Healthy Families Arizona
Annual Evaluation Report

October 2019 – September 2020

Healthy Families Arizona™

LeCroy & Milligan ASSOCIATES, INC.

Healthy Families Arizona, Annual Evaluation Report October 2019 – September 2020

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About LeCroy & Milligan Associates:

Founded in 1991, LeCroy & Milligan Associates, Inc. is a consulting firm specializing in social services and education program evaluation and training that is comprehensive, research-driven and useful. Our goal is to provide effective program evaluation and training that enables stakeholders to document outcomes, provide accountability, and engage in continuous program improvement. With central offices located in Tucson, Arizona, LeCroy & Milligan Associates has worked at the local, state and national level with a broad spectrum of social services, criminal justice, education and behavioral health programs.

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Executive Summary

The Healthy Families Arizona program is designed to help expectant and new parents get their children off to a healthy start. Families are screened according to specific criteria and participate *voluntarily* in the program, receiving home visits (in home or virtually) and referrals from trained staff. The Healthy Families Arizona program serves families with multiple stressors and risk factors that can increase the likelihood that their children may suffer from abuse, neglect, or other poor outcomes. By providing services to under-resourced, stressed, and overburdened families, the Healthy Families Arizona program fits into a continuum of supportive services provided to Arizona families.

The Healthy Families Arizona Program

Healthy Families Arizona is in its 29th year and is modeled after and accredited with the Healthy Families America initiative under the auspices of Prevent Child Abuse America. With combined funding from the Arizona Department of Child Safety (DCS), First Things First (FTF), and the Department of Health Services (DHS) Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, Healthy Families Arizona provides services to families in 13 counties through 11 sites with three family assessment teams and 45 home visitor teams. Healthy Families Arizona served a total of 4,337 families from October 1, 2019 through September 30, 2020. A total of 1,965 families were funded through DCS; 1,337 through FTF; 699 through MIECHV; and 266 through the State Opioid Response funding. An additional 70 families have outside funding in the Maricopa County area. Families come from 249 different zip codes in 14 counties in the most populous areas of Arizona.

Who Does Healthy Families Arizona Serve?

Overall, Arizona continues to perform more poorly than the national trend in 13 of the 16 child well-being indicators measured in 2020. In 2020, Arizona ranked 42nd out of 50 states (with 50th being the worst ranking) in overall child well-being. Healthy Families Arizona families have a significant number of maternal risk factors at entry into the program compared to the overall state rates, as shown in the table below. The mothers enrolled in Healthy Families Arizona are more likely to be teen parents, single parents, unemployed, undereducated, and with lower incomes.

Risk Factors of Mothers	Healthy Families Arizona	Arizona State
Teen Births (19 years or less)	10%	6%*
Births to Single Mothers	76%	45%*
Less Than High School Education	29%	17%*
Not Employed	56%	18%**
Median Yearly Income	$20,000	$56,581**

Sources: *2018 data from the Arizona Department of Health Services Vital Statistics records.
**U.S. Bureau of Labor Statistics, Geographic Profile of Employment and Unemployment, 2019.

Impacts of the COVID-19 Pandemic

On March 31, 2020, due to the COVID-19 pandemic, the State of Arizona implemented the executive order to "Stay Home, Stay Healthy, Stay Connected." As a result of this order, Healthy Families Arizona quickly shifted from conducting home visits with families in person to conducting them virtually via telephone and video starting in April 2020. Due to the variable nature of the pandemic, most areas throughout the state have continued to conduct most home visits virtually.

During the second half of FY 2020 due to changes from the pandemic, Healthy Families Arizona saw a decrease in the number of systematic referrals (i.e., those regularly coming from hospitals) and an increase in the number of referrals coming from other community organizations. In addition, fewer new families left the program due to lack of re-engagement from outreach efforts, but more declined continued services.

Outcomes for Families and Children Participating in Healthy Families Arizona

The Healthy Families Parenting Inventory (HFPI) revealed statistically significant improvement on all subscales except social support. This indicates that Healthy Families Arizona participants are continuing to see reductions in their risk factors related to child abuse and neglect. **Parents reported significant changes over time in:**

- Improved home environment
- Increased personal care
- Increased problem solving
- Improved mobilization of resources
- Increased parenting role satisfaction
- Improved parent/child interaction
- Improved parenting efficacy
- Decreased depression

Child Abuse and Neglect

Healthy Families Arizona teams provided voluntary home visitation services to a total of 882 families that were involved with the Department of Child Safety (DCS). Records of child abuse and neglect incidents (substantiated) were examined for program participants who had received services for at least six months. A total of 110 Healthy Families Arizona families had a substantiated case of child abuse and/or neglect out of 2,944 families that had participated in the program for at least 6 months.

Introduction

Healthy Families Arizona was established in 1991 by the Arizona Department of Economic Security (now housed at the Arizona Department of Child Safety [DCS]) as a home visitation service for at-risk families and is now in its 29th year. The Healthy Families Arizona program is accredited by Prevent Child Abuse America and is modeled after the Healthy Families America (HFA) initiative. HFA began under the auspices of Prevent Child Abuse America (formerly known as the National Committee to Prevent Child Abuse) in partnership with the Ronald McDonald House Charities. HFA was designed to promote positive parenting, enhance child health and development, and prevent child abuse and neglect. HFA has approximately 585 affiliated program sites in 38 States, the District of Columbia, five U.S. Territories, Canada, and Israel. HFA is approved as an "evidence-based early childhood home visiting service delivery model" by the US Department of Health and Human Services. The program model of Healthy Families is designed to help expectant and new parents get their children off to a healthy start. Families are screened according to specific criteria and participate *voluntarily* in the program. Trained staff provide home visits, in person and/or virtually, and referrals to families that choose to participate. By providing services to under-resourced, stressed, and overburdened families, the Healthy Families Arizona program fits into a continuum of services provided to Arizona families.

Healthy Families Arizona Statewide System

Healthy Families Arizona is an affiliate of the HFA State/Multi-Site system. Central Administration for all accredited Healthy Families Arizona sites is housed within the Office of Fidelity and Compliance under the Arizona DCS. There are five core functions of Central Administration which are designed to support the statewide system of single sites, these include: quality assurance/technical assistance; evaluation; training; system-wide policy development; and administration. Each of these functions covers a set of activities and tasks that guide operations at the Central Administration level as well as at the program level.

The funding structure for the Healthy Families Arizona Program is supported by three state agencies: the Arizona Department of Child Safety (DCS), First Things First (FTF), and the Arizona Department of Health Services (DHS). The DCS Central Administration supports collaboration with the three state agencies in a fully integrated system to enhance the quality of Healthy Families Services. In State Fiscal Year 2020, funding for Healthy Families Arizona included $8,356,766 from DCS/Lottery funds, $2,100,197 from State Opioid Response (SOR) funds, $3,482,100 from DHS through MIECHV funds, and $6,084,482 from FTF for a total of $20,023,545.

The combined funding allows the Healthy Families Arizona sites and teams to provide services to families living in 13 counties and 249 zip code areas around Arizona. At the end of the reporting period on September 30, 2020, there were 11 sites with three family assessment teams and 45 home visitor teams (18 DCS funded including SOR funding, 11 FTF funded, three DHS funded, and 13 receiving funding from more than one source) for a total of 48 teams. See Exhibit 1 for a summary of funding amounts and Exhibit 2 for a list of teams funded in Fiscal Year 2020.

Exhibit 1. Healthy Families Arizona Funding

Year	Annual Funding Amount
2008	$18 Million – Department of Economic Security (DES)
2009	$6.1 Million – DES (Year of funding cutback)
2010	$12.3 Million total - $6 Million DES, $6.3 Million FTF
2011	$12.5 Million total - $6.5 Million DES, $6 Million FTF
2012	$12.4 Million total - $6.3 Million DES, $5.9 Million FTF, $117,212 MIECHV
2013	$14.2 Million total - $6.6 Million DES, $5.6 Million FTF, $2 Million MIECHV
2014	$16.3 Million total - $6.6 Million DCS, $6 Million FTF, $3.7 Million MIECHV
2015	$17.9 Million total - $7.2 Million DCS, $5.9 Million FTF, $4.8 Million MIECHV
2016	$15.9 Million total - $6 Million DCS, $4.5 Million FTF, $5.4 Million MIECHV
2017	$18.1 Million total - $9.8 Million DCS, $4.2 Million FTF, $4 Million MIECHV
2018	$16.0 Million total - $8.2 Million DCS, $4.2 Million FTF, $3.5 Million MIECHV
2019	$18.6 Million total - $8.9 Million DCS, $6.1 Million FTF, $3.6 Million MIECHV
2020	$20.0 Million total - $8.4 Million DCS, $2.1 Million SOR, $6.1 Million FTF, $3.4 Million MIECHV

Exhibit 2. Healthy Families Arizona Program Sites in Fiscal Year 2020

Site	Number of Home Visitor Teams
Apache County / Navajo County	1
Cochise County / Santa Cruz County	4
Coconino County	1
Graham County / Greenlee County	2
Maricopa County	19
Mohave County	4
Pima County	5
Pinal County (including Gila County)	4
Verde Valley (in Yavapai County)	1
Prescott Valley (in Yavapai County)	1
Yuma County	3
Statewide	**45**

Report Overview

The purpose of the Healthy Families Arizona annual report is to provide information on families' outcomes, program performance measures, program process and implementation, and evaluation information that can be used to guide program improvement. This report covers Federal Fiscal Year reporting period of 10/1/2019 to 9/30/2020. During this time, the COVID-19 global pandemic greatly affected the standard practices of home visitation within the Healthy Families Arizona program. Starting at the end of March 2020, in-person visits switched to virtual/socially distanced visits, which included a mixture of telephone, video, and open-air distanced visits. Due to the impact of the pandemic, it was harder for home visitors to complete some data collection that would normally be included as part of this annual evaluation.

The evaluation of Healthy Families Arizona includes both process and outcome components. The process evaluation includes a review of statewide program implementation, describes the characteristics of families participating in the program, and provides general satisfaction of families participating in the program. The outcome evaluation typically examines program outcomes across several measures, with comparisons to previous years. However, due to the combination of the pandemic and the implementation of the Efforts to Outcomes (ETO) online data system in the prior year, some annual comparisons are not available for this annual report. All outcomes presented in this report should be viewed with these considerations.

Overview of the Evaluation Design

The FY 2020 evaluation examined process and outcome data across the teams and how successful the Healthy Families Program was in light of stated goals and objectives. The evaluation describes the types of families who use Healthy Families Arizona services and the changes they made after involvement in the program. Multiple process data and outcome indicators were gathered to assess the implementation and outcomes of this program. The goal of the evaluation is to provide a detailed analysis of the following: description of the program and implementation by team; data on numbers and characteristics of families served; satisfaction data, including from staff members and participating parents/caregivers; and the effectiveness of the Healthy Families Arizona model in terms of legislated outcomes.

Process Evaluation

The process evaluation is designed to describe how the Healthy Families Arizona program functions. The main purpose of the process evaluation is to gather information about the statewide implementation of the program and assess any changes in implementation that may influence the family outcomes. Process data and information is also used for regular

program monitoring and improvement. Process evaluation data is collected from program staff, supervisors, managers, and Healthy Families Arizona Central Administration through discussions at committee meetings, regular updates, and interviews or surveys.

Performance indicators on families served are collected ongoing by staff through data collection forms that are entered into ETO. These indicators include:

- Demographic information (such as ethnicity, language use, education, age of mother, marital status, income, geographic location)
- Provider/participant relations
- Satisfaction with the program
- Number of children served
- Number and types of services provided and received

Performance management information is provided through quarterly reports to each team and statewide to provide feedback on critical program elements. Performance data is also shared at supervisor's meetings, Advisory Board meetings, quarterly management meetings, and data collection trainings, as appropriate. The major components of the process or implementation study include describing the implementation of the Healthy Families Arizona program including:

- The overall model, its logic, and operations
- The program's goals and objectives
- Characteristics of those served
- Performance management information (rates of screening, missing data reports, etc.)
- The prenatal component of the program (especially efforts to reach potential participants early in their term of pregnancy)
- Staff retention and training (gathered by Central Administration)
- The organizational context of Healthy Families Arizona, including the leadership structure and systemic process for organizational development.

Key Process Evaluation Questions

Below are the guiding process evaluation questions that are addressed annually:

- What are the characteristics of the families participating in the Healthy Families Arizona Program? What are the targeted populations for referral to the program?
- Is the program being implemented consistent with the Arizona Healthy Families Policies and Procedures and best practices found in current literature?
- What are the patterns of service delivery (timing, frequency, format, purpose, attendance and facilitation) of Healthy Families Arizona? (Central Administration)
- What changes have taken place in the statewide system that impact program delivery and/or outcomes?

- What is the content of the Healthy Families Arizona training? (Central Administration)
- Are the participants (families and professionals) satisfied with the Arizona Healthy Families Program process? (Central Administration)
- What are the impediments to implementing the Healthy Families Program?

Outcome Evaluation

The outcome evaluation is designed to assess the impact of the Healthy Families Arizona program on families and children in terms of promoting child development and wellness, enhancing parent/child interactions, and preventing child abuse and neglect. Outcome data includes data from the Arizona DCS and the statewide child abuse database (CHILDS), evidence for changes in parent stress, and other indicators described below. Outcome data collected is entered into ETO to address the legislated performance measures as follows:

- Percent of families implementing safety practices; immunization rates for Healthy Families Arizona children; percent of children screened for developmental delays
- Length of time to subsequent pregnancies; percent of mothers enrolled in school; mother's employment status
- Percent of mothers screened for substance abuse
- Percent of families with a substantiated incidence of child abuse or neglect since entering the program (the evaluation will also assess the Scope of Work State Contract Performance Measure Goal that 99.7% of families receiving services will NOT have a substantiated report of child abuse or neglect.)

Key Outcome Evaluation Questions

- Has the program resulted in successful parenting outcomes?
- Is the Healthy Families Arizona program meeting the objectives outlined in the enabling legislation (e.g., children and maternal health outcomes)?
- Has the program been successful in achieving the program goals and objectives as outlined in the program logic model?
- Has the program provided for the care and protection of the child (e.g., Safety in the home environment and child abuse and neglect indicators)?

Arizona KIDS COUNT Data 2020

The Status of Children in Arizona

Since 1990, the Annie E. Casey Foundation, a private national philanthropy, has compiled and published an annual *KIDS COUNT Data Book* and state level reports. The purpose of KIDS COUNT is to provide national and state level data on the well-being of children living in the United States. The KIDS COUNT indicators are collected across all states at least biannually for children from birth through high school. There is a total of 16 indicators within four domains that are used to develop the overall rankings for each state to determine how well they are meeting the needs of their children. These indicators are used to show trends over time in child well-being. For states, the most currently available data is collected, and states are ranked within each category based on the indicators and given an overall ranking.

Overall, from a national perspective, children have seen improvements or consistency in the Economic Well-Being and Education domains, and mixed results in Health, and Family and Community domains. From a statewide perspective, children in Arizona have seen improvements in the Economic Well-Being domain, the Education domain, and in all but one indicator in the Family and Community domain. They have experienced a slight regression in some indicators of the Health domain. Data from the national KIDS COUNT Data Book (2020a) and Arizona (2020b) for the four domains and indicators are shown in Exhibit 3.

Exhibit 3. 2020 KIDS COUNT Profile for the United States and Arizona

Domains and Indicators	United States		Arizona	
	Previous Years	Current Year	Previous Years	Current Year
Economic Well-Being				
Children in poverty	**22%** (2010)	**18%** (2018)	**24%** (2010)	**20%** (2018)
Children whose parents lack secure employment	**33%** (2010)	**27%** (2018)	**35%** (2010)	**28%** (2018)
Children living in households with a high housing cost burden	**41%** (2010)	**31%** (2018)	**43%** (2010)	**29%** (2018)
Teens not in school and not working	**9%** (2010)	**7%** (2018)	**12%** (2010)	**8%** (2018)
Education				
Young children not in school	**52%** (2009-2011)	**52%** (2016-2018)	**66%** (2009-2011)	**61%** (2016-2018)
Fourth graders not proficient in reading	**68%** (2009)	**66%** (2019)	**75%** (2009)	**69%** (2019)
Eighth graders not proficient in math	**67%** (2009)	**67%** (2019)	**71%** (2009)	**69%** (2019)

Domains and Indicators	United States		Arizona	
	Previous Years	Current Year	Previous Years	Current Year
High school students not graduating on time	21% (2010-2011)	15% (2017-2018)	22% (2010-2011)	21% (2017-2018)
Health				
Low-birthweight babies	8.1% (2010)	8.3% (2018)	7.1% (2010)	7.6% (2018)
Children without health insurance	8% (2010)	5% (2018)	13% (2010)	8% (2018)
Child and teen deaths per 100,000	26 (2010)	25 (2018)	28 (2010)	31 (2018)
Children and teens (ages 10 to 17) who are overweight or obese	31% (2016-2017)	31% (2017-2018	26% (2016-2017)	27% (2017-2018)
Family and Community				
Teen births per 1,000 births	34 (2010)	17 (2018)	42 (2010)	20 (2018)
Children in single-parent families	34% (2010)	35% (2018)	37% (2010)	38% (2018)
Children living in high-poverty areas	13% (2008-2012)	10% (2014-2018)	22% (2008-2012)	18% (2014-2018)
Children in families where the household head lacks a high school diploma	15% (2010)	13% (2018)	19% (2010)	16% (2018)

Source: Annie E. Casey Foundation, 2020a, 2020b.

The **Economic Well-Being domain** showed positive changes for Arizona in all four areas, mirroring national improvements. In Arizona, fewer children were observed living in poverty, down from 24% in 2010 to 20% in 2018. In comparison, national rates showed a decline from 22% in 2010 to 18% in 2018. The remaining three Economic Well-Being indicators showed improvements both nationally and in Arizona. In Arizona, the rate of children with parents that lack secure employment dropped from 35% in 2010 to 28% in 2018. Additionally, the rate of teenagers not in school or working decreased from 12% in 2010 to 8% in 2018. Arizona shows continued improvement in children who are living in households with a high housing cost burden, which has decreased from 43% in 2010 to 29% in 2018. Arizona has reversed a downward trend in the Economic Well-Being category in recent years, moving from the 46th to the 36th position among states.

In the **Education domain**, Arizona continues to see improvements in all four indicators, while some national indicators remain unchanged. Arizona's rate of young children not in school decreased from 66% in 2010 to 61% in 2018. This rate is still higher than the national rate of 52% for both time periods. Likewise, the rates of student academic proficiency and on-time high school graduation continue to improve but lag behind the national average.

For the Education domain, Arizona's state ranking got worse from 44th in 2017 to 45th in 2018. Arizona dropped from 45th in 2018 to 46th in 2020.

In the **Child Health domain**, the percentage of children without health insurance has decreased in both Arizona (13% in 2010 and 8% in 2018) and nationally (8% in 2010 and 5% in 2018). The rate of low-birthweight babies is slightly worse nationally at 8.3% of infants in 2018, compared to 7.6% in Arizona in 2018. However, Arizona's rate of low-birthweight babies has slightly increased in 2018, compared to 7.1% in 2010. Child and Teen Deaths per 100,000 improved nationally (from 26 down to 25) and worsened in Arizona (from 28 up to 31). Arizona's national state ranking has improved over time in the Child Health domain, ranking 45th in 2016, 40th in 2017, and 38th in 2018. Arizona's position of 33rd overall for the 2020 Child Health domain is the state's best ranking compared to other domains. These rankings are out of 50 states, with 50 being the worst state ranking.

In **Family and Community domains**, Arizona saw improvement in three of four indicators yet remains higher than the overall national average. Arizona's teen birth rate dropped from 42 per 1000 births in 2010 to 20 per 1000 births in 2018. Additionally, the percentage of children in families where the household head lacks a high school diploma decreased from 19% in 2010 to 16% in 2018. Conversely, Arizona showed a mild increase over time in the percentage of children living in single-parent households (37% in 2010 to 38% in 2018). The percentage of children living in high poverty areas has improved from 22% in 2010 to 18% in 2018. Arizona's state ranking in the Family and Community domain remains unchanged at 46th, where it has remained consistently since 2016.

Overall, Arizona continues to perform more poorly than the national trend in 13 of the 16 child well-being indicators measured in 2020. In 2020, Arizona ranked 42nd out of 50 states (with 50th being the worst ranking) in overall child well-being, showing mild improvement yet remaining poor compared to national averages. These indicators demonstrate the strong need for Healthy Families Arizona, which provides additional supports to families and helps mitigate the risk of experiencing poor outcomes in early childhood and in transitioning to adulthood.

Arizona is ranked 42nd out of 50 states in child well-being (with 50 being the *worst* ranking).

Arizona rates are worse than the national average in 13 of 16 child well-being indicators.

Literature Review

This section of the report highlights some key takeaways from recent research on early childhood home visitation programs. First, we will discuss emerging research on the early impacts of the COVID-19 pandemic on home visitation programs. Then, we will turn to a review of factors that influence parental participation and retention in home visitation programs. Finally, we will highlight the importance of home visitor wellbeing and strategies for supporting home visitors' mental health.

Home Visitation Programs Adapt to the COVID-19 Pandemic

In 2020, the most notable development in home visitation programs across the globe has been the COVID-19 pandemic and how programs have responded and adapted to this crisis. Like all social service programs, home visitation programs have had to pivot their service delivery models to help protect the safety of program participants and staff in the middle of a global pandemic. Peer-reviewed literature has not yet been published regarding the impact of COVID-19 on home visitation programs like Healthy Families. This research will likely be published in future months and years. However, the Home Visiting Applied Research Collaborative (HARC) conducted an online survey in early April 2020 to gauge the early impact of COVID-19 on home visitation and reported on the results (HARC, 2020).

Survey respondents from the HARC survey provided information about over 1,300 programs across all 50 states, the District of Columbia, and several tribal communities (HARC, 2020). At that early point in the pandemic, nearly 90% of local programs had stopped in-person home visits altogether (HARC, 2020). In response, local programs used multiple modalities to reach participants, including text-messaging, telephone calls, and interactive video conferencing, relying fairly equally on telephone and video conferencing technology to conduct visits (HARC, 2020). Respondents shared about some of the challenges they experienced in using video conferencing. The most common challenge was a lack of consistent internet connection, for both families' and home visitors' (HARC, 2020). Many respondents also mentioned that families do not have access to technology such as tablets and webcams (HARC, 2020). Many local programs also experienced financial and workforce impacts from the pandemic. Although only a few programs had laid off staff by early April, half had been unable to hire new staff and some programs had to reassign staff to other areas (HARC, 2020). Given the ongoing public health and socioeconomic effects of the pandemic, additional research and evaluation is needed to further illuminate how home visitation has changed now that the pandemic has continued for most of a year.

Home Visitor and Program Characteristics Influence Parental Involvement

Maternal, infant, and early childhood visitation programs have long faced challenges related to parental involvement, which encompasses the enrollment, engagement, and retention of parents and caregivers in home visitation programs (Bower et al., 2020). Bower and colleagues (2020) recently published a review of research on this topic. They reviewed 22 studies published between 2007 and 2018. Among these, the most commonly researched aspect of parental involvement was retention/attrition (Bower et al., 2020). Researchers have often looked at the relationship between parental characteristics and retention, but this research has not shown consistent associations between parental factors such as age, race/ethnicity, marital status, income, education, or employment status and program retention.

Researchers have not examined home visitor and program characteristics as often as parent and family characteristics (Bower et al., 2020). Nevertheless, the limited research in this area has shown more consistent associations between these types of factors and parental involvement. Research suggests that these factors may be more salient in explaining and predicting differences in parental engagement and retention. Latimore and colleagues (2017) found that home visitor characteristics explained the vast majority, 87%, of the variation in family engagement in their study. It is well documented that the quality of relationship between home visitors and parents is an especially important factor related to parental retention, as confirmed by four studies in the review (Bower et al., 2020). Another study found that engaged participants described a close relationship and emotional bond with home visitors (Bower et al., 2020). Additional factors that appear to positively influence parental retention and/or participation include home visitor supportiveness, friendliness, and tendency to interpret parental unresponsiveness as a sign of stress (Bower et al., 2020). This last factor adds to the existing knowledge of the importance of home visitor and parent relationship and suggests addressing unresponsiveness as a stress reaction may lead to better retention. Home visitors and supervisors should monitor unresponsiveness and develop additional engagement plans as needed.

Programmatic characteristics may also affect parental involvement. One detrimental factor is staff turnover, which can sometimes be related to home visitors' occupational stress (Bower et al., 2020). We will discuss this further in the section below. Overall, Bower and colleagues (2020) emphasized the need for more exploration of home visitor-, program-, and even neighborhood-level factors rather than continuing to focus on parental characteristics alone. As a takeaway, home visitation programs may also want to focus more attention on improving home visitor and program factors to influence parental retention, rather than narrowly focusing on parental behaviors or characteristics.

Home Visitor Health and Wellbeing

As discussed, home visitor factors can make a big difference on participant retention. Home visitors' mental health and well-being are often overlooked in conversations about participant retention and service quality (National Home Visiting Resource Center [NHVRC], 2020a). When home visitors are stressed or burnt out it negatively effects both staff and participant retention (NHVRC, 2020). Visitors' emotional exhaustion appears to relate to participants' length of participation in programs (NHVRC, 2020a). Stress and burnout can also interfere with home visitors forming close relationships with participants, with negative implications for both staff and participants (NHVRC, 2020a).

Home visitors work with families who experience numerous stressors and both chronic and acute trauma (NHVRC, 2020a). Exposure to repeated secondary trauma can have a cumulative effect on social service providers' mental health and wellbeing, and can lead to compassion fatigue (NHVRC, 2020b). Home visitors are at risk for secondary traumatic stress responses. This year, the typical stressors of this work are exacerbated by the COVID-19 pandemic. Both families and staff are under stress and face potential trauma due to the pandemic as they navigate risk of infection, possible illness, disability and loss, increased isolation, job insecurity, economic stressors, and competing responsibilities related to work and child/eldercare. Social service providers are experiencing these same stressors, variously compounded by other stressors such as systemic racism and social determinants of health (Global Social Service Workforce Alliance et al., 2020).

What can home visitation programs do to support home visitors' mental health and wellbeing, particularly in the context of the pandemic? For one, home visitation programs can adopt trauma-informed approaches that extend to both participants and staff (NHVRC, 2020b). This can include providing opportunities for home visitors to reflect on secondary traumatic stressors and receive support via supervision (NHVRC, 2020b). Some promising practices include ongoing coaching to address sensitive topics with families, reflective supervision strategies to promote self-awareness and help home visitors cope with stress and providing training and support to promote mental health (NHVRC, 2020b). In the midst of the pandemic, Global Social Service Workforce Alliance (GSSWA), UNICEF and other partner organizations (2020) recommend providing training and regular supervision and supporting staff to develop and implement self-care plans. They also recommend that supervisors model self-care behaviors, such as taking regular breaks, and help staff members to connect to peer support and/or professional mental health resources as needed (GSSWA et al., 2020). Particularly in the context of the pandemic, home visitation programs should prioritize supporting home visitors' wellbeing to improve staff experiences and retention, and also to support service quality for participants.

Healthy Families Arizona Program Updates

Response to the COVID-19 Pandemic

On March 31, 2020, due to the COVID-19 pandemic, Arizona implemented the executive order to "Stay Home, Stay Healthy, Stay Connected." As a result of this order, in April 2020 Healthy Families Arizona quickly shifted from conducting home visits with families in person to conducting them virtually via telephone and video. Due to the variable nature of the pandemic, most areas throughout the state have continued to conduct most home visits virtually. The following adjustments were made to accommodate virtual service delivery:

- All forms were converted into fillable electronic versions.
- Regular program manager calls were conducted to provide support and shared learning.
- Quarterly supervisor meetings were conducted via Zoom.
- Advisory Board meetings were conducted via Zoom.
- Home visit observations were conducted in a socially distanced manner – the majority of which were conducted virtually via telephone or video.
- Stop-Gap Office Chats were implemented to support new staff and supervisors as in-person core trainings were halted while Healthy Families America developed an online training solution.

Training and Professional Development

Several staff trainings occurred between October 1, 2019 and September 30, 2020.

- Stop-Gap Office Chats were conducted from May through September for staff and supervisors. These were developed to support new staff and supervisors while the core trainings were on hold due to the pandemic.
- Two statewide coordinators, two supervisors, one home visitor, and the statewide evaluator presented four sessions at the Healthy Families America conference held virtually from October 20-22, 2020. Several other staff and supervisors attended.
- Three Parent Survey trainings for Family Assessment Workers (FAW) and supervisors were held November 2018, April 2019, and September 2019.
- Six Foundations of Family Support for Family Support Specialists (FSS) and supervisors were held August 2018, December 2018, February 2019, May 2019, August 2019, and September 2019.
- Additional trainings were held locally within agencies throughout the state in support of home visiting.
- Several Healthy Families Arizona service staff virtually the FTF Early Childhood Summit and the Strong Families Arizona Conference in September 2020.

- Statewide training in the online data system (HFAz AZ ETO) was conducted for new staff in April and May 2020, with additional training for supervisors in July 2020.

Statewide Supervisor Training Activity

The challenges of supervision in home visitation programs have been well documented and researched. Healthy Families Arizona, like many programs, is facing unique challenges in supervision during this period of remote home visiting. In the fall of 2020, there was an identified need for continuing training and support for supervisors to effectively support their staff who provide remote home visiting services, to assess quality of services being delivered by FSS, and to promote the use of data-driven assessment information as the home visitor makes choices about evidence-based interventions. In response to this need, in fall 2020, LeCroy & Milligan Associates designed and provided a three-part webinar series to provide information, resources, and facilitated dialogue around these supervision challenges. The Supervisor Series was offered and attended by almost all Healthy Families Arizona supervisors and included:

- An overview of research and promising practices around remote home visitation approaches, and supervision approaches and tools to assure quality service delivery.
- A forum for sharing best practices and generate solutions to supervision challenges through facilitated small group work during the webinar.
- Supervisor skills and approaches in insuring successful administration of assessment instruments.
- A focus on skills and knowledge needed to effectively support FSS in using assessment results to plan focused interventions, create better family plans, and select curriculum activities.
- The development of shared Checklists for Supervision Practice focused on key topics, quality indicators, approaches and tools to use in supervision.

2020 Statewide HFPI Training Activity

Home visiting staff and supervisors also received training on the Healthy Families Parenting Inventory (HFPI) provided by LeCroy & Milligan Associates. The HFPI is an assessment tool that is used to provide home visitors with insight into the families they serve and how they can best support their parenting skills. A total of 68 new staff received training over six sessions in May and June 2020. Home visitors indicated on satisfaction surveys that they felt better prepared to use the HFPI as a tool to help support the families and provide better services.

Collaboration between First Things First, Arizona Department of Health Services, and Department of Child Safety

Healthy Families Arizona Central Administration housed within DCS continues to participate in statewide coalitions to increase collaborative efforts with FTF and DHS. Healthy Families Arizona Central Administration focuses on maintaining healthy working relationships with FTF and DHS to support model fidelity and consistency across the program's statewide evaluation, training, quality assurance, technical assistance, program development, administration, and any other program related activity. Collaboration occurs in a variety of settings both formally and informally. Healthy Families Arizona Central Administration discusses budget and funding frequently with DHS and reviews monthly reports and billing. In addition, Healthy Families Arizona Central Administration participates in the Inter-agency Leadership Team, which is a joint effort between DCS, DHS, FTF, and several other agencies to work collaboratively to improve services offered to Arizona families. MIECHV funding received through DHS requires participation in a Continued Quality Improvement (CQI) component by MIECHV funded Healthy Families sites to improve outcomes such as child immunizations rates throughout the state.

State Opioid Response Grant

Starting July 1, 2019, Healthy Families Arizona received an additional $2 Million in funding through September 29, 2020. These funds come from the Arizona State Opioid Response Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) administered by the Arizona Health Care Cost Containment System (AHCCCS). This money was used to provide services to families who have a history of substance use. This funding helped replace the Title IV-E waiver funding that ended in September 2019. Families who are receiving Healthy Families Arizona services and funded by this source are indicated as such in the overall evaluation. However, there is no separate analysis conducted specific to these families.

Evaluation of Program Implementation

Staff Survey - April and October 2020

On March 31, 2020, due to the COVID-19 pandemic Arizona implemented "Stay Home, Stay Healthy, Stay Connected." As a result of this executive order, Healthy Families Arizona quickly shifted from conducting home visits with families in person to conducting them virtually via telephone and video starting in April 2020. To provide information and support to program managers and agencies, a survey was collected from Healthy Families Arizona staff in April 2020 about their experience of working from home. The April 2020 survey was designed to:

- Identify the kinds of resources that staff had available and were using;
- Identify how staff were connecting to families; and
- Identify other issues that staff were experiencing in this shift to a new way of delivering services.

A follow-up survey was conducted in October 2020 to determine changes in staff practices and experiences with virtual service delivery.

Survey Methodologies

The staff surveys were constructed based on questions of interest to Healthy Families Arizona Central Administration staff as well as suggestions from program managers. Both surveys were administered using the Qualtrics platform. All Healthy Families Arizona staff were invited to complete the surveys by email. A link to the first survey was sent on April 24, 2020 and the survey was closed on May 15, 2020 after sending two reminder emails. A total of 288 staff were contacted with 235 following the link to the online survey (it should be noted that five did not complete more than first question and four did not complete the working from home questions). The survey produced an 80% response rate to the survey overall and a 79% response rate for the working from home questions. A total of 226 Healthy Families Arizona staff answered the questions about working from home on the survey, however not all staff answered all questions. A link to the second survey was sent on October 22, 2020 and the survey collector was closed on November 4, 2020 after sending two reminder emails. Out of a total of 268 staff, 154 staff completed the October 2020 survey for a 57% response rate. It should be noted that that these results are not intended to be generalized to all Healthy Families Arizona staff. Results are interpreted from the respondents only and may or may not represent experiences of all staff. Healthy Families Arizona staff and leadership are encouraged to review these results with their respective staff to identify means to improve programming for families at this unique time. The total number of staff that responded to each question is provided in the report below.

Staff Experiences with Working from Home

Tools/Resources for Working from Home

Almost all staff surveyed in April 2020 reported having a laptop or computer and internet access, however less staff indicated that they have fast enough or stable enough internet for conducting video calls with their families (81%) (Exhibit 4). Most staff appear to have what they need to conduct virtual home visits, however, more than a fourth of respondents do not have dedicated space to conduct virtual home visits in privacy. Recommendations to agencies include providing staff with headphones with voice capability to provide at least some privacy for the staff who are lacking headphones or space for privacy during visits.

Exhibit 4. Tools and Resources that Staff Utilize to Work from Home, Reported in April 2020

Tools/Resources at Home	n	%
Laptop/computer	222	98%
Internet access	221	98%
Phone connectivity/good cell service	204	90%
Camera for virtual visits/meetings	203	90%
Microphone for virtual visits/meetings	184	81%
Good internet speed for virtual visits/meetings	182	81%
Headphones	173	77%
Dedicated space to conduct visits	167	74%

(N=226)

Exhibit 5 shows the materials, supplies, or processes that would help staff to work better from home, as reported in April and October 2020. The results are organized in descending order by the number of responses in October. The October survey responses indicate 50% of staff did not need additional resources. Equipment needs, such as computers, phones, and printers were generally much lower in October (8%) than in April (24%). Further, the need for improved internet capacity decreased from 11% in April to 3% in October. Electronic forms and use of confidential electronic signatures were requested by 5% (n=7) of the respondents in October, down from 9% (n=9) in April. One area that remained consistent over time is the need for financial support for supplies, which was 14% in April and 12% in October. It is recommended that each agency address these needs as they are able to, so that home visitors have the resources that they need to conduct their best work from home.

A total of 10% (n=14) of respondents to the October survey requested more resources for virtual engagement of the families, both by phone and video (down from 16%, n=15 in April). These include more online curriculum, more visually stimulating materials and fun, interactive activities, as well as additional methods or training for better engagement of families virtually. For example, one suggestion is having puppets or some visual materials to do the activities that would be more attractive to the family. Another respondent proposed short activities to do with families virtually and using home items. It is recommended that agencies explore further resources and trainings to suit this need and work with other agencies to share experiences and ideas for means to enhance the families' engagement and development in the virtual environment. Needs for additional physical resources for activities, curriculum, and materials for families remained around 7% in April (n=7) and October (n=10). Specific requests included curriculum for children over 36 months and activities for all ages, particularly ages four and five years. Having more efficient means to ship materials to families was mentioned by two respondents.

Exhibit 5. Materials, supplies, or processes that would help staff work better from home, Reported in April and October 2020

Other Supply Needs	April 2020		October 2020	
	n	%	n	%
No additional needs	0	0%	70	50%
Financial help for/provision of office supplies (ink, paper, items for families) and phone plans	14	14%	17	12%
Virtual resources and methods: Online Curriculum, Activities, materials/ Easier methods/training to engage families virtually	15	16%	14	10%
Printer/Scanner/Shredder	25	24%	11	8%
Physical resources for activities, curriculum, and materials for families	7	7%	10	7%
Computer/Phone/Camera/Monitor/Mouse/Keyboard/Microphone	13	13%	9	6%
Electronic forms/signature/confidentiality	9	9%	7	5%
Dedicated private/spacious home-virtual work environment	9	9%	6	4%
Better/working internet	11	11%	4	3%
Desk and chair	13	13%	3	2%
Better access to family's files (either paper or electronic)	7	7%	3	2%
Shipping/Efficient ways to get materials to families	0	0%	2	1%
File cabinet/lock box for files/storage	10	10%	1	.7%

(April: N=104, October: N=140)

Challenges with Working from Home

Both surveys asked staff the open-ended question, "What are the challenges you are experience working from home?" A total of 175 staff responded to this question in April 2020 and 144 in October 2020. The most common themes are shown in Exhibit 6 and the data is organized in descending order by the number of respondents in October.

Exhibit 6. Challenges with Working from Home, Reported in April and October 2020

Challenges	April 2020		October 2020	
	n	%	n	%
Families less engaged virtually due to or disinterest	14	8%	46	32%
Families losing internet or phones, lacking necessary supplies for activities	30	17%	26	18%
None	18	10%	24	17%
Technology Issues (Video failing, poor internet, Citrix connection issues, etc.)	37	21%	15	10%
Not having access to family files or curriculum materials, lack of consents available	13	7%	15	10%
Balancing work/life	37	21%	9	6%
Supplies/equipment - paper, printing, etc.	13	7%	8	6%
Having a dedicated space / organization	29	17%	7	5%
Feeling overworked, stressed, anxious, exhausted, or in physical pain (neck, back, ears), feeling micromanaged or unsupported	28	16%	7	5%
Missing team or connection with others	9	5%	2	1%
Child Care Needs	13	7%	0	0%

(April: N=175, October: N=144)

The greatest challenges reported in April by 21% of respondents (n=37) included balancing work/life issues and experiencing issues with technology, such as poor internet and connectivity issues. Both of these areas were reported less frequently in October. Of note, in October no staff reported experiencing child care issues, compared to 7% (n=13) in April. Additionally, a higher percentage of staff (17%, n=24) in October reported experiencing no challenges working from home, compared to 10% (n=17) in April.

The challenge that received almost a third of respondents in October (32%, n=46), up from 8% (n=14) in April, was the difficulty in engaging families due to their disinterest in virtual visits, phone/screen fatigue, and distractions from competing home and professional demands. Responses suggest that for some families, the in-person activities were an important component of their home visits. Without this interaction, these families are less interested in engaging. Additionally, staff reported that engaging families in assessments through virtual visits were more challenging than in person. A few staff commented that video visits made it more difficult to assess safety concerns and observe the families' behaviors. Some families also prefer phone visits over video, which further reduces staff abilities to model activities and observe and engage with the families. Staff reported needing to be more flexible in scheduling because families were less consistent in answering phone calls, scheduling, and returning paperwork, often rescheduling at the last minute or outside of usual hours, and not attending more frequently than prior to working from home. The flexibility in the staff work hours is still an express need.

Having access to files and transporting files or printing of materials was reported at a higher rate in October (10%, n=15) compared to April (7%, n=13). Some reported not having electronic access to curriculum, consents and files or only being able to access files while in the office. This impacted their ability to use them in some of their virtual visits, many of which were scheduled for the home office time or sporadically.

Areas for Support

The April and October 2020 surveys also asked staff the open-ended question, "What would help you feel more supported working from home?" A total of 114 staff responded in April 2020 and 120 in October 2020. The most common themes are shown in Exhibit 7. Over half of the staff that responded to this question in October (53%, n=64) indicated that they are feeling supported and did not ask for additional supports.

Exhibit 7. Areas to Help Staff Feel More Supported Working from Home, Reported in April and October 2020

Areas to feel more supported	April 2020		October 2020	
	n	%	n	%
None, staff feel supported	55	48%	64	53%
Better support from supervisor and agency - being trusted and not micromanaged	13	11%	14	12%
Printer/copier/better computer - financial help to cover ink, paper, internet	14	12%	6	5%
More time to work from home for COVID-19 avoidance	0	0%	6	5%

Areas to feel more supported	April 2020		October 2020	
	n	%	n	%
Social interactions with team or others	9	8%	4	3%
Access to family files at home either physical or online (not just ETO) and online curriculum	10	9%	3	3%
Coaching/training on how to structure virtual visits	6	5%	3	3%
Better IT support from agency	4	4%	2	2%
Able to go into office if needed	4	4%	1	1%

(April: N=114; October: N=120)

A common response given by 12% (n=14) of staff in October is that they could use better support or understanding from their supervisors or agency. While many felt supported overall with the agency adaptations since the pandemic began, several staff and some supervisors reported needing more understanding or empathy from their supervisors. A supervisor mentioned that supervisors have many requirements to manage while trying to balance taking care of themselves so that they are wholly health (emotionally and physically) for their staff and the families they support. Among responses in the April survey, several staff specifically felt micromanaged and feeling overburdened by the current level of "proof of work" and shortened times to turn paperwork. A staff member expressed this need as being *"Less micromanaging; I feel like our boss does not trust us with the hybrid work model and is changing the way we do things each week--providing us with very little consistency, then getting frustrated when we make errors. I also feel like there could be more empathy towards our Healthy Families, family's stress levels and their struggles with consistency at this time*." In another example, a staff person stated there could be *"less pressure to engage families that are not engaging."*

One area of support that was not reported in April (0%) but was reported by 5% (n=6) of staff on the October survey is the need for more time to work from home, particularly for COVID-19 avoidance, rather than requiring staff to return to the office when they are not comfortable doing so. A suggestion was made that managers should be given the ability to decide whether staff can work from home or in the office. The need for social interaction and team support was reported less often in October than in April. However, one staff member expressed a need for more mental health consultation and additional professional supervision consultation to help navigate the challenges during this time. A few expressed an interest in more coaching and training for structuring virtual visits and engaging families. A respondent felt greater opportunities to support each other, as well as sharing

experience across sites, around challenges and adaptations would be beneficial. Several areas of support reported in the April surveys were less prevalent in the October survey, indicating improvements in accommodating staff. For instance, difficulties in obtaining curriculum, materials and files reported were fewer in October (3%, n=3) than in the April survey (9%, n=10) and having supplies and resources went from 12% (n=15) to 5% (n=6) in October.

Staff Self-Care Practices

Exhibit 8 compares the open-ended responses of staff respondents in April 2020 (n=178) and October 2020 (n=143), with the results sorted in descending order by October responses. The question was: "Are you taking time for self-care? How are you practicing self-care right now?" Each respondent often had more than one answer to the question and all were coded for this question. At both time points, the majority of the self-care comments are about practicing self-care by getting exercise. Of note is that there was an increase from 4% (n=8) in April to 15% (n=22) in October of staff commenting that they were not doing well with self-care practices.

Exhibit 8. Staff Self-Care Practices, Reported in April and October 2020

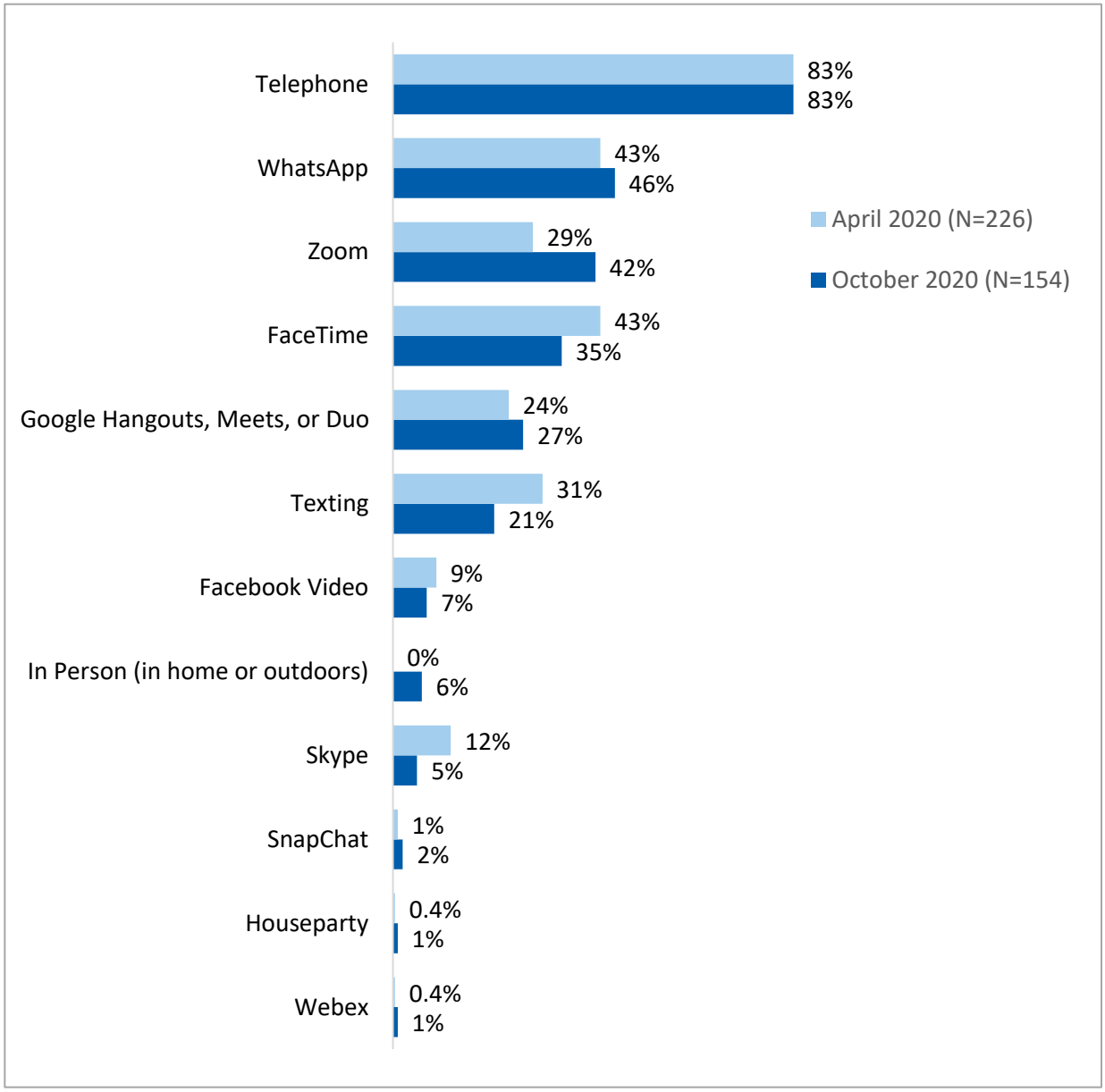
Self-Care	April 2020		October 2020	
	n	%	n	%
Exercise - walking, biking, playtime	94	53%	62	43%
Reading/ Hobbies/ Music/ Movies / Cooking	43	24%	26	18%
Not doing well with practicing self-care	8	4%	22	15%
Setting a schedule/ routine for myself - stopping work at end of day	19	11%	20	14%
Time with family or talking with loved ones	34	19%	17	12%
Deep breathing / Yoga / Meditation / Fresh Air	32	18%	17	12%
Resting / Relaxing/ Take a Brief Break	38	21%	14	10%
No specific answer given, but doing it	10	6%	8	6%
Regular Sleep Schedule or Extra Sleep	9	5%	7	5%
Healthy eating	13	7%	5	3%
Limiting exposure to news or social media	2	1%	4	3%
Bath or skin care	10	6%	2	1%
Talk with coworkers or supervisor	5	3%	0	0%
Staying home, washing hands, being careful	4	2%	0	0%

(April: N=178; October: N=143)

Virtual Visit Strategies

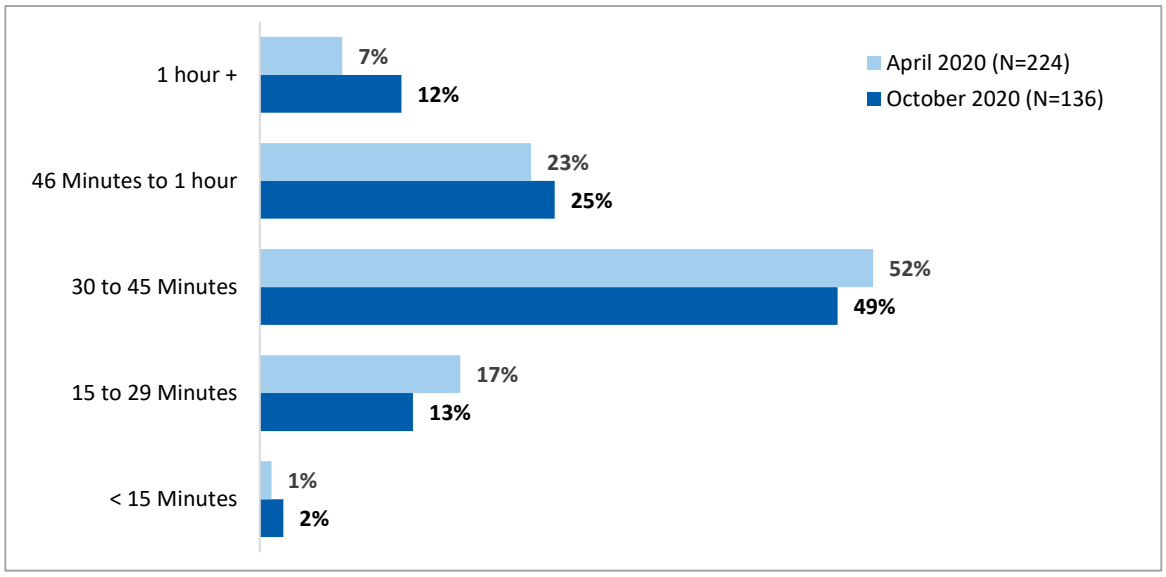
During both time frames, 83% of staff reported conducting virtual visits by telephone (Exhibit 9). Platforms used more commonly by staff in October that April include WhatsApp, Zoom, and Google Hangouts/Meets/Duo. Platforms less commonly used in October compared to April include FaceTime, texting, Facebook, and Skype. Of note, 6% of staff in October reported that visits had resumed to in-person, either in home or at an outdoor location. However, this type of visiting may no longer be allowed at the time of reporting, due to an increase in COVID-19 cases in communities.

Exhibit 9. Platforms for Conducting Virtual Home Visits, Reported in April and October 2020



October survey data showed that a higher percentage of staff in October reported that their average visits are an hour or longer or for 46 minutes to an hour, compared to staff reports in April (Exhibit 10).

Exhibit 10. Average Length of Virtual Visits, Reported in April and October 2020



In April, staff were asked "How are your virtual home visits going? What is the same and what is different about your visits with your families?" (N=159) and in October a similar question was asked, "How are your virtual home visits going? What is the working well and what challenges are you having in your visits with your families?" (N=125). Results are shown in Exhibit 11. In both time frames, over half of staff indicated that virtual service delivery was going well, however the percentage dropped slightly from 64% (n=102) in April to 57% (n=71) in October.

The challenges shown in Exhibit 11 are listed in descending order by the percentage reported in October. Three areas reported as challenges by a higher percentage of staff in October include: difficulties in engaging children and conducting assessments during virtual visits and that parents are stressed, which can distract them from the visit. Two areas that a higher proportion of staff reported in April compared to October were conducting virtual activities and observations of parent-child interactions. The lower percentage of staff reporting these areas may reflect staff becoming more comfortable and skilled in carrying out visits in a virtual environment.

Exhibit 11. Staff Reflections on Virtual Service Delivery

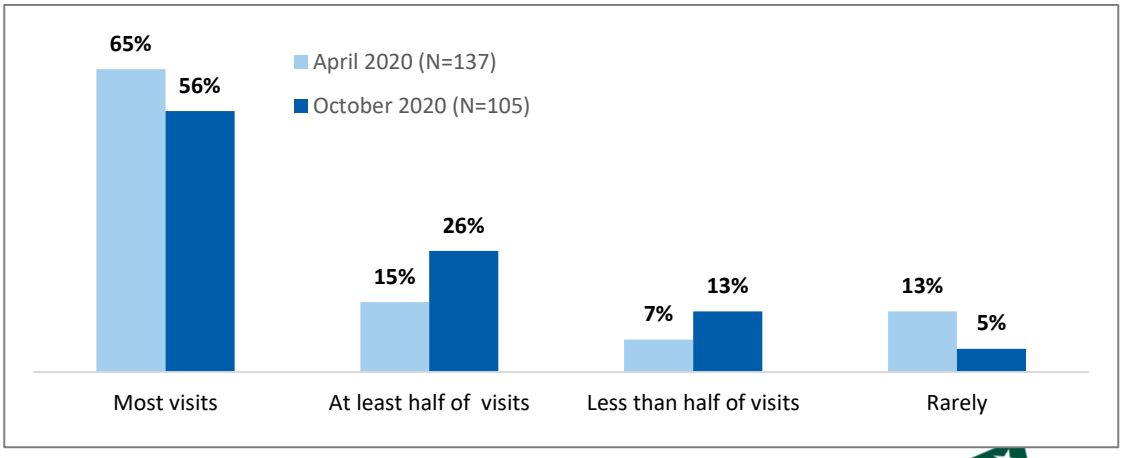
How are virtual home visits going?	April 2020		October 2020	
	n	%	n	%
Going well, families engaged, fewer cancelled visits	102	64%	71	57%
Challenges				
Difficult to engage with children, less personal	14	9%	21	17%
Difficult to do assessments remotely/ hard to engage new families	19	12%	17	14%
Parents are stressed, which distracts them from the visit	9	6%	10	8%
Activities are harder to do virtually or when parents do not have supplies	28	18%	9	7%
Families have to get off the phone, visits not as long, unable to see them via video for parent-child interaction	46	29%	8	6%
Technical issues, bad cell reception or internet, loss of phone	9	6%	7	6%
Families want to meet face to face; feeling burned out on virtual visits	3	2%	6	5%
Difficult to keep up with paperwork	5	3%	0	0%

(April: N=159; October: N=125)

Curriculum and Activities During Virtual Visits

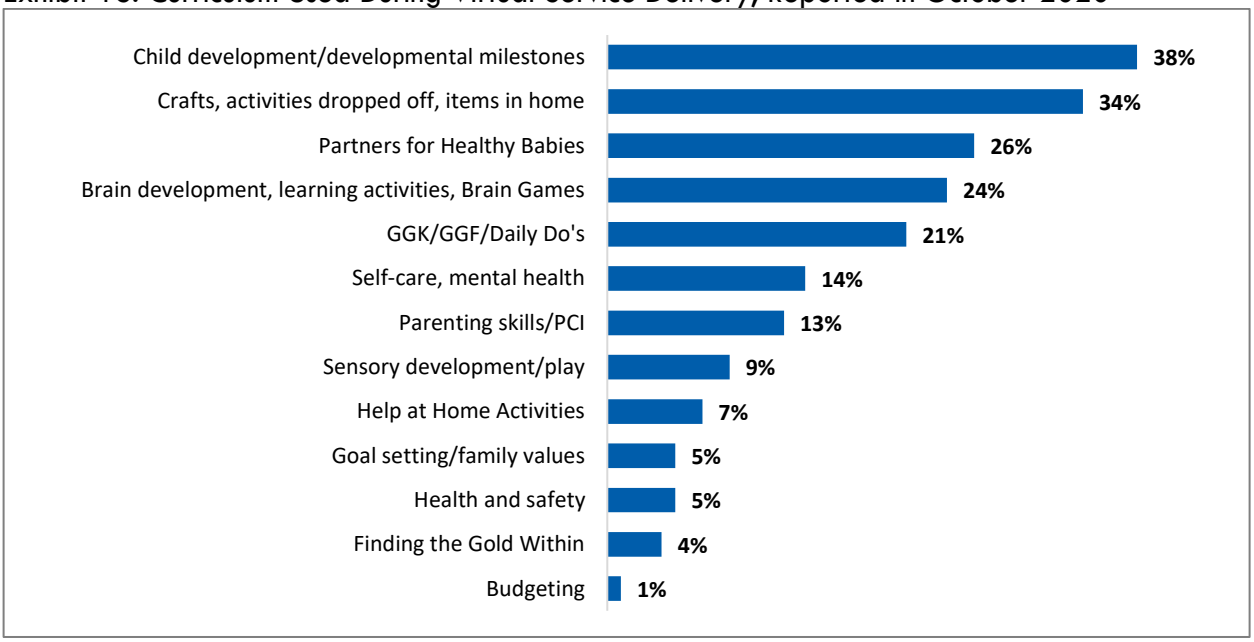
The majority of staff reported in April (65%, n=89) and October (56%, n=59) that they are conducting curriculum activities during most visits (Exhibit 12). However, a slight shift in percentages was observed from April to October, with a higher percentage reporting in October that activities are getting completed during at least half their visits (15% in April vs. 26% in October) or less than half of visits (7% in April vs. 13% in October). Continued support may need to be provided to home visiting staff who are not currently able to provide curriculum during the visits to help them develop creative solutions for virtual visits.

Exhibit 12. Frequency of Curriculum Activities During Virtual Visits, Reported in April and October 2020



The home visitors were asked the open-response question, "What types of curriculum activities are you doing with your families?" Exhibit 13 shows the types of curriculum and activities that FSS reported using with families during virtual service delivery on the October survey (N=103). The two major types of curriculum reported by staff include Partners for Health Babies (PFHB) and Growing Great Kids (GGK) and/or Growing Great Families (GGF). Other curriculum mentioned by a few staff include online links and handouts from Help at Home Activities, Just in Time Parenting, and Finding the Gold Within. Their responses are similar to the April survey as well as what is typically used throughout the state. The use of online supplemental curriculum is limited. It is recommended that all staff have access to an electronic version of curriculum that they can use during virtual visits.

Exhibit 13. Curriculum Used During Virtual Service Delivery, Reported in October 2020



(N=103)

Regarding child-focused activities, 38% (n=39) specified that they do child development activities with families, such as using checklists, reviewing developmental milestones, and conducting ASQ-3 assessments. Additionally, 34% (n=35) engage families in arts and crafts or other playful and learning activities during virtual visits. Many FSS specified that they will drop off an activity bag at the family's home or they will encourage families to utilize items that are readily available within the home. Almost a quarter of staff (24%, n=25) specified that they use age-appropriate learning or brain development activities with the child and 9% (n=9) specified using sensory development activities with the child.

Specifically supporting adults, FSS reported using curriculum for self-care and mental health, the GGF curriculum, and strategies to build parenting skills and support parent-

child interaction. These strategies include using positive discipline skills, working through difficult behaviors, and parenting during times of high stress (i.e., COVID-19). Other areas include setting goals and identifying family values, addressing family health and safety needs, and budgeting during challenging financial times.

Strategies for Virtual Visits

Staff were asked on the April and October survey, "What are your best tips and tricks for working from home and conducting visits virtually?" A total of 137 responded in April and 114 responded in October 2020. Common themes are shown in Exhibit 14. The most prominent theme mentioned at both time points was that staff should be prepared and organized for each virtual visit by having supplies, curriculum options, and notes from the last visit available. Staff commented that it is helpful to keep to a routine with the visits, followed by consistent documentation of paperwork. Other notable strategies for virtual home visits that were reported consistently at both time periods include: adapting to the family's needs and supporting them where they are at; setting aside a quiet workspace for conducting the visit; giving the family their full attention during the visit to make them feel comfortable; and sending resources or supplies to the family and sharing one's screen during the visit.

Exhibit 14. Strategies for Virtual Service Delivery, Reported in April and October 2020

Virtual Service Delivery Tips	April 2020		October 2020	
	n	%	n	%
Be prepared / organized / have a routine	49	36%	54	47%
Adapt to family needs / be flexible - support the family where they are	32	23%	25	22%
Set aside a quiet work space and times that work best for you	22	16%	18	16%
Give family your full attention / help families feel comfortable on virtual visits	15	11%	15	13%
Share your screen / send resources or supplies to families	12	9%	10	9%
More frequent communication with families	24	18%	9	8%
Be good to yourself (patience, understanding, set limits)	21	15%	4	4%
Try to keep things as normal or regular as possible	17	12%	3	3%

(April: N=137; October: N=114)

Perspectives on Supervision

Exhibit 15 presents staff responses in April (N=182) and October (N=138) to the question: "How do you feel about supervision right now?" At both time periods, the majority of staff reported feeling very supported. However, in October 2020, there was an increase in the percentage of staff (16%, n=22) who reported that supervision was "ok" or "as good as it can be," compared to 4% (n=8) in April. The percentage of staff respondents reporting that they do not feel supported by their supervisors continues to be very low at 5% (n=7) in October, compared to 3% (n=5) in April.

Exhibit 15. Staff Reflections on Supervision, Reported in April and October 2020

Staff Perspectives on Supervision	April 2020		October 2020	
	n	%	n	%
Feeling supported by supervision	169	92%	109	79%
Supervision is OK	8	4%	22	16%
Not feeling supported enough by supervision	6	3%	7	5%

(April: N=182; October: N=138)

On the April 2020 survey, staff were asked the open-ended question, "How much are your supervision sessions the same and how much are they different?" A total of 174 staff responded and they key themes are shown in Exhibit 16. Almost three-fourths of staff say they are getting the same things from supervision as they did when they were conducted in person. Overall, this speaks well to the consistency of supervisors in Healthy Families Arizona.

Exhibit 16. Staff Reflections on Changes in Supervision During Virtual Service Delivery, Reported in April 2020

Are supervision sessions the same or different?	n	%
Same	130	75%
Technical issues or not having files available	13	8%
More constructive / more effective	12	7%
Shorter	10	6%
Longer	8	5%
More Often	6	3%
Feels more disconnected/ more technical focused	5	3%
Some the same / some different (no explanation)	1	1%

Areas for Additional Supervisory Support

On the October 2020 survey, staff were asked how their supervisor could be more supportive at this time. A total of 122 responded to this question, with many respondents offering multiple suggestions. The common themes are shown in Exhibit 17. Nearly two-thirds (65%, n=81) of staff indicated that they are feeling satisfied with the support they are getting from their supervisor. Additionally, 8% (n=10) are not sure of how their supervisor could be more supportive to them. On the other hand, 15% (n=19) of respondents indicated that they would like supervisors to allow for more time in supervision to check-in with staff on their emotional well-being and provide them with emotional support. Additionally, some staff (8%, n=10) noted concerns with being too "micro-managed" in supervision and not feeling trusted to do their job. Finally, a few staff (4%, n=5) would like their supervisor to be more available but recognize that supervisors often have a lot of demands that impede on the time they can spend with staff on supervision.

Exhibit 17. Staff Suggestions for How Supervisors Could be More Supportive, Reported in October 2020

How could your supervisor support you better right now?	n	%
Satisfied with support from supervisor at this time	81	65%
Would like more emotional support from supervisor	19	15%
Not sure of how supervisor could be more supportive	10	8%
Experience supervision as being too "micro-managed"	10	8%
Would like supervisor to be more available; acknowledge that supervisor is very busy – "too much on their plate"	5	4%

Staff Rating of Assessment Tools

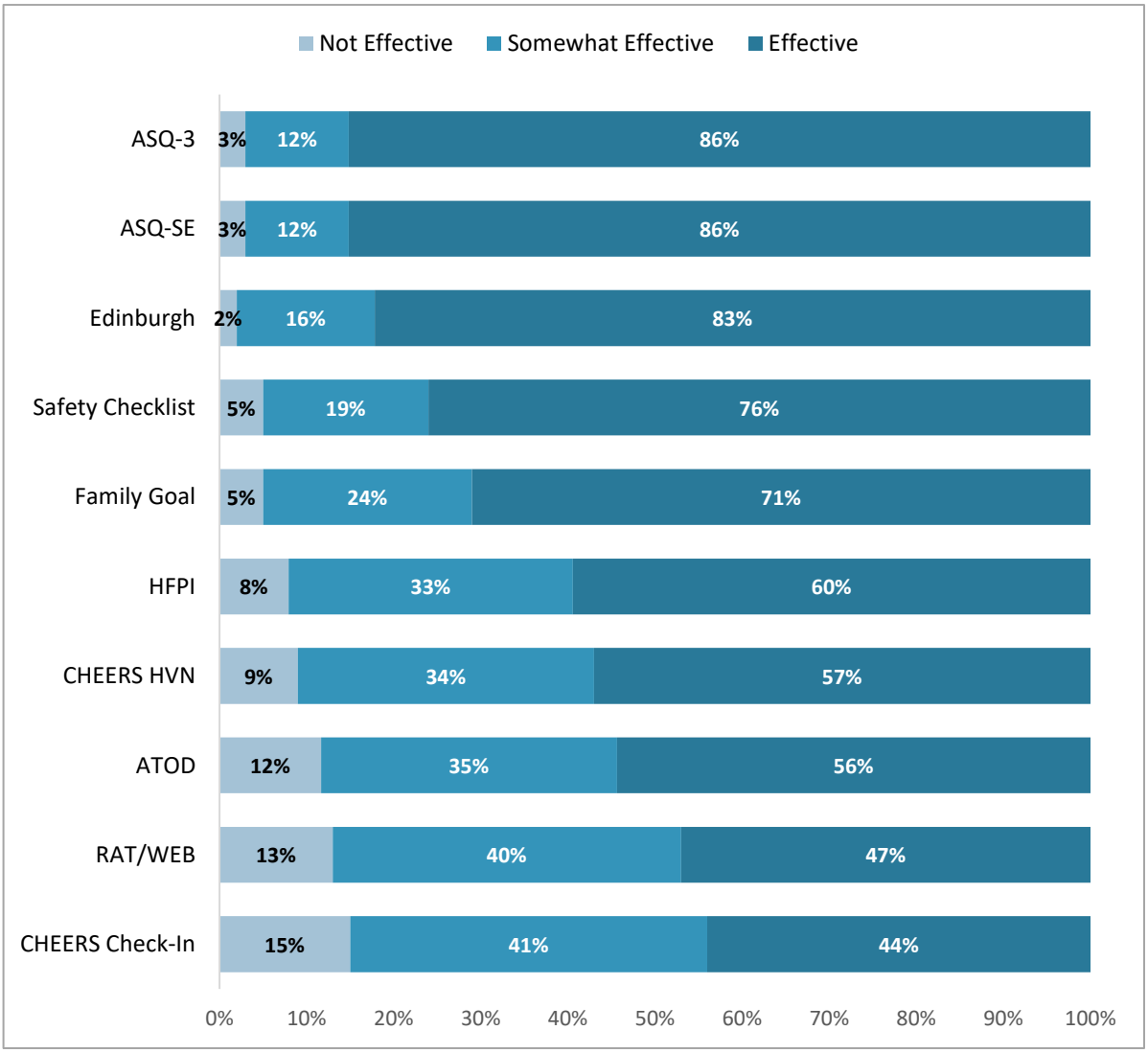
The October 2020 survey asked staff to rate each assessment tool using a 3 or 4-point rating scale for the following questions:

- How effective do you feel collecting this information [from the tool] from your families?
- How difficult or easy is the tool to collect data during virtual visits?
- How much does the tool provide you with information you use to engage with your families?
- How useful is the tool when building your service plan for your families?

Staff Efficacy to Collect Assessment Data

Exhibit 18 shows staff rating of how effective they feel in collecting assessment data/information from their families. Over 80% of staff rated themselves as "effective" in collecting the ASQ-3 (86%, n=103), ASQ-SE data (86%, n=102), and the Edinburgh Depression Scale (83%, n=104) with families. Approximately two-thirds to three-quarters of staff rated themselves as "effective" in collecting the Safety Checklist (76%, n=90), the Family Goal (71%, n=87), and the HFPI (60%, n=71). The three assessment tools that received 12% or more of respondents rating themselves as "not effective" in collecting this data include the ATOD (12%, n=14), the RAT/WEB (13%, n=15), and the CHEERS Check-in (15%, n=18).

Exhibit 18. Staff Efficacy Ratings to Collect Assessment Data

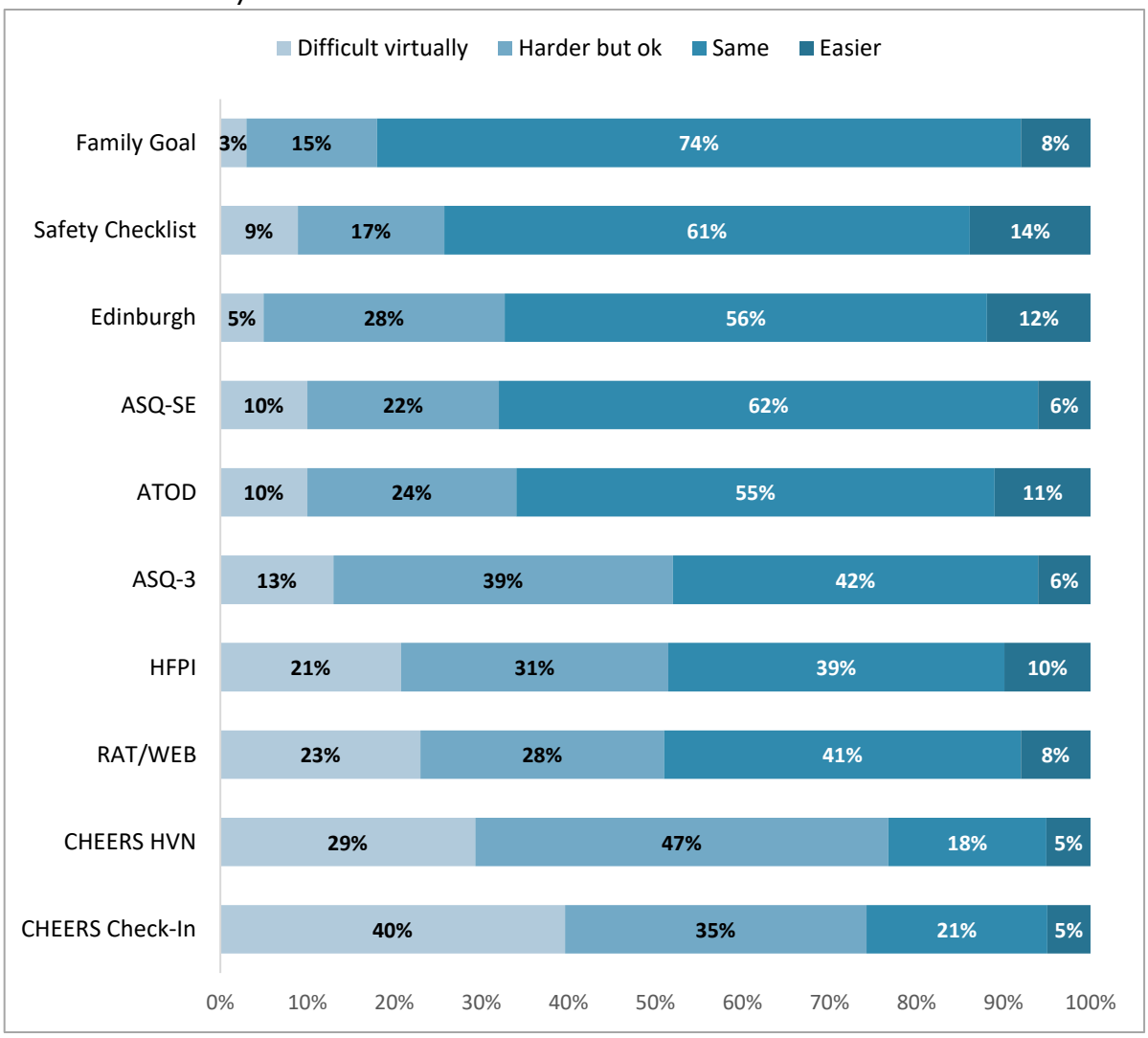


(N Ranges from 118-126)

Difficult or Ease in Collecting Data Virtually

Staff were asked to rate the level of difficulty or ease they have experienced in collecting data from the assessment tools virtually. A 4-point rating scale was used including 1 = "Difficult to do virtually", 2 = "Harder than in-person but okay," 3 = "Same as in person", or 4 = "Easier than in person." Exhibit 19 orders the assessment tools in descending order by the percentage of staff who rated it as being the "same" as in person or "easier" to collect than in person. The two tools that three quarters or more of staff rated as being the same or easier to collect virtually are the Family Goal and the Safety Checklist. Almost 30% or more of staff rated that the CHEERS on the Home Visit Note (29%, n=34), and the CHEERS Check-in (40%, n=46) are difficult to collect virtually.

Exhibit 19. Difficulty or Ease of Virtual Data Collection

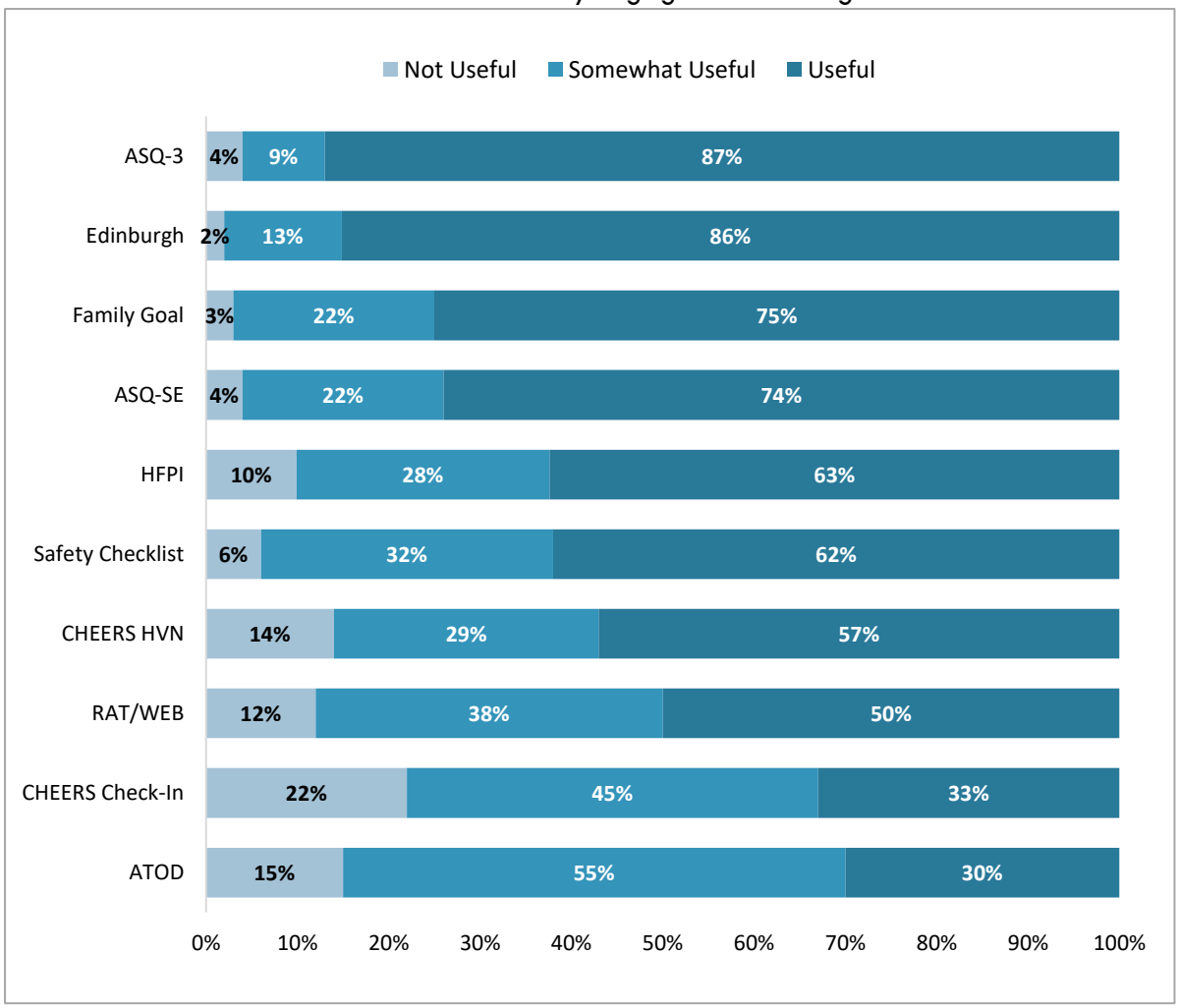


(N Ranges from 113-127)

Usefulness of Assessments in Engaging Families and Developing Service Plans

The October 2020 survey asked staff to rate how useful each tool is in providing them with information that they use to engage with families. Usefulness ratings are shown in Exhibit 20 and the tools are ordered by the percentage of staff that rated the tool as "useful". The ASQ-3 (87%, n=103) and the Edinburgh Depression Scale (86%, n=110) were rated by the majority of FSS as useful in providing them with information to better engage families. Approximately three quarters of staff rated the Family Goal (75%, n=94) and ASQ-SE (74%, n=93) tools as useful, and about two-thirds rated the HFPI (63%, n=79) and the Safety Checklist (62%, n=78) as useful tools for engaging with families. The three tools that received the highest percentage of staff rating of "not useful" for providing information to engage with families were the CHEERS Check-in (22%, n=27), the ATOD (15%, n=19), and the CHEERS domains noted on the Home Visit Note (14%, n=17).

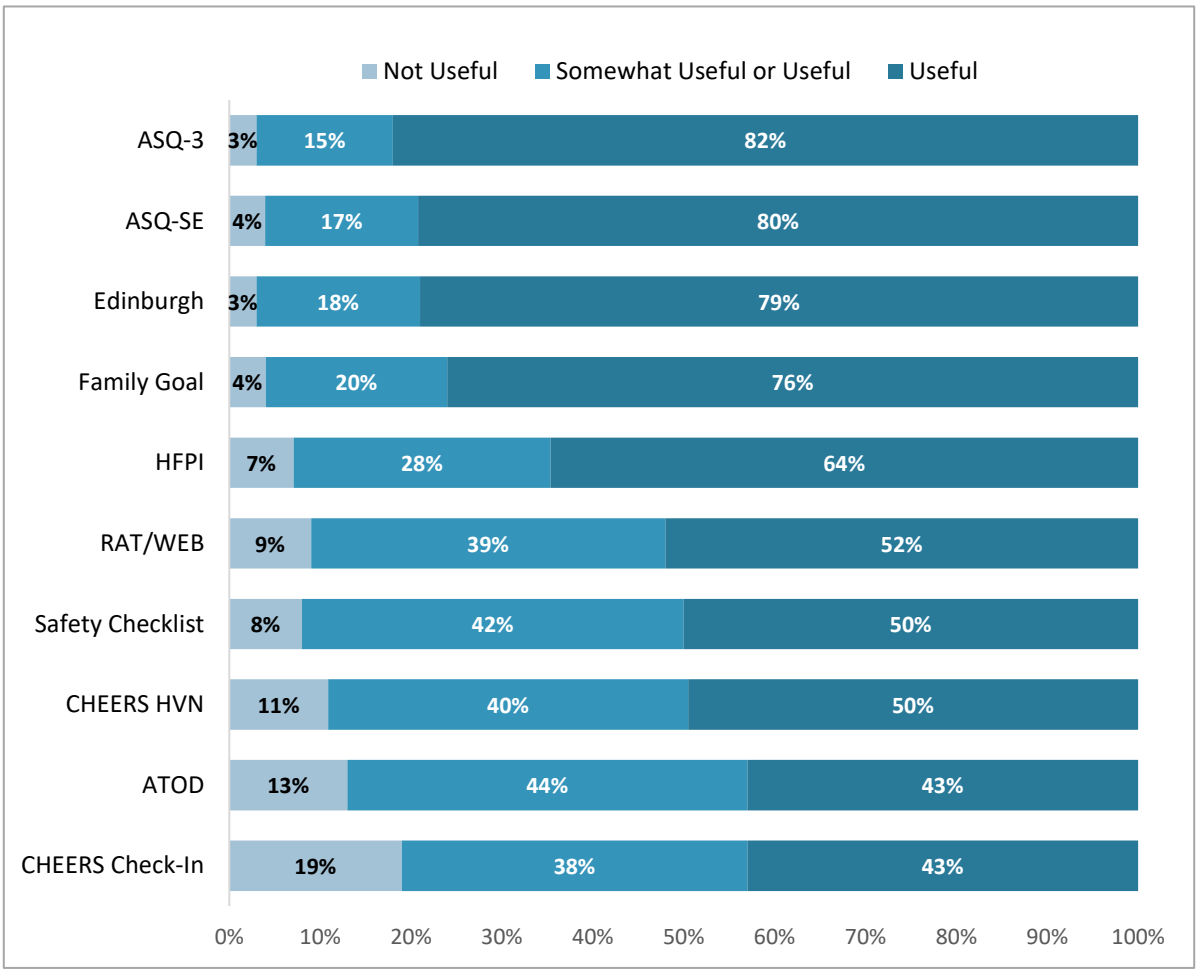
Exhibit 20. Usefulness of Tools to Inform Family Engagement Strategies



(N Ranges from 121-128)

Exhibit 21 shows that the most useful tools rated by staff for building service plans for families include the ASQ-3 (82%, n=92), ASQ-SE (80%, n=90), Edinburgh (79%, n=92), Family Goal (76%, n=87), and HFPI (65%, n=73). The three tools that received the highest percentage of staff rating the tool as "not useful" to building service plans include the CHEERS domains noted on the Home Visit Note (11%, n=12), the ATOD (13%, n=15), and the CHEERS Check-in (19%, n=21).

Exhibit 21. Usefulness of Tools to Build Service Plans for Families



(N Ranges from 111-117)

Paperwork Reduction Policy Impacts

The staff survey conducted in October 2020 asked, "How do you believe the policy change on delaying baseline data collection and reduced data collection overall is effecting the engagement of new families in Healthy Families Arizona?" Although 95 staff members responded to this question, only 73 responses were included in the analysis. 16 responses were excluded because the staff member was unsure, the question did not apply to their position, or they were too new to experience the policy change, and another six responses

were unclear or not related to the question. The unclear or unrelated responses suggest there may have been some confusion about this question. In addition, a number of staff answered as if it were a yes or no question, or gave their overall impressions about the policy change rather than focusing on family engagement. Despite potential limitations with the question, the results still provided useful information about the staffs' perspectives on the policy change. Twelve common themes were identified from the comments, which are described in Exhibit 22 below. On average, respondents indicated two themes in their open-ended comments.

Exhibit 22. Themes in response to question: "How do you believe the policy change on delaying baseline data collection and reduced data collection overall is effecting the engagement of new families in Healthy Families Arizona?"

Theme	n	%
Change has been positive/going well	53	73%
More time/opportunities to build rapport with family	26	36%
Less overwhelming for families	12	16%
Little to no change	11	15%
Benefits Family Support Specialists (more time/less stress)	8	11%
Reduces paperwork	7	10%
There are pros and cons to the new approach	7	10%
Improves data quality (family more comfortable/honest/accurate)	6	8%
COVID/going virtual has changed impact	5	7%
Challenging when working with families who start when child is almost 3 months	3	4%
Should collect information sooner	2	3%
Hard to tell the effects	2	3%

Overall, the majority of respondents (73%, n=53) felt that the policy change has been positive or has been going well. They mentioned specific benefits of the policy change, such as having more opportunities to build rapport with the family (36%, n=26) especially early on, and that the new process is less overwhelming for families (16%, n=12). For example, one respondent wrote, "*I think it has a positive impact. It gives our Home Visitors the opportunity to focus on building a firm solid & trusting relationship first.*" Another explained, "*I feel as though [it] has helped families become more comfortable during those first few visits and helps them not feel so overwhelmed by the amount of paperwork that needs to get done. What I noticed is*

that it helps families engage more and quicker." A number of respondents (11%, n=8) also mentioned how the policy benefits FSS by freeing up more time for other tasks and reducing their stress. Instrestingly, seven respondents (10%) described how the data collection delay improves the quality of data because families are more comfortable and more likely to be honest with their responses after building a trusting relationship. One staff member explained, *"It makes obtaining the assessments easier and more productive because the family is more honest because they know the FSS."*

Although most respondents described positive effects from the policy change, some staff (15%, n=11) felt there has been little to no change, while a few said it was difficult to tell (3%, n=2) or they felt that the information should be collected sooner (3%, n=2). Some felt the policy change has not done enough to address the burden of data collection, such as a respondent who said that families are *"still overwhelmed with the amount of paper work that they have to do with FSS instead of building rapport."* Others described negative effects such as a *"loss of focus"* or suggested collecting information sooner. For example, one staff member commented, *"I think that collecting this information sooner than later is better so that we can see where the family is at."* Some respondents described more nuanced implications of the policy—about 10% described both pros and cons to the new approach and 7% explained that virtual implementation changed the impact of the policy. For instance, one staff member wrote, *"I think it was effective before virtual visitation but that now assessments can help fill time and engage families."* Finally, there seemed to be some confusion about the timeline for data collection when working with families who enter the program when their child is nearing three months. Several staff (5%, n=3) mentioned challenges or time crunches when trying to collect baseline data in this situation.

Overall, the survey responses suggest that the policy change has been successful. The comments also suggest that additional flexibility could be helpful to allow FSS discretion about which data collection tools to use in the early months depending on implementation format (virtual or in-person) and the specific needs of the family. One comment that captured the importance of this type of flexibility wrote, *"I prefer flexibility on deadlines…Sometimes families are in various crises that need to take priority over the data."*

Staff Exit Survey Results

Staff members who leave Healthy Families Arizona have an opportunity to provide feedback via an online exit survey. Supervisors were asked to provide the online survey link to staff who left their position starting in April 2020. This survey is voluntary for exiting staff members. Of note, this survey was inclusive of staff who may have left one position within Healthy Families Arizona for another. The evaluation team received 13 completed surveys from staff who exited between April and September 2020 and their responses are analyzed below. Staff were asked about their role in the Healthy Families

Arizona program, the majority of whom worked directly with families (Exhibit 23). The average time staff reported working with the Healthy Families Arizona program was just over two years (28 months), with a median of just over one year (16 months). Of the respondents, 77% (n=10) reported that their position was classified as full-time compared to 23% (n=3) who worked part-time.

Exhibit 23. Roles of Staff who Completed the Exit Survey

Role	n	%
I mostly worked directly with families.	10	77%
I mostly worked as a supervisor, manager of employees.	3	23%

Staff were asked to indicate up to three reasons why they left their position with the Healthy Families Arizona program. Their responses are summarized in Exhibit 24. Options for leaving that were not marked by any respondents are not included in the table.

Exhibit 24. Reasons for Leaving Their Position with Healthy Families Arizona

Reason	n	%
Family moved away from the area	4	31%
The position was dissolved due to loss of funding	2	15%
Returned to school	1	8%
Position was not a good fit for me	1	8%
Other:	5	39%
• *Decided to stay home with my children.* • *I needed to take time to be with my family and care for my young children.* • *Going to be stay at home mom due to COVID-19 and daughters need me at home with virtual school.* • *I was wanting to start a career where the opportunity for growth was available.* • *Best for family for me to change jobs due circumstances pertaining to COVID 19.*		

No respondents indicated that they were terminated due to performance issues and no staff retired. Although no staff indicated that they left for better pay or benefits, this may have factored into the staff member's comment about wanting opportunities for growth. Notably, a common reason for leaving had to do with caring for children/family during the COVID-19 pandemic. Another two staff left due to loss of funding, which may have also related to the COVID-19 pandemic. As a retention strategy, Healthy Families Arizona may want to review its policies and practices for supporting employees who have childcare responsibilities, particularly in the context of the pandemic.

Exiting staff were asked, "Is there something that could have been changed to keep you from leaving?" and were asked to share what could have changed their decision (Exhibit 25). Most employees said that nothing could have changed their decision, but of the four staff members who said something could have changed, better pay was most often mentioned (n=2).

Exhibit 25. Could Something Have Changed to Keep Staff from Leaving?

Response	n	%
No	9	69%
Yes	4	31%
If yes, what could have been changed? • *Better pay, not so much micromanagement expected by supervisors, less paperwork, and less paper trails.* • *I did have difficulty with my direct supervisor. I felt unsupported and it was a huge factor in my decision to leave and obtain a job out of state.* • *Better pay*		

Staff members were asked to rate their agreement or disagreement with the following statement, "Most employees I knew and worked with at the Healthy Families program felt positive about their working situation." Their responses are summarized in Exhibit 26, and examples of comments are provided below each rating.

Exhibit 26. Exiting Staff Levels of Agreement That Most Employees Feel Positive About Their Working Situation

Rating	n	%
Completely Agree	3	23%
Agree	4	31%
• *Everyone was happy.* • *There were complaints about workload and general stress that comes with the job. Some coworkers felt that the pay was low for the stress that comes with the job. Overall though, despite the negatives, most people were happy with the job and the positives (flexibility, support, feeling good about work, etc.) outweigh the negatives.* • *Love the job, love the people, love helping families, hate all the paperwork and repetitive paperwork.*		
Neutral	5	39%
• *Working a rotating in office schedule was a burden to many coworkers.* • *Seems like the support has been ok but can improve more.* • *Most like the job but there was a lot on the workload and paperwork side of things. I feel like the systems need to be more up to date with the times. Also, most are under paid.*		

Rating	n	%
Disagree	1	8%
• *My direct teammates have been struggling as well with working with our supervisor.*		
Completely Disagree	0	0%

Staff members also shared about what they thought the organization did well regarding implementing the Healthy Families Arizona program. The most common theme related to trainings for staff (n=4). Below, is the full list of responses from exiting staff members:

- *Communication*
- *Met family needs*
- *Curriculum (new hires should be given more options to take curriculum training), supporting each other, supervision, helping each other learn and grow.*
- *The trainings provided were very important in preparing us to go out in the field.*
- *They do give you the right tools and trainings.*
- *There is a decent amount of connecting FSS's to additional resources and updates with trainings and certifications.*
- *Training*
- *Adherence to best practices.*
- *Supervision time, team meetings, flexible schedule*
- *Showed compassion and work ethic*

Exiting staff members were asked to "Please describe the three things you liked best about working with your supervisor and or at the agency." Responses are categorized into themes shown below, including several comments.

- Friendly/caring/kind (n=6)
- Supervisor is available/open (n=5) – "*Always available", "Feeling comfortable enough to talk to her about things"*
- Flexibility (n=4)
- Rewarding work/impact of work/working with families (n=4) – "*Making an impact in the community," "Feeling that I'm serving others"*
- Work culture/sense of team (n=3)
- Support/supportiveness (n=3) – "*My coworkers are very supportive"*
- Trainings (n=3) – "*Consistent educational opportunities"*
- Helpfulness (n=3)
- Positivity, leadership, clarity, supervision, paid time off (n=1 for each theme)

The exiting staff were also asked to share the "three most difficult things about working with your supervisor and or at the agency." Responses are grouped into themes and several exemplative comments are provided.

- Paperwork (n=5) – *"Lots of paperwork for time allotted for job"*
- Inconsistency/lots of change (n=4) – *"No consistent schedule," "Changing expectations from HR/accounting"*
- Not enough pay (n=3) – *"Lack of pay or incentives"*
- Challenges with supervisor (n=3) – *"Passive aggressive comments from supervisor," "Supervisor's inability to take my perspective working in home with families."*
- Stress (n=3) – *"Emotional Burden," "Sometimes personal life affects [my supervisor] at work"*
- Not enough time (2) – *"Workload to time ratio"*
- Micromanagement (2) – *"A tendency to micro-manage"*
- Strick deadlines and regulations (2)
- Getting enough time in the office (2) – *"Rotating in office days"*
- Personality/communication differences (2) – *"Getting to understand the way [my supervisor] does things," "Differences in personalities"*
- Hiring qualified people (1)

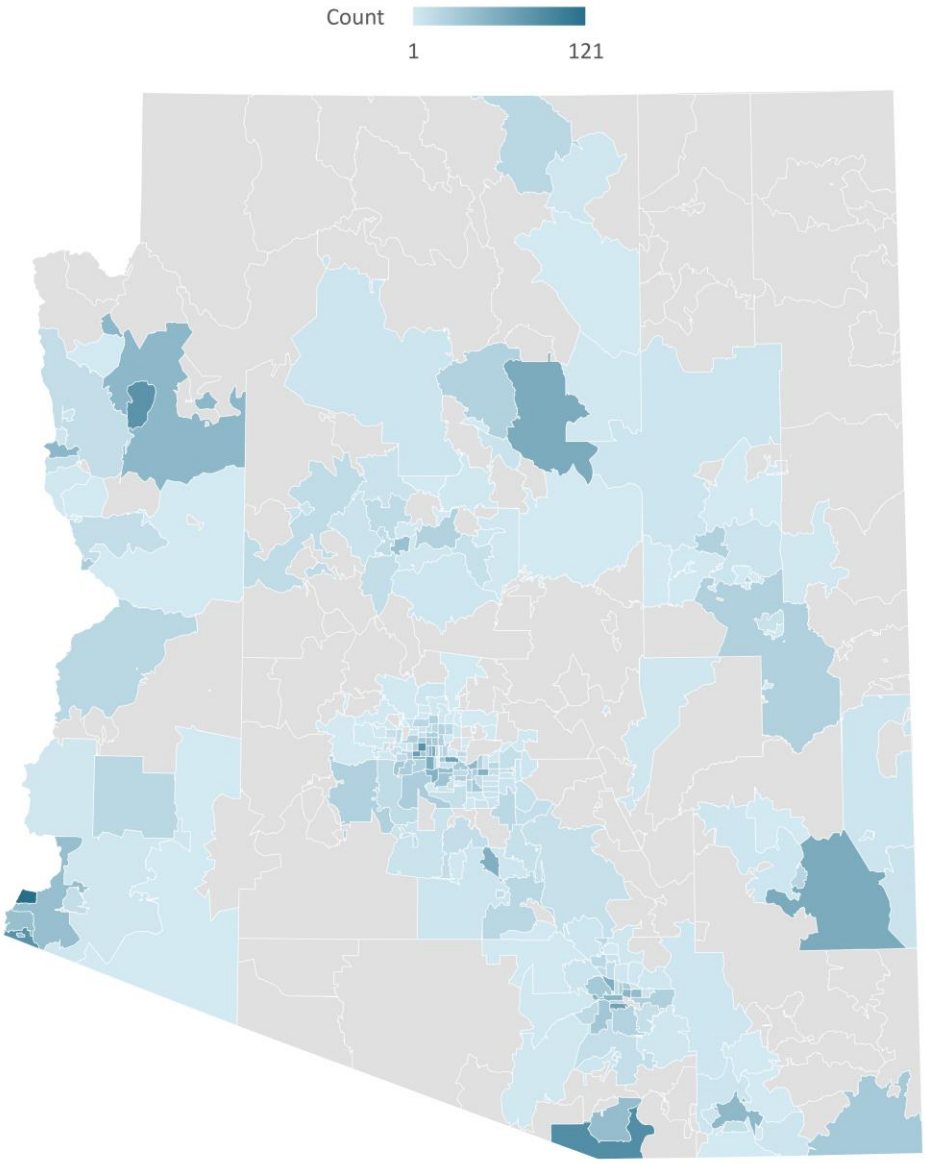
Finally, staff responded to the following question: "What advice would you have for the next person in your position?" Their responses with advice for future staff members are included below:

- *Stay positive, it gets better.*
- *Try not to take on the problems of the families you work with as your own. It gets overwhelming. Don't look at your work phone on the weekends or during time that's your personal time.*
- *I was hired for a 20-hour a week position. This position cannot be done in 20 hours due to meetings, trainings, workshops, etc. in addition to all the QA and office work. I feel like 75% of my job is office/clerical work and so the new hire should be aware of that.*
- *Create a bond with other coworkers, it helps prevent burnout and aids with additional support.*
- *you are not going to get everything done in a day, and that's ok.*
- *Understand the importance/ impact of Home Visitation. I think ACE's should be the first concept presented to new hires. Be curious and genuine families will pick up on that. Most of all, be yourself.*
- *Be open to change.*
- *Set-up systems early. Remain flexible and give yourself some grace.*
- *Organize yourself since day one and find the best routine that fits you.*
- *Learn curriculum and plan simple activities based on curriculum.*

Healthy Families Arizona Program and Participant Characteristics

Healthy Families Arizona served a total of 4,337 families from October 1, 2019 through September 30, 2020. A total of 1,965 were funded through the Department of Child Safety; 1,337 through First Things First; 699 through MIECHV; and 266 through the State Opioid Response funding. An additional 70 families have outside funding in the Maricopa County area. Families come from 249 different zip codes in 14 counties in the most populous areas of Arizona, as shown in the map in Exhibit 27.

Exhibit 27. Location of Families in Healthy Families Arizona, October 1, 2019 to September 30, 2020



Length of Time in Program and Reasons for Termination

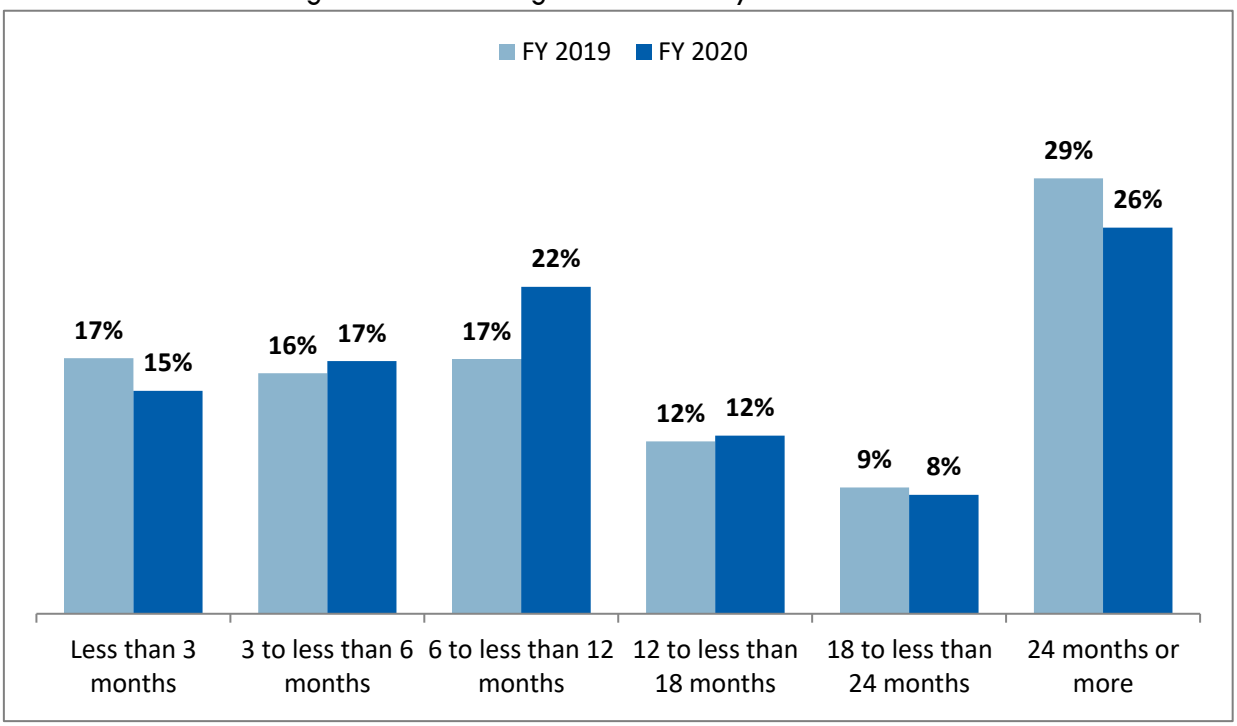
HFA Best Practice Standards recommends that services are offered until the child is at least three years old and can continue up to age five. From October 1, 2019 through September 30, 2020, a total of 1,538 of the 4,337 families closed out of Healthy Families Arizona. New enrollments account for 45% (1,971) of the 4,337 families served (Exhibit 28).

Exhibit 28. Families Served in Healthy Families Arizona, October 1, 2019 to September 30, 2020

Program Name	All Families	New Enrollments	Proportion of New Enrollments
Apache County / Navajo County	67	45	37%
Cochise County / Santa Cruz County	269	120	45%
Coconino County	126	54	43%
Graham County / Greenlee County	143	52	36%
Maricopa County	2,057	859	42%
Mohave County	318	190	60%
Pima County	658	306	47%
Pinal County	210	121	58%
Verde Valley (in Yavapai County)	46	11	24%
Prescott Valley (in Yavapai County)	118	57	48%
Yuma County	325	156	48%
Total Count	**4,337**	**1,971**	**45%**

For the newly enrolled families 591 closed (30%), for a retention rate of 70% which is an increase from 58% in FY 2019 and nearly the same as 69% in FY 2018. The median length of program service for families from October 1, 2019 to September 30, 2020 was 10 months, which is less than the 12 months for FY 2019 and 14 months for FY 2018. The proportion of families who have participated in the program for more than two years has decreased from 29% in FY 2019 to 26% in FY 2020 (Exhibit 29).

Exhibit 29. Families' Length of Time in Program for Healthy Families Arizona Families



Of the 1,538 families that closed, 63% did not complete a year of service. In FY 2019 there was an increase in the number of families that closed within the first three months of services from 6% in FY 2018 up to 17% in FY 2019. This rate stayed nearly the same in FY 2020 with additional increases in families closing prior to the first 12 months. There was some supposition that the increased lack of engagement of families might have been due to the data collection changes that occurred in FY 2018. Starting in October 2019 several policy changes were made to decrease the impact of data collection for new families. Home visitors were asked about the impact of the policy change with the majority of them stating that it was positive to developing their relationship with the families. However, the policy changes do not appear to have increased family engagement. Further research into why fewer families are retained past the first year is recommended. Exhibit 30 shows the distribution of length of time that families stayed in the program for all families who closed FY 2019 and FY 2020.

Exhibit 30. Families' Length of Time to Closure

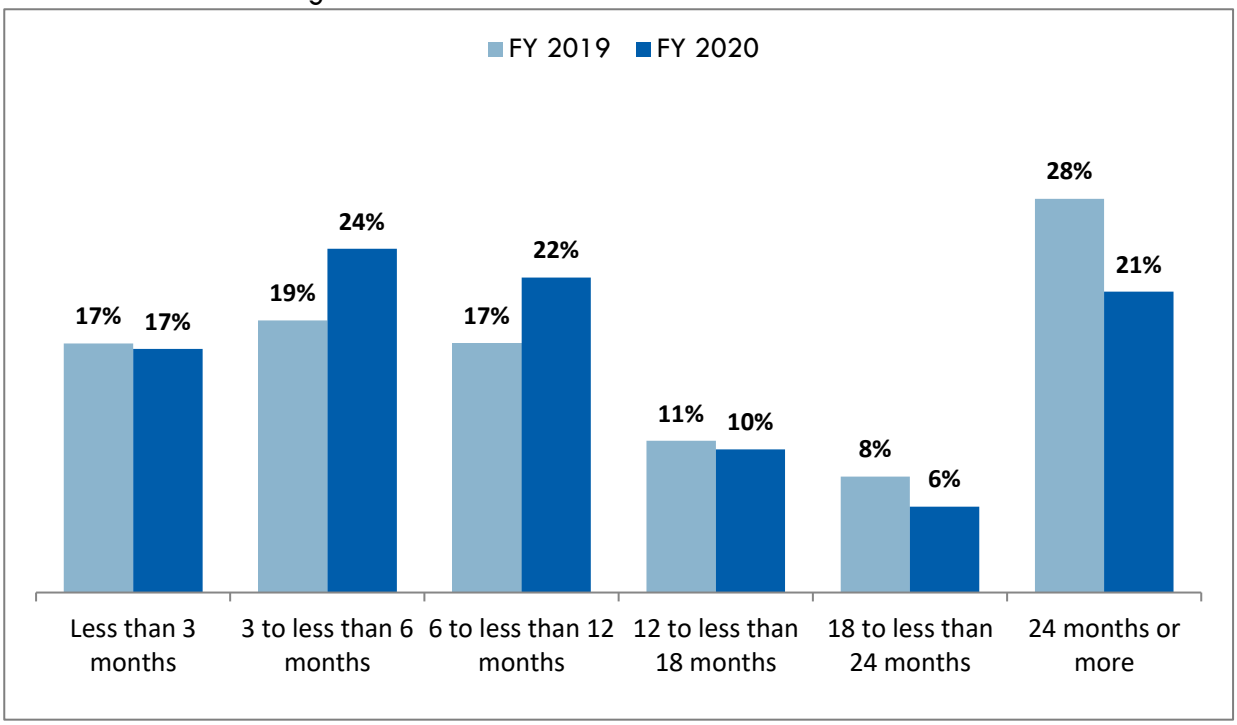


Exhibit 31 shows the most frequent reasons families left the program between October 1, 2019 and September 30, 2020, broken down by all families served and newly enrolled families who exited during the period. The most common reasons for case closures were that the family did not respond to outreach efforts, refused further services, moved, or completed the program. For *newly enrolled* families, the family declining services was the most common accounting for 37% of closures, an increase from 30% in FY 2019. Other top reasons that newly enrolled families left include not responding to outreach efforts and moving away.

Exhibit 31. Reasons for Family Closure in Healthy Families Arizona

Dismissal Reason	All Families Served		Newly Enrolled Families	
	n	Percent	n	Percent
Did not respond to outreach efforts	405	26%	159	27%
Family declined/refused further services	341	22%	220	37%
Moved	191	12%	79	13%
Completed program	183	12%	0	0%
Self-sufficiency established according to parent	70	5%	15	3%
Returned to school or work	84	5%	20	3%

Dismissal Reason	All Families Served		Newly Enrolled Families	
	n	Percent	n	Percent
Declined worker change	72	5%	12	2%
Unable to locate	69	4%	36	6%
Family no longer has custody	65	4%	25	4%
Other	19	1%	10	2%
Inconsistent living situation/homeless	9	1%	3	1%
Duplication of services	8	1%	0	0%
Child deceased	7	<1%	2	<1%
No longer pregnant	5	<1%	4	1%
Adoption	5	<1%	4	1%
Supervisor discretion	5	<1%	2	<1%
Total N	**1,538**		**591**	

Referral Source

Families are offered services in the Healthy Families Arizona via various methods. One primary method used by all sites is systematic screenings. These occur at hospitals and clinics throughout Arizona through contractual agreements with the local sites and involve a Family Assessment Worker regularly screening pregnant and postpartum women to offer then services. In addition to this, referrals come from multiple sources including the community (which can include doctors, social service agencies, or community members), self-referrals (which are often because a family has learned of the program through a brochure, website, or an individual), and the Department of Child Safety. The Department of Child Safety provides two types of referrals – general referrals and referrals from families who are offered to participate in the Substance Exposed Newborn Safe Environment (SENSE) program.

In FY 2020 there was a decrease in the percent of families coming from systematic referrals and the SENSE program. In FY 2019, 35% of newly enrolled families were systematic referrals and 14% SENSE referrals compared to 31% and 8% respectively in FY 2020.

Community referrals increased to 48% up from 39% in FY 2019. The changes this year are assumed to be due to the impact of the pandemic on limiting access to hospitals. Additional details are described in the COVID-19 impacts section below. Exhibit 32 shows the referral sources for all families and newly enrolled families for October 1, 2019 through September 30, 2020.

Exhibit 32. Referral Sources for Healthy Families Arizona

Referral Source	All Families Served FY 2020		Newly Enrolled Families FY 2020	
	n	Percent	n	Percent
Unknown	13	<1%	0	0%
Community	1,875	43%	948	48%
DCS	155	4%	75	4%
DCS/SENSE	345	8%	164	8%
Self	385	9%	165	8%
Systematic	1,567	36%	619	31%
Total N	**4,337**		**1,971**	

Caregiver Demographics

The Healthy Families Arizona program serves a culturally diverse population. Exhibits 33 to 35 show data on caregiver's ethnicity, race, and primary language. Over half of caregivers enrolled in the program self-identify as Hispanic, and three-fourths of caregivers identify as White/Caucasian, and 7 out of 10 of caregivers used English as their primary spoken language at home.

Exhibit 33. Caregiver's Ethnicity

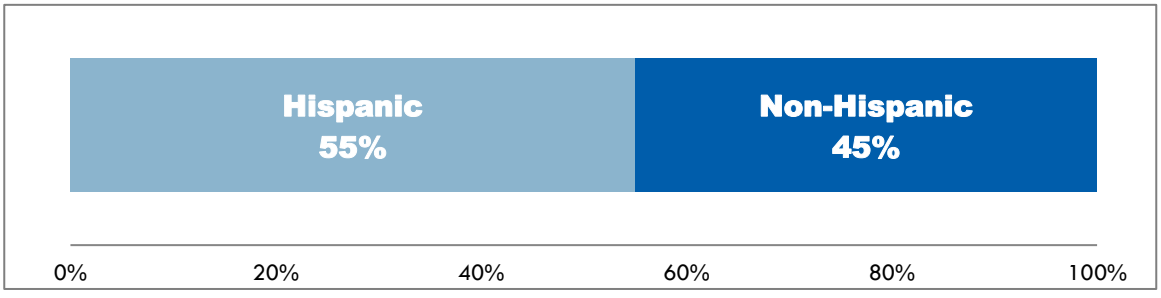


Exhibit 34. Caregiver's Race

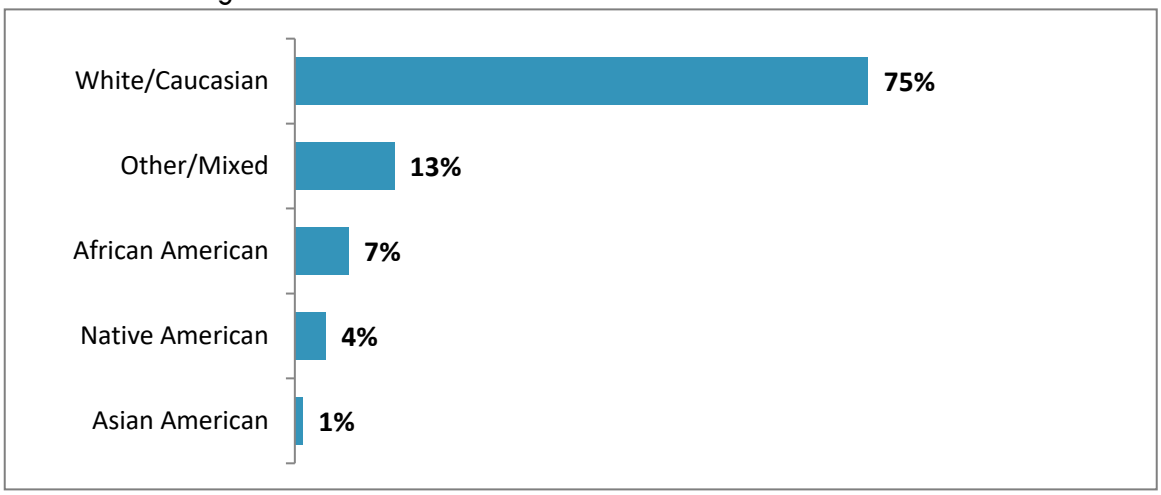
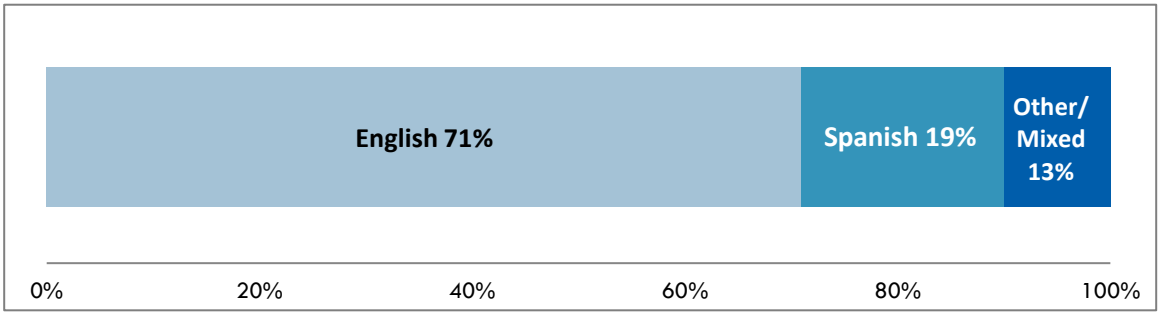
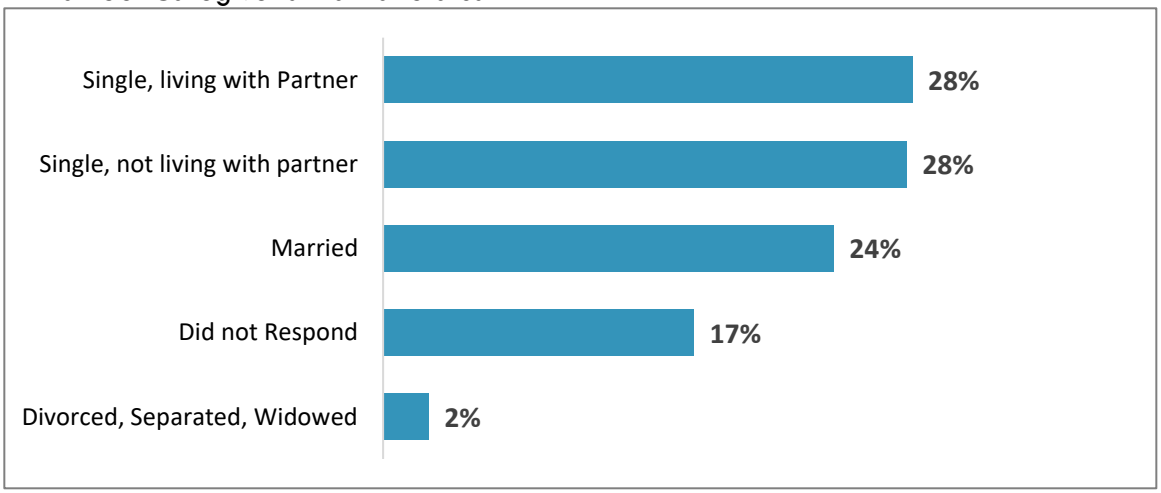


Exhibit 35. Caregiver's Primary Language



The majority of primary caregivers are the birth mother accounting for over 99% in all families. Fathers, grandmothers, and other relatives are the primary caregiver in less than 1% of families. Exhibit 36 shows caregivers' marital status with just under a quarter being married.

Exhibit 36. Caregiver's Marital Status



Maternal Risk Factors

Mothers have certain risk factors than can lead to less favorable childhood outcomes. Healthy Families Arizona takes these risk factors into account during the screening process and tries to provide services to those at highest need. In the Healthy Families Arizona program, mothers have certain risk factors that are higher than the average rates for all mothers in the State of Arizona. Exhibit 37 presents selected risk factors for mothers compared with state rates.

Exhibit 37. Selected Risk Factors for Mothers

Risk Factors of Mothers	Healthy Families Arizona	Arizona State
Teen Births (19 years or less)	10%	6%*
Births to Single Mothers	76%	45%*
Less Than High School Education	29%	17%*
Not Employed	56%	18%**
Median Yearly Income	$20,000	$56,581 **

Source: *2018 data from the Arizona Department of Health Services Vital Statistics records. **U.S. Bureau of Labor Statistics, Geographic Profile of Employment and Unemployment, 2019.

The percentage of Healthy Families Arizona mothers who are teenagers at time of birth continues to be higher than the overall rate for Arizona; however, the percentage has continued to decrease in recent years following the decrease in teen births overall. More than three-fourths of mothers are single (76%) at time of birth. Currently in Arizona 17% of mothers with infants have less than a high school education while 29% of Healthy Families Arizona mothers have less than a high school education. More than half (56%) of Healthy Families Arizona mothers are unemployed. The median household income is less than half of that for Arizona as a whole. These data confirm that Healthy Families Arizona participants do represent an "at-risk" group of mothers and that the program has been successful in recruiting families with multiple risk factors associated with child abuse and neglect and poor child health and developmental outcomes.

Exploring Healthy Families Arizona Enrollment Information in the Context of the COVID-19 Pandemic

This year the Healthy Families Arizona program has functioned in the midst of a global pandemic caused by the COVID-19 virus. Starting in early April 2020, state, county, and local municipalities have put into place various public health policies and regulations to try to limit the spread of the virus in the population; including restrictions on travel, work, and the closing of schools and child day care programs. As mentioned earlier in this report, the Healthy Families Arizona program staff has had to adapt to a virtual home visiting approach, while managing the negative health and economic consequences to their own families and in their local communities. The following is a presentation of results that begins to describe how the Healthy Families Arizona program model may be impacted by the COVID-19 pandemic. The results present comparisons on select enrollment issues and participant characteristics for two time periods; comparing the pre-COVID-19 public health restrictions 6-month time frame from October 1, 2019 to March 31, 2020 to the active COVID-19 public health restrictions 6-month time frame from April 1, 2020 to September 30, 2020. It is critical to note that the purpose in presenting these select results is to encourage Healthy Families Arizona staff and stakeholders to continue careful consideration of how the implementation of the Healthy Families Arizona model is influenced by this unprecedented and continuing public health crisis.

Total Number of Referrals

The total number of new enrollments to Healthy Families Arizona for this 12-month time period was 1,971. Between the time period of October 1, 2019 to March 31, 2020 there were, 1,086 enrollments to the Healthy Families Arizona program, which makes up over half (55%) of total enrollments for this 12-month time frame. Between April 1, 2020 and September 30, 2020, 45% (n=885) of families were enrolled into the program.

Referral Sources and Reasons for Dismissal

Exhibit 38 below presents the referral sources for those entering Healthy Families Arizona before and after COVID-19 public health measures were enacted in Arizona. During the time when public health restrictions were active, April 2020 to September 2020, there were significantly more referrals from community sources and fewer from systematic sources (x^2=35.01, p=0.00). The majority of systematic referrals in Healthy Families Arizona come through the maternity wards of hospitals and with hospitals closed to all outside visitors during the pandemic this was an anticipated outcome.

Exhibit 38. Referral Sources from Pre- to Active-COVID-19 Time Periods

Referral Source	Pre COVID-19 (10/1/2019 – 3/31/2020)	Active COVID-19 (4/1/2020 – 9/30/2020)
Community Referral Source	43% (n=468)	54% (n=480)
DCS Referral Source	3% (n=35)	5% (n=40)
DCS / SENSE Referral Source	9% (n=95)	8% (n=69)
Self- Referral	9% (n=92)	8% (n=73)
Systematic Referral	37% (n=396)	25% (n=223)

Exhibit 39 presents the reasons for dismissal from the program before and after COVID-19 public health measures were enacted in Arizona. There were statistically significant differences in reasons for dismissal from the program between the two time periods (x^2=44.27, p=0.00). Significantly more families are declining services in the active COVID time period and less that did not respond to outreach efforts.

Exhibit 39. Program Dismissal Reasons from Pre- to Active-COVID-19 Time Periods

Dismissal Reason	Pre COVID-19 (10/1/2019 – 3/31/2020)	Active COVID-19 (4/1/2020 – 9/30/2020)
Participant Did Not Respond to Outreach	30% (n=141)	14% (n=18)
Family Moved	15% (n=71)	6.4% (n=8)
Family Declines Services / Family Refused Further Services	32% (n=150)	56% (n=70)
Returned to School or Work	4% (n=19)	<1% (n=1)
All Other Reasons	18% (n=85)	22% (n=28)
Total	100% (n=466)	100% (n=125)

Characteristics of Parents Entering the Healthy Families Arizona Program

Another consideration to understand the impact of the COVID-19 pandemic on the program's implementation is to assess change in the types of parents/families who enrolled for services during these two timeframes. It is critical to know if the families accessing Healthy Families Arizona services are families with strengths and needs best aligned to benefit from the program model. The following exhibits present results exploring geographic location of referrals, parent characteristics, and the levels of risks that parents are presenting at enrollment, compared by before and after COVID-19 public health restrictions. Exhibit 40 shows that there were no statistically significant differences on where referrals were located between the two time periods (x^2 =0.03, p=0.98).

Exhibit 40. Geographic Location of Family Referral to Healthy Families Arizona from Pre- to Active-COVID-19 Time Periods

Referral Location	Pre COVID-19 (10/1/2019 – 3/31/2020)	Active COVID-19 (4/1/2020 – 9/30/2020)
Maricopa County	44% (n=473)	44% (n=386)
Pima County	16% (n=170)	15% (n=136)
All Other Counties	41% (n=443)	41% (n=363)

Shown below in Exhibit 41, no statistically significant differences on parent/caregiver characteristics were observed for ethnicity (x^2=0.31, p=0.58); race (x^2 =4.05, p=0.54); marital status (x^2=2.03, p=0.57); and first-time parent/guardian (x^2 =0.12, p=0.73). However, significantly more parents enrolled as a prenatal case status during the active COVID-19 time period compared to the pre-COVID-19 time period (x^2=13.33, p=0.00).

Exhibit 41. Participant Characteristics from Pre- to Active-COVID-19 Time Periods

Characteristic		Pre COVID-19 (10/1/2019 – 3/31/2020)	Active COVID-19 (4/1/2020 – 9/30/2020)
Ethnicity	Hispanic	53% (n=575)	55% (n=464)
	Non-Hispanic	47% (n=502)	45% (n=385)

Characteristic		Pre COVID-19 (10/1/2019 – 3/31/2020)	Active COVID-19 (4/1/2020 – 9/30/2020)
Race	White/Caucasian	76% (n=808)	74% (n=628)
	Black/African American	7% (n=79)	10% (n=82)
	Mixed Race	7% (n=69)	6% (n=52)
	American Indian/Alaskan Native	5% (n=54)	5% (n=40)
	Other	3% (n=32)	4% (n=31)
	Asian/Native Hawaiian or Other Pacific Islanders	2% (n=19)	2% (n=13)
Marital Status	Single, Not Living with Partner	35% (n=374)	36% (n=305)
	Single, Living with Partner	34% (n=365)	35% (n=293)
	Married	29% (n=312)	26% (n=218)
	Separated/Widowed/ Divorced	3% (n=28)	3% (n=21)
First Time Parent/ Guardian	Yes	44% (n=472)	45% (n=380)
	No	56% (n=608)	56% (n=474)
Case Status at Intake (x^2=13.3, p=.00)	Prenatal	21% (n=224)	28% (n=238)
	Postnatal	79% (n=856)	72% (n=616)

For housing status at enrollment, Exhibit 42 shows that there were also no statistically significant differences found comparing the pre-COVID-19 public health policy restrictions timeframe to the active-COVID-19 restrictions timeframe (x^2=8.98, p=0.11).

Exhibit 42. Housing Status from Pre- to Active-COVID-19 Time Periods

Housing Status	Pre COVID-19 (10/1/2019 – 3/31/2020)	Active COVID-19 (4/1/2020 – 9/30/2020)
Rent/Shares Own Home or Apartment	48% (n=517)	48% (n=405)
Lives with Parent or Family Member	27% (n=290)	31% (n=254)
Owns or Shares Own Home, Apartment or Condominium	15% (n=163)	14% (n=120)
Has Fixed, Regular, Adequate Residence	6% (n=61)	5% (n=38)
Homeless and/or No Fixed, Regular, Adequate Residence	4% (n=38)	2% (n=16)
Lives in Public Housing	1% (n=10)	.5% (n=4)

For Exhibit 43, there was no statistically significant differences between the two time periods for education level (x^2=3.66, p=0.60). However, for parent employment, significantly more unemployed parents enrolled in the active COVID-19 time period compared to the pre-COVID-19 time period (x^2=11.89, p=0.01).

Exhibit 43. Education and Employment Characteristics from Pre- to Active-COVID-19 Time Periods

Characteristic at Enrollment		Pre COVID-19 (10/1/2019 – 3/31/2020)	Active COVID-19 (4/1/2020 – 9/30/2020)
Education Level	Less than HS Diploma/GED	29% (n=309)	30% (n=249)
	High School Diploma/GED	32% (n=344)	33% (n=279)
	Completed Some College	16% (n=175)	15% (n=125)
	Voc. Tech. School / Tech. Training / Another Form of Academic Achievement	11% (n=123)	12% (n=97)
	Associates Degree	4% (n=43)	4% (n=37)
	Bachelor's Degree	8% (n=85)	6% (n=50)

Characteristic at Enrollment		Pre COVID-19 (10/1/2019 – 3/31/2020)	Active COVID-19 (4/1/2020 – 9/30/2020)
Employment Status (x^2=11.89, p=.01)	Unemployed	64% (n=687)	70% (n=581)
	Full-time Employed	24% (n=255)	20% (n=168)
	Part-time Employed	10% (n=109)	9% (n=76)
	Other	2% (n=21)	<1% (n=5)

Exhibit 44 below shows that significantly more Mothers presented with a Medium to High Risk at enrollment during the pre-COVID-19 time period compared to the active COVID-19 time period (x^2=8.82, p=0.00). The same result was found for Fathers, with significantly more presenting with a Medium to High Risk pre-COVID-19 compared to the active COVID-19 time period (x^2=17.33, p=0.00).

Exhibit 44. Mother and Father Risk Categories from Pre- to Active-COVID-19 Time Periods

Parent/Caregiver Risk Level		Pre COVID-19 (10/1/2019 – 3/31/2020)	Active COVID-19 (4/1/2020 – 9/30/2020)
Mother (x^2=8.82, p=.00)	No to Low Risk	41% (n=440)	48% (n=417)
	Medium to High Risk	59% (n=632)	52% (n=456)
Father (x^2=17.33, p=.00)	No to Low Risk	76 % (n=776)	84% (n=690)
	Medium to High Risk	24% (n=238)	16% (n=128)

Implications for Program Implementation

No differences were observed for the following characteristics of parents at enrollment into the program, regardless of timeframe:

- Ethnicity / Race
- Geographic Location – Comparing Maricopa County, Pima County and All other Area Referrals
- Marital Status
- Educational Level
- Housing Status
- First Time Parent / Guardian

Significant differences were found in comparing the two time periods specific to the following areas:

- During the active COVID-19 period, April 2020 to September 2020, there were significantly more referrals from Community sources and fewer from Systematic sources.
- There were statistically significant differences in reasons for dismissal from the program between the two time periods. Of note is that significantly more families are declining services in the active COVID-19 time period.
- Significantly more parents were unemployed at enrollment during the active COVID-19 timeframe compared to pre-COVID-19.
- Significantly more parents enrolled at a prenatal case status during the active COVID-19 timeframe compared to pre-COVID-19.
- Significantly more mothers and fathers presented with a medium to high risk from the Parent Survey in the pre-COVID-19 timeframe compared to the more recent active COVID-19 timeframe.

The COVID-19 pandemic has resulted in significant job loss and economic dislocation. Over the course of the year, more parents are enrolling into Healthy Families Arizona program who are unemployed. Fewer referrals during the active COVID-19 period from systematic sources may be due to the impact of the pandemic and less opportunity for staff to be at hospitals to promote enrollment into Healthy Families Arizona. Of concern as well is that more families are declining services in the more recent active COVID-19 period.

Finally, the fact that enrollments in the active COVID-19 timeframe consists of parents with lower overall risk factors may be the most important finding. Given the economic impacts of the pandemic on job loss, the loss of formal and informal child-care resources, and the demands on parents with the interruption of in-school education, many parents at higher risk may now be less able to access Healthy Families Arizona services. It may also be that families currently enrolled in the program are declining services due to having to respond to many types of new and ongoing stressors. Program leadership is advised to closely monitor who is able to enroll into Healthy Families Arizona services, to continually assess the effectiveness of outreach to families who may be at greater risk, and to follow-up when possible with families who are declining services to identify what barriers may exist or what are their reasons for declining services.

Key Healthy Families Arizona Services

The primary goals of reducing child maltreatment and improving child well-being are most attainable when families stay engaged in the program for an extended period of time and receive the services and support they need. One important aspect of the Healthy Families Arizona program model is linking families with needed community resources. Home visitors provide not only assistance and guidance in the home, but they also connect families with education, employment and training resources, counseling and support services, public assistance, and health care services.

Developmental Screening and Referrals for Children

Developmental screens are used to measure a child's developmental progress and to identify potential developmental delays requiring specialist intervention. The primary screening tool used by home visitors is the Ages and Stages Questionnaire, Third Edition (ASQ-3). This tool helps parents assess the developmental status of their child across five areas: communication, gross motor, fine motor, problem solving, and personal/social.

The Healthy Families Arizona program administers the ASQ-3 at 4 and 9 months in the first year of the infant's life, with optional ones at 6 and 12 months. Then starting at 18 months every six months until the child is three years of age, and then yearly at age 4 and 5. Screenings can be scored as typical meaning that the child is developing on schedule, questionable which indicates that they may be behind in an area or delayed which indicates that there is a developmental delay in at least one area of child development that should be address. Referrals are given to families when a child scores as delayed.

A total of 5,350 ASQ-3 screenings were completed and entered into ETO between October 1, 2019 and September 30, 2020 for 3,013 children (2,752 target children and 261 subsequent children). More than 4 out of 5 screenings showed typical childhood development (Exhibit 45). Of these families, 3,026 were marked in ETO as having received Healthy Families developmental activities and 598 referrals for services were made (Exhibit 46).

Exhibit 45. Outcomes for ASQ-3 Screenings

Outcome	n	Percent
Delayed	293	6%
Questionable	648	12%
Typical	4,409	82%
Total	**5,350**	**100%**

Exhibit 46. Services and Referrals Provided for ASQ-3 Outcomes

Services/Referrals for ASQ-3 Outcomes	n*
Provide HF developmental activities	3,026
Referred to AzEIP or School District	159
Referred to other community services	48
Referred to primary care provider or doctor	83

*Multiple referrals can be given to families. But not all families marked as having a referral had a specific referral type listed.

In addition to the ASQ-3, another measure of childhood development is the Ages & Stages Questionnaire: Social-Emotional (ASQ: SE-2). The ASQ: SE-2 is similar to the ASQ-3 but focuses on screening for social and emotional behaviors: self-regulation, compliance, social-communication, adaptive functioning, autonomy, affect, and interaction with people. The scoring is slightly different with Refer, Monitor, and No Concern as the final score designations. During October 1, 2019 through September 30, 2020, for 2,269 children (2,131 target children and 138 subsequent children), a total of 2,781 ASQ: SE-2s were completed (Exhibit 47). More than 90% scored as no concern, with 106 suggesting a referral with a total of 80 referrals given to families.

Exhibit 47. Outcomes for ASQ-SE-2

Outcome	n	Percent
No concern	2,515	90%
Monitor	160	6%
Refer	106	4%
Total	**2,781**	**100%**

Substance Abuse Screening and Referrals

The relationship between substance abuse and the potential for child maltreatment is strong and well known (Garner et al, 2014). When parents or caretakers have a substance use disorder, children may not be adequately cared for or supervised. While successful substance abuse treatment often requires intensive inpatient or outpatient treatment and counseling, home visitors can still play a critical role in screening for substance abuse, educating families about the effects of substance abuse on their health and the health of their children, and making referrals for treatment services.

As of October 1, 2019, Healthy Families Arizona ceased using the CRAFFT for substance abuse screening and is now using the Past 30-Day Alcohol, Tobacco, and Other Drug screening (Past 30-day ATOD) to be completed shortly after enrollment into the program. From October 2, 2019 to September 30, 2020, a total of 1,300 ATOD screenings were completed with newly enrolled parents and 1,258 families had the following results:

- 1 positive for alcohol, tobacco, and drug use
- 15 positive for alcohol and tobacco use
- 3 positive for alcohol and drug use
- 32 positive for alcohol only
- 152 positive for tobacco use only
- 15 positive for tobacco and drug use
- 12 positive for drug use only

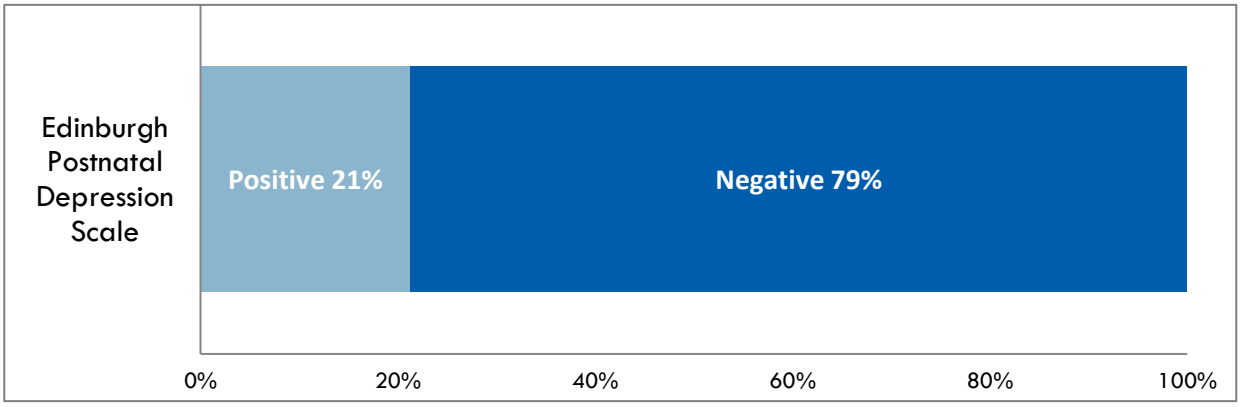
Also, starting October 1, 2019, two questions regarding the discussion of substance use with families and substance use/abuse referrals were added to the Parent Guardian Data collected every 6 months. From October 1, 2019 to September 30, 2020, a total of 390 parents/guardians and their home visitor discussed this issue 2,648 times and 443 referrals were made.

Postnatal Depression Screening

The Edinburgh Postnatal Depression Screen (EPDS) was developed for screening postpartum women in outpatient, home visiting settings, or at the 6–8-week postpartum examination. The EPDS consists of 10 questions scored from 0 to 3 by the parent. The overall screening is then scored and scores of 10 or higher are considered to be a positive screen for depression requiring a referral for services unless they are already receiving services to address their depression. Healthy Families Arizona requires that all families receive a screening within 3 months after the birth of each child.

A total of 4,504 EPDSs were recorded in the ETO data system between October 1, 2019 and September 30, 2020 for 3,288 parents. This resulted in 967 positive screens with 756 referrals given to the parent (Exhibit 48). An additional 264 were already receiving services to address their depression prior to joining Healthy Families Arizona.

Exhibit 48. Edinburgh Postnatal Depression Screen Results



Child Abuse and Neglect: Collaboration with the Department of Child Safety

A primary goal of Healthy Families Arizona is to reduce the incidence of child maltreatment and abuse. As part of this, Healthy Families Arizona accepts referrals of families directly from Arizona DCS workers as well as the SENSE program. The SENSE program provides services to families after the birth of a substance exposed child. The families receive a coordinated Family Service Plan of which Healthy Families Arizona home visitation is a part of the plan. Healthy Families Arizona provides supportive services for these and other families involved with DCS.

Overall, from October 1, 2019 through September 30, 2020, 20% of all families that received services had some level of involvement with DCS (882 of the 4,337). This is a decrease from FY 2019 at 25% and closer to the 18% in FY 2018. Of the families with DCS involvement, 500 had DCS or SENSE referrals, with the remaining 332 families referred to Healthy Families Arizona through systematic, community, or self-referrals. Healthy Families Arizona served a total of 345 SENSE referred families during this time accounting for 39% of all DCS involved families, a slight decrease from 41% in FY 2019. For newly enrolled families,164 of the 1,971 new families were SENSE referrals (8%). Healthy Families Arizona supportive services include:

- Acceptance of referrals from DCS;
- Providing screening and assessment for parent(s) if the parent(s) wished to determine eligibility to receive program services;
- Attending DCS case plan staffing;
- Utilizing best practices and a family-centered approach when working with families; and
- Coordinating with DCS staff to identify service needs and development of family and child goals.

Family Outcomes

Caregiver Outcomes

While reducing child abuse and neglect is the ultimate outcome, intermediate objectives, such as changes in parenting behaviors, can inform us about progress toward the ultimate goal. The intermediate goals of the Healthy Families Arizona program revolve around key factors known to be critical in protecting children from maltreatment (Jacobs, 2005):

- Providing support for the family;
- Having a positive influence on parent-child interactions;
- Improving parenting skills and abilities and sense of confidence; and
- Promoting the parents' healthy functioning.

Research from randomized clinical trials of the Healthy Families Arizona program (see LeCroy & Krysik, 2011, LeCroy & Davis, 2016) supports the finding that the program can produce positive changes across multiple outcome domains such as parenting support, parenting attitudes and practices, violent parenting behavior, mental health and coping, and maternal outcomes.

Healthy Families Parenting Inventory

The Healthy Families Parenting Inventory (HFPI) is a 63-item instrument that measures family outcomes across nine domains: social support, problem-solving/coping, depression, personal care, mobilizing resources, role satisfaction, parent/child interaction, home environment, and parenting efficacy. The HFPI was developed in 2004 to better evaluate critical goals of the Healthy Families program (LeCroy, Krysik, & Milligan, 2007), in part, because of measurement difficulties identified in the literature (LeCroy & Krysik, 2010). The development of the HFPI was guided by several perspectives and sources: the experience of the home visitors in the Healthy Families Arizona program; data gathered directly from home visitors, supervisors, and experts; information obtained from previous studies of the Healthy Families program; and examination of other similar measures. A validation study showed that the pattern of inter-item and item-to-subscale correlations, as well as an exploratory factor analysis and sensitivity to change analysis, supported the nine-factor model of the HFPI (Krysik & LeCroy, 2012).

Change in HFPI Subscales from Baseline to 12- or 14-Months Post

The evaluation team conducted a paired t-test analysis for each subscale of the HFPI. The level of significance is reported along with magnitude of the effect size (Exhibit 49). An effect size gives a sense of how large the improvement is from baseline to follow-up. Effect sizes below 0.20 are considered small changes and those between 0.20 and 0.50 are considered small to medium changes. This analysis was completed with data from participants who completed both instruments at the baseline, which was completed at approximately two months post enrollment into the program, and 12-months or 14-months later. Data utilized include those reported and entered into ETO from sites during the time frame of March 2014 to October 2020. (Note: the follow-up data collection time point shifted from 12 months to 14 months in October 2019. For the purposes of this evaluation, the two times are considered equivalent. The standard follow-up will be at 14 months moving forward.) The number of paired results by subscale are shown in Exhibit 49. The N-values vary because if a participant did not fully complete a subscale, their total score for that subscale was excluded from the analysis. The Cronbach's alpha score for the HFPI to gauge reliability of the scale showed strong internal consistency with an alpha of .96.

As shown in Exhibit 49, from baseline to 12- or 14-months post, there were statistically significant changes in all subscales except the Social Support, which has been a consistent finding over time. The largest improvements from baseline to approximately one-year post enrollment, as shown by the medium effect sizes, are for the areas of home environment (0.47), mobilizing resources (0.36), and problem-solving (0.21). Overall, these results indicate that the Healthy Families Arizona sites are effective at improving the atmosphere of the home, connecting parents to resources, and helping to strengthen parents' problem-solving skills.

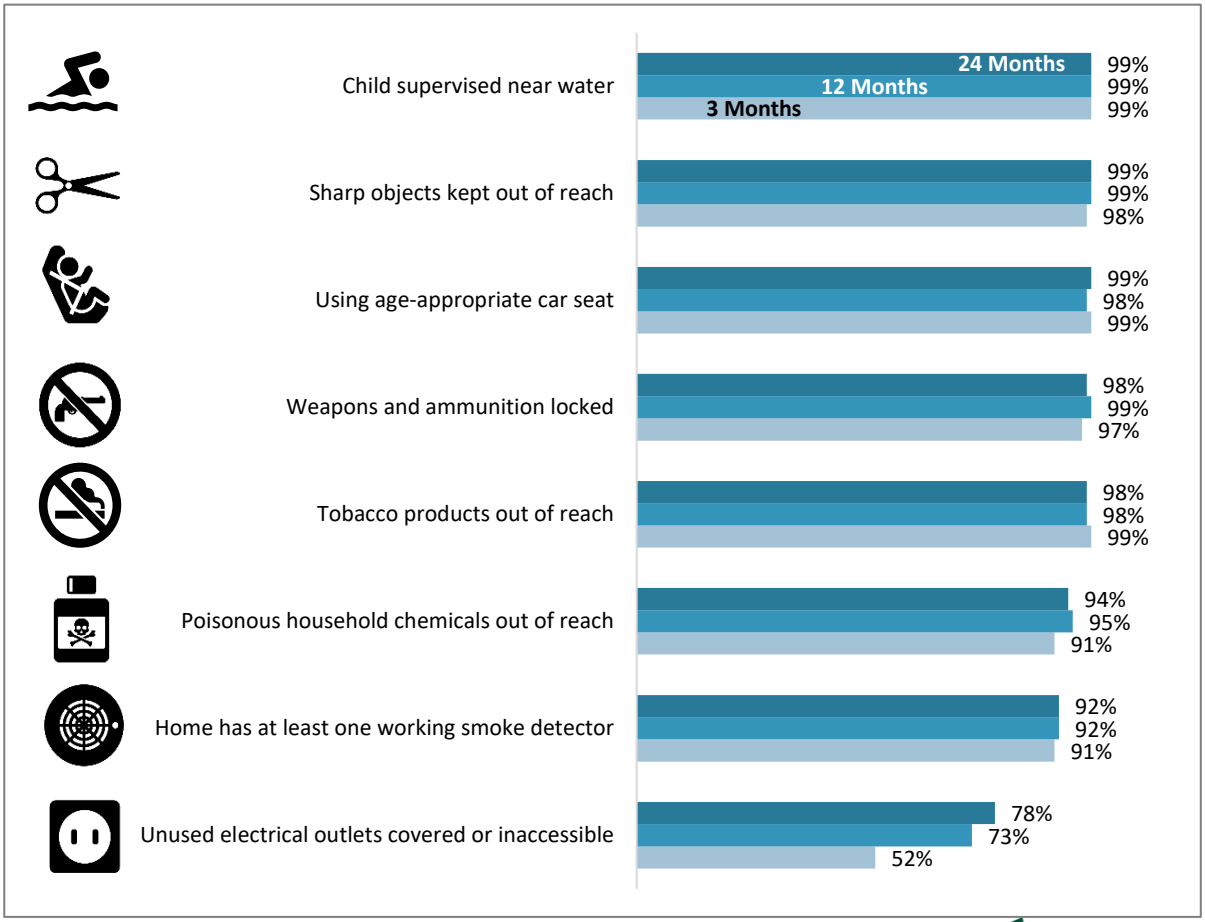
Exhibit 49. Change in Subscales of the HFPI

HFPI Sub-scale	Significant improvement from baseline to 12- or 14-months post	Significance (p-value)	Effect size	n
Home Environment	✓	.000	medium	1,415
Mobilizing Resources	✓	.000	medium	1,428
Problem-Solving	✓	.000	medium	1,437
Depression	✓	.002	small	1,430
Personal Care	✓	.000	small	1,430
Role Satisfaction	✓	.000	small	1,425
Parent/Child Interaction	✓	.000	small	1,430
Parenting Efficacy	✓	.000	small	1,413
Social Support	×	.404	small	1,436

Safety Practices in the Home

Unintentional injuries are the fifth leading cause of death for infants under the age of 1 according to the CDC. Suffocation is the leading cause of preventable infant deaths. One of the first messages that Healthy Families Arizona home visitors deliver to their families is the importance of safe sleep practices for infants. All families receive this information within the first couple of visits and it continues to be a topic of discussion throughout their home visits. The Healthy Families Arizona home visitors assess and provide education to families about safe home environments for children by completing the Safety Checklist with them. From October 1, 2019 to September 30, 2020 a total of 2,798 had safety checklist information entered into ETO for children's ages ranging from prenatal to 60 months. Exhibit 50 shows the various safety practices reported as "always" being followed, based on the age of the child. Safety areas that nearly all families always implement regardless of child age include children are supervised near water, sharp options are kept out of reach, age-appropriate car seats are correctly installed, and tobacco products and related items (matches and lighters) are kept out of reach. The one safety area that could potentially be improved is covering unused electrical outlets. While this is less of an issue for parents of infants, given the mobility of older children, home visitors should encourage this practice.

Exhibit 50. Percentage of Families "Always" Implementing Safety Practices by Child Age



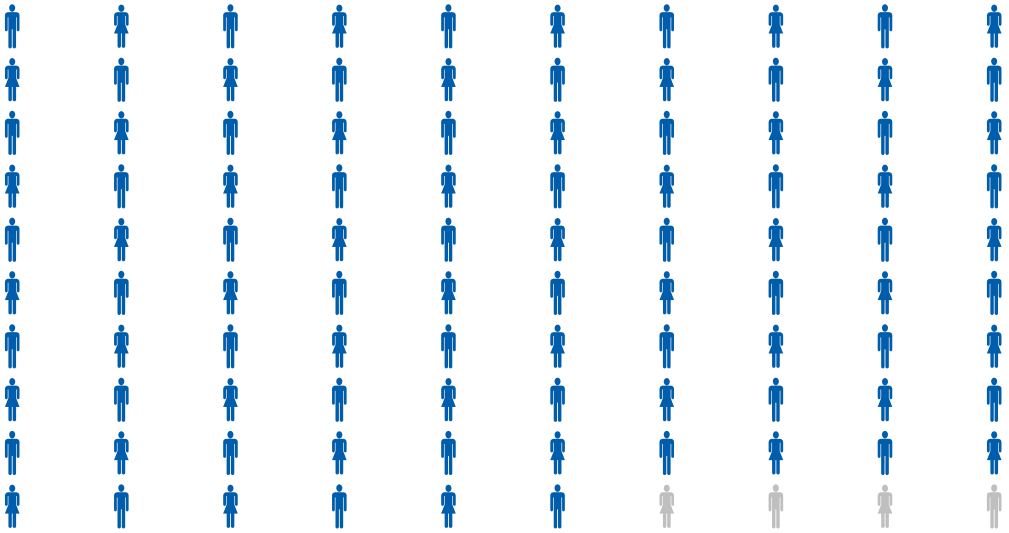
Child Maltreatment

One of the main goals of Healthy Families Arizona is to reduce the incidence of child maltreatment, inclusive of all forms of child abuse and neglect. In order to look at child maltreatment directly, data from CHILDS, the Arizona Department of Child Safety data system, is used to determine the rates for Healthy Families Arizona participants. It is important to acknowledge that using official child abuse and neglect data as an indicator of program success is complex and is unlikely to fully answer the question about the effectiveness of Healthy Families Arizona in preventing child maltreatment. The shortcomings in using official child maltreatment rates to assess the effectiveness of home visiting programs have been discussed in numerous journal articles (see for example, *The Future of Children*, 2009).

There are several reasons the use of child maltreatment data is believed to have limitations. First, child maltreatment is an event that occurs infrequently and, therefore, changes are difficult to detect with statistical methods. Second, using official incidents of child abuse and neglect does not necessarily reflect actual behavior—there are many variations in what constitutes abuse and neglect and using only reported and substantiated incidents of abuse captures incidents that rise to that level of severity. Some incidents of child abuse or neglect are undetected or may not meet some definitional standard minimizing the accuracy of the count. Third, using official data requires a process whereby cases are "matched" on available information such as name, social security number, and date of birth. When any of this information is missing, the accuracy of the match decreases. Finally, because home visitors are trained in the warning signs of abuse and neglect and are required to report abuse or neglect when it is suspected, there is a "surveillance" effect—what might have gone unreported had there been no home visitor show up in the official data.

In order to best represent families that have received a significant impact from the Healthy Families Arizona program, only families that have been in the program for at least six months are analyzed to determine if they have a substantiated report of child abuse or neglect. This year 96.3% of the Healthy Families Arizona eligible families, 2,834 out of 2,944 families, were without a substantiated report, as illustrated in Exhibit 51. This is the same rate as state fiscal years 2018 and 2019. A total of 110 reports were substantiated after investigation. A substantiated finding means that "the Department of Child Safety has concluded that the evidence supports that an incident of abuse or neglect occurred based upon a probable cause standard" (see DCS substantiation guidelines for further detail).

Exhibit 51. Percent of Families Showing No Child Abuse and Neglect Incidences



Service Plan Sub-Study

Service plans are a common component of social service programs and are often developed to meet accreditation and supervision requirements. As part of the HFA toolkit, practitioners are supposed to develop an individual service plan that addresses the concerns of families. The service plan provides an opportunity to work collaboratively with the family in identifying needs and developing objectives and a plan to address family concerns.

Service plans or treatment planning has increased in social service organizations to address needs of documentation and provide guidance when planning for how to assist individuals and families. One of the key assumptions in producing a service plan is that it can help practitioners focus their efforts while ensuring they are meeting the expectations of the family. Research supports the use of goal setting and the process of conducting planning to increase service satisfaction, worker alliance and promote better outcomes (Lindhiem, Bennett, Orimoto, & Kolko, 2016).

In home visitation service plans create a process for a collaborative relationship with the family. Furthermore, the service planning process can provide the family with a clearer picture of what the services have to offer and how those services can directly address the families concerns and interests. Because home visitation services are broad and not well defined it is likely that this process provides focus and shows the family what a concrete plan looks like. Psychotherapy research has found that this process is a "nonspecific" treatment benefit that sets expectations and builds hope about the process of working together (Donovan, Kwekkeboom, Rosenzweig, & Ward, 2009; Zilcha-Mano, et al., 2019).

Since the service plan is a written document it provides a further tool for administrators and accrediting bodies to review and assess if the program is addressing concerns as recommended. For supervisors it can provide information to help guide the process of delivering home visitation services and provides a structure to ensure that important aspects of the process are addressed. This can function like a checklist providing reference points and structure.

Under the best circumstances the HFA service plan can outline what services and activities would benefit the family the most. Home visitors and supervisors are directed to consider what activities, services, or referrals are best matched to the family's needs. A well-designed service plan should reflect careful thought and planning that practitioners undergo to meet the goals of the family. Ideally, families would make better improvements when a documented service plan is part of the helping process.

Service Plan Completion Analysis

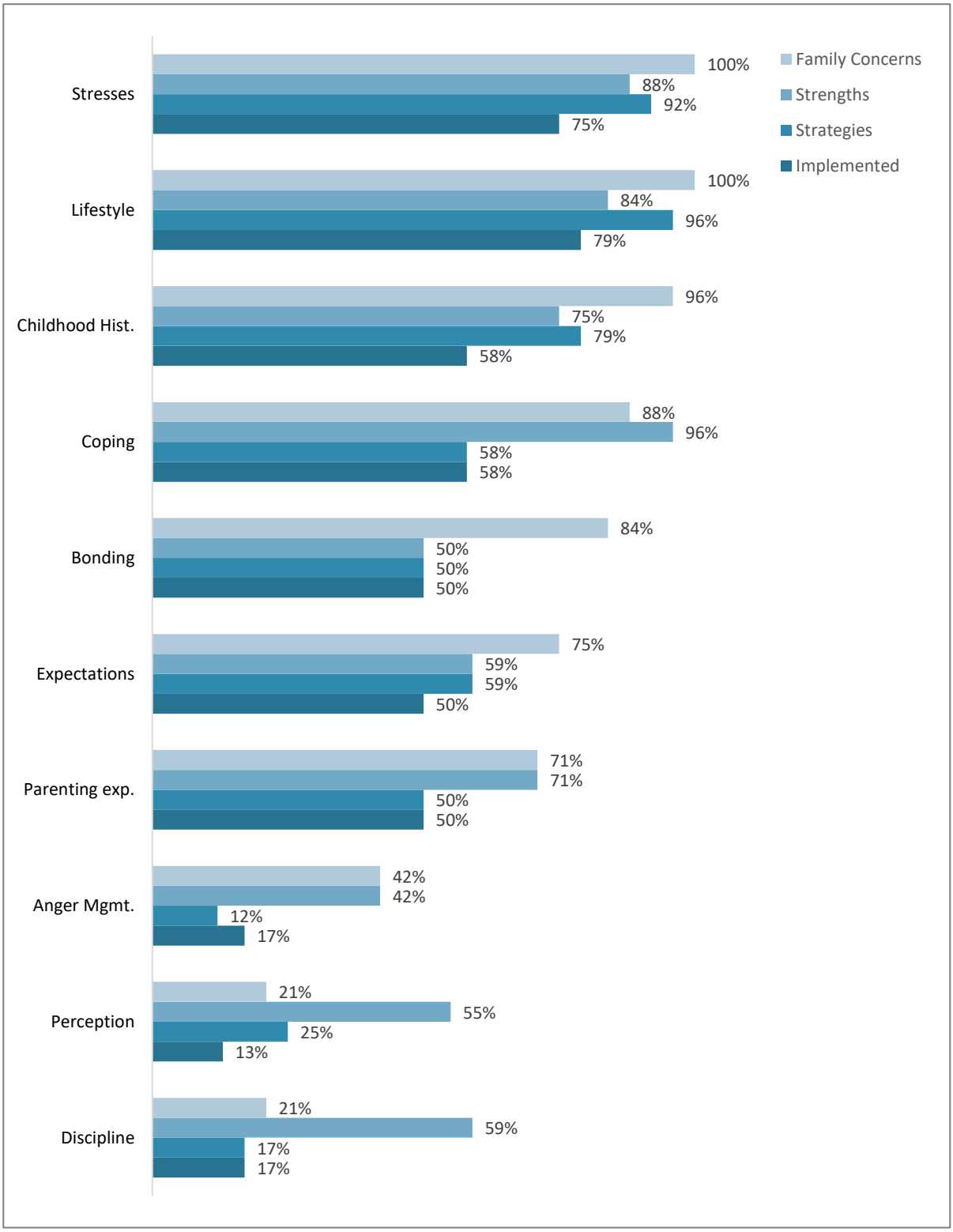
The evaluation team collected 24 service plans to examine for this case study. The purpose of the study was to analyze the plans and make recommendations for their improved usage. Analysis included the reports from the parent survey items (e.g., parent's childhood history, lifestyle behaviors) and the service plan items (e.g., family concerns, needs, risks, stressors, potential impact on the child). The evaluation team also conducted a quantitative analysis on the service plan completion. Exhibit 52 on the next page presents the result of service plan completion rates, showing for each assessment area the percentage of service plans that documented if the area was a concern, need, risks, or stressors ("Family Concerns"), any strengths or protective factors related to this area ("Strengths"), if a plan was developed with strategies for implementing it ("Strategies"), and if the plan was implemented or in progress, including notation of dates ("Implemented").

The data shows some large discrepancies between completion of Parent Survey items. In particular, current stressors, lifestyle behaviors, the parent's childhood history, and coping skills and supports had the largest completion rates on the service plans reviewed. The following areas had lower rates of completion on service plans reviewed: bonding/attachment, expectations of developmental milestones, parenting experience, anger management, perception of the infant, and plans for discipline. The three categories with the lowest completion rates were anger management, perception of the infant, and plans for discipline. Further study as to why the completion rates vary so much by assessment area is needed. This data could be shared with supervisors to learn more about what these data reflect and suggestions for additional staff training.

It is interesting to observe that "Family Concerns" had the highest rate of documentation on service plans for each area and "Implementation" had the lowest rate of documentation. Perhaps surprising is that strategies also shows low completion rates. Since strategies represent the action steps home visitors take to address family concerns, individual service plans may be more useful if home visitors documented strategies more often.

Reframing and reviewing the purpose and function of the service plan may be worthwhile. Home visitors can be encouraged to consider how a service plan helps the family share information, how it helps the home visitor conceptualize family needs, how it assists in supervision and quality. Home visitation is often referred to as a "black box" and that is because the provision of services is wide ranging and prioritizing goals is difficult, and much of the time home visitors must act immediately to respond to unforeseen issues that confront families.

Exhibit 52. Completion Rates of Assessment Areas on Service Plans



When reviewing the individual service plan template, the steps for service planning are well described:

- Identify concerns, risks, and stressors
- Identify strengths and protective factors
- Develop goals and strategies
- Develop plans for implementation

The following section reports on the results of having reviewed the case plans and examined the individual service plans.

Review of Individual Service Plans

All the obtained individual service plans (ISP) were reviewed and studied to examine how they were completed, what was described, the connection between the concerns and the strategies and the implementation plans. The plans reviewed varied considerably with some plans offering specific details and other plans vague and not very specific.

Several ISP were related to issues of depression. In many cases the strategies for addressing depression were not clearly stated. For example, one plan noted, "follow up with the postnatal depression scale in response to the mother feeling more depressed but did not specify how the home visitor was going to address the concern. In another ISP the note was more specific, "self-care goal" but not specific to depression. It may not be clear what the Healthy Families program is expected to do when identifying depression, however, since this is documented the ISP would be strengthened by having some clear goals and objectives that are appropriate for the home visitor when addressing issues of depression.

Many of the plans read more like progress notes than service goal plans. The final column of the service plan does request "progress" but much of the ISP are notes about the family and not true service plans with clearly defined problems and constructive plans, goals, and objectives to meet those goals.

Some of the plans identify the goal as "create goal" when the ISP should be the place where the goal is developed and documented. Other similar plans simply listed "referrals" not indicating what type or how the referral was to be acted on or "curriculum" not indicating what aspect of the curriculum was going to be used to address the specific concern. These ISP would be improved if they were more specific.

The best ISPs were ones that were specific and related a clear strategy that was logically linked to the problem. For example, some ISPs stated "do GGK module on X" or "teach baby 15 new words." In the case study review a few aspects of the ISP were observed

across several plans, for example, many plans included "GGK what I'd like for my child" or "protective shield." Increasing the use of more common strategies across the ISPs may be one way to improve the selection of strategies that logically follow from the identified concerns. Assisting home visitors to use more of a menu from which to select strategies can help them not overlook important strategies that might be most helpful.

The review was not able to find any information from the ISPs that related to establishing priorities. Since home visitors have different goals they are working on, it would be helpful if the ISP could point out the priorities. In one ISP depression and a history of suicide attempts was noted and this would seem to be an important priority that could be underscored in the ISP, but it was not. In another case plan a concern noted a "police call regarding a domestic dispute" and this was not highlighted as a priority and the strategy listed was simply "observations." In another case file it was noted "FOB has a history of violence behavior toward MOB" the plan was "resources" and the strategy was "DV information." Although this plan was more specific the concern was not noted as a priority. Reviewing this plan raised the question of whether the ISPs should have more standard protocols noted under these types of circumstances. It is noteworthy that embedded in the template is a priorities check box, but this was observed to be not used on almost all the case files reviewed.

Research on goal setting has important implications for service planning. Goal setting has a clear impact on performance. It is theorized that goal setting influences outcomes based on its ability to generate focus and attention, mobilize resources toward goal attainment for the family, and mobilize efforts of the home visitor to help the family (Jongsma, 2016). Research also supports the finding that specific goals lead to better outcomes than vague goals (Tryon & Winograd, 2001; Wilier & Miller, 1976). Working on vague goals is problematic because the home visitor and the family may not be clear on what is trying to be accomplished. Therefore, writing goals is often accompanied with instructions to make them specific and observable. Some researchers assert that setting goals can assist people as they make plans for changing behavior—moving people from the Model of Change stage of contemplation to the preparation to change stage. It is helpful to assist families to feel hopeful about their progress and goal attainment can be as aspect of building hopefulness.

The supervision process can encourage home visitors to use collaboratively developed and behaviorally stated goals and objectives to assess development, develop strategies, and conduct thoughtful service planning during discussions with family participants. Supervisors can teach and model the process by collaboratively developing behaviorally stated goals with each home visitors that will encourage the home visitor's professional development and growth. This can empower home visitors in the same way that home

visitors seek to empower participants. Supervisors can also encourage the common use of strategies that address similar concerns of families.

The intent of this study is to provide valuable and useful feedback regarding the individual service plan. We include a list of recommendations based on our review of the cases. The recommendations are based on our review of service plans and best practices in goal construction. Some of the recommendations may be feasible and some may not—they are offered in the spirit of what might be helpful to improve the process. We have also included a tip sheet on writing goals that could be shared with home visitors and a checklist that can be used when reviewing individual service plans.

Service Plan Recommendations

- Review the purpose and function of service plans with home visitors and provide additional training on the development of individual service plans.
- Review the process of family involvement in developing service plans. Since engagement and setting expectations with families is an important part of the home visitation approach reviewing the shared understanding and action steps of doing this could be beneficial.
- Create a sample template to guide home visitors in completing the individual service plan.
- Create stronger links between family needs, evidence-based strategies, and implementation when completing the individual service plans. At least for plan developed and plan progress a numbering system can help link the two actions, e.g., plan, 1. Follow up with discussion regarding depression; progress, 1. Made referral for treatment will follow up on referral at next visit on 11/2/2020.
- Consider including a stronger role of referrals in the service plans. Document specific referrals to collect information about using resources in each site setting.
- Document priorities within the Individual service plans that are easy to spot and follow up on.
- Empathize writing clear behaviorally stated goals and objectives.
- Consider including protocols for developing goals related to common concerns, for example, risk of domestic violence and depression. This menu approach might help home visitors not overlook important strategies for helping the families.
- Consider supervisor training and workshops to improve the use of goals in the individual service plan.

Tip Sheet for Writing Goals and Completing an Individual Service Plan

Family Concerns, Needs, Risks, and Stressors

When asking about concerns listen carefully to how the family describes their concerns. It may be helpful to ask the family. Being understood and affirmed in a safe environment is critical when beginning to develop a service plan. A key aspect of supporting a family may include helping them to accept difficult life experiences to minimize the negative impact of those experiences. Help families understand that describing their concerns is the process used to established goals (strategies) and review progress.

Strengths/Protective Factors

Identifying family strengths helps families find their own strengths and resources within themselves and their families. This can also function to provide them with a sense of hope. Focusing on strengths helps families focus on learning new knowledge and skills. When describing strengths consider how families are fulfilling their roles, for example, as a mother, as a daughter. What behaviors are they performing in that role that is helpful to the family? Keep in mind that enhancing positive behaviors is sometimes the best way of eliminating unwanted behaviors, for example, increasing positive parenting behaviors may decrease unwanted negative discipline behaviors. As much as possible, state strengths as actions that the family is performing in the present. Focusing on strengths may be particularly helpful with families that have experienced trauma. Parents can be helped to feel more in control when strengths are emphasized. Early childhood intervention work is evolving, and the field increasingly recognizes that using a strengths perspective does not require denial of family risks, vulnerabilities, and struggles.

Plan Developed/Strategies

When developing a plan with a family it can be helpful to ask them, "how would things be different if we were successful in our work?" This uses the process language of goals rather than having the family focus on what is not working. For example, it the mother was feeling isolated, and was asked how would things be different, she becomes directed toward goal oriented responses and might say, "I would talk to family members or friends on a more regular basis" and this becomes the basis for a goal or strategy. Goals can be framed within three key areas (see Exhibit 53):

1. Support- participating in a parent group.
2. Learning- learning how to distinguish between protest crying and distressed crying of the baby.
3. Action- going to bed at a more regular time to increase sleep.

Exhibit 53. Three Areas of Focus for Individual Service Plan Development

When goals are stated it can sometimes be useful to identify a few objectives needed to reach the goal. Achieving goals often comes about when families meet objectives toward the goal. Goals can be broader and bigger while objectives break the goal into stages or steps. Objectives should be described as behaviors that achieve the goal. Creating small steps of objectives is important because it helps families see that "change is possible" and promotes hope. A good question to ask is, "What would be a tiny step toward the goal?" Home visitors should encourage families to explore challenges in reaching the goal and problem solve how to best move in the right direction. If the mother states her goal is to increase her self-esteem some objectives could include these steps: 1) Decrease negative self-talk; 2) Identify positive aspects of herself and write them down and post them; and 3) Practice smiling more.

Plan Implemented/Progress

Progress indicators will assist the home visitor and supervisor in determining how progress is proceeding. Enter the date the strategy was implemented and note progress toward meeting the goal. A timetable for the goal provides feedback and helps establish new priorities and next steps. Indicate whether the goal was achieved and use this opportunity to share with the family progress in achieving goals.

Checklist for Reviewing Individual Service Plans

The following checklist can be completed by home visitors and supervisors when reviewing ISP for families.

- ☐ Family concerns and needs are clearly described.
- ☐ Specific risks and stressors are identified.
- ☐ Descriptive data are complete and accurate.
- ☐ Relevant historical data is included.
- ☐ Current life circumstances are clearly described.
- ☐ Strengths are identified and include past and current behaviors.
- ☐ Strengths include protective factors.
- ☐ Sources of data used in the ISP are noted.
- ☐ Assessment data is included when relevant.
- ☐ Family and environmental context is described.
- ☐ Strategies include goals and objectives written in measurable terms.
- ☐ Strategies are clearly described and logically linked to plan implementation.
- ☐ Strategies use best practices and evidence-based methods when possible.
- ☐ Strategies reflect interventions directed at the family, group, and community levels.
- ☐ Referrals are clearly identified and followed up on.
- ☐ Objectives are included and start with small steps toward goal attainment.
- ☐ Plan progress includes date of activities implemented.
- ☐ Progress toward goals is documented.
- ☐ Priorities are identified.

Staff Perspectives on Service Plans

The staff survey conducted in October 2020 asked, "How do you use the service plans for your families? Do you have any challenges or successes with using them?" A total of 92 staff members responded to the question, and a total of 78 responses were analyzed after excluding responses from staff who answered, "not applicable," indicated they do not use service plans, or whose answers were unclear or unrelated. Themes were identified and coded, revealing a wide variety of responses to this question. This may have been because this question contained three parts and respondents addressed different aspects of the questions. Exhibit 54 shows the identified themes related to how staff use service plans and the number and percentage of responses that included those themes. On average, responses included one theme related to the use of service plans with a range from none to four themes per response.

Exhibit 54. Themes Related to the Use of Service Plans

Theme	n	%
Use service plans to guide/generate ideas during supervision	10	13%
Use service plans to identify/address concerns	10	13%
Describe service plan as a "guide" or "map"	10	13%
Use service plans to plan/choose curriculum and interventions to use	8	10%
Use service plans to keep focused, especially on family goals	8	10%
Use service plans to identify family needs/priorities	6	8%
Use/review service plans regularly	5	6%
Use service plans to identify/support strengths/progress	5	6%
Describe service plans as "useful"	4	5%
Use service plans to support families	4	5%
Use service plans to organize information	3	4%

No one theme was repeated more than 10 times among the responses, again reflecting a variety of responses. The most common themes were that staff use service plans to guide or generate ideas in supervision (13%, n=10) and to identify/address concerns (13%, n=10). Exemplative comments include a staff member who said they *"walk through the [service plans] with a supervisor to brainstorm ideas for families"* and another who commented that they *"use curriculum and have conversations about areas of concern."* Another theme was that respondents described the service plans as a map or guide, such as a staff member who wrote that a service plan *"is like a map to know where to go."* Similar to how staff described how they use the CHEERS Check-In, staff also said they use the service plans to plan and choose curriculum and interventions to use with families.

Exhibit 55 lists the identified themes related to challenges with service plans. Approximately a quarter of respondents (25%, n=19) mentioned or described a challenge with service plans in their comments, while another 9% (n=7) specifically noted that they do not experience challenges with service plans. Given the relatively small of responses about challenges (n=19), there was quite a range of challenges mentioned, with no theme repeating more than four times. The most frequently mentioned challenge was that the service plan was redundant or not useful (5%, n=4). One respondent explained, *"Honestly, the service plans are not very helpful. It's mostly another box we have to check…"* Other respondents described the service plans as generally useful but noted there are challenges with implementing service plans currently due to COVID-19 (5%, n=4), especially because it may be difficult for families to achieve their goals during this global pandemic. Four

respondents (5%) also mentioned that it can be difficult to remember to refer to the service plans, especially over time. This contrasted the five respondents (6%) who described using the service plans regularly or routinely.

Exhibit 55. Themes related to challenges with service plans.

Theme	n	%
Described one or more challenges	19	25%
Specified they do not experience challenges with service plans	7	9%
Service plans are not useful/are redundant/are mostly a "box to check"	4	5%
Can be hard to remember to use/refer to service plans	4	5%
COVID-related challenges	4	5%
Challenging to use with families who are doing well	2	3%
There can be a disconnect between FAWs and FSS	2	3%
Families are sometimes resistant to goal setting	1	1%
Change takes a long time	1	1%
Time consuming to complete service plans	1	1%
Follow through could be improved	1	1%

A few challenges were only mentioned once or twice but are worth noting. Two staff members explained that it can be challenging to use service plans with families who are doing well and have few goals to work on. Also, two comments described a disconnect in information flow between FAW and FSS staff. One FAW asked, *"Can you share this data with the FAW's. It would be helpful when explaining the efficacy of service plans/goals with the family in the initial assessment."* Overall, the comments suggest that some but not all staff may experience a variety of challenges with service plans. Strategies to address these challenges include training about the purpose of service plans, guidance about how to use service plans during COVID-19 and with families who are doing well and providing service plans to FAWs for better continuity of care. Finally, if Healthy Families Arizona would like staff members to use service plans consistently for the same purposes, additional guidance and training may be helpful given that staff members provided such a variety of responses about how they use service plans.

CHEERS Home Visit Notes and CHEERS Check-In Comparison Sub-Study

LeCroy & Milligan Associates conducted a sub-study of the CHEERS data collection by Family Support Specialists (FSS) of the Healthy Families Arizona home visitation program to assess CHEERS data collection from two instruments and make recommendations for improving CHEERS data collection and utility by FSS. The CHEERS data collection by FSS occurs at least annually using the CHEERS Check-In (CCI) tool and at every home visit using the CHEERS on the Home Visit Note (HVN). The CHEERS domains include:

- **Cues** – How the parent responds to behaviors that the infant/young child uses to communicate.
- **Holding and Touching** – The presence and quality of physical contact that the parent has with the child.
- **Expression** – Whether the parent expresses themselves to the child, verbally or physically, and whether they are responsive to the child's efforts to communicate.
- **Empathy** – The parent's responsibility to the child's distress, including whether and how the parent responds.
- **Rhythm and Reciprocity** – how the parent supports the child's play.
- **Smiles** – the enjoyment the parent experiences in engaging with the child.

Exhibit 56 outlines the instruments, construct/purpose, and analytical strategies for the CHEERS sub-study.

Exhibit 56. CHEERS Sub-study Data Collected, Purpose, and Analysis

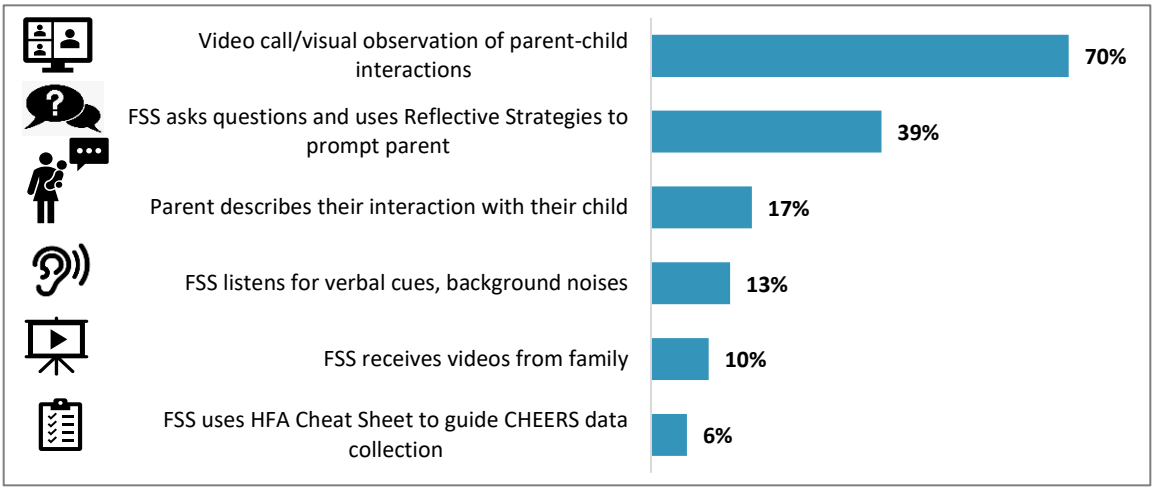
Data/Instrument	Construct/Purpose	Analysis
CHEERS Check-In Data (CCI)	• The CCI is a parent-child interaction observation tool designed to measure the quality of the relationship between parents and their infants, toddlers, and young children. • The CCI measures FSS staff observations that can support parents in developing healthy, nurturing relationships with their children. • The CCI assigns specific ratings for behaviors that may help staff to discern subtle changes to celebrate and support.	Item Level Score 1-7 interpreted as the following to be comparable to the CHEERS HVN: Concern = 1-3 Neutral = 4-5 Strength = 6-7
CHEERS documented as part of Home Visit Note (HVN)	The CHEERS HVN documents FSS overall parent-child observations during the visit. Each CHEERS domain is documented as being a concern, a strength, or neutral. FSS documents if and what type of reflective strategies/parent-child interactions were utilized in response to the identified concerns and strengths. FSS notes describe what was observed to account for the FSS's rating and use of strategies.	Concern Neutral Strength

Data/Instrument	Construct/Purpose	Analysis
FSS Online Survey	**Questions using a 3 or 4-point rating scale asked FSS to rate each tool separately:** • How much does the CCI/CHEERS HVN provide you with information you use to engage with your families? • How effective do you feel collecting the CCI/CHEERS HVN with your families? • How difficult or easy are the CCI/CHEERS HVN to collect during virtual visits? • How useful are the CCI/CHEERS HVN when building your service plan for your families? • How consistent do you feel you are when scoring the CCI compared to CHEERS in your Home Visit Notes (HVNs)? **Open-Ended Questions:** • How do you use information from the CHEERS Check-in to support your families? • How are you collecting the CHEERS Check-In and CHEERS Home Visit Notes in virtual visits? What are the challenges and what successes have you had?	Thematic Analysis Descriptive Analysis

Strategies for CHEERS Data Collection during Virtual Visits

On the FSS online survey conducted in October 2020, staff were asked "how are you collecting the CHEERS Check-In and CHEERS Home Visit Notes in virtual visits?" A total of 83 staff (out of 154 respondents to the staff survey) responded to this question. Open-ended comments from staff were categorized into common themes shown in Exhibit 57. Frequency counts and percentages were calculated for the major themes to facilitate interpretation of the data. The percentages do not add up to 100% because many responses included multiple themes.

Exhibit 57. Strategies Reported by FSS for Virtual Data Collection of CHEERS



(N=83 FSS)

As shown in Exhibit 57 above, most of those FSS who responded (70%, n=58) reported that they collect CHEERS data for the CCI tool or HVN through video calls with families (e.g., Facetime, WhatsApp, Zoom), which allows for visual observation of parent-child interactions during virtual visits. Over a third of FSS reported (39%, n=32) successfully collecting CHEERS data by asking questions of parents and using reflective strategies, such as *Explore and Wonder* or *Problem-Talk*, to prompt the parent to talk about their interactions with the child. FSS also encourage parents to engage in an activity with the child during the virtual visit, such as reading a book together or an interactive activity where they play and bond. A few staff specifically mentioned using the HFA "Cheat Sheet" to help guide the CHEERS data collection. Quotes from FSS survey responses that describes these strategies include:

"I will ask the parent to describe what the child is doing during a phone visit."

"I ask mother about interaction, how they respond to baby/toddler, what cues he/she is giving."

"I have found creative ways using finger play, songs, and crafts to engage the children and parents in CHEERS activities during the video chat."

"I will ask questions to prompt each area of CHEERS for the Home Visit Note, usually, Explore and Wonder and Problem-Talk."

"We always take advantage of the first half [of the visit] to talk about the development, improvements, and challenges of the Target Child."

"If I don't get to see or hear any interaction with the mom and Target Child, I usually ask about the Target Child and then explore a situation [with the mom]."

"I observe and listen to the parent child interaction during an activity or just normal conversation/interaction between the parent and child."

Additionally, several FSS (17%, n=14) reported that parents describing their interactions with their child facilitates virtual CHEERS data collection, especially if the visit is only by telephone. As one FSS commented, *"Moms enjoy sharing with me about the Target Child's improvements or something that happened during the day."* A number of FSS (13%, n=11) also mentioned using the specific strategy of listening for verbal cues, changes in tone of voice, background noises, and sounds of the home environment, to collect CHEERS data, especially if the family is participating by phone call. Quotes describing these strategies include:

"I ask questions and listen to cues throughout the visit."

"I see and hear the children's reactions to their parents and vice versa."

"I hear laughing, then I know baby is having a positive interaction with family."

"Video and/or parent description of the child's action and expression as well as the voices and verbiage."

"I collect [CHEERS] based off of the interactions I see during video calls or what I hear during phone calls."

"Being aware of the background noises."

A few FSS (10%, n=8) reported that their families will record and send to the FSS a video of themselves interacting with their child, which can be in addition to or in lieu of a video visit. Notable FSS comments about this strategy include:

"If [video] observation is not available, I will ask parents to send me a video for CHEERS observation."

"I ask the mom for a video. My families love to share videos and pictures about their baby's development and how they are part of the development."

Use of CHEERS Check-in to Support Families

The online staff survey conducted in October 2020 asked FSS to respond to the open-ended question: "How do you use information from the CHEERS Check-in to support your families?" A total of 78 staff members responded to this question (excluding staff who reported not using this tool as part of their position). Open-ended comments from staff were categorized into themes shown in Exhibit 58. Frequency counts and percentages were calculated for themes to facilitate interpretation of the data. The percentages do not add up to 100% because many responses included multiple themes. On average, each response included about two themes with a range from one to eight themes per respondent.

Exhibit 58. FSS Use of CHEERS Check-in Data to Support Families

Theme Description	n (N=78)	Percent
Identify and address concerns/areas for growth	37	47%
Inform interventions, activities and/or reflective strategies; guide selection and focus of curriculum to use with family	30	38%
Identify, reinforce, and praise areas of strength/achievement; use Accentuate the Positive (ATP)	26	33%
Support parent-child interactions	18	23%
Prompt/guide discussion and reflection with families	16	21%
Observe and assess parent-child interactions, connection, and/or cues	10	13%
Utilize scores as a reference point or benchmark	7	9%
Build family's confidence and self-esteem	4	5%
Guide supervision/staff discussions	3	4%

FSS most frequently mentioned using the CCI to identify and address concerns or areas for growth (47%, n=37), to plan interventions and curriculum (38%, n=30), and to identify, praise, and support strengths (33%, n=26). It is interesting to note that the most frequent theme was to use the tool to identify and address *concerns*. This finding is different than what was revealed in the analysis of CCI scoring in ETO (reported in the next section and in Exhibit 64 on the following pages) that showed staff overwhelmingly scored families high (positive) on all domains of the CCI. This finding from the open-ended survey data suggests that staff may still use the tool to identify concerns, potentially even if they score the CHEERS domains as strengths. For some staff, they only mentioned addressing concerns, such as one respondent who said they use the CCI, "*To know what areas need to be improved on*." However, many FSS (19%, n=15) mentioned using the CCI for assessing and supporting areas of concern/growth as well as areas of strength.

An exemplative comment with all three of the most common themes said that the CCI is "*…a guide that reminds me to praise the areas that the family is doing great in, and provide support in the areas that I'm not seeing. Either by asking questions or providing curriculum*." Another comment that captured many of the key themes said they use to CCI to "*Discuss in supervision, establish SATP (Strategic Accentuate the Positive), determine curriculum, tools, and activities to grow areas needing attention, ATP strengths and increase parental confidence*."

Many FSS described using the CCI not only as a form of assessment, but also as a planning tool. Staff use the CCI to inform decisions about interventions, activities, reflective strategies, and curriculum. For example, one respondent wrote, "*It gives me an idea on where to focus upcoming curriculum*." Some staff members who did not specifically comment on planning future interventions still implicitly mentioned how the CCI informs their use of reflective strategies. They talked about reflecting back strengths and areas of growth in conversations with families, such as by using ATP and/or SATP.

Some additional themes included using the CCI to support parent-child interactions (23%, n=18) and to prompt or guide discussion and reflection with family (21%, n=16). For example, one respondent wrote "*I verbalize the domains of the CHEERS asking families how they felt they were in the areas too*." Many staff described using the tool to guide or focus conversation and activities. Less common but notable themes included using the CCI as a reference point or benchmark (9%, n=7), to build families' confidence and self-esteem (5%, n=4), and to guide supervision or staff conversations (4%, n=3).

This survey did not ask staff to assess the utility of CCI either on its own or in comparison to other tools. However, the responses generally conveyed that staff do use the CCI to support families through assessment, discussions, reflective strategies, and planning curriculum. There were also a few subtle references to using the tool for building engagement and relationships through this process. Despite the overall themes about the

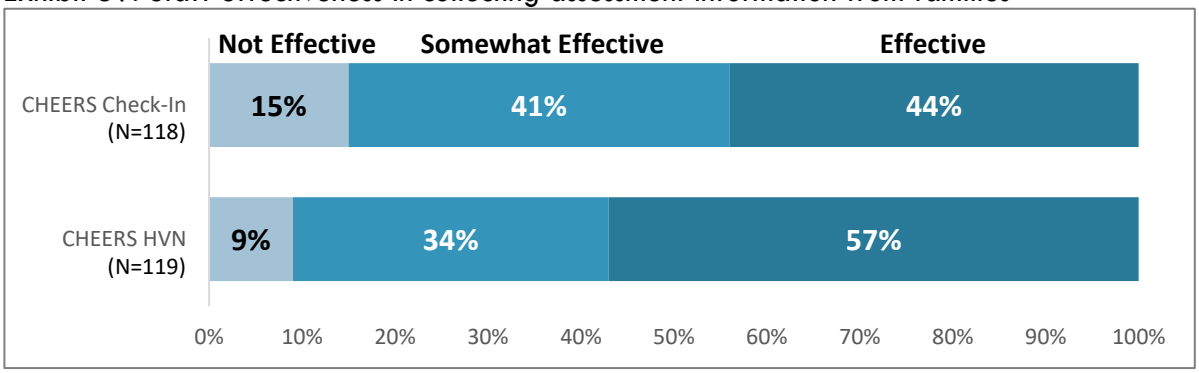
usefulness of the CCI, a small number of staff (n=4) noted that they did not find the tool useful or effective. For example, one staff member wrote "*I don't feel CHEERS Check-in is an effective tool - Depending on how the family is doing during that visit it may not be an accurate view of the parent child interaction*." A few others mentioned that they did not need the CCI to achieve the same results with families because they already understand the strengths and weaknesses of their families. Also, two respondents mentioned that they used the CCI the same way as the CHEERS Home Visit Note.

Overall, the survey results suggest that staff use the CCI to support families, and many staff use the tool to identify and address areas for growth, even if they score the CCI quite high. Many staff also use the CCI as a planning tool and to praise strengths and achievements. One limitation to this data is that even though the question referred to the CCI, staff may have also been thinking of the CHEERS HVN since they use this tool more frequently. Additional evaluation could further explore the potential contradictions between how staff described using the CCI and the way staff tend to score the CCI and could help identify the reasons behind these trends.

Perceptions of CHEERS Data Collection

In response to the online staff survey conducted in October 2020, FSS rated themselves as being more effective overall in collecting the CHEERS HVN compared to the CCI data (see Exhibit 59).

Exhibit 59. Staff effectiveness in collecting assessment information from families



In response to the online staff survey conducted in October 2020, Exhibits 60 and 61 show that FSS rated the CHEERS HVN as a more useful tool than the CCI to engage with families and build a service plan for families.

Exhibit 60. Usefulness of CHEERS Assessments to Engage with Families

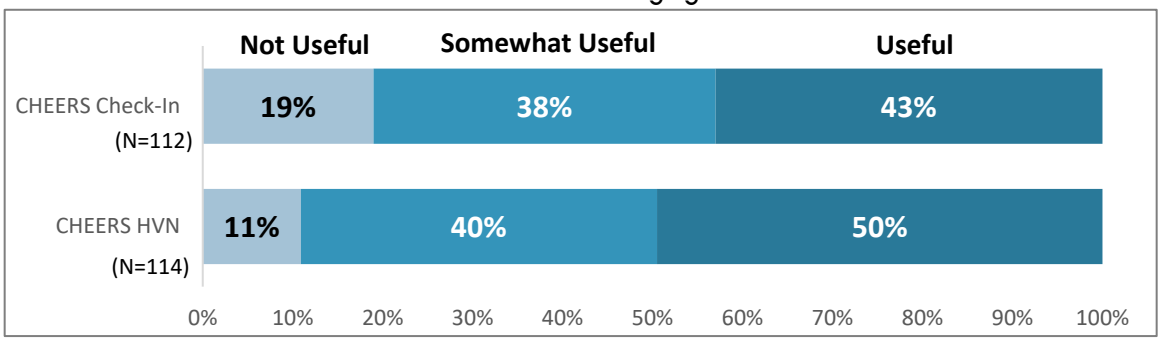
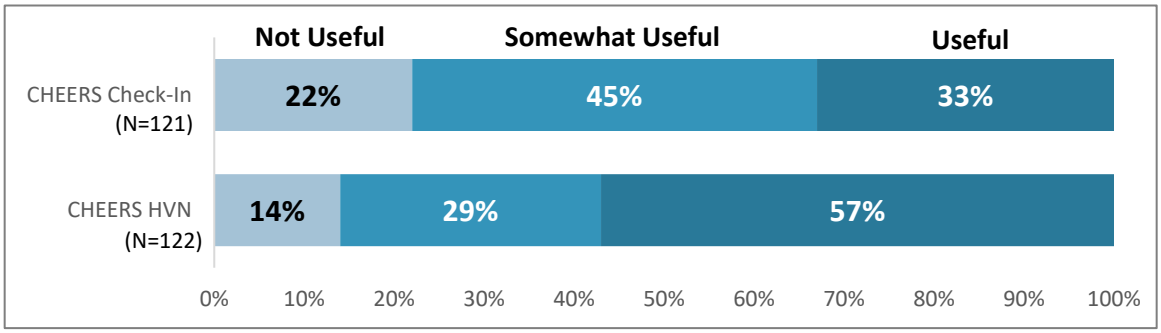


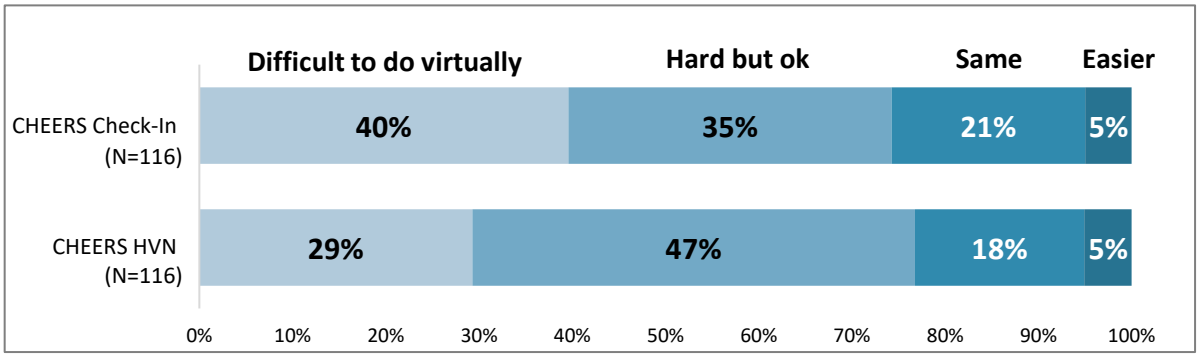
Exhibit 61. Usefulness of CHEERS Assessments to Build Service Plans for Families



Challenges with Virtual Data Collection

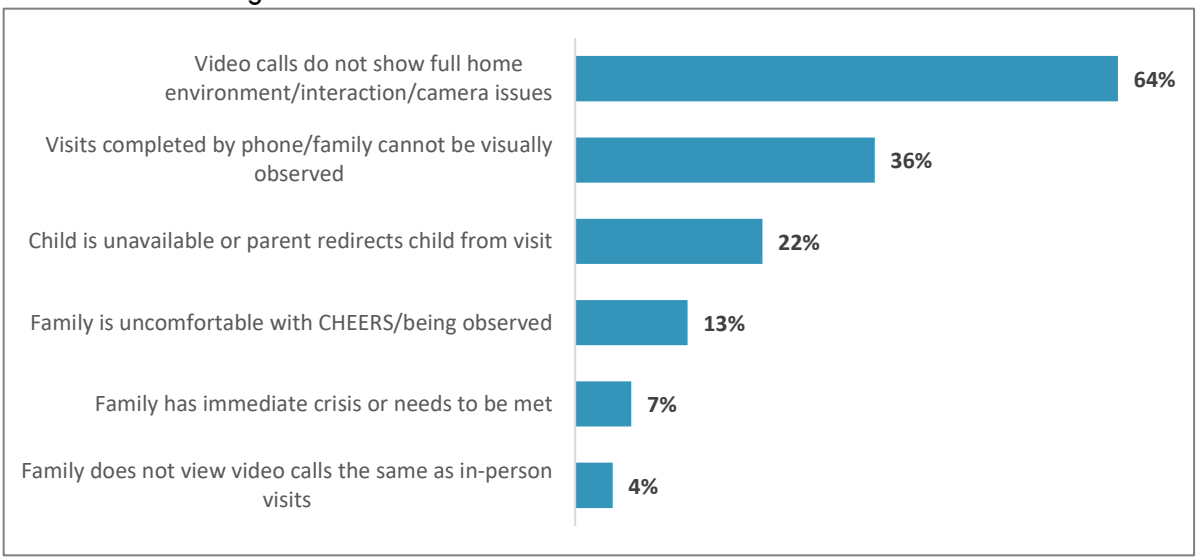
The online staff survey conducted in October 2020 asked FSS to rate how difficult or easy it is to collect the CCI and the CHEERS HVN during virtual visits. Exhibit 62 shows that 40% (n=46) of FSS rated the CCI as difficult to do virtually compared to 29% (n=34) of FSS who rated the CHEERS HVN as difficult to do virtually. However, 47% (n=55) of FSS rated that the CHEERS HVN is "harder than in person but ok" virtually, which suggests that both tools pose a challenge to collect in the virtual service environment.

Exhibit 62. Staff Rating of Difficulty or Ease to Collect CHEERS Data Virtually Compared to In-Person



A total of 83 FSS responded to the open-ended question on the online survey about virtual CHEERS data collection. Over half (54%, n=45) of these respondents identified specific challenges they have faced with virtual collection of CHEERS data. A summary of the challenges reported are show in Exhibit 63.

Exhibit 63. Challenges with Virtual Collection of CHEERS Data



(N=45 FSS)

Of the FSS surveyed who reported a challenge (N=45), the most common challenge identified by almost a two-thirds (64%, n=29) is the quality of video calls for observing the home environment (e.g., interactions with family members may occur off screen, the child may go in and out of the frame), or that the family may face technical issues with their camera or internet connection (e.g., low quality or lack of internet, frozen screen, poor camera angle/framing of observation). Families also may choose to not do a video call for the visit or may turn their camera off, which impedes observational data collection.

Examples of FSS comments include:

> *"I'm relying on the parents to aim the camera effectively, so that I can hear and see everything enough."*
>
> *"A challenge is seeing the entire picture; members of the family going in and out of frame of the video call."*
>
> *"I am only able to see a small part of the room and can't see the whole interaction."*

Another common challenge identified by over a third of FSS (36%, n=16) is the difficulty in collecting CHEERS observation data when the visit is conducted by telephone, without a video call. As indicated above in the strategies for virtual data collection reported by FSS, they must rely on keen questioning and listening skills to hear what is going on between

family members and the home environment. One FSS explained, *"The challenge when we do phone calls is that we are unable to see the child and the parent's interaction to document CHEERS correctly."*

An additional challenge noted by several FSS (22%, n=10) is that during a virtual visit, the child may not be available for observation or is off screen (e.g., child is sleeping or too active to sit still for the camera), or the parent redirects the child to do something else (e.g., play, color) rather than engaging in the visit. Other challenges noted by FSS in collecting virtual CHEERS data, which could also occur during in-person data collection, is that the family is not comfortable with being "observed" or "assessed", or the family is in a crisis or has immediate needs to be met that don't allow for the observation to occur.

CHEERS Check-in and CHEERS Home Visit Note Data Reported in ETO

The evaluation team analyzed the results of CCI and CHEERS HVN data entered into ETO to determine the consistency in FSS ratings of families using each tool. The CCI and CHEERS HVN data analyzed included data collected by FSS from April 2019 to March 2020. The CCI dataset included 2,667 CCI assessments that were completed during this time frame for 1,892 individual families by 40 teams across the state (Note: families could have had more than one CCI completed during this time frame). The CHEERS HVN dataset included 66,454 CHEERS HVN records recorded for 60,708 family visits by 43 teams across the state (Note: families could have had more than one CHEERS HVN completed during this time frame). Exhibit 64 shows the comparison of FSS ratings for each CHEERS domain by each tool. In order to compare results across instruments, the CCI ratings of 6-7 were equated to observing a "strength" on the CHEERS HVN, ratings of 4-5 were equated to observing something "neutral" on the CHEERS HVN, and ratings of 1-3 were equated to observing a "concern" on the CHEERS HVN.

Exhibit 64. FSS Rating Comparison for the CCI and CHEERS HVN Data Collected from April 2019 to March 2020

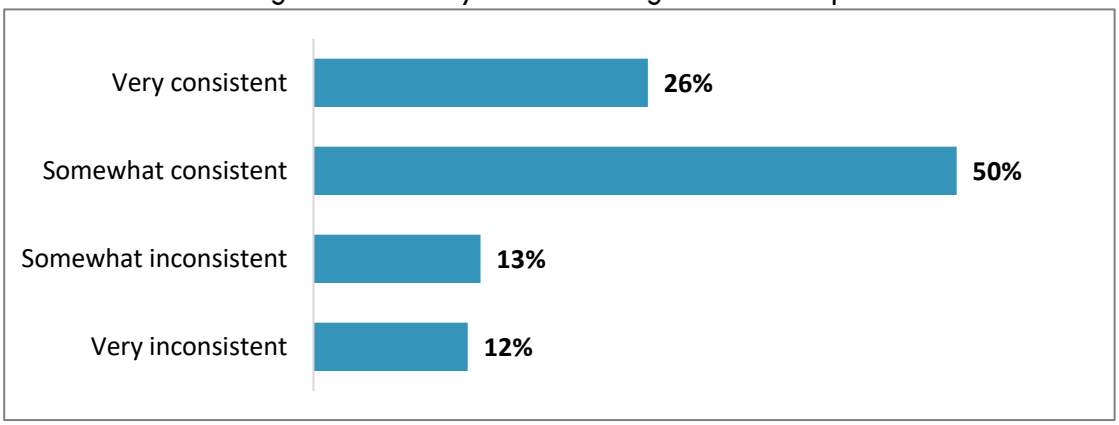
CHEERS Domain	FSS Rating on CHEERS HVN/CCI	Percent noted on CHEERS HVN % (n)	Percent noted on CCI % (n)
Cues	Strength/6-7	56% (31,424)	73% (1,939)
	Neutral/4-5	40% (22,553)	26% (681)
	Concern/1-3	4% (2,380)	2% (48)
Holding and Touching	Strength/6-7	53% (29,935)	70% (1,873)
	Neutral/4-5	45% (25,317)	27% (720)
	Concern/1-3	2% (1,310)	3% (75)

CHEERS Domain	FSS Rating on CHEERS HVN/CCI	Percent noted on CHEERS HVN % (n)	Percent noted on CCI % (n)
Expression	Strength/6-7	57% (32,308)	72% (1,909)
	Neutral/4-5	39% (22,099)	26% (704)
	Concern/1-3	4% (2,133)	2% (55)
Empathy	Strength/6-7	57% (32,267)	71% (1,883)
	Neutral/4-5	38% (21,450)	27% (719)
	Concern/1-3	5% (2,877)	2% (53)
Rhythm and Reciprocity	Strength/6-7	54% (30,158)	69% (1,838)
	Neutral/4-5	43% (24,275)	28% (755)
	Concern/1-3	3% (1,632)	3% (75)
Smiles	Strength/6-7	54% (30,439)	79% (2,094)
	Neutral/4-5	45% (25,338)	20% (543)
	Concern/1-3	2% (884)	1% (30)

The majority of data for both the CCI and CHEERS HVN show that FSS generally rate families as demonstrating a strength across all domains or as neutral. Neutral refers to if an observation was neither a strength nor a concern. A general trend in ETO data is that FSS observed and reported concerns across both tools and domains at a very low rate, ranging from 1% to 5% of assessments reporting a concern. Compared by tool, the CHEERS HVN data shows a slightly higher percentage of concerns noted compared to the CCI for the domains of cues, expression, empathy, and smiles.

The purpose of the CCI and the CHEERS HVN is to provide guidance to the FSS in identifying strengths to build upon with the family, and areas of concerns or growth to address through support or resources. It is hoped that the use of these assessments result in FSS being able to better plan interventions and approaches with the families. It would be expected there would be fairly strong consistency between the two tools (CCI and HVN). However, a finding of interest is that a quarter of respondents (25%, n=27) reported their scoring to be somewhat or very inconsistent when scoring the CCI compared to the CHEERS HVN (see Exhibit 64). Exhibit 65 shows FSS rating of their consistency when scoring the CCI compared to the CHEERS HVN, as reported on the FSS online survey collected in October 2020 (N=109 FSS responded to this question out of 154 survey respondents). Half (50%, n=54) reported that they score the two instruments somewhat consistently, and only 26% (n=28) rated themselves as scoring the two instruments very consistently.

Exhibit 65. FSS Rating of Consistency When Scoring the CCI Compared to CHEERS HVN



(n=109)

Additionally, open-ended data collected on the FSS online survey on how FSS utilize the CCI to support families showed that almost half (47%, n=37) reported that they use the CCI data to identify areas to support the family based on low scores or concerns. This finding seems inconsistent with the CCI data reported in ETO, where only a few concerns were reported. This inconsistency may bring into question how staff are trained to use and interpret the tool reliably, how they are instructed to enter it into ETO, or it may warrant further exploration related to the validity and reliability of the CCI instrument itself. ETO data suggests overall that FSS may be overestimating or overstressing strengths observed across the CHEERS domains for both the CCI and the CHEERS HVN. While Healthy Families Arizona is a strengths-focused program, acknowledging concerns provides the FSS and parent/caregiver with a learning opportunity to prevent potential risks and help build their skills or provide useful resources to the family.

Conclusions and Recommendations

Healthy Families Arizona is in its 29th year of service to families. This report covered October 1, 2019 through September 30, 2020 and included the start of the COVID-19 pandemic. The impact of the pandemic on home visiting was multi-fold. The limited access to hospitals caused a decrease in the number of enrollments into the program coming from systematic referrals. The increased number of enrollments from community referrals during this time is a testament to the importance of home visitation in the minds of community organizations. Healthy Families Arizona staff at all levels stepped up and met the challenges of the pandemic by continuing to reach out to new families, maintain relationships with current families, and bolster one another in addition to the families they serve. A total of 4,337 families received services from the Healthy Families Arizona program in FY 2020, very similar to prior years despite the pandemic.

A Critical Focus for 2021: Addressing the Impacts of the COVID-19 Pandemic

The impact of the COVID-19 pandemic is expected to continue into at least the first half of 2021. The results of the staff surveys in April and October suggest that there are additional supports that can be provided to help navigate home visitation during the pandemic. Staff and supervisors both reported a need for understanding and flexibility while trying to balance the needs of the program families with their own needs. Wide-spread accommodations for working from home, setting reasonable expectations for work flexibility, and provide a sense of safety and understanding from each agency will help staff feel better appreciated and supported. The number of staff that commented that they were not doing well with self-care practices increased from April to October indicating that supervisors and program agencies may need to provide additional time in supervision for emotional support and self-care practices.

Three areas home visitors reported as challenges include: difficulties in engaging children, conducting assessments during virtual visits, and that parents are stressed, which can distract them from the visit. Continued support may need to be provided to home visiting staff who are not currently able to provide curriculum during the visits to help them develop creative solutions for virtual visits. It is recommended that all staff have access to an electronic version of curriculum that they can use during virtual visits. Additional trainings for delivering curriculum and engaging families virtually would be helpful.

In addition, staff noted the difficulty in conducting assessments virtually. This may require more than just training to address the difficulties with conducting screenings and assessments virtually and consideration should be made about possibility of having a

hybrid model of home visitation that includes both socially distanced in-person visits combined with virtual visits to maximize the impact of the program while still conducting the appropriate screenings and assessments to best address the needs of the families.

Preparations for National Re-Accreditation

While the COVID-19 pandemic has delayed the start of the re-accreditation process for Healthy Families Arizona still needs to make preparations starting in 2021 to ensure a smooth process. As part of this process, additional work needs to be made in the online data collection system (ETO) to ensure both the accuracy of the data as well as the ability to provide useful reports. Regular reviews of missing and incomplete data should occur quarterly. Continued emphasis on developing useful and accurate reports in ETO is also necessary in order to reduce the burden of preparing for the re-accreditation process.

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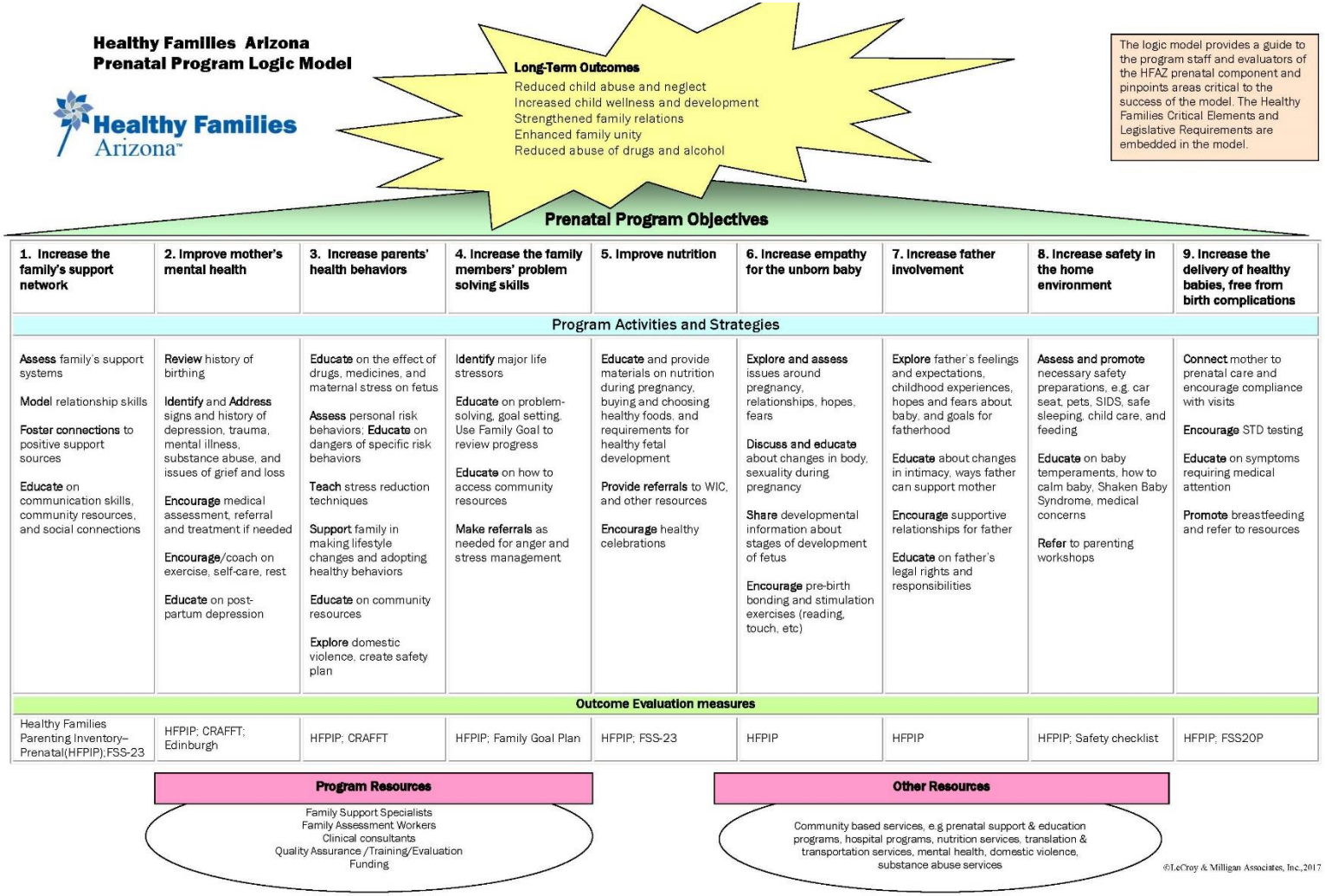
Appendix B. Healthy Families Arizona Prenatal Logic Model



Appendix C. Healthy Families Arizona Postnatal Logic Model