Child Crisis Arizona
Home Visiting Program
Annual Evaluation Report, FY 2016-2017

August 2017

LeCroy & Milligan
ASSOCIATES, INC.

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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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Report Contents

List of Exhibits

Executive Summary

The Child Crisis Arizona's (CCA) Home Visiting Program is funded by the First Things First Southeast Maricopa Regional Partnership Council. Serving pregnant mothers and families with children from birth to 5 years of age, this program utilizes the evidence-based Parents as Teachers (PAT) early childhood home visitation program model. The PAT program model incorporates four key elements: (1) personal visits, (2) group connections, (3) developmental screening, and (4) the provision of resources and referrals (PAT, 2016).

The Child Crisis Arizona Home Visitation Program utilizes the evidence-based Parents as Teachers (PAT) early childhood home visitation program model, incorporating four key elements:

(1) Personal visits,
(2) Group connections,
(3) Developmental screening, and
(4) Provision of resources and referrals.

LeCroy & Milligan Associates, Inc. conducted the evaluation of the Home Visiting Program, which includes both process and outcome components. Grounded in the evaluation approaches of Bamberger, Rugh, and Mabry's (2006) "Real World" evaluation and Patton's (2008, 2011)"utilization-focused" evaluation, the evaluation team employed a mixed-methods approach to examine:

1) Program process and implementation;
2) Demographic data on the number and characteristics of families served;
3) Participant satisfaction with the program; and
4) Effectiveness of the PAT home visiting model, including use of Case Managers to support higher needs clients, in terms of identified outcomes.

These assessment areas correspond with the four primary goals of the PAT National Center (2016). This evaluation report presents the findings for the program's eighth fiscal year (FY), for the time from July 1, 2016 through June 30, 2017 (FY16-17). This report highlights the results of the program's process and outcome evaluation, including demographics of families served, data on program activities, services, participant satisfaction, and outcomes.

Key Findings: Process Evaluation

The process evaluation of the Home Visiting Program examined program implementation and seeks to assess the methods and strategies used by the program staff to affect changes or produce desired outcomes in the target population of pregnant mothers and families with children from birth to 5 years. The guiding questions for the process evaluation are:

- What are the characteristics of families served, including caregivers and children?
- What are the patterns of participation in the program (i.e. number of participants, referral sources, length of time in program, home visit completion rate, attrition)?
- What types of services are provided to participants and at what intensity?
- To what extent are participants satisfied with the program?
- What do families perceive are the most helpful aspects of the program?
- In what ways do families recommend that the program can improve?
- What factors influence the retention and exit of families in the program?

Client Participation and Retention

Evaluation Area	Process Evaluation Findings: Client Participation and Retention
Families Served	• Between July 1, 2016 and June 30, 2017, the Home Visiting Program served 352 families and 558 children. • 36% of families were enrolled into the program during the current FY, while 64% enrolled in a previous FY.
Program Intensity	• Families participated in the program for an average of 17.8 months, median of 15 months, and a range of <1 to 75 months.
Family Referral	• 25% of families were referred to the program through word-of-mouth referral from friends or family members. Other prominent referral sources included: a staffed event (24%), another community service provider (11%), a government agency (10%), and a Primary Care Physician's office (6%).
Family Engagement	• At the end of FY16-17, 69% of families remained active in the program. • Families who engaged in services with a Case Manager, in addition to a Parent Educator, were significantly more likely to have remained active in the program (87%), compared to those who did not engage with a Case Manager (56%) (p=.00).

Evaluation Area	Process Evaluation Findings: Client Participation and Retention
Family Exit	• 32% of families exited the program in FY16-17. • Of these families, 54% completed the program per the PAT home visiting model, which is an increase compared to 39% in FY15-16. • 29% left the program because they moved out of the service area, were transitioned to another program, or their child aged out of the program. • 18% exited the program for reasons of discontinuing services by choice or program staff was unable to locate the family.

Services Provided with Fidelity to the PAT National Center Model

Evaluation Area	Process Evaluation Findings: Services Provided with Fidelity to the PAT Model
Home Visits	• Since their enrollment into the program, the 352 families served have received a total of 11,488 home visits. Families completed an average of 32.6, with a range from one to 152 home visits. All of these figures are higher compared to home visiting data reported in FY 15-16, when families completed an average of 26.7 home visits, with a range from one visit to 131 visits. • Home visit completion rates for the duration of program enrollment range from 40% to 100%, with an overall average of 84% (11.0 SD) (these completion rates include visits completed and attempted in all FYs in which families were served). This data suggests that families are participating in most of their home visits, as scheduled. These figures are higher than FY 15-16, when home visit completion rates ranged from 33% to 100%, with an overall average of 81%. • Looking at completion rate data for visits attempted and completed in FY16-17 only, 92% of families with a high needs status and 99% of families with a non-high needs status had a home visit completion rate of at least 75% of the required number of visits completed per month. These results exceed PAT National standard of 60% of families, for both types of families.
Case Management	• 56% of families received Case Management (CM) services in addition to Parent Educator (PE) services (CM+PE). Families utilized 1 to 18 instances of CM services, with by 79% receiving a CM+PE staff team home visit. • Of the 197 families who received CM+PE services in FY16-17, 89% received an average of 1.8 CM+PE services (considered "low-intensity" CM+PE) and 11% received a significantly higher average of 7.7 services, considered "high-intensity" CM+PE.

Evaluation Area	Process Evaluation Findings: Services Provided with Fidelity to the PAT Model
Supporting High Needs Families with Greater Service Intensity	• 21% of families served in FY16-17 are considered to have "high needs" because they meet two or more of PAT National's high needs standards. Caregivers with a high needs status are significantly more likely to be low-income, a have a low level of education, have a child with a disability, are a single parent, or are a disabled adult. • Exceeding PAT National Standards, families with a high needs status completed a significantly higher average of 2.5 home visits per month, compared to non-high needs families who completed an average of 1.9 home visits per month. • 22% of families with a high needs status utilized high-intensity CM+PE services (5 or more CM+PE services), compared to 8% of families without high needs.
Parent Group Connections	• The program held 23 parent group connections with varying themes in FY16-17. This number exceeds the PAT National Standard of at least 9 parent group connections held in a program year.
Father Involvement/ Engagement	• The program has a Father Engagement Resource Specialist on staff to support and enhance father involvement with families served. In FY16-17, this staff person worked with 23 families during a total of 170 home visits. The number of home visits per family ranged from one to 20 visits with the Father Engagement Resource Specialist. This staff person facilitated six events with 258 fathers; supported 48 play groups; and taught 153 classes/workshops throughout the reporting time frame.
Development, Sensory, and Health Screenings	• In compliance with the PAT National Standard, Parent Educators of the Home Visiting Program concurrently implemented a variety of screening measures that identify the child's strengths, abilities, and any developmental needs. A total of 2,404 screenings took place in FY16-17, occurring for five areas of child development, social-emotional, hearing, vision, and general health. • 97% of newly enrolled children received a complete initial screening within the required time frame and 98% of children received a complete screening during the program year. These figures exceed the PAT National Standard of at least 60% of children in both groups.
Resources and Referrals	• 98% of families served in FY16-17 were referred to at least one community resources during this time frame. This number exceeds the PAT National Standard of at least 60% of families being connected by their PE to at least one community resource during the program year.

Client Satisfaction with Services

Evaluation Area	Process Evaluation Findings: Client Satisfaction with Services
Quality of Interactions and Experiences with Parent Educators	• In compliance with PAT National Standards, the Home Visiting Program gathers and summarizes feedback from families at least annually, using the results for program improvement. • 99% of respondents to the Participant Satisfaction Survey affirmed that ✓ The program's services helped their family; ✓ They are satisfied with the services they received; and ✓ They would recommend the program to others. • These findings indicate that families have high quality interactions and experiences with Parent Educators, which has been consistent with the results from previous fiscal years. Caregivers' commented that Parent Educators: ✓ Are very knowledgeable; ✓ Listen to parents and support them in a non-judgmental way; ✓ Help parents find resources; ✓ Offer hands-on activities to help parents learn by doing; and ✓ Encourage families to be successful.
Most helpful Aspects of the Program	• Caregivers' open-response comments on the Client Satisfaction Survey show that the most helpful aspects of the Home Visiting Program include: ✓ Receiving resources, information, and expert guidance from their Parent Educator; ✓ Gaining ideas/activities to work with their child during home visits; ✓ Receiving referrals to community services; and ✓ Feeling supported by the program in their caregiving role.
Knowledge and Skills Gained	• The most commonly reported gains in knowledge and skills by caregivers include: ✓ Learning to better teach their child through play and activities learned during home visits; ✓ Using the knowledge and skills gained in their everyday lives; ✓ Being able to better understand and support their child's growth and development; and ✓ Engaging their child better/playing better/playing more often with their child.

Key Findings: Outcome Evaluation

The outcome evaluation assesses the impact of the Home Visiting Program on (1) increasing parent knowledge and improving parenting practices; (2) promoting child health and development; and (3) enhancing parent/child interactions. These assessment areas correspond with the primary goals of the PAT National Center (2016). Guiding questions for the outcome evaluation include:

- To what extent do participants improve their parenting skills, based on the Keys to Interactive Parenting Scale (KIPS) average scores of quality parenting?
- To what extent do families set and achieve goals? What types of goals are achieved?
- How many children receive developmental, vision, and hearing screenings and how many are referred out due to concerns?
- In what ways do parents report that they utilize the knowledge and skills learned in this program?
- How does use of case management services impact client outcomes?

Outcome Domain	Outcome Evaluation Findings
Improved Parenting Quality	• An initial KIPS assessment is conducted for families at 90 days post intake and follow-up assessments are conducted annually/at closure. KIPS is an observational instrument that assesses the construct of parenting quality, across 12 items. • From July 1, 2011 to June 30, 2017, a total of 1,814 caregivers had an initial KIPS assessment and 920 had between one and nine follow-up assessments. • A One-Way Analysis of Variance (ANOVA) was performed to determine the mean (average) KIPS score at each time period assessed, and whether or not the average scores for each time period significantly varied from each other. ✓ Comparing KIPS scores across data collection time points, the 1st assessment score was significantly lower than all other assessment time periods, indicating that parents demonstrated an improvement in parenting quality over time (p=.000). ✓ A significant improvement in parenting quality was observed from the 2nd assessment time, in comparison to the 3rd (p=.002), 4th (p=.012) and 5th (p=.001.) assessment times, indicating continued improvement in parenting quality from the second assessment onwards. ✓ The 3rd, 4th, and 5th assessment time points did not show a significant change in parenting quality at these later time points.

Outcome Domain	Outcome Evaluation Findings
Improved Parenting Quality	• A total of 509 families had an average score for both an initial (pre) and follow-up (post) KIPS assessment. Analysis of paired caregiver data shows that the total average KIPS score improved significantly from pre (average of 3.94) to post (average of 4.38) assessment (p=.000), yielding an increase in average score by .44 points. • These results suggest that participants of the Home Visiting Program who completed both a pre and post (annual/exit) KIPS assessment demonstrated a significant improvement in parenting quality over time. • Five KIPS areas that achieved the greatest increase in average score from initial to final (ranging from an increase in .50 points to .56 points) include: ✓ Being open to the child's agenda (↑ .56 points); ✓ Promoting exploration and curiosity (↑ .56 points); ✓ Adapting strategies to the child (↑ .54 points); ✓ Setting reasonable expectations of the child (↑ .52 points); and ✓ Promoting language experiences with the child (↑ .50 points).
Goal Setting	• 95% of families set at least one goal that was documented by their home visitor, which exceeds the PAT National Standard of at least 60% of families setting a minimum of one goal during the program year. • Families set a total of 2,269 goals that were documented by home visitors. The number of goals set per family ranged from one to 67 goals, with an average of 6.8 goals per family. Overall, families took an average of 4.1 months to achieve their goals. ✓ 71% of goals set were related to child development, such as supporting a child's cognitive development, completion of child development assessment, or transitioning a child through age appropriate activities; ✓ 11% of goals set focused on parenting behavior and the parent's relationship with their child, such as increasing parent/child activities; learning positive disciplining strategies; and developing routines.

Outcome Domain	Outcome Evaluation Findings
Progress towards Meeting Goals	• Of the 2,269 goals set by families, 41% were met, 48% are in progress, and 11% were abandoned; these statistics are consistent with the goal completion data from the previous FY. • 76% of families have met at least one of their goals and 70% are on working on meeting their family goals with the program. • The goal area with the highest completion rate of 75% is that of mental health and substance abuse; 25% are working on this goal; and 0% have abandoned this goal. These figures are consistent with data on this goal area reported in the previous FY. • Goal areas for which 50% or more were met include: ✓ Relationships with service providers; ✓ Parenting behavior/relationships with child; ✓ Basic essentials; ✓ Education and employment. • Goal areas with the highest percentage of goals in progress include: ✓ Health and medical care and child development.
Developmental, Sensory, and Health Screening and Referrals	• In compliance with PAT National Standards, Parent Educators completed a total of 2,404 screens with 515 children, of whom 9% were referred for further assessment. The screens that yielded the highest percentage of referrals include developmental screening (7%) and hearing screening (1%).
Caregiver Depression Screening and Referrals	• The Home Visiting Program uses the Patient Health Questionnaire 9-item depression screening tool (PHQ-9) to screen and refer caregivers. • From July 1, 2015 to June 30, 2017, a total of 629 people had an initial PHQ-9 assessment and 141 individuals had at least one follow-up assessment. ✓ 91% of caregivers' initial PHQ-9 scores placed them into the categories of none to mild symptoms of depression. ✓ 9% of caregivers produced a total score that indicated the person was experiencing moderate to severe levels of depression. In response, Parent Educators follow the program's intervention protocol for depression management, based on total score/depression level. • 141 caregivers completed both an initial and follow-up PHQ-9 assessment. ✓ Analysis of paired data showed that total PHQ-9 scores decreased significantly from pre to post, demonstrated a significant reduction in depression symptoms experienced by caregivers over time. The length of time between assessments ranged from one to 16 months and averaged 6.9 months.

Recommendations for the Home Visiting Program:

Based on this year's findings, the evaluation team recommends that the Child Crisis Arizona's Home Visitation Program:

- Continue to examine the program's longitudinal caregiver data to examine family retention and outcomes, specifically, those who receive Case Management services.
- Continue to evaluate family outcomes at pre and post intervals and analyze change in outcomes over time, ensuring that data collection intervals are accurately completed and results are recorded by staff.
- Continue to examine Home Visiting Program fidelity to the PAT National Center Essential Recruitments (2016).
- Consider client recommendations provided through the satisfaction survey, when reported by the evaluation team on a quarterly basis.
    - Hold group activities/classes on other days (e.g. weekends) or times
    - Offer home visits more often and longer home visits
    - Offer more group activities
    - Provide more instruction on behavior management
    - Ensure that home visits accommodate needs of multiple children (more time)
    - Offer programming in other geographic areas where families live.

Introduction

The Child Crisis Arizona's (CCA) Home Visiting Program is funded by the First Things First (FTF) Southeast Maricopa Regional Partnership Council. Serving pregnant mothers and families with children from birth to 5 years of age, this program utilizes the evidence-based Parents as Teachers (PAT) early childhood home visitation program model. The PAT program model incorporates four key elements: (1) personal visits, (2) group connections, (3) developmental screening, and (4) the provision of resources and referrals (PAT, 2016).

LeCroy & Milligan Associates, Inc. conducted the evaluation of the Home Visiting Program and this report presents the findings for FY8, for the time from July 1, 2016 through June 30, 2017 (FY16-17). This report highlights the results of the program's process and outcome evaluation, including demographics of families served, data on program activities, services, participant satisfaction, and outcomes.

The Child Crisis Arizona Home Visitation Program utilizes the evidence-based Parents as Teachers (PAT) early childhood home visitation program model, incorporating four key elements:

(1) Personal visits,
(2) Group connections,
(3) Developmental screening, and
(4) Provision of resources and referrals.

The focus of this evaluation is to collect and report process and outcome data on the Home Visiting Program, and consult and assist CCA in meeting reporting requirements for the FTF statewide evaluation. Grounded in the evaluation approaches of Bamberger, Rugh and Mabry's (2006) "Real World" evaluation and Patton's (2008, 2011) "utilization-focused" evaluation, the evaluation team employed a mixed-methods approach to examine:

1) Program process and implementation;
2) Demographic data on the number and characteristics of families served;
3) Participant satisfaction with the program; and
4) Effectiveness of the PAT home visiting model, including use of Case Managers to support higher needs clients, in terms of identified outcomes.

These assessment areas correspond with the four primary goals of the PAT National Center (2016).

Evaluation Methodology

LeCroy & Milligan Associates conducted a process and outcome evaluation of CCA's Home Visiting Program.

Process Evaluation

The **process component** examines program implementation and seeks to assess the methods and strategies used by the program staff to affect changes or produce desired outcomes in the target population of pregnant mothers and families with children from birth to 5 years. The guiding questions for the process evaluation include:

- What are the characteristics of families served, including caregivers and children?
- What are the patterns of participation in the program (i.e. number of participants, referral sources, length of time in program, home visit completion rate, attrition)?
- What types of services are provided to participants and at what intensity?
- To what extent are participants satisfied with the program?
- What do families perceive are the most helpful aspects of the program?
- In what ways do families recommend that the program can improve?
- What factors influence the retention and exit of families in the program?

Outcome Evaluation

The **outcomes component** of this evaluation assesses the impact of the Home Visiting Program on (1) providing families with resources and referrals to community programs; (2) supporting families to set and achieve individualized goals; (3) increasing positive parenting practices (e.g., parent knowledge, parenting behaviors, parent/child interactions); (4) promoting child health and development through the use of screening and referrals; and (5) helping higher needs families to be more successful in the program through the use of Case Management services. These assessment areas correspond with the primary goals and Essential Requirements of PAT National (2016). Guiding questions for the outcome evaluation include:

- To what extent do participants improve their parenting skills, based on the Keys to Interactive Parenting Scale (KIPS) average scores of quality parenting?
- To what extent do families set and achieve goals? What types of goals are achieved?
- How many children receive developmental, vision, and hearing screenings and how many are referred out due to concerns?
- In what ways do parents report that they utilize the knowledge and skills learned in this program?
- How does use of case management services impact client outcomes?

Instruments and Measures

The specific methods and measures used for this evaluation are shown in Exhibit 1. Quantitative analysis is performed with SPSS 24 and qualitative analysis is performed with Microsoft Excel 2013.

Exhibit 1. Data Collected, Purpose, and Analysis Method

Data/Instrument	Construct/Purpose	Analysis Method
Family Level Data	Assess demographic information of children and parents served by the program. Assess services and referrals provided to families per month; Assess status of health insurance receipt and/or receipt of assistance in insurance enrollment. Assess family goals set, in progress, and met.	Descriptive statistics. Cross-tabulation. Thematic content analysis.
Participant Satisfaction Survey	Evaluate family satisfaction with home visitation program services, annually and at case closure.	Descriptive statistics. Thematic content analysis.
Client Exit Survey	Understand why clients exited the Child Crisis Arizona's Home Visitation Program before successfully completing the Parents as Teachers (PAT) program model.	Descriptive statistics. Thematic content analysis.
Keys to Interactive Parenting Scale (KIPS)	Observational scoring instrument to assess parenting quality. Conducted three months post enrollment, annually, and at closure.	Descriptive statistics. Means comparison and t-test of pre and post scores. ANOVA of multiple time points.
Life Skills Progression (LSP)	Summary tool used by home visitors to sort and organize information gathered from visits, screening tools, and observation of the family.	Descriptive statistics. Means comparison and t-test of pre and post scores.
Patient Health Questionnaire (PHQ-9)	A self-administered depression module comprised of nine items. This tool screens for the presence of depression as well as the severity, ranging from mild to severe depression.	Descriptive statistics. Means comparison and t-test of pre and post scores.
Developmental and Sensory Screening Data	Examine the types of developmental and sensory screenings completed by home visitors, the outcome of the screen, and whether or not a referral was made. Results are shown per quarter and in total.	Descriptive statistics.

Data Collection Procedures

Family Level Data

Family level data includes demographic data on adults and children served, referral sources into the program, services and referrals provided to families (home visits, developmental screenings, etc.), and progress towards goal achievement. These data were collected by the Home Visiting Program staff from families at intake and during home visits, in accordance with the family's service needs, using customized agency forms. Home Visiting Program staff enters this data into the program's data collection system and submits this data to the evaluation team on a monthly, quarterly, or annual basis.

Participant Satisfaction Survey

The Participant Satisfaction Survey is administered to caregivers by Parent Educators in English or Spanish language using an online survey (paper surveys are also available), at three months post intake, annually, and at program exit. This survey includes 11 items that ascertain level of agreement with statements, using a 4-point scale, with 1 being "strongly disagree" and 4 being "strongly agree." Statements cover aspects of the program including ease of access, convenience of scheduling, quality of staff, and utility of information received. Items 1 through 11 related to program feedback demonstrated very strong internal consistency with a Cronbach Alpha score of .93[1]. The survey also includes three items with yes/no response categories regarding program helpfulness, satisfaction, and recommendation of the program. The instrument concludes with three open-response questions on the most helpful aspect of the program; use of knowledge and skills gained; and recommendations for program improvement.

Client Exit Survey

The Client Exit Survey is administered by the evaluation team on a monthly basis with families who exited the program in the month prior for reasons of "discontinued services" or "not able to be located by staff." This survey was developed as part of the process evaluation, to better understand the reasons why families leave the Home Visiting program prematurely and identify clients who might wish to re-engage with the program. The evaluation team utilized a brief six-item questionnaire that clients could complete through a telephone interview with a member of the evaluation team or an online survey through a link that was emailed to them. The question areas include: client expectations of the program; reasons for leaving the program; if a Program Supervisor had contacted them; and what their Parent Educator could have done differently to help them stay in the program. In case a client wanted to re-engage with the program, respondents were also asked whether or not they would like someone from the

[1] Utilizing SPSS 24, LMA computed the Cronbach's alpha score of the 11 items on the Client Satisfaction Survey to gauge reliability of the scale. Cronbach (1951) and Nunnaly (1978) report that a Cronbach alpha score of .70 or higher demonstrates strong internal consistency or average correlation of items in a survey instrument.

program to contact them and, if so, the best way to contact them. The evaluation team made up to seven attempts to contact families, utilizing telephone calls, text messaging, and email communication. In general, respondent data shows that it takes between two and six months of repeated attempts to reach a person for survey completion.

Keys to Interactive Parenting Scale

The Keys to Interactive Parenting Scale (KIPS) is a validated structured observational assessment that examines caregiver-child interactions during play (Comfort & Gordon, 2006; see also Comfort & Gordon 2011; Comfort et al., 2010; Comfort, Gordon & Unger, 2006). This instrument is completed by staff in order to guide home visitation services, monitor family progress, and evaluate program outcomes. With permission from families, Parent Educators video record a family's interactions for a 20 minute period. All observations take place in the home and the caregiver is instructed to play with their child as they would normally do. Outside of this session, the Parent Educator reviews and scores this video using the KIPS instrument, providing examples that explain ratings. Assessments are reviewed and approved by Supervisors to reduce investigator bias and ensure reliability and validity of data collected.

The KIPS instrument contains 12 items that are scored on a scale from 1 to 5, with 1 indicating low parenting quality and 5 indicating high parenting quality. The 12 KIPS items demonstrated very strong internal consistency across the three collection time points, with a Cronbach Alpha score of .93 at the initial assessment and .94 at the last assessment. Scores are summed and divided by the number of items scored to obtain an average overall KIPS score of parenting quality. Items that are not observed are excluded from the calculations. As per the developers of KIPS, the following score interpretations are used:

- An average score of 4.0 or higher is considered a "high score" or high quality parenting;
- An average score ranging from 3.9 to 3.0 is considered a "medium score;" and
- An average score of less than 3.0 is considered a "low score" or low quality parenting observed during the event.

Life Skills Progression

The Life Skills Progression (LSP) is an outcome measurement and intervention planning instrument designed specifically for use with parents during pregnancy and early parenting (Wollesen & Peifer, 2006). The Home Visiting program began using this tool in August 2014. It shows strengths, needs, and progress on individual, family, caseload, and program levels. LSP monitors 35 parental life skills in the areas of: Relationships; Education and Employment; Parent and Child Health; Mental Health and Substance Use; and Basic Essentials. The LSP takes approximately 5 to 10 minutes to complete and score. Home visitors complete the LSP for the primary caregiver within the initial 90 days and annually. Each of the 35 scales stands alone and is scored individually across a range of 0 to 5 points, using 0.5 increments. Scores range from a scale of 1 "Inadequate" to 5 "Competent," reflecting the characteristics, development, and/or

learning of the parent. Scores should apply only to skills, behaviors, or attitudes occurring currently or over the last six months. A score of 1 is assigned for violent behaviors or reportable conditions, such as child abuse or domestic violence that occurred within the last six months. A score of 0 is used for scales with no answer that were not asked, or not applicable. The LSP is specific to an individual parent; there is no family level score and no cumulative score for all of the scales.

Patient Health Questionnaire-9

The Patient Health Questionnaire-9 (PHQ-9) is a 9-item depression module extracted from the full PHQ (see Spitzer, Kroenke & Williams, 1999), which scores each of the 9 criteria as 0 or "Not at all" to 3 "Nearly every day" (see Kroenke, Spitzer & Williams, 2001). Total scores on the PHQ-9 can range from 0 to 27. The total score range and depression levels utilized by the Home Visiting Program for referring caregivers to external resources is: 0 = None; 1-9 = Mild; 10-14 = Moderate; 15-19 = Moderate/Severe; and 20-27 = Severe. Consistent with Kroenke et al.'s (2001) validation study, the 9 items demonstrated good internal consistency, with a Cronbach Alpha score of .78 at the initial assessment and .89 at the last assessment. There is also one item at the end of the diagnostic portion of the PHQ-9, asking clients who checked off any problems on the questionnaire: "How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?" using a 4-point scale from 1 "Not at all Difficult" to 4 "Extremely Difficult."

The Home Visiting Program uses the PHQ-9 as a depression screening tool. Caregivers complete this tool as a self-administered questionnaire at the following intervals:

- Under the general screening protocol, caregivers are screened initially at 90 days after enrollment into the program and again on an annual basis.
- The new parent screening protocol is administered to new parents when the child is two months old and again at seven months.
- In the case where a caregiver's responses produces a total score of 10 or higher, they are re-screened again at 30, 60, and 90 days.

Communication with the Program Director

The evaluation team maintains regular communication by email, telephone, and in person meetings with the Home Visiting Program Director regarding program implementation, data collection and interpretation, and client outcomes.

Characteristics of Families Served

This section presents information on the characteristics of the 352 families and 558 children served by the Home Visiting Program in FY16-17 (throughout this report, the adult N=352 and the child N=558 unless otherwise noted). Exhibit 2 shows aggregated program and service data of the Home Visiting Program since its start-up in 2009, to the end of FY16-17. **From 2009-2017, the Home Visiting Program has served a total of 1,388 families and 2,393 children (both represent unduplicated counts of families and children served). Through this program, families have received 37,823 home visits and 30,297 community resources and referrals.**

Exhibit 2. Program Service Data, 2009-2017

Measure	Total Service Counts from 2009-2017
Number of Families Served (unduplicated)	1,388
Number of Children Served (unduplicated)	2,393
Number of Home Visits Completed	37,823
Number of Resources/Referrals Provided	30,297

Caregiver Demographics

Of the 352 families served in FY16-17, 97% (342) of primary caregivers are female and 3% (10) are male. Over two-thirds of caregivers (69%, n=244) are in a partnered relationship (married or living with a significant other), 28% (100) are not in a partnered relationship (single, divorced, or separated), and 2% (8) did not report their relationship status. Exhibit 3 shows the race and ethnicity of caregivers served. Over half of caregivers self-identified as White/non-Hispanic (55%, n=192) and over a third (34%, n=121) identify as Hispanic/Latino. Primary languages spoken include English (81%, n=285) and Spanish (17%, n=59) and a few caregivers primarily speak Chinese, Japanese, Vietnamese, or Russian. A total of 18% (n=63) of caregivers speak English as a second language and 17% (n=60) were born in a country other than the US.

Exhibit 3. Race/Ethnicity of Caregivers

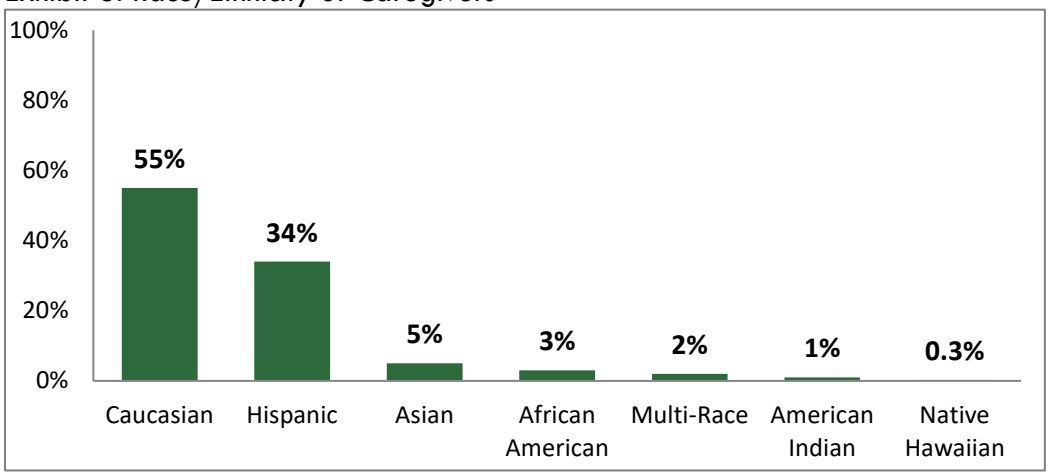
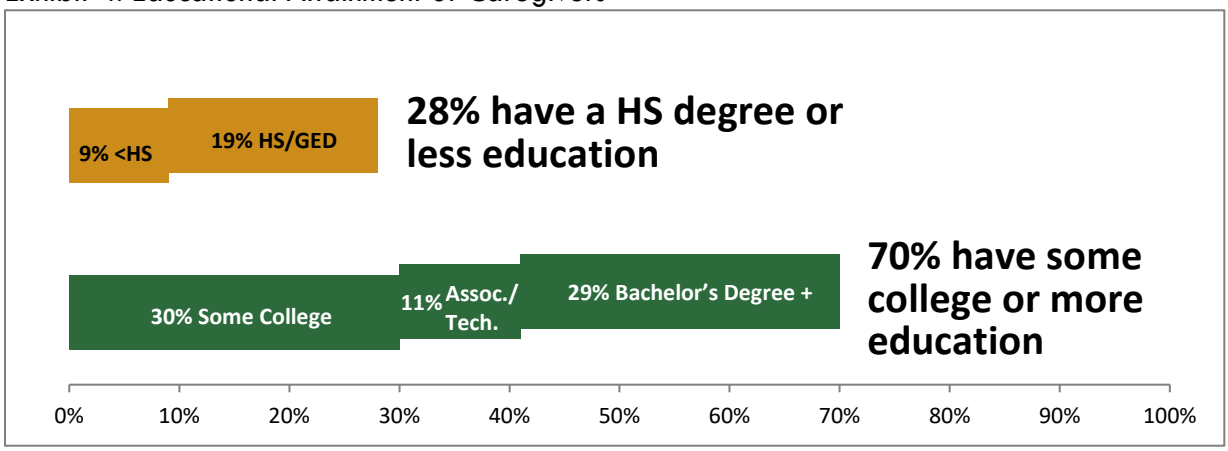


Exhibit 4 shows the highest level of education achieved by primary caregivers. Over two-thirds of caregivers served (70%, n=243) have some college education or a higher degree and 28% (n=98) have a high school education/GED or less. Data from 2% (n=6) was not reported and is not shown in the chart below.

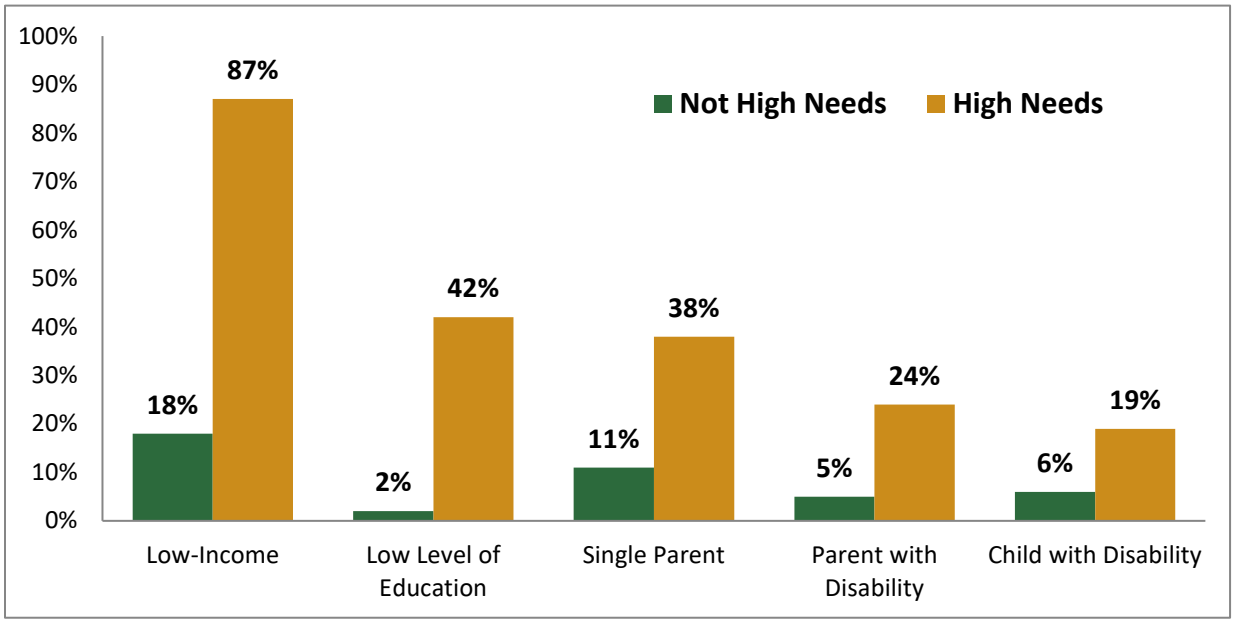
Exhibit 4. Educational Attainment of Caregivers



High Needs Status

Almost a quarter of families 21% (n=74) are considered to have "high needs" because they meet two or more of PAT National's high needs standards. Exhibit 5 shows that caregivers served by the Home Visiting Program with a high needs status are significantly more likely to be low-income, have a low level of education, a single parent, are a disabled adult, or have a child with a disability (p=.000).

Exhibit 5. Caregiver Characteristics Compared by High Needs Status



Family Characteristics

- 84% (n=294) of households have two caregivers and 17% (n=58) are single caregivers.
- 1% (n=4) are teen parents.
- 1% (n=3) are adoptive parents and .6% (n=2) are a court-ordered placement for the child in their care.
- 28% (n=100) are first-time caregivers.
- 39% (n=137) of families have more than one child in the family under the age of five.

Economic Status and Access to Health Insurance

- 32% (n=114) of families have experienced financial stress for six months or more.
- 31% (n=108) of families have both caregivers in the workforce and 69% (n=244) have one adult in the workforce. 1% (n=3) of families have an adult who is a member of the military (2 are on active duty);
- 6% (n=20) of adults do not have health insurance and 2% (n=6) of families are uninsured, meaning that both the adults and children do not have health insurance. The number of uninsured families served by the program this fiscal year fluctuated between three and five families per month.
- 2% (n=6) of families receive TANF Cash Assistance and .3% (n=1) receives Free and Reduced Lunch.

Health and History

- 9% (n=30) of children and 9% (n=31) of caregivers have an identified disability;
- 6% (n=20) of families utilize mental health and social services;
- 4% (n=13) of families have experienced a death of an immediate family member;
- 2% (n=6) of families have experienced domestic violence or abuse issues;
- 1% (n=5) of families have a child with serious behavior concerns;
- 1% (n=4) of adults are involved with the Department of Corrections (3 are incarcerated);
- 1% (n=4) of adults have a substance use disorder;
- 1% (n=3) of children served were born with a low birth weight; and
- .5% (n=2) of adults have an identified health issue.

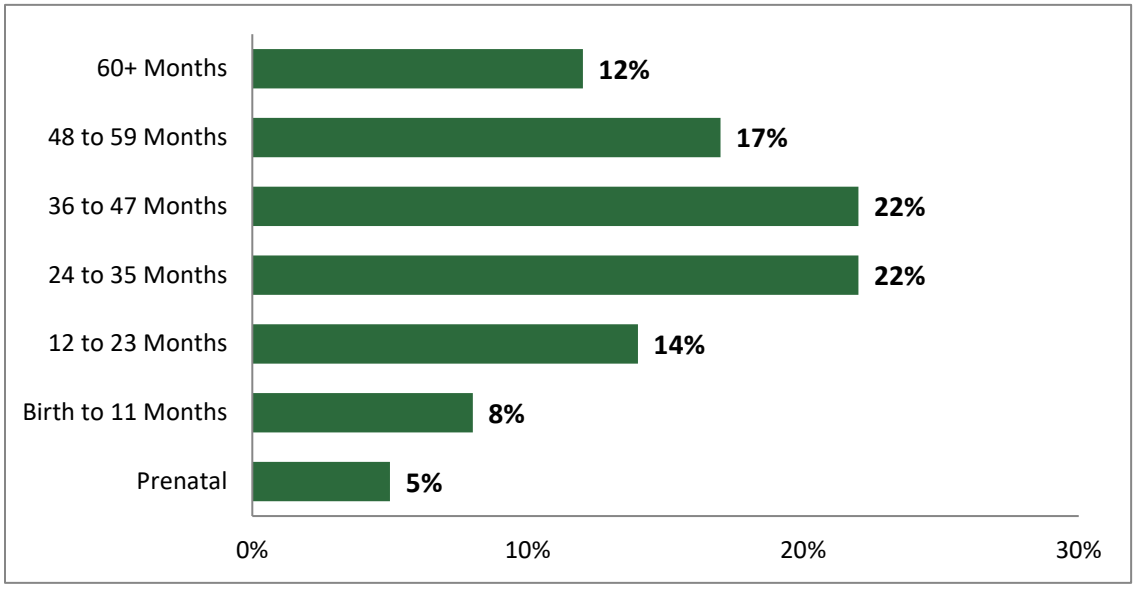
Child Demographics

The Home Visiting Program targets services to families with infants and children up until age six, although support is provided to the entire family through home visits and referrals. In FY16-17, the Home Visiting Program served a total of 558 children. Families served by the program this year have between one and five children enrolled in the program, with an average of 1.4 (.62 SD) and median of one child served by the program. Characteristics of children served include:

- 51% (n=282) are male, 43% (n=242) are female, and 6% (n=34) are prenatal (at the time of reporting);
- 48% (n=269) are White/non-Hispanic; 32% (n=181) are Hispanic/Latino; 10% (n=53) are multi-racial; 5% (n=25) are African American; 4% (n=24) are Asian; and 1% (n=6) are Native American.

The ages of children served in FY16-17 ranged from newborn to 70 months, with an average age of 37 months (17.4 SD) and median of 37 months (n=527), which excludes the 28 children who were prenatal at the time of their program exit date or the end of the fiscal year, 6/30/2017). Exhibit 6 shows the percentage of children by age ranges (including prenatal). Overall, 72% (n=399) of children served this year are less than four years old (as of their program exit date or the end of the fiscal year, 6/30/2017).

Exhibit 6. Percentage of Children Served by Age Groups (in Months)



Program Implementation

The process evaluation includes a review of the Home Visiting Program's implementation of services by program staff. Areas covered in this report include: referral sources to the program, family participation and retention, and services provided to families.

Referral Sources and Family Participation/Retention

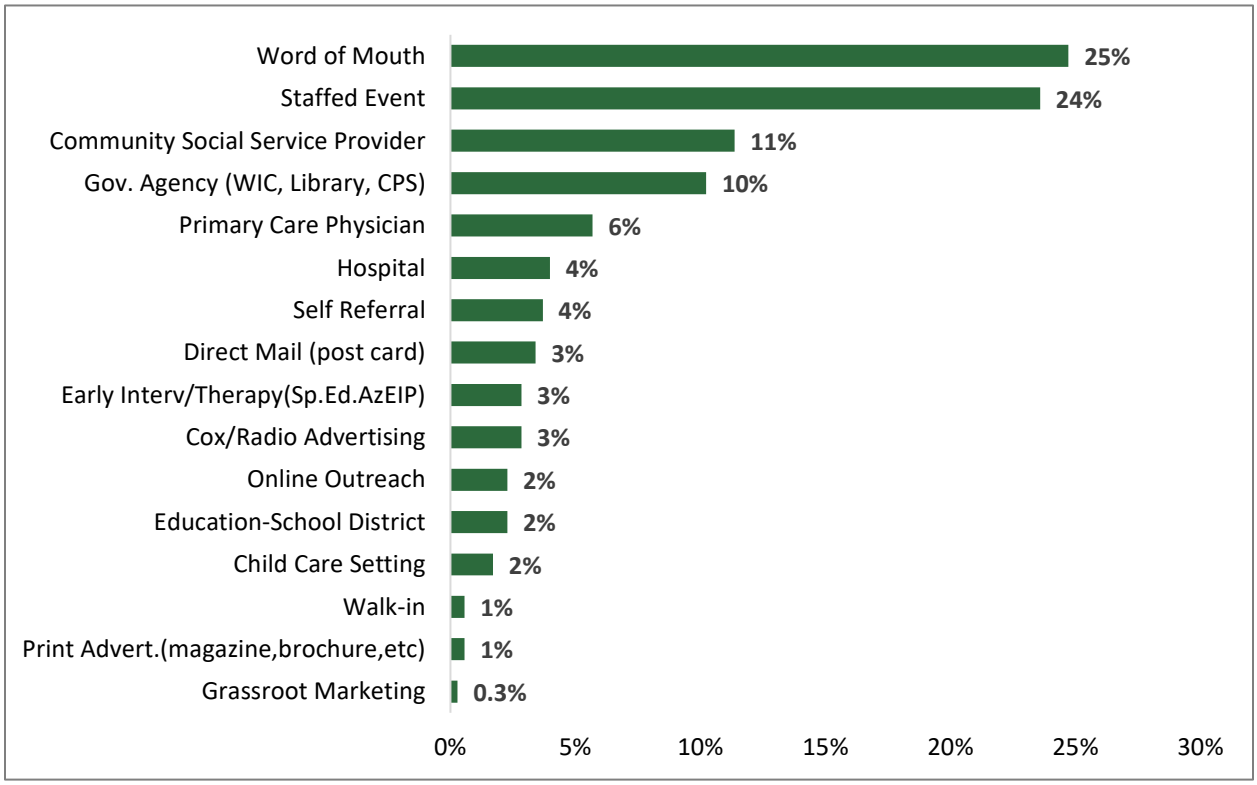
The process evaluation examines family participation in the Home Visiting Program in FY16-17, including:

- Sources of client referral to the program; and
- Number of participants served, retained, and exited.

Participant Referral to the Program

Exhibit 7 shows sources of referrals to the Home Visiting Program for this past fiscal year. A quarter of families (25%, n=87) were referred to the program through word-of-mouth referral from friends or family members. Other prominent referral sources include: a staffed event (24%, n=83); another community service provider (11%, n=40); a government agency (such as a WIC office, library, or Department of Child Safety office) (10%, n=36); and a Primary Care Physician's office (6%, n=20).

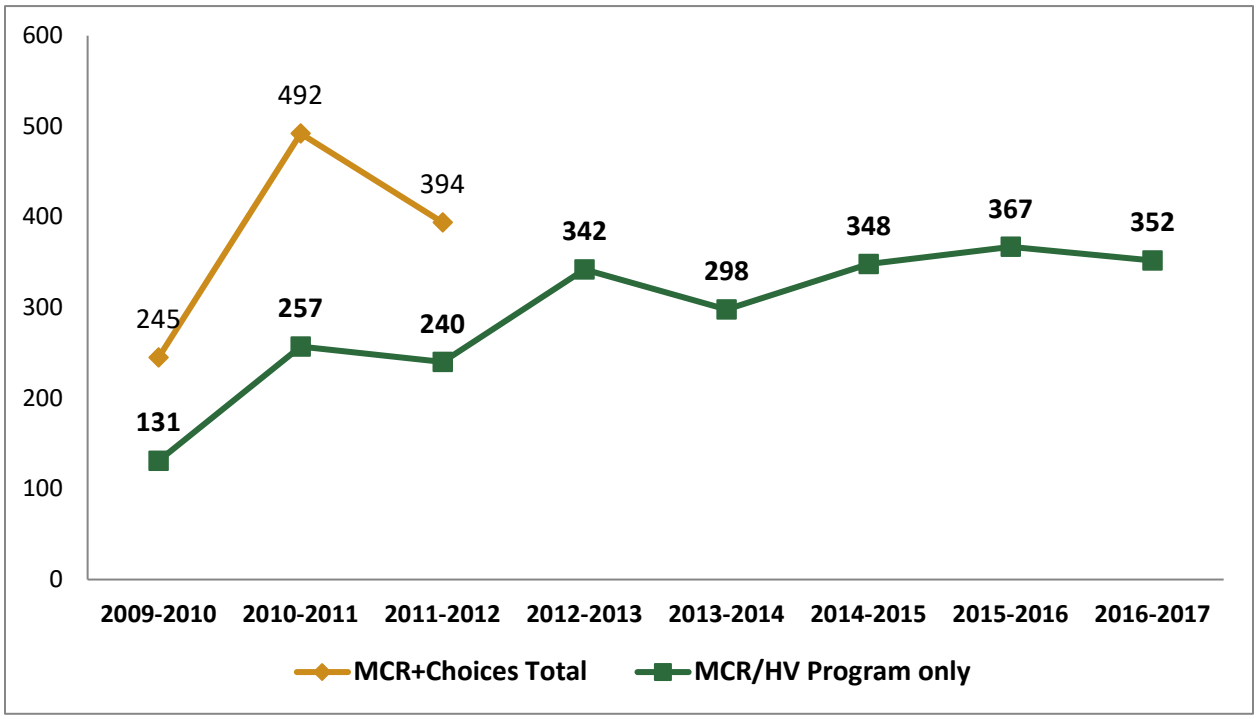
Exhibit 7. Sources of Referrals to the Home Visiting Program



Participant Enrollment

Exhibit 8 illustrates the number of families served by the Home Visiting Program for each fiscal year, beginning on July 1, 2009 to the present. The lighter colored line displays the total number of people served by the Home Visiting Program, which included the MyChild'sReady (MCR) PAT program and the Choices program from 2009-2012. The green line represents the number of people served by only the Home Visiting Program (operating under the name of MCR from 2009-2015), which demonstrates a general upwards trend in the number of clients over the past six fiscal years. The increased enrollment in FY12-13 reflects the expansion of the program into two Home Visiting teams and hiring of additional staff.

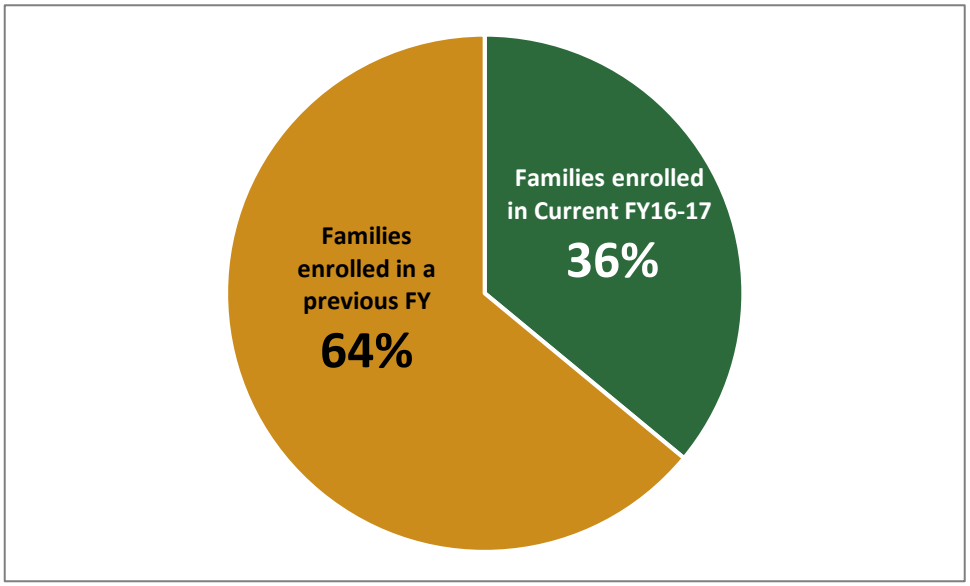
Exhibit 8. Number of Families Served, Annual Fiscal Year Comparison



Length of Time in the Program

The 352 clients served during FY16-17 participated in the program for an average of 17.8 months (14.8 SD) and range of less than one month to 75 months in the program. The wide range of months in the program reflects the varying years of client enrollment. Exhibit 9 shows that 36% (n=127) of those served this year enrolled during the current FY, while 64% (n=225) of those served this year enrolled during a previous FY.

Exhibit 9. Time Period of Client Enrollment



Participant Retention and Exit

Exhibit 10 displays the status of families served in FY16-17 at the end of the fiscal year (June 30, 2017). Over two-thirds of clients (69%, n=241) remained active in the program, while 32% (n=111) had exited the program at some point.

Exhibit 10. Family Status in the Home Visiting Program, as of June 30, 2017

Family Status	N	Percent
Active	241	69%
Exited	111	32%
Total N	**352**	**100%**

Of those who exited the program, Exhibit 11 shows that 54% (n=60) completed the program per the PAT model, as determined by their Parent Educator, which is an increase from 39% in FY 15-16. A total of 29% (n=31) left the program because they moved out of the service area, were transitioned to another program, or their child aged out of the program. Additionally, 18% (n=20) exited the program for reasons of discontinuing services by choice or program staff was unable to locate the family.

Exhibit 11. Reasons for Exiting the Home Visiting Program

Reason	N	Percent
Completed the program per the PAT model	60	54%
Moved out of serviced area	21	19%
Discontinued services	11	10%
Not able to be located by staff	9	8%
Transitioned to another program	5	5%
Child aged out of the program	5	5%
Total N	**111**	**100%**

PAT Essential Requirements states that "*Affiliates provide at least two years of services to families with children between prenatal and kindergarten entry.*" Exhibit 12 shows that clients who exited the program after completing it per the PAT model participated in an average of 27.4 months (12.7 SD) of programming, ranging from 11 months to 64 months.

Exhibit 12. Length of Time in Program, All Clients and by Active/Exit Status

	Average # of Months in Program	SD	Minimum # of Months	Maximum # of Months	N
Remained Active in the Program	17.2	14.7	<1	75	241
Exited, Completed Program per PAT Model	27.4	12.7	11	64	60
Exited, Discontinued Services/Not Located	7.2	6.4	<1	26	20
Exited, Moved/Transitioned/Aged Out	10.2	13.5	<1	68	31

Client Exit Study Results

As part of the process evaluation, LeCroy & Milligan Associates conducted exit surveys with families who exited the program for reasons of "discontinued services" or "not able to be located by staff," to better understand their reasons behind leaving the program and identify clients who would like to re-engage with the program. As shown in Exhibit 12 above, 11 clients discontinued their participation in the program before completing the PAT model and nine could not be located by program staff, despite multiple attempts by staff using a variety of methods (e.g., phone call, letter, drop by, etc.). These clients had participated in the Home Visitation Program for an average of 7.2 months, ranging from one month to 26 months. A total of 11 families (a 55% response rate) completed the program exit survey during FY16-17. A summary of their responses is shown below. Clarifying or exemplifying quotes are shown when available; some wording of quotes may be slightly altered to protect respondent confidentiality.

Referral Source

All clients heard about the Home Visiting Program from different referral sources, including: word-of-mouth referral from a person in the program (n=3); a WIC clinic (n=2); a library (n=2); an advertisement at a church (n=1); a seminar (n=1); a staffed event (n=1); and while at a treatment program for women (n=1).

Client Expectations of the Program

Respondents' expectations of the program were fairly consistent and in line with the focus of program services. They expected that by participating in the program, they would:

- Learn about parenting skills and techniques;
- Help their child to be ready for school;
- Help their child to be better behaved; and
- Receive guidance and advice specific to their parenting situation.

Reasons for Leaving the Program

All respondents provided a reason for leaving the program, summarized below.

- Three (3) respondents indicated that they **missed their initial or several home visiting appointments** and were dropped from the program. One person specified that she was very stressed out at the time and was not able to keep her appointments.
- Two (2) respondents indicated that their **work schedule conflicted** with participating in the program. One person commented, "The hours available were the same as my working hours."
- Two (2) respondents said that they left the program because their **child started day care or preschool**.

- Two (2) respondents said that the **family moved** out of the service region.
- One (1) respondent indicated that they were **no longer interested** in the program because she felt it had too many requirements for participation and it did not match her initial expectations.
- One (1) respondent **did not connect with her Parent Educator** and felt the program would not provide her with another Educator.

Supervisor Contact

Seven (7) respondents indicated that their Parent Educator's supervisor contacted them about leaving the program, however most did not actually speak with the supervisor. In these cases, the supervisor left a voice message and the client did not call them back. Additionally, three (3) respondents said that a supervisor did not contact them, and one (1) person was not sure.

Ways Parent Educators could have Helped Clients to stay in the Program

Seven (7) respondents indicated that there was nothing that their Parent Educator did to cause them to leave the program, often stating that their Parent Educator "did a really good job." One person suggested that Parent Educators should have more flexibility to schedule home visits with families in the evenings or on the weekend, when parents are not working.

Three (3) respondents provided feedback around their Parent Educator being more patient with them. One client felt that her Parent Educator was not very patient and understanding with her daughter during a home visit. Two (2) respondents would have liked their Parent Educator to be more patient with them in scheduling home visits, as they were still interested in being in the program even though they missed several appointments.

Re-engagement Efforts

Six (6) clients indicated during their Exit Survey that they would like to be contacted by the program. Their contact information was provided to the Program Director.

Services Provided

Home Visitation Services

Personal home visits occur two or more times per month at a time that is convenient for families. During home visits, PAT educators implement the data-driven and goal-based child/family plan by providing information and resources, and modeling developmentally appropriate activities within six developmental domains. Through this guided learning process, parents learn how to observe and monitor their child's play and development in reference to the six developmental domains.

Compared by high needs status, the **average number of home visits provided per month for families with a high needs status (n=74) is 2.5 visits per month**. This number is significantly higher than the average of 1.9 visits per month completed by non-high needs families (n=278) (t=6.067, p=.00). ***These results exceed PAT National Standards for both types of families.***

Since their enrollment into the program, the 352 families served have received a total of 11,488 home visits (a 17% increase from the 9,782 home visits completed in FY15-16). Families completed an average of 32.6 (25.6 SD) home visits, with a wide range from one to 152 home visits per family. These figures are higher compared to home visiting data reported in FY 15-16, when families completed an average of 26.7 home visits, with a range from one visit to 131 visits.

PAT National Center's Essential Requirements (2016) state that *"Families with one or fewer high needs characteristics receive at least 12 personal visits annually and families with two or more high needs characteristics receive at least 24 personal visits annually."* Compared by high needs status, the average number of home visits completed per month by families with **a high needs status (n=74) is 2.5 visits per month, which is significantly higher than the average of 1.9 home visits per month completed by non-high needs families (n=278) (t=6.067, p=.00).** These results exceed PAT National Standards for both types of families.

Clients' home visit completion rates for the duration of time they have been in the program were calculated by dividing the total number of visits completed by the total number attempted (this rate includes visits attempted and completed in all FYs in which families were enrolled). **Home visit completion rates for the duration of enrollment range from 40% to 100%, with an overall average completion rate of 84% (11.0 SD).** Home visit completion rate data for high needs families (n=74) ranges from 44% to 100% and averages 84%, which is consistent with non-high needs families' range of 40% to 100% and average 84% (n=278). This data demonstrates that regardless of high needs status, families are participating in most of their home visits, as scheduled. These figures are higher compared to home visiting data reported in FY 15-16, when total home visit completion rates ranged from 33% to 100%, with an overall average of 81%.

PAT National Standard's measurement criteria for home visit frequency is that *"At least 60% of families received at least 75% of the required number of visits per month"* (the required number of visits is determined by high needs status). Looking at completion rate data for visits attempted and completed in FY16-17 only, **92% of families with a high needs status and 99% of families with a non-high needs status had a home visit completion rate of at least 75% of the required number of visits completed per month. These results exceed the PAT National Standard of at least 60% of families, for both types of families.**

Case Management Services

Beginning in October 2015, the Program added Case Management services as an additional component of this program model, which allowed clients to work with both a Case Manager (CM) and a Parent Educator (PE) (CM+PE). While all clients are assigned a CM, use of their services is client driven and some clients only work with a PE. Please see LeCroy & Milligan Associates (2017) for a more in-depth analysis of Case Management services provided to families by the Home Visiting Program in FY16-17 and the impact on family participation and outcomes.

Over a half (56%, n=197) of families served by the Home Visitation Program in FY16-17 received at least one type of Case Management (CM) services in addition to Parent Educator (PE) services (CM+PE). Families utilized between 1 and 18 instances of CM services (median of two services). The different types of CM+PE services received by clients are shown in Exhibit 13. Please note that the percentages do not total to 100% because families could have received more than one type of CM+PE service (e.g., a family could have received a CM+PE home visit and a CM only home visit). Of those who utilized CM+PE services (N=197), 79% (n=156) received a home visit that included both their CM and PE. Approximately a third of clients received resources from a CM, either through their PE or directly from the CM. Additionally, 15% of families received a home visit with just their CM (i.e., their PE was not present during this visit).

Exhibit 13. Types of Case Management Service Received, FY16-17

Case Management Service	% (n) Utilized (N=197)*	Number of CM Services Received	Median Number of CM Services Received
Home visit with a CM and PE staff team	79% (156)	1 to 9 visits	1 visit
Resource provided by CM via a PE, because the CM could not reach the caregiver directly	33% (66)	1 to 4 resources via PE	1 resource
Resource provided by CM through a telephone call	30% (59)	1 to 7 CM resource calls	1 resource call
Home visit with CM only	15% (29)	1 to 14 visits	2 visits

*Percentages of CM+PE service types do not total to 100% because families could have received more than one type of CM+PE service (e.g., a family could have received a CM+PE home visit and a CM only home visit).

Case Management Service Intensity

Of the 197 families who received CM+PE services in FY16-17, Exhibit 14 shows that 89% (n=175) received **between 1 and 4 instances** of these services, considered **"low-intensity" CM+PE**, and 11% (n=22) received **5 or more instances** of these services, considered **"high-intensity" CM+PE**. The average number of CM+PE services received is significantly different between these two groups, with those in the low-intensity group receiving an average of 1.8 CM+PE services and the high-intensity group receiving an average of 7.7 services (t= -8.039, p=.00). **Families who utilized higher intensity of CM+PE services are significantly more likely to have a high needs designation.** A total of 22% (n=10) of families with a high needs status utilized high-intensity CM+PE services, compared to 8% (n=12) of families without high needs (x^2=7.185, p=.01).

Exhibit 14. Intensity of Case Management Service Received, FY16-17

Case Management Service Intensity	% (n) Utilized	Average Number of CM+PE Services Received (SD)
Low-Intensity CM+PE Services (1-4 services)	89% (n=175)	1.8 (.97)
High-Intensity CM+PE Services (5+ services)	11% (n=22)	7.7 (3.4)

Parent Group Connections

PAT National Center's Essential Requirements (2016) state that *"Affiliates deliver at least 12 group connections across the program year"* and the measurement criteria is that affiliates deliver 75% or at least 9 of the 12 required group connections during the fiscal year. Parent Group Connections are facilitated by the PAT educators and are designed to teach and provide parents with information related to education and developmental milestones, kindergarten readiness, parenting practices, and an opportunity for parents to network with other parents. Exhibit 15 shows the title, month/year, and attendance data for parent group connections held from July 1, 2016 through June 30, 2017. **The Home Visitation Program held 23 group connections with varying themes in FY16-17, which exceeds the PAT National Standard of holding at least 9 parent groups connections during a program year.** To better meet the needs of families, the program offered group connections on two Saturdays during the FY and held them at multiple locations to accommodate the different areas where families live in the service area.

Exhibit 15. Parent Group Connections Held by the Home Visiting Program, FY16-17

Parent Group Connections	Month/ Year	Number of Families	Number of Children
Dance Party	July 2016	50	68
Carnival of Music	July 2016	7	10
Pretend Play	August 2016	33	10
Animals Dancing	August 2016	10	14
Fun in the Kitchen	September 2016	34	14
Colors and Shapes	September 2016	8	9
Family Fun in the Park – Queen Creek	October 2016	22	32
Family Fun in the Park	October 2016	13	15
Music and Me	October 2016	5	7
Fall Festival	November 2016	31	43
Music and Me	November 2016	4	8
Gingerbread Party	December 2016	47	74
Happy and Healthy	January 2017	24	34
Blocks Party	February 2017	29	46
Dr. Seuss (3/4)	March 2017	24	46
Dr. Seuss (3/6)	March 2017	19	29
Resource Fair	March 2017	41	38
ABC Music and Me	March 2017	7	12
Messy Science	April 2017	30	15
ABC Music and Me	April 2017	10	15
Ocean Bash	May 2017	38	56
ABC Music and Me	May 2017	11	17
Games for All Ages	June 2017	30	46
ABC Music and Me - Feelings	June 2017	7	13

Father Involvement/Engagement

The Home Visiting Program has a Father Engagement Resource Specialist on staff to support and enhance father involvement with families served. This staff person worked with 23 families during home visits this past FY for a total of 170 home visits. The number of home visits per family ranged from one to 20 visits with the Father Engagement Resource Specialist. This staff person facilitated six events with 258 fathers; supported 48 play groups; and taught 153 classes/workshops throughout the reporting time frame. Examples of workshops include: Raising emotionally healthy children; Raising Healthy Sons/Daughters; Communicating Effectively with Infants and Toddlers; Beating Bedtime Battles; and Potty Training 101.

Developmental, Sensory, and Health Screenings

PAT National Center's Essential Requirements (2016) state that "*Screening takes place within 90 days of enrollment for children four months or older and then at least annually thereafter (infants enrolled prior to four months of age are screened prior to seven months of age). A complete screening includes developmental screening using PAT approved screening tools, along with completion of a health review that includes a record of hearing, vision, and general health status. Developmental domains that require screening include language, intellectual, social-emotional & motor development.*"

In compliance with this Essential Requirement for PAT affiliates, Parent Educators of the Home Visiting Program concurrently implement a variety of screening measures that identify the child's strengths, abilities, and any developmental needs. **In FY16-17, the Home Visiting Program completed a complete initial screening in the required time frame with 97% of children newly enrolled in the program. The program also completed screening with 98% of children during the program year. Both of these figures exceed the PAT National Standard of at least 60% of children in both groups.**

Exhibit 16 shows that a total of **2,404 screenings** took place in FY16-17, occurring for child development, social-emotional, hearing, vision, and general health. The numbers and percentages of each screen type completed are fairly consistent across the five major areas, which demonstrates that this program is compliant with completing a full health screen (including all five areas) of children enrolled in the program. Please see *Developmental and Sensory Screening* in the *Outcome Evaluation* section of this report for information on unduplicated counts of children screened and referrals made.

Exhibit 16. Screenings Completed in FY16-17

Screen Type	Total Number of Screens Completed	% of Total Screens
Ages and Stages Questionnaire (ASQ)-3	458	19%
ASQ-Social Emotional (ASQ-SE)	463	19%
Hearing Screenings	519	22%
Vision Screenings	480	20%
Health Questionnaire	480	20%
Hawaii Early Learning Screen	4	.2%
Total Screens Completed	**2,404**	**100%***

*The total percentage may exceed 100% due to rounding.

Resources and Referrals Made

PAT National Center's Essential Requirements state that "*Parent educators connect families to resources that help them reach their goals and address their needs*" and the measurement criteria is that at least 60% of families who received at least one home visit were connected to at least one community resource during the fiscal year. All 352 families served in FY16-17 received at least one home visit. Of these families, **98% (n=348) were connected by their Parent Educator to at least one community resource during this time frame, which exceeds the PAT National Standard of at least 60% of families being connected to at least one resource.**

PAT educators strive to connect families with community resources and referrals in a manner that develops parents' advocacy skills to work with community agencies and local school staff; these skills and relationships help to further identify early interventions that may assist the child and family in the child's development and school readiness, and reduce social isolation. Exhibit 17 shows that **the Home Visiting Program provided families with a total of 10,622 resources and referrals in FY16-17, which is the highest number of referrals provided over time, a 51% increase over the past fiscal year.** Two categories that account for this large increase in resources and referrals made this past year are an increase in donated items (n=3,904 in FY15-16 compared to 5,874 in FY16-17) and socialization/recreation and enrichment activities (n=1,392 in FY15-16 compared to 2,569 in FY16-17).

Exhibit 17. Number of Resources and Referrals Made, Seven Year Comparison

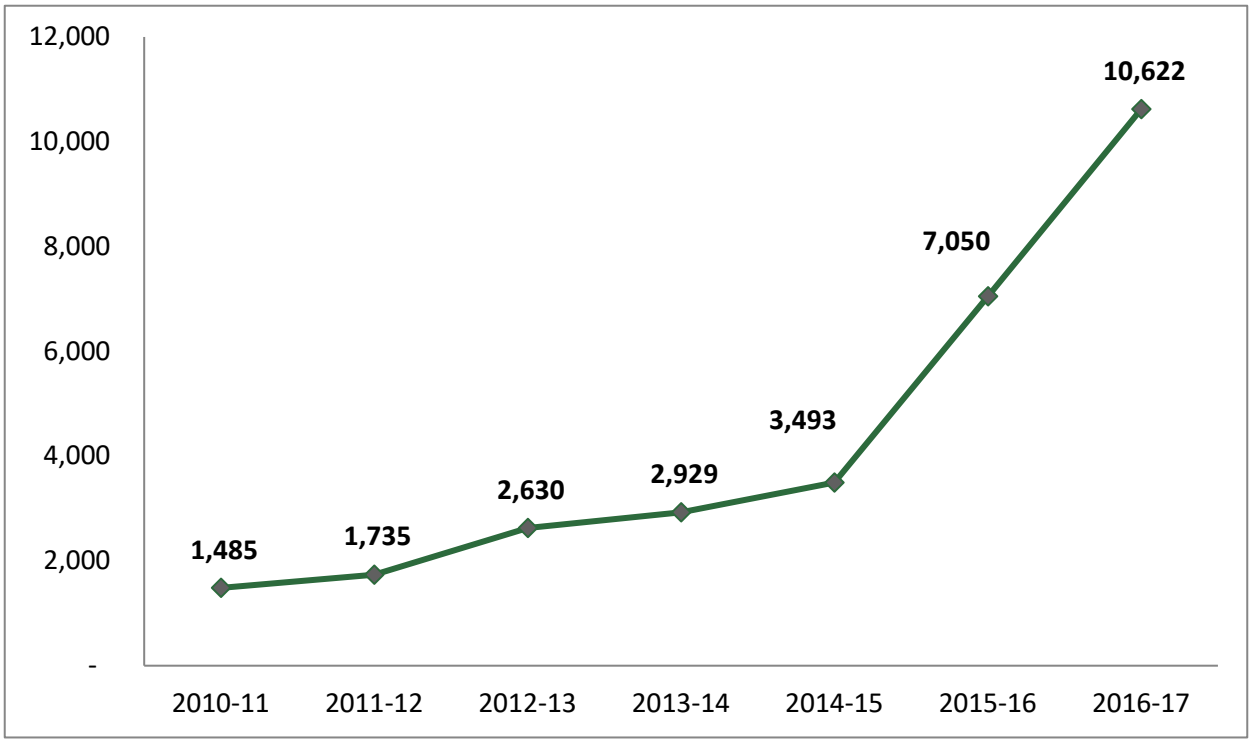


Exhibit 18 shows the number of resources and referrals made by Parent Educators in FY16-17, by category type.

- **Examples of donated items include**: school supplies, books, backpacks, holiday gifts, personal hygiene supplies, clothing, shoes, diapers, formula, toys, and safety supplies (e.g., outlet covers, cabinet locks, and door protectors).
- **Examples of socialization, recreation, and enrichment activities include**: event tickets (e.g., museum, culture pass), event fliers (e.g., classes, fairs, festivals, and holiday parties), and Family Resource Center event schedule.
- **Types of parenting education and support include**: information on the Birth to 5 help line, breast feeding, infant and child nutrition, speech and language development, and age appropriate chores; Arizona Parenting magazine and articles related to parenting; and information on parenting classes, such as at the Family Resource Center and classes geared towards fathers.

Exhibit 18. Number of Resources and Referrals Made, FY16-17

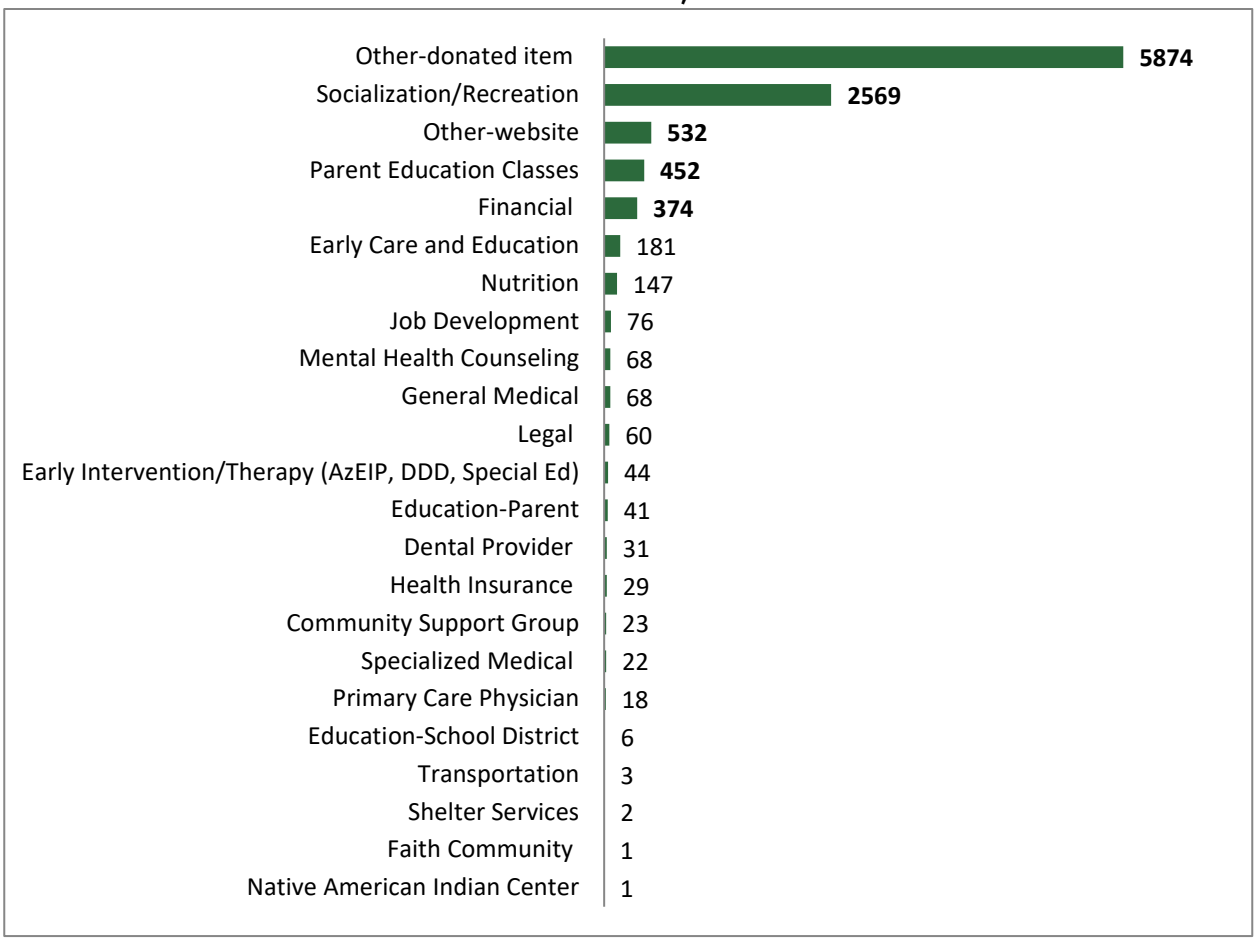
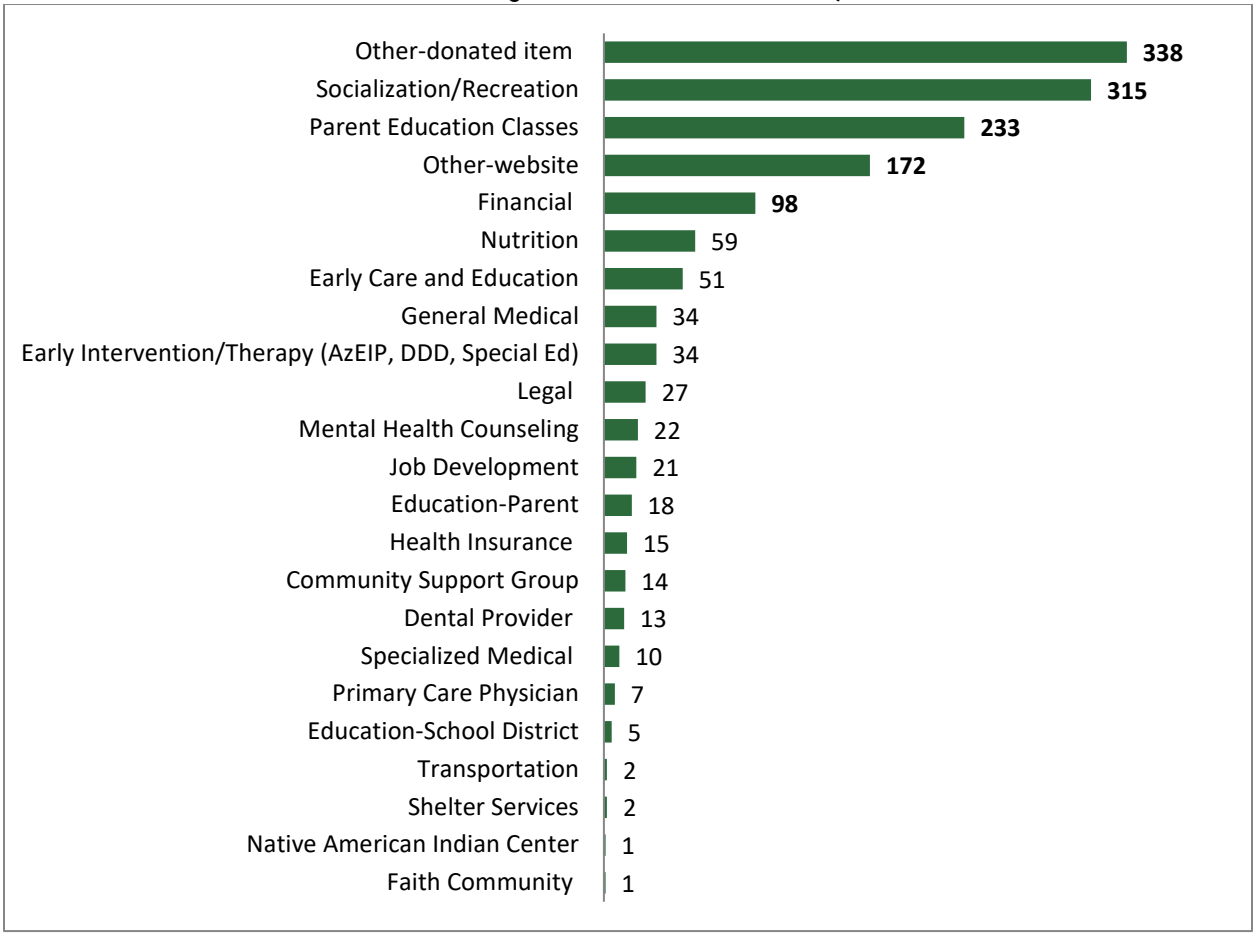


Exhibit 19 shows the unduplicated count of families that received each resource and referral type FY16-17. Of the major resource and referral categories, 96% (n=338) of families served received donated items; 89% (n=315) received socialization/recreation referrals; 66% (n=233) were referred to parenting education classes; 49% (n=172) were provided with information available online; and 28% (n=98) received financial assistance referrals.

Exhibit 19. Number of Families Receiving Resources and Referrals, FY16-17



Client Satisfaction with the Home Visiting Program

PAT National Center's Essential Requirements state that *"At least annually, the affiliate gathers and summarizes feedback from families about the services they've received, using the results for program improvement."* The Home Visiting Program collects feedback from caregivers in a variety of ways. Parent Educators perform two monthly feedback telephone calls with families. The program also administers feedback surveys at each Group Connection event. Finally, the program administers an online Participant Satisfaction Survey to gather feedback from families at three months post enrollment, annually, and at exit from the program. This section of this report summarizes the findings from the 365 respondents to the *Participant Satisfaction Survey.* The majority of surveys (50%, n=181) were completed as part of their annual review, while 34% (n=123) were completed as part of their three month review, and 18% (n=67) as their program closure survey.[2] Throughout this report, N=365 unless otherwise noted. Demographics of respondents include:

- 95% (n=345) are female.
- Ages ranged from 18 to 57 years, with an average of 32 years and median of 31 years.
- Length of time in the program ranged from 1 to 72 months, with an average of 17 months and median of 12 months.
- 89% (n=326) completed this survey in English and 11% (n=39) completed it in Spanish.

Rating of Program Areas

Items 1 through 11 related to program feedback, shown in Exhibit 20, demonstrates strong internal consistency with a Cronbach's Alpha score of .93. Exhibit 20 illustrates that nearly all respondents agreed or strongly agreed with statements concerning their satisfaction with program quality and their home visitor.[3] In FY16-17, 95% of respondents agreed (30%) or strongly agreed (65%) that "Finding services was easy," which again this year showed improvement over FY13-14 and FY14-15.

[2] The survey could reflect more than one interval time point for respondents so numbers may add up to more than the total of respondents.

[3] In cases where the respondent had open-ended responses that contrasted sharply with their responses to the questions on the Likert-type scale, we interpreted this as misunderstanding the directions for the quantitative items; their open-ended responses were assumed to accurately reflect their position and their responses to the quantitative questions were adjusted to missing. Their qualitative responses are included in analyses. This occurred for 12 or fewer respondents.

Exhibit 20. Satisfaction with the Home Visiting Home Visitation Program, FY16-17

Areas	Strongly Disagree	Disagree	Agree	Strongly Agree	N
Finding services was easy.	1%	4%	30%	65%	352
Program services were scheduled at convenient times.	2%	>1%	16%	82%	352
The program fit my family's beliefs, culture, and values.	1%	0%	18%	82%	351
My family's experience with the program was very good.	1%	0%	12%	88%	352
The program provided the help and services my family and I needed.	1%	0%	21%	78%	352
I received high quality services from my home visitor.	1%	0%	11%	88%	353
I felt comfortable discussing my concerns with my home visitor.	1%	0%	13%	86%	353
The program staff listened to my concerns and acted on them.	0%	0%	15%	84%	352
My home visitor did a good job explaining things to me.	0%	0%	12%	87%	347
I am satisfied with the information I received.	1%	0%	15%	84%	353
As a result of the program, I can support my children better.	0%	1%	17%	83%	351

Overall Helpfulness of Program and Client Satisfaction

The client satisfaction survey includes three yes/no questions pertaining to the program. Almost all clients who completed these questions affirmed:

- The services helped my family (99%, n=358);
- I am satisfied with the services I received (99%, n=361); and
- I would recommend this program to others (99%, n=359).

Most Helpful Aspects of the Home Visiting Program

A total of 333 participants responded to the open-ended question about the most helpful aspects of the Home Visiting Program. Exhibit 21 provides a summary of common themes from parents' open-responses to this question. The most common responses by far were related to informational resources (27%, n=89); followed by activities generally (13%, n=43); referral to or navigation of community resources (10%, n=34); having someone to listen to concerns and answer questions (10%, n=33); helps me teach my child (8%, n=26); learning new strategies for interacting with my child (6%, n=20); and helping me feel more secure in my parenting role (5%, n=17).

Exhibit 21. Most Helpful Aspects of the Home Visiting Program, Categorized Topics from Open-Responses

Area	N	%
Informational resources	89	27%
Activities (generally)	43	13%
Community resources (referrals/navigation)	34	10%
Listen to concerns/Help with them/Answer questions	33	10%
Helps me teach my child	26	8%
Social support/Support/encouragement (generally)	22	7%
Learn new strategies for interacting with my child	20	6%
Helps me feel secure in my parenting role	17	5%
Learning about child development	16	5%
Support/Activities/tools that address areas of special concern (special needs)	15	5%
Good connection with the HV	15	5%
Seeing child progress/child developing/learning	14	4%
Activities/tools that promote development	14	4%
Activities that promote learning	13	4%
Events (e.g. parent support group)	13	4%
Coming to my home	12	4%
Help dealing with behavior challenges/behavior management	11	3%
Assessments/Information on child's development	10	3%
Concern for my child reaching developmental goals	9	3%
Activities that are age or developmentally-appropriate	9	3%
Helps the whole family	8	2%
Time with my children	8	2%
The program or services generally or "everything"	7	2%
Activities that are engaging children	7	2%
One-on-one nature of the service	6	2%

Area	N	%
Motivation	6	2%
Concrete resources/Toys/books	6	2%
Knowledgeable Parent Educators	6	2%
Help with goal-setting for self/child (not developmental goals)	5	2%
Help me get my child ready for school	5	2%
To understand my child's needs	4	1%
Flexibility/Enough time to complete things	3	1%
Activities you can make with everyday objects	3	1%
Helping my child (generally)	3	1%
Learning (generally)	2	1%
Help getting my child into preschool or school	2	1%
That it's hands on/interactive	2	1%
About the importance of taking care of myself	1	>1%
Self-improvement	1	>1%
Efforts to make my child feel special	1	>1%
The HV interacts directly with my child	1	>1%
Learning the value of play	1	>1%
They give my child time to play	1	>1%

N=333. Please note that some individuals reported more than one area as being helpful.

Use of Knowledge and Skills from the Home Visiting Program

A total of 316 survey respondents responded to the inquiry "I will use the knowledge and skills learning in this program in the following ways…." Of these, six respondents reported simply "Yes." The remaining 310 respondents indicated ways in which they will use the knowledge and skills they learned in the Home Visiting Program. The categorized responses from their open-ended comments are shown in Exhibit 22. The most common responses were related to helping my child learn/teach my child (24%, n=74); using the knowledge and skills in their everyday lives (11%, n=35); helping their child develop (11%, n=35); helping their child prepare for school (10%, n=30); and engaging their child better/playing better/playing more often with their child (9%, n=29).

Exhibit 22. Parents' Use of Knowledge and Skills gained from the Home Visitation Program, Categorized Topics from Open-Responses

Area	N	%
To help my child learn/teach my child	74	24%
To use them with my kids (generally)/Integrate knowledge and skills into our everyday life	35	11%
To help my child develop	35	11%
To help my child prepare for school	30	10%
To engage better/play better/play more with my child	29	9%
To be a better parent	25	8%
To do the activities	24	8%
To help my child (generally)	20	6%
To make learning fun for my child/ integrate learning into play	17	5%
To communicate/interact more effectively with my children	16	5%
To better manage behavior	16	5%
To share knowledge with others	13	4%
To be able to identify activities that help my child	9	3%
To recognize/monitor developmental milestones	8	3%
To understand my child/their needs better	7	2%
For self-improvement	7	2%
To have a strong relationship with my child	7	2%
To be more patient	5	2%
To recognize what my child needs	5	2%
To spend time with my children	5	2%
To practice emotional self-care	4	1%
To use the community resources	3	1%
To create a healthy environment for my children	3	1%
To help my children get along with each other/with others	3	1%
As an ongoing resource	3	1%
To refer others	3	1%
To have a closer family	3	1%
To help my child manage their emotions	2	1%
To value play	2	1%
To follow my child's lead	2	1%
To encourage my child	2	1%
With my other children	2	1%
To meet more families	2	1%

Area	N	%
To make my own teaching tools	2	1%
To set goals	2	1%
To utilize routines	1	>1%
To use resources and handouts provided	1	>1%
To work with their children individually	1	>1%

N=310. Please note that some individuals reported more than one area as being useful.

Exhibit 23 shows a selection of quotes from participant's open-responses regarding the way parents will use the knowledge and skills learned from the Home Visiting Program.

Exhibit 23. Select Quotes on Using Knowledge and Skills Learned from the Home Visiting Program

Respondent Quotes to the Survey Question "I will use the knowledge and skills learned in this program in the following ways:"
"To be better equipped to teach my children and be a better mom!"
"I am more confident in my decision making and better at parenting."
"Remembering that there is opportunity to teach my kids through daily activities."
"In everyday parenting, looking at its details to understand how my child is doing and responds to language, directions."
"Teaching my children by incorporating activities in our play."
"Adding fun hands on activities that are age appropriate."
"Being more vocal during play time."
"By knowing how to respond to how my daughter is leading playtime."
"Helping my child reach each milestone and providing adequate games and toys for each step."
"To turn playtime into learning opportunities."
"To find fun age appropriate activities to do with my son."

Recommended Program Changes

Two hundred and twenty eight people responded to the question about recommendations for improving the program, of which 67 indicated that they had no recommendations (e.g., nothing or N/A) and 96 used the question as an opportunity to describe that the program is great as it is offered (e.g., "Everything is great! No need for improvement"). Fifty-seven respondents provided the following recommendations.

- Home visits more often (n=8)
- Group activities/classes on other days (e.g. weekends) or times (n=9)
- More group activities (n=6)
- More instruction on behavior management (n=4)
- Make sure home visits accommodate needs of multiple children (e.g., more time) (n=3)
- Have longer visits (n=3)
- Program closer to where I live (n=3)
- Greater flexibility in scheduling home visits (e.g. weekends) (n=2)
- Have or continue to have healthy food/gluten free food available at events (n=2)
- Less paperwork/administrative tasks/data collection (n=2)
- Change the name to promote greater accessibility/less stigma (n=2)
- More opportunity to meet other families (n=2)
- Be able to stay longer in the program (n=1)
- Have program last longer (n=1)
- Greater service area (n=1)
- More info on (free) community resources/activities (n=1)
- Knowing in advance what activities will be brought to a home visit, what to expect (n=1)
- More broadly accessible by other families (e.g. advertising) (n=1)
- Be able to borrow materials (e.g. games, toys) (n=1)
- More outside activities (n=1)
- Instruction in child psychology (n=1)
- Childcare during classes (n=1)
- Improve the music and program (generally) (n=1)
- More structured teaching (n=1)
- Have them teach the kids (n=1)
- Annual photo of the child give to parent at the end (n=1)

Outcome Evaluation

The outcome study assesses the impact of the Home Visiting Program on families and children in terms of its main goals: (1) promoting child health and development and (2) enhancing parent/child interactions. Guiding questions include: What changes occur in parenting quality over time, as measured by the KIPS pre and post survey? To what extent do families meet the goals they set? To what extent are children who are screened with newly identified delays referred out?

Keys to Interactive Parenting Scale (KIPS)

KIPS is a strengths-based, observational instrument that assesses the construct of parenting quality, across 12 items:

1. Sensitivity of responses
2. Supports emotions
3. Physical interaction
4. Involvement in child's activities
5. Open to child's agenda
6. Language experiences
7. Reasonable expectations
8. Adapts strategies to child
9. Limits and consequences
10. Supportive directions
11. Encouragement
12. Promotes exploration/curiosity

As per the developers of KIPS, the total average KIPS score is interpreted in the following way:

- Average score of **≤ 2.9 is a low score, indicating low quality parenting;**
- Average score of **3.0 - 3.9 is a medium score, indicating medium quality parenting; and**
- Average score of **≥ 4.0 is a high score, indicating high quality parenting.**

The Home Visiting Program began using the KIPS assessment in July 2011. This instrument is used by program staff to: identify service focus; inform family goals; open dialogues with families about parenting strategies that promote their child's development and learning; monitor changes in parenting behavior; and evaluate parenting outcomes. The 12 KIPS items demonstrated strong internal consistency across the three collection time points, with a Cronbach Alpha score of .93 at the initial assessment and .94 at the last assessment. KIPS average score interpretations are shown in the text box on this page.

Number of KIPS Assessments Performed

An initial KIPS assessment is conducted for families at 90 days post intake and follow-up assessments are conducted annually and at closure. It should be noted that if a family completes an annual KIPS assessment and then exits the program within six months, the program does not repeat this assessment due to it being too close together. From July 1, 2011 to June 30, 2017, a **total of 1,814 people had an initial KIPS assessment.**

- **352 individuals were initially assessed, but did not have a follow-up[4].**
- **920 individuals were initially assessed and had between one and nine follow-up assessments.**

Comparison of Average KIPS Score across Time Points

Exhibit 24 shows the average KIPS scores, related statistics, and parenting quality score interpretation at each time point.

Exhibit 24. Average KIPS Score at Initial, Ongoing, and Final Time Points

Assessment Number	N	Mean KIPS Score	SD	KIPS Parenting Quality Score Interpretation
1st	861	3.87	.80	Medium
2nd	509	4.24	.68	High
3rd	271	4.44	.63	High
4th	107	4.49	.59	High
5th	42	4.68	.39	High

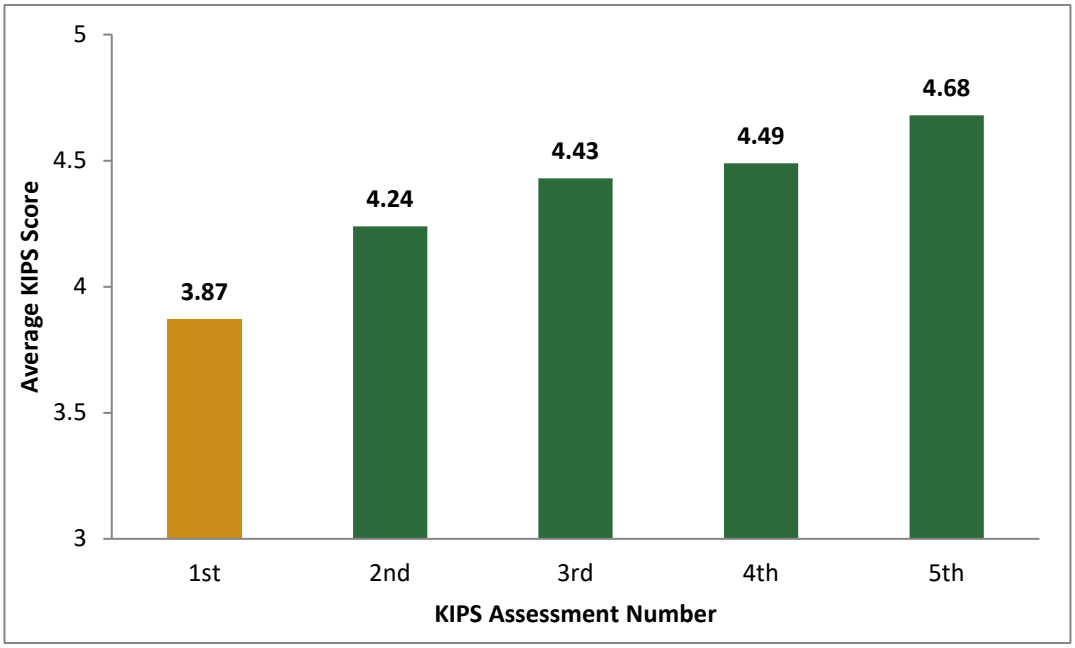
A One-Way Analysis of Variance (ANOVA) was performed to determine the mean (average) KIPS score at each time period assessed, and whether or not the average scores for each time period significantly varied from each other (see Exhibit 25). Due to the small number of individuals that had six or more follow-up KIPS assessment, these average scores are not shown.

- The 1st assessment score was significantly lower than all other assessment time periods, indicating that parents demonstrated an improvement in parenting quality over time (p=.000).
- A significant improvement in parenting quality was observed from the 2nd assessment time, in comparison to the 3rd (p=.002), 4th (p=.012) and 5th (p=.001.) assessment times, indicating continued improvement in parenting quality from the second assessment onwards.
- The 3rd, 4th, and 5th assessment time points did not show a significant change in parenting quality at these later time points.

[4] If a family exited the program prior to six months from their initial assessment, they would not have been re-assessed.

These results suggest that participants demonstrated significantly improved parenting quality from their initial assessment to subsequent assessments performed over the course of the program. Exhibit 25 shows the average KIPS score by time period.

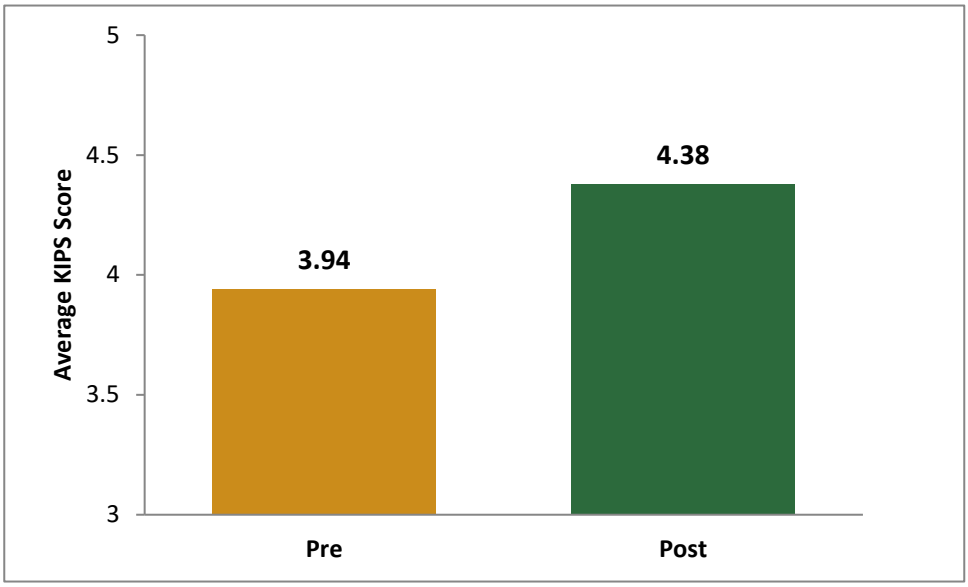
Exhibit 25. Average KIPS Score by Assessment Time Period



Comparison of Paired Pre and Post KIPS Scores

A total of 509 families had an average score for both an initial (pre) and follow-up (post) KIPS assessment (for analysis purposes, the post assessment is the last assessment that was completed for an individual, either annually or at program exit) and were included in the analysis of paired sample data. A Paired-Samples T-Test revealed (see Exhibit 26) that the total average KIPS score improved significantly from initial assessment (average of 3.94) to last follow-up assessment (average of 4.38) (t=13.065; df=508; p=.000), yielding an increase in average score by .44 points. **These results suggest that participants of the Home Visiting Program who completed both a pre and post (annual/exit) KIPS assessment demonstrated a significant improvement in parenting quality over time.**

Exhibit 26. Average KIPS Score at Pre and Post Assessment, Paired Sample



(n=509; t=13.065; df=508; p=.000)

Paired Sample Means Comparison at Initial and Final Assessment by KIPS Item

To help the program understand areas of strengths and those in need of further emphasis, a Paired-Samples T-Test was also performed for each KIPS item by individual pre and post assessments (see Exhibit 27). Eleven out of the 12 areas showed a statistically significant improvement in average score from pre to post assessment (p values were ≤ .05). Furthermore, all post average scores ranged from 4.09 to 4.64, indicating that a high level of parenting quality was observed at the post assessment (at annual or exit). **Five areas that achieved the <u>greatest increase in average score from initial to final</u> (ranging from an increase in .50 points to .56 points) include**:

- Being open to the child's agenda (🡅 .56 points);
- Promoting exploration and curiosity (🡅 .56 points);
- Adapting strategies to the child (🡅 .54 points);
- Setting reasonable expectations of the child (🡅 .52 points); and
- Promoting language experiences with the child (🡅 .50 points).

Growth in these areas are consistent with the paired KIPS pre/post statistical comparison in the previous reporting year.

Exhibit 27. Average KIPS Item Score at Pre and Post Assessment, Paired Sample

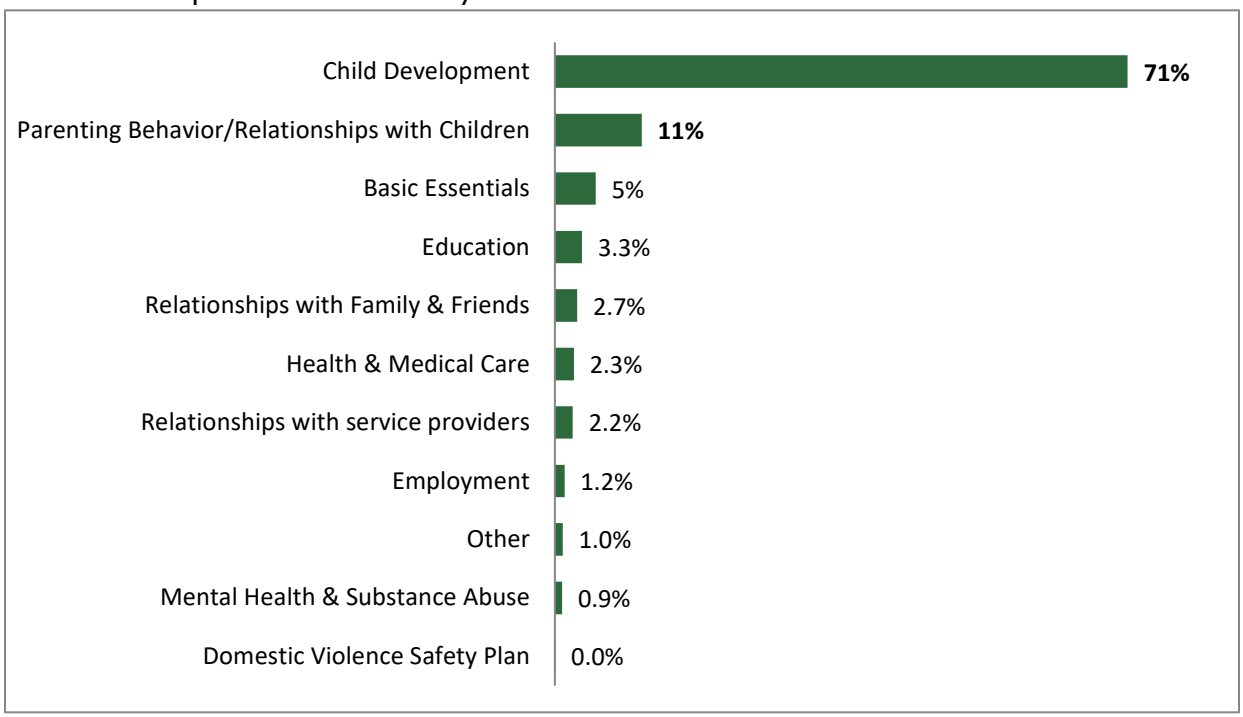
KIPS Item	Initial Average Score	Final Average Score	Average Change from Initial to Final Score	P-Value (2-tailed)	N
1. Sensitivity of responses	4.00	4.44	.44	**.000**	500
2. Supports emotions	3.82	4.26	.45	**.000**	433
3. Physical interaction	4.31	4.64	.33	**.000**	508
4. Involvement in child's activities	4.22	4.54	.32	**.000**	509
5. Open to child's agenda	3.73	4.29	.56	**.000**	491
6. Language experiences	3.98	4.47	.50	**.000**	504
7. Reasonable expectations	3.82	4.33	.52	**.000**	497
8. Adapts strategies to child	3.67	4.21	.54	**.000**	480
9. Limits and consequences	3.97	4.09	.12	.326	98
10. Supportive directions	3.96	4.38	.42	**.000**	454
11. Encouragement	4.21	4.48	.27	**.000**	507
12. Promotes exploration/curiosity.	3.66	4.22	.56	**.000**	505

Notes: Results are deemed a statistically significant change from pre to post when the p-value is ≤ .05. Significant areas are shown in bold font.

Family Goals

PAT National Center's Essential Requirements state that *"Parent educators develop and document goals with each family they serve."* The measurement criteria is that at least 60% of families that receive at least one home visit have at least one documented goal during the program year. **Of the 352 families that received at least one home visit, 95% (n=333) set at least one goal that was documented by their home visitor, which exceeds the PAT National Standard of at least 60% of families.** Families set a total of **2,269 goals** that were documented by home visitors. The number of goals set per family ranged from **one to 67 goals**, with an **average of 6.8 (8.5 SD) goals** per family. The main types of goals set are displayed in Exhibit 28. Consistent with previous years, the highest percentage of goals set by families are related to child development (71%), and parenting behavior/relationships with children (11%).

Exhibit 28. Major Goal Areas Set by Families



(n=2,269)

Main Types of Goals Set

A description of the major types of goals set is provided below.

Child Development

Nearly 3 out of 4 families (71%, n=1,601) set goals related to child development, including:

- **Supporting child' cognitive development and learning** - learning the alphabet; counting numbers; identifying shapes and colors; rhyming; sentence completion; reading books; writing one's name; and spelling.

- **Completion of child development assessments –** Keys to Interactive Parenting; Ages and Stages Questionnaire.
- **Transitioning the child through age appropriate activities** (e.g., daily tummy time; transitioning to a toddler bed; weaning off being bottle fed).

Parenting Behavior/Parent-Child Relationship

The second most common goal area, set by 11% (n=243) of families, focused on parenting behavior and the relationship that parents have with their children, such as:

- **Increasing parent/child activities** - parents and children spend more time together playing at home; asking open-ended questions during play to promote learning; engaging in outdoor activities; attending play groups; visiting recreation and play venues; and engaging in mother/baby bonding and attachment activities.
- **Learning positive disciplining strategies –** encouraging good listening skills; being consistent with use of "time outs;" developing a positive discipline plan; utilizing strategies to better support children during temper tantrums; setting consistent limits; using positive statements and praise with the children.
- **Developing routines –** establishing a consistent bath and bed time routine; developing an age appropriate responsibility, chore, and/or rewards system chart; scheduling regular trips to use the bathroom to promote toilet training; and following through with routines developed.

Basic Essentials

A total of 5% (n=114) of families set foundational goals, such as:

- **Improving the home environment** - reducing clutter in the home; unpacking from a move; moving to a different location; and reorganizing the home to improve space utilization;
- **Improving health and wellness** - following through with adult medical appointments; introducing new and healthy foods into the family's diet; establishing a sleep schedule; improving nutrition and fitness for postpartum weight loss; and self-care for parents;
- **Accessing community services –** socialization groups; legal services; hearing screening; obtaining a driver's license; and child's school registration; and
- **Meeting basic child development milestones –** toilet training; improving child's sleep habits.

Education

A total of 3% (n=76) set goals related to education, such as:

- **Meeting educational goals of children –** enrolling a child in preschool; applying for Head Start or Early Head Start.
- **Meeting educational goals of caregivers –** parents taking English language classes; completing a GED or higher education.

Relationships with Family and Friends

A total of 3% (n=62) for improving relationships with family and friends, such as:

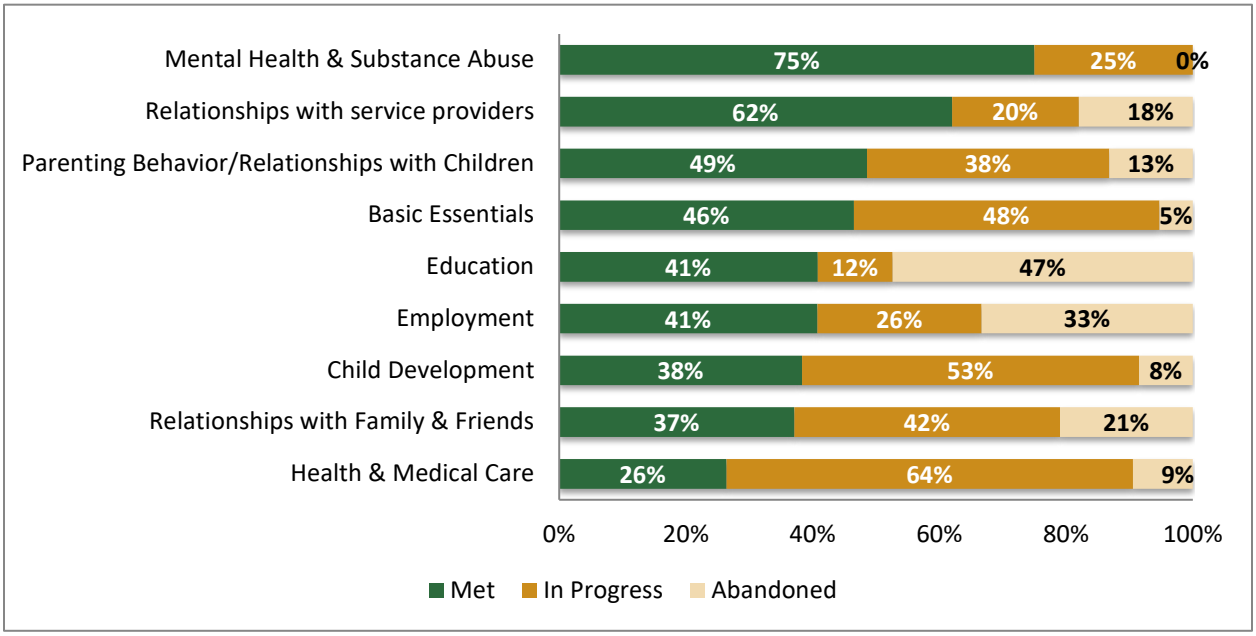
- **Improving relationships between parents –** having a date night; planning for a weekend getaway; exercising together.
- **Spending more quality time as a family –** having family meal times; attending play groups together; engaging in family counseling; going on nightly walks.

Goal Completion Rate

Of the 2,269 goals set by families in FY16-17, 41% (n=920) were met, 48% (n=1,096) are in progress, and 11% (n=252) were abandoned; these statistics are consistent with the goal completion statistics from the previous FY. Of the 333 families who have set goals, 76% (n=253) have met at least one of their goals and 70% (n=233) are on working on meeting their family goals with the program.

Exhibit 29 shows the percentage of goals that were met, in progress, and abandoned by goal type. The goal with the highest competition rate of 75% is that of mental health and substance abuse, and 25% are working on this goal; notably, this is the only goal area with a 0% abandonment rate. These figures are consistent with this goal area in the previous FY. Goal areas for which 40% or more were met include: relationships with service providers; parenting behavior/relationships with child; basic essentials; education; and employment. Goal areas with the highest percentage of goals in progress include health and medical care and child development.

Exhibit 29. Status of Major Goal Areas: Met, In Progress, and Abandoned



Number of Months to Meet Goal Types

Exhibit 30 displays the average number of months (and standard deviation (SD) it took families to achieve each goal area (sorted in descending order by average number of months, with the exception for "Total" rows). Overall, families took an average of 4.1 months (2.4 SD) to achieve their goals. Goals related to education, parenting behavior, and child development took the longest average number of months to complete (an average of 4.2 to 5.2 months). Goals related to relationships with service providers, health and medical care, and employment took the least amount of time to achieve (average of 2.2 to 2.5 months).

Exhibit 30. Average Number of Months to Meet Goal Areas

Goal Area	Average Number of Months	SD	n
Education	5.2	3.1	31
Parenting Behavior/Relationships with Children	4.5	2.4	118
Child Development	4.2	2.4	614
Relationships with Family & Friends	3.6	2.1	23
Basic Essentials	3.2	2.1	53
Mental Health & Substance Abuse	3.2	1.1	15
Relationships with service providers	2.5	1.7	31
Health & Medical Care	2.3	1.4	14
Employment	2.2	1.4	11
Total	**4.1**	**2.4**	**920**

Developmental, Sensory, and Health Screens and Referrals

Developmental screens are regularly provided by trained Parent Educators during home visits to measure a child's developmental progress and identify potential delays that require intervention by a specialist. Screenings may also be performed to document progress made by a child with an identified delay. Exhibit 31 displays the number of developmental, sensory, and health screenings performed, the number of individuals screened, and the number and percentage of children who were referred out due to an identified concern. **A total of 515 children were screened, of whom 9% (n=46) were referred for further assessment. The screens that yielded the highest percentage of referrals include developmental screening (7%, n=36) and hearing screening (1%, n=7).** Several outcomes may occur after a developmental screening: (1) the child is screened as having no delays; (2) results are unclear and the child is referred for more extensive assessment; (3) results show the child has a delay and is referred to services; and/or (4) the home visitor provides intervention or education to the family. Additionally, in some cases a child may have already been diagnosed by another professional and is receiving services. Therefore, the Parent Educator would not provide and additional referral unless additional services are needed for that child.

Exhibit 31. Developmental, Sensory, and Health Screens and Referrals, FY16-17

Screen Type		Total
Developmental Screenings (ASQ-3 and ASQ-SE)	Total number of screens conducted (duplicated individuals)	925
	Total individuals screened by the HV Program (unduplicated)	516
	Number (%) of children screened for developmental concerns who were referred for additional evaluation or assessment services (unduplicated)	36 (7%)
Hearing Screenings	Total number of screens conducted (duplicated individuals)	519
	Total individuals screened by the HV Program or another program (and reported to the HV Program) (unduplicated)	477
	Number (%) of children screened for hearing who were referred for further assessment (unduplicated)	7 (1%)
Vision Screenings	Total number of screens conducted (duplicated individuals)	480
	Total individuals screened by the HV Program or another program (and reported to the HV Program) (unduplicated)	474
	Number (%) of children screened for vision who were referred for further assessment (unduplicated)	1 (.2%)
Health Questionnaire	Total number of screens conducted (duplicated individuals)	480
	Total individuals screened by the HV Program (unduplicated)	476
	Number (%) of children who were referred for further assessment (unduplicated)	2 (.4%)
Total	**Total number of screens completed (duplicated individuals)**	**2,404**
	Total number of children screened (unduplicated individuals)	**515**
	Total number (%) of children who were referred for further assessment (unduplicated)	**46 (9%)**

Caregiver Depression Screening and Referrals

Number of PHQ-9 Assessments Performed

The Home Visiting Program uses the PHQ-9 as a depression screening tool. From July 1, 2015 to June 30, 2017, a **total of 629 people had an initial PHQ-9 assessment.** Of These individuals,

- 488 individuals were initially assessed, but did not have a follow-up.
- 141 individuals were initially assessed and had at least one follow-up.

Parent Educators score the completed instrument and follow the intervention protocol for depression management shown in Exhibit 32, based on the caregiver's total score.

Exhibit 32. Stepped Care Chart for Depression Managment

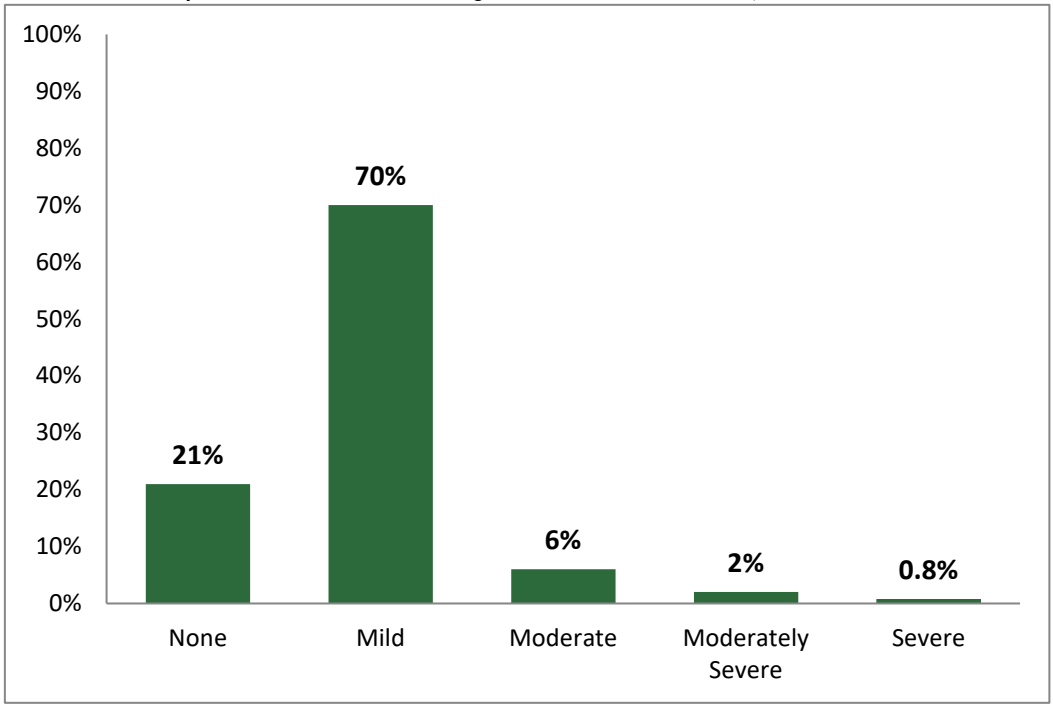
Depression Level	PHQ-9 Total Score	Intervention
1 (Mild)	**1-9**	• Depression Education • Reassurance/Supportive • Coaching/problem Solving • Discussion of Support Systems • Behavioral Activation discussion • Observation and discussion with parent regarding desirable PCI while symptomatic
2 (Moderate)	**10-14**	• Level 1 Interventions • Re-screen using PHQ-9, 1 time per month for 3 months • After screening monthly for 3 months and score remains the same, then screen every other month for 3 months. • Watchful Waiting • Referral to Mental Health Services/PCP if depression has lasted 2 or more year • Follow-up with client Mental Health referral
3 (Moderate/ Severe)	**15-19**	• Level 1 Interventions • Re-screen using PHQ-9, 1 time per month for 3 months • After screening monthly for 3 months and score remains the same, then screen every other month for 3 months. • Referral to Mental Health Services/PCP • Assist with treatment engagement • Adherence to MH Services and/or medications • Complete Suicide Risk Questionnaire
4 (Severe)	**20-27**	• Level 1 Interventions • Re-screen using PHQ-9, 1 time per month for 3 months • Immediate referral to Mental Health Services/PCP • Assist with treatment engagement • Adherence to MH Services and/or medications • Complete Suicide Risk Questionnaire

Depression Level	PHQ-9 Total Score	Intervention
5	**Suicidality (Any positive score on Item #9)**	• Complete Suicide Risk Questionnaire • If appropriate and needed, Contact County Crisis Line for immediate emergency management by qualified expert • Contact a supervisor immediately

Caregiver Depression Levels at Initial Screening

Including initial screening data collected in FY15-16 and FY 16-17, Exhibit 33 shows the percentage of caregivers that scored within each depression level on their initial PHQ-9 assessment (completed at 90 days post intake or, if a new parent, when the child turns two months old). The majority of caregivers' total scores placed them into the categories of none to mild symptoms of depression (91%, n=575). On the other hand, 9% (n=54) of caregivers produced a total score that was higher than 10, indicating the person was experiencing moderate to severe levels of depression.

Exhibit 33. Depression Level of Caregivers at Initial Screen, FY15-17

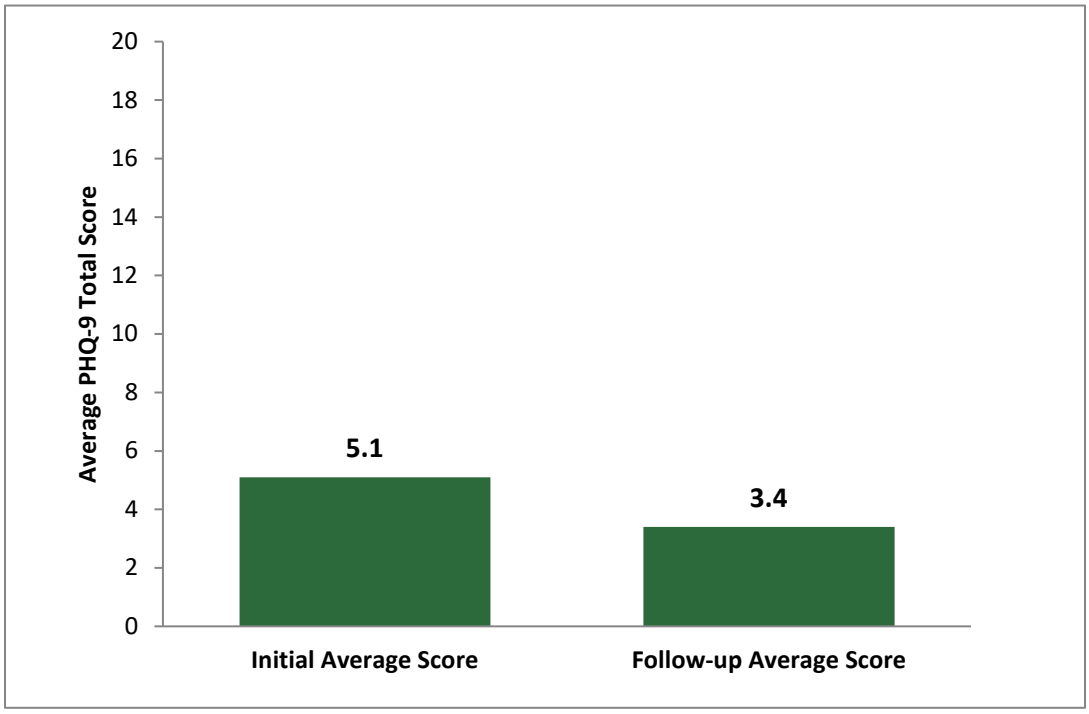


(n=629)

Comparison of Paired Initial and Follow-up PHQ-9 Scores

A total of 141 caregivers completed both an initial and follow-up PHQ-9 assessment over the past two FYs. Their initial (pre) and most recent (post) assessment scores were used to examine change in total scores over time. A Paired-Samples T-Test (see Exhibit 34) revealed that the total average PHQ-9 score decreased significantly from initial (average of 5.1) to last (average of 3.4) assessment (t=4.820; df=140; p=.000), which is an average reduction of 1.68 points. The length of time between pre and post assessment ranged from one to 16 months and averaged 6.9 months (3.9 SD). **These results suggest that participants of the Home Visiting Program who completed both a pre and post PHQ-9 assessment demonstrated a significant reduction in depression symptoms experienced by caregivers over time.**

Exhibit 34. Average PHQ-9 Score at Initial and Follow-up Assessment, Paired Sample



(n=141; t=4.820; df=140; p=.000)

Conclusions and Recommendations

This evaluation report for FY16-17 covers the time period from July 1, 2016 through June 30, 2017. The focus of this evaluation is to examine process and outcome data of the Home Visiting Program; and consult and assist CCA in meeting requirements for the FTF statewide evaluation. The Home Visiting Program continues to produce favorable process and outcome evaluation findings, which have remained consistent over time. Key findings include:

- Caregivers are satisfied with and find services helpful, especially their Parent Educators.
- Program staff are providing high quality services to families that meet or exceed the PAT National Center's Essential Requirements and Standards for PAT Affiliates (2016).
- Client participation data shows that the program has improved in providing families with more services in FY16-17, compared to FY15-16 data. Families served in FY16-17 received 11,488 home visits, which is a 17% increase from the 9,782 home visits in FY15-16). Families completed an average of 32.6 home visits in FY16-17 (range of 1-152 home visits per family), an increase compared to an average of 26.7 home visits (range of 1-131 visits in FY15-16).
- Looking at completion rate data for visits attempted and completed in FY16-17 only, 92% of families with a high needs status and 99% of families with a non-high needs status had a home visit completion rate of at least 75% of the required number of visits completed per month. These results exceed the PAT National Standard of at least 60% of families, for both types of families.
- The program is differentiating services based on family needs, providing more intense services, including more CM+PE services and more home visits per month to families with higher needs.
- The program held 23 parent group connections with varying themes in FY16-17. To better meet the needs of families, this past year the program offered group connections on two Saturdays and held events at multiple locations to accommodate the different areas where families live in the service area.
- Caregivers are improving their parenting quality and skills over time, according to KIPS pre, post, and change scores.
- Families are adequately setting goals, and are meeting or working towards them at an adequate rate. The program has a low goal abandonment rate of 7% of goals set.
- Children are being adequately screened by trained Parent Educators in five developmental, sensory, and health areas, measuring a child's developmental progress and identifying potential delays that require referral to an external resource for further assessment and intervention.

- Caregivers are being adequately screened for depression and Parent Educators are following the program's intervention protocol for depression management (based on total score/depression level).
- Of those who exited the program in FY16-17, 54% completed the program per the PAT model, which is an increase from 39% in FY15-16.

The Home Visitation Program should continue in its role in providing high quality home visiting services in the service area, utilizing the PAT model with a high level of fidelity. Based on the findings presented in this report, the following recommendations are provided.

1) Continue to examine the program's longitudinal caregiver data to examine family retention and outcomes, specifically those who receive Case Management services.

The Home Visiting Program should continue to examine caregiver retention, participation, and exit data, to understand factors that impact the retention of clients in the program. Additionally, the program should continue with conducting monthly exit interviews with clients who exited in the previous month for reasons of discontinued services or not able to be located by their Parent Educator. The combined results of these studies will help the program better understand reasons for program attrition and further develop retention strategies. Additionally, the program should continue to track data on Case Management receipt and referrals, so that the evaluation team may analyze the impact of this value-added service on client retention and outcomes (see LeCroy & Milligan Associates, 2017 for a more in-depth analysis of Case Management services provided to families).

2) Continue to evaluate family outcomes at initial and follow-up intervals and analyze change in outcomes over time, ensuring that data collection intervals are accurately completed and results are recorded by staff.

The Home Visiting Program should continue the practice of collecting paired pre and post client outcome data, using the KIPS assessments, the LSP, and the PHQ-9 instrument. Parent Educators should ensure that the interval of data collection (e.g., intake, ongoing, exit, etc.) is accurately recorded to facilitate paired analysis across time points.

3) Examine Home Visiting Program fidelity to the PAT national model standards.

LeCroy & Milligan Associates is experienced in conducing fidelity assessments to curriculum-based standards. The Home Visiting Program should consider utilizing the evaluation team as a resource to annually assess the extent to which the Home Visiting Program is meeting PAT national standards, similar to the way this report aligns process and outcome findings with the PAT National Center's Essential Requirements.

4) **Consider client recommendations provided through the satisfaction survey, when reported by the evaluation team on a quarterly basis.**

The Home Visiting Program should consider the recommendations that clients made in response to the Client Satisfaction Survey as suggestions for improving the program. Recommendations that were given by three or more people are shown below, with the number of respondents indicated in parenthesis.

- Hold group activities/classes on other days (e.g. weekends) or times
- Offer home visits more often and longer home visits
- Offer more group activities
- Provide more instruction on behavior management
- Ensure that home visits accommodate needs of multiple children (e.g., more time)
- Offer programming in other geographic areas where families live.

Limitations

A limitation of this evaluation is that it does not employ a quasi-experimental or experimental study design that utilizes a control or comparison condition to assess how families who do not receive the Home Visiting Program intervention fare in terms of outcomes measured. This evaluation utilizes a pre-test post-test study design, so results may be due to extraneous factors that are not measured as part of this study. Statistically significant findings reported indicate a correlation or a relationship between variables, however the results are limited in how they can be interpreted in terms of attribution to the program model.

References Cited

Bamburger, M., Rugh, J., & Mabry, L. (2006). Real World Evaluation: Working under budget, time, data, and political constraints. Thousand Oaks, CA: Sage.

Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. Psychometrika. 16, 297-334.

Comfort, M., & Gordon, P. R. (2006). The Keys to Interactive Parenting Scale (KIPS): A practical observational assessment of parenting behavior. *NHSA Dialog: A Research-To-Practice Journal for the Early Intervention Field, 9*(1), 22–48.

Comfort, M., Gordon, P. R., English, B., Hacker, K., Hembree, R., Knight, C. R., & Miller, C. (2010). Keys to Interactive Parenting Scale: KIPS shows how parents grow. *Zero to Three Journal, 30*(4), 33–39.

Comfort, M., Gordon, P.R., & Naples, D. (2011). KIPS: An evidence-based tool for assessing parenting strengths and needs in diverse families. *Infants & Young Children, 24*(1), 56-74.

Comfort, M., Gordon, P. R., & Unger, D. G. (2006). Keys to Interactive Parenting Scale: A window into many facets of parenting. *Zero to Three Journal, 26*(5), 37–44.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Kroenke, K., Spitzer, R.L., & Williams, J.B.W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9),606-613.

LeCroy & Milligan Associates, Inc. (2013). *Child Crisis Center/MyChild'sReady Program: Relationships of Client Characteristics to Attrition and Program Completion*. Tucson, AZ: Author.

LeCroy & Milligan Associates, Inc. (2014a). *Child Crisis Center/MyChild'sReady Parents as Teachers Program Client Retention Study: Relationships of Client Characteristics, Characteristics of their Parent Educators, and Program Completion or Attrition*. Tucson, AZ: Author.

LeCroy & Milligan Associates, Inc. (2014b). *MyChild'sReady Home Visitation Alliance Collaboration Assessment.* Tucson, AZ: Author.

LeCroy & Milligan Associates, Inc. (2017). *Child Crisis Arizona Home Visitation Program: Case Management Services and Family Participation and Outcomes*. Tucson, AZ: Author.

Nunnaly, J. (1978). *Psychometric Theory*. New York: McGraw-Hill

Parents as Teachers. (2016, May). *Quality Assurance Guidelines for Parents as Teachers Affiliates*. St. Louis, MO: Author.

Patton, M.Q. (2008). *Utilization-Focused Evaluation, 4th Edition*. Thousand Oaks, CA: Sage.

Patton, M.Q. (2011). (2011). *Essentials of Utilization-Focused Evaluation*. Thousand Oaks, CA: Sage.

Spitzer, R.L., Kroenke, K., & Williams, J.B. (1999). Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. Primary Care Evaluation of Mental Disorders. Patient Health Questionnaire. *Journal of the American Medical Association, 282*(18), 1737-44.

Wollesen, L., & Peifer, K. (2006). *Life Skills Progression. An outcome and intervention planning instrument for use with families at risk*. Baltimore, MD: Paul H. Brooks Publishing Co.