HEALTHY FAMILIES NEW YORK:

FINDINGS FROM A THREE-YEAR PILOT STUDY OF ENROLLMENT PRACTICES

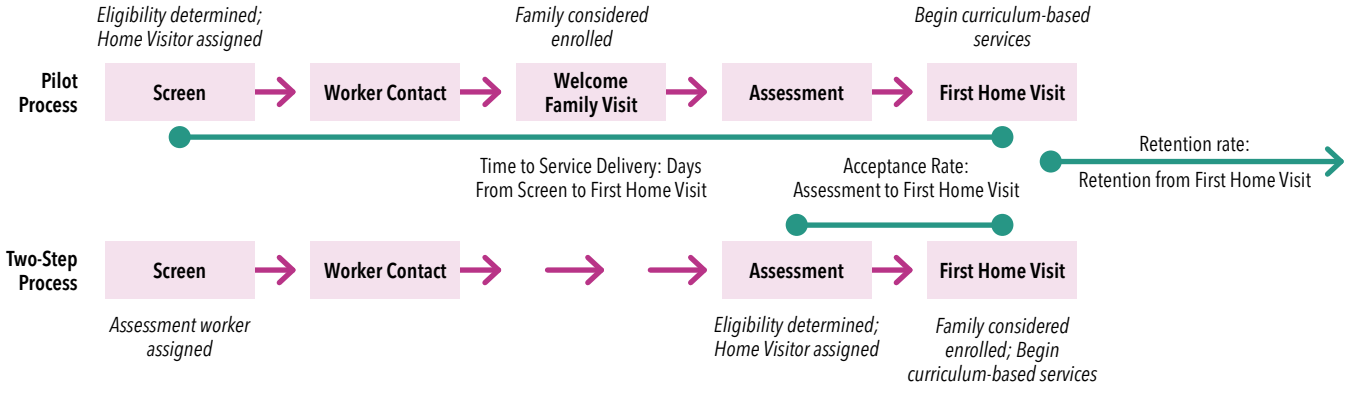
healthy families new york
An Affiliate of Healthy Families America™

Healthy Families New York (HFNY) is a voluntary, evidence-based Healthy Families America (HFA) accredited home visiting program supporting families with high needs across New York State. HFNY's goals are to foster parent-child bonding and relationships; promote optimal child and family health, development, and safety; enhance family self-sufficiency; and prevent child abuse and neglect (see: www.healthyfamiliesnewyork.org).

Under the long-standing "two-step" enrollment practices, eligibility is determined after an initial screen, followed by an in-depth semi-structured assessment and discussion with a trained worker. Eligible families are then offered home visiting; those who accept are referred to a home visitor for enrollment and service delivery.

In January 2018, HFNY embarked on a three-year pilot of a streamlined enrollment process in three program sites (two in Upstate New York, and one in New York City). Under this procedure, family eligibility is determined based solely on the initial screen.[1] One worker then conducts the "Welcome Family Visit," a short informal visit that serves to build rapport and buy-in with families, and, for those interested, subsequently conducts the in-depth semi-structured assessment and provides intensive home visiting services. This process allows for continuity of services for families, but also requires staff to master multiple skill sets.

FIGURE 1. Pilot versus Two-step enrollment processes, with key milestones and analysis definitions.



1 Over 95% of families that were eligible under the pilot process (i.e., using just the initial screen) would also have been found to be eligible using Parent Survey scores indicating the sensitivity of the screen.

The Center for Human Services Research (CHSR) analyzed data from families who were assessed and enrolled under the previous two-step process (Pre-Pilot) compared to the new process (Pilot Years 1 through 3)[2] across these sites and compared to the rest of the non-pilot HFNY sites.[3]

Given the pilot process' increased emphasis on early rapport-building and continuity of care, it was anticipated that this process would: (a) improve families' **acceptance** of the program, (b) shorten engagement **timelines**, (c) increase program **retention**, and (d) improve program **capacity fulfillment**. Its impact on assessment scores was also examined.

In this Brief, we present the impact of these changes on each stage of the enrollment process and family retention, with context from interviews with staff.

RESULTS

Pilot programs showed an approximately 20% increase in **acceptance** rate (defined as families having at least one regular home visit after assessment), with an immediate increase upon implementation maintained over the pilot period, while non-Pilot sites showed little difference (see Figure 2).

Time to Service Delivery, or the number of days from receipt of initial (positive) screen to first curriculum-based home visit, initially increased upon implementation of pilot processes at Pilot sites but decreased steadily over the pilot years to remain on par with Non-Pilot sites (see Figure 3). The decrease from Pilot Year 2 to 3, seen in both Pilot and Non-Pilot programs, may reflect shortened timelines facilitated by the shift to virtual visits, as necessitated by COVID-19.

Importantly, the pilot process includes the Welcome Family Visit, an additional step beyond those undertaken by Non-Pilot programs; the similar overall timing therefore actually reflects shortened wait times between steps.

Staff feedback was largely in agreement with these patterns. Many staff reported that families expressed feeling especially connected to their

FIGURE 2. Program acceptance improved upon pilot implementation, well exceeding that of Non-Pilot programs.

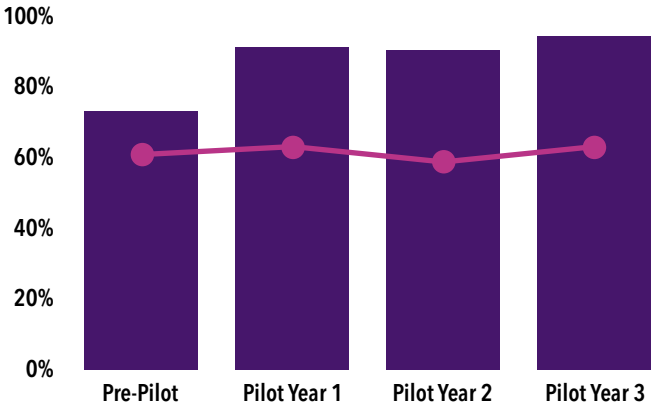
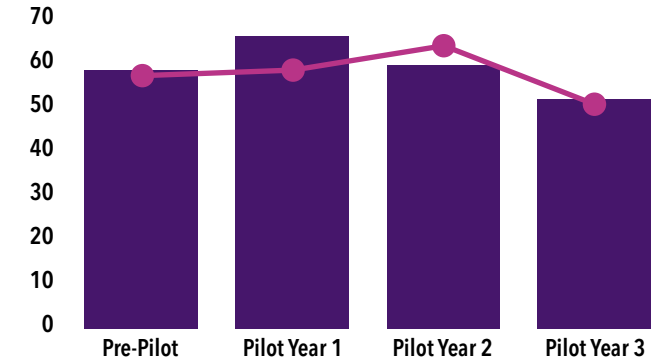


FIGURE 3. Time to Service Delivery decreased over the course of the pilot to match Non-Pilot performance, even with the addition of the Welcome Family Visit.



2 Initial implementation occurred on a rolling basis over the course of 2018; as such, "years" are defined individually for each program based on actual implementation timelines.

3 The onset of the COVID-19 pandemic in early 2020 falls during the second half of the pilot period (with Site 1 having just begun Year 3 and Site 3 having just begun Year 2). Findings from the later pilot years may thus have been impacted by programmatic changes necessitated by the pandemic (e.g., the adoption of virtual home visits). But since the pandemic also affected the rest of the HFNY network, these shifts should be similar between Pilot and Non-Pilot programs; thus the comparisons between implementations remain reasonable.

worker since they had known her from the beginning of the process, instead of having to "restart" with a new home visitor. Some staff emphasized the importance of the Welcome Family Visit in building rapport and creating a relationship that led to a better bond between workers and families and a greater willingness to engage further (thus leading to shorter waits and higher acceptance rates).

Veteran program staff reported that it took some time to get used to pilot procedures, some of which might not previously have been their responsibility. However, once they gained experience with the new process they were able to efficiently move families through the steps: "*To me, it's the new norm…It's nice to say to people, 'I'll see you next week.'*" Staff hired during the pilot, who thus only knew this process, did not have the challenge of learning a "new" way of doing things and did not express such challenges, though some did note that it was challenging to learn all aspects at once.

Six-month **retention** rates improved by 10% to 25% for two of the Pilot programs, with more families remaining enrolled for at least 6 months, but fell dramatically for one program, resulting in an overall negative trend.[4] Non-Pilot sites showed a slight increase (about 5%) in retention over the time period (see Figure 4).

Similarly, **capacity fulfillment**, or the number of families enrolled, generally improved at the Pilot sites, though not to the level of Non-Pilot programs (see Figure 5). This improvement was likely driven by the increased acceptance rates and improved retention at two of the Pilot programs, while being negatively impacted by the site that saw a substantial drop in Pilot Year 3. Overall, capacity remained higher than in the Pre-Pilot period.

CHSR also examined the impact of the pilot on **assessment scores** to determine whether scores decreased after the removal of the minimum eli-

FIGURE 4. Program retention improved at two of the three Pilot sites, approaching or exceeding that of Non-Pilot programs.

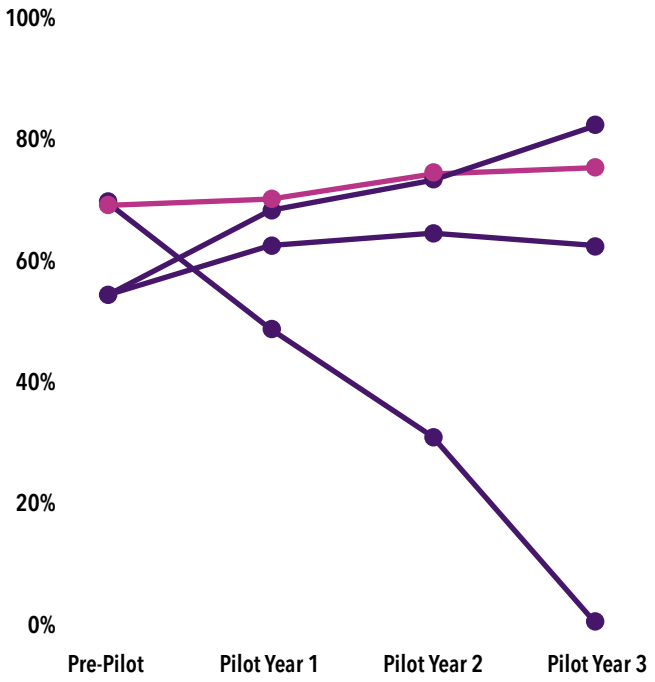
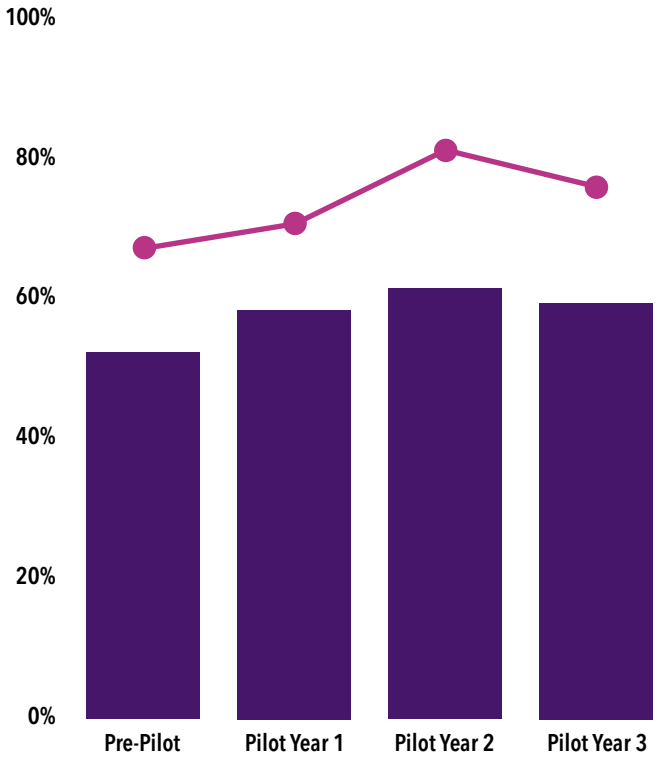


FIGURE 5. Pilot programs showed increased capacity fulfillment over the period, paralleling the Non-Pilot increases seen.

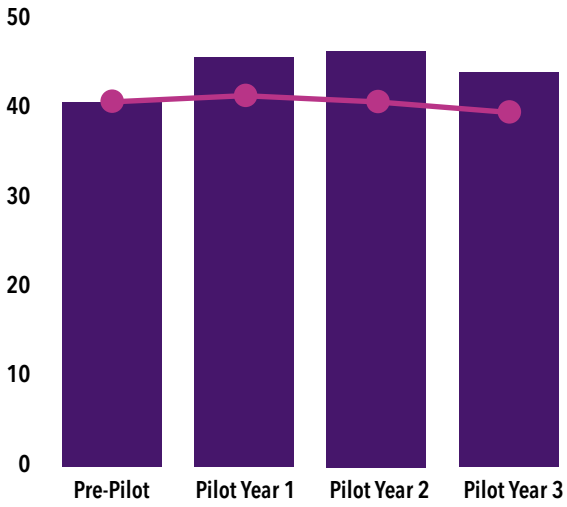


4 Site 2 was affected by myriad other changes over the course of the pilot (e.g., participation in a centralized intake, office relocation, etc.) which may in part explain the significant drops in retention and capacity fulfillment.

gibility threshold.[5] Instead, scores increased by an average of 5 points at Pilot sites, with one site showing a jump from 25 (i.e., the previous eligibility minimum) to over 40 (the Non-Pilot average), versus almost no change for non-Pilot sites (see Figure 6).

According to staff, this increase reflected the impact of the process change and not a change in need among eligible families. Staff indicated that the additional time for relationship building (via the Welcome Family Visit) enabled families to feel more comfortable sharing their backgrounds and needs during the assessment, resulting in higher scores that more accurately reflected family risks and needs. In the words of one worker, the Welcome Family Visit is "*absolutely necessary*" to building rapport, which another worker said helps when asking the "*nosey questions*" of the assessment.

FIGURE 6. Assessment scores increased after Pilot implementation, but did not change for Non-Pilot sites. (Non-Pilot in pink)

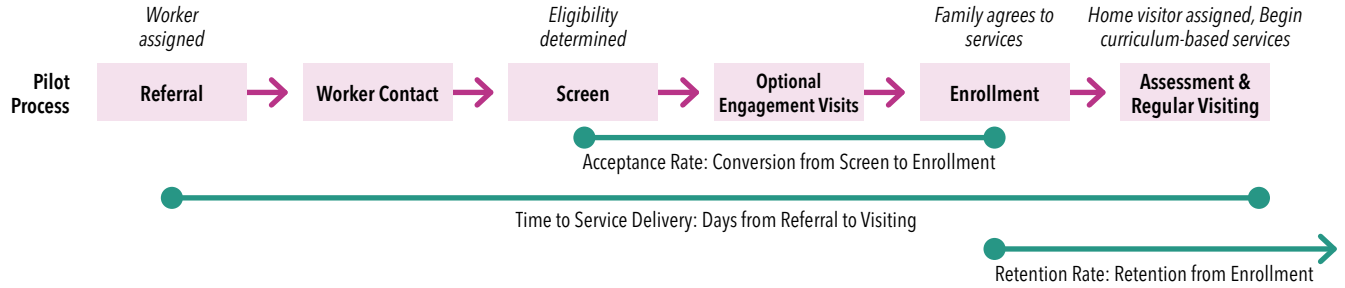


SUMMARY & CONCLUSIONS

HFNY expected that the pilot enrollment process would have positive impacts on program practice and family engagement and retention. After three years, the process was determined to: (a) improve program acceptance and enrollment; (b) move families through the engagement process at least as quickly as two-step procedures; (c) generally improve retention; and (d) generally improve capacity fulfillment. Assessment scores also increased upon pilot implementation, suggesting the benefits of early relationship building and worker continuity. Staff reported initial challenges with mastering a dual skillset, but gained confidence over time and felt the pilot model resulted in stronger relationships with families.

Bolstered by these results, Healthy Families New York is now in the process of transitioning all programs to a one-step enrollment process where family eligibility is determined at time of screen. It is not currently required for the same worker to perform the initial outreach, assessment, and subsequent home visits, but some programs are considering adopting this practice. See the diagram below for an overview of the current HFNY process. The implementation and impact findings from this pilot can now help these programs transition their practices to meet system requirements and best serve families.

FIGURE 7. Current HFNY one-step engagement processes, with key milestones and analysis definitions



5 During the pilot period, eligibility was defined as a score of at least 25 on the Parent Survey (range: 0 to 100; higher scores indicate greater risk and need). HFNY has since moved to the FROG as the assessment instrument.

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This study was conducted by the Center for Human Services Research under an agreement with the New York State Office of Children and Family Services.

About the Center for Human Services Research

The Center for Human Services Research (CHSR) is a research department at the University at Albany. CHSR has over 30 years of experience conducting evaluation research, designing information systems, and informing program and policy development for a broad range of agencies serving vulnerable populations.

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