2014 PROGRAM STAFF INTERVIEWS REPORT

Florida Maternal, Infant, and Early Childhood Home Visiting Evaluation

University of South Florida

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This project is supported by the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative, Florida Association of Healthy Start Coalitions, Inc.

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INTRODUCTION AND METHODS

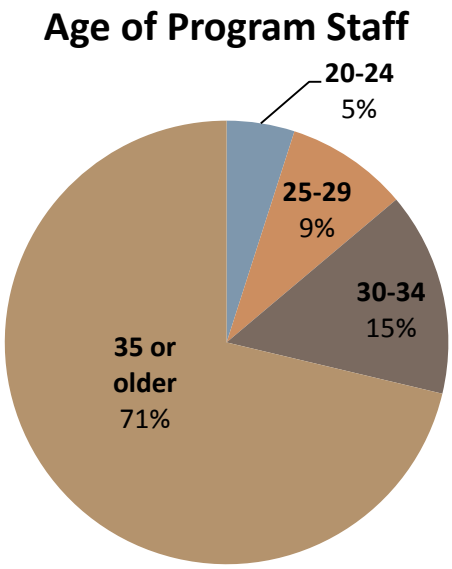
This report summarizes data collected as part of the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program independent statewide evaluation. During the fall of 2014, the University of South Florida MIECHV Program evaluation team conducted exploratory qualitative on-site interviews and focus group discussions with the 11 home visiting programs throughout the state of Florida (Alachua, Bradford/Putnam, Broward, Escambia, Duval, Hillsborough, Manatee, Miami-Dade, Orange, Pinellas, and Southwest) regarding how their programs are meeting the needs of families in their programs and communities. The current evidence-based models implemented by the programs are Parents as Teachers, Nurse Family Partnership, and Healthy Families.

The objective of this report is to describe various aspects of the Florida MIECHV Program from the perspectives of program administrators, supervisors, and home visitors. At each program site visit, the participants were divided into groups based on their current job position: administrators, supervisors, or home visitors. The MIECHV Program evaluation team conducted in-depth interviews and focus groups with program staff addressing topics that included: 1) the strengths of their program, 2) the general demographics of the families they serve, 3) the greatest needs of the families served, and 4) how the needs of the families affect retention in their program.

Overall, there were 32 interviews/focus groups conducted. These discussions were digitally recorded and transcribed verbatim by a professional transcription service. Transcriptions were further reviewed for accuracy by MIECHV Program evaluation team members. A preliminary, inductive content analysis approach utilizing open coding was used to identify recurring themes among the families. Inter-rater reliability for coding and thematic analysis were established through comparison, and consensus was reached.

PARTICIPANT DEMOGRAPHICS

A total of 17 program administrators, 15 program supervisors, and 49 home visitors participated in the interviews/focus groups. Participants self-reported demographic information. The majority of staff was relatively new to their role, with 43% working in their role for less than one year and 35% for 1-5 years. Fewer than half of the staff had been employed in their current position for more than two years (39%). The vast majority of the staff participants had a college degree (93%), were over age 35 (71%), and came from a variety of professional backgrounds, with the largest percentages in the fields of nursing (28%) and social work (21%). The participants were somewhat racially or ethnically diverse (25% Black, 19% Hispanic) and 67% lived in the communities in which they worked.



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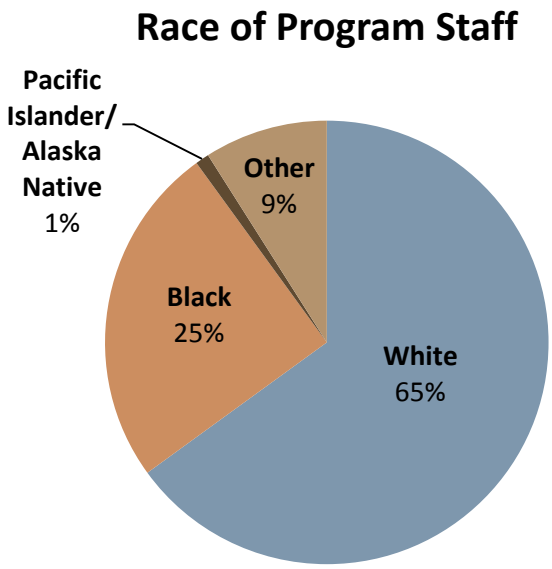

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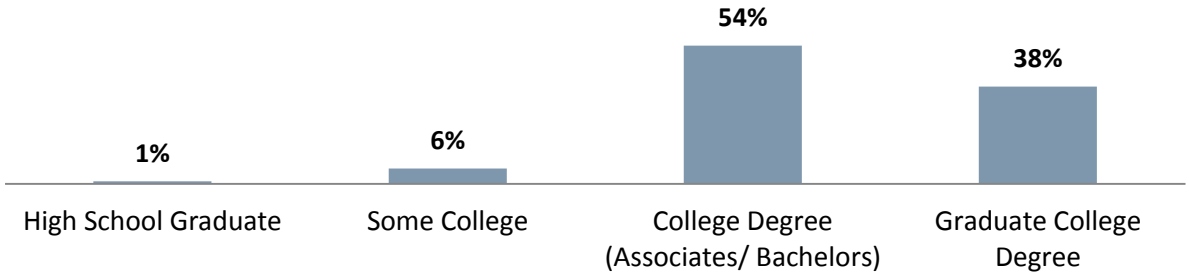
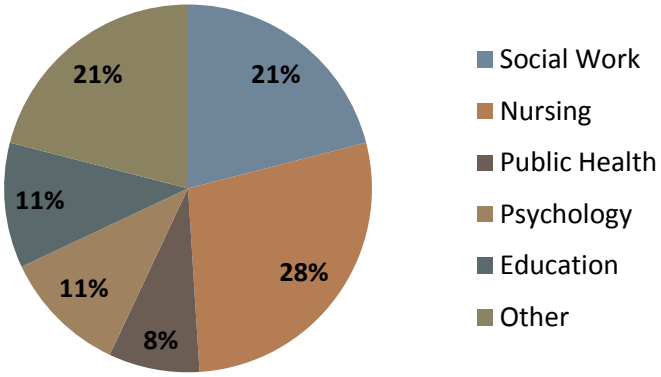
PARTICIPANT DEMOGRAPHICS

Highest Level of Education Completed



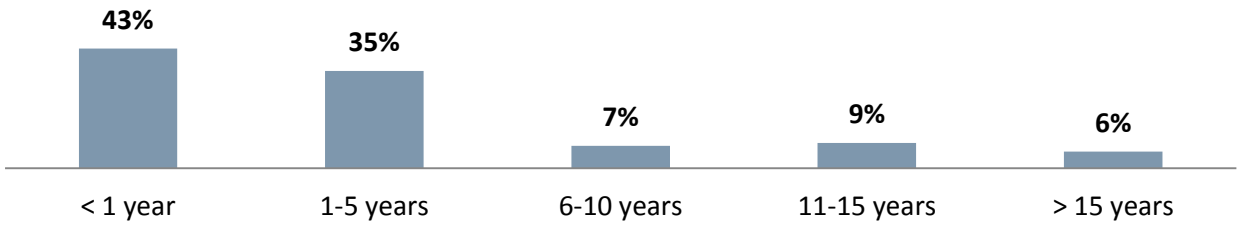
Note: N=81

Educational Background



Note: N=97, 2 missing/prefer not to disclose; results exceed N=81 due to 'Select all that apply' option

Length of Time in Current Staff Role



Note: N=80, 1 missing/prefer not to disclose

PROGRAM STRENGTHS & OUTCOMES

What do you consider the biggest strength(s) of your program?

During the MIECHV Program evaluation site visits, the administrators, supervisors, and home visitors of the programs were asked what they considered to be the biggest strengths of their program. Across programs, feedback centered around three main points: the qualities of MIECHV staff; aspects of the MIECHV Program and its models; and the infrastructure that the program operates within.

Firstly, the staff of the MIECHV Program was seen as one of the biggest strengths of the program for a variety of reasons. Administrators commented on staff's ability to keep participants engaged in the program, speak multiple languages, and relate to the families as a result of their own similar experiences (e.g., being single mothers themselves). Supervisors also highlighted staff as a major program strength because of their experience in social work and working with families experiencing poverty; their professional skills, dedication, and commitment; as well as some staff's higher education levels. Supervisors indicated that the staff's teamwork and ability to cooperate and communicate with each other facilitated better support and information sharing with their clients. Home visitors specified that it was the staff's supportive team environment that contributed to their role being seen as a tremendous strength of the program.

> *"I would say staff, but in terms of their ability, their team, the team they've built, and it's all based on each person's strengths and weaknesses."*

Characteristics of the MIECHV Program and its models were also seen as a major contributor to the programs' strength. Administrators stated that this was due to the programs' ability to provide services to those in rural areas where transportation was not readily available and the population was considered high-need. Administrators

> *"Biggest strength of the program to me, it's just kind of like going out to the participants homes and reaching out to them, letting them know that there's a program out there that reaches out to them."*

PROGRAM STRENGTHS & OUTCOMES

indicated that the MIECHV grant funding for the program allowed for the implementation of evidence-based programs, contributing to the program's strength. Supervisors noted that the family-focused prevention evidence-based model, in contrast to an intervention program, was a strength of the program, as it allows them to reach the family before a crisis happens. One supervisor explained: *"We are preventing child abuse and neglect through the type of services that we provide and being able to cross all types of cultural lines and parental expectation and go in and help them look at parenting from a different perspective, from a loving perspective."*

> *"I think for me the greatest thing that it offers is us being able to do that evidence-based program, and being able – knowing that if we do it the way they say we should do it, that we should make a difference."*

Some supervisors stated that professional development, trainings, and implementation of the program models are also perceived strengths, since they allow staff to reach out and visit clients in their homes. Home visitors said that the program itself is a strength, in conjunction with its models; the program permits home visitors to be able to go into their clients' homes and build comfortable, open relationships, as well as help families make improvements with every visit and tailor the curriculum to meet the specific needs of each family.

Lastly, the infrastructure that houses the MIECHV Program is also considered one of the program's biggest strengths. According to the program administrators, this is because it gives the clients access to a multitude of services and community partners that are already in place. Supervisors say it is a strength as a result of engagement and relationships developed within the community. They stated that this was beneficial for those counties that are considered to be high-need and allows for *"linking families with community resources, self-sufficiency, help them become empowered to accomplish their goals and dreams and their vision come to reality."* Home visitors indicated that the infrastructure connects families with community resources and allows for staff to provide resources directly to the clients and their families.

> *"Linking families with community resources; self-sufficiency; help them become empowered to accomplish their goals and dreams, and their vision come to reality."*

PROGRAM STRENGTHS & OUTCOMES

In your opinion, what do you think are the most important outcomes of the program?

The MIECHV Program staff were also asked what they considered to be the most important outcomes of the program. According to administrators, the most important outcomes of their respective programs were generally centered on the health of the clients and their children. The ability to empower and support their clients, prepare women to have healthy pregnancies, and provide families with the tools to help them build healthy bonds with their babies contribute to positive health impacts for the participants.

"I think it's a lot if they feel that independence and their self-worth because a lot of them, we are their only support."

Supervisors stated that they perceived the most important outcomes to be: child development, utilization of healthcare, child abuse prevention, improved pregnancy outcomes (including preterm births and low birth weight), immunizations, and self-efficacy. Home visitors noted that the most important outcomes they saw in the families they serve were increased self-sufficiency, empowerment, and independence. Home visitors also mentioned the significance of teaching the participants to better interact with their children, stimulate their development, increase their school readiness, and prevent child abuse and the summoning of welfare services. Family planning was also cited, as it helps families plan for the number of children that they will have in the future and feel positive in their role being parents, as well as provides client education on safe sex practices. Additionally, home visitors spoke about breaking the cycle of intergenerational poverty, by boosting families' knowledge, hope, understanding, and health, as well as behavior changes.

"Well the family – well they call it now family goal plan – is a good outcome on the health of the family because on some case they may not have thought about setting goals and things like that."

PROGRAM STRENGTHS & OUTCOMES

Lastly, home visitors referred to their service and supports to undocumented families; one of the most important outcomes is to help this population become more integrated into the community. They stated that doing so gave these individuals a sense of family (possibly being far away from their own), a supportive community and social network, and a place to receive resources in times of need.

Administrators and supervisors were also asked to share any "intangible benefits" that came from the program, those that may not be captured in the data system. Administrators mentioned observing their clients become self-sufficient, learn to cope, and prioritize and take advantage of the opportunity to change their lives. They mentioned that this program allowed participants to stabilize their lifestyles, as well as build healthy family relationships. Supervisors noted that knowing exactly how the home visitors directly affect the participants and what the mothers would have done without the program versus what they did because of it, as their "intangible benefits". These benefits allowed supervisors to be able to see how much a participant has changed as a parent, their desire to be a better parent, health choices, life skill progressions, and father involvement.

"Hard to measure, is probably the self-efficacy kind of goals because sometimes clients go back to work and school, and then they leave the program."
"That's actually a negative against us that they leave the program before they had two-and-a-half years, but actually they're doing exactly what we want them to do, but we're getting – we're getting a ding against us as retention."

COMMUNITY NETWORKS

Tell me about the community network that supports your families.

The community networks that supported families differed by program. For example, some programs were part of a larger, well-established infrastructure. In these cases, the program was usually associated with a hospital, and clients served by these programs had ample resources. On the other hand, for some programs, community networks were still being built or were very small, creating a barrier for clients to access needed resources. The latter was particularly true for programs that served rural communities. The table below lists a number of community partners often identified by administrators.

"There's something about our agencies; and I think this is how it should be where our focus is on our community, on the people we're serving, not necessarily on 'what's in it for me' as an organization."

"There is a culture of collaboration, working together."

Community Partners	
Health care providers	Domestic violence agencies
Hospitals/clinics/FQHCs	Shelters
Head Start	Mental health providers
Early Head Start	Housing authorities
Child welfare agencies	Home health agencies
Healthy Start	Not-for-profits
Healthy Families	Teen pregnancy prevention programs
School districts/boards	Emergency assistance networks
Juvenile justice agencies	Employment agencies
Health departments	WIC

COMMUNITY NETWORKS

How are partnerships created in the community? How do you maintain those partnerships? What barriers exist to establishing community partnerships?

When asked how partnerships were created, many administrators either stated that an infrastructure already existed when their MIECHV Program was funded in 2013 or that they asked for referrals from existing partners. One administrator joked that, when asking for referrals, established partners would tell you 'who to reach out to and who to avoid.' That is, an organization's willingness to work with others was usually well known within the community.

"We're going to bend over backwards to try to work with somebody to serve these families. We have a good reputation for doing that."

When administrators were asked how those community partnerships were maintained, most explained that there were regular MIECHV advisory board or coalition meetings to which community partners were invited. Likewise, most administrators stated that they or other MIECHV-related personnel sat on the boards or attended coalition meetings of other community partners. A few administrators also mentioned that they had close, professional one-on-one relationships with key personnel at different organizations and communicated with those contacts frequently.

"In our services, we have all of the home visitation programs there. We're also, from that group; we are identifying needs that we need to work on as a community."

"I mean knowledge is one of the biggest ones, just knowing about our programs, knowing about our mission."

Lastly, administrators identified a number of barriers to establishing and maintaining community partnerships. The primary barrier cited was lack of awareness of MIECHV. Simply stated, MIECHV programs, according to administrators, do not have the same name recognition as Healthy Start, for example. Furthermore, when reaching out, administrators found that community partners do not always understand how they can partner with MIECHV. However, most administrators agreed that, once they provided

information about the program, potential community partners expressed interest in collaboration.

> *"…everybody has got their little niche. You want all those niches to line up, so that you have a full array of service."*

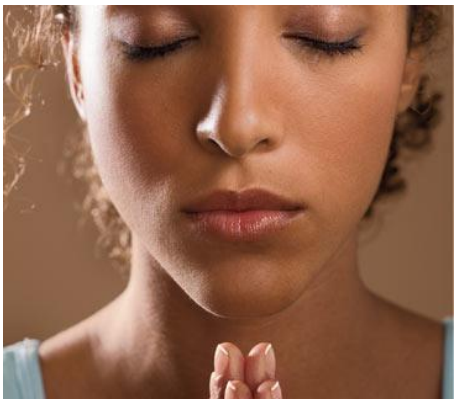
Most administrators stressed that limited money and time was a continuous barrier to collaboration. In fact, in some communities, competition for funding was a major barrier to community collaboration in general. Additionally, it was commonly stated that sometimes potential community partners would be "invited to the table" and simply would not participate for undisclosed reasons. Lastly, a major issue for programs that served mostly rural communities, community partners either did not exist or were over-extended. Likewise, programs in urban communities may have a larger number of resources but also a much larger population in need.

STAFF WORK-RELATED STRESS

In twenty separate interviews, MIECHV supervisors and home visitors from various Florida counties confirmed that emotional burnout among staff is a common reality. The act of listening to and witnessing many stressors and issues faced by their enrolled families on a day-to-day basis, sometimes for several hours per day, was reported to play a substantial role in contributing to the stress of home visitors. Most home visitors described their struggle in separating work-related issues from their personal life. For example, one home visitor noted how she allowed herself to deal with the stress of her home visits until she reached a certain point on her drive home from work, then forced herself to relinquish those thoughts thereafter. Others described how they contemplated their clients' struggles when at home, wondering what else they could do as far as providing referrals or support. Many home visitors connected their job performance directly to the outcomes of their clients. When their clients cannot access the referrals given, do not listen to advice, or spend several visits interpreting an element of the curriculum, the home visitor may feel inept in their position.

"When I see them, I wish there was more that I can do. Sometimes I go home and I'm just kind of like, 'What else could I do?' I just – Even after work hours, I'm like 'What else could I do?' I keep thinking about it."

"It's just that sometimes we are so grossly invested in the client, their success is truly our success, and their failure, sometimes, you take them on."



The impact of internalizing stress from witnessing clients' living conditions, decisions, or circumstances was described as an overwhelmed mental state. Luckily, most supervisors and home visitors alike identified open communication as an important part of their working environment. Most home visitors felt open in calling, texting, or speaking in person with their coworkers and supervisors about stress-related issues. Moreover, free mental health counseling was mentioned as available to many home visitors through an Employee Assistance Program or a specific county program.

STAFF WORK-RELATED STRESS

Even when home visitors did not speak about job stress, supervisors did take notice when it appeared that a staff member was struggling. Poor job performance, personality changes, and taking an increased amount of personal leave from work are ways that supervisors mentioned as possible signs that a home visitor may be having difficulty managing stress. The supervisors mentioned that frequent staff meetings are held to discuss both job-related and individual happenings as a sort of support system.

> *"It's seriously draining at times. They kind of pull a lot from you because you are giving and giving and giving and then at some point you're kind of like, "I'm tired." I might have to call them tomorrow. You know? You get tired."*

In terms of coping, nearly all site supervisors described activities to support emotional refueling: taking retreats to get away from the office or going out for lunch together as a way to decompress. The overall notion described by staff was that stress happens, but, with appropriate workplace support systems in place, stress does not have to be a debilitating integral aspect of the home visiting profession.

> *"Yes, [clients are] supposed to be self-sufficient….but they're in the program because they need help. They need something that they weren't able to do on their own. So, it's like training wheels for kids where basically they're training wheels and we're supposed to help provide a support, so they can stand on their own and see ride on two wheels, but sometimes if the bike breaks, we are not able to help them fix it. So, it can be emotionally draining."*

FOCUS POPULATION: IMMIGRANT FAMILIES

The particular challenges and barriers of serving families from other countries (undocumented and legal immigrants) in the MIECHV Program were frequently brought up during interviews and focus groups with program staff. When asked about the general needs of their families, seven of 11 programs mentioned the participation of immigrant clients who have limited English proficiency, lack of legal documentation, or less familiarity with United States service systems and culture. The largest immigrant populations served in MIECHV are Hispanic and Haitian Creole.

Program staff stated that immigrant clients often encounter barriers in navigating the healthcare system. A particular issue was difficulty completing forms or the inability to apply for insurance and government assistance due to non-citizen status. In addition, language barriers hindered communication of the clients' needs to healthcare professionals and receiving necessary health services (e.g., prenatal care). Home-visiting staff stated that it is imperative that their clients receive health services because many participants comorbid conditions, chronic and infectious diseases that increase health risks during pregnancy.

"…so far my experience with my families, because some of them are undocumented, and some of them don't speak the language. I find that most of my families have difficulties getting healthcare, like insurance or some type of assistance to be able to go to the prenatal visits. So, I think that is one of the main things. It's not only through pregnancy, but once they have the baby; they struggle again trying to get that for the baby, and because communication is the key - and you're there calling for them, trying to get what they really can't do for themselves yet. To me, that's the big issue, big part, what they need."

Social and physical isolation was also pointed out by MIECHV staff and may be related to the language barrier that immigrant participants may experience while also adjusting to their environment. It was stated that some of the participants lack transportation, cell phones, and

"I have a lot of moms that they don't have cellphones. They stay at home all day with no phone at all because the dad is working so he takes the cellphone with him. So, I think that's the biggest issue."

other forms of technology to connect to others and resources within their community. If a household had one car or one cell phone, for example, the father may drive to work and bring the phone, leaving the mother home alone without means of access or communication.

According to home visitors, some immigrant participants may have an initial mistrust of social services and healthcare systems, which could be caused by the fear of possibly being deported. Home-visiting staff mentioned that participants may be reluctant to participate in MIECHV at first, but through their training, they are able to build rapport with these clients and have their continued participation in the program.

These cultural barriers show the importance of continuing efforts to improve maternal and child health outcomes of MIECHV participants. MIECHV programs address these challenges by hiring staff that are bilingual and skilled in case management to act as advocates and build rapport with these families. Home visitors proactively guide them through the healthcare system and connect them to the available resources within the community.

"I mean the relationship is I think strong, I think once they develop, especially the Hispanic, the migrants, once they develop a trust in the educator then they start opening up and start letting to educate or know what they need or what's going on in their lives. In the very beginning, they're usually reluctant until they build that trust. I think as we go out to the visits, I know for me when I go out and I work with a lot of younger participants, once they know who they can trust and tell me things and it's confidential and that I can help them, then that relationship becomes very strong relationship."

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