HOME VISITING EVALUATION

Researching Implementation Support Experiences

RISE Home Visiting Evaluation Rural Case Study Brief Report

This brief report describes findings from a qualitative case study of four rural evidence-based home visiting (EBHV) programs in Washington State conducted as part of the Washington Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Researching Implementation Support Experiences (RISE) Home Visiting Evaluation study. The RISE Home Visiting Evaluation was a four-year study that ran from fall of 2013 to fall of 2017. The rural case study was conducted in the last year of the evaluation and focused on describing factors that are key to supporting rural home visiting programs in implementing evidence-based home visiting.

Brief Summary of Findings

Key findings across sites included:

- **Successful hiring and retention** of the appropriate staff is important for a home visiting program's long-term success.
- Once hired, **staff who feel supported are more likely to stay**. Pay and quality of life (e.g., hours worked, travel burden, paperwork burden, feeling supported by leaders and peers) have an impact on staff mental health and morale.
- A growing proportion of home visitor staff time is now spent on **documentation and data collection**, although thus far, programs have had limited success in using these data to inform their practice.
- Staff dissatisfaction leads to **turnover**, which then contributes to **client attrition** (i.e., many clients of departing home visitors exit the program due to loss of the relationship) and lower program capacity (i.e., new home visitors need training and carry lower caseloads.
- The ability to **maintain full caseloads** and **operate at maximum capacity** is important for a program's long-term success, and a **strong referral network** is necessary for maintaining full caseloads. Referrals are a product of trust built between two agencies; this relationship-building requires time and energy and is often disrupted when key staff turn over.

Background and Context

Washington's MIECHV grant goals included building a centralized support system for home visiting programs, and rural development.

In 2012, the Washington State Department of Early Learning (DEL) was awarded competitive grant funding through the federal MIECHV program to expand the implementation of evidence-based home visiting (EBHV) in the state.

One priority of Washington's grant application was to build an Implementation HUB, in partnership with the non-profit Thrive Washington, that would act as a centralized support system for home visiting programs in order to improve organizational capacity, model fidelity, and quality of service delivery. By providing supports including continuous quality improvement (CQI), program monitoring, model-specific supports, coaching, training, and technical assistance (TA) using Implementation Science frameworks, the HUB would work to:

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

Another related priority area for the state was rural development, with the goal of building the home visiting system's capacity to reach Washington's rural and frontier areas. Given this, MIECHV funds were used both to expand existing EBHV programs already serving rural communities (hereafter referred to as expansion programs), as well as to start up new programs in areas that did not have EBHV (hereafter referred to as start-up programs).

Description of Evaluation

DEL hired SRI International in fall 2013 to conduct an evaluation of the MIECHV grant activities. SRI's evaluation, known as the RISE Home Visiting Evaluation, was designed to (1) measure the progress and impacts of the Implementation HUB's centralized support system on participating programs and staff and (2) meet the federal funding requirement associated with the competitive MIECHV expansion grant to conduct a rigorous evaluation that will contribute to the national body of research and knowledge on implementing EBHV programs on a large scale.

The evaluation focused on programs that are implementing Parents as Teachers (PAT) and Nurse-Family Partnership (NFP), two EBHV models that are the target of Washington's MIECHV expansion funding. The rural case study we describe in this brief report represents one component of the RISE Evaluation. Evaluation findings are interpreted through an Implementation Science lens, since DEL and Thrive utilized an Implementation Science framework to inform the development of the HUB and guide its work with programs.

Implementation Science describes several stages of program implementation, including Exploration, Installation, Initial Implementation, and Full Implementation. It also identifies several implementation drivers that are critical to successful implementation: competency drivers (selection, training and coaching), leadership drivers (technical and adaptive leadership), and organization drivers (systems intervention, facilitative administration, decision support data system). The findings of the rural case study are discussed in these terms.

The rural case study represents one component of the RISE Evaluation.

Purpose of Rural Case Study

The purpose of this rural case study was to describe programs' experiences implementing EBHV within their rural communities, including their experiences expanding or starting up services using MIECHV funds, perceived successes and challenges of implementation, and receipt of implementation supports from Thrive Washington and other entities. The Implementation HUB at Thrive played an integral role in disbursing funds and providing various implementation supports to EBHV programs, including facilitating two rounds of a community planning process, described in more detail below.

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[1]For the complete Year 4 RISE Evaluation report, see Schachner, A., Gaylor, E., Chen, W., Hudson, L., & Garcia, D. (2017). RISE Home visiting evaluation: Final evaluation report, Selected findings from Year 1 and Year 4 of the evaluation. Menlo Park, CA.

[2]See the National Implementation Research Network (NIRN) website for more details: http://nirn.fpg.unc.edu/learn-implementation/implementation-drivers

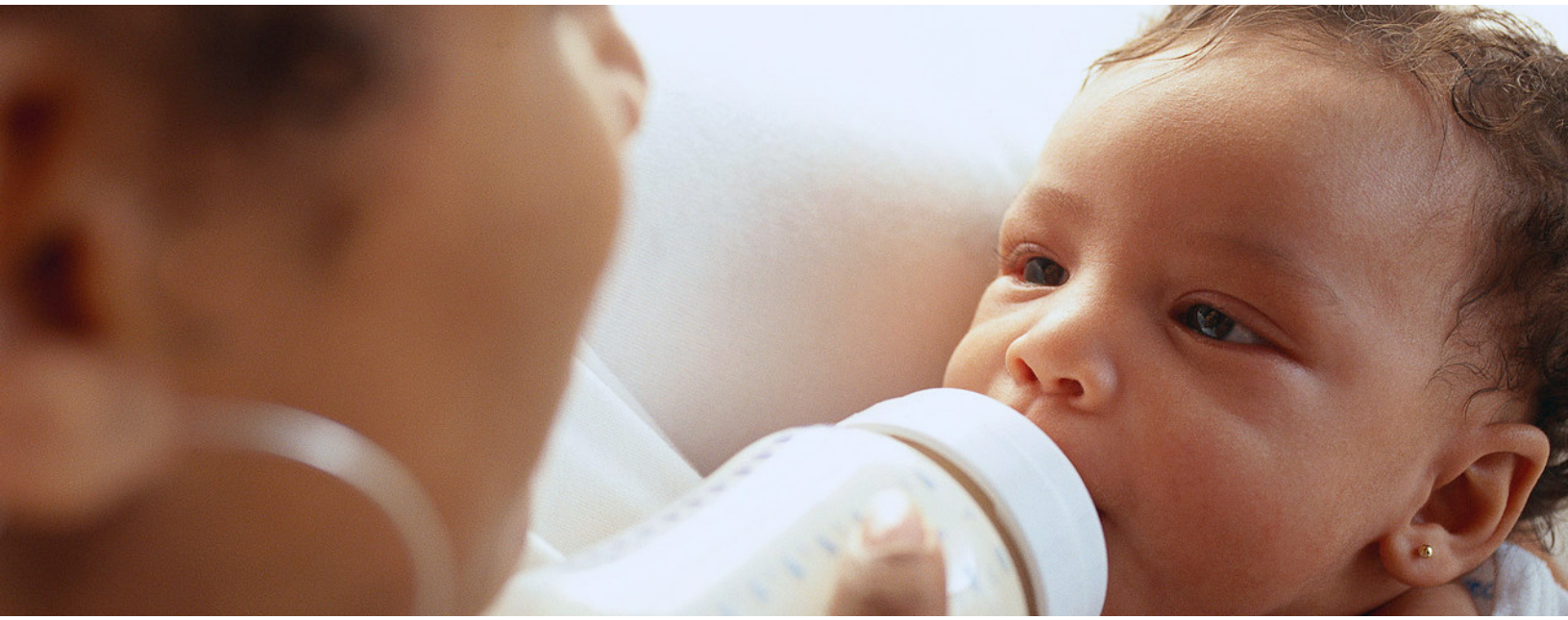
Community Planning Process

To help meet the rural development goals of Washington's MIECHV grant, HUB staff at Thrive (with assistance from consultants) undertook a community planning process designed to build capacity in rural communities for starting up and successfully sustaining new EBHV programs.[3] In late 2012, staff used the state needs assessment and conversations with state-level key informants to identify five rural communities to invite to participate in the planning process. Staff then traveled to each community to facilitate multiple meetings (three, on average) among various stakeholders in order to help community members assess their resources, needs, and readiness to implement EBHV.

HUB staff's facilitation of the process entailed identifying key stakeholders, convening the meetings, sharing funding guidelines, presenting information about the PAT and NFP models through national representatives or the state leads, and preparing the stakeholders to select a model and endorse a lead implementing agency. This first round of meetings was considered "Phase I" of the community planning process and lasted approximately 6–7 months. Four of the five communities completed Phase I and submitted applications for the funding. Based on their readiness for implementation, three of the four applicants were then awarded funding.

"Phase II" of the community planning process for awardees then consisted of another series of three meetings. First, HUB and implementing agency staff jointly conducted a Parent Café where they convened community parents to

[3]Additional information and resources about the community planning process including a fact sheet, theory of action, lessons learned brief and continuum of strength and preparedness can be accessed at https://thrivewa.org/work/expanding-hv/

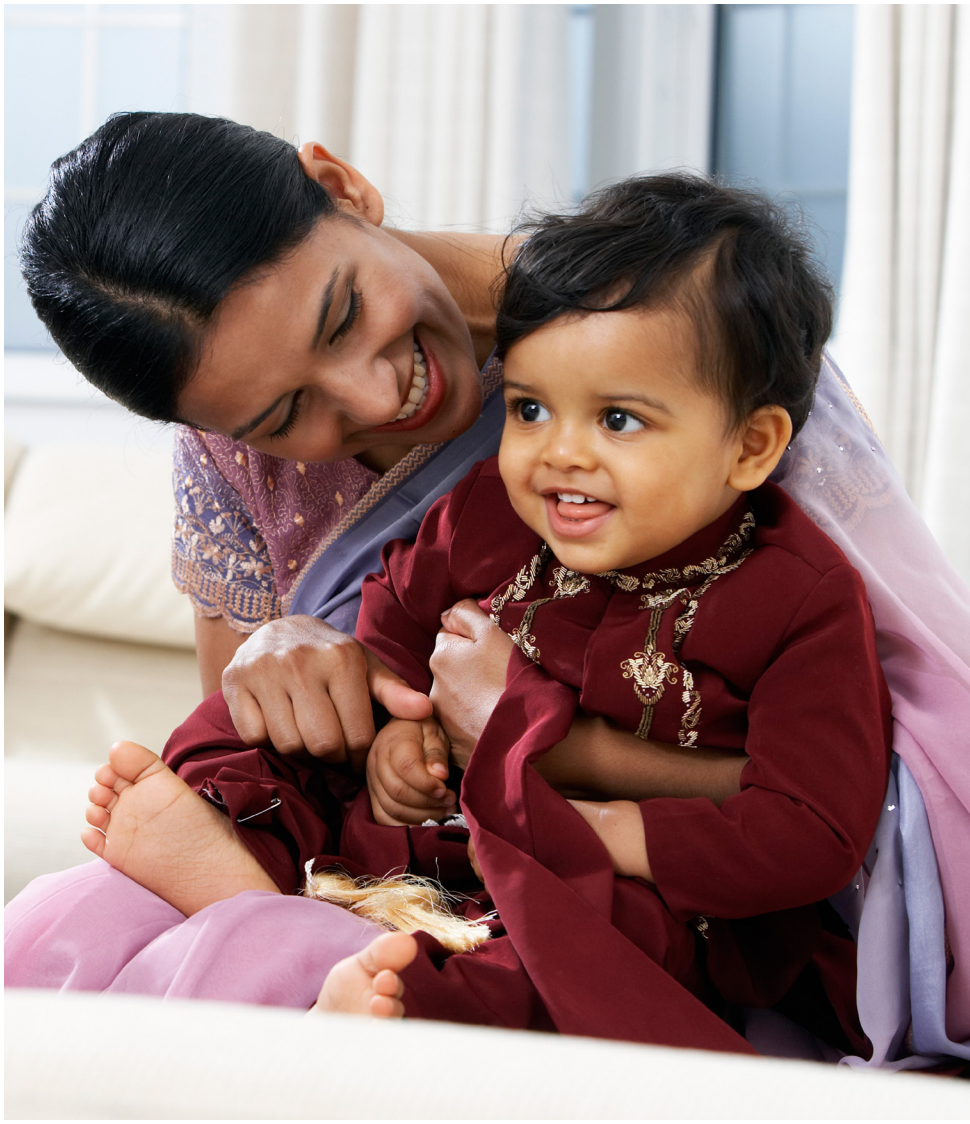


inform how the agency would implement the EBHV program, including discussing outreach and retention strategies. The agency then participated in a joint TA meeting with HUB staff and the state model lead to discuss their capacity assessment and draft an affiliate plan; all three funded communities chose to use the PAT model so they worked with the PAT state lead to obtain affiliate status.

The final step of Phase II involved bringing community stakeholders back together to finalize the implementation plan, ensure referral pathways were in place, and invite stakeholders to join the advisory board for the new program. During Phase II, support of the implementing agencies was transferred from the community planning personnel to the state model lead and other TA providers at the HUB. The role of the former corresponded to the Exploration Stage of the Implementation Science stages, and the role of the latter corresponded to the Installation and Implementation Stages. Later in this report, we profile the implementing agency in one of these communities, Alder Community Health Center, as an example of a start-up program that experienced the community planning process.

After the state obtained additional MIECHV grant funding, a second round of the community planning process was launched in 2015. Three rural communities participated in the process and applied for funding, and one was funded. The second round of the process differed from the first in a few key ways: it was faster-paced (lasting approximately 4.5 instead of 6–7 months); the PAT state lead had transitioned from supporting Washington through the HUB to supporting the Northwest region through the PAT NSO, changing the support structure for Washington PAT programs and prospective affiliates; and an external review process was used to make funding decisions.

The community planning process embodied the Exploration Stage of Implementation Science.



Data Collection Methods and Sample

Data were collected for the rural case study in two phases. The first was a planning phase (January–February 2017) that consisted of interviews with key informants at DEL and the HUB, accompanied by a review of relevant written documents, to learn about the history of the rural development work and community planning process. Through these interviews, the evaluation team heard from DEL and HUB staff about their role in administering the MIECHV funds and supporting rural programs' expansion or start-up. We also heard about their perceptions of the successes of implementing EBHV in rural communities, and of the community planning process in particular, as well as the challenges or barriers faced.

This information prepared us for the second phase of data collection (March 2017), which consisted of site visits to four of the rural communities receiving MIECHV expansion funds. These sites were selected to represent four different categories, or types, or programs: 1) expansion site, rural only, 2) expansion site, mixed rural and urban, 3) start-up site, participated in community planning process, and 4) start-up site, did not participate in community planning process.

We used information gathered during the planning phase to develop interview and focus group protocols to use with program leaders (i.e., supervisors and administrators) and home visitors, respectively. The protocols focused on understanding the history of the EBHV program and the agency housing it, the context of the rural community the program serves, program staff's perceptions of the successes and challenges of implementing EBHV in that community, experiences pertaining specifically to expansion or start-up, and program staff's experience of implementation supports from the HUB and other entities.

Data collected across these two phases were then systematically analyzed to generate the findings described below.

Lessons Learned from the Sites

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

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

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

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

The rural nature of the programs was only one factor that influenced their ability to implement EBHV.

Lessons learned from Alder Community Health Center (start-up with community planning process)

Alder Community Health Center (ACHC) serves a primarily agricultural community located on the eastern side of the state, with a population consisting largely of immigrant Hispanic farmworkers. The agency was founded in the 1970s as a grassroots community health clinic aiming to meet the needs of underserved migrant workers and has grown into a multi-site organization offering a comprehensive system of care. In addition to core medical, dental, optometry, pharmacy, and laboratory services, the agency provides a range of family support services, including Women, Infants, and Children (WIC), Maternity Support Services (MSS), and behavioral health programs.

ACHC's service area includes the entirety of one county and portions of two neighboring counties. In 2011, the state needs assessment identified ACHC's primary service county as having high poverty and a high teenage pregnancy rate, and the agency was invited by Implementation HUB staff to participate in the rural development community planning process. Following their participation in the planning process, the ACHC community successfully applied for MIECHV funds to open a new PAT program.

The ACHC PAT program start-up was by all accounts successful, due in large part to the agency's participation in the rural development community planning process. Staff attributed their success to a number of conditions, some that resulted from undergoing the planning process. First, the process fostered

cooperation and buy-in from key players across the community, which created a strong referral network for the PAT program. A program leader said,

For us, [the community planning process] was a win-win because along the way we establish the collaboration between the community partners. On day one, we already had people, eligible families for the program. In fact, by the time we trained -the first group of [home visitors], within a month, I think, we already had half a-a caseload waiting to enroll in the program. dozen. I think it took us two months to reach our caseload capacity. So everything kind of just fell into place for us.

In the language of Implementation Science, investing time and energy into the Exploration Stage created "conditions of success" that allowed ACHC to install and implement the PAT program efficiently and effectively. Agency leaders felt the community planning process worked so well that they aimed to use it to facilitate a future expansion of their services.

Second, choosing the PAT model for its flexibility around hiring facilitated the creation of a staff that connected well with, and was extremely dedicated to, the client population. They prioritized hiring home visitors who were most able to connect with and understand their clients, often via a close match in language and culture. The PAT model has less restrictive formal education requirements and would allow for a broader applicant pool, better enabling the agency to meet their hiring needs. The home visitors were also cohesive and mutually supportive as a group.

Third, program leaders expressed that staff flexibility is what ultimately enabled full caseloads; home visitors were willing to work nontraditional hours to meet the clients' needs. Also, driving long distances to visit families was less of a challenge for home visitors at ACHC because they were able to employ a regional model in which each staff member served a particular area. Although their clients moved often, it was usually within the same small area. Lastly, staff turnover was low because dedication to the families was high, and support for staff at all levels was also high, further increasing employee commitment.

Participating in the community planning process helped set ACHC up for successful program implementation.

Cedar experienced many implementation difficulties; it is possible some could have been avoided if they had been given dedicated planning time.

Lessons learned from Cedar County Health Department (start-up without community planning process)

Cedar County is a scenic rural county, naturally beautiful with sweeping views of rivers and trees. The area suffered a significant loss of jobs beginning in the late 1980s with the decline of the lumber industry, and Cedar was identified through the 2011 statewide needs assessment as a high-need county. The health department, which has a long history of providing maternal and child health services, was awarded (without engaging in an application process) MIECHV funds to start an NFP program. Although not ideal for planning, this experience was far from unusual; rapid disbursement of funds was an expectation of the MIECHV grant, so expedited EBHV program start-up or expansion was common practice in many states. The Cedar County NFP program operated for the duration of the MIECHV grant but closed at the end of 2016 due to intractable operational challenges.

The experience of the Cedar NFP program highlights what, in retrospect, could have been done differently to better set the program up for implementation success. The overarching lesson from the Cedar program is that simultaneously conducting start-up work (e.g., gaining the buy-in of key players in the community, building a referral network, learning the EBHV model) and implementation made the program particularly susceptible to implementation challenges. For example, over the course of implementation, Cedar learned that they needed to increase the home visitor position salary in order to attract and retain qualified staff. However, being housed in a governmental agency with union pay scales prevented this, which in turn resulted in an inability to reduce persistently high staff turnover. If Cedar had been given the opportunity to go through the Implementation Science stage of Exploration rather than immediately entering into Installation, it is possible that Cedar would have identified the county commissioners' unwillingness to alter the pay scale as a "deal breaker" early on, or could have taken steps to try to obtain the commissioners' buy-in prior to committing to program start-up.

Cedar also learned that an EBHV program needs a robust referral network in order to be successful in the long term. This requires staff to spend time building relationships with partners, helping them see value in the service being offered, and dispelling any view of their program as competition to the partners. Again, Cedar did not have an opportunity to do this type foundational work prior to program installation and thus needed to concurrently build the referral relationships and their caseload, perpetuating conditions for low caseload. Since they came into the MIECHV grant not having

specifically chosen the NFP model, Cedar also needed much more support in learning the model and understanding how to integrate it into their agency. This was made even more challenging by the need to simultaneously move forward with the tasks of program implementation, such as hiring staff and enrolling clients.

Cedar administrators expressed sadness and a profound frustration at the circumstances that made their program close. They had invested years of time and energy into start-up efforts and relationship building, learned many useful lessons through trial and error, and importantly, provided families with a valuable service. One leader expressed,

> *We worked so hard to get the program up and running and it was doing well and it was well received in the community and we know it benefits the client. It just felt so terrible to know that our commissioners were not willing to find a way to fund qualified staff to keep [home visitors] in our community, to keep services in our county.*

Despite the disappointing end to the Cedar County NFP program, NFP programming is, fortunately, still available to families in the Cedar area through a "regional model" of NFP implementation; beginning in early 2017, EBHV grant funding is being disbursed to and administered by a neighboring county's NFP program that hires, pays, and supervises home visitors who serve Cedar families.

Lessons learned from Pine County Health Department (mixed rural/urban expansion site)

Home visiting staff described the Pine community as friendly and engaged – a place where people look out for each other – but also very diverse with several different populations and pockets of people including farmworkers, students seeking professional education, and an environmentally conscious, naturalistic subculture. Historically, the main industries were lumber and agriculture, but in the last 20 years the area has seen an influx of new infrastructure and types of employment that attract a different population of residents.

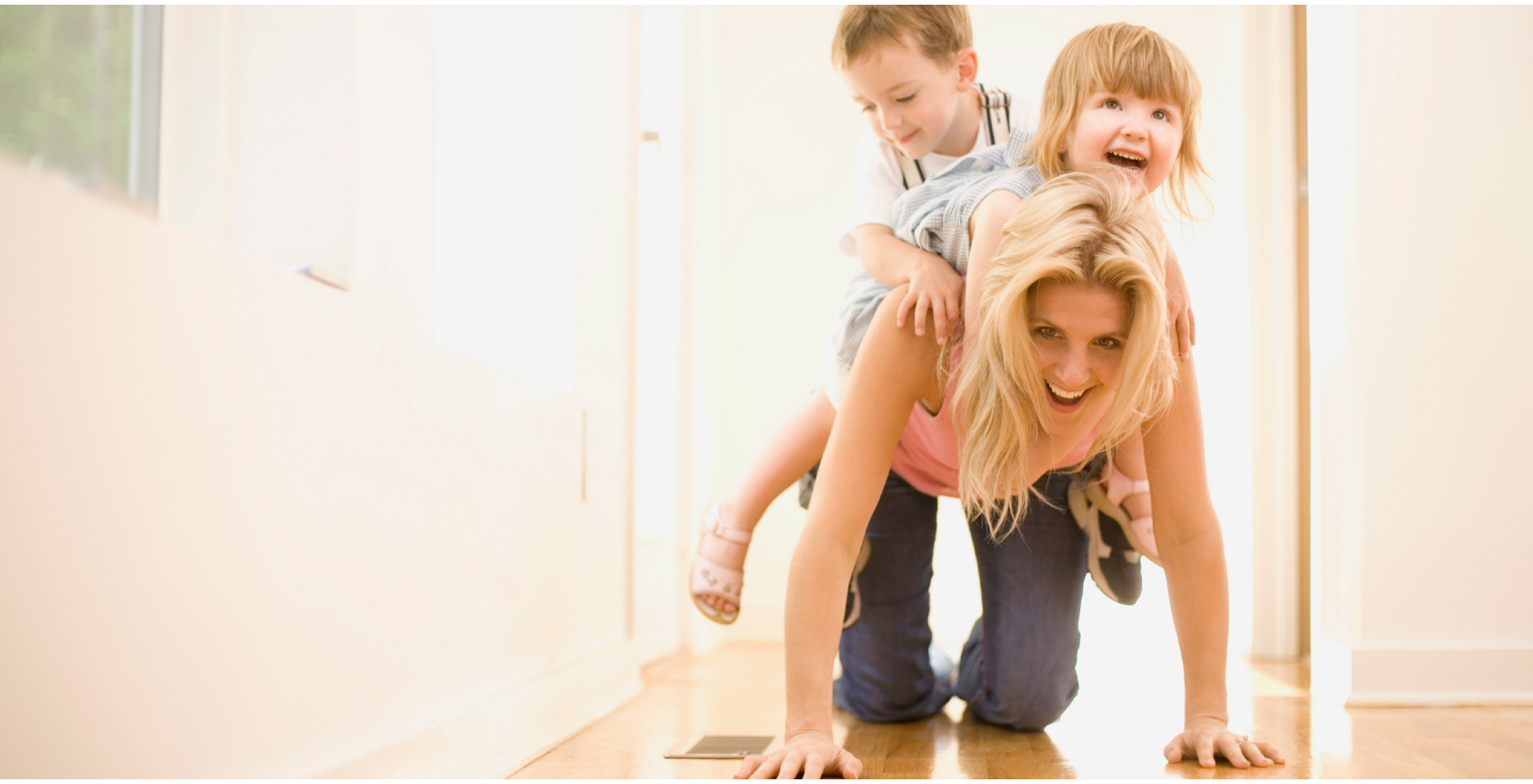
The Pine NFP program is located in the county health department and serves the county, which includes a large geographic area with clients typically residing 30–90 minutes away. The program opened in 2006 through a federal grant enabling the health department to partner with the local educational service district to conduct violence prevention work. This grant ended in 2010 and the NFP program

was at risk of closing until the county obtained MIECHV expansion funds in 2012. During the uncertain transition period, nearly all of the home visitor positions turned over. However, strong leadership and consistency in the program administration have been important drivers for success.

Conditions that enabled Pine's success included having strong community coalitions, professional support provided by the program leaders, and highly qualified staff. Pine home visitors and program leaders credited the supportive, involved, and caring community as a key condition for success, particularly the presence of strong community coalitions around early childhood, breastfeeding, and teen pregnancy.

Home visitors felt that the professional support that they received from program leaders through reflective supervision, encouragement for self-care, and opportunities for training were key for the home visiting program to realize success and impacts with families:

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



Program leaders also implemented strategies for improving home visitors' day-to-day experience of their jobs. For example, they aimed to increase personal safety by having staff share calendars so they were aware of each home visitor's scheduled destinations, and they accompanied home visitors on visits if a potentially dangerous situation was anticipated. They attempted to reduce travel burden by assigning home visitors to geographic service areas, but, as discussed above, this strategy was ineffective because the client population is very transient and frequently moves between areas.

Also critical to the success of the program and supporting the implementation of EBHV was having qualified home visiting staff, a supervisor and an administrator who have values consistent with the model's foundation, and adherence to model fidelity in their various roles. Staff also emphasized the value of having home visitors who have experienced adversity and who have similar backgrounds to clients that they are serving, such as assigning a home visitor who is also a single mom to work with single mothers.

Another lesson learned from the Pine experience is that maintaining consistently full caseloads can be difficult without a robust referral network. The Pine EVHV program previously received many referrals from the WIC program, which until recently had been co-located at the Pine County Health Department. With the loss of that direct connection, staff were actively working to build referral relationships with other programs and agencies. Strategies included making in-person visits to potential partners and putting ads on the Spanish-language radio station.

Lessons learned from Spruce Family Services (rural expansion site)

Home visiting staff described the community that Spruce Family Services serves as bountiful geographically and agriculturally, with a population that ranges from immigrant agricultural workers in small mountainous regions to more ecologically minded residents living in areas with a steady flow of tourists. Although most clients live 20 minutes to an hour away, some home visitors serve clients in areas that take multiple hours to reach.

Spruce Family Services is a longstanding non-profit community agency that began its work by providing Maternity Support Services (MSS) and infant case management supports. Leaders were seeking ways to serve families beyond the child's first year of life and to address the prevalence of substance abuse in their community when, they launched a family support program with a three-year grant from the Council for Children and Families. They then transitioned to a PAT program that they were able to fund on a short-term basis using behavioral health funds collected via

Strong and consistent leadership at Pine was a key factor contributing to their success.

The Spruce EBHV program benefited from being housed within an agency that provided many internal referrals.

a county sales tax until they received MIECHV expansion funds in 2012. In addition to MIECHV funding, the program continues to receive funding through the county sales tax and is able to leverage both funding streams to serve a larger population of families.

Key factors that enabled the success of the Spruce EBHV program include characteristics of the agency in which the EBHV program is housed, braiding multiple funding streams, and the qualities and commitment of the staff. The PAT program is located in a well-established, non-profit agency and most families already have heard of or know about the agency before they are referred to EBHV; this promotes a sense of credibility and trust among families in the EBHV program.

Another key factor in Spruce's success was the co-location of the EBHV program and multiple other maternal and child programs, such as Maternal Support Services (MSS), infant case management services, Parent Child Assistance Program (PCAP) for mothers struggling with substance abuse, Medicaid, a drop-in center, a postpartum depression support group, and lactation consultation. As a result of this proximity, the EBHV program has a very strong referral network with the other programs and is better able to support the whole family. In essence, the agency serves as an informal centralized in-take for the community because it offers so many maternal and child programs. Additionally, program leaders also have staff work or at least train in more than one program, which helps to create cohesion and a more holistic approach to serving families. Cross-staffing and training across programs also strengthens referrals and communication across services.

Spruce program leaders reported being mindful of sustainability and the value of braiding multiple funding sources to allow for flexibility in meeting families' needs; for instance, the program is able to serve teen mothers who do not present with any other risk factors. By braiding funding, Spruce is able to bring in a variety of resources that a program that is solely MIECHV funded would not be able to do.

[Because we braid our funding,] we have the opportunity to find the right timing and match what the family's needs are with the right program at the right time.

However, a challenging byproduct of diversified funding is that the already-complex data collection requirements associated with conducting EBHV are further amplified by having multiple funders to report to. Despite efforts to summarize and explain to the home visitors the relationships with various funders, and the rationale behind each data collection task, documentation remained a source of frustration for many home visitors and program leaders.

The qualities and dedication of the staff were critical assets to the Spruce EBHV program's success and longevity. Program leaders noted that the PAT staff is diverse in their experiences and areas of expertise, including staff who were previously clients themselves, staff who provide EBHV services through PCAP, early childhood educators, and former nurses and mental health professionals. Leaders also acknowledged the need to promote self-care among home visitors, since many have experienced challenges in their own lives and are at risk for re-traumatization while working with clients. Home visitors also identified a need for more supports, both in the form of additional case conferencing with program leaders, and in increased opportunities to problem-solve and debrief with peers.

Discussion of Cross-Cutting Findings

Notable findings gleaned from across the four sites as are follows, with applicable Implementation Science drivers described wherever there is alignment:

- **Successful hiring and retention of the appropriate staff is important for a program's long-term success.** This is consistent with the Selection (Competency) Driver, under Implementation Science. Successful hiring is dependent on a program's ability to attract qualified applicants; this requires congruency between the offered working and living conditions (including pay, community characteristics etc.), and the requirements of the positions they are hiring for.
  - **Using nurses, who have high levels of formal education, as staff compounds hiring difficulties in rural communities that already have a restricted labor pool.** Health departments and hospitals also tend to have unionized workforces and more rigid pay structure rules, so an NFP program may not have any discretion in adjusting pay as a means to attract and retain staff. This was a challenge for the Cedar County NFP program, which needed to hire bachelor's-level nurses using a pay scale that was too low to be attractive. Hiring and retention was less of a challenge for the Pine County NFP program, possibly due in part to their location being more desirable, and higher pay.
  - **The PAT model allows for more flexibility in hiring.** PAT programs can hire individuals with lower formal education but who may better reflect and connect with clients. The drawback is the program may need to conduct more in-service training of paraprofessionals once hired, but some programs are willing to accept this trade-off. ACHC used this strategy, as did Spruce, where some home visitors were former clients.
- **Once hired, staff who feel supported are more likely to stay.** Support can come from leaders (through formal supervision, moral support, and setting the tone and priorities of the program), from peers (through informal opportunities to debrief and "unload," and formal case-conferencing), and opportunities to grow their skills (through availability of training and professional development). This is consistent with a number of Implementation Drivers, including the Training and Coaching (Competency) Drivers, the Facilitative

Administration (Organization) Driver, and the Leadership Drivers. The level of peer support at ACHC was notably high; leader support at Pine was notably high; Spruce home visitors described adequate peer support but desired more leader support; and Cedar did not have consistently strong leader or peer support, as they struggled with persistent turnover of both home visitors and supervisors.

  - **Pay and quality of life (e.g., hours worked, travel burden, paperwork burden, feeling supported by leaders and peers) have an impact on staff mental health and morale.** *The Cedar program closed due to an inability to retain staff, which resulted largely from low pay and overall low support. Spruce also experienced a higher rate of home visitor turnover.*

- **A growing proportion of home visitor staff time is now spent on documentation and data collection, although thus far, programs have had limited success in using these data to inform their practice.** This represents a Decision Support Data System (Organization) Driver challenge. Duplicative data collection was particularly frustrating for program staff; they felt that at times they were reporting the same data in multiple places (e.g., for MIECHV benchmarks, to the models, Thrive, and other funders) and expressed a need for more coordination or data sharing among funders. This was expressed by staff at all four sites. The paperwork burden also negatively impacts home visitors' overall job satisfaction. Spruce was particularly impacted by this, likely due to their funding coming from multiple sources. The increase in data collection requirements also has implications for hiring staff. Paraprofessionals who have less formal education and computer experience may find it particularly challenging to meet this demand of the position. This was the ACHC experience.

- **Staff dissatisfaction leads to turnover, which then contributes to client attrition (i.e., many clients of departing home visitors exit the program due to loss of the relationship) and lower program capacity (i.e., new home visitors need training and carry lower caseloads.** *This was a challenge for Cedar; it is unclear if home visitor turnover at Spruce impacted client attrition, but they operated at full capacity, largely due to a strong referral network.*

- **The ability to maintain full caseloads and operate at maximum capacity is important for a program's long-term success,**

and a strong referral network is necessary for maintaining full caseloads. Having other programs, such as WIC or MSS, co-located within an agency to refer from internally can be a major advantage. *ACHC and Spruce had this, while Pine and Cedar did not.* Building a robust external referral network is also important; fostering collaboration instead of competition among community agencies makes this possible. Potential conflicts over "turf" can be avoided by establishing agreed-upon upon referral guidelines based on client characteristics and program priorities. This is consistent with the Systems Intervention (Organization) Driver. *Cedar had difficulty gaining referrals because other agencies viewed them as competition for clients, despite the fact that potential clients outnumbered available slots; they needed to bring HUB staff in to mediate.*

  - **Referrals are a product of trust built between two agencies; this relationship-building requires time and energy and is often disrupted when key staff turn over.** *This was a challenge for the Pine and Cedar programs.*

- **The community planning process that ACHC experienced created many of the "conditions of success" described above, such as successful hiring and retention of staff, and ability to maintain full caseloads and operate at maximum capacity, and positioned the agency to more efficiently and effectively start up and sustain their EBHV program.** The successes of the planning process demonstrated that investing in Exploration as an Implementation Science stage leading up to and distinct from Installation is worthwhile in the long term. The community planning process fostered support (buy-in) for the new ACHC PAT program from across the community, and promoted cross-agency collaboration rather than competition. It enabled the community to make an informed choice of EBHV model that best fit their needs; PAT allowed flexibility in visit content and staff hiring. A strong internal and external referral network, built through cross-agency collaboration, allowed them to quickly reach and maintain maximum program capacity. And finally, the flexibility in hiring allowed for the creation of an effective and cohesive staff, which contributed to low turnover.

  In general, the community planning process was viewed positively enough that ACHC staff reported wanting to use it internally as part of future efforts to expand their services. DEL and Thrive HUB staff also reported considering using it to develop capacity in other under-resourced communities, such as minority or immigrant communities.

  - **HUB staff observed that there were benefits to participating in the community planning process even for communities that went through the process but were not awarded MIECHV funding, because their level of preparation left them well-positioned to seek other sources of support.**
- **A challenge of the community planning process was that, with only two models, it was difficult for the facilitators to avoid giving the impression that the PAT and NFP models were in competition with one another.** Inherent characteristics of the process (i.e., constraints resulting from the funding amount and short timeline) also left NFP at a disadvantage. NFP programs are often housed within county health departments and hospitals, which have bureaucracies that require longer decision-making timeframes.
- **Rural communities often have more success implementing NFP using a "regional" or "mentoring" approach, in which a higher capacity county supports a neighboring lower capacity county via contracting of staff or supervisors.** This is because many rural county health departments are lower capacity departments that focus on enforcing health and

safety regulations, and do not independently have the infrastructure required to provide direct services such as NFP programming. This pooling of resources in order to better meet service delivery expectations is consistent with the Systems Intervention (Organization) Driver. *The Pine NFP program was able to provide contracted supervision to a neighboring county as the latter started its program, and the Cedar program ultimately employed a regional model by transitioning its client base to a neighboring county's program.*

- **HUB staff experienced both successes and challenges in supporting implementation of EBHV in rural communities.** Programs needed both model-specific and general operations support (e.g., with contracts), and they found support from the HUB to be invaluable, but also lacking in some ways. HUB staff reported their successes included model support provided by the NFP state model lead; the role it played as convener, bringing programs together and connecting them with one another; work conducted with programs on increasing their capacity for CQI; and rural development through the community planning process. Challenges faced included finding it harder to support the start-up of rural NFP programs; finding it harder to support rural programs that were smaller and had less capacity; contextual challenges among rural programs such as high staff turnover and the need for lower caseloads; and trying to dispel the "myth" that rural programs receive less TA than their urban counterparts because they are farther away.
  - **Programs cited staff turnover at the HUB, and the lack of an integrated PAT state model lead, as key barriers to their ability to access sufficient implementation supports.** The PAT programs generally felt that model-specific support was lacking, and at times in direct conflict with information received from the HUB. The need to increase supportive alignment across systems relates to the Systems Intervention (Organization) Driver.

Key Implications and Recommendations

Based upon the findings of the rural case study, we developed a set of key implications and recommendations for the HUB and state to consider as it continues to build its home visiting system and supports.

- **Use the community planning process whenever time and resources permit.** Dedicating time and energy to Exploration, as a stage leading up to and distinct from Installation, is worth the upfront investment, because it creates conditions that enable the agency to implement its chosen EBHV model more efficiently and effectively. Additionally, using the community planning process to prepare multiple communities to apply for competitive grant funding gives the granting entity latitude to fund only those communities that have demonstrated readiness to implement.
- **Get true buy-in, in the form of a deep commitment to facilitating a program's success, from the agency's key decision-makers, as this can be critical for the program's longevity.** Without a willingness from leaders to find creative solutions to problems that may arise, and at times, to challenge the status quo, some roadblocks to implementation may prove insurmountable.
- **Communities should choose an EBHV model keeping both client needs and program staffing needs in mind.** They must be able to meet the needs of the families, and the requirements of the model, with the applicants available to them in their particular community.
- **Support home visiting staff with a robust system of supervisory and peer supports to reduce burnout and turnover.** Opportunities for skill development, collective problem solving, and emotional "unloading" are important, as are policies demonstrating respect for home visitors' overall quality of life. The HUB and local program leaders can create a supportive environment for staff through both formal and informal means. The formal supports include reflective supervision and opportunities for professional development, while the latter includes instituting policies that value home visitors' daily experience and setting a warm and caring tone in the workplace.
- **Employ home visitors with varied backgrounds and a deep skill set to serve clients well, and support their continued professional growth and self-care.** Strategies can include holding meetings to address specific topics such as how to set boundaries with clients, and providing regular opportunities for home visitors to lighten their emotional burden through effective supervision and conferencing with peers.

- **Programs need a strong referral network to sustain their caseloads.** Relationship building with external partners is particularly important if there is no internal source of referrals.
- **If possible, co-locate an EBHV program with other maternal or child services within an agency.** Advantages include a ready source of referrals and a single point of entry into a network of services that may represent a more holistic approach toward serving families.
- **Open communication channels among local agencies to dispel the tendency to compete with one another for clients, and build referral relationships instead.** This may be best accomplished via third-party facilitation by a common funder, such as the Thrive HUB, or through existing community coalitions. Guidelines for matching clients to programs should be mutually agreed upon, so that slots at all agencies are filled, and families receive services that are the best fit for their needs.
- **Rural home visiting can be isolating work; programs value and are eager for more opportunities to stay connected and share across programs.** Rural program staff valued convenings that put them in touch with other individuals in similar roles facing similar challenges, because it enabled them to build relationships and provide mutual support. This benefit of having a centralized system where one entity can act as a common contact for others was perhaps unintentional, but should be fully leveraged as yet another means to support programs.

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