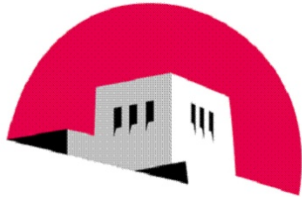

Catholic Health Initiatives St. Joseph's Children Home Visiting Program Implementation Review

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Introduction

Catholic Health Initiatives St. Joseph's Children (CHI SJC) is a faith-based, non-profit organization whose goal is to ensure that children reach kindergarten with the health and family capacity necessary to support learning. CHI SJC has three primary programs: Home Visiting, Enhanced Referral Services, and Advocacy. The Home Visiting and Enhanced Referral Services program are the subject of this report. CHI SJC is self-funded, its services are secular, and CHI SJC does not accept government funding.

The Home Visiting program is based on the **First Born Program** model (FBP) with other components. In 2002, FBP was named one of the nation's 10 most innovative and exemplary prevention programs by the Center for Substance Abuse Prevention and other collaborative national agencies. The success of the program is based on several key characteristics. FBP is community based and works toward meeting local priorities through community involvement and collaboration. It is evidence based, with strong medical community support, rigorous staffing requirements, and clinical training protocols. The program uses family education resources, including three core curricula: First Born Prenatal Curriculum, First Born First Year of Life Curriculum, and First Born Toddler Curriculum. Additionally, the program has clearly articulated theory, implementation protocols, culturally sensitive components, program fidelity, high retention rates, and integrity. The CHI SJC program is a universal access program that targets particular populations.

The FBP model is based on a simple equation: when the program's resources are combined with local assets, the culmination is a strong, community-based project. An effective and sustainable program is dependent upon its relationship with local stakeholders and the involvement of all community networks. Each community has an array of local public, private, and nonprofit organizations with their own resources—personnel, space, expertise, equipment, economic power, etc.—that can contribute to the success of FBP. After first tapping into these local assets, the program and the community may need to look outside the immediate area to satisfy additional resource needs. In this way, the FBP then becomes the community's bridge to external assets.

CHI SJC uses a team of trained Home Visitors to provide services and adheres to the FBP model. CHI SJC has become a hybrid of the FBP model through the use of a variety of enhancements. First, the program utilizes a Family Liaison/Registrar (Intake Specialist). According to program administrators this position is responsible for contacting families referred to the organization, scheduling a registration visit with the referred family in their home or another location, completing the registration, and finally, documenting all family contacts and notes from the registration visit in the CHI SJC information system. During the registration visit, the Family Registrar explains the program in detail, provides them with examples of the curriculums used, and if they register completes necessary consents and provides the family with the name, photo and business card of their Home Visitor. If the family registers, the assigned Home Visitor receives a text from the Family Liaison / Registrar with the family's name and contact information.

Second, the CHI SJC uses a Registered Nurse (RN) Home Visitor who provides a Postpartum and Well Baby Check for each family who needs this service. In the Fall of 2014, the program also implemented a Prenatal Visit. RN Home Visitor visits are scheduled in collaboration with the assigned Home Visitor. A Well Baby Check includes monitoring the baby's length, weight, head

circumference, and vital signs. The Postpartum check for the mother includes monitoring the mother's vital signs, screening for depression, and a discussion of breastfeeding. A prenatal visit includes screening and assessment of the mother's vital signs, depression, and domestic violence. The Nurse Home Visitor also serves as a Home Visitor with a reduced case load.

Third, the program employs Enhanced Referral Specialists (ERS) who are each assigned to support families in a specific geographic area by finding community resources to meet their needs. The Home Visitor submits a "task" electronically with the family need in the information system. Each electronic task may include one or more family needs. ERS staff assists and support each family as needed depending upon each family's ability to navigate access the resource that is needed. In order to meet each family's needs as quickly as possible, the four current ERS staff works as a team to assist and support each other in resource knowledge and access. Each family need is documented and followed up concerning the work that was done as well as when and how the information was conveyed to the family.

CHI SJC after a lengthy process chose a supplemental curriculum to address the need for a more varied curriculum. The program began using the **Partners for a Healthy Baby** curriculum developed by Florida State University in January 2015. The curriculum was chosen in October 2014 and staff was trained in December 2014. The research based Partners for a Healthy Baby curriculum was chosen because of five curriculum elements (Parental Resilience, Social Connections, Concrete Support in Times of Need, Knowledge of Parenting and Child Development, and Social and Emotional Competence of Children).

Services are free and offered to all women pregnant for the first time and first-time families within the program service area. Currently the program service area includes Bernalillo, Sandoval, Valencia, and Luna counties. At the program's core is the conviction that a healthy pregnancy and a healthy baby are not only critical to the immediate well-being of mother and child but are also integral to the long-term health and success of the family and community. The program curricula provides a comprehensive set of topics that families learn as well as specific tools, activities, and educational materials that home visitors can use to address them. The flexible and inclusive curricula can be adapted to each family's needs. As noted above the CHI SJC also includes a unique case management component designed to ensure families are referred to other needed services in the local community, a RN, a Family Liaison/Registrar, and a supplemental curriculum.

The model is outcomes-based and CHI SJC has asked the Institute for Social Research to conduct this preliminary research to study the implementation of the CHI SJC with the added Enhanced Referral Specialist component to ensure the program is following best practices and the FBP model.

This study is designed as a process evaluation. Process evaluations are conducted to measure service enhancement implementation. Implementing a program according to its design (and best practices) will improve outcomes more than if the program is not implemented according to the proposed design. Programs often do not produce expected outcomes because they vary in their emphasis on process and the length and detail of the planning and implementation. Process evaluations are aimed at understanding the internal dynamics of how the program operates. Process data permits judgments to be made about the extent to which the program is operating the

way it is supposed to be operating. Process evaluations also reveal areas in which relationships can be improved as well as highlighting strengths of programs that should be preserved. Process descriptions are also useful in permitting people not intimately involved in a program, for example: external funding sources, public officials, and external agencies, to understand how the program operates. By conducting a process evaluation we will be able to document implementation and adherence to design fidelity and known best practices.

While every home visiting program varies (in model, goals, outcome measures, definition of success etc.), research findings suggest that a broad set of key components, or best practices, have been associated with program success. Evidence supports that appropriate integration of specific components typically improves program goals and outcomes. Because of the nature of home visitation, most programs run into several common problems. In their review of home-visiting programs, Gaylor and Spiker (2012) explained that much of the uncertainty revolving around program outcomes was related to aspects of program implementation.

With this in mind, they identified several aspects of implementation with which programs struggled. First, programs may not identify and recruit their target population. Second, families may not receive the full number of planned visits. Third, planned activities and curriculum may not be presented according to the program model, and families may not follow through with their assigned activities outside of the home visit. Lastly, families may leave home visitation programs before their planned discharge date (Gaylor and Spiker, 2012).

And so, a very general and informal set of standards were developed—their universal applicability served as the foundation for which programs could build upon:

- Minimum requirements for frequency of visits
- Minimum education requirements for home visiting staff
- Supervision requirements for home visitors
- Pre-service training for home visitors
- Fidelity standards for local implementing agency
- System for monitoring fidelity
- Specified content and activities for home visits

From these, National, State, and program level evidence-based standards and practices have been developed.

The purpose of this study is to determine how well the CHI SJC program adheres to the program design and how well the program follows known best practices and/or science based practices. The CHI SJC program has not been studied to determine how the program operates. Our study includes several research tasks including the use of interviews of program administrators and staff, observations of services, focus groups, and a review of client files.

The completion of each research task is important in helping us better understand how CHI SJC Home Visiting program works, serve clients in need, and how the implementation of the Program model improves client outcomes. Collectively the completion of the five tasks tells us more than any task by itself.

This study is being completed in anticipation of designing and conducting an outcome study. We are interested in tracking a variety of outcomes. These outcomes include:

- Child development and school readiness
- Family economic self-sufficiency
- Maternal health
- Reductions in child maltreatment
- Child health
- Linkages and referrals
- Positive parenting practices
- Reductions in juvenile delinquency, family violence, and crime

This report contains several sections. First, we review client level data maintained in an electronic format by CHI SJC. This review allows us to report client demographics, services provided, and clients accepted and discharged. This review is also useful for documenting fidelity to the FBP model. Second, we include an analysis of administrator and staff interviews. These interviews were designed to collect information from administrators and staff on how the program functions. Third, we include a review of a meeting held with the four Enhanced Referral Specialists. The meeting focused on gathering information on what they do and how they perform their jobs and how this fits in the FBP. Fourth, we include a preliminary analysis of observations of home visits. Finally, we include a discussion and conclusion section.

Client-Level Data

CHI SJC provided the Institute of Social Research (ISR) agreed upon information from their online database. The information included demographic information about the clients (mothers, fathers, children, and grandparents), admission and discharge dates, testing and evaluations, and services provided. **This report primarily aggregates the information about clients to the family (case) level. However, some of the results are reported by client role. This difference is noted in the table descriptions and the text describing the tables. On average, there are 2.1 clients to each case.**

Number of Opened and Active Cases

This section presents information about the number of cases served by CHI SJC from May 2010-June 2014. CHI SJC capacity has increased dramatically over this time period. Specifically, the number of cases opened per month tripled over this time period. Additionally, the number of active cases at the end of June 2014 increased to more than 400 cases. This finding follows the growth of the program in size and capacity.

Figure 1 displays the number of opened cases per month from May 2010-June 2014. On average the number has been increasing over time. The largest number of cases occurred in September 2013 with 94 opened cases. Over the study time period there was an average of 31 cases opened per month. Table 1 shows the average number of cases opened per month by year of operation. This number has increased from 15.5 in the first year to 53.3 cases opened per month in the fourth year of operation.

Figure 1. Number of Opened Cases per Month, May 2010-June 2014

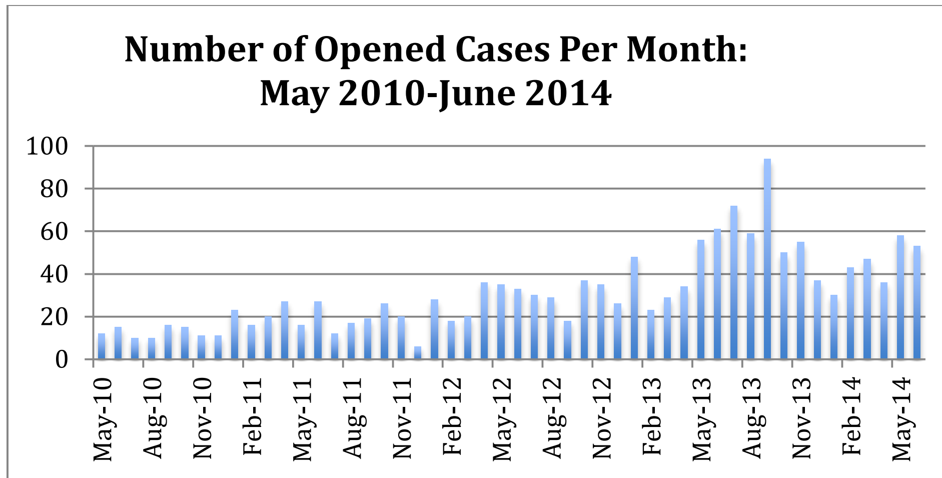
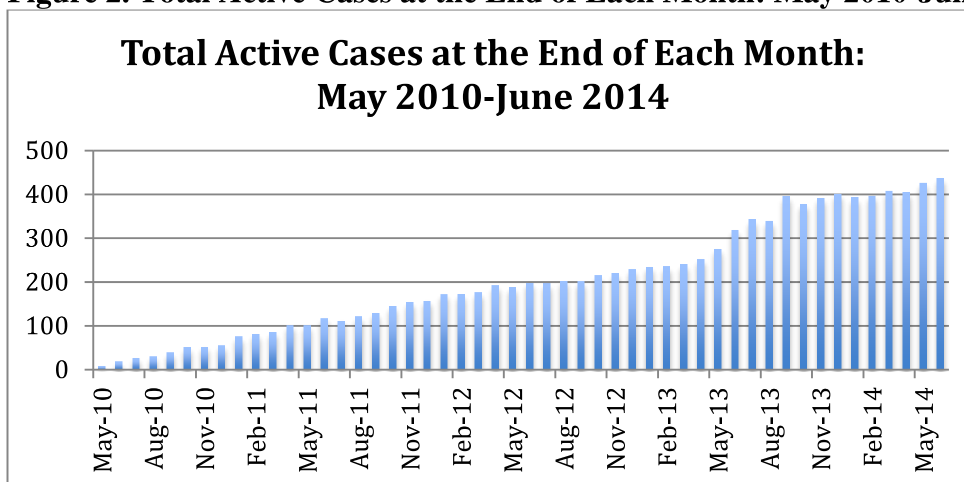


Table 1. Average Number of Cases Opened per Month by Year of Operation

Year Case Opened	Avg. Number of Cases Opened	Number of Cases Opened
1st Year (May 2010-April 2011)	15.5	186
2nd Year (May 2011-April 2012)	20.4	245
3rd Year (May 2012-April 2013)	31.4	377
4th Year (May 2013-April 2014)	53.3	640

Figure 2 shows the total number of active cases at the end of each month. On average the number of active cases has steadily increased each month. The last month in our data, June 2014, displays the highest number of active cases (436). Again, this finding tracks with the growth in capacity of the CHI SJC program.

Figure 2. Total Active Cases at the End of Each Month: May 2010-June 2014



Client and Case Demographics

This section provides information about the clients served by the CHI SJC program. This report does not include a review of 901 individuals who were referred to the program but did not enroll

and become clients. This typically occurs because the Family Liaison/Registrar (Intake Specialist) could not locate the referred family or the family was not interested. The Family Liaison/Registrar makes multiple attempts to enroll families. This information is shown in Table 2.

Unsurprisingly, we find that mothers and children make up the majority of clients. Over four out of every five clients identifies as non-White, with 63.9% identifying as Hispanic. Most clients reside in Bernalillo County, but a small minority reported living in Sandoval, Torrance, or Valencia Counties. Almost all clients are referred from a medical source.

Table 2 presents the frequency of each client's role as reported in the CHI SJC databases. The most frequent role was mother, with 39.4% of all clients being a mother. Approximately, three in ten of all clients (29.0%) were fathers and 31.1% of clients were children.

Table 2. Client's and Referral's Roles

	Clients		Referrals who did not become Clients	
	Frequency	Percent	Frequency	Percent
Child	750	31.1	147	16.3
Mother	953	39.4	602	66.8
Father	700	29.0	150	16.6
Child's sibling	7	0.3	0	0.0
Grandparent	1	0.1	1	0.1
Other	2	0.1	1	0.1
Total	2,413	100	901	100

Table 3 reports the frequency of the client's ethnicity. The modal or most common client ethnicity was "Hispanic", with 63.9% of clients being Hispanic. The second most common ethnicity was Caucasian (non-Hispanic) with 17.0% of clients reporting they were Caucasian. The remaining clients were American Indian or Native American (7.3%), African American or Black, non-Hispanic (3.6%), Asian or Pacific Islander (1.6%), and Other (6.6%).

Table 3. Ethnicity of Client's For Each Case

	Frequency	Percent
American Indian or Native American	242	7.3
Asian or Pacific Islander	52	1.6
Black - non-Hispanic	120	3.6
Caucasian – non-Hispanic	565	17.0
Hispanic	2,116	63.9
Other	219	6.6
Total	1,569	100

Table 4 reports the area of residence for the clients in each case. A large majority (83.2%) of clients resided in Bernalillo County. These Bernalillo County clients were approximately evenly distributed across the quadrants of Bernalillo County. The most common quadrant of residence was

Northeast Bernalillo (27.3%) and the least common quadrant was Southeast Bernalillo County. A little over one in ten (11.3%) cases resided in Valencia County. Almost five percent of cases (4.7%) lived in Sandoval County and less than one percent (0.8%) of cases lived in Torrance County.

Table 4. Area of Residence for Each Case

	Frequency	Percent
Northeast Bernalillo County	428	27.3
Northwest Bernalillo County	292	18.6
Southeast Bernalillo County	246	15.7
Southwest Bernalillo County	339	21.6
Sandoval County	74	4.7
Torrance County	13	0.8
Valencia County	177	11.3
Total	1,569	100.0

Table 5 shows the case referral source for each case. Unsurprisingly, most referrals have been from a medical source. The most common referral source was a hospital (34.2%). Almost two in five cases (19.4%) were referred from families receiving services. The only referral sources with more than a handful of referrals were Other Individual (14.6%), Medical Clinic (11.5%), Schools (7.3%), Self (5.9%), and Other (3.3%).

Table 5. Case Referral Source

	Frequency	Percent
Health care providers	536	34.2
CHI SJC client to client	304	19.4
Other (family member, relative, friend, community member)	229	14.6
Health Care Provider (clinics, hospitals, social workers, mid-wives)	181	11.5
Schools	115	7.3
Self	92	5.9
Other	51	3.3
Religious organization	16	1
Child Protective Services	7	0.4
Childcare	1	0.1
Early Intervention	5	0.3
Judicial and Law Enforcement	9	0.6
Legal	1	0.1
Medical - Private Practice	2	0.1
Public Health	4	0.3
Social Services	9	0.6
Total	1,562	99.6

Table 6 displays the frequencies of where cases heard about the CHI SJC program. Over four in five cases (80.8%) heard about the program from "outreach" (i.e. community outreach and family recruitment and education). Other sources included friends (11.3%), family members (5.1%), and the media (2.4%).

Table 6. Case Heard about CHI SJC From

	Frequency	Percent
Outreach	1,267	80.8
Friends	178	11.3
Family members	80	5.1
Media	37	2.4
Total	1,562	99.6

Days in Program

This section describes the number of days in the program by final case status and discharge reason. We find that active cases display higher average number of days in the program. This suggests that the proportion of successful graduates of the program will increase in the future. Additionally, the data shows a lot of variability in the number of days in the program by discharge reason. Most importantly, completed cases stay in the program for over three years.

Table 7 presents the average, median, and standard deviation of days in the program by final case status. Those "Removed from Referral" predictably displayed a low number of days in the program since these cases never actually enrolled in the program "despite repeated attempts to enroll them". Though, the records showed these referral cases took an average of 26.5 days and a median of 18 days for completion. Those still active in the program on July 9th, 2014 had been in the program for an average of 344 days and a median of 267 days. While those discharged from the program spent an average of 271.9 days and a median of 189 days in the program. The standard deviation for both active and discharged cases was relatively high (292 and 251, respectively), which indicates there is quite a bit of variation in how many days each case stays in the program.

Table 7. Average Number of Days in Program by Final Case Status

Status	Mean	Median	Std. Deviation	N
Active	344.3	267	291.6	401
Discharged	271.9	189	250.6	555
Removed from Referral	26.5	18	44.7	562
Total	197.6	92.5	253.6	1,538

Table 8 indicates there is a lot of variability in the average number of days in the program for discharged clients by discharge reason. Predictably, clients who completed the program were in the program for a much longer time than those clients that did not complete the program. Indeed, program completers spent a little over three years in the program. There is still some variation in the number of program days by other types of discharge. We found those cases that discharged for instability, lack of time, loss of contact, clients not interested or clients moved all stayed in the program for an average of seven to eight months. Those that discharged for reasons outside of the parents' control (death, health, problems, etc.) or for other reasons stayed in the program for the smallest average time (about three months).

Table 8. Average Number of Days in Program for Discharged Cases by Discharge Reason

Status	Mean	Median	Std. Deviation	N
Completed	1,118.5	1,119	111.8	19
Accident (Death, Lengthy Hospitalization, Miscarriage, Health Problems)	105.5	58	139.6	13
Instability (No longer custodian of child, environmental instability, parent incarcerated)	247	211.5	160.7	34
Lack of Time	266	221	200	111
Lost Contact	267.3	218	215.5	97
Moved	257	189	210.5	84
Not Interested	220.4	172	180.9	192
Other	109	87	62.4	5

Assessments

This section presents data on the number of assessments conducted. We found the CHI SJC program conducts numerous assessments. Table 9 presents the average total number of assessments per client role. Not unexpectedly children were assessed most frequently with an average of more than six assessments. Mothers were assessed the second most frequently, with an average of slightly more than three assessments. Fathers were assessed the least with an average of less than two assessments. Many of these assessments are based on the Ages and Stages Questionnaires (ASQ). The ASQ is designed to screen for developmental delays between one month and 5 ½ years and is routinely administered to families.

Table 9. Average Total Number of Assessments by Role

Role	Mean	Std. Deviation	N
Child	6.83	5.03	686
Mother	3.26	1.94	779
Father	1.46	0.81	41
Total	4.84	4.11	1507

Table 10 displays the average number of assessments per month by active and discharged cases. Discharged cases were assessed approximately once every two months, while active cases were assessed a little over once a month.

Table 10. Average Number of Assessments per Month by Active and Discharged Cases

Status	Mean	N	Std. Deviation
Active	1.1	401	0.66
Discharged	0.6	554	0.58

Services Provided

This section describes the number of services provided by the CHI SJC program. We found that CHI SJC has provided a large number of services representing tens of thousands of hours of services since inception.

Table 11 shows the average and total number of service hours and services for families and cases.

Table 11. Mean, Sum, and Number (N) of Total Service Hours and Number of Services for Families

Role		Total Service Hours	Total Number Services
Total	Mean	16.0	21.8
	Sum	23,583.1	32,150
	N	1,475	1,475

Table 12 presents the average and total number of service hours and services for families by active and discharged cases.

Table 12. Mean, Sum, and Number (N) of Total Service Hours and Number of Services for Mother, Father, and Child for Active and Discharged Cases

		Active		Discharged	
		Total Service Hours	Total Number Services	Total Service Hours	Total Number Services
Total	Mean	27.89	35.13	20.38	28.23
	Sum	11,268.3	14,192	11,777.49	16,317
	N	404	404	578	578

Table 13 displays the total services and service hours per month by active and discharged case types. Active and discharged had similar numbers of services and service hours per month. Active cases received 3.3 services and 2.5 service hours per month. Discharged cases received 3.5 services and 2.3 service hours per month.

Table 13. Total Services and Service Hours Monthly by Status Type

Status		Services/ Month	Service Hours/ Month
Active	Mean	3.29	2.48
	N	401	401
Discharged	Mean	3.47	2.28
	N	554	554

Table 14 shows the average number of types of services per month for active and discharged case types. The most common type of service received per month for both active and discharged cases was direct delivery services (3.21 and 3.07). The next most common type of service received per month was face-to-face services (2.63 and 2.08). The only other service types received on a regular basis were child family services (1.55 and 0.93), prenatal services (0.69 and 0.68), and postpartum services (0.32 and 0.27).

Table 14. Average Number of Types of Services/Month for each case by Status Type

	Active	Discharged
Case Support Services	0.09	0.40
Child Family Services	1.55	0.93
Postpartum Services	0.32	0.27
Pre-Registration Services	0.46	0.41
Prenatal Services	0.69	0.68
Service Coordination Services	0.07	0.22
Referral Services	0.11	0.56
Administration Services	0.01	0.03
Drive By Services	0.01	0.03
Email/Letter Services	0.20	0.11
Face-to-Face Services	2.63	2.08
Gathering Documents Services	0.06	0.16
Phone Services	0.20	0.56
Texting Services	0.19	0.47
Direct Delivery Services	3.21	3.07
Indirect Delivery Services	0.09	0.40
Number	401	554

Table 15 presents the average number of hours of types of services per month for active and discharged case types. As expected based on the number of services, the most common type of service hours received per month for both active and discharged cases was direct delivery services (2.45 and 2.15). The next most common type of service received per month was face-to-face services (2.35 and 1.89). The only other service types received on a regular basis were child family services (1.27 and 0.73), prenatal services (0.54 and 0.49), and postpartum services (0.25 and 0.20).

Table 15. Average Number of Hours of Types of Services/Month for each case by Status Type

	Active	Discharged
Case Support Hours	0.03	0.12
Child Family Hours	1.27	0.73
Postpartum Hours	0.25	0.20
Pre-Registration Hours	0.29	0.30
Prenatal Hours	0.54	0.49
Service Coordination Hours	0.02	0.06
Referral Hours	0.08	0.36
Administration Hours	0.01	0.01
Drive By Hours	0.01	0.01
Email/Letter Hours	0.02	0.03
Face-to-Face Hours	2.35	1.89
Gathering Documents Hours	0.03	0.10
Phone Hours	0.05	0.15
Texting Hours	0.03	0.08
Direct Delivery Hours	2.45	2.15
Indirect Delivery Hours	0.03	0.12
Number	401	554

Table 16 displays the total average number of hours of types of services for both active and discharged case types. Overall, we found the total average number of hours of types of services was fairly similar for both active and discharged cases. However, active cases (18.30) received almost twice as many "Child Family Hours" compared to discharged cases (10.03). This implies that the average total number of "Child Family Hours" for discharged cases will increase as more of the current active cases are discharged. Similarly, active cases received about thirty percent more "Face-to-Face Hours" (26.21 and 18.07) and "Direct Delivery Hours" (27.67 and 20.05).

Table 16. Total Average Number of Hours of Types of Services for each case by Status Type

	Active	Discharged
Case Support Hours	0.43	1.20
Child Family Hours	18.30	10.03
Postpartum Hours	2.10	1.62
Pre-Registration Hours	1.10	1.11
Prenatal Hours	4.05	3.46
Service Coordination Hours	0.30	0.70
Referral Hours	1.82	3.12
Administration Hours	0.03	0.05
Drive By Hours	0.03	0.05
Email/Letter Hours	0.17	0.20
Face-to-Face Hours	26.21	18.07
Gathering Documents Hours	0.58	0.83
Phone Hours	0.65	1.28
Texting Hours	0.43	0.66
Direct Delivery Hours	27.67	20.05
Indirect Delivery Hours	0.43	1.20
Number	401	555

Table 17 shows the average number of services per month by location for active and discharged case types. Active cases received an average of 2.63 at home services and discharged cases received 2.01 at home services per month. Additionally, active cases (0.52) received half as many at office services compared to discharged services (1.08). While both active and discharged cases received services at other community locations, at schools, and at other locations, it was not very common. This follows the program model design.

Table 17. Average Number of Services/Month by Location for each case by Status Type

	Active	Discharged
At Home Services	2.63	2.01
At Office Services	0.52	1.08
At Other Community Location Services	0.05	0.09
At Other Locations Services	0.06	0.22
At School Services	0.02	0.07
Number	401	554

Table 18 presents the average number of service hours per month by location for active and discharged case types. Similar to the number of services, cases received the most at home service hours per month (2.25 for active cases and 1.68 for discharged cases) and relatively few office service hours, other community location service hours, other location service hours, and school service hours per month. This follows the program model which focuses on home visits.

Table 18. Average Number of Service Hours/Month by Location for each case by Status Type

	Active	Discharged
At Home Service Hours	2.25	1.68
At Office Service Hours	0.14	0.36
At Other Community Location Service Hours	0.03	0.07
At Other Locations Service Hours	0.04	0.13
At School Service Hours	0.02	0.05
Number	401	554

Discharge Information

This final section provides initial information about the discharge of cases. Discharge reasons differed for those who actually enrolled in the program and those who never enrolled in the program even though they were referred. Furthermore, there is a lot of variability in reasons for discharge for those cases that are enrolled into the program. Finally, we look at the age of the child at the last service date for active and discharged cases.

Table 19 displays the reasons for discharge for both discharge cases and those cases that never enrolled in the program even though they were referred (Removed from Referral). The most common reason for discharge was because of a lack of interest. One out of three enrolled cases loses contact (17.5%) or moves (15.1%) and one out of every five enrolled cases cites "Lack of Time" (20.0%) as a reason for discharge. Almost 4% of discharged clients completed the program.

Table 19. Discharge Reasons Discharged and Removed from Referral

	Discharged	Removed from Referral
Completed	3.4%	0.0%
Accident (Death, Lengthy Hospitalization, Miscarriage, Health Problems)	2.3%	1.8%
Instability (No longer custodian of child, environmental instability, parent incarcerated)	6.1%	2.5%
Lack of Time in the family	20.0%	3.9%
Lost Contact	17.5%	26.7%
Moved out of service area	15.1%	5.5%
Not Interested	34.6%	56.8%
Other	0.9%	2.8%
Total	100.0%	100.0%
Number	555	562

Table 20 displays the frequency of the age of the child at the last service date for active and discharged cases. We found that over fifty percent of children were less than a year old at the last service date for both active and discharged cases. However, we also found a larger percent of active cases have a child older than one year old (29.0%) compared to discharged cases (16.2%). This suggests the number of successful program completions will increase dramatically as active cases discharge in the future.

Table 20. Frequency of the Age of Child at the Last Service Date for Active and Discharged Cases

	Active	Discharged
No Children Listed in Case	19.5%	26.5%
0-6 Months	30.2%	35.3%
7-12 Months	21.4%	22.0%
13-18 Months	12.0%	9.0%
19-24 Months	7.5%	3.4%
25-30 Months	4.5%	1.1%
31-35 Months	4.5%	1.1%
36-43 Months	0.5%	1.6%
Total	100.0%	100.0%
Number	401	555

Staff and Administrator Interviews

As part of the process evaluation, 25 home visitor staff interviews and 4 administrator interviews were completed in June and July of 2014. Each interview lasted approximately 60 minutes, and focused on the home visitor's background and how the program operated from their perspective.

The primary purpose of these interviews was to gain a better understanding of how the program is implemented, and how it adheres to the First Born Program (FBP) model and established best practices for home visitor programs.

The FBP model has identified ten best practices, they are as follows: relationship-based approach, screening and assessments, inclusion of parents/other family members, staff/family ratios, staff knowledgeable about very young children, staff supervision and training, core curricula, multidisciplinary coordination, intensity of services, and transition planning.

The staff interview consisted of eight sections. The sections are as follows: General Information, Section A: Program Information, Section B: Client Information, Section C: Services, Section D: Outcomes, Section E: Workplace Satisfaction, Section F: Final Perspectives, and Section G: Comments.

The staff interviews provided background information, allowing us to gain some insight regarding aspects of home visitor qualifications. For example, one of the most important aspects of CHI St. Joseph's Children Home Visiting program is the qualification of the home visitors, and the smaller home visitor to family ratio.

Of the twenty-five home visitor staff, 40% reported having a Bachelor's Degree or higher. Of these, more than half (56%) were in the social sciences field, and almost half (44%) reported their field of study was Child Development or Early Childhood Development.

Staff reported a fairly wide range of time as a member of the agency, with the lowest being two months and the highest being four years and eight months, with an average being one year and five months. More specifically, one (4%) reported being a member of the agency for more than four years, two (8%) reported being a member of the agency for three years, six (24%) reported being a member of the agency for two years, eight (32%) reported being a member of the agency for one year, and eight (32%) reported being a member of the agency for less than one year.

Additionally, the interviews provided several measures used to gauge home visitor feelings about aspects of the program. For example, a set of questions focused on the role of Enhanced Referral Specialists—an aspect that sets CHI St. Joseph's Children Home Visiting program apart from the other programs based on the First Born Program model. Communication and follow-up between the home visitor's and enhanced referral specialists is essential, as well as a clear understanding of each other's roles and responsibilities.

Of the 25 staff interviewed, three Home Visitors reported they worked with enhanced referral specialists "Occasionally". The remaining 88% reported using the Enhanced Referral Specialists either "Often" (56%) or "Sometimes" (32%).

Additionally, the Home Visitors were asked to rate their agreement with five statements, on a scale from one to six, where 1=Strongly Disagree, 2=Somewhat Disagree, 3=Disagree, 4=Agree, 5=Somewhat Agree, and 6=Strongly Agree.

Of the 25 Home Visitors, 92% (Agree=24%, Somewhat Agree=24%, and Strongly Agree=44%) reported they were aware of existing community resources. While referrals are not the responsibility of the home visitors, the home visitors' awareness of existing resources demonstrates their ability to exceed minimum expectations. Also, 100% reported they either "Somewhat Agreed" (12%) or "Strongly Agreed" (88%) that enhanced referral specialists were knowledgeable about community resources. With the exception of one Home Visitor, 96% "Strongly Agreed" Enhanced Referral Specialists have an important role in the First Born Program.

Table 21. Home Visitors' Perceptions of Enhanced Referral Specialists

Statement	Scale						Median	Mean	Total
	1	2	3	4	5	6			
I am aware of community resources to which I can refer clients	0	0	2	6	6	11	5	5.04	25
There are sufficient community resources to which I can refer clients	1	1	5	5	6	7	5	4.40	25
I am satisfied with my working relationship with the Specialists	0	0	0	0	0	25	6	6.00	25
The Specialist plays an important role in the First Born Program	0	0	0	0	1	24	6	5.96	25
The Specialist is knowledgeable about community resources	0	0	0	0	3	22	6	5.88	25

Finally, a subset of qualitative questions were coded and scored in order to provide further meaning. Each question was scored as either Good, worth 5 points, Marginal, worth 3 points or Poor worth 1 point, based upon the number of correct key words or answers. With a total of 25 questions, each question could receive a maximum score of 125 points, and there was a grand total of 3,125 points available for all 25 questions. Of the 25 questions, 13 (52%) fell under Section A: Program Information, 6 (24%) fell under Section B: Client Information, and 6 (24%) fell under Section C: Services.

In doing so, ISR staff was able to get a broad understanding of the staffs' program knowledge, and identify some of the strengths and potential weaknesses in program areas. First, a broad look at the findings show that of the 25 questions, 9 fell under the 90-100% quartile, 6 fell under the 80-89% quartile, 6 fell under the 70-79% quartile, 1 fell under the 60-69% quartile, and 3 fell under the 50-59% quartile. More specifically, a total of 10 scored 79% or less.

Second, data suggests that the home visitor staff have a clear understanding of client eligibility, client referrals, the length of time per home visit, the methods in which appointments were made with families, the services they provide and program goals.

Lastly, they were helpful in identifying areas of the program that were possibly unclear to them. The majority (52%) of these questions were from Section A: Program Information. These questions were focused on internal procedures such as what type of training Home Visitors receive and how frequently they receive that training, how they are supposed to coordinate with the Enhanced Referral Specialists, and how screenings and assessments are used.

Additionally, several questions concentrated on the transition process of families from hospital to home, and from home to graduation. Policy and procedures regarding keeping in contact with families after graduation appeared unclear to several home visitors. This may suggest that knowledge of transitioning processes is acquired, at least in part, through hands on experience. Thus, home visitors who have helped transition families (either from hospital to home or through graduation) would have a better understanding of those processes, than a home visitor who has not gone through that process.

Table 22. Scoring of Qualitative Questions on Staff Interview

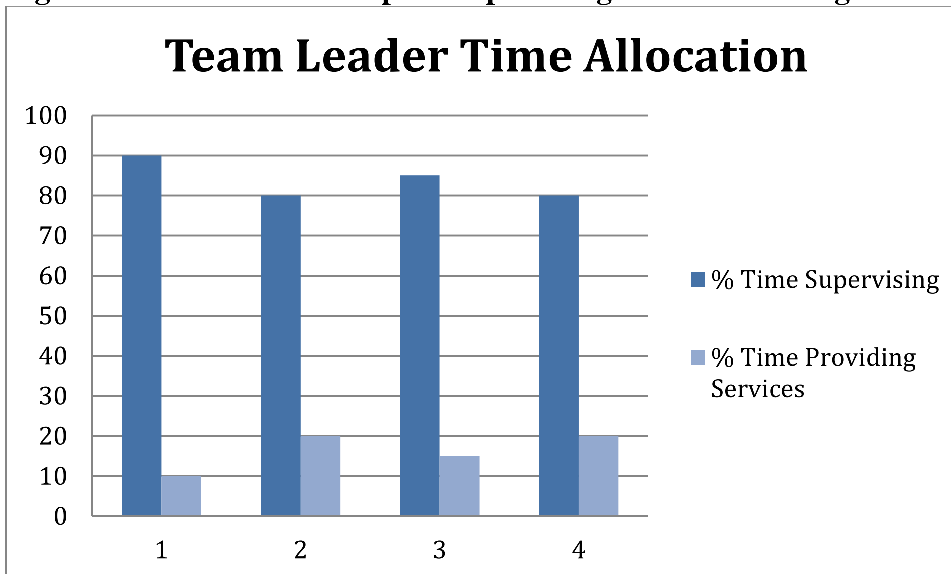
Question	Points	%
A3. Do you know the eligibility criteria for this program?	125	100%
B8. How are appointments scheduled with families?	123	98%
C8. How long are services typically in a session?	121	97%
B2. How are clients referred to you?	119	95%
C3. What services do you provide?	118	94%
B1. What are the major characteristics of clients?	117	94%
A4. What conditions must be met to complete the program?	115	92%
B10. How are families involved in developing goals?	115	92%
B14. How do you track these [made by enhanced referral specialists] referrals?	113	90%
A1. In your own words what is the main goal of the program?	111	89%
C2. How often are services provided to clients?	111	89%
A22. What kind of on-going training opportunities exist for you and other staff?	109	87%
A21. What kind of supervision do you receive?	109	87%
A20. How frequently is there staffing of client cases?	106	85%
B22. What types of activities are suggested?	105	84%
A23. How were you trained upon becoming employed?	97	78%
A14. How do you use information from the assessment(s)?	94	75%
A13. How do you use information from the screening(s)?	93	74%
C13. What kind of transition planning occurs with families as the child ages out of the program?	92	74%
A8. If you have received cultural diversity training, when was/is this [cultural diversity] training offered?	91	73%
A18. If assessments are conducted at other times, when are additional assessments completed?	90	72%
A10. If you have received cultural sensitivity training, when was/is this [cultural sensitivity] training offered?	81	65%
C15. Can you describe the contacts you maintain with families after they leave the program?	68	54%
C10. If your program coordinates services with other providers, if the family is involved with other service providers, can you describe how this coordination works?	68	54%
A16. If screenings are conducted at other times, when are additional screenings completed?	65	52%
Total Possible Points (125x25)=3125	**2556**	**82%**

The following is a brief review of the administrator interviews. The administrator interview consisted of seven sections. The sections are as follows: General Information, Section A: Program Information, Section B: Client Information, Section C: Services, Section D: Outcomes, Section E: Final Perspectives, and Section F: Comments.

Like the staff interviews, the administrator interviews provided insight into their background and their professional qualifications. Additionally, the interview allowed us to gain a deeper understanding of the internal workings within the office, such as training requirements and day to day procedures. Interview findings showed that 75% of administrators had 2 or more years of experience working with the agency and the First Born Program. Also, total professional experience ranged from 10 years to 42 years, with an average of 23.25 years. All administrators had an educational background centered on Child Development or Early Childhood Development, with degree's ranging from an Associates (14 years of education), to a Master's (18 years of education).

As Figure 3 presents, all team leaders reported they spent at least 80% of their time supervising the Home Visitors. They reported that on average; about 83.75% of their time is spent supervising, while the other 16.25% of the time is spent providing services to families.

Figure 3. Percent of Time Spent Supervising versus Providing Services



The number of home visitors they reported supervising ranged from 8 to 10, averaging 9.25. In regards to caseloads, administrators reported having between 2 to 4 families, with an average of 2.75.

Like the staff interviews, a total of 31 qualitative questions were coded and scored in order to assign meaning. Each question was scored as Good=5, Marginal=3 or Poor=1, based upon the number of correct key words or answers. Of the 31 questions, 16 (51.6%) fell under Section A: Program Information, 9 (29.1%) fell under Section C: Services, and 6 (19.3%) fell under Section B: Client Information.

In doing so, ISR staff was able to get a broad understanding of the administrators' program knowledge, and identify some of the strengths and potential weaknesses in program areas. First, a broad look at the findings showed that of the 31 questions, 17 (55%) fell under the 100% quartile, 8 (26%) fell under the 90-99% quartile, and 5 (16%) fell under the 80-89% quartile.

Second, data suggests that the administrators have an overall strong understanding of the program, the services they provide and the clients to whom they provide to. Additionally, the administrators also demonstrated a clear understanding of how coordination works between the home visitors and the Enhanced Referral Specialists, as well as the unique role the Enhanced Referral Specialists play in the program.

Lastly, they were helpful in identifying areas of the program that were possibly unclear to them. This included a small subset of questions that involved supplemental questions, such as any additional program goals, any additional program services provided, any reasons for excluding families from the program that do meet basic eligibility criteria, and when additional assessments are completed.

With a total of 4 administrator interviews, each question could receive a maximum score of 20 points, resulting in a maximum of 620 total possible points. The results are presented below.

Table 23. Scoring of Qualitative Questions on Administrator Interview

Question	Points	%
A1. What is the main goal of this program?	20	100%
A6. What are the eligibility criteria for this program?	20	100%
A10. Who makes the determination to remove a family from the program?	20	100%
A11. What conditions must be met to complete the program?	20	100%
A12. What days of the week and what hours is this program open?	20	100%
A21. How is the information from the [initial] screening used?	20	100%
A29. How frequently is there staffing of client cases?	20	100%
A30. What kind of supervision does staff receive?	20	100%
A31. What kind of on-going training opportunities exist for staff?	20	100%
B2. How are clients referred to this program?	20	100%
B8. How are appointments scheduled with families?	20	100%
B14. How does the program track these [outside agencies] referrals?	20	100%
C8. How long are services typically in a session?	20	100%
C11. Can you describe how does this [other service providers] coordination work?	20	100%
C12. How does the program transition families and children from hospital to home?	20	100%
C13. What kind of transition planning occurs with families as the child ages out of the program?	20	100%
C16. Can you describe the role of the Enhanced Referral Specialists?	20	100%
A9. Under what circumstances is a family removed from the program?	18	90%
A16. When is this [cultural sensitivity] training offered?	18	90%
A18. When is this [cultural diversity] training offered?	18	90%
A22. How is the information from the [initial] assessment used?	18	90%
A26. When are additional assessments completed?	18	90%
A32. How is staff trained upon becoming employed?	18	90%
B17. What types of activities are suggested?	18	90%
C2. How often are services provided to clients?	18	90%
A7. Does this program have a target population for families and children?	16	80%
B1. What are the major characteristics of this programs target population?	16	80%
B10. How are families involved in developing goals?	16	80%
Total Possible Points (20x31)=620	**579**	**93%**

Interestingly, the staff and administrator interviews have some similarities in their scoring distribution. Both staff and administrators scored high on topics regarding client eligibility, client referrals, the length of time per home visit, the methods in which appointments were made with families, and program goals. This suggests that both staff and administrators have a clear understanding of the First Born Program model and how it should be implemented.

Keeping in mind the ten best practices identified by the First Born Program, which were briefly addressed in previous sections, our findings suggest that staff and administrators have a strong understanding of the importance of relationship-based approaches, the inclusion of family in the home visits and in developing goals, having a low staff/family ratio, staff being knowledgeable

about young children, administrators prioritize and emphasize the importance of supervision and training, core curricula, coordination of services with home visitors, enhanced referral specialists, and outside agencies if necessary, and intensity of services.

Focus Groups—Comparison of CHI Parents and Non-CHI Parents

Three focus groups were conducted in the Fall of 2014 to better understand how CHI SJC home visitation participants viewed the St. Joseph's Program. Of the three focus groups, two consisted of families who did not participate in the CHI St. Joseph's home visitation program. The remaining focus group consisted of parents of children ages 0-3 who participated in the CHI SJC home visitation program. Utilizing site-based recruitment, a total of twenty-three participants were selected for the non-home visitation parent focus groups. The selection methodology that was utilized allowed researchers to compile a representative sample that was comparable in socio-demographic characteristics to that of CHI SJC home visitation participants. In exchange for their participation in the focus groups, the 23 participants received a $50 gift card for Wal-Mart. The third focus group consisted of thirteen parents who were participating in the CHI SJC prenatal, infant and toddler programs.

The discussion provided a rich narrative that illustrated Home Visitors were delivering the First Born Curriculum. In addition, we gained insight regarding families perception of what it means to be a good parent, how the model has improved their parenting practices, and their satisfaction with the program.

The comparison of CHI SJC parents to non-CHI SJC parents made evident that Home Visitors were delivering the First Born Curriculum in a manner that reflects the conceptual framework of the model. Specifically, families related the ways in which home visitation allowed them to strengthen their relationships with their spouse and child through engaging in positive and constructive activities. Such activities were focused on better understanding the growth, development, and behavior of their child, enabling mom and dad to practice healthy parenting and coping skills. They explained that home visitation not only provided a social support system, but also concrete strategies to help them maintain emotional stability and resiliency.

Ultimately, this comparison helped identify a key difference between non-home visitation parents and CHI SJC home visitation parents. Parents who did not participate in the CHI SJC home visitation program described that their parental responsibilities were to provide the necessities—to make sure their child has shelter, food, clothing, etc. CHI SJC home visitation parents described that being a good parents means doing more than providing the basic necessities—a good parent not only want their child and family to survive, but also to thrive and continue to grow.

Focus Groups—Enhanced Referral Specialists

On February 17, 2015 the Institute for Social Research conducted a focus group with the four Enhanced Referral Specialists (ERS) employed at CHI SJC. The purpose of the focus group was to gain an understanding of the ERS's role in the program and to understand the key needs faced by the families they serve. The analysis of the focus group generated several key themes described below.

The ERS's noted their main responsibilities include connecting families to a variety of resources in the community. Enhanced Referral Specialists are assigned to different geographic areas: the Southeast, the Northeast the Northwest, and the Southwest in Bernalillo County, Sandoval County, and Valencia County, but work collaboratively in making referrals. This enhancement, according to program staff improves efficiency by centralizing the referral task. When home visitors identify a need with a family, they create a task in the internal electronic chart system. The ERS receives the task and follows up with the family in a variety of ways. ERS's either work with the family by phone, through text messages, or in some cases, they attend a home visit or meet the family at various referral sites.

When the ERS works with the family over time, it is the home visitor's responsibility to continue to update the task list. This ensures the Home Visitor is aware of this service coordination. In addition, the program manager supervises the ERS's and monitors the scope and duration of the ERS's role with the family. Since the Home Visitor maintains the primary relationship with the family, the ERS's role is to work quickly to meet family's needs, so the Home Visitor can focus on improving parenting skills through ongoing home visits.

According to the group, the referrals coordinated by the ERS's depend on individual family needs, but there are clear differences in referral types according to the area served. For instance, in the Northeast area of Bernalillo County, the ERS primarily works with first time parents to coordinate referrals to childcare and to assist families with housing needs. In contrast, ERS working in the Southeast area of Bernalillo County serves families with more complex needs. According to these staff members, they commonly work with families on issues related to domestic violence, poor housing conditions, and obtaining benefits such as food stamps. The ERS working in Valencia County assists a high proportion of immigrant families that face a lack of resources due to their immigration status and the lack of services in Belen and Los Lunas. For instance, homelessness and lack of health care were commonly cited as barriers that immigrant families face.

The respondents also agreed their role in the program is to assist and empower families to solve problems. In their view, their primary role is to assist Home Visitors who provide the core intervention services with the family.

In conclusion, conducting the focus groups allowed ISR staff to consider the numerous aspects of the CHI SJC home visiting program. From this, ISR staff gained an understanding of the various roles within the program, such as home visitors and enhanced referral specialists, the ways in which they coordinate with each other and the families, and the services provided to those families. The following section will describe preliminary findings from observations of the home visits.

Home Visit Observation Data

This section provides preliminary findings from the home visit observations completed by ISR staff thru January 2015. The observation notes taken by trained ISR staff consisted of both quantitative and qualitative data. The observations were designed to document the core curricula topics addressed, the minutes spent per topic, and the percent of time the home visit focused on each topic. Topics that were addressed during the observed home visits were categorized as

either one of the core curricula topics, or coded as “Other,” with specification as to what that entailed. While a large amount of time and effort were put forth in the identification, mapping, and coding of “other” topics, specialists or individuals with a background in the First Born Program may consider such topic as part of the curricula. These data were supplemented with descriptions of the home visit environment, characteristics of the home visitor and parent(s), the style and/or key attributes of the home visitor, and the interaction between home visitor and parent(s). The primary purpose for this was to observe the ways in which the three First Born Program curricula were being implemented by home visitors.

After a brief description of the home visits, we report on our observations based on the age groups for each core curricula (Pre-Natal, Newborn/First Year of Life, and Toddler): the count of curriculum topics covered per home visit, the time spent on specific curriculum topics, other topics covered not on the curriculum, and some additional topics of interest.

Brief Sample Description

Between July 2014 and January 2015, 39 home observations were completed—of these, 6 were pre-natal, 23 were newborns/first year of life, and 10 were toddlers. More than half (58.2%) of the home visits observed consisted of families with a newborn or child in their first year of life. While the remaining consisted of pre-natal (15.5%) or toddler (26.4%). Of the 39 home visits observed, 34 took place at the family home, 1 took place at a park, 1 took place at the child’s day care, and 3 took place at the grandparent’s home. Additionally, the number of individuals who were present at the home visit ranged from 3-7, with an average of 3.6.

Core Curricula Topics Count

Below, Table 24 displays the minimum, maximum, and average number of curriculum topics discussed for each observed home visit, organized by core curricula age group. Between the 6 pre-natal home visits observed, a total of 37 topics were covered. Between the 23 newborn/first year of life home visits observed, a total of 139 topics were covered. Finally, between the 10 toddler home visits observed, 63 topics were covered. Of the 63 topics, one activity topic was not specified, thus only the 62 identifiable topics will be included in the upcoming analysis. From the 239 total topics, the findings suggest that on average, regardless of age, each home visit covered a little more than 6 curriculum topics.

Table 24 Count of Core Curricula Topics Covered Per Home Visit

Age	Observed Count	Number of Topics Covered Per Visit		
		Minimum	Maximum	Average
Pre-Natal	6	4	10	6.17
Newborn	23	2	10	6.04
Toddler	10	4	8	6.30
	39	10	28	

Table 25 presents the name and count of core curricula topics covered in all observed home visits. There are a few instances in which home visitors cover topics from more than one curriculum. For example, a Home Visitor discussed attachment and bonding, normally covered during the newborn/first year of life, during a visit with a family and their toddler.

While the First Born Program emphasizes the importance of fidelity to each core curricula, this variation has been explained as a way to tailor the program to family needs without substantially changing the program. Families with a newborn or child in their first year accounted for the lowest (2) and highest range (10) for number of topics covered at the observed home visits. Additionally, several clusters stand out in the table, including attachment and bonding (13), developmental sequences (15), growth and development (17), health (18) and nutrition (16). All five of the topics are predominately from families with a newborn or child in their first year.

Table 25 Name and Count of Core Curricula Topics Covered per Home Visits

Curriculum Topic	Pre-Natal	Newborn	Toddler	Total
Attachment and Bonding	0	12	1	13
Behavior Prevention Strategies	0	0	1	1
Breastfeeding	3	1	0	4
Caring for Your Baby and Yourself	3	1	0	4
Daily Care	0	8	0	8
Dealing with Challenging Behavior	0	0	2	2
Developmental Sequences	0	13	2	15
Father Involvement	2	1	0	3
Fetal Development	2	0	0	2
Goal Setting	0	0	1	1
Growth and Development	0	17	0	17
Health	0	15	3	18
Keeping Healthy During Pregnancy	5	0	0	5
Labor and Delivery	5	1	0	6
Language Development	0	0	3	3
Nutrition	0	11	5	16
Nutrition During Pregnancy	2	0	0	2
Playing and Learning	0	0	9	9
Positive Relationships	0	0	3	3
Safety	0	9	1	10
Sleep	0	0	6	6
Toddler Growth and Development	0	0	3	3
Toilet Training	0	0	4	4
Toys and Books that Teach	0	9	1	10
Warning Signs During Pregnancy	3	0	0	3
“Other” Non-Curricula Topics	12	41	17	70
Total	37	139	62	239

“Other” Non-Curricula Topics Count

Table 26 presents the other topics discussed during home visits that are not part of the core curriculum. It was observed that during the home visits, many of the families had one or more special needs that were specific to their personal situations and lives. Of the 39 observed home

visits, families with a newborn or child within their first year of life discussed the most amount of non-curricula topics (59%), leaving toddlers at 24% and pre-natal at 17%.

Certain non-curricula topics were more common than others, within the same age groups and also across all three age groups. Of the 10 home visits that discussed “Career, Job Prospects, Job Development, Employment,” 70% were families with a newborn or baby in the first year of life. Moreover, all three age groups discussed needing assistance with baby products and the safety of their living and/or environmental conditions. Lastly, 15 (20%) of the observed home visits each discussed a unique topic that was not discussed at any other observed home visit. This includes biological mother, cultural traditions, delivery, divorce, family dog and baby, feeding baby with blender, gambling problem, incarceration, maternity leave, new case manager, pamper party, graduation event, TANF benefits and transportation. Table 26 reports this information.

Table 26 “Other” Topics Covered for All Observed Home Visits

Non-Curriculum Topics	Pre-Natal	Newborn	Toddler	Total Count
Activity	0	1	2	3
Baby Products Assistance	1	2	1	4
Biological Mother	0	1	0	1
Career, Job Prospects, Employment	0	7	3	10
Child Care	0	4	3	7
Cultural Traditions	0	1	0	1
Delivery	0	1	0	1
Divorce	0	1	0	1
Family Dog and Baby	0	1	0	1
Father Involvement	0	2	0	2
Feeding Baby with Blender	1	0	0	1
Finances	2	0	0	2
Gambling Problem	0	1	0	1
Halloween	0	1	3	4
Incarceration	0	1	0	1
Living Conditions/Environment	1	2	1	4
Maternity Leave, Mother’s Health	1	1	1	3
Moving Out Of State	0	2	0	2
New Case Manager	0	1	0	1
Not Specified	2	0	0	2
Pamper Party	1	0	0	1
Small Talk	2	3	0	4
Social Support	0	3	0	3
Graduation Event	0	1	0	1
TANF Benefits	0	0	1	1
Thanksgiving	0	1	1	2
Transitions	0	2	1	3
Transportation	1	0	0	1
WIC Services	0	1	0	1
Total	12	41	17	70

Tables 28-30 present the count and percent of time during home visits used to cover each curricula and non-curricula topic. They are organized based upon the three age groups for which they belong.

Specifically, Table 27 shows that all eight core curriculum topics were covered between the 6 observed home visits. However, looking at each home visit separately, the tables show that 83% of the 6 home visits discussed keeping healthy during pregnancy and labor and delivery.

Warning signs during pregnancy, caring for your baby and yourself, and breastfeeding were discussed within 50% of the 6 observed home visits. Lastly, father involvement, fetal development, and nutrition during pregnancy were discussed at 33% of the 6 observed home visits.

Table 27 Pre-Natal Percent of Home Visit Spent on Curricula Topics

Curriculum Topic	Count	Percent Within Minutes
Breastfeeding	3	8.10%
Caring for Your Baby and Yourself	3	8.10%
Father Involvement	2	5.40%
Fetal Development	2	5.40%
Keeping Healthy During Pregnancy	5	13.51%
Labor and Delivery	5	13.51%
Nutrition During Pregnancy	2	5.40%
Warning Signs During Pregnancy	3	8.10%
"Other" Topics	12	32.43%
Grand Total	37	100%

Table 28 presents the findings of the 23 home visits observed of families with a newborn or a child in their first year. Less than 1% of the home visits discussed breastfeeding, caring for you baby and yourself, father involvement, and labor and delivery.

Like that of the pre-natal group, all eight of the core curriculum topics are covered between the 23 home visit observations, but not necessarily all with one family. The majority of home visits observed consisted of families with a newborn or child in their first year.

Table 28 Newborn Percent of Home Visit Spent on Curricula Topics

Curriculum Topic	Count	Percent Within Minutes
Attachment and Bonding	12	8.6%
Breastfeeding	1	.7%
Caring for Your Baby and Yourself	1	.7%
Daily Care	8	5.8%
Developmental Sequences	13	9.4%
Father Involvement	1	.7%
Growth and Development	17	12.2%
Health	15	10.8%
Labor and Delivery	1	.7%
Nutrition	11	7.9%
Safety	9	6.5%
Toys and Books that Teach	9	6.5%
"Other" Topics*	41	29.5%
Grand Total	139	100.0%

Table 29 shows the distribution of topics covered during home visit observations with a family who has a toddler. Of these, "other" topics account for almost 30% of the topics addressed, whole playing and learning accounts for almost 15% and sleep, accounting for less than 10%.

Table 29 Toddler Percent of Home Visit Spent on Curricula Topics

Curriculum Topic	Count	Percent Within Minutes
Attachment and Bonding	1	1.61%
Behavior Prevention Strategies	1	1.61%
Dealing with Challenging Behaviors	2	3.23%
Developmental Sequences	2	3.23%
Goal Setting	1	1.61%
Health	3	4.84%
Language Development	3	4.84%
Nutrition	2	3.23%
Nutrition/Health	3	4.84%
Playing and Learning	9	14.52%
Positive Relationships	3	4.84%
Safety	1	1.61%
Sleep	6	9.68%
Toddler Growth and Development	3	4.84%
Toilet Training	4	6.45%
Toys and Books that Teach	1	1.61%
"Other" Topics*	17	27.42%
Grand Total	62	100.00%

Discussion and Conclusion

The study resulting in this report was designed as a process evaluation. This was done preliminary to a long-term outcome study focused on short and long-term outcomes/impacts of the programs on the families and children served by the program. Some of these outcome domains are listed in the introduction.

As such, the purpose of the study was to determine how well the CHI SJC program adheres to the First Born Program model while incorporating the use of Enhanced Referral Specialists, whose primary job is to refer clients and their families to community resources and hence improve program outcomes, as well as best practices for home visiting programs. Our study included a number of research tasks described earlier:

- Program staff interviews
- Administrator interviews
- A review of client files
- Observations of home visits
- A focus group with the Enhanced Referral Specialists
- A focus group of CHI SJC families and two focus groups of non-CHI SJC and non-home visited families

Prior to this research the CHI SJC program has not been studied to determine how the program operates. This is important. Implementing a program according to its design and best practices improves outcomes more than if the program is not implemented according to the proposed design and best practices.

As noted in the introduction, process evaluations are aimed at understanding the internal dynamics of how programs operate. In completing this process evaluation we are able to document implementation and adherence to design fidelity and known best practices.

This section describes the CHI SJC program in comparison to the FBP model and research findings that suggest that a broad set of key components, or best practices, have been associated with program success. Evidence supports that appropriate integration of specific components typically improves program goals and outcomes. Because of the nature of home visitation, most programs run into several common problems. As noted earlier, in their review of home-visiting programs, Gaylor and Spiker (2012) explained that much of the uncertainty revolving around program outcomes was related to aspects of program implementation.

Our discussion revolves around the First Born Program model and a set of universally applicable standards listed in the introduction and that originates from the federal Department of Health and Human Services Home Visiting Evidence of Effectiveness (HomVEE) review. Following is the set of general and informal standards that should serve as the foundation for which programs could build upon:

- Minimum requirements for frequency of visits
- Minimum education requirements for home visiting staff
- Supervision requirements for home visitors

- Pre-service training for home visitors
- Fidelity standards for local implementing agency
- System for monitoring fidelity
- Specified content and activities for home visits

This study accomplishes the goal of completing a process evaluation and preparing the program for an outcome/impact study.

The CHI SJC program serves a large number of clients and has provided thousands of hours of services. Additionally, these clients represent high need populations. The number of cases has increased over time and parallels the growth of the program in capacity. Almost two-thirds of the clients served by the program are Hispanic and 17% are white. Referrals come from a large number of sources with slightly more than 33% coming from local hospitals. Multiple attempts are made to enroll families that referred to the program. Because the program has been in operation for only a short period of time relative to the program length few clients have completed the program.

On average active clients received 3.3 services a month and 2.5 hours of services. The most common type of service received per month for both active cases was direct delivery services (3.2). The next most common type of service received per month was face-to-face services (2.6). The only other service types received on a regular basis were child family services (1.1), prenatal services (0.7), and postpartum services (0.3). Almost all services are provided at the client's home. We also found that clients who don't complete the program discharge from the program for a number of reasons. Primarily they leave because of a lack of time (20.0%), they lose interest (34.6%), and they are lost to contact (17.5%). Average length of stay for clients who complete the program was 1,119 days or a little more than 3 years. Clients who were active in the program in June 2014 had spent an average of 344 days in the program.

A preliminary review of home visit observations found home visits often cover a large number of topics (average of 6) and some of these topics are not part of the core curriculum and sometimes are not directly part of the FBP model curriculum. It appears that many of the families being served have high or special needs that require a more personalized approach to home visiting. With this said, non-curriculum topics do not appear to have a negative effect on the amount of time spent on curriculum topics. In fact, data presented showed that most of the observed home visits still prioritized curriculum topics. Moreover, the predominance of families with a newborn or child in their first year, and the clusters of topics that were concentrated on suggest that many of the families are progressing through the curriculum and transitions into and out of topics at a consistent rate. This finding deserves further study.

Staff interviews general found staff understands the FBP model and follow the FBP curricula and CHI SJC procedures. The administrator interviews found the majority of time was spent on supervising Home Visitors and each administrator supervised between 8 and 10 Home Visitors.

The focus group of CHI SJC parents and non-CHI SJC parents who were not part of a home visiting program provided additional information regarding adherence to the FBP model. The focus group of CHI SJC parents compared to non-CHI SJC parents made it clear that home

visitors were delivering the First Born Curriculum in a manner that reflects the conceptual framework of the model. Specifically, families related the ways in which home visitation allowed them to strengthen their relationships with their spouse and child through engaging in positive and constructive activities. Such activities were focused on better understanding the growth, development, and behavior of their child, enabling mom and dad to practice healthy parenting and coping skills. They explained that home visitation not only provided a social support system, but also concrete strategies to help them maintain emotional stability and resiliency.

Parents who did not participate in the CHI SJC home visitation program described that their parental responsibilities were to provide the necessities which includes making sure their child has shelter, food, clothing, etc. CHI SJC home visitation parents described that being a good parents means doing more than providing the basic necessities— a good parent not only wants their child and family to survive, but also to thrive and continue to grow.

ERS focus group respondents noted their role in the program is to assist and empower families to solve problems. In their view, their primary role is to assist home visitors who provide the core intervention services with the family. The ERS's noted their main responsibilities include connecting families to a variety of resources in the community. According to the group, the referrals coordinated by the ERS's depend on individual family needs and there are clear differences in referral types according to the service area. Referrals includes childcare, assistance with housing needs, domestic violence, poor housing conditions, obtaining benefits such as food stamps, immigration issues, and healthcare.

In general, we found the CHI SJC program follows the First Born Program model. The CHI SJC program licenses the FBP model and is required to adhere to model guidelines that include three core curricula: First Born Prenatal Curriculum, First Born First Year of Life Curriculum, and First Born Toddler Curriculum. Our interviews of staff and administrators, home visit observations, and the review of electronic files confirmed the use of the curricula. Further, our review found staff and administrators understand the FBP model and the curricula. The review of electronic files confirmed the program provides the FBP services following the core curricula. The preliminary review of the home visit observations found Home Visitors provide the curricula consistently and cover, when appropriate, topics that are outside of the curricula but that are important for the home visit and family. The FBP model is enhanced through the use of Enhanced Referral Specialists (ERS) whose job is to connect families to a variety of resources in the community.