moms and home visitors due to my affiliation with a MIHOW evaluation research team. I had been a member of the MIHOW research team since May 2012. As a researcher directly involved with this project, I was already IRB approved. The experience gained as a researcher on this project gave me knowledge about who to contact for phone numbers and other information directly or indirectly related to the MIHOW program. I also gained experience, knowledge, and exposure to qualitative research methods. This was valuable since the researcher is the key research instrument in a qualitative research study (Glesne, 2011). Another strength of the study was the use of qualitative

methods that allowed me to get at “how” questions and at processes regarding how the MIHOW program actually played out day-to-day. Qualitative methods also allowed me to understand more fully what the program meant to the moms and home visitors. One limitation of the study was related to the field. Fieldwork limitations include difficulty contacting participants because of moms moving frequently and lacking phone reception. Another concern was the possible loss of participants in the sample. Although we included the data from six-to-ten moms, additional interview data from moms who exited the programs, and at least three home visitors, the moms and home visitors could decide to leave the program at any time.

Validity

Research bias is a validity threat related to how the researcher’s own beliefs, values, and interpretations may unduly influence a study (Maxwell, 2013). I was aware of my own preconceived ideas about child development and home visitation. These biases were based on prior experiences conducting home visits during graduate school. I also had biases as a result of my experience as a researcher doing MIHOW program evaluation. Another threat to the validity of this study was related to reactivity, the researcher’s influence on the setting or participants of the study.

Organization of the Study

Chapter one introduces the study and provides an overview of relevant literature. It includes an introduction, conceptual framework, related literature, problem statement, research questions, purpose and significance of the study, methods, strengths and limitations, and organization of the study. Chapter two details the literature related to this study. It focuses on what is currently known about home visitation and how it relates to child development.

Chapter three provides a more detailed description of the methods to be used in the study. It includes a description of the research design including data collection and analysis techniques. Chapter four consists of biographical information about the key participants in the study. Chapters five and six present the results and answers to research questions from each site. Chapter seven concludes with an interpretation of the findings, discussion of potential flaws of the study, and implications of the findings for practitioners and policymakers. This chapter also provides suggestions for future research.

Chapter 2: Literature Review

The scholarly home visitation literature includes research on program outcomes and research focused on program processes. The first category is related to program outcomes of home visitation for the mother, family, and child. The second category features home visitation program processes including research on programming and research on participants.

Programming literature can be further subdivided into program content and program delivery.

Research on participants can be subdivided into participant characteristics and relationships between participants.

Program Outcomes

The key issues in the home visitation literature related to outcomes for the mother and family are focused on the home environment, maternal depression, and learning. The second sub-category of outcomes relates to the influence of home visitation on the child. The key child outcomes pertain to positive developmental outcomes related to health, cognition, and social-emotional behaviors.

Moms and Families

A significant portion of the literature about home visitation and child development identifies program outcomes for moms and families. Historically, home visitation programs have focused most of their efforts on providing services that will benefit the moms. The key issues in the home visitation literature related to outcomes for the mother and family are focused on the home environment, maternal depression, and learning.

Home Environment. Home visitation is associated with improvements in the home environment for the mother and family. Improvements in the home are important for the

promotion of child development (Katz, Jarrett, El-Mohandes, Schneider, McNeely-Johnson, & Kiely, 2011). The key issues related to improvements in the home environment are social support, stimulation, and the reduction of smoking.

Social support is one method home visitation programs use to improve pregnancy outcomes for the mother (Katz, Jarrett, El-Mohandes, Schneider, McNeely-Johnson, & Kiely, 2011). Katz et al. (2011) conducted a study of 286 African American moms who had been in the Washington DC area participating in the Pride in Parenting intervention program for one year. The study was conducted to look at whether paraprofessionals from the community using home visitation and group interventions had an influence on moms' social support. Social support was described as either formal or informal support. Formal supports were identified as home visits or infant-mom play groups. Informal supports were existing networks of friends and family. The authors of the study concluded that the moms who received higher numbers of home visits rated formal and informal support higher than moms who received fewer visits. The parents who attended the infant-mom play groups achieved the greatest benefit. The play groups helped the moms to decrease stress related to depression during the postpartum period and improve overall child and mom outcomes. The social support helped to create a positive home environment for child-rearing.

Kemp, Harris, McMahon, Matthey, Vimpani, Anderson, Schmied, Aslam, and Zapart (2011) looked at the impact of a dual nurse home visitation program and post-natal parent education program on 208 at-risk moms living in socio-economically disadvantaged areas of Sydney, Australia. The purpose of the study was to determine the quality of the home environment related to social stimulation. The results of the study indicated that the parents of

infants and toddlers in the home visitation intervention group had a home environment more supportive of child development because of their verbal and emotional responsiveness to their children. The intervention also increased time breastfeeding and improved mental development for children whose moms had antenatal distress.

Plews, Bryar, and Closs (2004) looked at the social support of 37 moms. They looked at whether support was featured as part of the visit, whether it was specific to the individual home visitor, and what support meant to the home visitor. The results of this study indicated that the moms had positive outcomes in relation to the information received and increased feelings of reassurance based on their relationship with the home visitor. The home visitors contributed to their clients “well-being” and “ability to cope” (p. 796).

A third improvement in the home environment is related to the reduction of smoking for moms. Azzi-Lessing (2011) reviewed Early Head Start and Nurse Family Partnership Programs in the 1970s and then again in 1990s. The Nurse Family Partnership was evaluated in Elmira, New York in the late 1970s and was found to have positive impacts for the mom and child. The moms in the study reduced their prenatal smoking because of home visits with nurses. The moms participating in the Nurse Family Partnership who had been smokers were less likely to have babies born prematurely. Moms who were under the age of 17 had babies with a higher birth weight than young moms who did not have home visitation. Two subsequent studies of the Nurse Family Partnership were conducted in Memphis, Tennessee, and Denver, Colorado in the early to mid-1990s. The results of the follow-up studies concluded that families did benefit from the home visitation programs but benefits were smaller than in

the initial study. There were no differences between the control and experimental groups related to health at birth or premature births, cognition, and incidence of behavior problems.

Depression. Some home visitation programs help with maternal depression whereas others do not (Harden, Chazan-Cohen, Raikes, & Vogel, 2012; Azzi-Lessing, 2011; Tandon, Parillo, Mercer, Keefer, & Duggan, 2008; Ammerman, Shenk, Teeters, Noll, Putnam, & Ginkel, 2011; Ferguson & Vanderpool, 2013; Shaw, Levitt, Wong, Kaczorowski, & The McMaster University Postpartum Research Group). The moms in these studies used mental health support during home visitation to reduce their depression (Tandon, Parillo, Mercer, Keefer, & Duggan, 2008; Shaw, Levitt, Wong, Kaczorowski, & The McMaster University Postpartum Research Group, 2006). In contrast, Ammerman, Shenk, Teeters, Noll, Putnam, and Van Ginkel (2012) found that the mother's level of depression impacted home visitation delivery and prevented the moms from learning skills associated with child development.

Tandon, Parillo, Mercer, Keefer, and Duggan (2008) conducted a study of families' reasons for home visitation enrollment in order to provide better service delivery. Three neighborhoods used Healthy Start and Healthy Families America home visitation models for one to three years. The home visitors went to the homes at least every two weeks. One hundred-twenty-three women participated in the initial interview which looked at the moms' reasons for entering and remaining in home visitation programs. The results of this study indicated that while in the study 46% of the moms had symptoms associated with depression. The findings from this study suggest that the inability to complete one's education and gain employment are two factors associated with depression. The researchers noted that when paired with home visits, cognitive-behavioral approaches used by mental health providers for

treating moms with depression could help provide moms with the skills to cope with stress associated with education and employment. For example, cognitive-behavioral approaches used in conjunction with home visitation changed the individuals' way of looking at their situation and reduced depression.

Ammerman, Shenk, Teeters, Noll, Putnam, and Van Ginkel (2012) looked at 180 depressed and non-depressed moms who participated in one of two models of home visitation through Healthy Families America and the Nurse-Family Partnership Programs. Depression was found to interfere with the mother's ability at important early stages of development to help the child acquire specific developmental skills. For example, it was noted by home visitors that moms with depression were less able to benefit from home visitation programs. One year into the study, the results indicated that depressed moms had smaller social networks, increased stress, and poorer home environments than did the non-depressed moms. The results indicate that the effectiveness of home visitation varies depending on the mother's level of depression. Home visitation did appear to improve the quality of the home environment for depressed moms by improving the physical environment. Increased social domains reduce stress for non-depressed moms but were a source of stress for depressed moms. Overall the moms with depression were less able to benefit from home visitation than the non-depressed moms.

Ferguson and Vanderpool (2012) looked at 64 families in the comprehensive home visitation program, Kentucky HANDS, to assess pre-and post-levels of parent risk factors. The results of the study indicated that the risk factors associated with lifestyle behaviors, mental health, coping skills, support systems, stresses, and anger management were reduced after participation in a comprehensive home visitation program.

Shaw, Levitt, Wong, Kaczorowski, and The McMaster University Postpartum Research Group (2006) conducted a systematic review of 22 studies of randomized controlled trials of interventions that utilized postpartum support for women after birth through one year. The results of the meta analysis indicate that postpartum support in relation to maternal mental health with women at high-risk for depression appears to improve mental health outcomes for the moms.

An outcome related to the mother's mental health that does appear to be affected by home visitation is stress. In 1997-1999 Early Head Start conducted a 17-site study of 1,385 families at the conclusion of the Early Head Start program when the child was three years old, and then again prior to kindergarten entry (Harden, Chazan-Cohen, Raikes, & Vogel, 2012; Azzi-Lessing, 2011). The data collection methods used in this study were parent questionnaires, the Bayley Mental Developmental Scale, and video-taped observations of parent-child interactions. At 36 months, the outcomes associated with maternal mental health included less parental distress for individuals in the intervention group than those involved in the control group. By the end of the two-year period, individuals receiving home visitation interventions reported less parent stress. According to Harden et al. (2012) the reduction of stress in the home environment can significantly improve the moms' maternal mental health and the home environment for the child.

Learning. New knowledge is also a benefit for moms participating in home visitation programs. Several studies looked at types of mom learning, where the learning was taking place, who was responsible, and how learning occurred in home visitation programs.

Hammond-Ratzlaff and Fulton (2001) investigated the amount of new knowledge that 47 first-

time moms obtained after participating in home visitation at birth and then again after six months. The study looked at whether there was a difference between the amount of knowledge gained by adolescent and older moms. The results of this study indicated that both younger and older moms gained knowledge about child development. The study determined that first-time moms gained the most knowledge about infant and school-age child development. This was because the moms were thought to be most interested in infant development and to have some recall of their school-age years. The moms demonstrated no increase in knowledge about toddler and preschool development. It was concluded from this study that older and younger moms gain the same amount of knowledge about child development.

Tough, Johnston, Siever, Jorgensen, Slocombe, Lane, and Clarke (2006) looked at 1,352 women to determine the impact of supplementary prenatal care on their use of resources in a community-based home visitation program. The women were randomized into one of three groups in the study: 1) current care standard, 2) current care standard with nurse as prenatal support, and 3) current care standard with nurse support and home visitor for non-medical support. The results indicated that women who use home visitors and nurses as additional support increased the use of community-based resources and had increased knowledge related to prenatal development, nutrition, and parenting.

Shaw, Levitt, Wong, Kaczorowski, and McMaster University Research Group (2006) conducted a meta analysis of 22 studies from 1999 to 2005 on the effectiveness of home visitation to improve maternal knowledge related to parenting. Postpartum support was offered to low-risk and high-risk women during home visits. Postpartum support was defined

“as an interpersonal interaction between a postpartum woman and trained individuals or health care professionals” (p.211). The high-risk women were at-risk for family dysfunction. The results indicated that knowledge about post-partum support did not increase as a result of the interventions. However, the women at risk for family dysfunction showed improvements related to parent knowledge and parent-child interactions as a result of home visits, case conferencing, and information from a pediatric doctor.

Tandon, Parillo, Mercer, Keefer, and Duggan (2008) looked at the Healthy Start Program for one to three years to determine moms’ intentions for program enrollment. Tandon et al. identified the three most common reasons for program enrollment as job training and employment, information on how to complete education, and information related to child development. The results of the study indicated that home visitors were prepared to provide direct education about perinatal health but not information related to employment, education, or “life course needs” (Tandon, Parillo, Mercer, Keefer, & Duggan, 2008, p.125). Rather, the home visitors made outside referrals to agencies for education and employment information.

Mills, Schmied, Taylor, Dahlen, and Schuiringa (2012) conducted a qualitative study of six professional staff providing home visitation over an 18 month period in Sydney, Australia. The interviews focused on the staff’s experiences working with young moms. The home visitors in this study were identified as non-nurse professionals. The professionals came from different “philosophical backgrounds” (p.668). The findings of this study identified two themes related to the professional’s perception of the moms associated with *connecting* and *learning*. The themes *connecting* and *learning* were interrelated. The professionals valued their connection with the moms during home visits because the visits helped to facilitate mom learning. The

results indicated that during home visitation professionals place value on their relationship with moms and deliver content during home visits similar to nurses.

Children

There are fewer studies related to the influence of home visitation on outcomes related to the child directly. This trend is related to the focus of home visitation on the mother, and the lack of child-specific services offered in home visitation programs (Harden, Chazan-Cohen, Raikes, & Vogel, 2012). The outcomes of home visitation for the child pertain to health, cognitive development, and social-emotional behaviors.

Health. Many publications identify an association between home visitation and improved health outcomes, especially as they relate to the birth weight of the baby (Lee, Mitchell-Herzfeld, Lowenfels, Greene, Dorabawila, & DuMont, 2009; Peacock, Konrad, Watson, Nickel, & Muhajarine, 2013). Some studies showed that home visitation helped to promote immunizations.

Lee, Mitchell-Herzfeld, Lowenfels, Greene, Dorabawila, and DuMont (2009) looked at 1,297 women and adolescents in home visitation programs who were interviewed at three different sites. Those in the intervention group received bi-weekly visits for an hour. The home visits were conducted so the moms could have the best pregnancy experience possible. The prenatal visits focused on areas related to social support, prenatal education, and linkages to community resources. The results of the study indicated that moms who received home visitation were less likely than the control group to deliver low birth weight babies. The earlier the moms received home visitation the greater the reduction of low birth weight babies.

Peacock, Konrad, Watson, Nickel, and Muhajarine (2013) compiled a literature synthesis of 11 studies of home visitation programs that used medical records to assess outcomes associated with psychomotor and cognitive development, child behavior, and language development of children age six or less. A health assessment summary documented outcomes associated with physical growth, illness, injury, and immunization. The results of this study indicated that home visitation reduced the number of low birth weight babies, reduced some health problems related to illnesses and injury, and helped to promote immunizations.

Cognitive Development. The influence of home visitation on child development and cognition was documented in a number of articles. In other words, home visitation was found to be associated with some improvements in cognitive development for the child (Peacock, Konrad, Watson, Nickel, & Muhajarine, 2013; Katz, Jarrett, El-Mohandes, Schneider, McNeely-Johnson, & Kiely, 2011; Harden, Chazan-Cohen, Raikes, & Vogel, 2012). Peacock, Konrad, Watson, Nickel, and Muhajarine (2013) synthesized the data collected on developmental outcomes of home visitation programs in the United States from 1990 through May 2012. Eleven studies looked at specific developmental outcomes focused on psychomotor and cognitive development, child behavior, and language development. The results of this literature synthesis indicated that small cognitive improvements can be found in children who receive “stimulation intervention,” especially if this is paired with nutritional supplementation (Peacock, Konrad, Watson, Nickel, & Muhajarine, 2013, p. 8). Modest improvements were identified in areas related to cognition such as locomotor and hand-eye coordination in one study. Another study identified an effect on developmental stimulation, but not on motor.

Language is a separate developmental category which did not show the same improvements after home visitation.

Katz, Jarrett, El-Mohandes, Schneider, McNeely-Johnson, and Kiely (2011) report the results of a controlled trial of home visitation using the Pride in Parenting Program for high-risk African American moms in Washington, DC. The home visitation program was used to provide health and developmental intervention. Those in the intervention group received home visits and met with parent groups for one year. The intervention groups also participated in bi-weekly playgroups and parent discussions when the child turned five months. The control and intervention moms also received a monthly visit from a social worker for one year post-birth. The results of this study indicated the importance of the early home environment on cognitive development. The influence of the home environment on cognitive development was associated with appropriate play interactions during home visits rather than a focus on broad developmental concepts. According to Katz et al., children who grow up in a home with limited developmental support often demonstrate a decline in intelligence after having normal development at one year. The lack of developmental support after age one leads to potential academic failure later in school. The results of the study suggest that there is a positive correlation between improvements in the home environment and maintaining strong cognitive development scores for children.

Harden, Chazan-Cohen, Raikes, and Vogel (2012) discuss the effectiveness of the Early Head Start program that provides home-based services. The developmental outcomes of the Early Head Start program for the child were studied at the conclusion of the program and then two years later. The results of the study concluded that Early Head Start had the ability to

improve children's scores on cognitive, language, and applied problem solving tests (Harden, Chazan-Cohen, Raikes, & Vogel, 2012).

Social-emotional Behaviors. Research on the influence of home visitation on children's social-emotional development reports inconsistent findings. One study noted improvements in the social-emotional behaviors of the child after home visitation whereas the other study did not identify any change for the child as a result of home visits. Harden, Chazan-Cohen, Raikes, and Vogel (2012) conducted a study of children and families who participated in the Early Head Start home visitation program to determine if the program had any influence on child and family outcomes. The results indicated that they had fewer behavior problems at pre-kindergarten. This was determined to be a result of the positive adult-child relationships that were modeled during the home visits. The ability to have positive social emotional functioning was identified as an important part of "school readiness" (Harden, Chazan-Cohen, Raikes, & Vogel, 2012, p.449). This study concluded that there were long term social-emotional benefits of home visitation for children in the areas of social-emotional functioning.

In contrast to Harden, Chazan, Cohen, Raikes, and Vogel (2012), Manning, Homel, and Smith (2010) conducted a meta analysis of 17 studies of early developmental prevention programs. The study included preschool children ages birth-to-five in home visitation, center-based, parent-education, and family-support programs. The study addressed non-health adolescent outcomes of at-risk populations using seven outcome domains related to educational success, cognitive development, social-emotional development, deviance, social participation, criminal justice, and family well-being. Forty-five percent of the programs in this study related to home visitation. The results of this study indicated that educational success

and cognitive development were correlated with participation in home visitation. There was little influence on social-emotional development and family well-being. This was thought to be because of the changes in the home environment and the lack of preventative interventions after program completion.

Summary of Outcome Findings

The literature on home visitation outcomes for the mother and family were related to the home environment, maternal depression, and learning. The second subcategory of outcomes relate to the influence of home visitation on the child. Some positive developmental outcomes for the child relate to health, cognition, and social-emotional behaviors. Research on home visitation program processes, discussed below, provides further understanding about the content and delivery of home visitation programs.

Program Processes

In addition to research on home visitation outcomes, there is a growing body of literature about home visitation program processes. Process refers to *how* home visitation programs are being implemented, for whom, and in what ways. Research on program processes will be discussed in two categories—programming and participants.

Programming

Programming literature is related to home visitation program content and program delivery. Home visitation delivery is related to service dosage and contextual factors. The content of some home visitation programs is focused on monthly age-appropriate milestones and development. The successful delivery of home visitation appears to be influenced by the

number of home visits a mom receives and the nature of the community in which the family lives.

Content. The national PAT (Parents as Teachers) home visitation model was developed around age-appropriate learning and developmental activities (Woolfolk & Unger, 2009). The PAT model is focused on parent support and education by home visitors who are themselves parents. The program teaches parents about child development, developmental issues, abuse prevention, and school readiness. The strengths of the parent are the foundation of the program.

Likewise, Katz-McNeely, Johnson, and Kiely (2011) described the Pride in Parenting intervention model based on topics related to the infant's age and development. The content of the lessons focused on parent health and child care. The home visitation sessions included play activities that were modeled from the Partners Educational Curriculum.

The curriculum in the MIHOW Program, in partnership with Vanderbilt University, is also focused on age appropriate milestones (Retrieved from <http://www.mc.vanderbilt.edu>). The MIHOW curriculum is used prenatally until the child turns three. It was developed to influence areas related to attachment, emotional health, cognitive development, and discipline. The MIHOW program also is designed to build on the strengths of the family and community.

The participant moms in the West Virginia MIHOW home visitation program identified two types of curriculum content which were simultaneously uniform and customized (Spatig, Carlson, Lockwood, & Wellman, 2013). The curriculum was uniform in that with all moms it focused on pregnancy, delivery, and pre- and postnatal child development. The curriculum was also customized based on the individual needs of the moms and families. In addition to the

standard child development related curriculum, the customized curriculum related to specific issues related to health, housing, and jobs.

Delivery. Many articles focused on inconsistencies related to the dosage of home visits. Inconsistent and/or infrequent visits appear to influence the outcomes of home visitation programs for the mom and child. Russell, Britner and Woolard (2007) concluded that the dose, or amount, of contact with families before and after child birth is essential. The inconsistencies related to time and duration of home visits were identified in several studies as factors that influence the parent and child outcomes of home visitation.

Zolnoski, Stacks, Kohl-Hanlon and Dykehouse (2012) conducted a first-year evaluation of 17 families enrolled in a small-scale home visitation program using pre-and post-interviews with participants using child development screenings. The results of the study, after 10 months of service to high-risk families, indicated that few parents had changed their attitudes about child maltreatment. Researchers reported that this was because of less frequent home visits due to missed appointments by parents. The program was not delivered as intended due to the infrequent home visits.

Ogbuana, Jones, McTigue, Baker, Heim, Baek, and Smith (2009) looked at 176 records of a retrospective program evaluation of postpartum/newborn home visitation services in Aiken County, South Carolina to determine if the program was being carried out as designed. The results determined that the home visits were not conducted on time. The researchers determined if services were not conducted in a specific time frame the visits were unlikely to meet the intended program objectives. In other words, the home visits were not conducted on time which diminished participant outcomes.

In a paper about preventative home visitation models in the United States, Russell, Britner, and Woolard (2007) discuss traditional and non-traditional outcome variables of home visitation. Several studies of home visitation documented the importance of time and duration of early home visits with the mother and home visitor. The authors of the study recommend home visits conducted often and long enough to influence child and parent outcomes.

Azzi-Lessing (2011) identifies critical issues for effective home visitation. One of the identified issues is service dosage and family engagement. Based on a meta-analysis of literature about the outcomes of home visitation programs, families receiving the appropriate number of home visits had better outcomes. The families who receive fewer home visits than they expected typically drop out of home visitation programs. Understanding why families remain engaged in home visitation programs often correlates directly with the program's ability to understand the family's needs. Azzi-Lessing calls for more information about the frequency, duration, and intensity of services related to program success.

The context in which families live also plays a role in program delivery. Laws, policies, and linkages to community resources influence program delivery and the outcomes of home visitation. Azzi-Lessing (2011) discussed the role that context plays in home visitation programs using the program reviews of the Nurse Partnership and Early Head Start home visitation programs. The results concluded that home visitation delivery is influenced by community and the availability of resources. Home visitors have difficulty providing effective services for families in communities with fewer resources. Azzi-Lessing calls for research on the role that context plays on the success of home visitation programs.

A study by Matone, O'Reilly, Luan, Localio, and Rubin (2012) looked at prenatal smoking cessation of 24 home visitation participants in Pennsylvania and comparison women within a local area. The results of the study indicated that there was a reduction in smoking cessation for those moms in the home visitation program. The county smoking rate was identified as a contextual challenge to home visitation programs.

Participants

The second category of program process research is related to the people who participate in home visitation programs. In this section, I divide participant literature into two categories—research related to the characteristics of participants and research related to the relationships among participants. The engagement of moms in home visitation programs is sometimes related to the characteristics of the home visitors. Some moms prefer home visitors with a degree, whereas other moms prefer home visitors who are non-degree paraprofessionals. Several articles also address the importance of the relationship between the home visitor and mother on the outcomes for the mother and call for the further study of these relationships. There is only one study that focuses on the home visitor relationship with the child.

Professional versus paraprofessional. Several articles identify the moms' perceptions of the benefits of professional and/or paraprofessional home visitors. Many moms preferred lay workers without degrees because of their personal experiences and familiarity with the community. On the other hand, some moms preferred the expertise and knowledge of home visitors who are professionals with degrees. Murphy, Cupples, Percy, Halliday, and Stewart (2008) conducted a qualitative study of 11 first-time moms in socio-economic disadvantaged

areas of Belfast using thematic analysis of semi-structured interviews. These moms in low socio-economic areas were receiving visits from lay workers. Lay workers were defined in the study as individuals from the same community, with at least one child, and without professional degrees. The program was supervised by mid-wives. The results of this study add to previous reports that moms value the support of lay workers because they can provide social and health support based on their personal experiences.

Gaffney and Altieri (2001) authored a study of 138 low-income moms of infants who were four months old to determine the moms' preferences between eight clinical intervention strategies used during home visitation. The intervention strategies in the study included: home visits by nurses, group sessions, lay home visitors, classes in clinics, health diary, videotapes in home, brochures, and videotapes in clinic. In contrast to several other studies, the findings indicated that a home visit by a nurse was the most preferred intervention strategy. The moms reported that the nurses increased their knowledge about what to do with a baby and helped with problems or questions. Lay home visitors were cited as the third most preferred strategy because of their experience, competence, and social networks.

Katz, Jarrett, El-Mohandes, Schneider, McNeely-Johnson, and Kiely (2011) used a randomized controlled trial of home visitation for high-risk African American moms in Washington, DC to determine whether the paraprofessionals in the community could influence parent attitudes and behaviors. The curriculum used in the study was standardized, contained information about health and parenting, and was aligned with the child's age and development. The curriculum was used for home visits and parent groups for one year. The key findings of this study indicated that using the paraprofessional home visitors to implement the Pride in

Parenting Program was less expensive than using professional home visitors. It also reported that paraprofessionals had more connections to resources in the local communities that could benefit Pride in Parenting participants. Katz et al. (2011) concluded that moms showed benefits from paraprofessionals as home visitors and that they did influence parent attitudes and behaviors. Future research which would compare the effectiveness of paraprofessional and professional home visitors was suggested.

Likewise, an older study by Knott and Latter (1999) looked at the characteristics of professional health visitors from the moms' perspective. Knott and Latter used qualitative research methods to interview 12 single, unsupported moms. The purpose of this study was to learn about the moms' perceptions about whether the program was meeting their needs during the first year after having a baby. The results of this study found that health visitors were viewed by the single moms negatively. The moms felt that the health visitors were not interested in them. Most of the moms did not find the health visitors in this study helpful. The moms wanted the health visitors to be more approachable and friendly.

Other home visitor characteristics. Brookes, Summers, Thornburg, Ispa, and Lane (2006) used qualitative methods to examine the results of two Early Head Start programs. The purpose of the study was to understand the reasons why families and home visitors believe they do or do not have success with home visitation programs and engagement in the home visitor-mother relationship. They looked at factors that strengthened or impeded the home visitor relationship. One program used prolonged ethnographic engagement with nine families over five years using cross-case analysis and constant comparison techniques. The other program was an Early Head Start program. The investigators looked at multiple data sources and various

families and staff in both programs. The results of this study echo similar comments from moms in other studies about the importance of home visitor characteristics related to dependability, honesty, and persistence and how these characteristics influence the home visitor/mother relationship.

Rossiter, Fowler, McMahon, and Kowalenko (2012) conducted a qualitative research study using thematic analysis to analyze the responses of 111 moms with maternal depression in Australia who received home visitation from nurses until their child was one. The study looked at the moms' perception of the home visitation program to determine things about the intervention that they felt were valuable. One theme identified the personal and professional qualities of the home visitors. The participants described the characteristics of effective home visitors as understanding, empathetic, and warm. The results of the study indicated that participants in the program felt that the nurses genuinely cared about them and their family. They focused on parent strengths during home visits.

Characteristics of moms and families. The characteristics of moms and families are also addressed in the home visitation literature. Brookes, Summers, Thornburg, Ispa, and Lane (2006) looked at the results of two Early Head Start programs to understand why families were not perceived to be successful in the home visitation programs. The study looked at two urban sites identified as A and B. The results of the study identified factors that facilitated or impeded family participation in home visitation. Parent personality traits were associated with successful or unsuccessful engagement in home visitation programs. The parents who were successful were able to put their child's needs first and remain flexible regardless of program personnel

changes. In contrast, the parents who were unsuccessful viewed the program from the perspective of how it could benefit them.

Kirkpatrick, Barlow, Stewart-Brown, and Davis (2007) conducted a qualitative study to explore the perceptions of 20 women about the value of home visitation during pregnancy through the first year of their child's life. Many moms in the study were identified as vulnerable. The women were interviewed about home visitor qualities they found helpful or not helpful. The results of the study determined that although the moms were unsure about developing a relationship with their home visitor, many moms went on to have positive relationships with them. These positive relationships influenced the moms' success in the home visitation program. The participating moms found qualities associated with home visitor trust and reassurance to be the most helpful for the development of a close relationship.

Relationships among participants. The relationship between the home visitor and mother is complicated and multi-dimensional (Woolfolk & Unger, 2009). This section discusses studies that provide a general understanding of the relationship between the home visitor and mother and how this relationship influences program outcomes for the mom and children (Woolfolk & Unger, 2009; Jack, DiCenso, & Lohfeld 2005; Kirkpatrick, Barlow, Stewart-Brown, & Davis, 2007; Brookes, Summers, Thornburg, Ispa, & Lane (2006); Plews, Bryar, & Closs, 2004).

Woolfolk and Unger (2009) discussed the perspectives of lower socioeconomic African American moms who participated in the Parents as Teachers (PAT) Home Visitation Program. The PAT program provides services to new moms with children from Birth-to-Three. Moms who had been receiving services for at least six months were interviewed. The questions focused on the moms' perceptions of the PAT program, parenting likes and dislikes, activities used during

visits, expectations about the program, their home visitors during the visit, and on the relationships they had with their home visitors. The results of the study suggest that the home visitor and mother relationships can be divided into two categories—those built around the needs of the family and those focused on the child. For example, relationships built on family needs influenced education, housing, and shopping. The relationships which were focused on the child's needs were related to child development such as what the child needs to be learning, what they are learning, and what types of activities are developmentally appropriate.

Jack, DiCenso, and Lohfeld (2005) conducted a study that described the perceptions of moms who engaged with public health nurses and paraprofessional home visitors in a blended home visitation program in South West Ontario. The data were collected through 29 interviews and questionnaires. The sample included 20 moms who had experience with the nurses and paraprofessionals. The results of this study indicated that the most important outcome for the moms was the development of a connected relationship with the nurse or paraprofessional. The moms wanted to feel that they were making a contribution to the relationship through mutual collaboration. The moms were also motivated to overcome the fear of judgment by the nurse or home visitor during the home visits. The moms wanted to have an opportunity to build a relationship with their home visitor based on a foundation of trust.

Kirkpatrick, Barlow, Stewart-Brown, and Davis (2007) conducted 20 in-depth interviews with vulnerable women to determine the value of a home visitation program prenatally through age one using professional health visitors. The intervention was conducted in Oxford and Buckinghamshire, England, using the Family Partnership home visitation program. The women participating in the interviews received intervention for one hour per week. The home

visits began during the second trimester of pregnancy and continued for 18 months. The interviews were conducted to determine what provider and program qualities were most helpful to moms. The results of this study were similar to the study conducted by Jack, DiCenso, and Lohfeld (2005), suggesting that the moms wanted to build a partnership with the home visitors based on trust and non-judgment. This study also reported that the moms valued the home visitor relationship and found the home visitors to be like “friends” (Kirkpatrick, Barlow, Stewart-Brown, & Davis, 2007, p.43). The moms found the advice and encouragement from the home visitors helpful, particularly relating to behavior management and older children.

Brookes, Summers, Thornburg, Ispa, and Lane (2006) synthesized the results of two qualitative studies conducted by two investigative teams that partnered with Early Head Start in two urban areas. The two sites varied in the type of qualitative research methods used. One site used ethnographic case studies with prolonged engagement, whereas the other site used the Early Head Start program as a case study to collect multiple forms of data from stakeholders, moms, and home visitors. The home visitors in both site studies were professionals and held at minimum a bachelor’s degree in social work or early childhood education. Multiple forms of data were used to triangulate the results. Content analysis was used to determine themes associated with the relationship between the home visitor and mother. The results of the study determined that the moms expected to get what they were promised from the home visitors. They wanted the home visitors to be “conscientious” (Brookes, Summers, Thornburg, Ispa, & Lane, 2006, p.38). The most successful home visitor and mother relationships were from programs that translated home visitor purposes clearly and looked carefully at matching home visitor and mother personalities.

Relationship between home visitor and child. Only one study directly addressed the relationship between the home visitor and child. Woolfolk and Unger (2009) describe several child outcomes in their study of the perspectives and experiences of low-income African American moms. These moms participated in the Parents as Teachers home visitation program in the mid-Atlantic United States. The results of this study indicated that the Parents as Teachers home visitation program had a strong focus on the child and on child development issues. Many of the moms reported that they remained in the program because their children enjoyed the activities and their relationship with the home visitors.

Literature Synthesis

The literature on home visitation and child development was divided into two categories, one related to program outcomes, and the other to program processes. The main outcomes associated with home visitation for the mother are related to the home environment, maternal depression, and learning. One key positive child development outcome of home visitation is related to low birth weight. Some improvements also were identified in cognition. However, it is unknown why some studies report minimal improvement in language and inconsistent improvement in other factors related to child development.

The program process literature was divided into two categories, one related to programming and the other to participants. Programming was further sub-divided into program content and delivery. The content of most home visitation programs is based on information related to monthly age-appropriate milestones and to unique needs of moms and families. The key issues in program delivery are related to the dosage of home visits and the contextual factors of the community. Azzi-Lessing (2011) calls for more research related to the frequency,

duration, and intensity of home visits. Participant-focused literature was subdivided into research on participant characteristics and research on the relationships among participants. The characteristics of participants and the nature of their relationships with each other appear to influence the success of home visitation programs. A successful mother/home visitor relationship appears to influence participant engagement in home visitation programs.

A primary gap in the literature, which was addressed by my study, is a lack of information regarding participants' lived experiences of home visitation programs and their perception of how home visitation programs influenced child development. Few studies addressed *how* home visitation programs influenced outcomes related to child development for children. Harden, Chazan-Cohen, Raikes, and Vogel (2012) argue that the "mechanisms by which home-based programs impact child and family development should be examined" (p.450). Chopra (2012) adds that very few studies exist on the influence of early intervention on developmental outcomes because most studies look at school-related outcomes. The literature is also inconsistent on why home visitation programs influence some areas related to child development and not others.

The relationship between the family and home visitor is another factor that warranted further investigation. According to Peacock, Konrad, Watson, Nickel, Muhajarine (2013), there is a gap in the literature regarding the benefits of an effective relationship between the family and home visitor. Peacock et al. noted that most studies about home visitation do not include "the impact of the quality of the relationship between the paraprofessional and the family" (p.12). Peacock et al. recommended further study of this relationship with the use of qualitative

research methods. The results of this research provide a better understanding of the benefits of home visitation for families.

As noted by Astuto and Allen (2009), “knowing what works under what conditions is a challenge for every program, as well as a concern for policymakers who have limited funds to support home visitation” (p.13). The results of this study about home visitation and child development may assist policymakers in making improvements in the development of home visitation programs and monitoring those existing programs for quality assurance. This study sought to fill a research void regarding how moms and home visitors perceived and experienced home visitation programs regarding curriculum, visits, others services, and relationships. It also sought to understand how moms and home visitors perceived the program’s influence on child development related to physical, cognitive, communication, and social-emotional growth.

Chapter 3: Research Methods

This study used qualitative research methods. Qualitative research is appropriate for understanding the experiences and perceptions of families in home visitation programs (Azzi-Lessing, 2011). I used a collective case study design to examine the perceptions of moms and home visitors related to home visitation and child development.

Design

This study was part of a larger mixed method, program evaluation study. The research design was a phenomenological, collective case study. According to Bogdan and Biklen (2007), the research design is “used in research to refer to the researcher’s plan of how to proceed” (p. 54). The design was flexible, in accordance with “emergent design flexibility” described by Patton (2002) as a design that is flexible enough to adapt as the understanding of the phenomena deepens. This phenomenological case study enabled me to “understand the meaning of events and interactions to ordinary people in specific situations” (Bogdan & Biklen, 2007, p. 25). In this study, I looked at moms’ and home visitors’ perceptions and experiences related to the influence that MIHOW had on child development. In a collective case study, the researcher examines multiple cases to investigate “a phenomenon, population, or general condition” (Glesne, 2011, p. 22). The phenomenon of interest in the study was the participants’ perceptions of home visitation and child development. The primary data collection methods were interviews, participant observations, and written documents. Extant data from the larger study were also utilized.

Setting

The settings for the study were the two MIHOW home visitation programs in rural West Virginia. The Blue Lake program is located near Beckley, West Virginia. The Mountain Ridge program is located in a small town in northern Mingo County. This organization also serves a more rural population located in the southern part of the state. Both sites are rural, economically disadvantaged, and socially isolated areas of West Virginia.

Sampling/Participants

Participants included moms who were enrolled in the West Virginia MIHOW home visitation programs in the locations described above, as well as home visitors who worked for the programs. The sample consisted of six-to-ten moms and at least three home visitors who were in the program at least three months. The sample also included additional interview data from moms who have exited the programs. From this sample of information-rich cases, I sought knowledge and understanding about issues associated with the research (Patton, 2002).

For the quantitative part of the larger study, in each site the women/moms were randomly assigned to a treatment or control group. Qualitative participants were selected from those assigned to the treatment group— in other words, those receiving home visitation and the full MIHOW program. We initially randomly selected participants from the lists of treatment moms/women in both sites. Due to difficulties with disconnected phone numbers, we began contacting all moms from the list who had working phone numbers. We went to the top of the list, which was organized by date of entry into the program, and called every name until we were able to get a favorable response. We interviewed the first mom we could reach.

The sample included both younger and older moms. It also included first-time and single moms, and moms with more than one child. The emerging design of the research required flexibility because the moms we used in the study could have dropped out of the program or been difficult to contact for repeat interviews.

Data Collection

Continuing work already in progress in the qualitative part of the larger study, the primary data collection strategy in this study was semi-structured, individual interviews with moms and home visitors associated with the MIHOW home visitation program in West Virginia. Three or more interviews with six-to-ten moms over a two-year period were included, but also additional interview data from moms who exited the programs. I also interviewed at least three home visitors who worked with these moms. We provided moms we interviewed a ten dollar Walmart gift card as a monetary payment for their time and effort.

Interviews with moms and home visitors were conducted by telephone. Telephone interviews are a credible method to gain data because they give a voice to those who otherwise might be unheard (Glogowska, Young, & Lockyer, 2011). Telephone interviewees sometimes feel more comfortable discussing personal information over the telephone than in person (Glogowska, Young, & Lockyer, 2011). Wilson and Edwards (2003) concluded that the advantages of cost and flexibility of phone interviewing far outweigh the disadvantages of rapport and data limitations.

In the first interview, the moms were asked how they got involved in the MIHOW program, their feelings about pregnancy, what they expected the program to be like, and how they would explain the program to someone who had not experienced a home visit. They were

also asked questions related to their learning, such as what kinds of information they received during the home visit. The first interview concluded by asking moms what the program might include to make it better and whether they felt the program was helpful.

In the second interview, moms were asked follow-up questions from the first interview to find out how they are doing. It included questions about what kinds of things have happened at the home visits since the last interview, how the baby was doing, what things they were working on, and if they had concerns about the baby or the program. The second interview concluded by asking moms if there were improvements that could be made to the program.

In the third interview, moms were asked to describe their child's growth. Moms were asked about developmental checklists, or milestones— what they consist of, how they were used in the MIHOW program, and how they understood them. The moms were asked to describe how the child was doing in relation to physical, cognitive, social, and communication domains. They were asked how the child was developing in these areas and if there were concerns and what MIHOW was doing to address them. The third interview concluded by asking moms how/if their ideas about parenting have changed since they have been participants in the program. (See Appendix B).

In addition to the interviews, I also conducted two participant observations of home visits to obtain a deeper understanding of how the program was implemented and experienced. During the participant observations, I had an opportunity to observe what goes on during home visits and how the curriculum was implemented. I only did two participant observations of home visits due to the difficulty of scheduling, time, and distance. They were different participants.

Finally, I obtained written documents related to the home visits and relevant to the research questions. The documents included developmental checklists. The documents provided information related to elements absent during the phone interviews. The documents provided further information that helped to answer the research questions. This method provided more depth of understanding about the relationships that existed between home visitation and child development than interviewing and participant observations alone provide.

Data Analysis

According to Bogdan and Biklen (2007), the process of qualitative data analysis consists of several steps. The first step was ordering the data chronologically and keeping similar forms of data together. This was done by organizing the interviews and participant observations chronologically. The second step was reading through data using observer comments and memos simultaneously to gain more understanding about how the participants perceived home visitation and the MIHOW program. This included systematically reviewing and coding interview transcripts and participant observation notes. The third step was developing coding categories or themes using specific words or phrases to capture ideas and issues in the data that could be explored further. The fourth step involved sorting units of data from field notes and interviews into the established coding categories.

This study extended prior and on-going analysis of data from the larger study by examining moms' and home visitors' perceptions of the MIHOW Program and its influence on child development. My analysis was built on what we had learned, or preliminary findings, from the first two years of the qualitative research evaluation. Qualitative findings from the larger study identified four emerging themes from major coding categories: how the program was

experienced in terms of both *uniform* and *customizing* services for individuals and families, forging strong human *connections*, encouraging *learning* for moms and home visitors, and the way that the program was *empowering* for moms.

The final step consisted of data interpretation. Interpretation is the process of relating findings to extant literature and applying findings to other concepts and issues (Bogdan & Biklen, 2007). I interpreted the findings in relation to what was documented in previous research about home visitation and child development as well as literature about the prevention of developmental delays.

Methodological strengths/delimitations

There were several strengths and delimitations that I was aware of during my study. The strengths were related to my MIHOW affiliations, use of qualitative research, and my extended time in the field. The weaknesses were related to participant accessibility.

The first strength of the study was based on my affiliation as a MIHOW research team member. I had access to moms and home visitors. We received regular updated phone lists to keep track of the mothers' participation in the program. There were also opportunities to attend other MIHOW sponsored events which were useful for collecting data using participant observations.

The use of qualitative research methods for this collective case study was a second strength of the study. Qualitative research methods allowed me to get at *how* the moms and home visitors perceived home visitation and child development in the MIHOW program. Azzi-Lessing (2011) concluded that qualitative research methods are the best way to document the experiences of families participating in home visitation programs. Glogowska, Young, and

Lockyer (2010) discuss the practicality of using qualitative research methods and telephone interviewing. They determined that the advantages of using telephone interviewing outweigh disadvantages. They noted that this type of interviewing allowed for open-ended questions with interviewees who might otherwise be unheard.

Another strength of the study was that I have participated on the MIHOW research team for an extended period of time. I have been on the MIHOW research team since summer 2012. My affiliation with the MIHOW research team allowed me to understand with more depth how a home visitation program works and to see how participants perceive its influence on their families and children.

There were also access limitations for this study that needed to be addressed. The moms in WV MIHOW moved frequently, had difficulty with phone reception, and lacked access to employment opportunities due to a variety of constraining factors. These were all factors which influenced their experiences with and perceptions of home visitation and influenced the reliability of their participation in the study. This also inhibited my ability to conduct data collection. The difficulty with participant access inhibited the study because the moms were sometimes unavailable for follow-up interviews which made identifying patterns and themes difficult during data analysis. I minimized this by maintaining close contact with the moms and home visitors often during data collection and interpretation.

Validity

Validity, as described by Maxwell (2013), “refer (s) to the correctness or credibility of a description, conclusion, explanation, interpretation, or other sort of account” (p.122). A potential threat to the validity of this study was researcher bias. Identifying personal biases and

having a plan on how to deal with them effectively was one of the goals of the research (Maxwell, 2013). Although it was impossible to eliminate researcher biases completely, it was important to understand how biases influenced the researcher and the conclusions of the study. I regularly added observer comments to interview transcripts in an on-going attempt to identify any biases. I also conducted member checks to be certain that I was recording the moms' and home visitors' perceptions accurately. Another strategy to downplay bias and strengthen validity was prolonged engagement. The use of prolonged engagement in the field allowed me to develop a deeper understanding of the MIHOW program and how it was experienced by moms and home visitors. Further, peer reviews and debriefing as a part of the larger study assisted in the triangulation of the data for my study. Triangulation, as described by Glesne (2011), is the "use of multiple data-collection methods, multiple sources, multiple investigators, and/or multiple theoretical perspectives" (p.49).

Another threat to validity in qualitative research is reactivity. Maxwell (2013) described reactivity as "the influence of the researcher on the setting or individuals studied" (p. 124) and noted that it is impossible to entirely eliminate researcher influence on a study. It was important to recognize how my current role in the MIHOW study influenced the participants during interviewing and subsequently affected the study findings. For example, the moms could tell me what they believed I wanted to hear during the interviews. One way I reduced this was by reminding them that their responses were confidential and were combined with the responses of other moms.

Conclusion

The completion of this study was the culminating project of my doctoral program in Curriculum and Instruction. As a graduate level researcher, I had the confidence to use qualitative research methods to conduct this research for the completion of the terminal degree. As an educator with a strong background and sincere interest in the field of special education, I found it satisfying to answer my research questions and to understand, through the eyes of moms and home visitors, to what degree and in what ways the MIHOW home visitation program influenced child development. In interpreting the results of the study, I explored how my findings could be used to help policy makers determine whether home visitation programs had any influence on child development and the prevention of developmental delays.

Chapter Four: Description of Settings and Participants

In order to answer the research questions, I have interviewed three home visitors and six moms at two MIHOW sites in West Virginia. This chapter contains a description of the national MIHOW program and the two local MIHOW settings which were involved in the study. It describes sites located near Raleigh County, and northern Mingo County, West Virginia. Biographical information about three home visitors and six moms from the two sites is also included. In order to maintain confidentiality, I have used pseudonyms for the two site names and for the nine participants.

National Maternal Infant Health Outreach Worker Program

For this study, I interviewed moms and home visitors who were participants in the Maternal Infant Health Outreach Worker (MIHOW) program. MIHOW is a national home visitation program that serves “economically disadvantaged and geographically and/or socially isolated families with children birth to age three” (MIHOW Program: Vanderbilt University Medical Center, 2013). The MIHOW program was developed from an initiative in 1982 by the Vanderbilt Center for Health Services. The program was developed in order to improve early child development and health in Appalachia (MIHOW Program, 2014). The Vanderbilt Center for Health Services created peer outreach programs for pregnant women using lay women from the community as the home visitors. The local MIHOW programs use the training and technical support provided by the Vanderbilt Center for Community Health and individual community agencies (MIHOW Program, 2014).

The national MIHOW program was initially funded by the Ford and Robert Wood Johnson Foundation for sites located in rural areas of Tennessee, Kentucky, and West Virginia between 1982-1987 (Elkins, Aquinaga, Clinton-Selin, Clinton, & Gotterer, 2013). Outreach workers were hired at six agencies in Tennessee, West Virginia, and Kentucky. This program was developed to promote prenatal care, good nutrition and eating habits, and education about what to expect during and after pregnancy (MIHOW Program, 2013). Thirty years and 15 sites later, MIHOW has served 15,000 families located in the Appalachian areas of Kentucky, Mississippi, Tennessee, and West Virginia (Elkins, et al., 2013). Many of these families struggle with issues relating to poverty, transportation, education, and health. MIHOW aims to impact the moms by improving birthing and parenting outcomes. Although program services are often customized to meet an individual family's needs, the main components of the program are focused around a strengths-based approach, training moms from the community, monthly home visits, community linkages, and monitored program fidelity (Elkins, et al., 2013).

West Virginia MIHOW

Two MIHOW programs within the state of West Virginia were chosen as the settings for this study. The first is the Blue Lake Program located in Raleigh County, West Virginia. The second setting is the Mountain Ridge Program located in northern Mingo County, West Virginia. Both programs, which are located in economically disadvantaged and geographically isolated areas, operate under the direction of the national MIHOW program at Vanderbilt University Center for Community Health Solutions and community based organizations (Vanderbilt University Medical Center, 2013). The West Virginia programs were structured using the

administrative support and partnerships of the national MIHOW program (MIHOW Program, 2014).

Demographic information about moms at both sites includes age, race, marital status, employment status, education, health care, housing, children in home, and income (Amerikaner, et al., 2015). According to Amerikaner's report, the mean age for the moms, across both sites, was 24.7. The moms ranged in age from 14-45. Ninety-six percent of the moms were Caucasian. As of the 2015 MIHOW Program Evaluation Report, more than half of the moms were unemployed and not looking for work, with 37% employment. Of the moms in both sites, 34% had at least a high school diploma, and 38% had some college. Finally, 64% of the women had Medicaid health care and stable housing.

Setting One: Blue Lake

The Blue Lake site, located in Raleigh County, West Virginia, was the second MIHOW site to be identified nationally. This site was first identified as a pilot project. At the time of this study, the Blue Lake program, located beside a community medical health clinic, served four rural West Virginia counties which included Fayette, Raleigh, Nicholas, and Greenbrier. According to the 2013 census report, Fayette, Raleigh, Nicholas, and Greenbrier counties had 19.3% living below the poverty line. This is the average across the four counties.

The Blue Lake site had 151 participant moms (Amerikaner, et al., 2015). As of October 2014, the Blue Lake site had eight home visitors, served 72 families, and conducted 78 home visits during the month of October, 2014. The Blue Lake site had one site leader and two site coordinators who also served as home visitors.

Beyond the basic MIHOW program, a focus unique to the Blue Lake site was their use of the MIHOW curriculum with local community organizations to promote knowledge about parenting. Once a week one of the home visitors went to the local alternative sentencing program and led a parenting group. The curriculum was also used at the Raleigh County Rehabilitation Center twice a month. A second focus for the Blue Lake site was oral health. The national MIHOW at Vanderbilt received funding to focus on oral health for all MIHOW programs. Improved oral health was a focus for the babies and moms during the home visits.

Home Visitors

Two home visitors from the Blue Lake program participated in this study—Laura and Tammy. The home visitors were each interviewed twice. The home visitor profiles below provide information related to how long they had been a home visitor, their educational background, employment, and any other information related to their understanding of the program.

Laura. Laura, who described herself “as an older home visitor,” had been with the program for 22 years. Laura had short, brown, wavy hair, professional dress, and a pleasant, easy-going manner. Her personality was nurturing; she always seemed ready to help those in need. I first interviewed Laura on July 17, 2012, and conducted a follow-up interview on June 23, 2014. She had lived in the Fayetteville area of West Virginia for most of her life, except during college when she lived in Morgantown. Her education included a bachelor’s degree in Editorial Journalism and a double minor in Psychology and English at West Virginia University.

Laura often spoke of her family during our interviews. She had a husband and three grown sons. During a participant observation of a home visit, she mentioned that her youngest

son was 18 and getting ready to leave for college in a week or so, an event that seemed bittersweet to her. She mentioned having the “empty nest syndrome,” and admitted that she was apprehensive about his departure. She seemed to value family and her role as a mother.

Laura worked several jobs before getting a job with MIHOW as a home visitor. She initially worked for a newspaper in Beckley, and owned and operated a jewelry store for fourteen years. Laura says she “kind of came through the back door” when she initially started working for MIHOW. Laura reflected on her early experience at a MIHOW meeting:

I didn’t know a whole lot about what it was, what kind of meeting I was going to, but I went to a meeting of this wonderful group of women that were working with the MIHOW program, and identified me as a good resource for breastfeeding, and she identified me as a person that might work as a MIHOW visitor.

Laura said one of the reasons she was interested in working for MIHOW was her desire to be a midwife. In addition to labor and delivery, Laura was also interested in child development.

Laura was one of the first local MIHOW home visitors to collaborate with the national MIHOW program at Vanderbilt University on the development of the MIHOW curriculum. Collaboratively with several women at Vanderbilt, Laura worked to help Blue Lake become accredited. The Blue Lake site received accreditation through the national MIHOW site currently housed in the School of Nursing at Vanderbilt University in Nashville, Tennessee. She developed specific curriculum for the prenatal period through age three. Laura reflected on many of the changes she had witnessed in her 22 years with the MIHOW program. She discussed the increased number of trainings that MIHOW provided home visitors, explaining, “I feel like we have just gotten more and more training over the years. Many of the trainings were

held at local, state, and national MIHOW conferences.” Some of the ones she identified related to breast feeding, child development, child brain development, and smoking, among others.

Laura recalled that in her early years with MIHOW she had less paperwork than she has to do now in the program, saying, “We don’t like it, but we understand the importance of it.” The increase in paperwork for many home visitors is related to developmental screenings. The home visitors complete them, score them, determine what the scores mean, and look at what to do after the screening and scoring for the mom and child. She noted that MIHOW is nationally recognized and that they network with other state agencies which eliminates the duplication of services among agencies. Laura described some of the remote areas where she goes to visit moms, some homes that are not accessible by car, and others that are only accessible by swinging bridges. She joked that it was getting harder for her to walk over swinging bridges with no handrails.

Tammy. Tammy has worked as a MIHOW home visitor for 25 years, since 1990. Tammy was spunky and full of life during her telephone interviews. The first interview with Tammy was conducted on July 16, 2012, and the second was conducted on October 30, 2014. She graduated from Harper Jr. College in Illinois with an associate’s degree in early childhood. In addition to her associate’s degree in early childhood, she completed a nursing degree at the Fayette Institute of Technology in Oak Hill, West Virginia and is a licensed practical nurse. She was pregnant and working as a preschool teacher before she became a MIHOW home visitor. She described how she became a MIHOW home visitor: “The woman who, like on the board of the preschool, pretty much invited me to become a MIHOW home visitor. So right from there, after I had my baby I became a visitor.” She also worked full-time as a nurse.

Tammy described working for MIHOW as something that she “liked to do.” She was able to homeschool her two sons and take them on home visits with her. After her husband passed away she had to take another job and conduct her home visits for MIHOW on the weekends. Although MIHOW was technically a part-time job, Tammy said that she viewed it as a full-time job. She had an office in her house for her work with MIHOW. At the time of our second interview she said that she had around fourteen families on her caseload.

Moms

I interviewed four moms from Blue Lake. The moms, all of whom are Caucasian, ranged in age from 24-33. The profiles below include information about the age of the moms, how many children they had, how long they had been enrolled in the MIHOW program, their education and employment, and any other information related to the program.

Fay. Fay was a married, stay-at-home mom with four children. She had short, blonde, cropped hair, and a sweet smile. She was easy to interview and appeared to be eager to learn all she could from her home visitor about her children’s development. Fay, who entered the program on March 20, 2012, has been in the MIHOW program for two years and seven months. At the time of our third interview, Fay was 24 years old and had four, small children all under the age of four. Her two sons were one year apart—ages three and four—and were identified as having an autism spectrum disorder. She also had two daughters, one age three, and the youngest five months old. She wanted to go back to school to become a certified nursing assistant or a nurse.

Fay’s husband worked for a heating and cooling company. She explained that he worked long hours at the heating and cooling business, and he was really tired at the end of the

day. She said that she tried to take care of the children in the evenings because he was so exhausted. Fay told me that she would like to one day work as a tour guide at the local river excursion company, but for now she was busy taking care of the children. Fay beamed with pride when she spoke of doing something all for herself. With the help of her cousin, she trained and participated in a five-k race. Her cousin helped to take care of her four children while she participated in the race.

Fay explained that initially she had not heard of the MIHOW program, only Birth-to-Three. She described her first contact with a MIHOW home visitor:

I'm not exactly sure of her last name, her first name was Kathy, and she does some part-time work at the clinic. No, I had never, I mean I heard about Birth-to-Three because my oldest son has developmental services, so I had to do some searching for the program after I met with the home visitor because I did not know the names of them other than the Birth-to-Three.

Fay went on to describe her feelings about being in the MIHOW program: "There are a lot of women my age or younger that I know who are either in the same situation as me or in a tougher situation, and I think that they would benefit from something like this."

Dana. Dana entered the MIHOW program on March 15, 2012. At the time of our third interview, she was 25 years old and had been in the program for two years and seven months. Dana had one son. I interviewed Dana for the third time on March 19, 2014 when he was just over two years old. Dana graduated from a local high school near Beckley and attended three years of higher education at West Virginia University in broadcast journalism. She previously had worked at a local rafting company as a tour guide.

Dana was referred for the MIHOW program during a prenatal counseling appointment with a home visitor. Dana feels the MIHOW program was not particularly helpful to her, although she said it might be helpful for others. Dana explained, "I wanted to be involved in it." She had mixed emotions, however, as to whether the MIHOW program was helpful:

I don't feel like it's counterproductive. I can see where it would be helpful to a lot of other people but in my situation it wasn't that helpful. I'm not sure what specific examples, but my husband and I both already had done so much research with our midwife and with the home birth it was kind of a different kind of scenario than I think ... the program is set up for.

Haley. Haley entered the program on March 27, 2012 and has been in it for over two years and seven months. I interviewed Haley for the third time on October 3, 2014 when she was 25 years old. Haley had two children, one boy who was two years and two months, and another boy who was two months old. At the time of this study, Haley was a stay-at-home mother. She worked two jobs for the last two and half years as a certified nurse's assistant, and at Taco Bell.

Haley mentioned that she would like to go back to school. She was thinking about going back to school either this spring or the following fall to complete her LPN or RN nursing degree. She said that getting support from her fiancé's family could help her to reach her goal of going back to school. She also said that she would return to school where her fiancé was going. He was going to school at a local vo-tech to be an automotive technician. Haley commented that she was trying to rebuild herself: "I don't have a lot of self-confidence and I don't do anything for me... [and I] would like to go back to work or to school to feel like I'm worth something

either in the community or from my family instead of just a stay-at-home mom.” Haley spoke about the fact that she was not getting any younger: “I’ve got to make up my mind one of these days.”

Haley was referred to MIHOW by a home visitor at a local clinic during her pregnancy. Haley felt disappointed initially with the MIHOW program. She said that she was “hopeful at first but now it’s like I haven’t gotten any contact from her for like a month and a half or like two months, and it was kind of consistent ... in the beginning, and now it’s like never.” Haley’s biggest concern during her first months with MIHOW related to consistency. She said that home visits were not consistent.

Dawn. Dawn entered the program on April 30, 2013. She was interviewed initially on March 18, 2014, and again on October 30, 2014. At the time of our last interview, she was 33 years old. She had been with the MIHOW program for one year and six months at the time of this study. Dawn had three children, one son who was twelve, a daughter who was six, and a one-year-old son, Braxton, who was enrolled in the MIHOW program. Dawn has a two-year degree in healthcare administration. She would like to go back to school at a local college near Bluefield, West Virginia to get a bachelor’s degree in finance. She hopes to get a job as an office manager for a healthcare facility, or at a hospital. She identified “transportation” as the biggest obstacle she had to overcome in order to reach her goals.

Dawn initially learned about the MIHOW program through social media: “I got a message from Facebook from a friend stating that one of the MIHOW workers needed so many people to interview and so I called the number that they gave me and volunteered to help out.” Dawn reflected positively about the program and her home visitor:

I think it's a great program. It's just nice to have a worker that relates to you. Like she has the same amount of children. She just had a little boy and I have a little boy. And she had gestational diabetes and I had gestational diabetes. That's a nice part that we can relate and have something in common, and plus she's very informative. I like that.

Setting Two: Mountain Ridge

The second MIHOW setting for the study was the Mountain Ridge program, located in northern Mingo County. The Mountain Ridge program was connected to a food and clothes pantry in the other side of the building. This program connected families with local community-based services which provided donations related to clothes, food, and other miscellaneous items. They also helped families pay utility bills and helped with educational goals. The median county household income was \$34,518 (United States Census Bureau, 2013). In 2008-2012, Mingo County had 22.9% living below the poverty line. The West Virginia state average of individuals living below the poverty line was 17.6%.

Mountain Ridge was the smaller of the two programs with 77 participant moms (Amerikaner, et al., 2015). Most of the moms reside in Mingo County which has a population of 26,103 (United States Census Bureau, 2013). More recent numbers, as of September 2014, reported by the Mountain Ridge regional site coordinator, identified that the program served 89 adults, which were defined as moms and dads. During the month of September, Mountain Ridge served 86 children, 49 families; and home visitors conducted 52 visits, according to the regional site coordinator.

As of September 2014, Mountain Ridge employed six home visitors and was getting ready to hire a seventh. According to the site coordinator at Mountain Ridge, the site also

served around 25-30 children per day in an after-school program. A coordinator and three other individuals worked at the after-school program. The children were transported to the site from school, provided a hot meal, and given assistance with their homework. The program also had an employee who worked with adults on their educational goals, helping individuals obtain their GED, apply for jobs, and assisting with college readiness.

The Blue Lake and Mountain Ridge Programs were different in many ways, but also shared some similarities which may influence overall program impact. The differences related to employment, being a stay-at-home mom, child care, cell phone/landlines, birthing practices, maternal depression, smoking, access to food and food stamps, and attrition (Amerikaner, et al., 2015). Mountain Ridge had a three times higher attrition rate than Blue Lake in 2014 which was likely related to demographic differences between the two programs (Amerikaner, et al., 2015).

Other differences between the two programs related to number of participants and program goals. Blue Lake had 151 participants and Mountain Ridge had 77 (Amerikaner, et al., 2015). Blue Lake had eight home visitors and Mountain Ridge had seven. Both programs conducted community outreach outside of home visits, but in different ways. Mountain Ridge had an adult education coordinator on staff who guided people in obtaining GEDs, getting prepared for college, and applying for jobs. Blue Lake used their curriculum to teach about parenting methods at an alternative sentencing program once a week, and at a local substance abuse center twice a month. Overall, Blue Lake had more participants and home visitors, and participated with more community organizations for parent learning.

A similarity between the two sites was related to economics. Although initial indicators point to economic variability within the Blue Lake program, there was really no difference between the two program sites regarding participants' income (Amerikaner, et al., 2013). In other words, both programs were serving economically disadvantaged rural individuals with high unemployment, low monthly income, and high numbers receiving food stamps. In fact, most of the participants at both sites according to the year three report, remained largely unemployed and received a monthly income of no more than \$1000.00 (Amerikaner, et al., 2015).

Home Visitor

One home visitor from Mountain Ridge was interviewed twice. The home visitor profile includes information about how long she had been a home visitor, her educational background, employment, and any other information related to her understanding of the program.

Trisha. Trisha was the only home visitor I interviewed from the Mountain Ridge Program in Mingo County, West Virginia. At the time of this study, she had worked for MIHOW for a year and a half. A first interview was conducted on January 21, 2013, and I went on a home visit with her on August 12, 2014. She demonstrated confidence, spunk, and enthusiasm in her role as a home visitor.

Trisha worked for a community action council for 18 years before getting a job with MIHOW. She has taken classes related to social service and education. Trisha completed classes for certification but held no formal degrees. She also had a commercial driver's license.

Trisha discussed differences in the expectations for a position with MIHOW compared with the community action council where she previously worked, contrasting programs that

required degrees and those that did not. Trisha was outspoken, direct, and passionate about issues related to MIHOW. She frequently expressed concerns about the fact that MIHOW did not require their home visitors to have any formal education: “All you have to do is go through their trainings and be a mom, you know, be a mother.” Trisha reflected on the importance of having a degree in order to teach on a child’s level: “Anybody can be a teacher but it takes someone that has got the degree that can really teach and understand the teaching that they give.”

Trisha identified another difference in the expectations of MIHOW compared to her previous employment. MIHOW was a part-time job, whereas her prior positions had been full-time. Trisha discussed the importance of seeing pregnant moms more often for home visits:

I think that home visiting should be... more than once a month. They’re going to need you at least three times a month, because there’s things that come up that you won’t know until the next time you go see her the following next month. The MIHOW home visitors are only required to see the moms once a month.

Moms

I interviewed two moms, both of whom are caucasian, from Mountain Ridge. The moms ranged in age from 33-35 years old at the time of this study. The profiles below provide information about the age of the moms, how many children they had, how long they had been enrolled in the MIHOW program, their education and employment, and any other information related to the program.

Elizabeth. Elizabeth entered the program on February 2, 2012, and at the time of this study had been enrolled in the MIHOW program for over two years and eight months. She was

one of the first moms I interviewed. She was 33 years old at the time of our third interview on July 18, 2014. Elizabeth had four children—a 12 year old stepson, two girls ages eight and nine, and a son who was two.

Elizabeth had an easy, relaxed spirit about her. She was bubbly, charismatic, and told it like it was. She had a real zest for life that came through during our interviews. Similar to many of the moms in the MIHOW programs, Elizabeth was a stay-at-home mom. Recently she went back to school in an on-line program for digital photography: “With the photography I hope to have my own business. I want to have my own studio.”

Elizabeth maintained a busy household while attending football games with her stepson, coaching a cheerleading squad, attending cheer practices, and taking on-line courses. She mentioned that she would like to learn more about how to manage her time better through the MIHOW program.

Elizabeth learned about MIHOW from a home visitor when she became pregnant with her last son two years ago. As an older mom at the time of her last son’s birth, she explained the value of MIHOW: “They come out and visit you, bring information, and kind of keep you company type thing.” For Elizabeth, unlike some new moms, this program was not necessarily giving her all new information, but “reminders” about pregnancy and health-related issues.

Quinn. Quinn entered the program on September 28, 2012 and was 35 years old at the time of the third interview. Quinn had been with the MIHOW program for two years and one month as of August 12, 2014. She had one son who was over a year old. I conducted a participant observation of her home visit on August 12, 2014. At that time, Quinn, who had

brown hair pulled up in a short ponytail, lived in a trailer in a holler. Quinn was spunky and independent: “I don’t ask for too much... because I try to do it all on my own.”

Quinn’s previous employment included working for Head Start as a teacher’s aide, sitting with a lady at a nursing home, and working at a gas station. Quinn lost her job at the gas station because she had to take her son to the doctor for bronchitis, and they would not let her off work. In her words, “My baby comes first.” Quinn mentioned wanting to re-apply to Head Start, but that they wanted her to drive a bus and she remarked, “I don’t know if I’ve got nerve for that.” At the time of our last interview Quinn was not working outside the home.

In our third interview Quinn described several major changes in her personal life. She was currently living with her parents. She said that she “had been through a lot but I got my own trailer, been working on it. Me and him’s going to have our own place pretty soon,” referring to the trailer she would occupy with her son.

Quinn described herself as a “workaholic” yet explained why she did not want to continue working like that during her last pregnancy: “I know not to do those things ... because in June I had a miscarriage because I wouldn’t slow down or anything. And then July I found out I was pregnant again.” Quinn was contacted by a home visitor about joining MIHOW when she was approximately two months pregnant. She initially thought that she lived too far out to receive visits from MIHOW workers. Quinn had only positive things to say about the MIHOW program, even referring others in her community to the program. Quinn believed that the MIHOW program “had taught her how to be a mom.”

Chapter Five: Results from Blue Lake

This chapter includes the case findings from two home visitors and four moms and how they perceive and experience the Blue Lake program. In this chapter, the results and answers to the research questions will be presented. Chapter Six will contain the results and answers to the research questions from the Mountain Ridge program. Chapter Seven will contain a cross-case analysis of both sites, interpretation of the findings, discussion of potential flaws in the study, and implications of the findings for practitioners and policymakers. It will also provide suggestions for future research.

The findings from this study have been grouped for organizational purposes into categories that align with the research questions. The answers to the research questions are divided into perceptions of the home visitors, and moms. In this chapter the following research questions will be addressed:

1. How do moms and home visitors perceive and experience the MIHOW home visitation program in relation to curriculum, visits, other services, and relationships?
2. How do moms and home visitors perceive the MIHOW's program's influence on child development related to physical, cognitive, social-emotional, and communication?

Setting One: Blue Lake Program

Home Visitors

This section addresses the home visitors' perceptions of the program related to the first research question. This question relates to curriculum, visits, other services, and relationships.

At the Blue Lake site two home visitors were interviewed two times each. Each home visitor has over twenty years with the MIHOW program.

Curriculum: *“It’s Pretty Much Led by the Mom.”* The home visitors from Blue Lake viewed the MIHOW curriculum, based on monthly development, as the foundation of the MIHOW program, although not always the focus of the home visits. Often the curriculum was customized based on the current needs of the families. One home visitor explained how the mom’s needs set the tone for the home visit. “You know it’s pretty much led by the mom, but we have the curriculum.” Another home visitor described the curriculum and how it was used: “We have these curriculum guides that kind of guide us through the information that we need to cover. But I like to go there [to the home] and see what they [the parents] know because I’m a teacher at heart. I don’t want to re-teach if someone already knows things.”

The curriculum was originally written at one of the West Virginia sites by Linda Stein, who eventually submitted it to the national MIHOW site. Interns at Vanderbilt University in Tennessee took the submissions and created the national curriculum. A home visitor described the content of the curriculum as it related to monthly development:

We had specific curriculums for prenatal each month during the prenatal period, like a big three-ring binder curriculum for... each month during the prenatal period. We have a curriculum for the first year for each month. We have a curriculum for the second year for each month, and then we have a curriculum for the third year, which doesn’t go so much by each month of the third year but very important topics, be it dental or safety or just a lot of great information for parents. So that is our curriculum and we base every home visit we do from our curriculum. We take information or go with intentions to

cover those things as well as whatever the family needs covered and what is the most important, but we do have a curriculum and use that to design our visits.

According to one home visitor, the third year of the curriculum was expanded to include topics outside of monthly development. The third year included information related to areas such as play, positive discipline, and children with special needs.

Visits: “I Don’t Know What People Learned Sometimes but They Say It Helped.” Home visitors in the Blue Lake program conducted a home visit with each family for about an hour and a half once a month. Home visitors in Blue Lake planned home visits related to methods and materials, as one home visitor described:

It’s a program that is volunteering and is free and one that home visitors visit about once a month, for about an hour and a half ... I would prepare my visit. I have a folder and a file for each family I visit...What are the plans for this visit? And I gather my materials that I need for the visit, which might be a handout. It might be a visual to demonstrate something that I’m trying to get across like how do you figure how many teaspoons of sugar are in that little can of root beer you are drinking... And when you show them that. It just sends a greater impact than telling them.

Echoing the first home visitor, another home visitor from Blue Lake explained that her typical curriculum-focused home visit only lasts about an hour. However, the additional time that she spends with the moms during the home visits varies based on the moms’ needs: “I don’t even use a watch.” She said it usually takes her over an hour and a half and that she allows for more time during the home visits based on where the moms are in their pregnancy and depending on

their intellect: “Sometimes if you move too fast and they’re a little slow it is hard for them to retain everything and understand it.”

Another issue the home visitors discussed was the learning that occurred for moms and whether moms were actually retaining information. Home visitor comments about moms’ learning were divided into categories related to learning about the mom and child’s health and related to getting a drivers license. Related to learning about health during home visits, one home visitor from Blue Lake recalled a mom in a busy household of three small children under the age of four learning about the sugar in soft drinks:

[There were] lots of soft drinks in the house. The kids drank soft drinks. The kids were wired up you know. We addressed that, talked about it, and again you know I’m not telling them what to do, but the whole thing about the soft drinks. When you talk about the sugar, see it, but one day I came back in the house and the first thing, she just kind of grabbed my arm and said, “You’ve got to come in the kitchen.” So I went in and all the countertops were filled with these little short water bottles of water. She said, “There will not be any more pop in this house.”

Another health-related method moms learned about was breastfeeding. A home visitor described how she provided direct assistance to a mom in a domestic violence situation who was having trouble with breastfeeding:

I helped one woman over at the bridge overlook. She was homeless and she needed help breastfeeding. She was having domestic violence trouble so I met with her and we got the baby to latch and the baby ate. So that was good. So she learned how to feed

her baby. I mean there's just so many instances so it's so hard to tell what people are learning exactly.

Home visitors also discussed how moms learned about issues such as getting a driver's license.

Another issue that emerged in home visitors' comments related to whether moms were paying attention and learning during home visits. Two home visitors shared concerns about whether the moms were learning and retaining information during home visits. One described how she realized that moms were listening even if they appeared distracted:

Well they, you know, like on some visits you're sitting there and you're talking about things, especially like labor and delivery. I have a little flipchart and we kind of go through labor and delivery....Then maybe on the next visit they'll just spit right out something that you physically said, you know, like how to comfort yourself. So you know they listened and you're like, "Yay, they were on the phone a little but they were listening."

Another home visitor also reflected on what moms were learning from the home visits:

"I don't know what people learn sometimes but they say it helped. Like one lady I saw years later and she told me, 'I got my driver's license. You taught me how great that was to have a license.'"

Home visitors also spoke about the scheduling and frequency of visits. Both of the home visitors interviewed voiced concerns related to difficulties with scheduling the home visits. As voiced by one of the home visitors at Blue Lake, "My least favorite thing is trying to schedule these visits." Both home visitors believed that it was much more difficult to schedule home visits now than in previous years. They attributed the increased difficulty to people moving and

fewer moms having landline phones. Two home visitors touched on the increasing reliance on text messaging to reach moms, as one home visitor described:

It used to be that everyone had a home phone. If they were home they answered it. If you left a message they would call you back. And now those cell phones change every month and the ones designed by Wal-mart cannot leave a voicemail, and then texting has become just awesome. So it's a challenge. The visits are always good when you get there, but it's a challenge getting there sometimes and I just don't like to drop in.

Another home visitor experienced similar problems with reaching moms by phone and text messaging: "I mean it used to be you... got ahold of somebody on the phone and they'd show up. [Now] it's mostly texting and they're not home if you go on a visit...Maybe it's helped in some ways because it's easier to get ahold of younger people that text."

Other Services: "We Kind of Just Tailor it to the Family's Needs." According to home visitors at Blue Lake, they connected moms to available services and resources in their community. The Blue Lake program identified a large number of resources for their families, and services were suggested to the moms and families based on their individualized needs. As one home visitor explained, "There's a million resources. We kind of just tailor it to the family's needs." She also pointed out that MIHOW does not connect families to resources that take things away, such as Child Protective Services. WIC was a common resource offered to moms by the home visitors, "Well we of course always ask moms about have they signed up for WIC, which a lot of moms do that now but not all. Some of them don't really know." Another resource mentioned was the tobacco prevention specialist because, "We see a lot of smoking." Some of the other resources identified by the home visitors from Blue Lake were DHHR food

stamps, smoking cessation clinic, Right from the Start, Parents as Teachers, Quit-Line, food pantries, and parent playgroups.

One issue raised by both home visitors was the lack of transportation for the moms to access resources within the community. There was a lack of transportation at the Blue Lake site for the home visitors to use to transport the moms to doctor's appointments and any other appointments such as WIC. One home visitor discussed the impact transportation had on one of her families, "Transportation is still an issue.... I have a family I visit that has four children and just can't get to the WIC appointments and they so much would benefit from it." Another home visitor discussed the challenges associated with connecting moms without transportation to services:

But to be honest with you, in our area transportation is a major issue. And people don't have the money. They don't have money to keep a car, to keep oil in the car, to keep gasoline in the car, and if they do have a car it's usually the whole holler uses it. And if they are using a vehicle it's to get back and forth to work so a lot of people don't get out to playgroup.

Relationships: "I Just Enjoy the Families." For the home visitors, the relationship between the home visitor and the families was an important part of the MIHOW program. In fact, they viewed getting to know the families as one of the most rewarding parts of the program. The home visitors' relationships with the moms at Blue Lake were based on mutual respect of one another. Both home visitors developed rapport easily with the moms and they felt comfortable with the families with whom they worked. The home visitors agreed that their

favorite part about the home visits was getting to know the families and hearing their stories.

One home visitor described how she enjoyed the families and hearing their stories:

My favorite part is just absolutely... the privilege to go sit in somebody's house that I don't know even know at first, to think that they'll just let you come in and do that and keep coming back....I just enjoy hearing their stories. And like I said I learn something at every visit. I mean they will tell you things you just wouldn't have known. I'd never known things if I didn't home visit, and it's part of the families in [this county] their lifestyle. I just enjoy the families.

Home visitors at Blue Lake perceived their relationships with moms as friendly but in "a healthy kind of way." A home visitor from Blue Lake described the relationship that she had with one of her moms:

I don't try to be their friend. I don't try to be their mother or grandmother. I'm just, and I've been happy about the relationship with teens. They always know I'm there for them day or night anytime.... Especially when they're breastfeeding, they can call me any time day or night. I do not mind.

Another home visitor from Blue Lake described how she maintained a dividing line in her relationship with moms enrolled in the program:

I'm your home visitor. You have to set parameters... and I have learned this through time. They want to call you and have you pick up diapers for them and pick up cigarettes on your way home, because it's the community where you live.

She went on to explain how she sees their relationship: "I'm not going to be somebody's best friend, but I am there to be somebody's listener, somebody's advocate." Another home visitor

perceived her role as a home visitor and her relationship with the moms similarly: “It’s to go in there and listen, observe, and help that family use their strengths that do exist in every family... I don’t try to be their friend. They know that I’m there for them but they are respectful back. I feel like it’s a real healthy relationship.”

Moms

This section addresses the moms’ perceptions related to research question number one. Four moms in the Blue Lake program were interviewed three times each. Each of the moms had been in the program for at least one year, and several had been in the program for two years. These moms had varying degrees of education, employment, and overall program satisfaction.

Curriculum: “Everything Pretty Much from Conception to Birth.” Moms at Blue Lake described the MIHOW curriculum as content related to month-to-month development during pregnancy and the monthly growth of the baby. One mom described it as, “Everything pretty much from conception to birth and what to expect.” The moms discussed content related to purple peak crying, uterus growth retardation, diabetes, breastfeeding, vaccinations, and when to give infants solid foods. Some of the content related to developmental milestones and how to use developmental games and songs.

The moms often referred to developmental checklists home visitors used to see how the baby was doing, solicit mom feedback, talk about concerns, and to determine things the baby excels in and needs to work on. Some checklists related to maternal depression and were used to help identify abusive relationships. The checklist questions also targeted the mom’s moods, often difficult topics for discussion. One mom viewed the content of the curriculum as “very

helpful” even though some of the content was information she had found online: “It’s common sense stuff most of it but some of it you know is like the same stuff I’ve been looking at here and there online. It’s all very helpful.”

Moms also discussed how they used the content in various ways. One mom explained how she used the content of the curriculum by posting goals from the milestone handouts on a dry erase board for her son. Another mom said she used the content in the handout so she could sing songs with her son. One explained how it assisted her in efforts to improve her son’s problem solving skills: “Different types of ways to help him with his problem solving skills, different mental games, just a lot of different things we did not know about.” One mom talked about the variety in the handouts and how she used them: “She gives me handouts with different games that we can do. One mom described how the home visitor brought information on over-the-counter medications: “Certain over-the-counter remedies that turn out not to be so great for your baby.” One mom described how she found the information about what to eat during pregnancy helpful: “I liked reading that kind of stuff. You know like what I should eat and what I shouldn’t eat. That kind of information was helpful as well.”

On the other hand, one mom had an issue related to the lack of depth in content: “It’s just kind of scratching the surface, like I remember that last visit she talked about discipline and positive discipline, and that’s something that I’ve been looking into and reading about lately, and I have a few books and stuff.” She used an example to illustrate her frustration: “You know she [home visitor] mentioned not hitting your child when they make you mad or whatever, but didn’t really give examples of what you could do instead of that.” Another mom was concerned

that she had received the same information for several months: “Well you know I was given some handouts a couple of months ago and then got them again in the last visit.”

Visits: “She’s Always Asking What Kind of Information I Need.” One mom felt more informed because of her home visitor and the information, methods, and materials she brought with her: “You know she’s always asking me what kind of information I need....Every time she leaves I always feel like I’m more informed than I was about different things.” Similarly, another mom described how her home visitor brought her information: “Any information I ask for she’s been very helpful with, and I know she’s very helpful with other people too....You know she’s always asking me what kind of information I need.” In addition to the information, the moms explained that the home visitors brought methods and materials such as games, songs, growth charts, and other activities to pique child interest and stimulate development during home visits. One mom talked about the samples, coupons, baby toothbrushes, and other little gifts that her home visitor brought when she came to visit.

One mom raised an issue related to the frequency and consistency of home visits. She was concerned that there were things that she was promised during earlier home visits, related to specific information about epidurals, that she never received information about: “She [home visitor] hasn’t really gotten back to me in about two months. Not consistent.” The mom noted inconsistency in the home visits, especially related to the home visitor not getting back to her on questions and how to get more aid related to diapers or food. The mom expressed frustration about having inconsistent home visits and how the inconsistency affected her life:

You can’t be consistent for three months and then not show up or call or whatever for two, and then show up for one, and then not call or show up for two, because that’s

not, it only messes up that person's life. But if that person's ticked off to the point to okay I don't need this stupid program I can do it myself, it's like okay they haven't got time to be consistent with me and I should stay consistent with them kind of thing. Like why interrupt my life when I'm really busy right now when you could've done it last month or two weeks ago.

Although not upset by the inconsistent visits, another mom said that her home visitor came every "two to three months." She explained, "When he was born and about six weeks later she [came] back, and then when he was four months she [came] back, or three months, I can't remember. But she's visited several times."

Other Services: "I Got a lot of Stuff that I Needed." Through the MIHOW program, moms were often connected to services within the community. This was usually related to information provided by their home visitors. The services related to health, maternal mental health, and resources for the child. The lack of transportation for the moms was identified as a barrier to services within the community.

The WIC program was one resource with which moms were connected. Home visitors provided information to the moms about the WIC program. The YMCA was another resource that one mom learned about because of her home visitor. This mom was interested in losing weight after the birth of her child. Her home visitor told her about the YMCA and "their open door policy" and that "they go off your income." Related to maternal mental health, one mom dealing with postpartum depression was given contact information for people to talk to about her depression. One mom was given information related to a community baby shower: "She spoke fondly of sitting with her home visitor and listening to the speakers. She also described

what the home visitor found for her at the shower, “She had a bag of those clothes that were either six to nine months or 12 months.” One mom was given a personal baby shower. She described her excitement about having a personal baby shower organized by her home visitor:

I didn’t have a baby shower for either one of my kids, I mean I did have one for Michael but nobody showed up, and then for this one I told [home visitor] about that and then with my second child they have this big thing at the [community center] and I felt like wow, you know, I got a lot of stuff that I needed and I felt like it was a celebration. There was a bunch of people there.

On the other hand, transportation was identified as a barrier by one mom because she felt it impeded her access to employment and educational opportunities:

Well I am hoping to find transportation and begin working either at a hospital or just a healthcare facility and then work my way up so that I can be an office manager for a healthcare facility so I can provide more for my children.

The same mom described how transportation could connect her to educational opportunities within the community: “I did enjoy the online community but if I had a car I would like to go to like Mountain State...It would have to be somewhere close.”

Relationships: “Like a Friend.” For many of the Blue Lake moms, the most important part of the program was the positive relationship they shared with their home visitor. Issues related to empowerment, reassurance, and companionship were identified as benefits of their relationship with their home visitor. Often moms felt their home visitor gave them a sense of empowerment with family members. One mom described how her home visitor was able to speak directly to her family members: “It’s a voice that you wish that you had,” and “She’s fun

to a point and she's not afraid to tell other family members, 'Hey, you're supposed to be here for her and help her out, and no smoking in the house.' She gave me that attitude and that strongness, but I'm not going to take any crap from anybody. Me and the kid come first." The home visitors also reminded the moms that they needed to take care of themselves, as described by one mom: "She wants me to take care of me. If I don't take care of myself then I can't take care of kids properly."

Moms also benefitted from the reassurance and support they received from talking to their home visitor who were described as "like a friend." One mom described her relationship and the support she received from her home visitor as her favorite part of the program:

She's just really friendly and really easy to talk to about anything. If I feel like there's anything that I want to talk to her about I can bring it up and not feel weird about it. I just think she's a great person.

Often the moms lived in isolated areas with little company. Some family members lived far away and were of little support, as one mom explained: "Like if you don't have a family, like me I don't have any of my family members around me at all. I don't have a lot of friends, so for me that kind of side view is just awesome." Another mom talked about how she felt she could text her home visitor at any time: "She doesn't mind if I text her at eight o'clock at night 'cause she's like you know, 'I'm here for you. If there's anything that you need give me a call, give me a text, let me know.'" One mom also received reassurance that it was okay not to breastfeed since she had so many other responsibilities:

So I mean her just reassuring me that... both [breastfeeding and bottle-feeding] are fine; you don't have to worry....And now I'm going to cry because it was so important to me and I just was like, "I don't know what I'm going to do. I can't do this." And she's like, "You can, but if you realize that you're not going to be able to take care of all of your children if you just say hey, a bottle is fine."

Another mom talked about how her home visitor reassured her and helped her to find answers to her questions:

Having somebody there to listen and help and answer and research questions that you have whether it be a rash, she researches stuff for me. Questions about the community...like even if it's just for me or if it's personal or if it's for Michael and [is his behavior normal], she gives things to do or some ways to get his attention.

Moms also talked about the companionship that they gained from their home visitor. The home visits were considered the best part of the program for moms who valued having someone to talk to. They looked forward to home visits because many of the moms did not work outside the home and felt isolated. One mom talked about the care that she received from her home visitor:

So even if she can't show up or talk to me, she'll text me to see how I'm doing, and I never expected that because I don't get many people in programs who care enough about the people that they visit that just text them randomly and ask them how they're doing.

One mom described how she liked to talk to her home visitor: “Yes, I mean she’s been a total godsend. Even without her helping, it’s been nice to share my pregnancy with her and be able to talk to someone who could understand the situation I’m in or that I’ve been in.”

Home Visitors

This section addresses the home visitors’ perceptions related to research question number two and discusses child development areas related to physical, cognitive, social-emotional, and communication. At the Blue Lake site, two home visitors were interviewed two times each. Each home visitor has over twenty years with the MIHOW program.

Child Development: “Anything That’s On a Parent’s Mind We Have It Covered.”

According to home visitors, the Blue Lake program addressed child development often, and in many ways, with the moms using a uniform curriculum. The home visitors identified changes in the number of family members present in the home and how they related to the increase in mom’s need for information about child development: “I think it has a big influence because I just see a lot of families that for whatever reason aren’t with their parents or their grandparents. I think that’s a lot of things that parents knew or that was passed on from grandparents, but I think we [home visitors] do that now.”

The Blue Lake home visitors addressed child development using the basic MIHOW curriculum as laid out in the home visitor guide. The content of the curriculum, according to one home visitor, covered topics related to parenting, nutrition, health, and development. She explained: “Visitor guides address everything during the prenatal period, which covers everything from conception up through having this baby, and that goes into nutrition, and child development in utero, and every month of pregnancy.” Based on these home visitors’ guides,

they provided information related to topics such as potty training, activities, songs, and discipline. The home visitors conducted monthly developmental screenings and did many activities with the children such as making toys and making things with play-doh.

The curriculum was also customized for the moms; in one home visitor's words, "Anything that's on a parent's mind, we have it covered." The curriculum was customized related to child development. One mom talked about how she questioned her daughter's development because her two younger sons had autism:

But I really had nothing to go off of because the boys, their development was nothing of the normal, so I questioned her development a lot, but I was always reassured by the [home visitor] that no, she's where she needs to be...The home visitors also used various methods and materials during the home visits. So I would just listen to the exercises the [home visitor] would like suggest and bring up and work with her [the daughter] on those.

The home visitors often attended training to learn more about topics associated with child development. The trainings related to development, discipline, and hygiene. One home visitor explained, "It could be inviting somebody to come in and speak about brain development and child development, and we would seek out a specialist in that field. So it can be very different each month."

Physical: "We Encourage Them to do Certain Things that We Know Will Help."

Home visitors used screenings as a method to assess child development. One home visitor explained differences in physical development:

They're not all going to do exactly the same thing on the same day nor are they supposed to, but if we do the seven month screening and that baby is really strong say in gross motor skills, they're really starting to turn their heads or when they're on their tummy they're kicking their legs, but then in communication they're not starting to verbalize...If the milestones weren't met....like there's two months and you're not seeing any progress, [then] we encourage them [moms] to do certain things that we know will help.

Another home visitor described a screening related to the pincer grasp: "There's little things like, 'Oh are you noticing your baby using his finger and thumb together?'"

Often the differences, or delays, in gross motor development were thought to be a result of the lack of tummy time: "Sometimes babies, you know, we'll see some [lack of] gross motor skills. I mean a lot of babies are left in carriers now. They don't want to put them on their tummy. They can't get the core muscles strong by doing that."

One home visitor explained that moms were sometimes referred to the Birth-to-Three Program and the home visitors are able to use their connections to speed up the intake process. The home visitor said that while she does not have any families currently receiving Birth-to-Three, she has referred a couple of children for issues related to swallowing and low muscle tone in a child with autism, and one child with a delay in physical development with large muscles. Often the parents are reluctant about getting a Birth-to-Three referral but "you can kind of plant the seed."

Cognitive: *"I Love to Teach Kids to Read."* For several home visitors, reading was a way to encourage cognitive development. One home visitor commented, "I always try to include

something for everyone. It might be a little educational cover page, or it might be a book for the older one to read to the younger one.... Another home visitor described how she always liked to have several books with her if there is another child there during the home visit: "Sometimes I'll read a story or I'll show the mom. We've really been trying to read more and encourage reading and literacy." The same home visitor talked about how she liked to make books, and how "I love to teach kids to read." She described how her love for reading translated into goals for the mom and child:

So possibly the goal of the day might be that the mom is going to sit down and read with the child at least four out of five nights, three out of five days. I don't know, whatever they decide to set. And that would be our goal and then we'd talk about it the next time I come and I'm like, "Oh so did you ever get a chance to look at the book we made? Oh, is she pointing at the noses? Oh are you reading it by labeling now?"

Another home visitor talked about the positive influence home visitors had passing along information to moms about reading, and how encouraging newborns to track with their eyes strengthened their eye muscles. According to one home visitor, this was information which was previously shared by grandparents to new parents. According to one mom, "I wouldn't have known anything if you [home visitor] didn't visit with me....I read to him because you told me to."

Another issue related to cognition was the continuing education and training home visitors received through the MIHOW program. One of their recent trainings related to brain development. One home visitor described the content of the training:

We went recently saw [a speaker] talk about children...and how their brains are developed and different brain development, everything and anything that entails kind of condensed into like a three hour session....Like I said, development is really big.

Social-Emotional: “A Lot of Discipline Things.” Of the areas related to child development, social-emotional was addressed with less frequency by the home visitors. According to Blue Lake home visitors, the Social-Emotional Ages and Stages developmental screening was used at six months and about every six months after that. According to one home visitor, the third year of the MIHOW curriculum addressed a variety of social and emotional areas, some related to discipline: “It has just all kinds of things in there as far as play activities and dealing with positive discipline—a lot about discipline, about special needs children.” Another home visitor described the behavioral content covered in the curriculum as potty training information, discipline, songs, and activities: “There’s such a wide variety.”

The same home visitor also described the variety of training that home visitors attended related to various areas of child development, some dealing with discipline. She explained, “I’m trying to think about, a lot of discipline things have come up. Different ... ways to deal with different scenarios.”

Also related to social and emotional development, one home visitor described how she customized the home visit based on what was going on in the home related to discipline: “Like [if] I see something crazy, like the mom is going after the kid with a fly swatter, well I think that is more important than me talking about what’s on my agenda.”

Communication: “I Do a Lot of Things that Center Around Language.” The home visitors spoke about how they assess language development and how they teach moms

methods to improve language for their babies using talking, reading, modeling and other activities. The amount of time spent working with moms on language was also an issue mentioned by one home visitor.

One home visitor identified speech delays as one of the most common areas in which home visitors see developmental delays: “We see lots of speech delays which can usually be taken care of pretty well.” One of the ways home visitors addressed possible speech delays was with the use of the Ages and Stages developmental screenings. As one home visitor explained, “They are really just good indicators for children that aren’t meeting their milestones.” The monthly screenings followed a format with six questions in five different areas: communication, gross motor, fine motor skills, problems solving, and personal-social.

Another issue related to the amount of time, and the kinds of methods that the home visitors used with the moms, related to language development for the babies. As one home visitor put it: “I do a lot that centers around language.” Talking and reading were two methods the home visitors used with the babies to encourage language development. One home visitor described how talking and reading to the baby was used to help the baby meet language milestones through face-to-face listening between the baby and mom:

[If] you’re not hearing those little cooing sounds, that’s going to be something that before I leave you know I’m going to say, “Okay this will really help you, to help baby meet those milestones you know, talking to the baby, reading to the baby, face-to-face, whole face listening.”

Another home visitor described how she used modeling: “That’s my biggie, just encouraging reading and modeling, the necessity of speech and words.” The same home visitor

explained that “We talk about speech and how babies can see your lips and doing things deliberately.”

In addition to modeling, one home visitor explained, “There’s so many different language activities.” She identified activities such as puppet play, magnets for the refrigerator, making books, and writing labels on things in Spanish. She said she promoted activities so that the babies had fun while they were learning.

Moms

This section addresses the moms’ perceptions related to research question number two and discusses areas related to child development in physical, cognitive, social-emotional, and communication areas.

Child Development: “Gives Me an Idea of Things to Work on With Her.” According to the moms, Blue Lake home visitors provided information related to growth and child development, especially related to age-appropriate milestones. According to one mom, “She brought over some charts and that kind of thing about the baby’s growth.” Another mom spoke of how the program identified “what to expect at his age or whatever and what to work on which is helpful.” Often the moms were able to determine whether the children were meeting or exceeding their milestones, as one mom explained:

She, [the home visitor] said that he [son] was meeting his. You know she asked me how many words he says and that kind of thing. You know she told me the exact number of words that you know most babies at this time are saying and his exceeded that.

Another mom described how the program helped with any health or developmental concerns that she might have: “Once the baby comes they keep track of you know developmental issues

or any health problems they may have and try to help.” One mom talked about how the milestone checklists “guided your way so that you’re not feeling lost as to your child’s development.” She explained that it “gives me an idea of things to work on with her.”

Several moms also explained how the home visitor provided reassurance and redirection regarding their child’s development as one mom with two children with autism explained:

I really had nothing to go off because the boys [with autism] their development was nothing of the normal, so I questioned her [my daughter’s] development a lot, but I was always reassured by [my home visitor] that no, she was where she needs to be.

Another mom described changes in her thinking regarding child development because of the program and her home visitor:

I was totally on the wrong track providing for him [first child prior to MIHOW participation] when I was in that deep depression and I was working a lot like 16, 18-hour shifts, coming home, sleeping , and just you know spending the bare minimum with him....I really let him down. Like where I wasn’t talking to him; I wasn’t reading to him. I was just taking care of him and just sitting there holding him. I was really not myself.

According to the moms, a second way the program helped with child development related to *how* they used the information from the milestone checklists to set goals and implement developmentally appropriate activities for their children. One mom explained her use of the milestones in developing goals for her child: “There’s milestone papers that she [the home visitor] gives me. I’ll read them like three times a week and get it embedded in my head

and then I'll post it next to his. I have this dry eraser like list of goals for him." One mom explained that she practiced different exercises with her daughter to promote child development: "Like to practice different exercises and get her to doing those things so that [at] the next milestone meeting I can check off new things."

Physical: "He Can Pick Stuff up by Himself." For most of the moms, home visits provided an opportunity for the home visitors to look over checklists to determine whether or not the baby was meeting her or his monthly developmental milestones. Often the checklists asked questions related to physical development: "Is the baby rolling over? Is the baby grasping tiny objects?" The moms used activities and exercises suggested by their home visitor related to physical development. For example, one mom described how her home visitor suggested she use balls to encourage balance: "I got different sized balls and that helps his balance and stuff. She [home visitor] said like roll him back on it and kind of make a game of it and then that way he can learn to like kind of stabilize himself." Sometimes the home visitors suggested activities for the mom to model: "She [home visitor] actually gave him a bottle and a couple little, I think cheerios or some kind of thing and he put them in and out of a bottle." Another mom described a fine motor activity she observed the home visitor doing with her child:

Like the little button where you thread stuff through because the kids are delayed in that too. She'll work with them on those too to try to get them to do some little games and let them pick it up.

One mom provided an example of a fine motor exercise her son had been doing for a while:

"Like with putting shaped blocks in the containers, which he's been doing that for a really long time.... She gives me tips on little toys that he should be playing with now." Another mom

talked about how she used hand toys to work on fine motor development: “I have little hand toys that I wasn’t working with him on a whole lot and now that I have and I keep giving it to him, he tries and grabs it and he can pick stuff up by himself.”

One mom described an eye-hand coordination exercise the home visitor did: “Like if somebody puts an object in front of her [the baby] will she reach for it? And then if I’m not really sure, she’ll do an exercise with her and like pull out something to see if she’ll grasp onto it.” Another mom described a similar exercise related to eye-hand coordination: “The last few times she’s come she’s brought over a water bottle with like cheerios in it for [my son] to play with. And she goes, like, ‘Oh, he should be trying to reach the cheerios inside of it, and he always does.’”

Cognitive: “Little Inexpensive Things that You Could Make.” According to the moms, home visitors also gave them tips on toys and books they could make to stimulate their babies’ cognitive development related to reading and repetition. One mom talked about how the home visitor told her how to make a rattle out of an onion peel container and some beans so the baby could shake it like a rattle: “You know, little inexpensive things that you could make for them to play with that was appropriate for their age.” The same mom also described how the home visitor made a touch-and-feel texture book with her for the baby: “Well it was like a touch-and-feel type of thing. It was a texture book, but I thought that was fun.”

Based on developmental checklists used to assess cognitive development, the moms described how the home visitors used various exercises and repetition to improve cognition. One mom described how the home visitor wanted her to use repetition with her son to

improve cognition and communication: “That’s why they’re trying to get me to do repetition. Every time I give him his cup, [I] say ‘Cup.’ Don’t just give it to him you know.”

Social-Emotional: “It’s Basically Just Scratching the Surface.” According to moms, the social-emotional area of child development was the domain they wanted to learn more about from their home visitors. In fact, one mom declared: “You know we didn’t talk about that at all, the social or emotional....I mean we really just barely talked about it.” The same mom said: “It’s basically just scratching the surface of this whole broad thing” of discipline. Another mom echoed similar concerns about not knowing how to handle her son’s listening behavior:

I’ve been wanting to ask her some questions on his behavior and not listening to me and just [how to] straighten out his tantrums. I don’t know what to do. Do I do this? Do I spank him? Do I put him in time out, which would be in his bedroom in his bed?

When asked about whether the home visitor talked with her about his behaviors, she responded, “Yeah, but mainly listening and talking and she wants me to keep reading you know and keep asking more questions.” The same mom concluded that the program could be improved with more research on how to get a toddler’s attention. She explained, “I could probably use a little more of that. My patience is there. I just don’t know how to connect to where he was pretty young, I’m trying to redo that bond. It’s kind of hard.” The mom described her need for more information from her home visitor about getting her toddler’s attention. She also described the difficulty she had bonding with her son since she was working a lot when he was little.

Communication: “She’ll Look at Baby and Talk to Baby.” For at least one of the moms, the area of communication was one of the developmental areas that received the most

attention in the program: “Mostly... it’s been about communication and... making eye contact and that kind of thing.” One mom described how her home visitor assessed communication development using checklists: “She asks like does he say two words you know consecutively like daddy bye-bye or [if] he says, ‘I got it.’” Another mom mentioned a similar [communication] guideline from the checklist: “And sounds, like communication with sounds, is baby making certain types of sounds or words, putting words together and stuff like that? So every month there’s like a little bit more added on.”

Several moms provided examples of how their home visitors used modeling and repetition to improve the child’s communication, as one mom explained: “ She’ll look at baby and talk to baby and see if she can get her to smile and do a couple of things.” One mom gave an example of how she needed to use repetition to strengthen her daughter’s communication: “Just repetition and it’s more I realize like my part, like just keep at it.” Another mom talked about how the home visitor used books with her children to improve communication and cognition. The mom also described how both she and her home visitor are open to learning from other professionals in the field:

Books. She’ll bring in books and she’s brought in a couple of like atlases and things. Or we’ll talk about their speech or occupational therapy and what we’re doing... so she can gain knowledge [from other professionals] because... she doesn’t really get it either. Like we’re both just as lost. I’m learning about it.

Chapter Six: Results from Mountain Ridge

In the previous chapter the findings from the Blue Lake site were presented. This chapter includes the findings from two moms and one home visitor and how they perceive and experience the Mountain Ridge program. Chapter Seven will contain a cross-case analysis of both sites, an interpretation of the findings, discussion of potential flaws in the study, and implications of the findings for practitioners and policymakers. It will also provide suggestions for future research.

The findings from this study have been grouped for organizational purposes into categories that align with the research questions. The answers to the research questions are divided into perceptions of the home visitor, and of the moms. In this chapter the following research questions are addressed:

1. How do moms and home visitors perceive and experience the MIHOW home visitation program in relation to curriculum, visits, other services, and relationships?
2. How do moms and home visitors perceive the MIHOW's program's influence on child development related to physical, cognitive, social-emotional, and communication?

Setting Two: Mountain Ridge

Home Visitor

This section addresses the home visitor's perceptions of the program related to the first research question. This question relates to curriculum, visits, other services, and relationships.

At the Mountain Ridge site one home visitor was interviewed two times.

Curriculum: “It Helps Moms Know What to Do.” The MIHOW curriculum, according to one home visitor, was practical help for the mom. She described how it was helpful: “Because they’ve got a curriculum they go by and it helps moms who just don’t know what to do.” The home visitor described the content of the curriculum and how it focused on the development of the child:

A home visit ... consists of one piece of paper.... It is based on whatever month of pregnancy you are in, what the baby’s development is, and what is developed on the child. Then whatever stage you’re in we talk to you about that, and then write down if there were any concerns or anything like that.

She provided another example of the content of the curriculum and how it focused on the development of the child:

You go exactly where the child, even if it’s a new one or say that I’ve got a six month old. I’m seeing her this month and it’s turned six months. I’m going to look up the six months lesson plan and I’m going to pull out of there mostly the activities I need to see the child doing.

The curriculum was also customized to fit the needs of individual moms and depending on what was happening in a home at the time of the visit. The home visitor provided a strong example of how the content of the curriculum can be customized:

She [the mom] had two kids in the program. She had everything ready for the children, and when I got to the door the husband met me at the door. He said, “Look where she stabbed me with an ink pen.” You know you can’t just fly off. You’ve got to see what the

surroundings is like a little bit before you do anything... I said, "Come on let's see where mommy's at." And we walked on in there and she was picking glass out of her head.

The home visitor changed her plans for the visit based on the urgent need of the family at that time.

Visits: "*I'm There for the Child.*" For the Mountain Ridge home visitor, issues related to home visits focused on mom and child learning, and frequency of visits. The home visitor from Mountain Ridge talked about the learning that occurred during home visits for the mom and child related to their monthly development during pregnancy, why they [the moms] hurt in certain areas, and what's going on with their body. The home visitor explained how it is important to connect with the mom where she is in her thinking:

You can go in and you've got to know your families. You can't push stuff on them that they're not ready for. You've got to teach on their level. Some of the parents are not educated. And then just by going in afterwards, teaching them about pregnancy, a lot of them will say to me I wish I knew this with my first one I had.

The home visitor explained how she helps the mom to determine how the child did on the previous week's lesson using questioning:

How did they do on the lesson plan [this past] week? Do we need to go over anything?
Or [do you] want to repeat the same lesson or do you have a question about an area that the child is not doing [well in] and we could work together and see if...[the child will] do it.

In addition to learning from their home visitors about their experiences during pregnancy, such as why they hurt in certain areas and what's going on with their bodies, moms also learned about their babies' development from discussions with other moms during playgroup. One home visitor described how the moms were learning and sharing with each other. "They also get to come out twice a month to playgroup and that's interacting with the other pregnant moms." She described what they discussed during play group:

With the babies we do activities and stuff, reading, do songs and dance, things like that. They get to do art. And then [with] the pregnant moms we talk over a fruit tray, you know, if they want to discuss their baby's development, how many months they're pregnant, you know, about their family life, what's going on with them and their pregnancy, you know, just things like that is what we want to focus on.

In addition to how moms were learning, the home visitor also spoke about the frequency of home visits because she believed that increased visits would benefit the moms. She felt that one home visit per month was inadequate, especially as the moms get further in their pregnancies. She explained: "They're going to need you at least three times a month, because there's things that come up that you won't know until the next time you go see her the following... month." She commented that she would like to see the program include "more visiting, just more and more visits."

Other Services: "They Like You to Use Your Own Resources." Often the home visitors were affiliated with community services or resources and knew of them before becoming home visitors. One home visitor from Mountain Ridge explained: "They like you to use your own resources." The home visitor conducted car seat safety trainings and trainings on home safety

for the baby where they gave away items such as car seats, wall plug-ins, safety doorknobs, and door latches. She described how she was a resource for her families related to car seat safety:

I'm a car safety tech.... I'll check the car seats that are given to them [the moms]... and you know tell them that you really don't want to do that [accept car seats from others] because you don't know if that car seat has been in a wreck. It may look good but it may have lost its strength once it is in a wreck. So we have bought some car seats for our programs.

In addition to resources provided directly by the home visitor, the home visitor described additional community resources, some connected with the MIHOW program that she assisted moms in connecting with. Transportation was a service that the home visitors helped moms access: "We help them if they need rides to the doctor, their appointments that they can't get to They need us to go to them, you know, go with them." The same home visitor identified the use of a vehicle as a personal resource that she would like to see the program provide for home visitors to use in order to get moms to WIC and doctors' appointments. In addition to transportation provided through Mountain Ridge, she mentioned a food pantry located nearby. Mountain Ridge also sponsored an activity where home visitors took the moms out for a day of pampering from a beautician, including a new haircut and style. This event happened bi-annually for moms that home visitors felt would benefit from the activity.

Relationships: "You Have a Good Connection with These Families." The rapport between the moms and home visitor was important to their relationships. The home visitor said that it was not difficult for her to gain rapport with the moms: "They tell me everything." The

home visitor explained that often she was the only person coming around the house regularly to see moms:

Some of them tell me too much but...I realize I'm the only person that probably comes in the home once a month and talking about her and her baby and the family, you know. I'm also the only person these moms see on a regular basis.

The home visitor provided an example of how moms confide in their home visitors even with the most private information:

Okay, like one of them her boyfriend went to jail. She told me everything, what he went to jail for and that was only after I had been to her house twice. She told me the whole story and sometimes I don't want to know all this stuff but I just listen.

The home visitor described one mom who felt so comfortable with her that she approached her to pay her boyfriend's \$600.00 attorney's fees.

The home visitors' ability to identify mom's strengths was a second issue related to their relationships. A home visitor from Mountain Ridge described her relationship with the moms as beneficial to reinforcing the mom's strengths. She explained: "I felt like my relationship with her helped to bring out that strength. Her strength was to make sure that she had a home to go to. She didn't want to always focus and rely on her mom and dad." She also said that many of the moms tell her too much, but that if you do not establish that rapport and get to know them, "you will ... get nothing." Similar to home visitors at Blue Lake, the home visitor interviewed at Mountain Ridge explained how she loved her job and getting to know her families:

I love my job because I get to visit different families and I get to meet them and understand...their values, their life, their history, what's coming up, the development of their kids. You have a good connection with those families.

Moms

This section addresses the moms' perceptions of the program related to the first research question. This question relates to curriculum, visits, other services, and relationships. At the Mountain Ridge site two moms were interviewed three times.

Curriculum: "They're Like a Big Bible of Information." Moms described the curricular content for the Mountain Ridge program as based on the month-to-month development of the child. According to moms, the curriculum related to the child's development and content was contained in pamphlets and booklets. The monthly information focused on what to expect and not expect for that month. One mom explained, "They have like a guideline of like every month you're pregnant," for instance, "Like three months you're going through morning sickness, and they bring pamphlets and stuff about morning sickness." In addition to monthly pre and post-natal development, moms talked about content related to gestational diabetes, morning sickness, weight of the baby, what to eat, emotions, breastfeeding, drugs, and alcohol/tobacco. One mom described the content as "a big Bible of information."

Visits: "Gives You a Little Bit of Company." The moms described the home visits in terms of methods, materials, activities, companionship, being informed, and the frequency of visits. As was true at Blue Lake, the home visits at Mountain Ridge were arranged by home visitors who called the moms and scheduled the visit ahead of time. The home visits ranged from one to two and a half hours long. As discussed in prior sections, the content covered in the

home visit consisted of a guideline for every month and the home visitor also used pamphlets, checklists, and other screening tools. One mom described the information her home visitor brought her, especially because she was suffering from gestational diabetes: “And she always brings me information like pamphlets, booklets, and she goes over with me what the pamphlets were, what the booklets are about, asks me if I have any questions.” The home visitors also worked with the child on developmental activities related to cognitive, gross motor, fine motor, and language development. One mom recalled an activity by reviewing one of the handouts:

Let’s see, activities: lay baby in front of you. Put toys in front of them. Make a fist, extend your finger, see if he’ll do it. Hold your fingers a few inches in front of the baby’s chest and see if he’ll grab it. And just like call his name to see if he responds to you.

The same mom talked about how the home visitor brought a song list and color chart to use with the baby during a home visit: “She brought like some song lists that I could sing to the baby. She brought a color chart that I could play with him and little pictures that’s black and white that I tape up in his room and let him look at them.”

As a result of the home visits, moms believed they were more informed. According to one mom, “Well basically you have somebody that comes to your house once a month [and] they bring you information; if you’ve got any questions, they’ll hunt information for you.” The same mom explained, “Yeah, like I said, every time she comes she comes with something new.” Another mom echoed a similar perception: “Then she’ll ask me if I need anything or do I need to know any other information.... She’ll look it up and the next time she comes she’ll talk to me about it.”

Moms also valued the companionship the home visitors provided during home visits. Two moms were very positive about receiving home visits from their home visitor. One mom described how she enjoyed having a home visitor come over for her company: “She just goes through things like that and then she just kind of visits you, know what I’m saying? Checking up on you and give you a little bit of company, which is welcoming when you sit at the house.”

Like the Mountain Ridge home visitor I interviewed, one mom expressed concerns about the frequency and consistency of home visits: “It would be nice if they came out more often— every two weeks or something like that and bring more information.” On the other hand, another mom described the lengths to which her home visitor went to set up a visit: “My worker is here every month like she is supposed to be. She calls me with all new information, if we’re doing anything at all....You know it’s the little stuff that makes it.”

Other Services: “Everything They Do Out There at Mountain Ridge and Stuff, They Include Us On.” The moms at Mountain Ridge spoke positively about community services that the MIHOW program was able to inform them about and in some cases, connect them with. Both moms explained that they did not need the help, but knew of other moms who benefitted from the services. One mom explained: “I try to do it all on my own but they did bring information through the welfare office to get help for gas mileage [for] going to the doctor and stuff.” Another mom explained: “I know of several moms around here; they’re single moms [and] don’t have [anybody] else.” She identified several activities that Mountain Ridge provided for them such as the Easter Egg Hunt, Mother’s Day Out, Thursday Playdates, and Dinner in a Sack. The Mother’s Day Out Activity was a Mountain Ridge sponsored event that the moms and home visitors attended which allowed them to get their hair and eyebrows done. They also

were taken out to eat. Dinner in a Sack was an opportunity for the moms to learn how to cook something new and then take the ingredients home to make the meal that evening with their family. According to this mom, “You join with Mountain Ridge, there’s vehicles and...they come pick you up [and] they bring you home. I mean your workers come get you.” One mom summed up her appreciation for services at Mountain Ridge: “[It’s] always something; everything they do out there at Mountain Ridge and stuff, they include us on.”

Relationships: “These People Become Part of These Kid’s Lives.” The moms clearly valued their relationships with their home visitors. Themes associated with consistency, support, comfort, and trust were identified by the moms as characteristics of their relationships; Moms also described the importance of home visitors to their children. One said, “These people [home visitors] become part of these kid’s lives.” Another valued the consistency and reliability of the home visitor and how that influenced her child’s life, “She’s been a staple in his life since the moment he was born.”

Two moms described their relationship with their home visitors as a support system: “Yeah. It’s a very good support system. I believe in my heart of hearts, [if] something was wrong I could call my home visitor in the middle of the night and ask her opinion about something.” Another mom echoed a similar feeling about her home visitor, “We get along great. If I have questions, she gave me her home phone number, I call her at home. If I can’t make it to the meeting she tries to come and get me and take me up there. They do offer that.”

The moms also enjoyed the comfort and trust that the home visitors provided, “Having someone to talk to. When you can’t talk to other family members, my home visitor is always there to talk to you. That helps a lot.” One mom described the connection that she had with her

home visitor and how she valued talking to her: “She would put you in mind of a sister that you could talk to... and know it’s not going anywhere. Because the rest of the family we’re not close but you know I can talk more to her than I can any of them.” Some moms were even more comfortable with their home visitors than with family: “It’s just, I feel more comfortable asking her to help than a family member.”

Home Visitor

This section addresses the home visitor’s perceptions related to research question number two and discusses the child development areas related to physical, cognitive, social-emotional and communication. At the Mountain Ridge site one home visitor was interviewed two times.

Child Development: “Whatever Stage You’re in, We Talk to You About It.” A home visitor explained that the Mountain Ridge program addressed child development through trainings and during discussions with the moms during home visits and program sponsored activities. She indicated that although the program training was about child development, much of the training was focused around the moms: “Yeah, it’s about the pregnant moms too. It’s mostly right now they want to focus on the pregnant moms.” She also said that she would like to go to more trainings related to infant massages and breastfeeding. Recently the home visitor received training related to immunizations. The program director has also suggested training related to sign language.

A second way the home visitor described the program in relation to child development was in terms of Ages and Stages Questionnaire screenings with the babies after they are born, “It’s about child development mostly.... If there’s concerns we talk to them [the moms] and

then we do a referral to Birth-to-Three.” The home visitor did explain however, that the program did not keep people out of Birth to Three programs. According to her, home visits were also focused around brain and child development, “It helps with a lot of things about the child development, all of that; it’s brain development, just all of that. Then whatever stage you’re in we talk to you about that; and then you write down if there were any concerns or anything like that if the moms had.” She explained how the home visit is focused around the stage of development the child is in even prenatally:

The home visit is based on whatever your pregnancy [stage] is. If you’re three months, [I] go in there...[and] talk to you about what’s going on while you’re in three months of pregnancy, about your baby’s development, what is the baby doing right now, if it’s got eyelashes, you know, how big it is, what’s developed on the child because we have information for that.

According to the home visitor, a third way the program addressed child development indirectly was through program-sponsored activities such as playgroups for the moms and babies. In playgroups, the home visitors provided activities for the babies which included reading, songs, and dance. Meanwhile, moms had an opportunity to visit with each other and discuss issues related to their baby’s development, pregnancy, family life, discipline, and fatherhood around a fruit tray.

Physical: “I Always Explain What She’s Doing.” The home visitor used screening checklists with the moms in order to improve physical development for the babies. The home visitor described how she used the Ages and Stages developmental screening to assess child development in the areas related to social-emotional, gross motor, fine motor, cognitive, and

language. She also provided an example of how she taught the mom to work with the baby in the areas of language, cognition, and physical development and how these developmental areas often overlap:

And here's what I'll say, [to mom] "What is she [the baby] doing?" She'll say, "Why she's just picking up that ball." I said, "What color is the ball? Red." I said, "What is she picking it up with? Well, with her hands." And I said, "Is she using her fingers?... Look how much language I brought out to you." And she'll go, "Well." And then I'll say, "Oh my, she's taking right, left, right, left steps. She's looking over the couch. She went to the couch, you know, she went to the couch and got her puzzle. She brought her puzzle to you. She's holding the puzzle with four pieces, you know." I said, " I always explain what she's doing."

The home visitor described to the mom methods to use in order to stimulate physical, cognitive, and language development with her baby.

Cognitive: "They are Like a Sponge, Their Brain Is." The home visitor used talking and making things with the baby to stimulate cognition while simultaneously teaching the moms how to work with their babies. One home visitor described how she worked with the mom: "[I said to mom] 'Just keep naming them.' She [mom] said, 'Is that what you want me to do?' I said, 'Yes.' She said, 'That's a lot of work.'"

The home visitor had another example of how she taught a mom to work with her baby related to shape and color:

I said [to mom], "At this age they are like a sponge, their brain is, and they're just like soaking everything in at one time...You can enhance something and another with them and I said, "Let them be part of making things." And I said, "You take red construction

paper, cut it out as a triangle. If you're going to do shapes, there you've got color and you've got your shape."

Social-Emotional: Fewest Examples of Child Development. Similar to the results from Blue Lake, the area of social-emotional development had the fewest examples from the home visitor. The home visitor described the Ages and Stages Questionnaire for Social-emotional development as a screening tool that she used, in addition to the ones for gross and fine motor, cognitive, and language. According to the home visitor's descriptions, playgroups were one way they worked with the babies and moms in a social setting. During playgroups the home visitors worked with the babies using activities such as art, songs, and dance. They simultaneously talked with moms about issues related to pregnancy, their baby's development, discipline, and fatherhood.

Communication: "I Push Language." According to one home visitor, the MIHOW program has a strong focus on language. The use of conversation was one of the ways the program encouraged home visitors to work on language with moms and babies. A home visitor explained difficulties she was having with the push for language development with moms for their babies: "They're not doing too good right now but I push it," and "They don't like to repeat at home." She explained that since language and reading were two major components of education, she may be working with a parent that is lacking in education, "So when I visit with her she is learning to repeat, because she never had you know, a good education, so I help her."

The home visitor described how she conversed with one mom about how to use conversation to encourage language development: "I always explain what she's [the baby is]

doing. She [mom] said, “That’s a lot of talking.” I said, “Yes, but who’s learning?” She said, “Me.” And I said, “No, she [the child] is.” She said, “Oh, is that what you want me to do?” I said, “Yeah.”

Moms

This section addresses the moms’ perceptions related to research question number two and discusses the child development areas related to physical, cognitive, social-emotional, and communication. At the Mountain Ridge site two moms were interviewed three times.

Child Development: “It Was Something New to Me.” According to moms, the Mountain Ridge program helped to show them what to expect and not to expect related to monthly development of their babies. The moms also received information related to nutrition and teething from home visitors. But most examples from the moms related to expectations related to growth and development. The moms described handouts that the home visitors brought related to the baby’s growth and milestone development:

I like the ones [handouts] about the baby’s development and like what they’re doing, what they should be doing, if they’re not doing it. If you haven’t had other kids and you’re not sure about developmental stages and how kids age,...[it] would be hard.

Another mom described how she used the handouts about child development, and how she was unfamiliar with the information:

I’ve never looked it up or nothing till they brought me the paperwork...They printed off stuff out of a book how a baby was developing each month. They bring pamphlets to us and little books telling us what’s to be expected and what not to expect and how to stay healthy as you’re doing it and stuff like that.

Several moms also learned about nutrition, breastfeeding, allergies, teething, and eye-hand coordination from their home visitors. One mom described how her home visitor helped her with eye-hand coordination since she had only worked with older children:

Like the eye-hand coordination, I would've never thought nothing like that until she brought me the paperwork on it. So it was something new to me, because I had worked at Head Start...but that was already four-year old kids and five, so.

Physical: "They're Supposed to Be Eating with Two Fingers Instead of the Whole Hand." For some moms the developmental handouts provided by the home visitor were beneficial to understanding fine motor development. One mom explained how it provided useful information about milestones: "Well, I know she's brought a handout that they're supposed to be eating with two fingers instead of the whole hand, picking them up with the two fingers instead of all the fingers."

Another mom spoke of fine motor skills the home visitor did with her son: "She actually comes in and works a lot with his fine motor skills and things like that." She also described activities the home visitor did with her son related to both fine motor and cognitive skill development, "And as he put the blocks back in she was counting them. Well the next time she comes he could unscrew the lid, he could dump them all, and he was counting 1, 2, 3, with her." Another mom described a similar exercise: "Put toys in front of them. Make a fist, extend your index finger, see if he'll do it." One mom explained how her home visitor helped her work on eye-hand coordination with her son: "She's real good about bringing me games and stuff that's good like to help with eye-hand coordination" and "She showed me how to transfer an object from one end to the other in front of him and help him to transfer it."

Cognitive: “See if He Responds...See if He Notices.” Both of the moms cited several examples of activities using games, stickers, songs, toys, and books that their home visitor used with their children related to cognition, especially stimulating talking, singing, memory, object permanence, and reading. Activities using observation and memory were identified as a way to improve cognition. One mom identified an example related to memory where the home visitor had the mom to place different stickers on trucks as she explained, “Put stickers of different colors on just like his trucks and stuff and see if he responds to the stickers being there or without being there, see if he notices.” The same mom described another example of how the home visitor brought her songs and a color chart, which used singing and memory to stimulate cognition. She described how she used the songs with her baby, “Well I know she brought me song lists that I could sing to the baby. She bought a color chart that I could play with him and little pictures that’s black and white that I tape in his room and let him look at them.” One mom described an activity which used a mirror and the home visitor had the baby to try and recognize himself. Another mom described how the home visitor used a blanket and a toy to stimulate object permanence:

Like she showed me this one game, it’s like put a blanket over a toy, lay the toy in the floor and put the blanket over it to help him learn the concept that it’s gone for now but if you move the blanket it’s still there.

A second method to stimulate cognitive development related to the use of reading and books. A mom described the book she was given by her home visitor and how she used it:

It’s got pictures of animals, then you turn it over and it’s got pictures of like fruits and vegetables. And then the next page has like cars, like automobiles or something that

runs, like planes, jets, stuff like that. And then the other page has like clothing, and we usually go through that and his alphabet book.

Social-Emotional: “Make It Like It’s A Sharing Thing.” Although the Blue Lake moms had serious issues related to social-emotional development, and wanted more information and support from their home visitors and the program in this area, one mom at Mountain Ridge did not express these concerns. One mom described information she received related to social-emotional development and seemed to feel informed. She described several examples of ways the home visitor was helping her to deal with issues associated with the baby’s separation anxiety and difficulty with sharing. She described the advice her home visitor provided related to sharing with his siblings: “She’s [home visitor] the one that told me about the idea about making the girls share with me, even though [I’m] not a kid....She said, ‘Whenever...you’re eating something and he wants a bite of it, you make it like it’s a sharing thing.’”

The same mom also discussed another issue she was having with her son related to separation anxiety. Her son would not let her out of his sight around the house. She was eager to discuss this issue with her home visitor: “I’m going to talk to her about separation issues with him too because I can’t leave him [any]where.” The other mom did not provide information as to how her home visitor was assisting her with the area of social-emotional development.

Overall, the area of social-emotional development had the fewest examples from the moms.

Communication: “The Biggest Worry is His Talking.” Communication was one of the areas that moms shared concerns about, yet several gave examples of how the program and their home visitors addressed language. Home visitors shared methods with the moms related to modeling and repetition to stimulate language development for the babies. One mom

expressed concerns about her son: “But like I said, the biggest worry is his talking.” His expressive communication was more of a concern for her than receptive communication: “It’s real funny because... I’m concerned about his talking and stuff but like I said he completely understands everything you’re saying to him.” She relied on the expertise of her home visitor regarding his language: “Yeah, I’ll speak to her. I’m going to speak to her about it, and also I mean he has to go for his two-year check-up. I’m going to talk to his pediatrician too.”

Modeling was a method used by home visitors to promote language development for the babies. According to one mom, the home visitor used modeling to promote communication: “She does stuff with language... She gave me like a list of words...told me that you know have him look at you while you’re speaking those words.” The mom explained that the home visitor taught her the importance of having her son hear the sounds simultaneously while watching the movement of her mouth. The mom explained: “For him to learn how to move his mouth or... his tongue, you know, because when you talk your tongue has a position; your mouth has a position.”

One mom shared an example of how the home visitor had brought her son a book with lullabies: “Well actually he will try to coo and try to sing with it. I know he’s not singing but he tries to make noises when he’s listening. So it’s trying to help him talk too.”

Chapter Seven: Cross-Site Analysis and Interpretation

This study was conducted to explore the moms and home visitors' perceptions of the MIHOW home visitation program from two West Virginia sites. The participants' perceptions were explored in relation to the curriculum, visits, other services, and relationships. The participants' perceptions of the program's influence on child development were also explored. Chapter four contained the descriptive information about the two sites, home visitors, and moms. Chapter five featured findings based on the interviews with home visitors and moms from the Blue Lake site. Chapter six included findings based on the interviews with home visitors and moms from the Mountain Ridge site. Results in both chapters were organized around the two research questions. In Chapter seven, the results of a cross-site analysis are presented. Additionally, interpretation of the findings, issues related to current literature on home visitation and child development, and implications of the findings for practitioners and policymakers will be discussed. This chapter will also provide suggestions for future research and the final conclusions and significance.

Based on the research questions, five themes emerged from the findings. The first theme was related to the developmental checklists and screening materials and moms' understanding of how the checklists related to the child's monthly growth and development. The second theme related to how moms characterized home visitors as "like a friend," and the nature of peer relationships between the home visitors and moms. The third theme was related to the frequency, consistency, and scheduling of home visits. A concern about a lack of transportation was the fourth theme and how this lack created a barrier for moms connecting

with community resources. A lack of attention to social-emotional development was the fifth theme.

Theme One: “Childrearing to the Checklist”

Across both sites, the curriculum used during the home visits often was focused around the monthly development of the babies. The checklists that were used during the home visits featured prominently in moms’ understanding of child development. The checklists helped the moms know what to expect about their child’s growth and development, keep track of their child’s progress, and guide their own parenting behaviors. This section is subdivided into knowing what to expect, keeping track of progress, and guiding parent behavior.

Home visitors used checklists related to the child’s monthly development. The checklists helped the moms know what to expect about growth and development. Moms at both sites provided many examples of how they learned about their child’s development during home visits from the content contained in the checklists.

Moms described how the monthly checklists home visitors brought helped them to understand fine motor skills, cognitive development, and strategies related to modeling and repetition to stimulate language. Most of the moms’ learning was related to the monthly expectations of growth and development as one mom recalled: “I like the ones [informational handouts] about the babies’ growth and development and what they are doing. If you haven’t had other kids and you’re not sure about stages it would be hard.”

Moms also found the checklists helpful in keeping track of their babies’ progress. The home visitors at Mountain Ridge taught the moms how to assess their babies using activities

which often related to cognition, language, and physical development. One mom described how the home visitor used the checklists with her baby to assess development: “She’ll mark off not only what she sees but my feedback as well, what my concerns are, or if I think my baby is developing right where she needs to be or even sometimes a bit ahead.” The mom explained that the score on the checklist gave her an idea of what things she needed to work on with the baby or in what areas the baby was excelling.

The content contained in the checklists was also useful for guiding parenting behaviors. Moms provided many examples of how the content in the checklists provided ideas that they found useful. Often the checklists provided a basis for understanding what areas the babies needed to work on. Based on the child’s checklist assessment, the home visitors worked with the moms, demonstrating methods that would strengthen particular developmental areas. For example, home visitors and moms both provided several examples of activities and methods to use in order to improve skills related to physical development, cognitive development, and communication. The moms had very few examples of methods to promote social-emotional development.

With the support of the mother and home visitor during home visits, the babies could function in their zone of proximal development, which relates to tasks that the baby can accomplish with some help or support (McDevitt & Ormrod, 2013). Findings of the current study are consistent with the description of Vygotsky’s zone of proximal development: “the range of tasks that children cannot yet perform independently but can perform with the help or guidance of others” (McDevitt, & Ormrod, 2013, p. 219). The zone of proximal development is right where the baby should progress with assistance, guidance, or scaffolding. The monthly

developmental checklists demonstrate skills that should be in a baby's zone of proximal development.

The findings of this study are consistent with previous literature regarding the curriculum content used in home visitation programs that are based on the babies' monthly and yearly development (Woolfolk & Unger, 2009; Katz, McNeely, Johnson, & Kiely, 2011). Many current models of home visitation programs use curriculum that is based on the babies' monthly and yearly child development. This current study adds more specific information related to moms' understanding of child development in relation to checklists. The checklists are contained in the content of the MIHOW curriculum developed by Vanderbilt University. For moms in the program, the checklists were effective in providing them knowledge about what to expect with their babies' development, a tool for keeping track of their babies' progress, and guidance for their own parenting behaviors.

Theme Two: "Like A Friend"

Across both cases, moms valued the relationship they shared with their home visitor, which they characterized as "like a friend." Both Mountain Ridge and Blue Lake moms described their relationship with the home visitors similarly, especially as they discussed the support, companionship, reassurance, comfort, and trust the relationships provided. Moms in both programs provided examples of how their home visitors also helped to empower them and identify their strengths. Based on this trusting relationship, moms often talked to their home visitors about concerns they had associated with growth and child development and whether or not their child was meeting developmental expectations. The moms felt

comfortable with their home visitors discussing concerns related to child development. The home visitors were often able to ease their fears.

The home visitors at Blue Lake and Mountain Ridge shared similar feelings related to the importance of the relationships they developed with the moms. All of the home visitors believed that getting to know the families and hearing the moms' stories were the best parts of their jobs. Home visitors at both sites easily gained rapport with moms, and one home visitor even felt like the moms told her too much information. Although the home visitors identified getting to know the families as one of their favorite parts of the program, following their MIHOW training, they set boundaries for their relationships with moms and did not try to be their friend: "I'm not going to be somebody's friend, but I am going to be somebody's listener, somebody's advocate." They viewed their relationship with the moms as a "real healthy relationship." Although both moms and home visitors described their relationship in terms of characteristics often associated with friendship, neither considered the other friends. In other words, they were *not* friends; they were *like* friends.

The current study is consistent with previous research that reports that moms described home visitors with characteristics associated with trust (Kirkpatrick, Barlow, Stewart-Brown, & Davis, 2007; Jack, DiCenso, & Lohfeld, 2005; Brookes, Summers, Thornburg, Ispa, & Lane, 2006). Rossiter, Fowler, McMahon, and Knowalenko (2012) described moms' perceptions of their home visitors as empathetic, warm, and able to nurture friendship. Similar to the home visitors in this study, several studies identified the home visitors' relationship with the family as a benefit of the home visits (Brookes, Summers, Thornburg, Ispa, Lane, 2006; Kirkpatrick, Barlow, Stewart-Brown, Davis, 2007).

The current study adds new knowledge about the nature of peer relationships between home visitors and moms and what those relationships mean to them. The mom-home visitor relationship was not a friendship, but it was *like* one. This seemed to be a satisfying and productive arrangement for both moms and home visitors.

Theme Three: “More Is Better, But It’s a Challenge”

In both sites home visitors and moms were concerned about the frequency, consistency, and scheduling of home visits. The Mountain Ridge home visitor believed that the number of home visits per month should be increased in order to benefit the moms. Similar to the home visitors at Blue Lake, the Mountain Ridge moms had concerns related to the frequency of visits and wanted home visits increased to as often as every two weeks. The concerns about the frequency, consistency, and scheduling of home visits also relate to child development. Infrequent home visits limited the home visitors’ ability to provide monthly developmental information to the moms, to assess their babies’ progress on a regular basis, and to provide regular support and guidance to the moms on how to work with their babies.

The inconsistency of home visits was another issue identified at both sites. Moms at both sites expressed how the inconsistent visits affected them personally, especially related to information they were promised but never received. The inconsistent visits for some moms, especially at Blue Lake, were viewed as a disruption to them and ultimately frustrating. On the other hand, some moms had consistent visits and their home visitors even called between visits with new information.

In addition to concerns about the frequency and consistency of home visits, scheduling the home visits was a concern for several of the home visitors at Blue Lake. They had difficulty

scheduling home visits with moms due to the fact that they moved so often and because very few moms had landline telephones. Most of the time they connected with the moms using text messaging.

The current study's findings associated with the frequency, consistency, and the scheduling of home visits are consistent with previous research. Several prior studies related to the frequency of home visits. Zolnoski, Stacks, Kohl-Hanlon and Dykehouse (2012) looked at 17 families using pre-and post-interviews with participants using child development screenings. The results of the study indicated that after 10 months the at-risk families had not changed their ideas about child maltreatment. In relation to this finding, the researchers reported that the frequency of the visits was inconsistent due to missed appointments by parents. The program was not delivered as it was designed to be because of problems associated with making regular home visits. Also related to the frequency of home visits, Azzi-Lessing (2011) identified critical issues for home visitation, noting that the issues of service dosage and family engagement were important. Better outcomes were identified for the moms if they received the appropriate amount of home visits. Understanding why families remained in the programs was directly correlated with whether or not the programs met the families' needs on a regular basis.

Theme Four: "Transportation Is Still an Issue"

Across both sites, transportation was a barrier for moms in connecting with community resources. The lack of transportation was a barrier to services, according to the home visitors and moms. Many moms in the study did not have cars or the fuel for cars. Some of the moms shared a car within a community. There was also no public transportation. The lack of

transportation was a concern since many of the moms were located in mountainous, geographically isolated areas. Some moms lived in areas with few visitors.

The lack of transportation, particularly for the Blue Lake site, impeded the ability to fulfill the goals of the MIHOW program, especially those related to health and child development. The inability to attend doctors' and WIC appointments, and connect to local services was a serious limitation to the ability to monitor child development. One home visitor suggested the program should provide home visitors the use of a personal vehicle as a way to connect the moms to their doctors and WIC appointments so several home visitors would not have to share the same van.

The current study adds to the limited previous research since there are few studies related to rural home visitation programs and the influence of transportation on program implementation and effectiveness. Kovalesky (2001) identified transportation, drug use and health status, the effects of the visits on the child, scheduling visits, and the support of others as five factors that could either promote or inhibit home visitation programs. Transportation was clearly a concern for the moms and home visitors at Blue Lake. They felt the lack of transportation impeded their access to medical appointments, employment, and educational opportunities.

Theme Five: "I Could Probably Use a Little More" Help on Social-Emotional Development

In both West Virginia MIHOW sites, the area of social-emotional development was mentioned less by home visitors than other areas of child development. Home visitors at both Blue Lake and Mountain Ridge used the Ages and Stages Questionnaire related to social-emotional development as a screening checklist, beginning around six months, and reassessed

every six months. Blue Lake home visitors identified examples in their curriculum of how discipline was addressed in year three, in addition to information related to children with special needs. They also attended training related to child development and discipline. The Blue Lake home visitors also conducted screenings, used curriculum on discipline, and customized home visits related to issues associated with discipline. In comparison to the Blue Lake home visitors, the Mountain Ridge home visitor had even fewer examples of how the area of social-emotional development was addressed, only identifying discipline-related topics which were discussed during playgroup.

Moms at Blue Lake identified social-emotional as an area that they wanted to learn more about: "It's just basically scratching the surface of this whole broad thing." Moms wanted more information related to listening, tantrums, and toddler's attention. On the other hand, several moms did not express the same concerns. Some moms received information related to sharing and separation anxiety and seemed to feel informed. Overall, moms from the program wanted more information in this area, and were receiving less information about it from the program than about other developmental areas.

The current study finding is consistent with the results of a study conducted by Manning, Homel, and Smith (2010). They conducted a meta-analysis of 17 studies of early developmental prevention programs. The results of the study indicated that although there were benefits associated with home visitation for educational success and cognitive development, there was little influence on social-emotional development and family well-being. On the other hand, Harden, Chazan,-Cohen, Raikes, and Vogel (2012) conducted a study of children and families who participated in early Head Start to determine if the program had

any influence on child and family outcomes. The results indicated that they had fewer behavior problems than at pre-kindergarten because of the positive adult-child relationships that were modeled during the home visits. This study concluded that there were long-term benefits for children in areas related to social-emotional functioning. Although we know from prior research that the results of home visitation related to social-emotional development is mixed, the current study shows that the moms and home visitors were not on the same page as to whether or not the moms were adequately informed.

Implications for Future Research

The current study explored two home visitation programs in rural Appalachia to examine the perceptions and experiences of moms and home visitors regarding the influence MIHOW had on child development in relation to physical, cognitive, social-emotional, and communication. The study also looked at how moms and home visitors perceived and experienced the MIHOW home visitation program related to curriculum, visits, other services, and relationships. Five themes emerged from the study. One theme related to how moms understood child development in relation to checklists and screenings. Few research studies focus on the use of home visitation checklists and screenings and how those help moms understand child development. A future qualitative research study might actually observe how moms are using the checklists and how they influence parenting behaviors.

Another theme related to peer relationships between moms and home visitors. The current study explored moms' perceptions that home visitors' were "like a friend," and that they identified home visitor characteristics associated with empowerment, trust, empathy, warmth, and the ability to nurture friendship. The home visitors did not see themselves as

friends with the moms and they had set parameters on their relationships with them. On the other hand, the home visitors described getting to know the moms as one of the most important parts of the program. A future qualitative study might feature the “like a friend” theme more fully and explicitly. This would produce new knowledge about the nature of peer relationships and how the relationships between home visitors and moms share many characteristics associated with friendship, yet neither considers the other as a friend. In addition to interviewing, observing the relationships between the mom and home visitor during a home visit might also add insights about why moms often consider their home visitors as “like a friend”, and how that friend-like relationship is developed.

Another theme in this study was related to the area of social-emotional development. Social-emotional development was mentioned less than other developmental areas in interviews with moms and home visitors at both MIHOW sites. Some moms wanted more information and were receiving less information in this area compared with other child development areas. A future qualitative research study might investigate reasons why social-emotional development is not discussed as often as other developmental areas. It might also look at whether individual beliefs about discipline have any influence over this and how programs can include more information related to managing specific toddler behaviors.

Conclusions and Significance

The findings of this study add to the limited research on home visitation and child development. Moms learned about child development through checklists used by home visitors which focused on the monthly growth and development of babies. The checklists helped moms understand what to expect about their babies’ development, how to keep track of progress,

and they guided their behaviors as parents. The nature of the peer relationships between the home visitors and moms added new knowledge because although both acknowledged that their relationships shared many characteristics associated with a friendship, neither really considered the other as a friend; rather they were “*like a friend.*” Issues associated with the frequency, consistency, and scheduling of home visits were a concern for moms and home visitors. Some moms described feelings of frustration about not receiving information, while others praised their home visitors for consistent visits and timely information. Transportation-related issues continued to be a barrier for some moms and home visitors. Some of the home visitors believed the moms were unable to connect to services within the community. Several moms indicated that they wanted more information related to the area of social-emotional development from their home visitors, although home visitors provided examples of how it was addressed within the program. Moms and home visitors were not on the same page.

This study provides important information in an area where there is inconsistent information on how home visitation influences child development. It also adds to information related to moms’ understanding of child development related to checklists; peer home visitation relationships; the frequency, consistency, and scheduling of home visits; barriers associated with transportation; and the focus on social-emotional development in home visitation programs. Additionally, this study adds to our understanding about the ability of home visitation programs to prevent developmental delays. This study will provide information related to the prevention, identification, and assistance of children with developmental delays in home visitation programs. This program is on target with the prevention of developmental delays. My study is evidence that the checklists and relationships helped to prevent

developmental delays in the areas related to cognition, communication, and physical development. The program may not be as effective with moms in preventing delays related to social-emotional development.

Based on previous research, we know that early intervention is beneficial to young children with developmental delays and their families. The results of this study show that participants believe that home visitation has an influence on moms' understanding of the monthly growth and development of babies, helps them keep track of progress, and assists in guiding their behaviors. The ability of the program to intervene prenatally is one of the most effective ways to assist in the prevention of development delays because it promotes the health and development of the mom and baby. The checklists and screenings provided moms an understanding of child development and whether their child was meeting expectations. The home visitor also suggested methods and materials that that they could do with them. Home visitors also described working closely with Birth-to-Three in order to assist families with referrals as needed.

The data from this study will provide practitioners and policymakers more information regarding the developmental areas that programs should focus on during home visits, and how these areas should be addressed with moms. It also provides knowledge about development issues about which moms want more information. This study will provide practitioners and policymakers knowledge about the prevention, identification, and assistance for effectively addressing developmental delays using home visitation programs. Since early intervention programs have received increased funding through the Affordable Health Care Act and Obamas Universal Preschool Act, this study will help policymakers to better understand what services

and information were most beneficial for moms and families. This study identified the methods moms used to identify atypical child development and what resources programs should be focusing their attention on to assist families with the prevention of developmental delays.

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APPENDIX A: Letter from Institutional Research Board



Office of Research Integrity
Institutional Review Board
401 11th St., Suite 1300
Huntington, WV 25701

FWA 00002704

IRB1 #00002205

IRB2 #00003206

October 25, 2012

Martin Amerikaner, Ph. D.
Psychology Department

RE: IRBNet ID# 263395-3

At: Marshall University Institutional Review Board #2 (Social/Behavioral)

Dear Dr. Amerikaner:

Protocol Title: [263395-3] Randomized Control Group Evaluation of the Maternal Infant Health Outreach Worker (MIHOW) In-Home Visitation Program

Expiration Date: October 25, 2013

Site Location: MU

Submission Type: Continuing Review/Progress Report APPROVED

Review Type: Expedited Review

The above study and informed consent were approved for an additional 12 months by the Marshall University Institutional Review Board #2 (Social/Behavioral) Chair. The approval will expire October 25, 2013. This continuing review also includes the addition of Amy (Knell) Carlson and Debra Lockwood as research staff. Continuing review materials should be submitted no later than 30 days prior to the expiration date.

If you have any questions, please contact the Marshall University Institutional Review Board #2 (Social/Behavioral/Educational) Coordinator Michelle Woomer, B.A., M.S at (304) 896-4308 or woomer3@marshall.edu. Please include your study title and reference number in all correspondence with this office.

APPENDIX B: Research Study Questions

The following are the questions that were used to interview the moms and home visitors in the qualitative study. The moms were interviewed using three sets of interview questions and the home visitors were interviewed using two interview sets.

Ethnographic Explanations:

Well first I want to thank you for taking your time to talk with me today. As we spoke about before, the purpose of this study is to look at the MIHOW program and get a better understanding of how it works, especially from the point of view of someone who is directly involved in it like you are. We just really want to “pick your brain” about the program. This information you give us will help us understand the program, how it works, what works well and what can be better. This and all interviews will be confidential and no information will be shared with anyone, including your home-visitor. All information you give us and any personal information about you will be kept completely confidential. This process is voluntary and you can stop participating in this interview or any other portion of this study at any time. We are tape recording this interview just to make sure we get an accurate account of what you say. Is this okay with you? Do you have any questions for me before I start recording?

Don't forget to ask for **EXAMPLES** throughout the interview!!!

Remember to exhaust all categories (Anything Else?)

- Tell me a how you got involved with the MIHOW program.
 - Were you referred by someone else, or did you sign yourself up for the program?
 - If referred, by who?
 - Why referred or why did they sign up?
 - If referred, thoughts about being referred? (excited, embarrassed, nervous, no strong emotion. Trying to get at how a referral is received, do they view it as punishment and think of it like CPS, for example, or is it a positive perception?)
- After you decided to do the program, what did you expect the program to be like before you started?
 - How is the program different than what you expected?
 - How is the program similar to what you expected?
- How would you explain the program to someone who has never heard of it before?
 - How does it work?
 - What services have you received so far, if any?
- I've never been on a MIHOW home visit. Walk me through what that is like. (could also open the door for asking about observing home visit at some point)
 - General questions about home visitor if this information isn't provided

- I haven't met your home visitor, what is she like?
 - How well they get along?
 - Development of rapport?
 - Social bonding/support?
- Does your home visitor provide you with new information?
 - If yes, what kinds of information does your home visitor provide you with?
 - What of this information do you agree with?
 - What do you disagree with?
 - Do they provide you with new materials or handouts?
 - What do you think about the materials?
- Do you think you have learned anything new from being involved with MIHOW?
 - Tell me more about that?
- Has the MIHOW program been helpful to you yet?
 - How so? (Or why not?)
- What are some things you would like to see the MIHOW program include?
 - What are some of your pregnancy/delivery/parenting related concerns?
 - What are your thoughts on being pregnant? (not phrased like that, but getting at that notion of is pregnancy a positive thing for thing, negative, unknown?)
- What is your favorite part of the program so far?
- What is your least favorite part of the program so far?
- Have you had any experience since you've been involved with the MIHOW program that really stands out? If yes, what was it?
- Anything you would like to add that I didn't ask?

MIHOW Research
Second Round
Interview Questions
Follow-Up Questions
(Only mothers)

1. Reminding them who we are.
2. How are they doing?
3. What has happened since last time we talked?
4. Any kind of MIHOW things that have happened since we talked? What kinds of things have happened during the home visits? How are you using the techniques? handouts? How helpful are those? Can you give me some examples?
5. If the baby is born, how is the child doing these days? Is that connected with anything in the MIHOW program?
6. What things are you working on or things are you concerned with? Anything that you have needed in relation to the program?
7. What could be an improvement(s) that could be made to the program?

MIHOW Research

Third Round

Interview Questions

Follow-Ups; child development/milestones; learning; mom's future

A: Greetings, catching up, re-gaining rapport

1. Reminding them who we are.
2. How are they doing?
3. What has happened since we last talked?
4. How has the baby been doing these days?
5. How about you? How have you been doing since we last talked?

B. Child Development/Milestones

Today I'd like to ask you some questions related to how ____ [child's name] is growing and developing. As we have been talking to moms in the MIHOW program, we've been hearing a lot about developmental milestones that home visitors discuss with you about your child.

6. Could you please tell me a little about those - just anything you can remember (verbalize description of the milestones and how they are used in the program.)
7. Ask follow-up questions about the kind of milestones, what they consist of, and how the moms understand them.
8. What about the milestone checklists? I've been hearing about those too. Could you tell me a little about those? Could you walk me through one of those and how you go about using it so I can be sure I understand? (You are looking for a description of what kinds of tools are used to "measure" the child's movement towards the milestones.)
9. So how do you think your child (use the child's name) is doing on the milestones so far? (try to get them to talk about the various developmental domains (physical, cognitive, social, language). Follow *their* lead on the wording instead of using these categories.
 - a. Are there areas where the (child's name) is doing well? Could you tell me about those? Get stories, examples.

- b. Are there areas where you have concerns about (the child's name)'s progress? Could you tell me about those? (get stories, examples, etc).
- c. If they have identified concerns, be sure to ask for what, if anything they're doing about those and what if anything about the home visitors has said or done about those. Ask how they are feeling about the whole thing.

10. How does (child's name) let you know what they want or don't want?

Talk to me about how they communicate? (words, gestures, show you, lead you to things they want?)

11. Talk to me about how you play with your baby? (Social routine games, songs, games, toys, read, etc..)

12. How does [child's name] behave these days? Any concerns about his/her behavior? Get stories/details about how child behaves and how parent responds to that.

C. Learning

Now I'd like to ask a couple of questions about *you* - and how your ideas might have changed since you've been in the MIHOW program?

13. Any changes in your thinking about Child development or developmental steps? If you did learn something new, how did you come to learn it?

14. Anything new you've learned about the community you live in? (get details)

15. About being a parent? (details)

16. What about yourself? Have you learned anything new about yourself? Your strengths? (get details)

D. MIHOW effectiveness and mom's future plans

I'd like to finish the interview with a couple of general questions - one about the MIHOW program and one about your future plans.

17. As a mom whose been participating in the MIHOW program for ____ months now, what is your view about how well the program is doing?
- a. What do you think is working well? (details, stories)
 - b. What do you think could be improved? (details, stories)
18. The last question comes back to you again - I'm wondering how you see yourself in the future. What kinds of plans do you have at this point? (get details/stories – plans about jobs, school/education, family)
- a. What, if anything, do you think might *get in the way* of you reaching the goals you have for yourself in the future? (details, stories)
 - b. What kinds of things might *help* you reach your goals? (get stories, details)

Home Visitor Interview Guide #1

Ethnographic Explanations:

Well first I want to thank you for taking your time to talk with me today. As we spoke about before, the purpose of this study is to look at the MIHOW program and get a better understanding of how it works, especially from the point of view of someone who is directly involved in it like you are. We just really want to “pick your brain” about the program. This information you give us will help us understand the program, how it works, what works well and what can be better. This and all interviews will be confidential and no information will be shared with anyone, including your supervisor, other staff, or the mothers you work with. All information you give us and any personal information about you will be kept completely confidential. This process is voluntary and you can stop participating in this interview or any other portion of this study at any time. We are tape recording this interview just to make sure we get an accurate account of what you say. Is this okay with you? Do you have any questions for me before I start recording?

Don't forget to ask for **EXAMPLES** throughout the interview!!!

Remember to exhaust all categories (Anything Else?)

- Tell me a how you got involved with the MIHOW program.
- After you decided to work with the program, what did you expect the program to be like before you started?
 - How is the program different than what you expected?
 - How is the program similar to what you expected?
- How would you explain the program to someone who has never heard of it before?
 - How does it work?
 - What services have you provided so far, if any?
- What types of training do you receive as a home visitor?
- I've never been on a MIHOW home visit. Walk me through what that is like. (could also open the door for asking about observing home visit at some point)
 - General questions about home visitor if this information isn't provided
 - I haven't met the women you meet with, what are they like?
 - How well they get along?
 - Development of rapport?
 - Social bonding/support?
- What kind of information does the mother provide you with?
 - How do you use this information?
 - What of this information do you agree with?
 - What do you disagree with?
- Do you think you have learned anything new from being involved with MIHOW?
 - Tell me more about that?
- Do you have any sense of what the mothers are learning or getting out of the program?
- What are some things you would like to see the MIHOW program include?

- What is your favorite part of the program so far?
- What is your least favorite part of the program so far?
- Have you had any experience since you've been involved with the MIHOW program that really stands out? If yes, what was it?
- Would you recommend the program to others?
- Anything you would like to add that I didn't ask?

Home Visitor Interview #2 Guide

(For HV's that have had a 1st interview, review transcript and open with something that lets them know you recall what they have said about their experiences with MIHOW already.)

1. Tell me about the training you've received as a home visitor? (Examples)
2. What do you think are the most beneficial parts of the initial MIHOW training?
3. What parts of your training (initial or continuing) do you think could have been better? (Examples)
4. Can you talk to me about any new information you've learned from participating in the MIHOW trainings? (Tell more about that, can you give me an example?)
5. Tell me about the continuing education you receive as a MIHOW home visitor.

6. The training literature talks about Home Visitors (Outreach Workers) recognizing and building on mothers' strengths. Would you explain how you may recognize moms' strengths and how you work with them to build upon them?
7. Would you be able to provide examples of ways in which moms have used their strengths to work toward their life goals?
8. Based on understanding moms' goals for themselves now and in the future, what kind of community resources have they been referred to?
 - a. What kind of experiences have they had with accessing community resources?
9. The training literature also talks about home visitor's helping moms with balancing home and work. Could you tell me how you help moms with this? (Get examples)
10. Could you tell me your thoughts about the MIHOW curriculum? (How is it used)?
11. Do you feel you have the support you need to do your job effectively? (Get examples of how they do or do not get the support they need AND get examples of what kinds of support do they believe are needed)

12. Do you see the MIHOW program as having any influence on child development? If so, how? (If they respond yes, probe further asking how it relates to the areas of cognition, social-emotional, and physical development.)
13. Do you see MIHOW having any influence on language development? If so, how? (GET EXAMPLES)
14. Do you feel MIHOW's training prepared you to work on promoting language development? If so, how? If not, were you prepared in other ways? Tell me about those ways.)
15. How would you describe your relationship with moms? What do you think makes a difference in your relationships with them? (successful versus unsuccessful)
16. What do you see as the most beneficial information you discuss with the mothers? The least? Why?

APPENDIX C: Mom and Home Visitor Consent Forms

Informed Consent to Participate in a Research Study

Randomized Control Group Evaluation of the Maternal Infant Health Outreach Worker (MIHOW) In-Home Visitation Program

Marty Amerikaner, Ph.D. Principal Investigator

Introduction

You are invited to be in a research study. Research studies are designed to gain scientific knowledge that may help other people in the future. You may or may not receive any benefit from being part of the study. Your participation is voluntary. Please take your time to make your decision, and ask your research investigator or research staff to explain any words or information that you do not understand.

Why Is This Study Being Done?

The purpose of this study is to help determine the value of an in-home visitation program during pregnancy and infancy for the health and well being of babies and parents.

How Many People Will Take Part In The Study?

About 200 people will take part in this study. A total of 200 subjects are the most that would be able to enter the study.

What Is Involved In This Research Study?

In this study, all participants will be contacted up to 4 times. This will include once at the time they begin participating in the study, once about a month after the baby is born; once when the baby is around 1 year old, and one final time when the baby is approximately 18 months old. Each contact will either be by phone or in person at a time and place that is convenient for the participant. Participants will be interviewed about topics such as their own health, their babies development and their parenting behaviors.

Participants will be in one of two educational groups. Half of the participants will be enrolled in the Maternal Infant Health Outreach Worker (MIHOW) program; in this program, a specially trained community person will visit participants regularly to provide support, education and assistance in preparing for parenting the new baby. The other half of the participant group will receive educationally oriented informational packets about babies and parenting in the mail. All participants will receive practical “thank-you” gifts (such as extra diapers) each time they participate in our data collection interviews.

Women who agree to participate will be randomly assigned to one of the two groups discussed above. This assignment is not made until after you agree to participate; neither you nor any project staff people know which group you will be in at this time, and it is not possible to change groups once the assignment is made.

How Long Will You Be In The Study?

You will be in the study until just after your baby reaches 18 months of age. You can decide to stop participating at any time. If you decide to stop participating in the study we encourage you to talk to the study investigator or study staff as soon as possible.

The study investigator may stop you from taking part in this study at any time if he/she believes it is in your best interest; if you do not follow the study rules; or if the study is stopped.

What Are The Risks Of The Study?

There are no known risks to those who take part in this study.

Are There Benefits To Taking Part In The Study?

If you agree to take part in this study, there may or may not be direct benefit to you. We hope that the educational materials are beneficial to all participants and that the information learned from this study will benefit other people in the future. The benefits of participating in this study for participants in the MIHOW program may include additional knowledge about parenting and about the development and health of infants. The benefits of participation in this study for participants who are not enrolled in the MIHOW program will include receipt of practical “thank you” gifts for participating, the opportunity to learn more about parenting as well as infant health and development from the written material we will send. All participants will benefit from receipt of thank-you gifts such as diapers or similar practical items.

What About Confidentiality?

We will do our best to make sure that your personal information is kept confidential. However, we cannot guarantee absolute confidentiality. Federal law says we must keep your study records private. Nevertheless, under unforeseen and rare circumstances, we may be required by law to allow certain agencies to view your records. Those agencies would include the Marshall University IRB, Office of Research Integrity (ORI) and the federal Office of Human Research Protection (OHRP). This is to make sure that we are protecting your rights and your safety. If we publish the information we learn from this study, you will not be identified by name or in any other way.

What Are The Costs Of Taking Part In This Study?

There are no costs to you for taking part in this study. All the study costs, including any study tests, supplies and procedures related directly to the study, will be paid for by the study.

Will You Be Paid For Participating?

You will receive no payment or other compensation for taking part in this study, other than the “thank you” gifts provided to all participants that were mentioned earlier.

Who Is Sponsoring This Study?

This study is being sponsored by the West Virginia Office of Maternal, Child and Family Health. The sponsor is providing money or other support to help conduct this study. The researchers do not, however, hold a direct financial interest in the sponsor and have no financial interests in the outcome of the study.

What Are Your Rights As A Research Study Participant?

Taking part in this study is voluntary. You may choose not to take part or you may leave the study at any time. Refusing to participate or leaving the study will not result in any penalty or loss of benefits to which you are entitled. If you decide to stop participating in the study we encourage you to talk to the investigators or study staff first.

Whom Do You Call If You Have Questions Or Problems?

For questions about the study or in the event of a research-related injury, contact the study investigator, Dr. Marty Amerikaner at (304) 696-2783. You should also call the investigator if you have a concern or complaint about the research.

For questions about your rights as a research participant, contact the Marshall University IRB#2 Chairman Dr. Stephen Cooper or ORI at (304) 696-4303. You may also call this number if:

- You have concerns or complaints about the research.
- The research staff cannot be reached.
- You want to talk to someone other than the research staff.

You will be given a signed and dated copy of this consent form.

SIGNATURES

You agree to take part in this study and confirm that you are 18 years of age or older. You have had a chance to ask questions about being in this study and have had those questions answered. By signing this consent form you are not giving up any legal rights to which you are entitled.

Subject Name (Printed)

Subject Signature

Date

Person Obtaining Consent (Printed)

Person Obtaining Consent Signature

Date

Informed Consent to Participate in a Research Study

Randomized Control Group Evaluation of the Maternal Infant Health Outreach Worker (MIHOW) In-Home Visitation Program

Marty Amerikaner, Ph.D. Principal Investigator

Introduction

You are invited to be in a research study. Research studies are designed to gain scientific knowledge that may help other people in the future. You may or may not receive any benefit from being part of the study. Your participation is voluntary. Please take your time to make your decision, and ask your research investigator or research staff to explain any words or information that you do not understand.

Why Is This Study Being Done?

The purpose of this study is to help determine the value of an in-home visitation program and to better understand the experiences of MIHOW staff, home visitors, and administrators.

How Many People Will Take Part In The Study?

Approximately 30 people will take part in this study. A total of 30 subjects are the most that would be able to enter the study.

What Is Involved In This Research Study?

In this study, all participants will be contacted up to 3 times. Each contact will either be by phone or in person at a time and place that is convenient for the participant. Participants will be interviewed about topics such as their own training, their experiences with MIHOW as a home visitor, their interaction with families, the support they receive from MIHOW, and how they experience and understand MIHOW's goals and mission.

Participants will be from one of the two selected WV Maternal Infant Health Outreach Worker (MIHOW) program sites. Participants will include MIHOW staff, home visitors, and administrators. By agreeing to be interviewed you are agreeing to being a part of the study.

How Long Will You Be In The Study?

You will be in the study until just after your final round of interviews.

You can decide to stop participating at any time. If you decide to stop participating in the study we encourage you to talk to the study investigator or study staff as soon as possible.

The study investigator may stop you from taking part in this study at any time if he/she believes it is in your best interest; if you do not follow the study rules; or if the study is stopped.

What Are The Risks Of The Study?

There are no known risks to those who take part in this study.

What About Confidentiality?

We will do our best to make sure that your personal information is kept confidential. However, we cannot guarantee absolute confidentiality. Federal law says we must keep your study records private. Nevertheless, under unforeseen and rare circumstances, we may be required by law to allow certain agencies to view your records. Those agencies would include the Marshall University IRB, Office of Research Integrity (ORI) and the federal Office of Human Research Protection (OHRP). This is to make sure that we are protecting your rights and your safety. If we publish the information we learn from this study, you will not be identified by name or in any other way.

What Are The Costs Of Taking Part In This Study?

There are no costs to you for taking part in this study. All the study costs, including any study tests, supplies and procedures related directly to the study, will be paid for by the study.

Will You Be Paid For Participating?

You will receive no payment or other compensation for taking part in this study, other than the “thank you” gifts provided to all participants.

Who Is Sponsoring This Study?

This study is being sponsored by the West Virginia Office of Maternal, Child and Family Health. The sponsor is providing money or other support to help conduct this study. The researchers do not, however, hold a direct financial interest in the sponsor and have no financial interests in the outcome of the study.

What Are Your Rights As A Research Study Participant?

Taking part in this study is voluntary. You may choose not to take part or you may leave the study at any time. Refusing to participate or leaving the study will not result in any penalty or loss of benefits to which you are entitled. If you decide to stop participating in the study we encourage you to talk to the investigators or study staff first.

Whom Do You Call If You Have Questions Or Problems?

For questions about the study or in the event of a research-related injury, contact the study investigator, Dr. Marty Amerikaner at (304) 696-2783. You should also call the investigator if you have a concern or complaint about the research.

For questions about your rights as a research participant, contact the Marshall University IRB#2 Chairman Dr. Stephen Cooper or ORI at (304) 696-4303. You may also call this number if:

- o You have concerns or complaints about the research.
- o The research staff cannot be reached.
- o You want to talk to someone other than the research staff.

You will be given a signed and dated copy of this consent form.

SIGNATURES

You agree to take part in this study and confirm that you are 18 years of age or older. You have had a chance to ask questions about being in this study and have had those questions answered. By signing this consent form you are not giving up any legal rights to which you are entitled.

Subject Name (Printed)

Subject Signature

Date

Person Obtaining Consent (Printed)

Person Obtaining Consent Signature

Date

VITA

Debra L. Lockwood

Education

Doctorate in Education (2015)
Marshall University Graduate College
South Charleston, West Virginia
Major Area: Curriculum and Instruction
Minor Area: Special Education
Cumulative GPA 4.00

Doctorate in Education (coursework completed)
West Virginia University (2005)
Educational Theory & Practice
Morgantown, West Virginia
Special Education (Major)
Educational Leadership (Minor)
Cumulative GPA 4.00

Master of Arts in Education
Special Education (1997)
Marshall University
Huntington, West Virginia
Preschool Special Education
Multi-categorical Certification in Mental Impairments,
Learning Disabilities and Behavior Disorders
Cumulative GPA 4.00

Bachelor of Arts in Education (1995)
Marshall University
Huntington, West Virginia
Elementary K-8
Mental Impairments K-12
Cumulative GPA 3.08

Work Experience

2007-2015 Marshall University
 Assistant Professor
 Special Education

Huntington, W.V.

- 2005-2007 Special Education Teacher
West Middle School
Cabell County Public Schools
Huntington, WV
- 2005-2007 Marshall University
Adjunct Professor
Special Education
Huntington, WV
- 2004-2005 Marshall University
Assistant Professor
Special Education
Huntington, WV
- 2003- 2004 Instructor
Marshall University Graduate School
Special Education Programs
So Charleston, WV
- 1999-2003 Marshall University
Assistant Professor
Special Education
Huntington, WV
- 1995-1999 Special Education Instructor
Enslow Middle School
Cabell County Public Schools
Huntington, WV

Publications

Conner, D., Ludlow, B.L., & Schechter, J. (2005). Low incidence disabilities and personnel rural areas: Current status and future trends. *Rural Special Education Quarterly*, 24 (3), p. 15-24.

Heaton, L., Bolen, J., Carlson, A., Lawson, K., Lockwood, D., McCormick, R., Rhodes, M., & Shafer, S. (2012). Title: Exploring The Application of Gaming and Gaming Principles in Education Published in the Conference Proceedings for EdMedia National Conference in Denver, Colorado. June 22-26, 2012.

Lockwood, D. (2013). Book review: Special education in contemporary society: An introduction to exceptionality, Gargiulo, R.M. (2012). Thousand Oaks, California: Sage Publications. *National Social Science Association, 40(2)*, 108-109.