Preventing Rapid Repeat Births Among Adolescent Mothers:
Implementing Steps to Success in San Angelo, Texas

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OVERVIEW

Rapid repeat pregnancies can have adverse consequences for young mothers and their children. A small but growing body of research suggests that intervention programs for adolescent mothers, particularly those that promote the use of long-acting reversible contraceptives (LARCs), can reduce the risk of rapid repeat pregnancies. The study of Steps to Success in San Angelo, Texas, aims to build on this growing body of research.

This study will examine the effectiveness of Steps to Success, a home visiting program that offers counseling on contraception and adequate birth spacing, as well as parenting and child development issues, relative to an alternative home visiting program, Traditional Healthy Families, which focuses only on parenting and child development. Steps to Success differs from Traditional Healthy Families in other important ways. Steps to Success offers weekly home visits for a longer period, actively engages fathers in home visits as appropriate, and covers education and career planning. HFSA, an experienced, community-based organization in San Angelo, implemented both the Steps to Success and Traditional Healthy Families programs. This report examines the implementation of these two programs.

HFSA successfully implemented both Steps to Success and Traditional Healthy Families during the period covered by this report. As planned, Steps to Success provided substantially more support than Traditional Healthy Families. Families in Steps to Success averaged 20 home visits during their first year in the program, compared with 12 home visits for families enrolled in Traditional Healthy Families. Both programs provided child development and parenting education using a curriculum developed by HFSA and a child development screening tool. In Steps to Success, however, the home visitors conducted weekly home visits for a longer period; made consistent efforts to engage fathers in home visits; and addressed a much broader range of topics, including adulthood preparation and reproductive health and contraception, especially LARCs, using additional curriculum materials developed by HFSA. In addition, Steps to Success home visitors were able to retain a larger proportion of families than Traditional Healthy Families home visitors during their first year in the program (65 compared with 42 percent).

According to home visitors, HFSA leaders, evaluation site visitors, and the participants themselves, participants in both programs valued the child development and parenting information they received and appreciated the support of their home visitor. During home visit observations, mothers (and fathers, in Steps to Success) actively engaged in the home visit activities. Parents who attended the focus groups appreciated having someone to talk to and the information they received.

This study of the implementation of Steps to Success and Traditional Healthy Families was conducted in conjunction with a rigorous impact study based on a random assignment research design. At program application, mothers were randomly assigned to either Steps to Success or Traditional Healthy Families, about half to each program. Upcoming impact reports, scheduled for release beginning in 2018, will examine the effects of Steps to Success relative to Traditional Healthy Families on participating mothers' contraceptive use, subsequent pregnancies, and other outcomes one and two years after they enrolled in the program.

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I. INTRODUCTION

Adolescent parenthood can have substantial negative consequences for young mothers and their children. Young women who give birth as adolescents are at greater risk of dropping out of school, relying on public assistance, and living in poverty as adults (Hoffman and Maynard 2008; Perper et al. 2010). Their children face increased risk of abuse and neglect and are more likely to experience poor health, behavior, and educational outcomes than are children born to older mothers (Hoffman and Maynard 2008). These risks can be compounded if the young mother gives birth again within just a few years (Klerman 2004). About one in six teen births are to young mothers who already have at least one child (Hamilton et al. 2015).

A small but growing body of evidence suggests that intervention programs for adolescent mothers can reduce the risk of rapid repeat pregnancy by providing a combination of individualized support services and improved access to effective contraception. For example, the long-standing Nurse Family Partnership (NFP) program has shown favorable effects in reducing rates of subsequent pregnancies and births at 24 months postpartum by providing regular home visits to first-time, low-income mothers (Olds et al. 2002). More recently, a randomized controlled trial of the Teen Options to Prevent Pregnancy (TOPP) program for low-income adolescent mothers found that the program reduced rates of unprotected sex and increased use of highly effective long-acting reversible contraceptives (LARCs) through a combination of one-on-one motivational interviewing sessions and facilitated access to contraceptive services (Smith et al. 2015). The TOPP findings are consistent with a larger body of clinical guidance and health services research highlighting LARCs in particular as an effective method to reduce unintended teen pregnancies and births (ACOG 2012; Secura et al. 2014; Ricketts et al. 2014).

To further enhance our understanding of effective approaches for reducing rapid repeat pregnancies among adolescent mothers, Mathematica is collaborating with Healthy Families San Angelo (HFSA) in San Angelo, Texas, to conduct a rigorous evaluation of the Steps to Success program. HFSA developed Steps to Success by adapting the traditional Healthy Families America home-visiting model that has already been found to improve parenting skills and other outcomes related to child development (LeCroy and Krysik 2011; Duggan et al. 2007; Caldera et al. 2007; King et al. 2005). HFSA adapted this model for adolescent mothers by adding material on contraception and the benefits of adequate birth spacing, advocating with medical providers and providing transportation to medical facilities, actively engaging the baby's father in home visits even if the father does not live with or have a relationship with the mother, and incorporating material on relationship skills and education and career goals. HFSA based the Steps to Success model on research highlighting the prevalence of repeat pregnancies among adolescent mothers and the importance of encouraging young mothers to use LARCs to delay another pregnancy. LARCs are a key element of the Steps to Success approach. Research also suggests that promoting more positive relations with partners and encouraging young mothers to stay in school are promising approaches to reduce the risk of rapid repeat pregnancy. Steps to Success aims to promote both of these goals.

HFSA recruited young mothers for the study and randomly assigned them into one of two groups: (1) a treatment group that was offered Steps to Success home visits or (2) a control group that was offered Traditional Healthy Families (a more traditional home-visiting curriculum focused on child development and parenting). The Steps to Success evaluation examines the

relative effectiveness of these two approaches. Both Steps to Success and Traditional Healthy Families aim to incorporate Healthy Families America's critical program elements.

Both Steps to Success and Traditional Healthy Families deliver services in regular home visits. Both begin with weekly home visits to develop a trusting relationship between the home visitor and the family, then gradually decrease in frequency as families meet program milestones. Steps to Success home visits continue weekly until criteria are met related to family stability, reproductive planning, parenting, and child well-being (typically when the child is 3 to 6 months old), then transition to biweekly. Visits continue biweekly until criteria are met related to family stability, progress toward goals, problem solving, parenting, and child well-being, then transition to monthly until the child reaches 2 years old. Traditional Healthy Families home visits transition to biweekly after the first three or four visits, then transition to monthly when criteria are met related to family stability, parenting, and child well-being and continue until the child is 2 years old.

HFSA invited mothers 14 to 20 years old in the San Angelo area who were pregnant or had a child under 3 months old to apply for Steps to Success. Beginning in May 2013, applicants were randomly assigned to either the treatment group, which could enroll in Steps to Success, or to the control group, which could enroll in Traditional Healthy Families. Between May 2013 and May 2016, when random assignment ended, 299 teen mothers were assigned to the treatment group and 296 teen mothers were assigned to the control group.

The evaluation's primary objectives are to carefully document the implementation of Steps to Success in and near San Angelo, Texas, and test its effectiveness relative to Traditional Healthy Families on contraceptive use and repeat pregnancies. The Steps to Success theory of change indicates that the additional curriculum topics, more frequent home visits, and engagement of fathers will (1) facilitate coverage of the intended dosage and content and (2) increase participant engagement. Program staff expect that participants in Steps to Success will learn about and practice key skills to help them prepare for adulthood. The program's ultimate goals are promoting healthier birth spacing by increasing the use of contraception, especially LARCs, and delaying repeat teen pregnancies among participants (Figure I.1).[1]

The implementation study of Steps to Success is being conducted in conjunction with a rigorous impact study using a random assignment research design. The Steps to Success evaluation will add to the evidence base on effectiveness of programs aimed at preventing rapid repeat pregnancies among teen parents. Impact reports, scheduled for release beginning in 2018, will examine the effects of the program on participant outcomes one and two years after they enter the program.

We base the findings in this report primarily on data collected by the PREP in-depth implementation study team during site visits conducted in June 2014 and February 2016. During

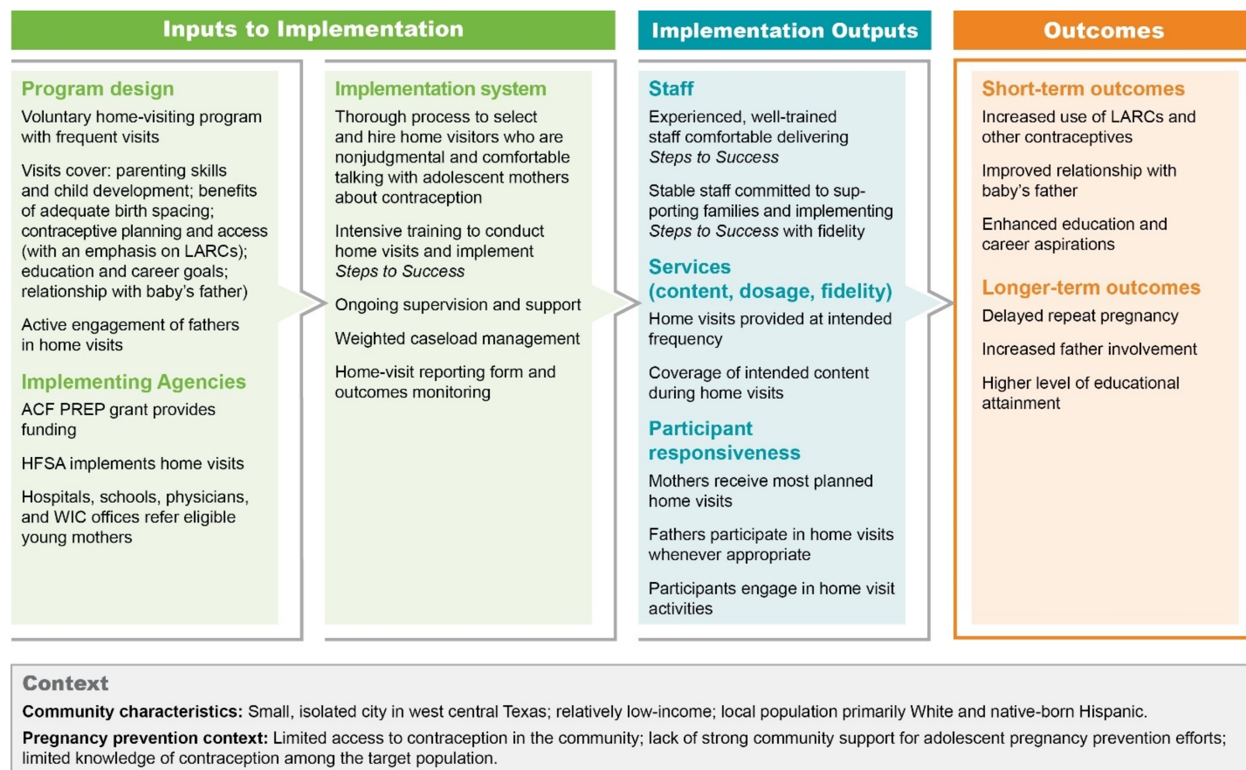
[1] The implementation framework focuses not only on whether the program was implemented with fidelity and whether participants were responsive, but on the factors that influenced fidelity and responsiveness, including the program's design, characteristics of the agencies implementing it, the support systems for implementing the program, and the context in which this activity takes place. The development of the implementation framework was guided by the implementation factors defined by Damschroder and Hagedorn (2011), Durlak and DuPre (2008), Fixsen et al. (2009), and Berkel et al. (2011).

these visits, the team conducted interviews with HFSA staff and community partners. They also observed home visits and conducted focus groups with teen mothers and fathers participating in Steps to Success and teen mothers participating in Traditional Healthy Families.[2] In addition, the team asked the HFSA staff working directly with the two programs to complete self-administered surveys about their service-delivery experiences.

In addition to these data sources, the team reviewed documents on the Steps to Success curriculum, caseload management, program management and reporting forms, and agency and community information from websites. Finally, this report also incorporates data from self-administered baseline surveys that sample members completed at study intake, as well as service-use data collected by HFSA staff.

Evaluation team members coded the interview data using qualitative data-analysis software and conducted descriptive analyses of the quantitative survey data. The team examined the coded data to identify emergent themes. They triangulated across all qualitative and quantitative data sources to develop the findings included in this report. Appendix A provides more information on the methodological approach and data sources.

Figure I.1. Implementation framework for Steps to Success in San Angelo, Texas



This report presents findings from the implementation of Steps to Success and Traditional Healthy Families in and near San Angelo, Texas. In the following chapters, we describe the

[2] Traditional Healthy Families did not serve fathers. Therefore, we did not include fathers in families served by Traditional Healthy Families in focus groups.

context in which these programs were implemented, the planning process for Steps to Success, the support that staff received for implementing both programs, staff adherence to implementation plans, and participant responsiveness. The report concludes with a summary of key findings about the implementation of Steps to Success in San Angelo.

II. THE COMMUNITY CONTEXT FOR IMPLEMENTING STEPS TO SUCCESS AND TRADITIONAL HEALTHY FAMILIES

HFSA has been providing child development and parenting support through home visits in San Angelo for many years. The federal PREP grant offered an opportunity to broaden this support for teen parents to include adulthood preparation skills, reproductive health planning, and more structured support for use of effective contraception. By addressing these topics systematically and engaging fathers in home visits, HFSA aimed to delay subsequent pregnancies of adolescent parents in and around San Angelo, where teen pregnancy rates and subsequent birth rates among teens are high. This chapter briefly describes HFSA's experience and the context for teen pregnancy prevention in San Angelo.

High rates of initial and repeat pregnancies among teens in San Angelo point to the need for teen pregnancy prevention services

San Angelo, a small, remote city of approximately 100,000 people, is located in an agricultural area in west central Texas, about 90 miles from the nearest town of similar size (Abilene) and about 150 miles from the nearest large city, Fort Worth. The population is mostly White (53 percent) and Hispanic (39 percent).[3] In 2013, the median income level in San Angelo was $44,516, 14 percent below the median income level for the state.[4]

San Angelo is located in a region with high rates of teenage births. Texas has the fifth-highest teen birth rate in the country (37.8 births per 1,000 teens age 15 to 19 in 2014)[5]—and the highest proportion of teen births that are repeat births (22 percent of births to teens age 15 to 19 in 2010).[6] Teen birth rates in Tom Green County, which encompasses San Angelo, are comparable to the state average (52 births per 1,000 teens age 15 to 19 in both the county and the state during the period from 2007 to 2013).[7]

The community lacks support and resources for teen pregnancy prevention and teen parenting

Programs exist to provide access to contraception for young women in the San Angelo area; however, coverage is incomplete, particularly for those under age 18. In Texas, low-income women 18 to 44 years old are eligible for the Texas Women's Health Program, which provides health insurance to cover preventative care, including birth control and LARCs.[8] However, those under 18 cannot use the state program and must rely instead on Medicaid and other public sources of coverage that provide free or low-cost health care coverage to low-income pregnant

[3] www.city-data.com/San-Angelo-Texas.html

[4] http://www.city-data.com/city/San-Angelo-Texas.html

[5] https://thenationalcampaign.org/resource/key-information-about-us-states

[6] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6213a4.htm?s_cid=mm6213a4_w

[7] http://www.countyhealthrankings.org/app/texas/2016/rankings/tom-green/county/outcomes/overall/snapshot

[8] http://www.texaswomenshealth.org/

women from pregnancy through labor and delivery, and for 60 days postpartum.[9] Because Texas did not accept Medicaid expansion under the Affordable Care Act, coverage for pregnancy and birth control is limited to prenatal care and 60 days postpartum (for example, see healthcare.gov and kff.org). Some young mothers under 18 years of age might be eligible for state Children's Health Insurance Program (CHIP) coverage for birth control. HFSA staff noted, however, that accessing this coverage can be challenging. The young mother's parents must enroll her, which is not always feasible, because they may no longer be in contact with each other or they may face other barriers to enrollment. HFSA staff thus regard the 60-day postpartum Medicaid coverage as the most viable way to support access to contraception for adolescent mothers in the area.

HFSA staff described San Angelo as a community in which there is a general lack of knowledge about teen pregnancy prevention, coupled with some denial of teen sexual activity and little support for teen pregnancy prevention programs. One staff member described the overarching attitude as, "If we don't talk about it, it won't happen." Staff describe youth as uncomfortable talking to their parents and asking questions, saying "[youth] don't get the information at home, which makes it difficult." They say the youth also appear to accept teen pregnancy and describe the attitudes of young mothers as complacent. Some staff felt that this attitude played a greater role in teen pregnancy than did the apparent lack of access to contraception in the community. During the site visits, staff and focus group participants could not identify any active teen pregnancy prevention programs in the community or the schools. Both groups reported that San Angelo had some relevant programs and resources for teens, especially through Planned Parenthood. In 2013, however, the state passed new guidelines that led the local Planned Parenthood office to close. Staff cited this closure as significantly reducing youth access to information and resources related to reproductive health and contraception. Three staff members and a focus group participant also recalled an abstinence-only program (Right Choices for Youth) offered in the schools in partnership with a local hospital, but noted that it had ended several years ago. In practice, staff had the impression that no one in the community is talking about teen pregnancy prevention.

Several staff and focus group participants mentioned the Pregnancy Help Center, which they described as offering an abstinence-only approach to pregnancy prevention. According to its website, the Pregnancy Help Center offers abstinence education, pregnancy testing, prenatal and parenting classes, baby and maternity clothes, and information about abortion procedures, risks, and alternatives, among other services. Another staff member described the center as "the only resource in town" for parenting teens, noting that a few of the HFSA families participate in the center's parenting classes. HFSA staff hypothesized that these classes were attractive to young mothers because they offer points for attendance that can be used for free diapers, baby clothes, and baby gear. Several mothers and fathers mentioned the center, with some confirming that they attended classes to earn maternity and baby clothes, car seats, cribs, strollers, and other baby items.

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[9] According to Medicaid.gov, the program covers "the full range of FDA-approved [birth control] methods without co-pay" including LARCs. Following the Medicaid Family Planning expansions of the 1990s, Medicaid covers pregnancy care for low-income women in states that took up the family planning expansions (including Texas); this coverage does not depend on the state's acceptance of Medicaid expansion under the Affordable Care Act (ACA). The ACA mandates that health insurance plans and Medicaid pay for all FDA-approved forms of birth control without a time limit.

Local schools appeared to offer only limited youth-focused sexual and reproductive health education. Staff reported there's little sex education at school beyond discussions of "anatomical things." HFSA staff also referred to school guidance counselors as a resource for pregnant youth; when a girl self-identified as pregnant, HFSA staff explained that the school guidance counselor would meet with her to discuss child development, prenatal information, and maternal and child nutrition. During a second site visit, a school staff member reported that health classes were not mandatory, and she was unaware of any sex education at the high school level. She described a need for more pregnancy prevention services but did not believe the community would be receptive to them.

Focus-group participants indicated that they had received some sex education through the schools, but that it was fairly limited. One participant explained that in 8th grade health class, they discussed sexually transmitted diseases (STDs), birth control, and sex but said the discussion "grossed me out, [was] pretty scary, [and] wanted to scare you away from having sex." Another focus-group participant described a 5th grade class in which the instructor explained "about your bodies. Just about your period and abstinence." Two others indicated that they had never had a sex education class and that sex and pregnancy prevention were never discussed at school. Another participant explained, "I didn't know about [birth control]. Nobody really informed me about it after I had my son. Then I had my daughter."

HFSA's experience designing and implementing home-visiting programs in San Angelo paved the way for Steps to Success

HFSA is a nonprofit organization founded in 1992 to promote healthy child development and enhanced family functioning through home visits to families in need. HFSA's clients are primarily native-born, English-speaking Hispanic families with infants who live in and around San Angelo. Traditionally, HFSA staff have worked with both mothers and fathers through home-based family support services. These services are designed to help expectant and new parents care for their babies and prevent child abuse and neglect by providing new parents with child development and parenting information and overall support.

HFSA's services to fathers have sought to encourage fathers' involvement in their babies' lives, child support, and employment. Its Building Strong Families (BSF) program, which the agency launched in 2005, added group sessions focused on relationship skills for young, expectant, or new parents enrolled in its home-based and fatherhood programs. BSF demonstrated HFSA's commitment to serving both mothers and fathers in parenting and child development programs.

HFSA's offices are located in downtown San Angelo, near one of the city's main hospitals and within a short drive to one of the main high schools, both primary recruitment sites. HFSA's building, a converted fire station, contains a large, open reception area and public space, with a kitchen and private conference room for weekly staff meetings and home visitor training sessions. This space also allows HFSA to host annual events for program participants—for example, a costume Halloween party and a December holiday party—as well as provide space for occasional meetings with parents with living arrangements that are not conducive to home visits.

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III. PLANNING AND PREPARING FOR STEPS TO SUCCESS AND TRADITIONAL HEALTHY FAMILIES IMPLEMENTATION

Many factors come together in planning and preparing to implement a teen pregnancy prevention program. To develop and implement Steps to Success, HFSA built on its experience implementing home visits to provide parents with information on child development and parenting. HFSA continued this focus for mothers only in Traditional Healthy Families, while for Steps to Success, HFSA expanded program content to cover adulthood preparation and reproductive health topics, increased the planned intensity of services during the first year, and planned to engage fathers.

HFSA implemented Steps to Success in San Angelo as a voluntary, intensive home-visiting program for teen parents. In addition to the typical Healthy Families America content on child development and parenting, the program aimed to help teen parents set goals for education, employment, and reproductive health; provide them with information and assistance in obtaining effective contraceptive methods; and assist them in developing their communication and relationship skills. Because the program is voluntary, a key part of planning and preparation focused on recruiting teen parents to participate. In the following sections, we discuss these aspects of planning and preparing to implement Traditional Healthy Families and Steps to Success in San Angelo and provide background for understanding the implementation results.

HFSA designed Traditional Healthy Families to focus on child development and parenting

With the exception of not actively engaging fathers, Traditional Healthy Families is similar to the home-visiting services HFSA has historically offered to young families in and around San Angelo. The plan for Traditional Healthy Families was to provide young mothers (14 to 20 years old) with 2 to 2.5 years of home-visiting services from a trusted home visitor. The visits would focus only on infant development and parenting skills. The plan also included a primary focus on the mother, without actively engaging the father, as well as less intensive support for referrals and follow-up than would be offered by Steps to Success. Home visitors could make referrals, but would not actively ensure that families pursued them.

Supervisors planned for Traditional Healthy Families home visitors to carry a larger caseload than Steps to Success home visitors, reflecting the fact that mothers would move from weekly to biweekly home visits more rapidly than in Steps to Success. Families were to receive weekly visits for three to four weeks (to establish a relationship), then move to biweekly visits until criteria related to family stability, parenting, and child development were met. Visits then transitioned to monthly until the end of the program when the child reached age 2.

HFSA planned for Traditional Healthy Families to concentrate exclusively on supporting the baby's development and helping the mother to improve her parenting skills. Traditional Healthy Families home visitors were to assess the baby's progress at each visit and discuss mother-baby interactions, how to stimulate the baby's development and growth, and the importance of keeping doctor's appointments and maintaining immunizations. To support these objectives, the home visitors used the *Ages and Stages Questionnaires* developmental screener and HFSA's *Healthy Babies…Healthy Families* curriculum. They planned not to discuss the topics added to the child development and parenting topics in Steps to Success. If a mother asked about one of

these topics, such as contraception, the home visitors planned to suggest that the mother consult with a medical professional but would not discuss the topic nor verify if the mother acted on the suggestion. Similarly, if a father was present during the home visit, he would be welcome to listen, but the home visitor would neither address questions to him nor attempt to actively engage him in the visit.

HFSA added a teen pregnancy prevention focus and adulthood-preparation subjects for Steps to Success

Steps to Success and Traditional Healthy Families differ in a number of important ways. Steps to Success provides weekly home visits for a longer duration, adds reproductive health planning and contraception as well as adulthood preparation to the topics of infant development and parenting, and systematically engages fathers in home visits regardless of the parents' relationship status. The home visitors in Traditional Healthy Families seek to build positive, supportive, and trusting relationships with teen mothers, while Steps to Success home visitors focus on developing trusting relationships with both parents.

As program materials and HFSA staff describe, the goals of Steps to Success are to support young parents to "choose healthy birth spacing, pursue educational and occupational goals, and mature personally and as parents." The staff seek to "create a positive, supportive, trusting relationship with the family that builds on existing strengths and brings out the capacities in individuals and couples" as a strategy for supporting these goals. Through this relationship, home visitors engage families in curricular materials and activities and provide young parents with "accurate information about the risks of rapid repeat pregnancy." Young parents also learn about and practice key skills designed to prepare them for adulthood, including, for example, communicating, making decisions, solving problems, and setting goals.

HFSA leadership expected that Steps to Success home visitors would help young parents develop critical thinking, communication, and decision making skills by building close relationships with them, delivering program content, and actively connecting them to community resources. Program leaders also expected that including the topics of contraception and adulthood preparation and actively encouraging fathers' engagement would enhance—rather than "crowd out"—the focus on infant development and parenting, because the babies would motivate young parents to focus on the future and become better parents by pursuing goals.

The Steps to Success model hypothesizes that solid critical thinking, communication, and decision making skills will lead young parents to delay repeat pregnancies, engage in safe sex behaviors, develop more productive adult relationships, identify and pursue education and employment goals, become stronger parents, and support healthy infant development.

Based on their primary hypothesis, program rationale, experience working with young parents, and research literature, HFSA staff developed several key program elements for Steps to Success to prevent rapid repeat pregnancies, support adulthood preparation skills such as positive relationships and good parenting, and ensure healthy development of the children of adolescent parents. These key program elements include (1) engaging fathers; (2) building trusting relationships with families; (3) offering long-term home-based services for up to two years following the birth of the baby; (4) interactive teaching, motivational interviewing, and modeling; (5) encouraging extensive practice of critical thinking and interpersonal skills; and (6) screening for intimate partner violence. Three

additional program features not listed in planning materials but discussed in detail by staff and focus-group participants are its voluntary nature, flexibility in working with families, and intensive support for referrals to community resources. HFSA staff originally planned to offer young parents voluntary group sessions focused on adulthood preparation (healthy relationships, education and career success, and financial literacy) as a complement to individual home visits. They later decided against group sessions due to concerns about costs. Instead, HFSA decided to cover these adult-preparation subjects as part of home visits.

To address child development and parenting skills in both programs, HFSA used the *Healthy Babies…Healthy Families* curriculum and the *Ages and Stages Questionnaires*. HFSA developed additional curricular materials for Steps to Success that focus on contraception, healthy birth spacing, communication and relationship skills, and adulthood preparation. Home visitors planned to use these materials to support program implementation (Table III.1).

HFSA aimed to serve adolescent mothers in the community

HFSA planned to serve its traditional client base of predominantly English-speaking Hispanic families with infants who live in San Angelo and the surrounding areas. It focused on adolescent mothers who were 14 to 20 years old at program enrollment and were pregnant or parenting an infant age 3 months or younger. The HFSA staff also planned to engage fathers of the babies in home visits when appropriate, with the goal of 80 percent of fathers participating. By working with local hospitals and high schools, they identified families who met the residence and age criteria. They expected many to have inadequate academic skills, lack advocacy in the school system, and have limited employability, few successful role models, and a limited support system.

HFSA planned to adjust the frequency of home visits as families progressed in the programs

In both Steps to Success and Traditional Healthy Families, HFSA planned to serve families for two years after the birth of the baby. In both programs, HFSA staff planned to have three levels of home-visiting frequency—weekly, biweekly, and monthly—with visits typically lasting about an hour. HFSA planned to adjust the frequency of home visits over time according to the age of the baby, family stability, and parental ability to achieve program milestones (Table III.2). HFSA planned for Steps to Success to be a more intensive program than Traditional Healthy Families, with weekly home visits occurring over a longer period. In Steps to Success, staff reported that under most circumstances they aimed to conduct home visits with families weekly for their first three to six months before transitioning the family to biweekly visits. In contrast, in Traditional Healthy Families, program staff aimed to move the family from weekly to biweekly visits after three to four weeks unless the family required continued weekly visits.

Parents' ability to meet the criteria listed in Table III.2 determined their pace of progression to the next level of home-visit frequency. HFSA planned for the supervisor and home visitor to determine together during supervision meetings whether a family was ready to move to the next level.

Table III.1. Program elements of Steps to Success and Traditional Healthy Families

Title	Description	Used in Traditional Healthy Families	Used in Steps to Success
Healthy Babies… Healthy Families Curriculum	The *Healthy Babies… Healthy Families* curriculum focuses on the milestones of child development from birth to 36 months and how parents can guide that development. The curriculum provides detailed information on healthy parent-child relationships, developmental stages, health and safety needs, brain stimulation, and building positive self-esteem. The home visitor brings a lesson from the curriculum for each home visit and the parent adds it to a three-ring binder for reference.	X	X
Ages and Stages Questionnaires	The *Ages and Stages Questionnaires (ASQ)* are a developmental screener intended to identify whether young children (2 months to 5 years) need early intervention or other special services. The ASQ contains 21 age-specific questionnaires to be completed by parents or other primary caregivers. HFSA staff use the ASQ with families regularly during their home visits to help parents understand whether their children have any developmental areas of concern.	X	X
Steps to Success Curriculum	The Steps to Success curriculum focuses on several goals, including healthy birth spacing through the use of contraception, with a particular emphasis on LARCs. The "steps to success" include (1) taking charge of your life, (2) taking responsibility, (3) taking action, (4) overcoming fear, (5) getting an education, (6) developing good work habits, (7) asking for help, and (8) learning from others' successes and failures. The Steps to Success curriculum includes activities to help parents achieve these goals. For example, "Getting Started on the Road to Success" is an activity that helps parents define success, think about family planning, and set goals. Each parent chooses five to six goals from a set of objectives and then the parents work together to make plans for pursuing those goals.		X
Maps for Dads: Welcome to Dadhood! and Doin' the Dad Thing!	*Maps for Dads* is a two-volume set of curricula for use with fathers in home visits, office visits, or group settings. The first volume covers the prenatal period, and the second volume focuses on the development of newborns through age 3. The activities and interactive style of the curricula support fathers in creating nurturing father-child relationships, promoting healthy child development, and developing skills for effective co-parenting, regardless of the parents' living situation.		X
Couple Activities for Home Visits	Home visitors can use this list of 24 activities to work with parents to improve communication and relationship skills throughout the home-visiting period. For example, "Accentuate the Positive: Some Things I Like About You," "Trust Scale," "Getting to Know Me," and "Message in a Bottle" focus on identifying what couples appreciate about one another.		X

Program staff indicated that they took a holistic approach to determining when a family was ready to progress to the next service level. As one Steps to Success home visitor described it, "Some families have more crisis than others. As they are successful achieving goals, we'll move them to Level 2, which is every other week. As they are closer to leaving the program, they transition to monthly visits. Getting them ready to go on and do their thing without us.... [We are not looking for] one specific thing. We [need to know] they are doing well, that they're going to

Table III.2. Home-visit levels and criteria for promotion

Level	Traditional Healthy Families	Steps to Success
Level 1: Weekly home visits	Staff expected most families to remain at this initial level for three to four weeks. *Criteria for promotion to Level 2:* Parent has maintained stability in the home with no crisis for 30 days or responded appropriately to crisis with assistance of home visitor. Parent has kept home visit appointments or called to reschedule at least 75 percent of the time. Parent can identify at least one positive support system or person (other than home visitor). Parent asks home visitor for help in problem solving as needed. Parent expresses feeling or concerns to home visitor as appropriate. Parent is responsive to parent-child interaction interventions. Parent has a primary health care provider for the child and is attentive to the child's medical needs.	Staff expected most families to remain at this initial level for three to six months. *Criteria for promotion to Level 2:* Parent has maintained stability in the home with no crisis for 30 days or responded appropriately to crisis with or without assistance of home visitor. Parent has kept home visit appointments or called to reschedule at least 75 percent of the time. Parent can identify at least one positive support system or person (other than home visitor). Parent demonstrates responsive, nurturing practices with child. Parent shows interest in child development. Parent provides adequate stimulation for child. Parent provides child a safe home environment, including adequate nutrition and attention to medical/health needs. Both immunizations and well-care checkups are current. Parent has a primary health care provider for the child and is attentive to the child's medical needs. Parent has discussed healthy birth spacing and has made an informed choice for reproductive planning.
Level 2: Biweekly home visits	*Criteria for moving to Level 3:* Parent has maintained stability in the home with no crisis for 30 days or responded appropriately to crisis with assistance of home visitor. Parent able to utilize at least one other positive support system or person regularly. Parent able to demonstrate effective problem solving skills in most situations. Parent demonstrates ability to implement positive parent/child interaction skills with guidance of home visitor. Parent takes infant to all scheduled well-baby care and to medical home when sick. Infant immunizations are all up-to-date. Parent demonstrates reduction of one or more high risk factors.	*Criteria for moving to Level 3:* Parent has maintained stability in the home with no crises for 30 days or responded appropriately to crises without assistance of home visitor. Parent regularly utilizes at least one positive support system or person other than the home visitor. Parent demonstrates effective problem-solving skills in most situations. Parent demonstrates positive parent-child interaction skills. Children are current on immunizations and well-care checkups. Parent is free of substance abuse challenges. Parent has established fertility goals and is taking action to achieve those goals. Parent has achieved or is achieving stated educational or employment goals.
Level 3: Monthly home visits	Families remain at this level until their child reaches age 2.	Families remain at this level until their child reaches age 2.
Level X: Creative outreach	Families are placed in this level when they are reluctant to begin services, begin declining services, or are temporarily out of the service area for more than one month and have informed the home visitor that they will be returning to services.	Families are placed in this level when they are reluctant to begin services, begin declining services, or are temporarily out of the service area for more than one month and have informed the home visitor that they will be returning to services.

be okay. If they had a crisis in the off week, they would call. 'Hey, I need… Hey, where do I go?' Generally, things are going well—they are settled with baby, with birth control.... We like to know the baby is doing well, healthy, getting what they need. We had a family that found out the baby has serious delays. We've moved them to Level 2, but the worker is in regular contact

with them to check in and make sure things are good. ...We have another family where it was about time to switch to Level 2, but right at that time, we found out there was some violence going on in their relationship. So we kept them at Level 1...to make sure they know how to communicate better."

HFSA emphasized the importance of trusting relationships with teen parents for implementing both programs

A planned core goal of both Steps to Success and Traditional Healthy Families was to establish long-term, trusting relationships between the home visitors and participants. HFSA aimed to select flexible, patient, and nonjudgmental staff with the capacity to develop trusting relationships. For Steps to Success, HFSA also sought staff who were comfortable discussing sexuality and contraception. HFSA did not set minimum education or experience requirements for home visitors.

To achieve its desired staffing for Steps to Success, HFSA trained three existing home visitors, hired three new home visitors, and promoted an existing home visitor to a supervisory position and assigned her a reduced caseload. HFSA considered home visitors' qualifications based on performance in past assignments or, for new staff, extensive interviews and discussions after the applicant accompanied staff on home visits.

Recruiting young mothers to participate required working closely with hospitals, schools, and other community agencies

Before sample enrollment began in May 2013, HFSA and the PREP evaluation team agreed on a recruitment target for the agency of 20 young mothers per month over 36 months. This target would generate a research sample of about 700 at the end of study enrollment. With these targets in mind, HFSA's outreach supervisor and two intake staff began recruitment for Steps to Success when the study was launched and enrolled the first young women into the research sample on May 1, 2013.

As planned, HFSA outreach staff recruited young mothers through two local hospitals, visiting both daily. When it became clear that recruitment solely from these two hospitals would not be enough to meet enrollment targets, the outreach team expanded recruitment to three local high schools, and further extended to offices of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Pregnancy Help Center, and Esperanza (local health) clinics. The decision to work with the local high schools was also motivated by the desire to enroll families prenatally to provide support as early as possible.

HFSA outreach staff worked hard to develop relationships with hospitals and stay in close contact. During daily visits to the hospitals, the HFSA outreach staff consulted nurses before approaching teen mothers. If a nurse felt that a mother was not ready to meet with a staff member or discuss the program (because she was tired or distressed, for example), the staff member waited until the nurse felt the mother was ready. HFSA staff indicated that this approach demonstrated respect for the nurses' views and helped nurses feel like they were part of the program. Over time, HFSA outreach staff increased their visits to twice daily, which made them seem more integral to hospital procedures and also made the nurses feel more a part of the program. Intake staff described collaboration of this kind as "huge"—a key to identifying mothers in need and facilitating effective recruitment. Staff also noted that when the father was present, they often spoke with him first or at the same time as the mother to ensure his

understanding of the program. Nearly half of the participants in the four mothers' focus groups reported learning about HFSA's home-visiting services in the hospital. Others learned about it from friends, family, a doctor's office, a WIC office, or their local high school.

Involving the high schools in recruiting initially proved more challenging. In one area high school, the principal would not allow HFSA to recruit at the school. Recruitment could not begin there until a new principal was hired. HFSA also found that school guidance counselors were protective of their roles in the schools. To decrease the perception that HFSA staff were trying to interfere with the work of the guidance counselors, the outreach staff supervisor shared program content and activities with the schools to demonstrate that HFSA had a "legitimate curriculum," and HFSA staff avoided taking mothers out of core classes to discuss the program. These efforts helped HFSA gain a positive reputation with the schools, but staff described establishing relationships and opening this avenue of recruitment as "a slow process."

HFSA's efforts to establish local relationships and a positive reputation in the community also supported outreach and recruitment. Local doctors who accept Medicaid, for example, now refer young mothers in need to HFSA. Focus group results supported the importance of doctor referrals as a recruitment source. Among the 21 mothers who participated in the second round of focus groups, five reported learning about HFSA from their doctor, one reported learning about it at the WIC office, and two reported learning about it through their school. Most others reported that they learned about HFSA's services at the hospital after giving birth. Staff reported that further efforts to reach enrollment targets included broadening outreach and services to include families living in outlying communities up to 70 miles away.

Despite their diverse, intensive recruitment efforts, HFSA's average monthly sample enrollment did not reach the original 20-per-month enrollment target. From May 2013 through April 2016, the agency recruited 595 young mothers for the study—an average of 16.5 each month, 83 percent of the original target. HFSA staff members tracked the number of young mothers they were able to recruit against the number of births to young women under age 21 in San Angelo's two hospitals. They reported that these numbers were very similar. For this reason, they believed they had reached almost all eligible young women in the region through their recruitment efforts. HFSA staff indicated that an important reason for the agency falling short of initial enrollment targets was the declining teen birth rate in the region, which has been trending downward in recent years, mirroring national trends.

Once a mother expressed interest in participating in home-visiting services (either in the hospital, at the school, or by phone), intake workers followed up within 48 hours to enroll her. Staff explained that if they were able to make contact with the mother again within 48 hours, she was more likely to complete intake and enroll in the program. If the mother was assigned to Traditional Healthy Families, intake staff collected some additional information regarding the pregnancy, school status, and other background information as indicated by the Healthy Families America protocol. If the mother was assigned to Steps to Success, the home visitor (rather than intake staff) conducted the intake assessment during the initial home visits to facilitate tracking the family's goals and progress from the beginning.

Most study participants were Hispanic and primarily spoke English; two-thirds were age 18 or older at enrollment

The characteristics of the teen parents served by HFSA reflect the characteristics of the broader San Angelo community. Among those enrolled through December 2015, 68 percent were Hispanic and 91 percent reported that English was the primary language they spoke at home (Table III.3). The young mothers ranged in age from 14 to 20 years old at sample enrollment, with two-thirds age 18 or older. About 4 in 10 had already graduated from high school or obtained their GED, and most of the remainder were still enrolled in school. About three-quarters of the mothers reported being in a romantic relationship with the baby's father around the time of sample intake. At study enrollment, 43 percent were pregnant, with the rest recruited within a few months of the birth of their baby. For most sample members, the pregnancy that made them eligible for the program was their first. Many had become sexually active at a young age. The median age at first intercourse was 15 years old.

According to program staff, most participants lived in San Angelo, with others living in small outlying towns. HFSA services were not limited to families with incomes below a specified level. Even so, staff reported that participants tended to be low-income. As one staff member indicated, "They're all poor." Staff also emphasized that, in practice, they have found that there is no "typical" family served by HFSA.

Staff and focus-group participants identified several key risk factors shared by study mothers and fathers. According to staff, the most prevalent risk factor was lack of knowledge about birth control and pregnancy, including low awareness of forms of birth control, a lack of understanding of STDs and their sources, and poor communication within families. A staff member reported that many "do not use and/or don't know about different types of birth control, how to use them, and their effectiveness," and have not "thought about how can we prevent that next baby." Staff reported that teens get most of their information from friends. Several staff members similarly noted low awareness of STDs.

Staff also talked about participants' limited "executive functioning" and ability "to think critically, make logical connections, [and] become better problem solvers" as primary risk factors. One staff member explained, "They're teenagers…the thought processes are totally different." Participants tend not to have good communication with their parents, especially about sexuality; a staff member noted that "if it has to do with sex, they don't want to talk to their parents about it." Other risk factors cited by staff included being young parents who are children of teenage mothers themselves, having criminal records, or having a history of domestic violence or drug abuse. Staff also reported that several families had unstable housing and stayed with friends or relatives and moved frequently as their circumstances changed.

Focus-group participants emphasized that the most common risk factor they faced was their lack of a support system in their lives and in the community. One participant explained, "I don't really have friends. I don't really talk to people. I like being able to talk to somebody." Another said, "I don't have very many friends. My home visitor is my best friend." Yet another explained that, "We are not from here, and we don't have anybody else that visits us." They regarded lack of support as one of the biggest challenges they faced prior to enrolling in HFSA.

Table III.3. Steps to Success and Traditional Healthy Families sample characteristics

Measure	Percentage
Demographics	
Age (in years)	
14 or 15	9
16	9
17	15
18	18
19	23
20	26
Race/ethnicity	
White, Non-Hispanic	28
African American, non-Hispanic	3
Hispanic	68
Other	2
Language spoken at home	
English	91
Spanish	7
Both English and Spanish	2
Sex	
Male	0
Female	100
Education	
Has high school degree or GED	42
No degree or GED but enrolled in school	38
No degree or GED and not enrolled in school	20
Family relationships	
Lives with biological mother	42
Lives with biological father	24
Lives with biological mother and biological father	18
Biological parents are married	29
Relationship with baby's father	
Married	15
Living together but not married	41
Dating but not living together	23
Not in a relationship	22
Pregnancy history and sexual risk behaviors	
Currently pregnant	43
Been pregnant more than once	20
Age at first Intercourse (in years)	
13 or less	10
14	17
15	25
16	24
17	19
18	6
Lifetime sexual partners	
One	27
Two	25
Three	20
Four or more	28
Sample size	**542**

Notes: Figures include those enrolled in the HFSA study from May 2013 through December 2015.

Percentage may not sum to 100 percent due to rounding.

Most participants had little or no sex education prior to study enrollment

Study participants reported little exposure to sex education prior to study enrollment. Less than one in five teen mothers in the study sample reported receiving any sex or relationship education in the year prior to study enrollment (Table III.4). Only about half had received information in the past year from a doctor, nurse, or clinic on STDs, methods of birth control, or where to get birth control. When they enrolled, many of the teen moms did not respond accurately to questions about contraception and STDs. For example, only about one-third were aware that condoms substantially reduced the risk of pregnancy or HIV/AIDS. Most did not know that oral contraceptives do not decrease the risk of HIV/AIDS.

Table III.4. Study participants' prior sex education and knowledge of contraceptive effectiveness at study enrollment

Measure	Percentage
In the past year, attended classes/sessions on:	
STDs	15
Abstinence	7
Relationships, dating, or marriage	7
Methods of birth control	12
Where to get birth control	12
Any of the above	17
In the past year, received information from a doctor, nurse, or clinic on:	
STDs	47
Methods of birth control	53
Where to get birth control	48
Condoms decrease the risk of pregnancy	
A little or not at all	23
A lot	37
Completely	8
Don't know	32
Condoms decrease the risk of HIV/AIDS	
A little or not at all	21
A lot	32
Completely	7
Don't know	41
Oral contraceptives decrease the risk of pregnancy	
A little or not at all	21
A lot	30
Completely	5
Don't know	43
Oral contraceptives decrease the risk of HIV/AIDS	
Not at all	14
A little	15
A lot or completely	18
Don't know	54
Sample size	**542**

Source: Figures include those enrolled in the HFSA study from May 2013 through December 2015.

IV. PREPARING AND SUPPORTING HOME VISITORS TO DELIVER STEPS TO SUCCESS AND TRADITIONAL HEALTHY FAMILIES

For a strong test of the effects of Steps to Success relative to Traditional Healthy Families, HFSA had to implement both programs with fidelity to their plans. To achieve this objective, HFSA invested considerable resources in selecting home visitors with characteristics that would enable them to implement each program well, and in the case of Steps to Success, home visitors who would also be comfortable discussing reproductive health topics. Home visitors also received extensive training that included practice and feedback. After they began working with families, they received regular supervision and feedback. HFSA also facilitated supportive communication systems within HFSA and with other organizations. Below, we describe in more detail these aspects of preparing and supporting home visitors.

HFSA selected home visitors carefully to meet the needs of each program

When the evaluation began, HFSA needed home visitors for (1) Steps to Success, for young mothers in the treatment group and (2) Traditional Healthy Families, for young mothers in the control group. For both programs, some home visitors were staff members who already worked at the agency; HFSA hired others after the evaluation started.

HFSA leaders felt strongly that the two programs required home visitors with different strengths. They therefore did not assign home visitors randomly to the two programs. HFSA's leadership wanted Steps to Success staff to be comfortable with, and nonjudgmental about, topics related to youth sexuality, sexual intimacy, contraception, and reproductive health, and actively sought these characteristics in staff selections and new hires. If a manager did not think a staff member could readily discuss these topics, or staff members themselves indicated that they were uncomfortable with these topics, the manager did not select that candidate for Steps to Success.

When hiring new staff, HFSA leaders invested considerable time in interviewing applicants and assessing their skills and attitudes to ensure that they would be a good fit with the organization and Steps to Success. HFSA did not use a specific set of qualifications when making hiring decisions, but focused on selecting and hiring staff who were flexible, patient, nonjudgmental, comfortable discussing sexuality, and had the "right attitude" toward supporting young families, as determined through interviews and discussions with applicants after they observed home visits conducted by staff.

Staff in both programs reported the importance of having a nonjudgmental orientation toward young parents as critical to their work. They noted that they had to be able to address the many challenges the young families faced openly and without being judgmental. This approach served as a basis for establishing a relationship with their families, and they regarded the trust that emerged from these relationships as central to program success. Staff delivering both programs expressed a notably positive orientation toward HFSA as an organization and toward the Steps to Success and Traditional Healthy Families program models individually. For example, by the time of the second site visit, 93 percent of the staff working with the two programs strongly agreed with the statement, "I feel like HFSA's home-visiting programs can make a difference for program participants." Most respondents (60 percent) strongly agreed (and the rest agreed) with the statement, "HFSA's home-visiting programs address many of the risks young people in our community face."

HFSA employed 15 women and 3 men; 2 of the 3 men served in supervisory positions. HFSA staff members included a mix of recent hires and long-term employees. By the second site visit, nearly half of the 15 staff members working directly with the two home-visiting programs had worked with HFSA for five or more years, while 13 percent had worked for HFSA for less than a year. Eight reported their ethnicity as Hispanic; other staff reported that they were non-Hispanic whites. Staff members ranged in age from 29 to 58 with an average age of 43 years old. Forty percent had bachelor's degrees. Anecdotally, a few staff members reported having been teen parents themselves. One explained, "I was a teen mom myself…All the things they're going through, I can relate totally, with a total nonjudgmental side…I know that's why this job really fits me and speaks to me."

Because staff members were not assigned randomly to the two programs, there were some differences in the characteristics of Steps to Success and the Traditional Healthy Families home visitors. Two differences were particularly notable: (1) the length of time they had worked with HFSA and (2) their level of education. The organization hired several new home visitors to meet the needs of the evaluation and assigned these staff members to work on Steps to Success. As a result, Steps to Success home visitors had shorter tenures with HFSA, on average, than Traditional Healthy Families staff. In addition, on staff surveys, the two groups reported different educational levels, with 63 percent of Steps to Success home visitors holding a bachelor's degree, compared with 25 percent of Traditional Healthy Families home visitors.

HFSA provided home visitors with intensive training

Both Steps to Success and Traditional Healthy Families home visitors received multifaceted training from the executive director, supervisors, and experienced home visitors. This instruction included classroom-based education with active learning and role playing, shadowing more experienced home visitors, and conducting home visits accompanied by a supervisor or more experienced home visitor who then provided feedback.

Staff reported that when the evaluation began, new hires received a full week of training primarily led by the executive director, incorporating both one-on-one and group sessions on a range of topics (Table IV.1). The purpose of the training was to teach staff HFSA's approach to home visiting, especially the importance of developing a relationship with the young families, to "establish rapport, trust" through "communication strategies you use to get information across while keeping dignity intact, stimulating thinking, getting them to move forward." They practiced reflective or guided questioning, a key feature of HFSA's approach.

A group of relatively new hires described their group training as a 40-hour-long "core training" that was both "very structured and experiential," focused on topics and strategies for developing trust and supporting program goals. Staff described training goals as designed to "get people trained on how to live the concepts…to be able to automatically see the strengths in a person, an environment, a situation" and to help the home visitor help the young parents to help themselves.

Table IV.1. Overview of HFSA home visitor training topics

Training focus	Topics
Both Steps to Success and Traditional Healthy Families home visitors	
HFSA organization	Vision, history, accomplishments, and organizational structure Goals Philosophical foundation
Working with families	Strength-based approach Relationships with families Communication Problem-solving Creative outreach/engagement Cultural competence Child development Parenting, parent-child interactions *Healthy Babies… Healthy Families* curriculum *Ages and Stages Questionnaires* Building trust and creating rapport Family support Home visiting Shadowing a home visitor Family support assignments
Steps to Success home visitors only	
Types of questions	Open-ended questions Motivational questions to inspire action
Initial home visits	Guide to contraceptive counseling Assignment to a family Priorities for early visits
Getting to know families	Guide to gathering assessment information Prenatal families Postnatal family guide Reflection on first home visit with a family
Working with men	Primary needs Father involvement with children Father influence on school readiness Consequences of father absence Involving dads prenatally Mothering and fathering Getting men to talk, act Adopting a new behavior Common pitfalls
Using the curriculum with both parents	How to use the strategies in the basic training with both mothers and fathers

Note: Appendix B includes a more detailed list of training topics.

New Steps to Success home visitors also described receiving training focused on contraception and LARCs, engaging fathers, and adulthood preparation, especially education and career-focused planning and activities. Staff reported that in this part of the training they practiced a motivational interviewing technique in which they asked young parents a number of questions that encourage them to think critically about their choices, their baby, contraception, and future plans to encourage parents to come to their own decisions. Home visitors also learned a mirroring technique to adjust their orientation and interactive style to the individual family to help increase the comfort of the home visit.

After classroom-based training, home visitors were paired with experienced home visitors from the program in which they would be working (Steps to Success or Traditional Healthy Families) so they could shadow them on visits. During shadowing, the new home visitors were encouraged to observe the relationship between the parents and the experienced home visitor, how the home visitor built rapport, and how the curriculum was presented. After the visit, the new home visitors discussed the visit with the home visitor they accompanied; completed a structured observations sheet; completed a form collecting information about the visit, the services provided, and key status indicators as if they had conducted the home visit; and met with their supervisor to review questions and compare the written home visit record form to the one completed by the experienced home visitor. New home visitors reported that this formal training period lasted two to three weeks. After the formal training, home visitors were assigned their first family as soon as a new family enrolled in the program.

New staff who joined the program after the initial training received similar training. The initial classroom-based training was provided one-on-one instead of in a group and varied in duration, but it addressed the same topics. New staff also participated in the experiential elements of the training (shadowing and home visits accompanied by experienced staff who provide feedback). Supervisors indicated that training usually takes about a month, but the training period varies according to the individual and the availability of new families to assign to the new home visitor.

Staff described their home-visitor training positively. All survey respondents affirmed that they "have the necessary training needed to implement the program" and that the training helps "facilitate implementation of HFSA's home-visiting programs." No staff agreed that "training activities take too much time away from delivery of home visiting and other program services" or that "it is too difficult to adapt information and skills learned in the trainings so that they will work in HFSA's home-visiting programs."

Ongoing training involved supervisor observation and feedback on selected home visits. Initially, supervisors observed a home visit for each home visitor about once a month to ensure that home visitors were adhering to the program model. During an observation visit, the supervisor would monitor the interactions between the visitor and the family. Afterward, the supervisor met with the home visitor to offer coaching, critiques, suggestions for improvement, and positive reinforcement. By the second site visit, when all home visitors had been with the program at least six months, an experienced home visitor was responsible for supervisory observations in both Steps to Success and Traditional Healthy Families, and she reported observing a home visit for each home visitor every three to four months.

Staff for both programs received strong supervisory support

For both Steps to Success and Traditional Healthy Families, HFSA's supervision system involved structured weekly, one-on-one meetings between supervisors and home visitors, as well as the regular home-visit observations described above. HFSA employed one outreach and intake supervisor, who oversaw outreach and intake staff (two workers initially, then one worker by the time of the second site visit); one Traditional Healthy Families supervisor, who supervised three to four Traditional Healthy Families home visitors; and one Steps to Success supervisor who oversaw six Steps to Success home visitors and another home visitor who conducted quality-assurance home-visit observations and carried a reduced caseload of families.

The 60- to 90-minute weekly supervisory meetings with each home visitor focused on reviewing a form that home visitors completed after each visit documenting the time, length, and location of the visit; who participated; what services were provided; results from an infant development screening tool; and a contraception update (Steps to Success visits only). The supervisor and home visitors reported discussing the progress of each family in their caseload, identifying any challenges or questions. The supervisors also initiated ad hoc check-ins with their home visitors after the first visit with a new family or if a challenge emerged.

Home visitors in both programs reported enjoying supportive relationships with their supervisors; many of them commented on the open communication and open-door policy. One staff member elaborated, "They bring everything up. We never feel like we're being attacked. It is all for the family." Staff survey respondents from both Steps to Success and Traditional Healthy Families affirmed that supervisors provided "clear, concrete feedback that [the home visitor] can use to improve the delivery of HFSA's home-visiting programs." Supervisors described the importance of supervision for coaching home visitors to gain perspective and improve their skills; they also described the home visitors as open to and eager for feedback.

Supervisors also met weekly with HFSA leadership to discuss issues with implementation, struggles faced by new staff, or the need for refresher trainings for experienced staff, among other issues. They reported that the purpose of these meetings was to address challenges proactively.

HFSA developed a system for assigning home visitors' caseloads to ensure manageable workloads

HFSA designed a caseload management system to help each home visitor maintain a schedule of about 15 home visits per week. This level of home visits was chosen so that home visitors would have the necessary time with families to build trusting relationships and complete planned activities. This expectation for the number of home visits to be completed weekly also allowed home visitors time to reschedule canceled home visits and complete required planning and reporting.

HFSA planned for each home visitor in both programs to have a weighted caseload of about 30. According to program documents describing the weighted caseload system, families at Level 1 (weekly home visits) receive a weight of 2.00; families at Level 2 (biweekly home visits) receive a weight of 1.00; and families at Level 3 (monthly home visits) receive a weight of 0.50. New families who are reluctant to begin services and families who have been receiving services

for at least three months but begin declining services are considered to be in creative outreach (designated as Level X in the program's level system) and receive a weight of 0.50 while home visitors work to re-engage them. HFSA supervisors also took into account travel time needed to complete home visits with families who lived outside of San Angelo in the areas to which HFSA expanded recruitment; they assigned families in outlying communities to the same home visitor and adjusted caseload weights to account for increased travel times when necessary.

HFSA aimed for home visitors in both programs to complete no more than 15 home visits per week. At one extreme, a home visitor might have a caseload of 15 families receiving weekly visits (equivalent to a weighted caseload of 30), or at the other extreme, a caseload of 60 families receiving monthly home visits (also equivalent to a weighted caseload of 30). In practice, home visitors' caseloads included a mix of families at different levels of home visit frequency. HFSA leaders anticipated that on average, Steps to Success home visitors would have smaller caseloads than Traditional Healthy Families home visitors. Families in the latter program were expected to move through the levels of home-visit frequency more quickly, because they had to meet fewer criteria for moving to the next level.

Strong communication and coordination internally and externally supported implementation of both programs

HFSA communication systems included formal and informal pathways, from the regular all-staff meetings and separate Steps to Success meetings, to deliberately informal peer-to-peer learning and problem-solving discussions. All staff across both programs met weekly to discuss broad issues related to home visiting, brainstorm problem solving, and address organizational issues. During these meetings, staff explained that the executive director shared new information about home-visiting practices, local resources available to young parents, and other relevant developments in the local community. The executive director also used these meetings to obtain feedback from all staff.

After the weekly all-staff meeting, supervisors met with their home visitors as needed. Steps to Success staff noted that they met as a team (without the Traditional Healthy Families home visitors) about once a month to share program information and discuss how to address emerging program issues and challenges.

The HFSA office space encouraged informal communication. All home visitors shared a large, open office space, with nine desks arranged around the perimeter of the room and located next door to offices of the intake staff, supervisors, and executive director. According to the staff, informal discussions focused on problem solving, brainstorming, identifying resources in response to various parent needs, and peer-to-peer support occurred throughout the day in HFSA's shared office space. The executive director explained that the shared space was designed to encourage this kind of communication among home visitors, as they are often best positioned to help one another develop solutions to key challenges and questions they experience in implementing home-visiting services.

An annual staff retreat also provided an opportunity for communication. All staff spent three days together each July discussing the organization, home visiting, teamwork, and other key topics related to supporting staff and institutional functioning. On the staff survey, 93 percent of staff at the time of both site visits (all Steps to Success staff and all but one Traditional Healthy Families staff) indicated that HFSA communication protocols were "clear" and that they knew who to consult about problems or issues that arose from their work implementing HFSA's home-

visiting programs. Among the staff involved in implementing each program, all of the Steps to Success and all but one of the Traditional Healthy Families staff agreed that the communication pathways were clear.

HFSA maintained clear communication with external partners. HFSA had memoranda of understanding in place with two local hospitals and informal relationships with two other hospitals in the surrounding area to recruit young parents to the home-visiting programs. HFSA also developed informal relationships with the local high schools to conduct outreach and recruit pregnant teens with the help of school guidance counselors. In addition, the agency had informal relationships with three local OB/GYN doctors who referred young mothers to the program. HFSA staff also obtained state approval to recruit in local WIC offices.

HFSA maintained collegial relationships with several faith- and community-based organizations that provide support to young parents, including health clinics, support groups (for example, for survivors of domestic violence), food pantries, second-hand furniture programs, shelters, housing programs, and employment training programs. These relationships provided important referral resources for the programs (Steps to Success home visitors worked to connect families with needed resources, while Traditional Healthy Families home visitors told families about resources but did not follow up on referrals). HFSA staff also reported “broad” community support for their program, as often demonstrated through word-of-mouth referrals to HFSA, community donations, and positive relationships with these local institutions and organizations.

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V. ADHERING TO THE IMPLEMENTATION PLAN AND ENGAGING PARTICIPANTS

The evaluation team conducted the implementation study of Steps to Success and Traditional Healthy Families in conjunction with a rigorous impact study. This impact study will measure the effects of Steps to Success, relative to Traditional Healthy Families, which takes a more typical approach to home visiting. In this chapter, we examine a central question for the implementation study: whether HFSA succeeded in operating two distinct programs that generally adhered to their initial plans. The answer to this question will be crucial in our interpretation of impact findings. Specifically, we examine the actual services delivered by each program. We also examine whether HFSA home visitors delivered the services with fidelity, and whether the services of each program differed as planned. Our assessment of fidelity encompassed adherence to plans for the delivery of program content and dosage, the quality of program delivery, and the participant responsiveness (retention, completion of home visits and engagement in visit activities).

HFSA staff generally followed through with their initial implementation plans for both programs

In implementing both Steps to Success and Traditional Healthy Families, HFSA followed through on its initial plans for both programs but made a few adjustments when circumstances warranted. As noted earlier, for Steps to Success, HFSA originally planned to address adulthood-preparation topics in group sessions but instead decided to address these topics in home visits due to concerns about the cost of group sessions.

HFSA also encountered difficulties in meeting enrollment targets. These experiences led HFSA to expand its service area and expand recruitment efforts to more schools. HFSA also sought community referrals (doctors, WIC offices), and word-of-mouth referrals. In addition, HFSA initially planned primarily to recruit teen parents at local hospitals when their babies were born. After enrollment began, the program recognized the value of enrolling mothers prenatally not only to increase recruitment but also so that there would be more time to discuss contraception with mothers in Steps to Success.

In both Steps to Success and Traditional Healthy Families, HFSA aimed to keep families with the same home visitor throughout their time in the program. HFSA leadership reported that they were generally able to achieve this goal. HFSA staff reported that home visitor turnover was low and poor family-home visitor matches were rare.[10] Prior to the first site visit in 2014, one Steps to Success home visitor left on maternity leave and, after having the baby, decided in consultation with HFSA not to return. HFSA redistributed her caseload among the other Steps to Success home visitors. Between the first and second site visits, a Traditional Healthy Families home visitor left HFSA because her family relocated due to her husband's work. No other home visitors or supervisors had left HFSA at the time of the second site visit in February 2016.

[10] HFSA tried to match parents and home visitors based on personality and needs using information about a family's situation collected during intake and the intake worker's sense of the parents' personalities. According to staff, in a few cases, the home visitor and family "just don't click," and the program assigns the family to a new home visitor.

Following the Healthy Families America critical elements and their initial plans, HFSA assigned caseloads to home visitors in both Traditional Healthy Families and Steps to Success so that home visitors would have about 15 families to visit each week. This approach was possible with fewer home visitors in Traditional Healthy Families because, as expected, families in Traditional Healthy Families moved more quickly than Steps to Success families to higher levels that involved less frequent home visits. Staff in both programs reported that families moved through the levels as they achieved the benchmark criteria applicable to each program.

Supervisors and home visitors estimated that Steps to Success home visitors carried nonweighted caseloads of about 20 to 25 families, compared with nonweighted caseloads of about 28 to 35 families among Traditional Healthy Families home visitors. The smaller caseloads for Steps to Success home visitors are consistent with the expectation that families will take three to six months to meet the criteria for less-frequent home visits, instead of three to four weeks as expected for families in Traditional Healthy Families.

Steps to Success home visitors confirmed that their workloads were manageable, and they felt that the system for assigning caseloads was fair. Some home visitors had worked previously at other agencies and commented that HFSA keeps the workload "low compared to other programs." Traditional Healthy Families home visitors also indicated that their workloads were manageable, but some reported that their workload varied depending on their families' circumstances and availability for home visits.

Steps to Success participants received more home visits than Traditional Healthy Families participants did; this frequency reflects both Steps to Success' higher intended dosage and its lower rate of attrition

Participants in both Steps to Success and Traditional Healthy Families received a substantial number of home visits during their first year in the program. However, as planned, Steps to Success participants received more visits, on average, than Traditional Healthy Families participants did. Among all Steps to Success participants who enrolled through March 2015, home visitors conducted an average of 20 visits and spent an average of nearly 18 hours with either the mother or the father during the families first 12 months in the program (Table V.1). In contrast, participants in Traditional Healthy Families received an average of 12 visits lasting a total of 11 hours during their first year in the program (Table V.1).[11]

Because the number of planned home visits for each family is based on their progress in meeting program benchmarks, it is not possible to precisely measure how the average number of home visits for the two programs compare to the planned dosage. We can, however, develop a rough approximation of the ratio of actual to planned dosage. The expectation for Steps to Success families was that they would move from weekly to biweekly home visits within three to six months. For this approximation, we can use the midpoint of this range, four and a half months, for a family's time in Level 1 (weekly visits) and then assume that they move to Level 2 (biweekly visits) for the next four and a half months, before progressing to Level 3 (monthly

[11] As a comparison, the three studies of Healthy Families America programs that provided this information and that were summarized by ACF's Home Visiting Evidence of Effectiveness (HomVEE) review reported the average number of home visits during the child's first year of life as 13, 17, and 34 visits (http://homvee.acf.hhs.gov/Implementation/3/Healthy-Families-America--HFA--Implementation-Experiences/10/8).

visits) after nine months. These assumptions imply an expectation of 30 home visits in the first year for Steps to Success for the typical family. HFSA delivered, on average, 20 visits during the first year, about two-thirds of that expected level.

Table V.1. Number of home visits and proportion discharged during first year after program entry

	Steps to Success	Traditional Healthy Families
Percentage of sample members who had a visit that included[a]:		
Mother	95	85
Father	67	19
Mother only	92	84
Father only	36	2
Both mother and father	65	18
Either mother or father	95	85
Average number of visits with:		
Mother	18.7	12.2
Father	7.5	0.8
Mother only	12.2	11.5
Father only	1.4	0.1
Both mother and father	6.2	0.7
Either mother or father	20.0	12.3
Average length of time (in hours) with:		
Mother	16.7	10.9
Father	6.7	0.7
Mother only	10.7	10.3
Father only	1.0	0.1
Both mother and father	5.8	0.6
Either mother or father	17.7	11.0
Percentage of cases discharged within 12 months of program entry:		
Because they moved out of the service area	16	19
Because they declined program services	19	35
Another reason	0	4
Any reason	35	58
Sample size	**210**	**205**

Note: Data include cases randomized between May 2013 and March 2015.

[a] These categories are not mutually exclusive and therefore sum to more than 100 percent.

The expectation for Traditional Healthy Families participants is that they would move from weekly to biweekly home visits after three to four weeks. If we assume three visits in the first month, and then assume that families should move to Level 2 (biweekly visits) for the next eight months, before progressing to Level 3 (monthly visits) after nine months in the program, we would expect 22 home visits in the first year for Traditional Healthy Families participant. HFSA delivered, on average, 12.3 visits, 56 percent of that expected level.

An important reason that the average dosage of home visits fell below these targets was that HFSA discharged a substantial number of families during their first year in these programs. Among families enrolled through March 2015, HFSA discharged 35 percent of Steps to Success participants and 58 percent of Traditional Healthy Families participants within 12 months of program entry (Table V.1). The most common reason for discharge recorded in service use logs

was that participating families declined programming. During their first year in the program, HFSA discharged 19 percent of Steps to Success families and 35 percent of those in Traditional Healthy Families because they declined services. The second most common reason for discharge recorded in service use logs was moving out of the service area, with 15 percent of those in Steps to Success and 19 percent of those in Traditional Healthy Families discharged for this reason.[12]

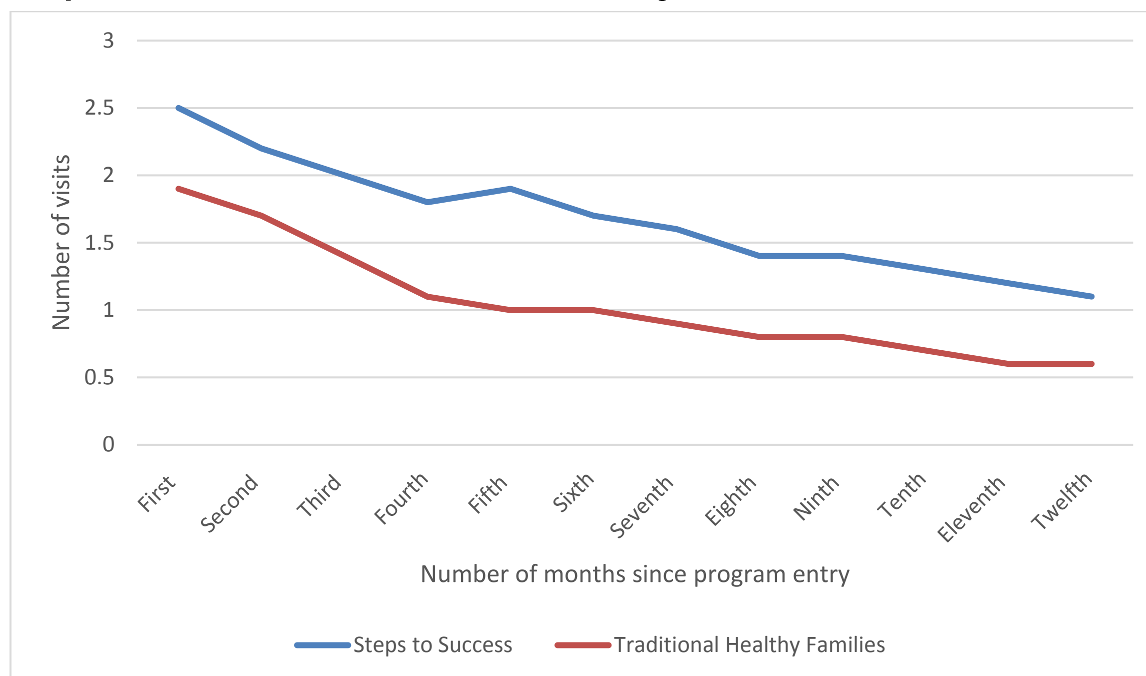
The difference between the two programs in attrition rates may reflect several factors. First, intake staff conducted the initial assessment with families in the Traditional Healthy Families program, while home visitors conducted the initial assessment with families in Steps to Success, which may have enabled home visitors in Steps to Success to engage families and start building trusting relationships with them right away. Second, staff indicated that because caseloads were higher in Traditional Healthy Families, home visitors did not have as much time to do creative outreach to engage reluctant families. Finally, the more comprehensive nature of Steps to Success relative to Traditional Healthy Families—with home visits focusing on contraception and career planning in addition to parenting and child development, and the active engagement of fathers in the program—may have made families more willing to maintain their participation in the program.

The higher intended dosage in Steps to Success relative to Traditional Healthy Families, combined with the lower rate of attrition from the program, led to more home visits each month for Steps to Success participants. Steps to Success participants averaged 2.5 visits during their first month in the program, compared with 1.9 visits for Traditional Healthy Families participants. By the 12th month, Steps to Success participants averaged 1.1 visits, compared with 0.6 visits for Traditional Healthy Families participants (Figure V.1).

As observed during the site visits, Steps to Success home visits primarily took place in the homes of participating families and lasted from about 45 to 90 minutes. Occasionally (staff estimated less than 10 percent of the time), home visits had to be conducted in other locations. For example, in one of the home-visit observations, the mother had just moved from a domestic violence shelter to an apartment provided by a faith-based organization that does not allow visitors. The home visitor picked the mother and baby up and brought them to the HFSA office, where they found a private space and proceeded with the visit. In another example, a home visitor described how one of her families had unstable housing and was staying with various friends. The mother was not comfortable having home visits where she was staying, so the home visitor met with the family at community locations—for example, the library or a shopping center.

[12] Program staff indicated that they only recorded a case in service use logs as having moved if participants told them they were moving. If families moved without informing the program, the program recorded the reason for discharge as “declined services.”

Figure V.1. Average number of visits each month during the first year in Steps to Success and Traditional Healthy Families



Note: Data include cases enrolled through March 2015.

HFSA maintained a strong contrast between the content delivered in Steps to Success and Traditional Healthy Families

Each individual home visit was guided by a weekly "plan for contact" log in which home visitors document their planned topics and activities for each family. Home visitors submitted their plans to the supervisor at the beginning of each week for use in supervision. These plans were based on previous progress through the sequence of curriculum topics (based on the child's age and stage of development and in Steps to Success, the family's duration in the program) and sometimes current family issues and concerns. In addition to reminding home visitors what curriculum materials and worksheets to bring, this documentation reminded them of planned activities for each home visit. They kept visit plans short to allow the visits to respond to immediate family needs and questions. Figure V.2 illustrates a sample weekly plan from a Steps to Success home visitor. Many of the home-visit plans focused on child-development topics, but also included other key Steps to Success topics, such as birth control, the importance of fathers in children's lives, and relationship skills.

In practice, home visitors explained—and observations confirmed—that visits integrated curricular materials, planned activities, and in Steps to Success visits, follow-up on ongoing referrals, but allowed current family issues to lead where necessary. Home visitors in both programs noted that they sometimes had to defer all planned activities to immediate needs, especially in cases of a crisis. If they were unable to cover planned content during the visit, they indicated that they returned to it during the next visit. After each visit, the home visitors documented the topics and activities using a form that they later submitted to their supervisor.

Figure V.2. Sample brief plan for contact (Steps to Success home visitor)

Brief Plan for Contact

Date	Family	**Brief Plan for HV Contact** (e.g. curriculum, concepts to be emphasized and/or developed, goals, specific issues to be addressed, etc.)
9/2014	[illegible] ✓	Child Development: 15 months: Helping her learn language and about life, the magic shirt
9/2014	[illegible] ✓	Spot the Butterfly Child Development: 3 months: Helping her body and brain grow, learn language and about life
7/2014	[illegible] ✓	Child Development: 11 months: how much food , handling the No No's, more on baby proofing / Play and grow: Name those parts and where did it go!
8/2014	[illegible] ✓	Child Development: keeping her world safe couple time, time out, a mouth full of sound, play with your food, track down the toy 9 months
8/2014	[illegible] ✓	Child development: 7 month: Helping his body , brain grow, TV or not TV, helping him learn language and about life
8/2014	[illegible] ✓	Child Development: 11 months: Helping his body grow, a health diet, helping his brain grow , helping him
6/2014	[illegible] ✓	Child development: prenatal 17 weeks / Step to success: Quick look at choices
8/2014	[illegible] ✓	Child Development: 5 months : Helping her learn language and about life, a whole night of sleep / Step to Success: birth control
8/2014	[illegible] ✓	Child Development: 3 months: helping his body grow and brain grow, What color is your baby's brain /Step to success: review birth control
7/2014	[illegible]	Child development: prenatal 17 & 18 weeks / Getting to know the family and assessment/ step to success: LARC
7/2014	[illegible] ✓	Child development: 1 month: Your Child's Health and Safety, Play and Grow: "Hanging Around, why Dad is so important, what can happen if dads aren't involved./ assessment
7/2014	[illegible] ✓	Child development: 1 month: Helping your baby grow, bonding, feeding, sleeping-dressing - grown/ Getting to know the family and assessment/ Step to success: birth control
7/2014	[illegible]	Child development: 38 prenatal/ Step to success: birth control
1/9/14	[illegible] ✓	Child Development: 4 months

Note: Names have been blurred to maintain family privacy.

Frequently, home visitors reported that when they arrived, they were required to attend to other issues at hand. Even so, they tried to weave in discussion of the planned topics, and they left written curriculum materials for the parents to read and keep in their baby book (a notebook provided by the program) for later reference. For example, during one observation, the home visitor had planned to cover key topics in infant development, but learned that the mother was having trouble getting food for her family because she had let her government benefits lapse. As a result, they spent most of the visit problem solving, discussing how to get re-enrolled in Supplemental Nutrition Assistance Program (SNAP) and WIC, and which food pantries to use in the interim. This matter took up most of the visit, but toward the end of the visit, they discussed the planned infant-development topics. Program records indicate that despite the need for home visitors to respond to the family’s immediate needs, they were typically able to cover core content area. For example, parenting education was discussed in almost every visit—19.3 out of 20.0 visits in Steps to Success and 12.2 out of 12.3 visits in Traditional Healthy Families (Table V.2).

Program data indicate that HFSA staff maintained the planned differences between Steps to Success and Traditional Healthy Families home visit subjects. During their first 12 months in Steps to Success, most participants discussed contraception, education, and employment with their home visitor, while almost no participants in Traditional Healthy Families did so (Table V.2). Steps to Success home visitors covered each of these topics with families in an

average of 8 to 10 visits during their first year in the program. Some Steps to Success participants also discussed relationships skills, financial literacy, and STDs with their home visitor, while no Traditional Healthy Families participants did so.

Table V.2. Content covered and services delivered during first year after program entry

	Steps to Success	Traditional Healthy Families
Percentage who discussed the following PREP topics:		
Contraception	90	0
STD education	13	0
Employment and career training	82	0
Educational training	84	2
Financial literacy	21	0
Relationship skills	50	0
Any of the above	92	2
Percentage who discussed parenting education	95	85
Percentage who received:		
Referral	71	39
Transportation assistance	32	16
Average number of visits	20.0	12.3
Average number of visits where the following PREP topics were discussed:		
Contraception	7.9	0.0
STD education	0.3	0.0
Employment and career training	9.8	0.0
Educational training	8.9	0.0
Financial literacy	0.5	0.0
Relationship skills	2.1	0.0
Any of the above	16.5	0.0
Average number of visits where parenting education was discussed	18.0	12.1
Average number of visits where family received:		
Referral	3.2	1.2
Transportation assistance	1.1	0.6
Sample size	**210**	**205**

Note: Data include cases randomized between May 2013 and March 2015.

During their first 12 months in the program, Steps to Success participants were nearly twice as likely as Traditional Healthy Families participants to receive a referral and to receive transportation assistance. The higher prevalence of referrals in Steps to Success likely reflects the broader range of needs addressed by Steps to Success home visitors. The greater likelihood that Steps to Success participants received transportation assistance is consistent with home visitors' descriptions of their commitment to taking mothers to medical appointments for contraception if necessary to help them obtain a LARC while they still had Medicaid coverage.

Site-visit interviews corroborated these differences, with Steps to Success home visitors reporting that they covered more topics and included more components than did Traditional Healthy Families home visitors. Steps to Success home visitors discussed how they worked to support young families to find and use contraception, especially a LARC; improve their communication, decision making, and problem-solving skills; locate available community resources and services; and identify and pursue goals, especially educational and career aspirations. Traditional Healthy Families home visitors reported covering healthy infant

development and parenting skills, as well as offering a few referrals to community resources. Steps to Success home visitors reported extensive use of the Steps to Success curricular materials, provision of significant follow-up on referrals offered, and active engagement of the fathers, none of which were noted by Traditional Healthy Families home visitors.

As intended, Steps to Success engaged many fathers in home visits while Traditional Healthy Families did not

Engagement of the baby's father was a core component of Steps to Success implementation. Throughout Steps to Success, staff reported actively seeking to engage fathers in home visits, even if the father was no longer in a relationship with the mother. The home visitors encouraged fathers to be involved in all decisions, including those related to birth control, if appropriate.

HFSA employed one male Steps to Success home visitor. He had a regular caseload and like other female home visitors, worked to engage fathers whenever possible. He was also available to work with fathers in other families when needed, for example, if the father provided a large part of the baby's primary care or had questions or concerns he would prefer to discuss with another male.

The Steps to Success home visitors noted that they were countering the stereotype that dads don't change diapers or cook. They tried to increase fathers' confidence. For example, a home visitor might say, "Look at the curriculum, you can bond with the baby; it'll help the baby do better in school. Look at how he smiles at you, how he looks at you!" The home visitors noted that sometimes the fathers had never been told that they could be active and engaged parents and that their involvement was important.

The fathers participating in focus groups expressed appreciation for the support and skill-building activities of Steps to Success, especially the opportunity to improve communication and co-parenting skills, and to learn about their infant's development. They described attending almost all home visits, unless they had to work. One father explained, "I'm there every time they come visit, we talk about a lot of stuff and how to be better parents and how to keep the baby growing healthy, and we have fun." Another father explained, that home visits are "worth it for all the knowledge that they give you. If you don't know what you are doing, it is hard to raise a kid…everything she brings, we read and talk about."

Program data confirm fathers' involvement in Steps to Success. Among Steps to Success families, 67 percent received at least one visit that included the father during their first 12 months in the program; 36 percent had a visit that included the father only during this period (Table V.1). These figures contrast sharply with the experience of families enrolled in Traditional Healthy Families. Among these families, only 19 percent received a home visit that included the father during their first 12 months in the program; only 2 percent had a visit that included the father only. Staff emphasized that Traditional Healthy Families "does not involve dads," explaining, "dads will be around, but they're not involved in the home visit." Home visitors did not attempt to schedule the visit around the father, nor did they directly engage him during the visits.

Medicaid time limits on postpartum coverage created time pressures for discussing contraception with participants in Steps to Success

Steps to Success home visitors worked hard to quickly establish trusting relationships with their new families so they could begin discussing goals, healthy birth spacing, and contraception to support the family's goals. Home visitors emphasized long-term contraception but worked with families to choose the method that they felt was best for them. Because Medicaid pays for all forms of FDA-approved birth control (including LARCs) for a limited time after a child's birth, home visitors made contraception a high priority in their early discussions with families (unless participants were enrolled prenatally and the Medicaid time limit was not imminent). Because Texas did not accept Medicaid expansion under the Affordable Care Act, for mothers under 18 years of age, available coverage for birth control and other postpartum health care ends 60 days after the birth of the baby.[13]

The limited time frame for Medicaid coverage created a challenge for Steps to Success. Several staff noted that LARC options tend to be very expensive, costing as much as $1,200 if not covered by insurance.[14] Staff and young parents frequently mentioned Medicaid coverage as their best option for paying for contraception and a strategy central to Steps to Success.[15] As one staff member put it, "We have eight weeks to make it happen."

Although home visitors gave priority to discussing goals, healthy birth spacing, family planning, and contraception, they did not always lead with the topic, particularly prenatally, and wanted the mothers to come to a decision on their own about what might be right for them. The home visitors focused on asking detailed questions designed to encourage the young mothers to think critically about their choices and to help them identify their "obstacles [to contraception] and plan for all of them."

Steps to Success home visitors noted that one challenge in educating families about LARCs was figuring out what the barriers to LARCs were for each individual family and dispelling myths and misinformation. Staff used curriculum materials to introduce mothers and fathers to LARCs but also had to address teens' reluctance to consider LARCs because of stories they heard from people they know or that they read on the Internet. One home visitor noted that TV commercials that included warnings about side effects were not helpful, because helping teens understand the small risks highlighted in the commercials "takes a lot of education on our part and finesse."

[13] As we note in Chapter II, women 18 to 44 are eligible for the Texas Women's Health Program, which covers birth control, including LARCs. The Affordable Care Act allows states "to expand eligibility for family planning, up to the highest income-eligibility level for pregnant women in place under either the state's Medicaid or CHIP state plan." See Sonfield et al. "Estimating the Impact of Expanding Medicaid Eligibility for Family Planning Services: 2011 Update" at http://www.guttmacher.org/pubs/Medicaid-Family-Planning-2011.pdf.

[14] According to Advocates for Youth, some LARCs such as Implanon or Nexplanon cost $400 to $800 for insertion and $100 to $300 for removal and protect against pregnancy for three years. IUDs cost $500 to $1,000 for both the device and insertion, and protect against pregnancy for 5 to 10 years. (Removal involves additional cost.) http://www.advocatesforyouth.org/publications/publications-a-z/2083-providing-larcs-to-young-women.

[15] The Affordable Care Act requires private insurers to cover "[a]ll Food and Drug Administration-approved contraceptive methods prescribed by a woman's doctor," including LARCs. Some religious employers are exempt from covering contraception and contraceptive counseling (healthcare.gov).

Staff reported that their approach to healthy birth spacing and contraception was to first "build that trusting relationship with our families," as a basis for having a conversation (or series of conversations) about contraception and family planning. Staff explained that they tried to make the conversations about contraception "natural," as if they were "talking to a neighbor," without seeming "forced or intrusive." Steps to Success home visitors explained that the topic of birth control tended not to arise organically or at the request of participants. Instead, almost all staff described how they initiated the topic when the mother was still pregnant or very soon after the baby's birth. If the mother did bring up contraception, the home visitor addressed her concerns immediately, even if she had not planned to cover that topic.

Critical to supporting their identification of a method of birth control was helping the mothers keep their six-week postpartum appointment with their doctor. As the standard of care, Medicaid pays for this appointment and any birth control requested (including a LARC) at the visit. Following their approach of guided questioning, the home visitors encouraged the mothers to keep this appointment by asking, "When is your checkup? How are you going to get there? Do you want me to go with you? [Should I] come pick you up?"

During focus groups in 2014, several Steps to Success participants corroborated staff descriptions of the emphasis on contraception. They described how the home visitors introduced the topic. One noted that her home visitor "talked about birth control a lot before the baby was born." Another explained that her home visitor helped her "decide which birth control I wanted." Similarly, a father in the 2014 focus group also noted a frequent emphasis on the topic. Participants in the 2016 focus groups rarely mentioned contraception. On average, they had been in the program for 12 months, and the focus group discussions may not have stimulated memories of early discussions about contraception. Program data also show that the contraception was discussed in an average of eight home visits in the first 12 months after random assignment, consistent with the emphasis on contraception during the first eight weeks postpartum.

Steps to Success home visitors discussed goal setting and birth control even when the teen mother lost her child

When young women who enrolled in Steps to Success while pregnant experienced a miscarriage, gave their child up for adoption, or had their child removed by Child Protective Services, Steps to Success home visitors continued to serve them, focusing on reproductive health and adult preparation. When this happened in Traditional Healthy Families, the home visitor continued to see the young women for several months but then closed the case. If the child was adopted by other family members, the program assessed whether the adopting relative needed child-development information and attempted to engage the adoptive parents in services.

Steps to Success home visitors felt they had been successful encouraging mothers to use contraception, especially LARCs. As one home visitor noted, "The other thing I have been amazed at is how many of these moms do get on the birth control as a result of Steps…I have a homeless mom on the implant." Program data indicated that, among those enrolled in the program through March 2015, 89 percent of postpartum Steps to Success mothers within the first 12 months after entering the program were using contraception at the time of their most recent home visit, with 71 percent using a LARC.

Illustrative Steps to Success home visit

This Steps to Success home visit took place in the home of a young mother and father who live together with the mother's family. The visit included both parents and the baby. The visit lasted approximately 45 minutes.

The home visitor focused the first part of the home visit on the development of the baby. The mother reported that the baby was cooing, smiling, and generally doing very well. The home visitor used a curricular sheet on infant communication to review how babies cue their parents on wants and needs through specific cries, responses to adult voices and tones, and facial expressions. The parents appeared very knowledgeable about their baby's communication and comfortable with the material. They asked the home visitor about specific behaviors of the baby and discussed how to respond appropriately.

The home visitor then turned to a relationship-building exercise called Message in a Bottle. The parents each completed a handout that instructed them to write down what they would want the other person to know if they were trapped on a desert island and could only communicate via a message in a bottle. The home visitor explained that the purpose of this activity is to help them recall the qualities they appreciate in one another. The parents completed the sheets separately. Then, the home visitor asked them if they would feel comfortable reading their responses to one another, which they did, with some shyness. They then discussed with the home visitor and one another why they had written each response.

After this exercise, the home visitor asked both parents about work and school. The mother had recently gone back to work full time now that the baby was more than 3 months old, which she reported as "a lot to handle" but going well. They also discussed school—both parents had recently completed high school—and the father's plans to take college courses. The home visitor concluded the meeting by asking the parents whether they had any questions.

Home visitors used motivational interviewing and guided questioning to encourage participants to develop good decision-making skills

Both Traditional Healthy Families and Steps to Success home visitors reported using motivational interviewing and guided questioning to help teen mothers learn to solve problems and be more assertive. In Traditional Healthy Families, home visitors indicated that they did not just provide mothers with child-development materials but guided them in solving problems with their children to teach them to be independent and give them confidence in their parenting.

Staff reported that Steps to Success home visitors encouraged young parents to develop the critical thinking skills necessary to support good decision making, goal setting, and action. Multiple staff described how they did not simply give information to the Steps to Success mothers or fathers, or even recommend different paths. They focused instead on motivation—getting a parent to identify and pursue a goal, and begin to act on it. They used motivational interviewing techniques, asking the mother and father questions designed to encourage them to think critically about their choices, their new baby, and their future. As one staff member described, the home visitors might initiate and guide a conversation about a key program topic, for example, contraception.

She described a guided questioning process in which a home visitor would ask, "How did you feel when you found out you were pregnant? Who's the first person you told? Was [the pregnancy] something you planned? What were you [using for contraception] then?" If the mother had been using any contraception, the staff member explained, it was likely an oral

contraceptive, which she said often proved ineffective in these cases. These mothers would generally tell their home visitors that their plan was to “go back on the pill.” The staff member explained, however, that despite seeing better alternatives, “we don’t tell people what to do, we just ask questions to stimulate thinking. That’s the art of this job…especially when you know what they need to do.”

Staff at various levels noted that motivational interviewing and guided questioning to encourage parents to arrive at their own decisions were crucial to Steps to Success. One staff member described the process as “a back door approach,” in which they start by talking about the definition of success, and then progress to how “one of the ways to take charge” is to decide if and when you want to have another baby. The staff member explained, “We want to make it more important to them than it is to us. That’s just more effective.” Steps to Success focus group participants reported that the desire to be a good parent motivated them to develop their skills and plan for their and their babies’ futures.

Steps to Success home visitors linked education and employment topics with parenting and contraception; Traditional Healthy Families home visitors did not focus on these topics

Unlike home visitors in Traditional Healthy Families, Steps to Success home visitors placed a strong emphasis on education and employment. Home visitors described how they focused on keeping young parents in school and considering college and a career. Both Steps to Success staff and young parents in the focus groups explained that home visitors often asked, “What did you want to do before you found out you were pregnant? Did you want to finish school? Go to college? Find a job?” Home visitors wanted the mothers and fathers to remember that “their lives [had] not stopped at age 15 or 18 or 20 just because they have had a baby.” Their approach involved integrating the message that the mothers and fathers should continue to plan for and pursue their future goals while parenting their babies, which will help make them better parents.

Steps to Success home visitors also linked future planning for education and employment to using effective contraception. As part of their approach to supporting parents to pursue their educational and employment goals, they wanted to help the parents think things through. One staff member explained, “A lot of [parents] are trying to finish high school, go to college…We’re there to give them support, get them the [family-planning] resources to get there.”

Steps to Success home visitors and participants also reported making and receiving extensive referrals and following up to connect parents with a diverse set of resources designed to support them in their pursuit of education and employment goals. This support included, for example, referrals to educational and employment training; contraceptive, counseling, and medical services; and providers of family supplies (such as food, diapers, baby clothing, and furniture). They also reported regularly assisting parents to follow through on these referrals and frequently followed up to ensure that families continued to use them.

Illustrative Traditional Healthy Families home visit

The Traditional Healthy Families home visit described below occurred in the home of a young mother and father who live together. The visit included the mother and her baby while the baby's father was at work. The visit lasted about 45 minutes.

The home visitor focused on child development for most of the visit. Several weeks prior to this visit, the baby was nipped on the cheek by the family dog. Part of the home visitor's agenda for the visit was to check on the baby's cheek and ensure the parents were taking him to any doctor's appointments necessitated by the injury. The small bruise on the baby's cheek looked like it was healing. The mother reported they have a follow-up visit in a few weeks. The home visitor planned to check back with the mother after that appointment even though it would be during her planned time off from work.

After talking about the baby's injury, the home visitor reviewed child-development topics including teething, the baby's sleep schedule, and branching out to different types of solid foods; each of these topics was initiated by the mother. The home visitor shared some tips about early solid foods and giving the baby different teething solutions such as a mesh fruit holder with a handle.

In addition to talking about child development, a small portion of the visit (about 10 minutes) was spent talking about other topics in the mother's life. She mentioned that she and her husband are thinking about selling their house. She also talked with the home visitor about spending time with her husband, and her home visitor encouraged her to set up a regular date night. She suggested that this time away from the baby would help them nurture their own relationship, which would in turn have a positive impact on their relationships with the baby.

The visit went very smoothly. The home visitor and the mother transitioned seamlessly through a diverse set of topics, and the home visitor reviewed the curriculum she brought with her as planned. The baby was crawling on the floor throughout the visit and seemed very comfortable interacting with the home visitor. She gently teased the baby a few times, and the mother got up from her chair to redirect the baby as needed. It was clear from the observed interactions that the mother and home visitor were very comfortable with each other.

The home visitor reported after the visit that she was pleased the baby was doing so well and that he was a few developmental milestones ahead of where she expected him to be by this visit.

Traditional Healthy Families home visitors told families about WIC, Medicaid, and other helpful resources. They did not, however, assist families in following through on this information or follow up to ensure that families used the resources. Traditional Healthy Families home visitors almost never discussed education or employment training or contraception, areas in which Steps to Success home visitors made referrals. According to program records, Traditional Healthy Families home visitors were substantially less likely than Steps to Success home visitors to provide referrals. During their first year in the program, 40 percent of Traditional Healthy Families participants received a referral, compared with 72 percent of Steps to Success participants (Table V.2).

Developing a trusting relationship with participants was important in both programs and key to addressing Steps to Success topics

Home-visiting programs seek to engage parents by providing social support and practical assistance in a nonjudgmental manner and building a trusting relationship with them. Through their relationships with parents, home visitors can reassure parents and persuade them to act on the information and advice provided in the program (Gomby 2005). Thus, a key goal for both

Steps to Success and Traditional Healthy Families home visitors was to build a trusting relationship with families.

Home visitors in both programs worked to build trusting relationships by focusing on supporting mothers (with Steps to Success also supporting fathers) with information and discussion. As one staff member explained, home visitors identify the parent's motivation and then tailor their approach to it: "Very few moms don't have motivation to connect with the child." To gain trust, some home visitors also said that when they visited a family, they brought only the curriculum material for that day. They intentionally avoided writing things down during the visit, so that the visit would feel personal and nonthreatening. If they needed more materials, they returned to their car to retrieve them.

As we discuss earlier, home visitors in both programs used active listening and guided questioning to gain a family-specific understanding of the situation and needs. This approach helped them determine which topics to present and when to present them; how much information the family could absorb at one time; and, in Steps to Success, how to focus on key goals, including contraception, building skills, setting goals, and pursuing future plans.

Focus-group participants in both programs often described their home visitor as a nonjudgmental and supportive friend. One participant explained, "At first it's weird, because you don't know them, but now I can talk to her about anything." Another described her home visitor as someone she could talk to "without being judged." She explained, "If you have a certain question or something's wrong, they're not going to look at you ugly and think 'what makes you think that?'" Another focus group participant described her home visitor as "a really good friend," explaining, "she kind of reminds me of a really good family member."

Establishing a trusting relationship with the family was particularly important for Steps to Success home visitors, given the array of issues the program addressed—contraception, romantic relationships, and education and career planning, in addition to parenting and child development—and the intimate nature of some of these topics. One staff member characterized "the relationship and the trust that's developed initially between the worker and the mom" as perhaps the most important component of Steps to Success. Multiple staff members and participants cited trust as critical to addressing difficult Steps to Success subjects, including parenting, romantic and sexual relationships, and pregnancy prevention. One staff member explained, "This whole program is a safe thing for them. We're there to talk them through their whole thing as a parent without them being afraid we're going to call CPS [child protective services] on them…We jump in there; we're uplifting, positive."

Program observations of both Steps to Success and Traditional Healthy Families home visits corroborated the reported positive home visitor-family rapport and trust. Observers assessed that the mothers were consistently engaged during the observed visits. Likewise, they assessed that the fathers, who were present (and sometimes the only parent present) during some of the Steps to Success observations, were nearly as engaged in the visits as the mothers. Observers also noted that parents frequently asked questions and actively participated in program activities. Parents appeared eager to report their accomplishments, to share their excitement over babies' achieving key milestones (such as turning over, smiling, or sleeping through the night), and to demonstrate their progress (such as one father showing the home visitor a new college computer

textbook). Parents also raised sensitive topics; for example, a mother reported that she had attended the first meeting of a survivors of domestic violence group, and a father mentioned that he was coping with single parenting during the mother's incarceration for unpaid traffic tickets. The mode and content of communication observed during site visits demonstrated trust and engagement between the home visitors and parents.

Completing visits often required home visitors to be flexible

Another notable feature of both Steps to Success and Traditional Healthy Families was the home visitors' flexibility and ability to adjust to parents' needs. This flexibility was often essential for completing regular visits in home-visiting programs. At HFSA, for example, 5 of the 10 planned observations during the first site visit had to be rescheduled at the request of the parents, which staff noted was not atypical. Parents had forgotten, did not show up, and in one case had been incarcerated so they could not meet with their home visitor. Home visitors quickly rescheduled each home visit for later that same day, the next day, or in one case the following week. By the second site visit, home visitors reported few home visit cancellations, but some experienced frequent rescheduling.

Staff had systems to ensure that visits could be rescheduled—either during planned gaps in their schedules or during evening or early morning hours. Strategies for minimizing cancellations and rescheduling included waiting to schedule visits until the beginning of the week and planning visits to families on the same day and at the same time every week. Nevertheless, flexibility was apparently central to completing regular home visits, building trust with parents by demonstrating home visitors' commitment to them, and supporting mothers and fathers even in the face of challenges or irresponsible behaviors. Program managers monitored home-visit completion by each home visitor and reported that completion rates were typically 90 percent or higher.

Flexibility was also required for creating rapport with diverse families. A supervisor noted that one of the things supervisors look for when hiring a new home visitor is a "very flexible personality" that allows the home visitor to adapt to every family she visits. One home visitor noted, "We go in not knowing how they're going to feel about us. We're trying to match up."

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VI. CONCLUSION

About one in six teen births are to young women who have already had a baby (Hamilton et al. 2015). Rapid repeat pregnancies can have adverse consequences for these young mothers and their children (Klerman 2004). A small but growing body of research suggests that intervention programs for adolescent mothers, particularly those that promote the use of LARCs, can reduce the risk of rapid repeat pregnancies (Smith et al. 2015). The study of Steps to Success in San Angelo, Texas, aims to build on this growing body of research.

This study will examine the effectiveness of Steps to Success, a home visiting program that offers counseling on contraception and adequate birth spacing, as well as parenting and child development issues, relative to an alternative home visiting program, Traditional Healthy Families, which focuses only on parenting and child development. Steps to Success differs from Traditional Healthy Families in other important ways. Steps to Success offers weekly home visits for a longer period, actively engages fathers in home visits as appropriate, and covers education and career planning. HFSA, an experienced, community-based organization in San Angelo, implemented both the Steps to Success and Traditional Healthy Families programs. This report examines the implementation of these two programs.

HFSA developed Steps to Success to address a pressing service need in the community. Teen pregnancy and birth rates in San Angelo and throughout Texas are among the highest in the nation. In addition, youth in the area receive little sex education and have access to few pregnancy prevention programs or services. Services that schools have offered have typically not provided instruction on contraception and have not focused on adolescent parents.

HFSA successfully implemented both Steps to Success and Traditional Healthy Families during the period covered by this report. Home visitors were key to the successful implementation of both programs. For this reason, HFSA placed substantial emphasis on selecting appropriate staff for each program and creating a supportive work environment. HFSA implemented an extensive, thorough process for selecting and hiring staff who would be a good fit for the organization and the job; established a caseload management system to ensure that home visitors in both programs had manageable caseloads; and provided extensive training and consistent supervisory support.

The contrast in services between Steps to Success and Traditional Healthy Families was strong. As planned, Steps to Success provided substantially more support than Traditional Healthy Families. Families in Steps to Success averaged 20 home visits during their first year in the program, compared with 12 home visits for families enrolled in Traditional Healthy Families. Both programs provided child development and parenting education using a curriculum developed by HFSA and a child development screening tool. In Steps to Success, however, the home visitors conducted weekly home visits for a longer period; made consistent efforts to engage fathers in home visits; and addressed a much broader range of topics, including adulthood preparation and reproductive health and contraception, especially LARCs, using additional curriculum materials developed by HFSA. Steps to Success home visitors provided whatever support they could to help participants obtain effective contraceptive methods and followed up to encourage their ongoing use.

Completing scheduled visits and implementing the planned curriculum is often a challenge for home visiting programs; HFSA's implementation of Steps to Success and Traditional Healthy Families was no exception. Home visitors from both programs reported that the families in their caseloads sometimes cancelled planned visits. However, because of the good relationships the programs established with the families they serve and the flexibility they had to reschedule visits, they were often able to reschedule and complete cancelled visits.

Steps to Success home visitors were able to retain a larger proportion of families than Traditional Healthy Families home visitors were, 65 percent compared with 42 percent during families' first year in the program. Different procedures for conducting initial family assessments, more time available to Steps to Success home visitors for creative outreach to engage families, and the broader range of services offered in Steps to Success might account for the program's greater success in engaging and retaining families.

According to home visitors, HFSA leaders, evaluation site visitors, and the participants themselves, participants in both programs valued the child development and parenting information they received and appreciated the support of their home visitor. During home visit observations, mothers (and fathers, in Steps to Success) actively engaged in the home visit activities. Parents who attended the focus groups appreciated having someone to talk to and the information they received. Fathers in Steps to Success also especially liked the communication and relationship-building activities.

This study of the implementation of Steps to Success and Traditional Healthy Families was conducted in conjunction with a rigorous impact study based on a random assignment research design. At program application, mothers were randomly assigned to either Steps to Success or Traditional Healthy Families, about half to each program. Upcoming impact reports, scheduled for release beginning in 2018, will examine the effects of Steps to Success relative to Traditional Healthy Families on participating mothers' contraceptive use, subsequent pregnancies, and other outcomes one and two years after they enrolled in the program. These reports will provide important new evidence on the effectiveness of integrating contraceptive services and other program enhancements into a home visiting program designed to promote good parenting practices.

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APPENDIX A

METHODOLOGICAL APPROACH

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This appendix describes the methods that Mathematica Policy Research used to collect and analyze data about the Healthy Families San Angelo (HFSA) implementation of Steps to Success for the Personal Responsibility Education Program (PREP) in-depth implementation study. It also discusses the limitations of the data and analysis.

Data sources

Two members of the PREP in-depth implementation study team visited San Angelo, Texas, in June 2014 and February 2016, to collect information about the planned and actual implementation of Steps to Success, as well as the organizational influences, system, and context for implementation. The research team conducted the following key data-collection activities, which we further specify in Table A.1:

- Reviews of the HFSA Steps to Success project summary, curriculum, and staff training materials, and other documents (for example, the home-visit plan and family contact notes form)
- Individual interviews with HFSA leadership and supervisory staff (executive director, Steps to Success supervisors [two in 2014, one in 2016], program director and Traditional Healthy Families supervisor, and outreach and recruitment supervisor [2014 only]), a high school counselor, and a hospital maternity-ward nurse
- Small group interviews with HFSA outreach staff (intake workers [two in 2014], outreach and recruitment supervisor and intake worker [2016]), Steps to Success home visitors (two groups, each with three or four participants, in both years), and Traditional Healthy Families home visitors (three participants in 2014 and four participants in 2016)
- Focus-group discussions with three groups: (1) Steps to Success mothers (11 mothers in 2014 and 10 mothers in 2016), (2) Steps to Success fathers (7 fathers in 2014 and 8 fathers in 2016), and (3) Traditional Healthy Families mothers (6 mothers in 2014 and 11 mothers in 2016)
- Semistructured observations of Steps to Success home visits (six in 2014 and six in 2016) and Traditional Healthy Families home visits (four in 2014 and two in 2016)
- A self-administered survey of HFSA staff involved in home-visiting implementation (15 in 2014 and 15 in 2016, a 100 percent response rate in both years)[16]
- Service-use data collected by home visitors on dosage and content received during the first six months after randomization for mothers enrolled between May 2013–June 2015
- Web searches for information about the agency and schools

Participation in the study was voluntary.

[16] HFSA employed 18 to 19 staff, 15 of whom were eligible to complete the staff survey. In 2014, this group included two outreach staff, three Traditional Healthy Families home visitors, six Steps to Success home visitors, and four supervisors. In 2016, this group included one outreach staff member, four Traditional Healthy Families home visitors, seven Steps to Success home visitors, and three supervisors. (The receptionist, data-entry staff member, and executive director were not asked to complete the staff survey.)

Staff from Mathematica, Twin Peaks Partners, and Decision Information Resources conducted the interviews, focus groups, observations, and document collection. The site-visit team collected data using Office of Management and Budget and institutional review board-approved semistructured interview and focus-group protocols developed for the PREP implementation study. Interviews ranged in length from 60 to 90 minutes. The focus groups took place during the evening and lasted about 45 minutes. Staff from Mathematica and Twin Peaks Partners and observers hired by Decision Information Resources conducted the home-visit observations. During the visits, the site-visit team collected relevant documents for the document review.

Telephone and in-person interviews, as well as focus groups, included the following components: (1) overview of the purpose of the interview or focus group; (2) informed consent (oral for interviews, written for focus groups); and (3) a facilitated discussion of themes related to the development, implementation, operation, challenges, and successes of Steps to Success. Following in-person interviews, interviewers asked HFSA staff to complete the self-administered staff survey. Focus-group participants received $20 gift cards.

Table A.1. Data sources for each implementation study site visit

Data source	June 2014	February 2016
Interviews		
HFSA executive director	X	X
HFSA staff		
Program directors	X	X
Senior home visitor/QA supervisor	X	n.a.
Outreach and intake supervisor	X	X
Intake workers	X	X
Home visitors	X	X
Community partners		
Hospital nurse		X
School guidance counselor		X
Focus groups		
Steps to Success mothers	X	X
Steps to Success fathers	X	X
Traditional Healthy Families mothers	X	X
Observations		
Steps to Success home visits	X	X
Traditional Healthy Families home visits	X	X
Other data		
Staff survey	X	X
Service-use data	X	X
Baseline survey data	X	X
HFSA documents (curriculum, reporting forms, etc.)	X	X

HFSA = Healthy Families San Angelo.

QA = quality assurance. n.a. = not applicable.

Data analysis

During the interviews and focus groups, the site-visit team took detailed notes on all responses and used probes to clarify perspectives. After the visit, the team typed and organized notes, and cross-checked them against site documents. These notes, as well as documents from HFSA staff, were imported into qualitative data-analysis software. To code these data, the research team (1) created site- and respondent-level codes and a hierarchy of conceptual categories linked to the study's research questions and conceptual framework, (2) established a process for coding the data and identifying emergent themes and patterns, (3) piloted the codes, and (4) informally assessed intercoder reliability.

Trained coders used the qualitative data-analysis software to assign codes to the data. The top-level codes were (1) planned intervention and control conditions, (2) implementation context, (3) organizational influences, (4) participant and staff characteristics, (5) implementation system, (6) reach and retention, (7) implemented intervention, and (8) fidelity of implementation. The coding scheme also included subtopics under each primary code to support more detailed coding of the data within many of the primary topic areas.

After coding all site-specific qualitative data, the team used the software to retrieve data on the research questions and subtopics and identify common themes across data sources and individual respondents. Analysts examined the retrieved data to estimate the relative frequency with which each topic was mentioned (without collecting a strict frequency) and the relative amount of data devoted to a specific topic. They also triangulated across data sources and looked for patterns and trends within each topic area and across data sources, extracted illustrative quotations, and identified primary themes in the data. Analysts also generated descriptive statistics from the staff survey and observation data. The site-visit team used the primary themes and the descriptive statistics to identify primary themes across respondent and data types. We reported key findings that were highly consistent across respondents and documents.

Study limitations

The study design and methods for this report have two primary limitations: (1) respondents represent a small, selected convenience sample that is not representative of the population of PREP programs and (2) data could reflect a social desirability bias. Interview and focus-group participants represent a convenience sample of participants drawn from the site based on their roles in Steps to Success and Traditional Healthy Families. HFSA staff had to be working on Steps to Success and Traditional Healthy Families during their implementation, and focus-group participants had to be current program participants. Respondents participated voluntarily in the interviews, focus groups, and observations, and may not have been drawn from the entire population of staff and participants, creating the potential for self-selection bias. It is possible that those who chose to participate in the site visit differed in important ways from those who did not. For example, parents who agreed to participate in the focus groups might have had stronger positive or negative feelings about Steps to Success or Traditional Healthy Families than those who did not.

Another limitation is the potential for self-reported data to be subject to a social desirability bias. Social desirability bias is the tendency for study participants to respond in a way they

believe will please others (for example, exaggerating their positive reactions to a program to please program staff).

In spite of these limitations, the research yielded compelling data from which to draw findings about the implementation of Steps to Success. In particular, the opportunity to explore themes and trends across diverse respondents and data-collection activities increased the evidence for findings and enhanced our understanding of them.

APPENDIX B

DETAILED LIST OF HOME VISITOR TRAINING TOPICS

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Table B.1. Detailed list of HFSA home visitor training topics

Training focus	Topics
Both Steps to Success and Traditional Healthy Families home visitors	
HFSA organization	Healthy Families vision, history, accomplishments, and organizational structure Goals Philosophical foundation

Working with families	Strength-based/deficit-based
	Strength-based is not…and is!
	Strength-based no-no's
	Strength-based beliefs
	Words to avoid
	What you focus on grows
	Empower
	Foundations for working with families
	Relationship-focused
	Family-centered programs
	Elements of a helping relationship
	Strength-based communication strategies
	    Accentuate the positive
	    Intrinsic qualities
	    Feel, felt, found
	    Normalizing
	    Wondering curiosity
	Scenarios to practice communication strategies
	Problem-solving strategy
	Practice sheet
	Creative outreach/engagement
	Culturally competent services
	Creating cultural competence
	Culturally competent staff
	Family support traps
	Child development
	Parent-child relationships and healthy child growth and development
	Parent-child interaction, relationship, and bonding
	The first years last forever
	Brain development research tells us
	What color is your baby's brain?
	Promoting positive emotional growth in infants
	What is attachment?
	Indicators of the quality of parent-infant attachment relationships
	Indicators of insecure, anxious, and/or ambivalent attachments
	CHEEERing on the parent-child relationship
	CHEEERS
	CHEEERS: accentuate the positive
	Healthy Babies… Healthy Families curriculum checklist
	Ages and Stages Questionnaire overview
	Ages and Stages activity pages
	Ages and Stages example
	What to do on your first home visits

Training focus	Topics
	What families want to know Create rapport Trust building Foundations for working with families 25 common pitfalls of home visiting Reflect on your first home visit with a new family Shadowing a home visitor Interaction with the FSW Shadowing a home visitor worksheet Family support assignments
Steps to Success home visitors only	
Types of questions	Open-ended questions make better conversations Sample open-ended questions Motivational questions to inspire action Examples of motivational questions Open-ended and motivational questions activity
How it goes	Guide to contraceptive counseling When you are assigned a family Priorities for early visits
Getting to know you	Guide to gathering assessment information Prenatal family Postnatal family guide Reflection on first home visit with a family
Men are from Mars	Primary needs How children benefit from father involvement Dads influence on school readiness Consequences of father absence Involving dads prenatally Mothers mother fathers father How to get men to talk How to get men to act Adopting a new behavior Don’ts Common pitfalls
Using the curriculum with both parents	How to use the strategies in the basic training with both mothers and fathers

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