RISE Home Visiting Evaluation Summary: *Final Report*

This executive summary includes selected findings from the Researching Implementation Support Experiences (RISE) Home Visiting Evaluation follow-up study. The RISE Home Visiting Evaluation was a three-year study that ran from fall of 2013 to fall of 2016 and concluded with a final report. During fall of 2016 to fall of 2017, a follow-up evaluation occurred to collect an additional year of outcome data, four years after the initial implementation of the intervention, the Implementation HUB (HUB). The follow-up evaluation explored factors related to longer-term outcomes as well as unique factors necessary to support rural home visiting programs in implementing evidence-based home visiting.

Introduction

Washington State Department of Early Learning (DEL), in partnership with Thrive Washington (Thrive), is using MIECHV funds to support an Implementation HUB that works to:

- broaden **the availability of home visiting** services,
- develop **community capacity** for implementing home visiting services, and
- support the **quality and accountability** of home visiting program implementation.

The Implementation HUB is a centralized support system for home visiting programs to improve **organizational capacity, model fidelity**, and **quality of service delivery**. Supports include continuous quality improvement (CQI), program monitoring, model-specific supports, coaching, training, and technical assistance (TA) using Implementation Science frameworks. The follow-up evaluation included both an outcome evaluation and rural case study. The **outcome evaluation** measured the impact of the HUB on three major outcomes: use of training and TA; model fidelity and implementation quality; and program staff competency and self-efficacy. The primary research question was:

> *How do the identified programs in Washington that receive support from the Implementation HUB differ from comparison programs in other states with regard to the three major outcomes?*

The **rural substudy** used mixed methods to learn more about the experiences of rural programs to answer the primary research question:

> *What are the unique features of implementing evidence-based home visiting in rural communities?*

Although the HUB is part of a system that supports home visiting using both evidence-based programs and promising practices, the **evaluation** focused on programs in Washington state that are implementing two evidence-based programs—Parents as Teachers (PAT) and Nurse-Family Partnership (NFP) which are the target of the state's MIECHV expansion funding. Comparison programs for the outcome evaluation were also PAT or NFP programs. Most comparison programs

received MIECHV funding, and were similar on key program characteristics (e.g., capacity, geography, length of time providing services).

Outcome Evaluation

In the outcome evaluation, SRI used a quasi-experimental design to understand differences between the home visiting programs that received TA and support from Washington's Implementation HUB and comparison programs in other states. The primary research question for the outcome evaluation was: *How do the participating programs that receive support from Washington State's centralized support system (Implementation HUB) differ compared with similar programs in other states on the outcomes of interest*:

- use of and satisfaction with training, TA, and coaching;
- model fidelity and implementation quality; and
- staff competency and self-efficacy.

Data were collected about programs and staff at the beginning, referred to as Time 1, of implementation and then again at the end of the project, referred to as Time 3 for all data sources except the Home Visiting Snapshots, which were collected twice, fall 2015 for Time 1 and then again in the add-on year in Fall 2016 for Time 2. Data for the outcome evaluation were collected through a number of sources, including

- **TA logs (2014–15 and 2016–17)**: documented amount, format, content, and source of TA.
- **Home Visiting Snapshot Form (Fall of 2015 and 2016)**: collected data on home visit content and activities, assessment of family needs and strengths, referrals and outreach, and use of progress monitoring and assessments.
- **National Service Office (NSO) Data Exports (2012–13 and 2015–16)**: included data routinely submitted by programs to the PAT or NFP national office on model fidelity and implementation quality.
- **Program Practices Survey (2014 and 2017)**: collected data on perception of TA and support, supervision practices, self-efficacy, and best practices.

Selected Findings from the Outcome Evaluation

Using multiple methods in a longitudinal design, we compared findings from 18 programs and staff in Washington receiving support from the HUB (intervention programs) with 32 programs and staff in other states (comparison programs).[1]

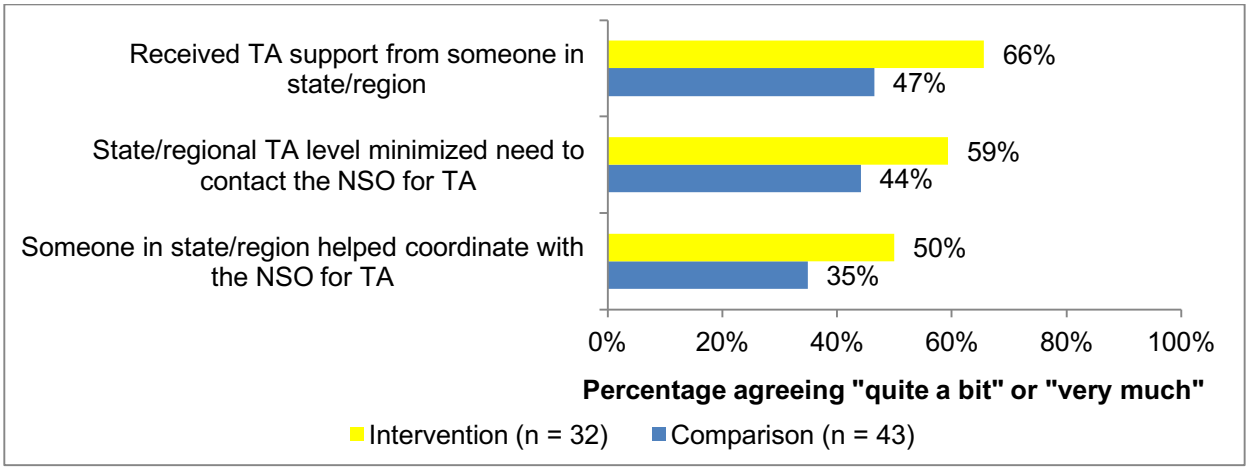
[1] At the start of the add-on year in Fall 2016, comparison programs were asked to continue participating in data collection activities. At that time, 8 of the 32 comparison programs (5 NFP programs, 3 PAT programs) declined to continue.

What impact did the HUB have on TA? How did the amount, content, format, source and quality of TA compare to TA for programs in other states?

Evidence from the final year of the evaluation indicates that the HUB actively provided TA and support across many different formats and topics to program staff.

- Data showed that staff members across the states in the sample and in **both groups were receiving TA throughout the project period** although the intervention programs reported an increase in TA (average hours per staff per month) from Time 1 to Time 3 and the comparison programs reported a decline in the amount of TA from Time 1 to Time 3.
- Intervention programs received much of their TA from the HUB at Thrive, including state model leads, whereas staff at comparison programs received TA from a broader range of sources. At Time 3, intervention programs reported a decrease in TA from state model leads and a corresponding increase in TA from the NSOs and government agencies likely due to changes in staffing and interim vacancy for one of the state model lead positions.
- Staff members from intervention programs were much more likely than staff from comparison programs to report **having support from someone in their state/region that minimized their need for NSO TA** or helped them coordinate with the NSO for TA (Exhibit 1).
- Most of the TA continued to be provided to program supervisors and sometimes to administrators.
- Similar to previous time points, only about one-third of staff in both the intervention and comparison groups described the TA they received as **relationship-based** or **tailored to their individual needs**. However, the percentage of staff in intervention programs who endorsed their TA as "mostly" or "always" relationship-based did increase about 5% while staff in the comparison programs decreased by the same amount.
- In terms of **content** of TA, **building home visitor and supervisor competencies** and **meeting model requirements** were key topics for TA at both Time 1 and Time 3 and in both groups. There was an increased focus on contract requirements for intervention supervisors from Time 1 to Time 3. For home visitors in the intervention group, there was a decreased focus on program administration and connections/referrals from Time 1 to Time 3.

Exhibit 1. State/Regional TA Support Received by Program Supervisors/Administrators at Time 3



Source: Program Practices Survey, Spring 2017

Note: No between-group differences reached statistical significance.

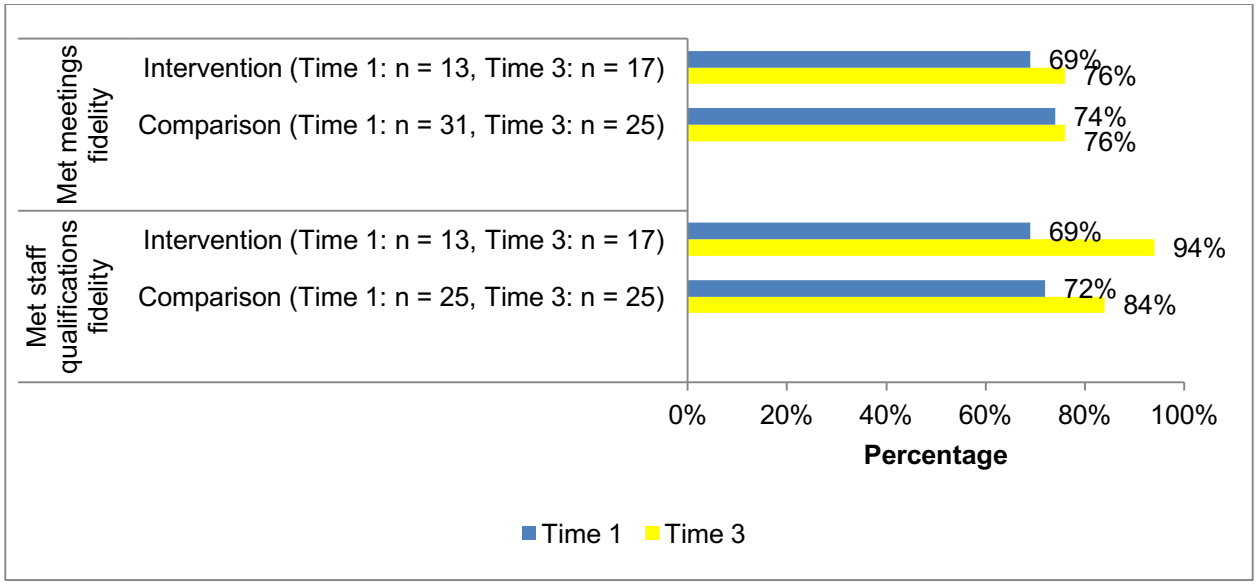
The HUB is providing centralized support to home visiting programs in the state of Washington, but the nature of the support is still developing. The increase in TA from Time 1 to Time 3 is promising and suggests the HUB continues to evolve and develop to serve the needs of program staff. The increase in TA in the Washington programs and decrease in TA over time in the comparison programs suggests that the HUB may allow for more sustainability of needed TA.

Were intervention programs with access to the HUB's TA different from comparison programs in model fidelity and implementation quality?

The evaluation also considered **model fidelity and implementation quality**. Data suggest that **most programs in both groups met the targets set forth by NFP and PAT**. While there are some limitations in interpretation given the ways in which NSOs gathered these data and in how much we know about the stage of the family being visited, these data are consistent with common challenges observed in maximizing participation from families in home visiting programs.

- Both intervention and comparison programs generally had fidelity that was consistent with their home visiting model guidelines at Time 1 and Time 3.
- Most programs met model-specific guidelines when it came to staff and/or cross-team meetings and staff qualifications (Exhibit 2).
- Most program staff also reported that they had a clear, systematic approach for training new staff.
- Information from home visits showed that home visitors were reporting consistently assessing family strengths and needs, building strong participant-provider relationships, and covering content during visits that was consistent with model expectations.
- Both intervention and comparison programs were implementing home visiting practices as expected by their home visiting models and in keeping with quality practices.
- The main area for improvement for both intervention and comparison programs continued to be enrollment, and maintaining and engaging families.

Exhibit 2. Percentage of Programs That Met Meeting and Staff Qualifications Criteria, by Time and Condition



Source: Data export (2012-13 and 2015-16).

Note: No between-group differences at Time 1 or Time 3 reached statistical significance.

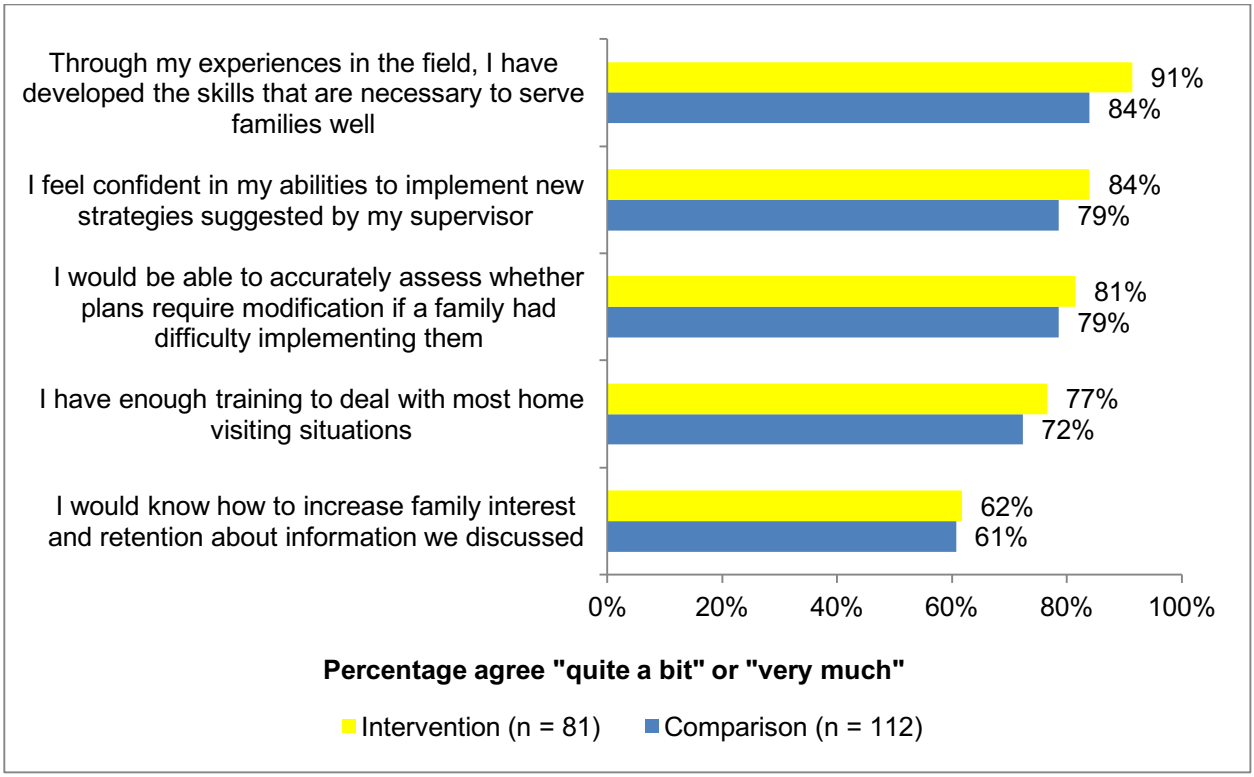
Were intervention programs with access to the HUB's TA different from comparison programs in staff competency and self-efficacy?

With regard to **staff competency and self-efficacy**, we found that staff report **confidence** and **comfort implementing evidence-based practices**. Data about staff competency and self-efficacy suggest staff in both intervention and comparison programs have a high level of **self-efficacy** about their work and there is evidence that staff believe in implementing evidence based practices, and personally feel that it is important to use interventions in the same way they were done in the studies in their own home visits.

- Results showed that programs receiving HUB TA and support have staff members who feel relatively confident in their own abilities to implement the model and work with families.
- Staff in both intervention and comparison programs reported having a fairly high level of understanding about model goals and requirements.
- Most home visitors reported using quality practices in their work with families and an even greater understanding of how their specific practices relate to the goals of the NFP/PAT models.
- Supervisors confirmed these ideas as well, indicating that their staff showed competence implementing the model effectively with children and their families.
- Most program staff in both groups support use of evidence-based practices. In particular, intervention home visitors were more likely to report families engaging in new activities both at Time 3 compared to Time 1 and compared to the comparison group at Time 3. Also, the data indicate that over time there were increases in endorsement of evidence-based practices in both groups (Exhibit 3).

- Most staff reported that they both schedule and actually participate in supervision meetings at least a couple times a month, consistent with model guidance. However, there was a slight decrease in regular supervision (both scheduled and actual) at Time 3 in the intervention group as reported on the Program Practices Survey.

Exhibit 3. Home Visitor Report of Self-Efficacy Implementing Best Practices at Time 3



Source: Program Practices Survey, Spring 2017.

Note: No between-group differences reached statistical significance.

Taken together, the current evidence does not suggest that staff with support from the HUB differ in major ways from staff at comparison programs. However, the data do suggest intervention and comparison programs are implementing a number of key model indicators with fidelity.

Rural Substudy

In the rural substudy, SRI used qualitative case study methodology to obtain perspectives of home visiting program, HUB and state staff. Quantitative analyses were also conducted by disaggregating the outcome evaluation data by rural and non-rural programs.

For the rural case study, data were collected in two phases. The first was a planning phase that consisted of interviews with key informants at DEL and the HUB, accompanied by a review of relevant written documents, to learn about the history of the rural development work and community planning process. The second phase consisted of site visits to four rural sites selected to represent four different categories, or types, of programs in Washington: 1) expansion site, rural

only, 2) expansion site, mixed rural and urban, 3) start-up site, participated in community planning process, and 4) start-up site, did not participate in community planning process.

In what ways were the rural case study site ssimilar and different from one another?

Our four profiled evidence-based home visiting (EBHV) programs were both similar to and very different from each other due to a number of factors that were as defining of their character as the rural status that united them. In order to paint a broader picture of rural programs' MIECHV implementation experiences, we purposely selected sites that represented a combination of start-up and expansion programs, NFP and PAT models, those serving a mainly rural community versus a mixed rural and urban community, and programs that did or did not participate in the community planning process. The four sites[2] and their primary characteristics were as follows:

- Alder Community Health Center (ACHC): PAT start-up program that served a mainly rural community and participated in the community planning process
- Cedar County Health Department: NFP start-up program that served a mainly rural community that did not participate in the community planning process
- Pine County Health Department: NFP expansion site that served a mixed rural/urban community
- Spruce Family Services: PAT expansion site that served a mainly rural community

Additionally, the specific community context of each of the four programs varied greatly; for example, ACHC served a predominantly Hispanic migrant population in an agricultural community, while Spruce had a significant number of migrant clients but still served mostly White families living in an area that was rural but very popular with tourists. Despite the differences, we did see some commonalities across the four programs:

- Staff at all four programs cited seeing positive change in the behavior and circumstances of their clients as their primary and most important success.
- Some challenges common to all sites were the data collection and documentation burden, and the stress inherent to working with high-needs clients experienced by home visitors.
- Common challenges related to being a rural program included having fewer available resources in the community, needing to refer clients outside of the community especially for specialty services, transportation challenges for both clients and home visitors, and a restricted labor pool which affected the ability to hire and retain qualified EBHV program staff.

[2] Pseudonyms are used for confidentiality.

What are important factors to consider for leadership and administration to facilitate implementation of evidence based home visiting (EBHV) in rural communities?

- Successful hiring and retention of the appropriate staff is important for a program's long-term success. Using nurses, who have high levels of formal education, as staff compounds hiring difficulties in rural communities that already have a restricted labor pool. The PAT model allows for more flexibility in hiring.
- Once hired, staff who feel supported are more likely to stay. Pay and quality of life (e.g., hours worked, travel burden, paperwork burden, feeling supported by leaders and peers) have an impact on staff mental health and morale.
- Staff dissatisfaction leads to turnover, which then contributes to client attrition (i.e., many clients of departing home visitors exit the program due to loss of the relationship) and lower program capacity (i.e., new home visitors need training and carry lower caseloads.

> *The reflective supervision and the support from the supervisors is key [...] without those, I don't know that we could continue with the program, and the encouragement with self-care. There's just so many opportunities for training. I've never worked in a program where there was more opportunity to be an ongoing learner.*

- The travel time involved in providing home visiting services in rural area is a feature that can present a barrier to quality implementation.[3] Travel time and dispersion of clients was a common cross-cutting challenge identified in the rural case study site visits. The added travel time may reduce the time available for important activities outside of home visits, such as supervision. In the outcome analysis, home visitors at rural sites were significantly less likely to report actually meeting with their supervisors a couple times a month or more frequently that home visitors in non-rural programs.

What are important factors to consider and address at an organizational level facilitate implementation of evidence based home visiting (EBHV) in rural communities?

> *I think this is the one job that has so much paperwork… [We're] grant-funded and so it is very, very overwhelming. You talk about the demand and it partly relies on us to just be organized and do our paperwork but I think sometimes there just isn't a balance where we carry, you know, a high caseload and then we have all this documentation and data to input on a daily basis. […] For me, I think that is my biggest challenge – documentation.*

- A growing proportion of home visitor staff time is now spent on documentation and data collection, although thus far, programs have had limited success in using these data to inform their practice.
- The ability to maintain full caseloads and operate at maximum capacity is important for a program's long-term success, and a strong referral network is necessary for maintaining full caseloads. Referrals are a product of trust built

[3] While all of the case study sites serviced rural areas, one of the sites, Spruce Family Services, also services a predominantly frontier and remote area as designated by the United States Department of Agriculture Economic Research Service.

between two agencies; this relationship-building requires time and energy and is often disrupted when key staff turn over.

- Rural communities often have more success implementing NFP using a "regional" or "mentoring" approach, in which a higher capacity county supports a neighboring lower capacity county via contracting of staff or supervisors.

What are important considerations for supporting the start-up of EBHV in rural communities?

- The community planning process created many of the "conditions of success" described above, such as successful hiring and retention of staff, and ability to maintain full caseloads and operate at maximum capacity, and positioned the agency to more efficiently and effectively start up and sustain their EBHV program. HUB staff observed there were benefits to participating in the community planning process even for communities that went through the process but were not awarded MIECHV funding, because their level of preparation left them well-positioned to seek other sources of support.
- A challenge of the community planning process was that, with only two models, it was difficult for the facilitators to avoid giving the impression that the PAT and NFP models were in competition with one another.

> *For us, [the community planning process] was a win-win because along the way we establish the collaboration between the community partners. On day one, we already had people, eligible families for the program. In fact, by the time we trained - the first group of [home visitors], within a month, I think, we already had half a-a caseload waiting to enroll in the program.*

Were rural program outcomes different from non-rural programs?

Overall, there were few differences between rural and non-rural programs in Washington, which suggests that by enlarge the implementation drivers of successful implementation of evidence based home visiting are not unique to rural areas.

- While providing evidence based home visiting services in a rural setting may present additional or unique implementation challenges, the lack of significant differences on model fidelity and implementation quality items suggest that rural programs are just as capable of reaching fidelity and quality implementation.
- There were several notable differences found on outcome items related to use and satisfaction with training, TA and coaching. Rural program staff were found to receive more TA hours than non-rural staff, but more of their TA is received in remote formats. On average, rural staff receive a fair amount of in-person workshops and trainings, but receive noticeably less in-person individualized TA. Although most of their TA is provided remotely, rural program staff were more likely to be satisfied with in-person workshops than non-rural staff (Exhibit 4).
- By enlarge, rural and non-rural staff were not significantly different on outcome items relating to staff competency and self-efficacy. Rural home visiting staff were found to be lower on two items but higher on another. Rural home visitors were less likely to report

actually meeting with their supervisors as planned and may not be doing as much facilitation of effective parent-child interactions during home visits as their non-rural counterparts. Yet, a strength found was that rural program staff were more likely to report positive attitudes toward implementing evidence-based home visiting than non-rural staff.

Exhibit 4. Percentage of TA Events by Format for Rural vs. Non-rural Staff at Time 3

TA Format	Rural Supervisors (%) *n* = 11	Non-rural Supervisors (%) *n* = 12	Rural Home Visitors (%) *n* = 63	Non-rural Home Visitors (%) *n* = 51
In-person workshops, meetings, trainings	33	35	59	52
Remote individualized	27	10	3	3
Remote workshops, meetings, trainings	31	24	32	12++
On-site/in-person individualized	6	29	5	26+++
Other	2	2	1	6

Source: TA log data (2016–17).

Note: Differences tested for statistical significance were those between rural and non-rural supervisors (*$p < .10$; **$p < .05$; ***$p < .01$) and between rural and non-rural home visitors at Time 3 (+$p < .10$; ++$p < .05$; +++$p < .01$).

What are the Key Implications or Recommendations?

Based upon the information from the additional year of the outcome evaluation from a wide variety of sources at both the individual- and program-level, and the findings from the rural substudy, we developed a set of key implications and recommendations for the HUB and state to consider as it continues to build its home visiting system and supports.

Key Implications	Rationale & Strategies
Support transmission of skills and knowledge from supervisors to home visitors.	Develop a consistent message about expected indirect benefits from TA. Provide HUB TA staff with strategies to use with supervisors to encourage further transmission of ideas and changes.
Support change in both program and system level outcomes.	Clarify how HUB work is connected to program and systems level outcomes and specify the amount of time HUB staff are expected to focus on program-focused vs. systems-focused activities.
Support change in practice around a specific topic.	Generate an annual TA plan with emphasis on specific topics. Include planned activities that supplement individualized TA work.
Use the community planning process whenever time and resources permit.	Dedicating time and energy to Exploration, as a stage leading up to and distinct from Installation, is worth the upfront investment, because it creates conditions that enable the agency to implement its chosen EBHV model more efficiently and effectively. Additionally, using the community planning process to prepare multiple communities to apply for competitive grant funding gives the granting entity latitude to fund only those communities that have demonstrated readiness to implement. to Implementation Science and document them for future use.

Key Implications	Rationale & Strategies
Get true buy-in, in the form of a deep commitment to facilitating a program's success, from the agency's key decision-makers, as this can be critical for the program's longevity.	Without a willingness from leaders to find creative solutions to problems that may arise, and at times, to challenge the status quo, some roadblocks to implementation may prove insurmountable.
Communities should choose an evidence-based home visiting model keeping both client needs and program staffing needs in mind.	They must be able to meet the needs of the families, and the requirements of the model, with the applicants available to them in their particular community in balance in program planning.
Support home visiting staff with a robust system of supervisory and peer supports to reduce burnout and turnover.	Opportunities for skill development, collective problem solving, and emotional "unloading" are important, as are policies demonstrating respect for home visitors' overall quality of life. The HUB and local program leaders can create a supportive environment for staff through both formal and informal means. The formal supports include reflective supervision and opportunities for professional development, while the latter includes instituting policies that value home visitors' daily experience and setting a warm and caring tone in the workplace.
Employ home visitors with varied backgrounds and a deep skill set to serve clients well, and support their continued professional growth and self-care.	Strategies can include holding meetings to address specific topics such as how to set boundaries with clients, and providing regular opportunities for home visitors to lighten their emotional burden through effective supervision and conferencing with peers.
Programs need a strong referral network to sustain their caseloads.	Relationship building with external partners is particularly important if there is no internal source of referrals.
If possible, co-locate an EBHV program with other maternal or child services within an agency.	Advantages include a ready source of referrals and a single point of entry into a network of services that may represent a more holistic approach toward serving families.
Open communication channels among local agencies to dispel the tendency to compete with one another for clients, and build referral relationships instead.	This may be best accomplished via third-party facilitation by a common funder, such as the Thrive HUB, or through existing community coalitions. Guidelines for matching clients to programs should be mutually agreed upon, so that slots at all agencies are filled, and families receive services that are the best fit for their needs.
Rural home visiting can be isolating work; programs value and are eager for more opportunities to stay connected and share across-programs.	Rural programs received more remote TA than non-rural programs but report the highest satisfaction with in-person workshops. Thus, it may be worth increasing opportunities for in-person TA when possible as the results suggest it may have a greater impact.

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