

2015 MIECHV PROGRAM STAFF INTERVIEWS REPORT

Florida Maternal, Infant, and Early Childhood Home Visiting Evaluation
University of South Florida Chiles Center for Healthy Mothers and Babies

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Introduction and Methods

Introduction

Florida communities selected three evidence-based home visiting models to implement the Maternal Infant and Early Childhood Home Visiting (MIECHV) program: in 2015 the majority of the programs implemented Nurse-Family Partnership (NFP), four sites implemented Parents as Teachers (PAT), and two implemented the Healthy Families Florida model (HFF) (<http://flmiechv.com/about/the-models/>):

Nurse-Family Partnership

- Through NFP, registered nurses (who have undergone NFP training) meet with first-time mothers in low-income communities from pregnancy until the child is two years of age over the course of 64 planned home visits. During these visits, nurse home visitors are focused on improving prenatal health, child health and development, and increasing family self-sufficiency.

Parents As Teachers

- The PAT program employs trained bachelor's level parent educators to visit high-need families for at least two years from pregnancy to Kindergarten. The PAT model includes one-on-one home visits, monthly group meetings, developmental screenings, and a resource network for families. Parent educators conduct the home visits using structured visit plans and guided planning tools. The curriculum emphasizes parent education on child health and development, child abuse and neglect prevention, school readiness, and early detection for developmental delays.

Healthy Families Florida

- In the HFF program, mothers facing high-risk situations are eligible to enroll prenatally through the first three months of the child's life. Trained paraprofessional home visitors provide services until the child is five years of age with a focus on preventing child abuse and neglect, promoting child health and development, increasing positive parent-child relationships, and providing resources for families to meet their social and medical needs.

Each MIECHV Community is unique, and programs are operated by local Healthy Start Coalitions, hospitals, federally-qualified health centers and other community-based organizations. The populations served, areas of focus, frequency of visits, caseloads, and staff qualifications vary by home visiting model and by program. The state grantee, Florida Association of Healthy Start Coalitions (FAHSC), funds all programs at an equal base rate per client (\$5,000).

Methods

This report summarizes the data collected by the MIECHV program independent statewide evaluation. In the fall of 2015, the University of South Florida evaluation team conducted a series of on-site focus groups with 82 MIECHV staff members and collected their demographic information by questionnaire. The home visiting programs span across the state of Florida, including Alachua, Broward, Duval, Escambia, Hillsborough, Manatee, Miami-Dade, Orange, Pinellas, Lee, Collier, and Hendry counties. The purpose of the focus groups was to discuss the strategies MIECHV programs use to meet the needs of its

families, including organizational factors and community collaboration networks. This year the focus was on mental health. This report describes various aspects of the Florida MIECHV program from the perspectives of program administrators, supervisors, and home visitors.

For each focus group conducted at the individual sites, participants were divided into groups based on their current job position. Administrators and supervisors represented one group, while home visitors constituted another group. Topics that were discussed included: 1) general and mental health issues of the families being served, 2) substance abuse and intimate partner violence (IPV) among the families, 3) how the gap can be closed in terms of meeting the families’ needs, and 4) work-related stress faced by the home visitors. Participants also completed a short demographic survey composed of eight questions.

In total, twenty focus groups were conducted and digitally recorded, then transcribed verbatim by a professional transcription service. Each transcript was reviewed for accuracy by MIECHV program evaluation team members. A preliminary, inductive content analysis approach utilizing open coding was performed to identify recurring themes throughout the transcripts. Inter-rater reliability for coding and themes was established through comparison until consensus was reached.

Participant Demographics

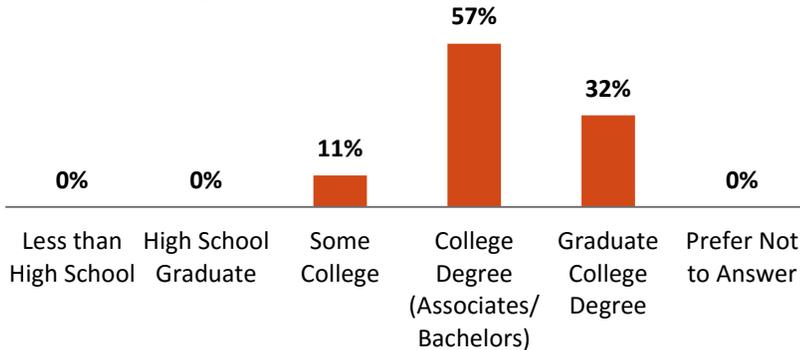
In total 82 participants were interviewed. The participants constituted 47 home visitors, 11 supervisors, 13 administrators/directors, and a few other professionals including therapists and data analysts. The length of time in which the program staff worked in their current positions ranged from less than a year to two decades. The majority of staff members were in the first five years of their position (MIECHV was funded in 2013).

The vast majority of MIECHV staff reported having received a higher education, with 89% having earned either their associate, bachelor’s, or graduate degree. Participants’ education and professional backgrounds varied, but most reported their backgrounds being in nursing (28%), social work (20%), and psychology (15%).

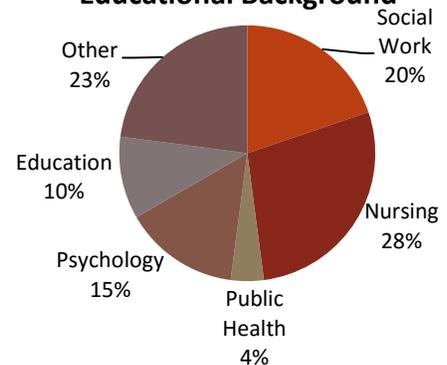
Years in Current Staff Role



Highest Level of Education Completed

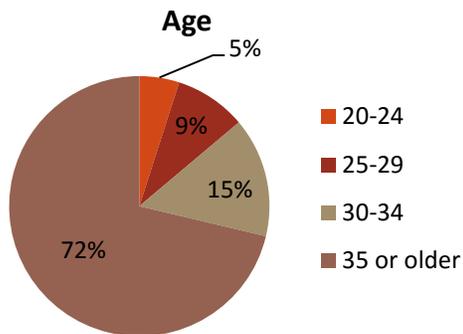


Educational Background

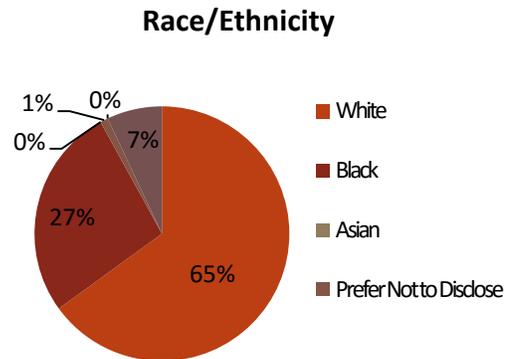


Note: 1 missing/prefer not to disclose; results exceed N=82 due to ‘Select all that apply’ option

The staff members ranged in age, with 72% falling within the 35 years or older category and 5% within the 20-24 years old category. The self-reported race of staff members revealed that 65% identified as white while 27% identified as black, and a small amount identified as biracial. It was also reported that 78% lived in the communities that they served.



**The
best
thing**



about being a MIECHV staff member

To start the focus group discussions, home visitors were asked what they liked best about their jobs. Numerous positive work-related aspects were discussed, including providing relevant information to their families and then witnessing families' growth in terms of interpersonal skills, caring for their children, and increased access to resources. Home visitors also enjoyed being able to: talk with their families in a one-on-one setting; make a positive impact in their families' lives; and empower and instill confidence in their families throughout the child-raising process. Home visitors expressed gratitude regarding how most of their families value their opinions and appreciate the opportunity that the home visitors provide them to use the skills learned in order to better address complex needs.

MIECHV administrators reported answers similar to the home visitors when asked what they liked best about their jobs. Much like home visitors, the administrators enjoyed being able to provide families with resources to help raise their children. Administrators also reflected on how satisfying it is to make a difference in the health outcomes of families.



"We are not only watching the babies grow, we are actually seeing changes in the mom's behavior. That's what actually I like, because I feel like I'm educating them and they are actually educating me too because we learn from each other."

Addressing Clients' Health and Mental Health Needs

Health concerns of families served

MIECHV home visitors were also asked to describe common health-related concerns among participants in the program. Many cited clients' inability to obtain health insurance (especially in the immigrant population) and chronic health conditions, such as obesity and hypertension. They also reported a need for improvements in dental health. Home visitors observed challenges with substance abuse, and also identified hepatitis, Human Papilloma Virus (HPV), and Human Immunodeficiency Virus (HIV) infections as needing to be addressed. Additionally home visitors cited a need for preventative health care, particularly during pregnancy. Even when appropriate care is sought, some program participants have told their home visitor they felt the quality of care they received was unsatisfactory.

"They're sick or they will take NyQuil or whatever, and then it ends up being that they get hospitalized because it was bronchitis or something worse because they didn't go to the doctor because they don't have a doctor, just a clinic."

Administrators had a number of concerns regarding the health of families participating in their respective programs. Some issues include: access to health care for rural and undocumented participants, inadequate contraceptive care due to a lack of health insurance, and insufficient income to afford insurance or out-of-pocket cost for care. In addition to the lack of access to general health care, administrators discussed the issue of accessing well-child visits and immunizations. Many of the families do not have a primary care physician and may not possess the knowledge or skills needed to navigate a complicated health care system. This results in families using the emergency room as their sole form of health care when they, their child, or children become ill. Much like the home visitors, administrators

"Limited access to health care for the parents. Because of the Medicaid gap in our state, that's a huge problem."

observed issues with chronic illness and comorbidities, including obesity, cardiovascular disease, gestational diabetes, and hypertension. Moreover, there was particular concern for participants with infectious illnesses, including hepatitis C and HIV infections.

Mental health concerns of families served

When questioned about the mental health concerns of their clients, the MIECHV home visitors stated that they encountered issues with depression, anxiety, bipolar disorders, and schizophrenia. They also reported witnessing problems with stress, post-traumatic stress disorder (PTSD) due to intimate partner violence, and participants being unable to receive various services, such as disability payments for illnesses that are debilitating. Another challenge expressed by staff is that many of their clients have intellectual disabilities, which can add to family stressors and which require adaptations to home visiting curricula and educational strategies. The home visitors expressed how there is a lack of mental health resources in participants' communities, and even when

"It's just a lot of stress and that then reflects on their life and their children and everything that they're going through, not having a way to cope with depression or anxiety or anger, whatever it may be, but we definitely see a need."

resources are available, the stigma surrounding mental health issues often prevents families from accessing them. Administrators' views echoed the home visitors' when asked about participant mental health issues. Depression, toxic and chronic stress, untreated psychiatric disorders, and PTSD were all listed as being mental health concerns for participants in their respective MIECHV programs.

Substance abuse among families served

Home visitors cited cocaine, methamphetamines, and methadone use among some of their participants. There was concern among home visitors as they discussed the perceptions of participants that marijuana and alcohol are not as detrimental as other drugs, which causes a struggle in getting pregnant mothers to quit. Even among those who quit, home visitors noted relapse as an issue. Administrators reported abuse of prescription drugs, opium, marijuana, and methamphetamines in participants' environments. They also conveyed concern regarding a new drug coined "Flakka," a synthetic stimulant, as well as methadone, heroin, and cocaine. As a result of mothers with substance abuse issues during pregnancy, administrators noted subsequent issues with neonatal abstinence syndrome.

"You suspect it but you can't confirm it because they are not necessarily honest on their health habit form."

"[The home visitors are] coming back, and they're telling us these stories where somebody is obviously on drugs. They're going into houses where they can smell drugs, and a lot of people nowadays don't consider marijuana a "drug" drug, but they're going into these houses and they can smell it."

Intimate partner violence/family violence

Regarding IPV, home visitors discussed how disclosure varies among families. In some cases, participants disclosed directly to their home visitor while others declined to talk about the subject. When disclosure occurred, home visitors explained how their participants bring up the subject in different ways. Some participants would speak openly about the exact situation, whereas other participants would ask their home visitor what might hypothetically happen if one were to disclose IPV. For participants who disclose, many are reluctant to leave their situation. Staff surmised that this could stem from various reasons, including financial dependence, exposure to violence as a child thus not perceiving their situation as IPV, or a cultural background where IPV is the norm. When asked about IPV, program administrators reported higher or lower rates of abuse depending on their respective county. Much like home visitors, administrators commented on how IPV is perceived by some participants to be the norm in their culture. Administrators also noted how some clients are subjected to controlling behaviors by an intimate partner due to economic or housing situations, and noted observing higher levels of IPV among families with substance abuse. Lastly, staff clarified that even when the abuse was not occurring with the current partner, it still had negative effects on the family.

"I've had several moms that have actually confessed [disclosed], and then I would say that we were able to refer them to the shelter to get out."

"When most people say domestic violence or family violence they automatically assume it's the physical component of things, not looking at what leads up to eventually having that physical and emotional abuse ...they just don't recognize."

The MIECHV home visitor's role in mental health support

Home visitors reported their roles with families, in terms of mental health, to clients to receive professional counseling services. However, through the trust established with participants over time, home visitors also evolve into a sort of counselor, validator, and “sounding board” for their participant's situations and emotions. Home visitors also helped families disclose and address IPV.

MIECHV-specific population needs

When asked whether there were subgroups of families with particular health care or related service needs, MIECHV home visitors confirmed that they did have families with higher need. Immigrant families of Hispanic or Haitian descent, teenage and young mothers, single mothers, and mothers with multiple children under the age of five were all identified as subpopulations with specific needs. Other populations discussed by the home visitors as needing specific support were those participants who juggled family life and receiving home visiting services with their job(s); mothers with disabilities; participants who did not receive a high school diploma; and those who had felony records.

“They're able to share and feel comfortable, and they trust us.”

Social Supports for MIECHV Families

Formal and/or informal social supports for families served

When questioned about the formal and informal social support for MIECHV families, many home visitors felt the program was a primary source of support for enrolled families. This support included weekly “group connections” where participants could talk through their issues, and the home visitor's interpersonal relationship with the participant. Similar to the group connections, participants had the option to attend the Nurse Family Partnership and Young Life organization support groups.

Home visitors also described participants' family members, including the extended family as a source of support. Home visitors also noted how church and other community organizations provide support for some families. Albeit nontraditional, participants' drug network was identified as a source of support by home visitors.

“Some of them have their drug support system – which is obviously a bad influence, and it's hard for them to get out of that when they do decide to get into a program.”

Administrators were similarly asked to detail the primary sources of formal and informal social supports for the families they serve. They described how many participants used their parents, grandparents, significant others, and friends as support systems. Participants additionally used their home visitor and others in their community, including group homes and other services that allow families to interact with other families to provide support.

“So they'll come to the group connections and then they'll recognize somebody or they'll get to talk to somebody who's got the same age baby, and then they end up making friends.”

MIECHV implementation and addressing mental health needs

When asked about how the MIECHV program is being implemented and the kinds of services provided to address health and mental needs, administrators had a plethora of information to share. These needs are identified through the use of various screening tools, such as the relationship assessment tool (RAT), which helps home visitors ascertain intimate partner violence.

To help improve outcomes outlined in the MIECHV benchmarks, in addition to community referrals, family specialists have been incorporated into some programs, and a MIECHV staff therapist in another. Some programs arranged for in-home counseling, community mental health services, and peer support programs.

“So being in the program, they’re getting that information, whereas if they weren’t in a program, they wouldn’t even know any of that information.”

Other Family Needs

Strategies to identify participants’ needs



“Yes. We just pretty much talk with them. That’s how we do it.”

Home visitors stated that they were comfortable with assessing the needs of their families and were well-versed in needs assessment, facilitated by trusting relationships with their clients. Home visitors reported using their instincts to detect problems along with the use of screening and assessment tools as part of the program model.

“I’m used to being in people’s homes and finding out what they need and helping them on the path. So it’s easy.”

Services that families seem to need but rarely ask for

Home visitors identified counseling for depression and other mental health issues, aid in paying bills, and obtaining common necessities as needs that families rarely asked for. Other needs that were mentioned included birth control education, intimate partner violence resources, and social support services.

“Mental health. I know they’re depressed, and I tell them, ‘I think you’re depressed because of the score,’ but they don’t ask for help.”

Families’ needs and their retention in the MIECHV program

When asked about the relationship between the needs of their families and retention in the home visiting program, home visitors in some programs reflected on how there is an abundance of resources in their counties; thus, they have numerous means of connecting families with those resources and this seemed to encourage participants to remain in the program. However, home visitors also expressed

how retention can be negatively affected when clients obtain jobs, which makes it difficult for them to keep up with scheduled home visits. In addition, participants who move frequently have difficulty maintaining scheduled visits due to their changing housing situations. Home visitors in some programs noted how there are some families who join the program with the intention of receiving “handouts”; when this did not happen, such clients tended to drop out of the program.

Perceptions about associations between referrals and client retention varied among the home visitors. Some home visitors conveyed that the types and amounts of referrals needed did not necessarily affect retention rates in their programs; rather, retention was based primarily on the relationships that clients had with their home visitors. Other home visitors stressed how mental illness and IPV referrals were at times problematic, negatively affecting retention. Issues with retention were additionally noted when mothers were facing various stressors or transitions, such as employment and recovery from birth. Clients may also drop out of the MIECHV program as a result of drug use, incarceration, and decreased frequency of home visits (engagement).

“I think the retention is more about the confidence and the relationship between the home visitor and the parents.”

“To me, I feel like with some of my clients or with most of my clients, if there’s a lack of resources for them, I feel like they’re in it because of the relationship that they have with us.”



MIECHV Family Referrals

Types of referrals

The types of referrals that home visitors most commonly offered to clients included mental health counseling, GED services, shelters, therapy, family planning, and transportation. Additional referrals included those for professional development, health care, housing, child care, food (WIC), and utility payment assistance. Other resources that participants often found useful were for clothing, furniture, library resources, various baby items, and others related to health including birth control, immunizations, and the community health center.

Home visitors identified family planning, child care, breast feeding support, and smoking cessation as common referrals. Also noted were referrals for the health department or free health clinic, dental services, WorkSource, colleges, and transportation. Other referrals discussed included those for food assistance, utility bills assistance, and diaper banks.

“Hand them their resumes and ‘Dress for Success’ and all this stuff... and they have a teens program too. They can enroll, and they can take some classes and get ready to find a job.”

Challenges to families accessing community services

Home visitors reported that families would have difficulties with accessing transportation, child care, and schools with day care support, as well as Supplemental Nutrition Assistance Program, health insurance, and Medicaid. These resources were even more burdensome to access when clients did not have knowledge of the oftentimes complex processes to enroll. Also noted were issues with finding housing, where many locations had long waiting lists as well as restrictive age and income eligibility requirements. Difficulty accessing services was usually exacerbated by having an inadequate employment history, language barriers, limited access to and knowledge of the internet, financial strain, and having a criminal record.

“We just encourage them to keep calling, keep trying.”

Home visitors provided participants with pamphlets/brochures, names of personal contacts to other agencies, or they make the phone call while they are with their client. Additionally, the home visitors mentioned following-up with agencies to ensure that the participants made contact. Medicaid transportation was identified as a resource for families to use to access health care, and some programs will provide transportation to these referred-to agencies. In selected MIECHV sites, home visitors noted how there were agencies co-located within the same building, which facilitated referrals. In situations where MIECHV clients had difficulty accessing services, home visitors noted constraints on the extent to which they could help based on program policies. Home visitors often suggested to their clients to seek social

“They’re on the waitlist for child care, which is backed up well over six months and have nobody to care for their kids, so that they can go to get done what they need to get done.”

groups for support and encourage them to go out and look for these services themselves. Home visitors also use local community resource manuals provided by their MIECHV program.

Community services that are less available for program recipients

According to home visitors, services most lacking in their communities include transportation, affordable housing, health insurance for undocumented residents, food banks, child care, and shelters.

Administrators also reported challenges with the unavailability of jobs, medical homes, financial resources, dental care, counseling, and related in-home services.

In order to address gaps in services, home visitors described how they connect clients with mobile clinics, and provide transportation, assistance with obtaining food, clothing, child safety items, and help with applying for subsidized housing. Administrators additionally mentioned referrals to social services, public libraries, and resources through community partnerships.

“Mental health always comes up; it’s just probably the biggest need.”

“We have them do scavenger hunts like we give them the list of resources. Our team of FSWs [Family Support Workers], they just went out to each resource, got a pamphlet or something from the agency to find out what they did.”

MIECHV Community Collaboration

MIECHV’s contribution to collaboration and systems development at the state and community levels

Administrators described how their program contributed to collaboration and systems development at the community level. Such contributions included hosting home visiting advisory groups, partnering with substance abuse and intimate partner violence coalitions, and participating in interagency groups that address parenting and nutrition education. Some partners meet monthly or twice monthly to discuss recurring issues with decision-making, organization leaders, and direct services providers.

“Strong partnerships where brainstorming is conducted to solve main issues.”

Administrators also reported leveraging resources from local mental health agencies, Temporary Assistance for Needy Families (TANF), and Children’s Services Council funds to obtain assistance for participants in emergency situations. Administrators noted how many community collaborations were established before the implementation of MIECHV. According to MIECHV administrators, coalitions and partners are highly involved with each other. Other partnerships discussed were Reach Up, Strong Start, Healthy Start, and the Department of Children and Families.

“We have a lot of good partners, we can just pick up the phone and call them at any time. They are very responsive.”

MIECHV Home Visitor Work-related Stress, Coping, and Support

Sources of stress among home visitors

Home visitors were asked to participate in a pile sorting activity using their free-listed top sources of work-related stress. In all programs, work-related stressors included managing paperwork and data requirements, client caseloads, and the number of monthly home visits required. Many home visitors felt that the paperwork they needed to complete interfered with the time they needed to spend talking with their clients or helping them through crises. A second theme across all sites was the amount of time it took to prepare for each visit, then rescheduling and cancellations on behalf of clients. For many sites, required meetings and trainings required staff to cancel scheduled visits, which staff perceived leaves clients feeling abandoned. Some home visitors mentioned a lack of support in their work

environment as the primary stressor, noting feelings of under-appreciation, while others described a highly supportive environment. Home visitors shared a perception that the data does not always fully reflect or convey the importance of

"I was doing the intake. There are so many pages on it. She said 'I feel like I'm in school.' I'm like, 'okay, let's stop now.' I don't want to lose her on our first visit."

their work to funding agencies. Another important theme in the staff stress discussions was related to serving a population with high levels of community risk and family stressors. Working in unsafe neighborhoods and unsanitary homes; addressing family crises, trauma, and unmet needs with a lack of resources to address them; and lack of engagement or commitment by some clients were challenges that contributed to stress and burnout among home visitors. Additionally, unavailability of adequate written materials for non-English speakers, lengthy travel time and/or traffic to and from home visits, and low salary considering the difficulty of the occupation were all factors contributing to workplace stress according to home visitors.

"You've invested in a family....you've gone through a lot, they trust you, and then you never hear from them again. You don't know where they went. You never hear from them again and that's just really – I mean, that hurts."

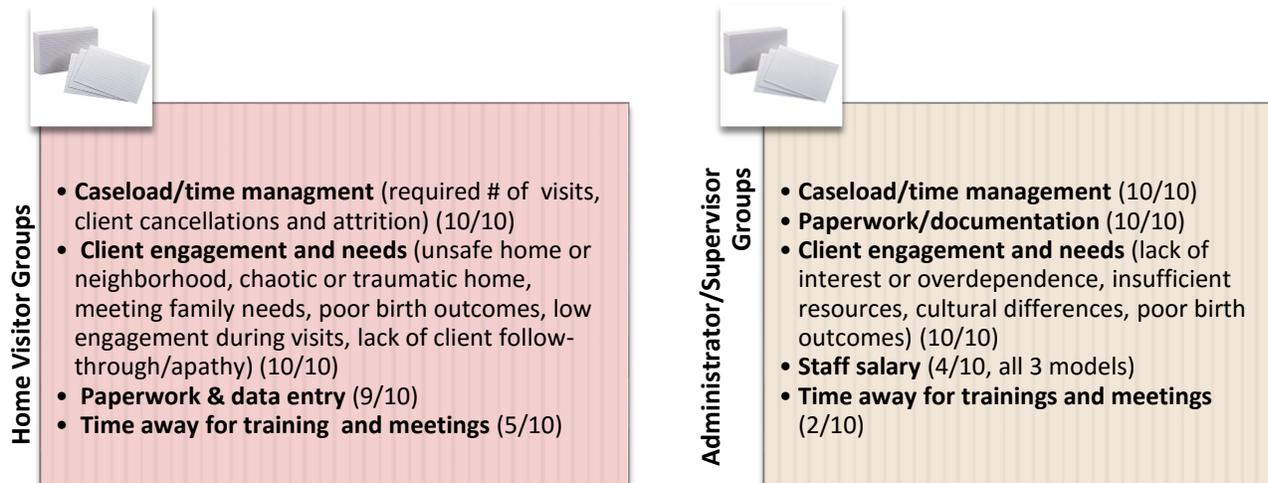
Administrators mentioned similar sources of stress, including documentation, data entry, and pressure to meet MIECHV benchmarks. They were aware of the stress of trying to connect with clients to complete appointments (in the face of frequent rescheduling and cancellations), travel distance, and also attributed stress to staff and leadership turnover. Another

"They really struggle... sometimes they just take on too much."

source of stress for home visitors that administrators noted was the amount of required trainings, meetings, and conferences that took away time to work in the office, as well as time with clients. Some administrators identified other stressors like secondary trauma to home visitors, frustration at being unable to help families in crisis, and the pressure of meeting numerous deadlines. Administrators and home visitors in several programs, across program models, remarked that they felt that the salaries were low for the skill level and amount of work that home visiting requires.

"It's below a living wage, and that's just not okay with me... I have a real heartburn about that. These people work hard. They work really hard."

Pile sorting activity- staff stressors (listed from most reported to least)



Stress and staff recruitment and retention

As for the effect of stress on staff recruitment and retention, some home visitors conveyed that there is no or very little turnover, while others expressed the opposite. Turnover resulted in higher caseloads for remaining staff and compounded stressors associated with those programs. Administrators also talked about the effect of stress on staff recruitment and retention. Some said, as home visitors did, that stress did not have an effect on recruitment and retention. These administrators faulted other issues for recruitment and retention, such as certain aspects of administration and each unique Florida MIECHV model, insufficient salaries, and high caseloads. Other factors discussed dealt with the frustration of having to restart the program with new clients after they drop out, meeting quotas, paperwork, and being unable to see their full capabilities. Those who described the role stress played in staff recruitment and retention felt that home visitors were overwhelmed with too many tasks, difficult working conditions, and lacked appropriate compensation.

Stress and its effect on engagement

When asked about how stress affects their work with families, home visitors believed that it affected the quality of home-visitor and client engagement. They shared how they sometimes needed to rush with a current client to meet the next appointments, and how at times their mind was already in the next appointment while conducting the current one. Some home visitors reported that they were able to work effectively under stress because they internalized their stress; however, at times this stress impacted their own families at home.

“The reality is when we’re overwhelmed by these various stressors; it affects the quality of home visits. That, in turn, will ultimately affect your relationships with your clients.”

“When I go to a visit it’s about them. It’s not about what happened to me or how hard it is for me to do my job or whatever. It’s just about being there for them and whatever they need from me. But of course you’re frustrated and it is very hard.”

Administrators were also asked how they thought that stress among home visitors affected their work with families. Some administrators responded that these stressors contributed to a decrease in job performance and the development of preferences for certain clients. Other administrators, however, did not have the impression that their home visitors were affected by the stress, and handled their visits effectively.

“As soon as they walk in the door, they leave their personal stuff behind. They’re all really good at that.”

Stress management and support strategies for home visitors

Stress management

Coping strategies described by MIECHV home visiting staff included talking to their supervisors, discussing issues among their co-workers, and being able to reflect on their work with the entire team during group meetings. Home visitors additionally cited their use of the Employee Assistance Program (EAP), stress management techniques, massage therapy, yoga, tai-chi, and professional referrals. Home visitors also discussed the support of their own families and significant others at home to reduce stress.

“When we do our supervisions with her, she allows us to just vent and get things out of our system.”

“We used to years ago – have this nice little happy quarterly meetings with the whole staff, but that doesn’t happen anymore. That was a morale booster because we got little gifts, little things we can use.”

Organizational supports

Staff described a variety of organizational strategies implemented by their programs to alleviate workplace stress. For example, home visitors mentioned being allowed to take longer breaks and had access to retreats when they felt particularly overwhelmed. In response to the burden of paperwork, supervisors in some MIECHV programs have added staff to assist with data entry.

According to administrators, supports for MIECHV home visitors include talking with other home visitors, visiting partner programs that provide compassion fatigue training (in-person and online), and attending webinars on stress reduction and time management. Similar to home visitors, many administrators reported the use of the EAP, massage therapy, discussion in regular team meetings, reflective supervision, and joint visits with supervisors every few months. Home visitors also benefit from reflective supervision, additional staff (data entry or administrative support, mental health counselor), trauma reduction trainings, team building activities, and organizational tools.

“They do team-building, group activities like the movie date, or anything that allows them to spend fun time together.”

State-level supports

FAHSC has implemented a number of supports to address work-related stress among MIECHV home visitors. Firstly, FAHSC partners with the Ounce of Prevention to provide web-based and on-site training on: Skill building (Motivational Interviewing, Reflective Supervision, Setting Professional Boundaries); Assessment Tools and Techniques (ASQ, ASQ-SE, Perceived Stress Scale, HOME, Edinburgh Postnatal Depression Scale & others); Interventions (Seeking Safety, SCRIPT); and Foundations (Social-Emotional

Development of Children, Trauma-Informed Care, Pregnancy & Women’s Health, Domestic Violence & others). These trainings support development aligned with the 2015 MIECHV Core Competencies, which define knowledge and skills for home visitors and other staff that work with families of young children (<http://flmiechv.com/wp-content/uploads/2015-Core-Competencies-MIECHV.pdf>).

Additionally, FAHSC funds at a \$5,000 per-client rate, equivalent to NFP funding and significantly higher than the rate of community-based home visiting programs implementing the PAT or Healthy Families models. Additional funds have been offered to programs for FY2016-2017 earmarked specifically for: 1) salary increases for frontline staff (annual salaries currently range from \$27,000 to \$65,000 depending on program model, agency, and home visitor qualification); 2) hiring of additional data entry support staff; or 3) staff support in programs participating in continuous quality improvement (CQI) efforts which require additional training, data collection, and reporting. The state program has also received federal funding to implement a mindfulness-based stress reduction (MBSR) program for all MIECHV home visitors beginning in the 2016-2017 program year. The evaluation team will be implementing a Staff Stress, Coping, and Mindfulness Survey and focus groups to identify successful strategies to reduce work-related stress in the Fall of 2016.



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Florida
Maternal Infant & Early Childhood
Home Visiting Initiative

