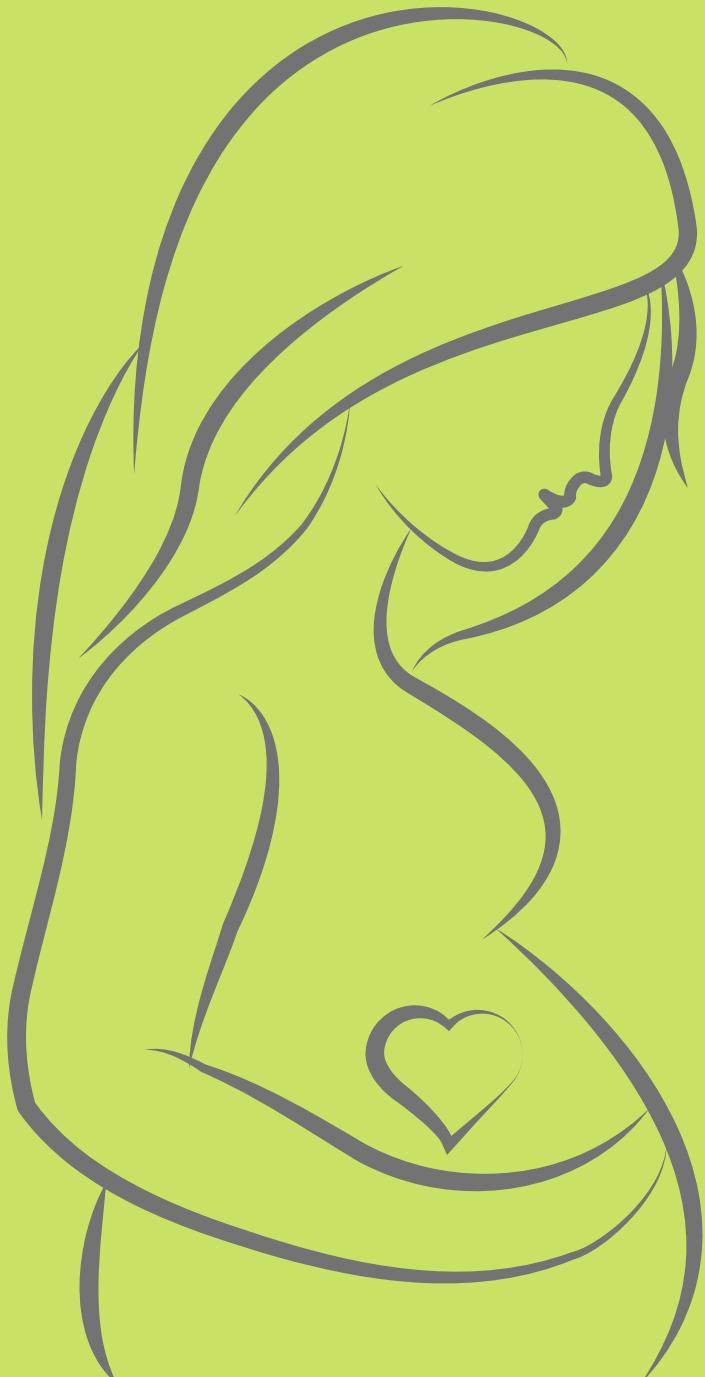


MARCH 2019

Florida Maternal, Infant and Early Childhood Home Visiting Initiative (MIECHV)



2014 -
2018
Evaluation
Reports
Compendium

Table of Contents

Executive Summary.....	3
Current State of Florida MIECHV.....	4
Evaluation Components & Outcomes.....	5
Cohort Participant Interviews	
Staff Interviews	
PARTNER Survey/Program Profiles	
Coordinated Intake & Referral	
Staff Stress	
Maternal Depression Analysis	
Parental Mental Health	
Baby's Best Sleep	
Engagement & Retention.....	261
Staff Perceptions of Engagement & Retention	
Survival Analysis: Individual- and Program-level Characteristics	
Journey Mapping	
Alumni Interviews	
Photovoice Illustration of Engagement & Retention	
Social Determinants.....	337
Intimate Partner Violence Screening, Support and Referral	
Characteristics and Experiences of Adolescent Participants	
Housing Stability	
Immigrant Health	
Social Support	

Welcome!

The evaluation team at the University of South Florida College of Public Health, Chiles Center has been delighted to work with the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative and Florida Association of Healthy Start Coalitions since 2012. Florida MIECHV is an inspiring and rewarding partner to work with, because of the vision and direction from the Project Director, and the skills and passion of the state leadership team who lead continuous quality improvement (CQI), continuing education and technical assistance, data quality and use, and contract management. We equally appreciate the incredible MIECHV program directors, supervisors, staff and home visitors who support the evaluation activities and continuously strive to provide high quality services, embrace learning, and implement many cutting-edge initiatives. Florida is truly an exciting place for home visiting innovation. Finally, in spite of the hardships faced in their circumstances and communities, the families who participate in the program are wonderful partners in evaluation, openly sharing their perceptions, experiences, and suggestions for improvement. The program is voluntary, so these families are dedicated to learning all that they can to support their children's development and well-being.

We aim to balance neutrality with participatory program evaluation. The evaluation team maintains a strong collaboration with the FAHSC state MIECHV team, state home visiting model developers, and community LIAs by participating in learning collaboratives, on-site focus groups and interviews with staff, and statewide calls and meetings. The evaluation designs are theory-based, examine multiple levels of implementation, and use triangulation of mixed methods to understand implementation processes, measure outcomes, and to disseminate findings. Evaluation plans, reports, and presentations can be found on the Florida MIECHV website: <http://health.usf.edu/publichealth/chiles/miechv>

This is a compendium of evaluation reports from the past six years, which have focused on community collaboration to support families' diverse needs, participant engagement and retention, parental mental health, staff stress and mindfulness, CQI initiatives, and safe infant sleep promotion and practices. Additional evaluation projects have related to specific MIECHV benchmarks and sub-populations, such as the impacts of the program and participant needs (food security, neighborhood safety, health and mental health care), maternal depression, and special populations such as immigrants, Spanish- and Creole-speaking families, and adolescents.

Please use this book to learn more about the program – its participants, staff, development, and accomplishments. We hope that the findings will continue to inform quality improvement and development of new initiatives to support families and children across the state.

Jennifer Marshall, PhD, CPH
Assistant Professor
USF College of Public Health
[\(jmarshal@health.usf.edu\)](mailto:jmarshal@health.usf.edu)
(813) 396 - 2672

Carol Brady, MA
MIECHV Project Director
Florida Association of Healthy Start Coalitions
[\(cbrady@fahsc.org\)](mailto:cbrady@fahsc.org)
(904) 608 - 8046

Current State of Florida MIECHV (2018)

Nurse-Family Partnership | Parents as Teachers | Healthy Families

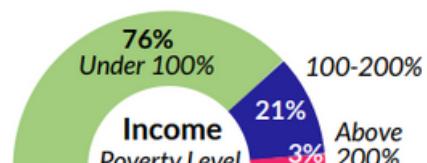
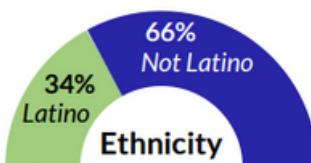
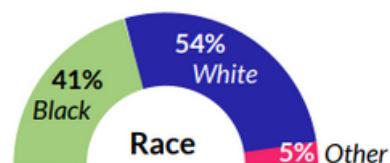
Served

2,546 families

including

1,086
pregnant women

**2,165
children**



Key Performance Outcomes

10.7% of births were preterm, down from 12.0% in 2017.

A horizontal bar chart titled "Key Risk Factors" on the y-axis. The x-axis represents percentages from 0 to 35. Five categories are listed with corresponding green bars: "No High School Diploma" at 32%, "History of Child Abuse or Neglect" at 22%, "Tobacco Use in the Home" at 19%, "History of Substance Abuse" at 16%, and "Pregnant & Under Age 21" at 15%. The bars are green with black outlines.

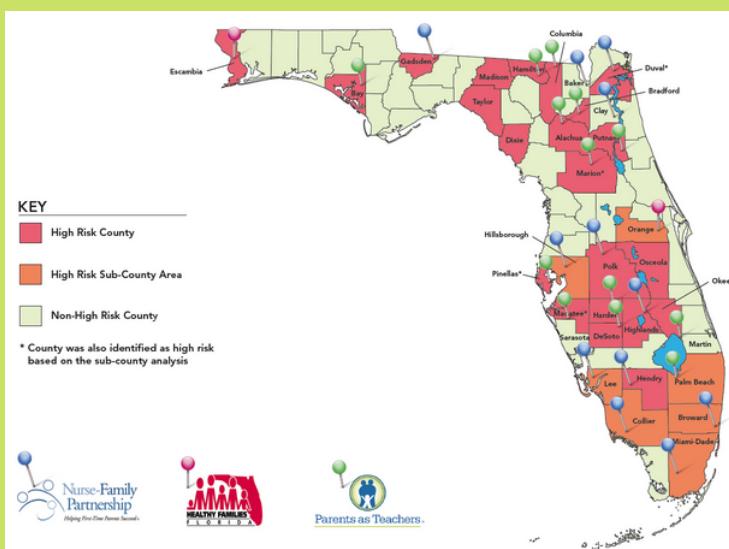
Key Risk Factor	Percentage
No High School Diploma	32%
History of Child Abuse or Neglect	22%
Tobacco Use in the Home	19%
History of Substance Abuse	16%
Pregnant & Under Age 21	15%

88% of mothers initiated breastfeeding, surpassing the Healthy People 2020 goal of 82%. More than 40% breastfed for six months or longer.

96% of enrolled children had no investigated reports of abuse or neglect.

91% of tobacco users were referred to tobacco cessation services soon after enrollment, up from 35% in 2017.

15 of 19 Performance Outcomes Improved from 2017 to 2018



Evaluation Components & Outcomes



Florida MIECHV Evaluation: 2014 Program Participant Interviews for Cohort 1

Marshall, J., Birriel, P. C., Olson, L., Baker, E., Estefan, L. F., and the USF Florida MIECHV Evaluation Team

This project is supported by the Florida Maternal, Infant and Early Childhood Home Visiting Initiative.

Methods

The MIECHV Program Evaluation team conducted in-depth, semi-structured phone interviews with English- and Spanish-speaking home visiting participants from the five initially funded programs. Each family received a flyer from their home visitor with a short description of the evaluation, the contact information for the MIECHV Evaluation Team, and a notice that participants would receive a \$25 Walmart gift card for their participation. Those interested set up a phone interview during a time that was most convenient for them. Interviews were conducted with the family member who self-identified as the primary caregiver of a child enrolled in the MIECHV Program. During interviews, participants were asked a series of questions relating to their perceptions of their home visiting experience, including: (1) the types of referrals they receive, (2) what parts of the home visits are most helpful to them, (3) what their relationship is like with their home visitor, and (4) how home visiting lessons and activities are utilized in their daily life.

Phone interviews lasted approximately 20 minutes, were digitally recorded, and professionally transcribed verbatim. The recordings and transcripts were simultaneously reviewed by evaluation staff to ensure accuracy. As a team, the MIECHV Evaluators then performed a preliminary content analysis of interview data, producing a thematic review and short summary of preliminary findings (presented here). Self-reported demographic information was also recorded and entered into Qualtrics survey software. Qualitative analytic methods include using Atlas.ti, a qualitative data analysis software, and a hybrid approach of *a priori* coding.

The *a priori* codebook contains initial codes based on the questions and topics in the interview guide, and emergent codes are added to the codebook as appropriate. Data analysis uses the constant comparative method. Two researchers are independently code each transcript until an appropriate level of agreement is reached. This systematic qualitative analysis is currently in progress.

Participants

The five initially funded programs include six Florida counties: Alachua, Bradford, Duval, Escambia, Pinellas, and Putnam. Seven to ten participants from each program were interviewed, totaling 45 interviews. The majority of participants were female (96%), single (71%), under the age of 25 (53%), unemployed but job searching (40%), and did not have a college degree (22% less than high school, 36% high school diploma). Most participants identified their race as Black (44%) or White (40%) and 13% identified as Hispanic.

Preliminary Results

How did you get involved with the home visiting program?

The majority of participants said they were referred to the program through their doctors' offices. This is likely a reflection of the universal screening that Florida conducts on all pregnant women, and the local triage and referral systems that follow risk screening. Other participants learned about the home visiting program from family or friends or were referred during participation in another public program, such as Healthy Start and/or the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Also, a few participants heard about the program (1) through advertisements, (2) during a hospital stay, or (3) from other agencies, such as the Health Department or the Department of Children and Families.

What generally happens during a home visit?

Participants provided rich descriptions of their home visits. These descriptions varied widely and were program specific. For example, some programs offered home visiting during pregnancy, while others did not. Likewise, some met on a weekly basis with their home visitor, while others met biweekly. Some participants also reported having more than one home visitor during their participation in the program, while others only had one.

In general, most participants described their first visit, where home visitors focused on getting to know them and their family. During the following visits, participants reported that their home visitors covered a range of topics from pregnancy to birth to developmental milestones through toddlerhood. For example, for those participants who entered a home visiting program during pregnancy, many reported that their home visitor reviewed topics such as what to expect during the first, second, and third trimesters and first-time motherhood. Most in this group also reported that their home visitors helped track their health during their pregnancy. For those who already had children, participants reported learning how to incorporate their older children into activities. Participants particularly appreciated the opportunity to ask questions and to have some control over the topics being discussed. For example, many reported having the opportunity to pick out the topic of discussion for their next visit (e.g., child safety).

Participants also reported receiving a number of informational materials, including pamphlets, worksheets, and other handouts. Some had the opportunity to watch videos, and most reported engaging in a number of hands-on activities, including games.

Participants discussed receiving emotional support and assistance with goal setting (e.g., finishing school, losing weight, and finding employment) from home visitors. Home visitors were often referred to as "life coaches," "mentors," and "instructors." They were also described as friendly, full of wisdom, and experienced. Likewise, most participants reported receiving needed tangible items from their home visitors, such as baby food/formula, diapers, toys, and books.

University of South Florida Florida MIECHV Evaluation Team



Participants also mentioned receiving community referrals and information about community events.. For example, participants discussed receiving help with enrolling their child in school, finding employment, identifying health professionals, and accessing other resources/services for themselves or family members. A couple of participants stated that they usually end each home visiting session by setting goals collaboratively for the child or the parent. They also determine ways to successfully attain goals which the home visitor tracks through progress assessments. Participants also mentioned that they found the information they receive very educational, particularly bed safety (safe sleeping), feeding, having patience and better parenting.

Who is present?

During home visits, most participants were alone with their child. If any other family member was involved, it was usually the participant's fiancé/husband and/or the child's father. Their participation ranged from being fully involved to sitting nearby and listening to being present but completely disengaged (e.g. on the phone throughout the visit). Of the fathers participating, many used this time to ask questions and to learn how to be more involved. The participants' mothers were also sometimes present. While some were helpful (e.g., explained concepts that the nurse could not convey adequately), others were bothersome and "took over" the visit, and others were disengaged.

Family members, including sisters, significant others, and other children, and seemed to participate about the same across the counties. Those who were outside of the immediate family, or from the significant others' family, were reported to be considerably more enthusiastic about participating and being involved in the home visiting activities than the immediate family, though their involvement was based more on the chance that they were already there when a visit occurred or they happened to walk in on one already in progress.

What other activities or discussions are part of the home visit?

Topics (listed here from most prevalent to least) covered during the home visits were not always specific to just the mother or child (i.e., included both or other family members). Topics specific to the mother included: changes during pregnancy, mother's health, breastfeeding, interaction with child, personal support (i.e., emotional, mental, and social), and parenting techniques. The discussions of health included nutrition, physical activity, and addressing specific health needs or concerns of the mother. Topics related to the child were more frequently discussed than those pertaining to the mother. Those topics include: child development, learning (with an emphasis on reading and safety) (i.e., baby-proofing and safe sleep), and health. When discussing development with a mother, the home visitor included activities for the child, such as ways to improve motor skills and introducing tummy time. Home visitors also conducted height and weight checks, provided limited medical advice, and followed up on doctors' appointments the child may have had since the last visit. Other activities included arts and crafts, mother-child bonding, and involvement of other family members, including any other children.

University of South Florida Florida MIECHV Evaluation Team



What part(s) of the home visit have been most helpful to you so far?

Generally, components of the home visits reported most helpful to participants can be categorized under emotional support, maternal education, resources, childhood learning and development, goal setting, and convenience.

Aspects of the home visits reported to be most helpful (listed from left to right, most prevalent to least):

Emotional Support	Maternal Education	Resources	Childhood Learning & Development	Goal Setting	Convenience
<ul style="list-style-type: none">● The home visitors being personable, relatable, and easy to talk to● The home visitors giving advice and support about other parts of life besides the child/ pregnancy● Stress management● Allows mom to spend one-on-one time with child	<ul style="list-style-type: none">● Lessons on safety, parenting techniques, breastfeeding, and how to interact and communicate with child● Material is a good reminder of some things that may be more common sense● Covering new topics each visit	<ul style="list-style-type: none">● Providing formula or diapers when needed● Referrals for food, clothes, or job opportunities● Referrals for other services● Information packets● Referrals to education classes at other organizations	<ul style="list-style-type: none">● Maternal and childhood nutrition advice to help child's development● Learning which stages of development are appropriate at specific ages● Learning age-appropriate activities to help development	<ul style="list-style-type: none">● Goal setting for the child, mother, and family● Setting goals for the different stages of pregnancy and checking in on progress● Encouragement to stay focused on goals	<ul style="list-style-type: none">● Helpful that the home visitor will come to the house● Home visitor will meet anywhere● Home visitor is on time

Generally, participants stated that all aspects of the home visits were helpful. Therefore, no part was considered to be “least helpful.” However, the most common complaint was that some of the information provided by the home visitors was repetitive and not helpful since it covered a topic that the mother already knew about (i.e., reviewing first trimester information when the participants was in her second trimester). Other aspects of home visiting that were reported to be least helpful include: going over developmental activities that the child could already do, providing lessons that overlapped with other organization’s lessons (i.e., daycare), having no resources for immediate assistance, and providing specific referrals that were out-of-date (i.e., “hot jobs list”).

“I would definitely want them to know that it makes you feel comfortable about being pregnant because I know when I was pregnant, I would say because I was in high school still and the lady, she helped me have confidence in myself like I’m not the only one and I can do it even though I’m young or whatever.”

Service Referrals

Have you received any referrals to other agencies or organizations?

Have you used any of those services?

What other services would you like to have from the home visiting program in general?

The number of services available and referrals received and utilized varied widely. Most participants received a list of resources upfront. One participant said, “*Any number you would want is on this paper.*” They also received referrals based on needs that came up in conversations during the home visit. Typically, the home visitor would learn of a need and provide a referral on the spot or at the next visit. Many services/resources were provided directly (the home visitor would bring the item directly to the parent). For example, one home visitor took a family to the grocery store and bought them groceries.

Participants also mentioned that their home visitor facilitated referrals by calling to follow up, bringing the paperwork to the family’s home and helping them to complete it, or bringing a laptop to the family’s home to help them enroll for services online. Most families utilized the services that they were referred to, found them helpful, and could not think of additional services they would have needed but had not received. In some areas, participants reported that they would like to have access to childbirth and new mother classes, bus passes, rent and utilities assistance, diapers, education for the mother, children’s books, and child care. Some participants stated that they had not utilized a resource, because they “haven’t needed it yet.” One participant compared how her DCF worker provided resources directly (vouchers, bus passes, etc.), while her home visitor only provided telephone numbers for agencies that she could have found on her own by calling 2-1-1 and that had limited availability due to the high need in the general community.

Service referrals most utilized (from most to least in each category):

Basic needs	Health-related services	Mental health resources	Other
<ul style="list-style-type: none"> ● Clothes for parent and child x5 ● Housing x6 ● Utilities (water, power bill) x6 ● Food bank x3 ● Food stamps x3 ● WIC ● Baby shower ● Diapers 	<ul style="list-style-type: none"> ● Birth control “child planning” ● Breastfeeding class ● Smoking cessation ● Healthier diet options ● Health insurance/clinic for boyfriend ● Dental care for mom and Fiancé 	<ul style="list-style-type: none"> ● Counseling for mother ● Behavioral support for child ● Counseling for child’s older sibling ● Mentoring/support for graduates (alumni) ● Counseling x3 	<ul style="list-style-type: none"> ● Child care x8, including RCMA for migrant workers ● Car or bus passes x5 ● Education for mother x2 ● Employment ● Car seat (safety class) ● Stroller ● Child support ● School supplies ● Kiddy cash (earned after HV) ● Map of the area

University of South Florida Florida MIECHV Evaluation Team



Participation in the MIECHV Home Visiting Program

What does the home visiting program mean to you and your family?

Generally, most women voiced thanks for the informational support each program provided. However, the relationships (i.e., emotional support) that participants formed with their home visitors seemed to mean the most to participants. When asked, "What does the home visiting program mean to you and your family," participants said:

"Help and guidance. Definitely guidance and support. Pretty much a lot. It came in handy at the time that it showed up because I needed it. It wasn't just – not just for resources but just again her, she's special. So she definitely got me, helped me a lot."

"To me, it honestly means, to me it kind of equals a better relationship with my children, a better calm in my house, a better home space happy environment."

For some first-time moms, in particular, it gave them the hope and reassurance that they needed:

"It meant a lot when I was pregnant because that was the first time I was honestly scared. And I was worried about how things are going to be as a mother. I knew I wasn't going to be a bad mother but I wasn't ready. So that helped me keep going, stay motivated and be happy about it all."

"Part of it is a sense of...stability that I know I'm going to meet with her...I know that she's coming...she's stable and the program has given me the stability that the baby's coming and it's going to be okay and there are things out there – there are organizations out there that can help me if I need it."

For more information, please contact:

Jennifer Marshall, PhD, MPH
Research Assistant Professor
University of South Florida College of Public Health
Department of Community & Family Health
(813) 396-2672

MIECHV Evaluation Team

Dr. Jennifer Marshall
Pam Birriel
Leandra Olson
Rema Ramakrishnan
Deviquea Rainford
Suen Morgan
Oluyemisi Aderomilehin

Chantell Robinson
Loreal Dolar
Dr. Elizabeth Baker
Dr. Lana Yampolskaya
Dr. Sheri Eisert
Dr. Bill Sappenfield
Dr. Marti Coulter



2015 MIECHV PARTICIPANT INTERVIEWS REPORT

Florida Maternal, Infant, and
Early Childhood Home Visiting
Program Evaluation
University of South Florida

INTRODUCTION AND METHODS

This report utilized data collected as part of the Florida MIECHV independent statewide evaluation. During the spring of 2015, the University of South Florida MIECHV evaluation team applied a qualitative approach to better understand the home visiting experience from the perspective of participants in the second MIECHV program cohort, which consists of six programs (Broward, Hillsborough, Manatee, Miami-Dade, Orange, and Southwest) across eight counties in Florida funded in September of 2013. In-depth and semi-structured interviews were conducted with women from each program in the second cohort. Interviews were conducted via phone and lasted an average of 20 minutes. All interviews were recorded, and each participant provided a verbal consent to participate.

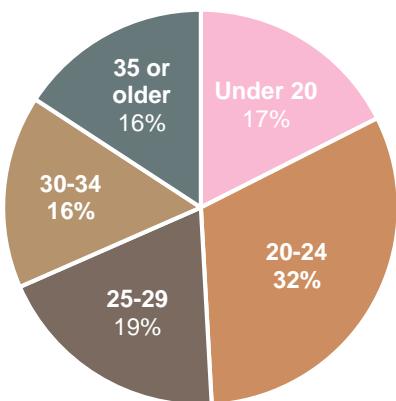
Recruitment was conducted by home visitors who distributed flyers to families participating in the selected MIECHV programs. Interested families directly contacted the evaluation team to schedule an interview appointment. Although all MIECHV participants qualify for the program based on their high-risk communities and challenging circumstances, we also sought to gather the perspectives of MIECHV participants with limited English language proficiency to determine if they faced unique challenges addressed by the home visiting program. Thus, 7-12 interviews were conducted by trained research staff with participants from each program, totaling 58 interviews, including 13 conducted in Spanish and 9 in Haitian/Creole. In addition to questions about services and referrals consistent with 2014 Cohort 1 interviews, this phase included questions specifically targeting access to health care and mental health services.

Interviews conducted in English and Spanish were professionally transcribed, and Haitian/Creole interviews were transcribed and translated by bilingual research staff. All recordings and transcripts were reviewed by research staff to ensure accuracy. A qualitative, thematic content analysis was conducted by trained research staff. Access to health and mental health services were specifically targeted and analyzed as emerging focus areas for this research project. Additionally, questions regarding referrals were included in the analysis and examined for all participants, and also separately for Spanish- and Haitian/Creole-speaking participants.

PARTICIPANT DEMOGRAPHICS

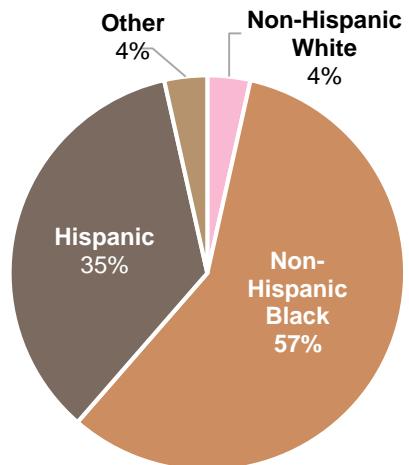
Participants self-reported demographic information following the completion of the interview, which was then entered into Qualtrics survey software. All participants were female (100%), and the majority were non-Hispanic Black (57%), 20-29 years old (51%), single (62%), had less than a high school education (33%), worked as a homemaker (32%), and had one child living in the household (61%). Participant demographics are reported below:

Parent Age



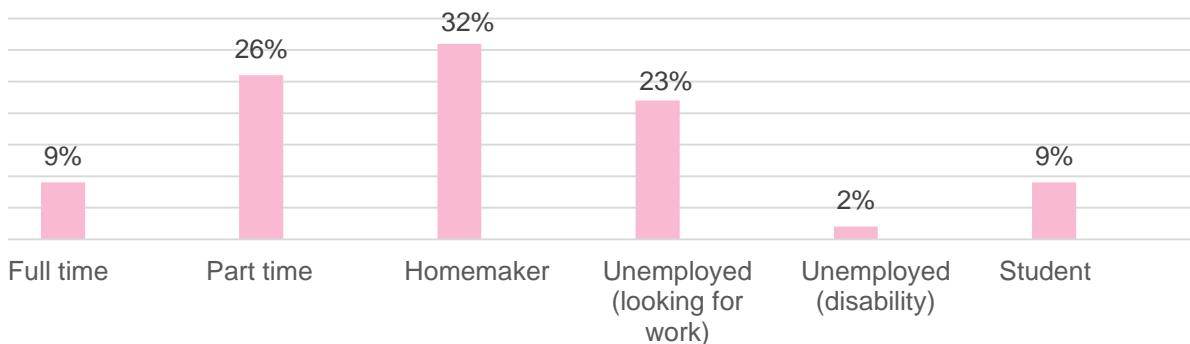
Note: N= 57, 1 missing/ prefer not to disclose

Parent Race / Ethnicity



Note: N= 57, 1 missing/ prefer not to disclose

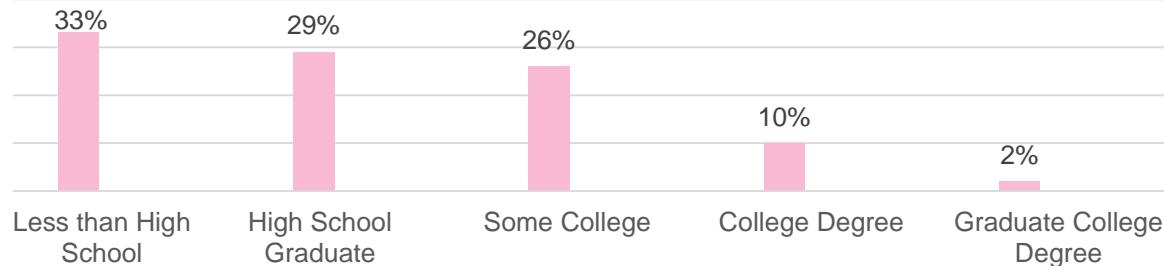
Employment Status



Note: N= 57, 1 missing/ prefer not to disclose

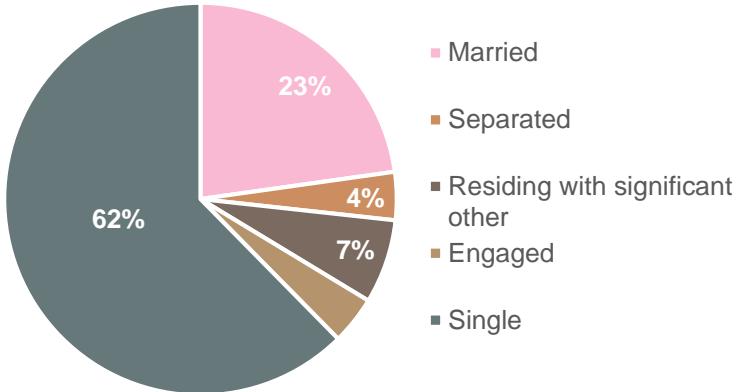
PARTICIPANT DEMOGRAPHICS

Education Level



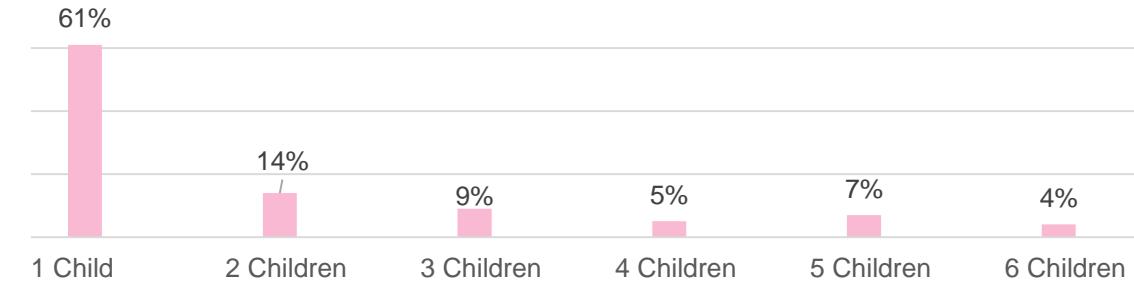
Note: N= 57, 1 missing/ prefer not to disclose

Marital Status



Note: N= 56, 2 missing/ prefer not to disclose

Number of Children Living in the Household



Note: N=57, 1 missing/ prefer not to disclose. Current pregnancy counted as 1 child.

HIGHLIGHTED POPULATIONS

Haitian/Creole-Speaking Participants

Florida MIECHV programs serve a population of Haitian/Creole women who expressed several common benefits of participating in the home visiting program. The USF MIECHV evaluation team conducted nine participant interviews in Haitian/Creole. At the time of the study, 25 participants were identified as Haitian/Creole-speaking in the statewide data system. Fourteen of those participants contacted the study team to participate in interviews, and 12 completed interviews, 9 in Haitian/Creole, and 3 in English according to their preferences.

The most frequently mentioned benefit was the friendship between the mother and the home visitor. One participant described how thankful she was for the program, explaining that she felt alone during her pregnancy until she connected with a home visitor who consistently checked in with her and became more like a family member than a service provider.

Three of the Haitian/Creole participants talked about their management of gestational diabetes and one mentioned high blood pressure, explaining that they received health assessment and resources from their home visitors on how to eat healthier and incorporate exercise into their daily routines. Participants also reported that the home visitor provided information on stress management as an additional part of the healthy lifestyle changes. The home visitor was perceived as a resource for referrals to counseling and confidant for the women to talk to about their current struggles. This information is critical, as six of the Haitian/Creole participants reported to experiencing stress, depression, and anxiety related to their pregnancy or in dealing with general life circumstances. One participant commented about the support her home visitor provided, saying if not for the program she would be “*overwhelmed with stress, upside-down, don't know what to do.*”

Overall, Haitian/Creole participants reported that MIECHV programs offered a range of services - from emotional support to promoting physical health and increasing knowledge on newborn care- exemplifying a holistic approach to meeting the unique needs of the mothers they serve.

HIGHLIGHTED POPULATIONS

Spanish-Speaking Participants

At the time of this study approximately 21% of Florida MIECHV participants self-identified as Hispanic, and 12% spoke Spanish as their primary language. The evaluation team conducted 13 Cohort 2 interviews in Spanish based on participant preference. The results in this section reflect the comments from the 13 Spanish interviews (not the comments from all Cohort 2 participants who self-identified as Hispanic). These primarily Spanish-speaking participants reported that they found the home visits useful. Participants underscored that they appreciated the fact that their home visitor took the time to provide information about topics they did not know much about, as well as clarify any questions or concerns they may have had after their doctor's visits.

"I think it has all been useful. It's been a great learning experience for me. Since I had my first [child] not in this country, but it has been like if I was a first-time mom. I wish I could have had this help with my first baby. With this second one, I have learned so much, it's as if I were a first-time mother with someone helping me the whole way. It's been a wonderful help."

The majority of the Spanish-speaking participants found the referrals helpful, while some reported no need for the services. Generally, these participants reported little difficulty accessing the services. The table below specifies additional services that Spanish-speaking participants would like assistance with from the home visiting program.

Service referrals most utilized by Spanish interview participants:

Health-related services	Educational resources	Other
<ul style="list-style-type: none">• Health insurance assistance for child• Help with Medicaid application	<ul style="list-style-type: none">• General Educational Development (GED)• English language tutoring	<ul style="list-style-type: none">• Child care• Educational materials for the baby• Bed/sofa• Playpen• Car seat• Breast pump

HIGHLIGHTED POPULATIONS

All of the Spanish-speaking participants expressed that the home visiting program positively influenced their lives. They emphasized that the program was good for participants who were from other countries, as it was '*instrumental, useful, essential, and important*' and increased general knowledge and parenting skills. Participants said their lives would have been different without the program in that they would have missed out on information, had difficulty raising their child, and had doubts about parenting. Three participants stated that they would not have learned about proper parenting techniques and child development; one mentioned how the program empowered her personally; and one said that her child would have not received speech therapy without the help from the MIECHV program.

"We are the type to have the babies on the walker just because we are cleaning, cooking, because once he is on the floor you have to be more careful. But they taught me to let him because he will learn whether is for learning how to crawl or anything else he may want to learn."

"It's been a great help to me every day in knowing how to properly take care of my baby. I've applied things I have learned to taking care of my older [child], too. It's really been a great help. I think I do a better job of parenting, now. Now I know what I need to do and what I can do."

"It's been very important and with a lot support. When you're pregnant and you don't have family close by, you need help and someone to talk to. Those that do have them close are not well educate about the topic for all of the question. Here you feel more confident and more secure with the information. I think it's very important."

REFERRALS FOR COMMUNITY RESOURCES

Service Referrals

All Cohort 2 participants were asked:

- “Have you received any referrals to other agencies or organizations?”
- “Have you used any of those services?”
- “What other services would you like to have from the home visiting program in general?”

Participants reported a wide variety of referral services received and utilized as part of their enrollment in the MIECHV program. The majority of participants received a list of numerous referrals and informational flyers from their home visitor. Through conversations during home visits, home visitors could determine the needs of the family and give specific referrals to meet those needs. Participants also explained that some home visitors provided direct assistance to meet participants' basics needs, such as transportation and diapers. Participants also mentioned home visitors helping them fill out paper work to apply for food stamps, faxing it for them, and facilitating referrals by bringing a laptop to their visits to search for additional services available.

The table below highlights the need of Florida MIECHV families related to food security, housing, transportation and other basic resources.

Participants also accessed a variety of health, mental health, and perinatal services and resources through their home visitor. Many participants used at least a portion of the services that their home visitor referred them to and found them helpful, but several expressed continuing unmet need related to child care. Some participants also suggested that group counseling and parenting classes should have a variety of scheduling options for those mothers in school and working. Others continue to need transportation assistance to community services

The participants who did not use the referrals mainly stated it was because they did not have a perceived need for those services at that time. Those participants who received direct referrals and whose home visitors directly helped them apply for services reported that they referrals more often than those who only received a flyer or pamphlet for the services available. Overall, the majority of participants had positive

REFERRAL USAGE

feedback on their home visitors and the services they used. For example, one participant stated “*Whatever I want to do, I know I can do it because of this program.*”

Service referrals most utilized (from most to least in each category):

Basic needs	Health-related services	Mental health resources	Other
<ul style="list-style-type: none">● Food/Nutrition (WIC, food bank, food stamps)● Housing/rent assistance● Transportation (car or bus passes)● Furniture for baby and mother● Utilities● Clothes for parent and child● Cash assistance	<ul style="list-style-type: none">● Pregnancy support programs● Parenting class● Child birth class● Breastfeeding class● Doula program● Health insurance	<ul style="list-style-type: none">● Counseling for mother● Counseling for father	<ul style="list-style-type: none">● Books/toys for baby● Diapers● Child care● Car Seat● Education for mother

Other service referrals participants would like to have (from most to least in each category):

Basic needs	Health-related services	Mental health resources	Other
<ul style="list-style-type: none">● Housing/rent assistance● Transportation● Food stamps● Diapers● Cash assistance	<ul style="list-style-type: none">● Parenting class● Doula program	<ul style="list-style-type: none">● Group counseling with various time options	<ul style="list-style-type: none">● Child care● Education for mother● Stroller

DAILY USE OF HOME VISITING INFORMATION

Healthcare Service Referrals

This question “Has your home visitor helped your or other members of your family access any health care services?” was introduced to all Cohort 2 interview participants to better understand their health care needs and also determine how Florida MIECHV facilitates access to health care. For the context of this summary, access to care includes insurance, personal care, medical home for the mother, medical home for the child, care for other family members, and health-related information.

Some interview participants explained that their home visitor did not assist them with access to health care services because they: did not have a need for health care services; already had access to care in the form of health insurance or a medical home; and had not discussed needed health care services with their home visitor. Additionally, participants explained that they did not remember health care access as a specific topic of discussion. Instead, they explained that conversations were mostly centered on their pregnancy and their baby’s health rather than the mother’s personal health.

However, several participants expressed that their home visitor helped them access health care services, including: access to health insurance, such as assistance with Medicaid application; access to health information; assistance with health services for other family members; and assistance in establishing a medical home with a physician that best fit their personal and family health needs. Participants explained that their home visitor helped them with health care services in varying amounts, but supporting them through the application process for health insurance, such as Medicaid, was the most common assistance.

“We did speak about the Medicaid program. I didn’t know certain members in my family were going to be eligible for it as far as my fiancé, which is not the father of my child. She did give me information and I did file and he was able to get health insurance.”

DAILY USE OF HOME VISITING INFORMATION

Mental Health Service Referrals

Participants were also specifically asked, “Has your home visitor helped you or other members of your family access mental health services, such as counseling?” Additionally, issues related to mental health were raised by participants throughout the interviews in response to other questions.

Several participants who shared that their home visitor assisted them with mental health services explained that they received information about depression, stress, or anxiety during their sessions. Additionally, home visitors provided specific information about available services and provided referrals to counseling. Participants also mentioned that issues around domestic violence were discussed, mainly to inform participants of existing resources to address such problems.

Those who reported that they did not receive mental health services referrals explained that they: did not need the services; did not discuss mental health with their home visitor; or were already enrolled in services. Several explained that they receive emotional support from her home visitor, and therefore, did not need any additional help.

“I think she mentioned it in the beginning on how to deal with being a new mom... we talked about baby blues. So in the beginning, she kind of explained it’s okay for them to cry. She explained you have to show them love because they’re at an age - and she gave me the age group. She was like, ‘Newborn up to eight or nine months, they need to learn how to develop their trust, so the hugging and the kissing and stuff like that.’ Then we talked about post-partum depression and stuff like that. I think that was our first or second visit, they did have some slips on that but that’s not something that I need.”

Parent: It's really helpful especially when I was depressed.

Interviewer: Does she get you counseling for your depression?

Parent: Yes. She talks to me, yes.

Interviewer: She talked to you, but she didn't send you anywhere else?

Parent: Well, it wasn't that bad. They actually always say, if you need more information you can look deeper into it, but it wasn't that bad. Maybe I just need someone to talk to.

DAILY USE OF HOME VISITING INFORMATION

When asked, “How have you used in your day-to-day life what you have learned during the home visits?” the most common responses related to health and safety measures for their newborn. Specifically mentioned were: tips on baby proofing the house; preventing shaken baby syndrome; safe sleep practices to prevent sudden infant death syndrome (SIDS); and infant and child choking prevention and response. Several participants also mentioned learning how to provide their infant with proper nutrition and feeding their baby; interacting with their child; and bathing, changing, and swaddling their child.

“I feel more prepared and less worried for what is happening to me and what is to come with giving birth.”

“Basically, I use everything like when I take care of the baby and I remember what the nurse had been telling me.”

Lastly, participants described lesson topics that pertained to their own health and well-being. These lessons included managing stress, setting goals for themselves, and monitoring their own health.

“There are some things she tells me to use like she went to the store and bought me a measuring cup so that I can measure everything that I eat and I always do that. Everything she tells me, I always do it.”

“I know about nutrition and what I should eat. I didn’t know about that so I try to do that, and also how I should take care of my body. To sleep... before I didn’t sleep enough; I fainted two times and it was because I was not sleeping well caused my pressure to get low... and she advised me about this. How [it] is not the same thing as not being pregnant, that I have to eat right? It was very useful.”

IMPACT OF HOME VISITING PROGRAM

Finally, participants were given the opportunity to reflect on the question, “How do you think your life would be different if you didn’t participate in the MIECHV program?”

The majority of the participants stated they would not have the knowledge they have now if they had not participated in the program. Often, they said they would have made more mistakes; participating in the program makes it easier to learn. One mother exclaimed, *“I’d be frantic not knowing where to go or what to do.”* Other participants made statements similar to this, saying that they would not be as emotionally stable as they were, and had it not been for the program, they would be more stressed, depressed, and lonely.

“Without it, I might be very lost.”

“I wouldn’t know anything. I’d be stuck on Google.”

Another common response was that participants felt they would lack necessary resources like diapers and housing had it not been for the program. *“I don’t even want to imagine what we would be without it, like we might be homeless right now.”* A few participants felt there would not be a significant difference in their life but stated they have learned and enjoyed the program. One participant who felt this way stated, *“It’ll be okay but I chose to have it because it’s fun and good to learn different things and just ask questions if necessary.”*

“I don’t think I would know how to be stress-free.”

“When my nurse came, well, I was depressed so I would probably not have anybody to talk to.”



2014 PROGRAM STAFF INTERVIEWS REPORT

**Florida Maternal, Infant, and Early
Childhood Home Visiting Evaluation**

University of South Florida

INTRODUCTION AND METHODS

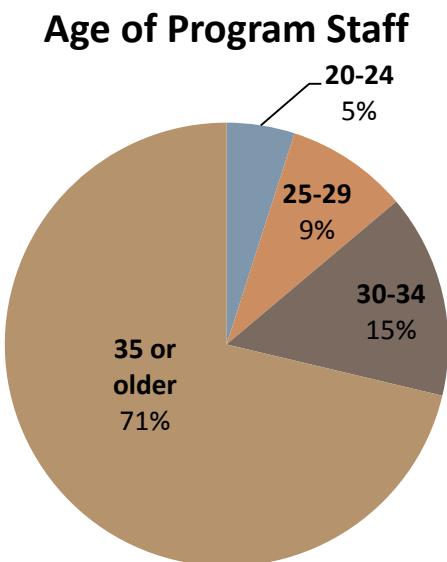
This report summarizes data collected as part of the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program independent statewide evaluation. During the fall of 2014, the University of South Florida MIECHV Program evaluation team conducted exploratory qualitative on-site interviews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

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

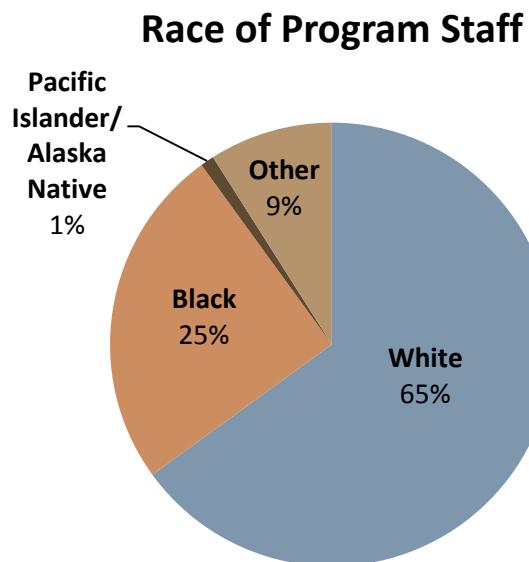
Overall, there were 32 interviews/focus groups conducted. These discussions were digitally recorded and transcribed verbatim by a professional transcription service. Transcriptions were further reviewed for accuracy by MIECHV Program evaluation team members. A preliminary, inductive content analysis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

PARTICIPANT DEMOGRAPHICS

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



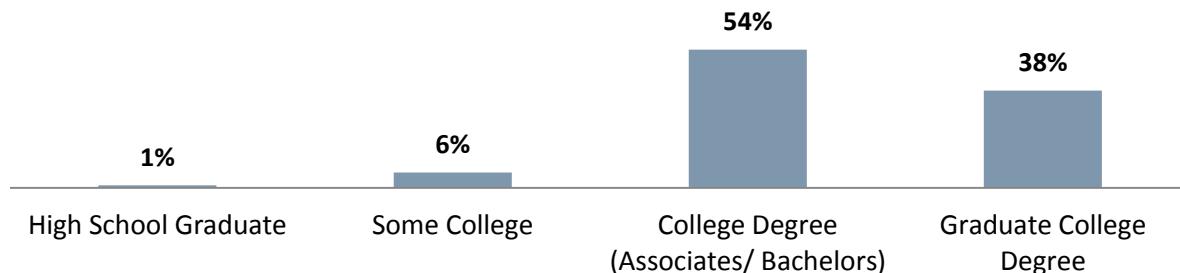
Note: N=81



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

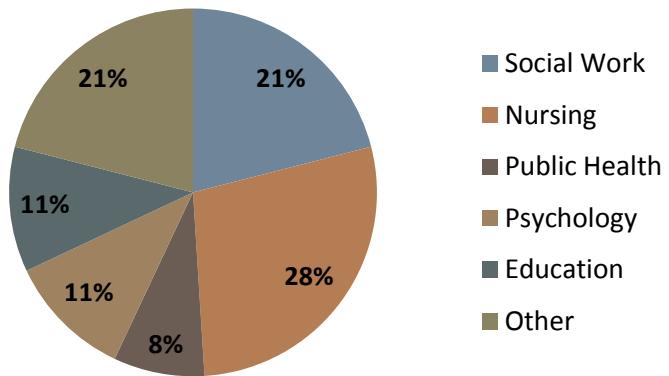
PARTICIPANT DEMOGRAPHICS

Highest Level of Education Completed



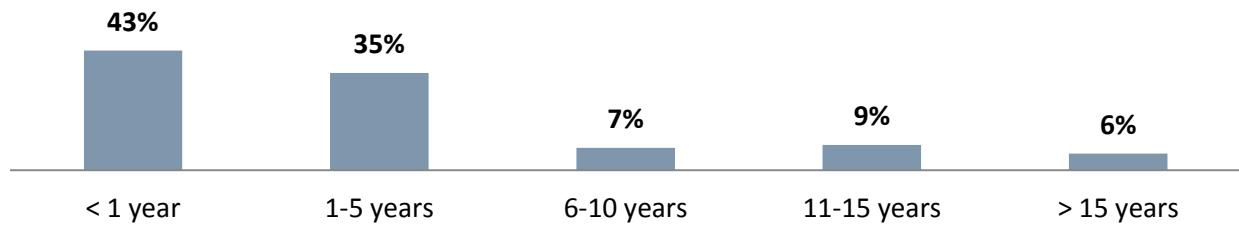
Note: N=81

Educational Background



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

Length of Time in Current Staff Role



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

PROGRAM STRENGTHS & OUTCOMES

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

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

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

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

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

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

PROGRAM STRENGTHS & OUTCOMES

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

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

visitors to be able to go into their clients' homes and build comfortable, open relationships, as well as help families make improvements with every visit and tailor the curriculum to meet the specific needs of each family.

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

Some supervisors stated that professional development, trainings, and implementation of the program models are also perceived strengths, since they allow staff to reach out and visit clients in their homes. Home visitors said that the program itself is a strength, in conjunction with its models; the program permits home

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

PROGRAM STRENGTHS & OUTCOMES

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

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

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

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

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

PROGRAM STRENGTHS & OUTCOMES

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

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



“Hard to measure, is probably the self-efficacy kind of goals because sometimes clients go back to work and school, and then they leave the program.”

“That’s actually a negative against us that they leave the program before they had two-and-a-half years, but actually they’re doing exactly what we want them to do, but we’re getting – we’re getting a ding against us as retention.”

COMMUNITY NETWORKS

Tell me about the community network that supports your families.

The community networks that supported families differed by program. For example, some programs were part of a larger, well-established infrastructure. In these cases, the program

was usually associated with a hospital, and clients served by these programs had ample resources. On the other hand, for some programs, community networks were still being

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

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

built or were very small, creating a barrier for clients to access needed resources. The latter was particularly true for programs that served rural communities. The table below lists a number of community partners often identified by administrators.

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

COMMUNITY NETWORKS

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

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

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

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

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

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

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

Lastly, administrators identified a number of barriers to establishing and

COMMUNITY NETWORKS

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

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

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

STAFF WORK-RELATED STRESS

In twenty separate interviews, MIECHV supervisors and home visitors from various Florida counties confirmed that emotional burnout among staff is a common reality. The act of listening to and witnessing many stressors and issues faced by their enrolled families on a day-to-day basis, sometimes for several hours per day, was reported to play

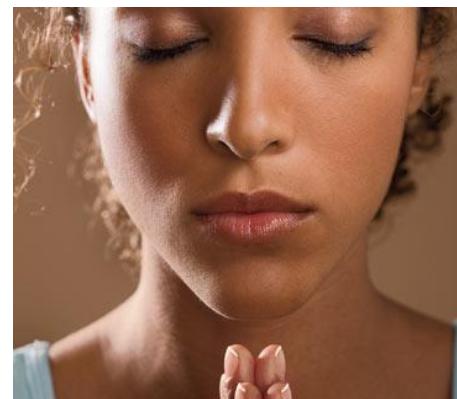
"When I see them, I wish there was more that I can do. Sometimes I go home and I'm just kind of like, 'What else could I do?' I just – Even after work hours, I'm like 'What else could I do?' I keep thinking about it."

then forced herself to relinquish those thoughts contemplated their clients' struggles when at home, wondering what else they could do as far as providing referrals or support. Many home visitors connected their job performance directly to the

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

outcomes of their clients. When their clients cannot access the referrals given, do not listen to advice, or spend several visits interpreting an element of the curriculum, the home visitor may feel inept in their position.

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



STAFF WORK-RELATED STRESS

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

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

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

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

FOCUS POPULATION: IMMIGRANT FAMILIES

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

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

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

participants comorbid conditions, chronic and infectious diseases that increase health risks during pregnancy.

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

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

FOCUS POPULATION: IMMIGRANT FAMILIES

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

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



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

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

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

Jennifer Marshall, Pamela Birriel, Chantell Robinson, Amber Warren, Paige Alitz, & Rema Ramakrishnan



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.

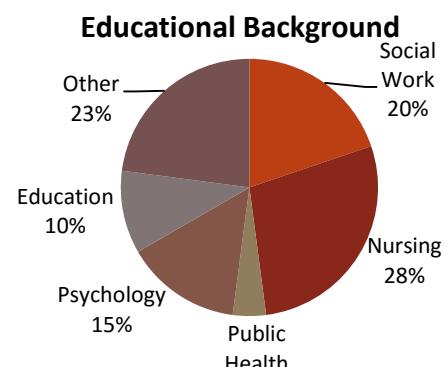
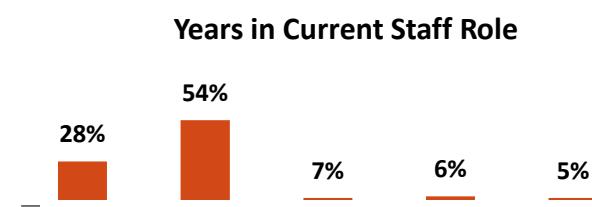
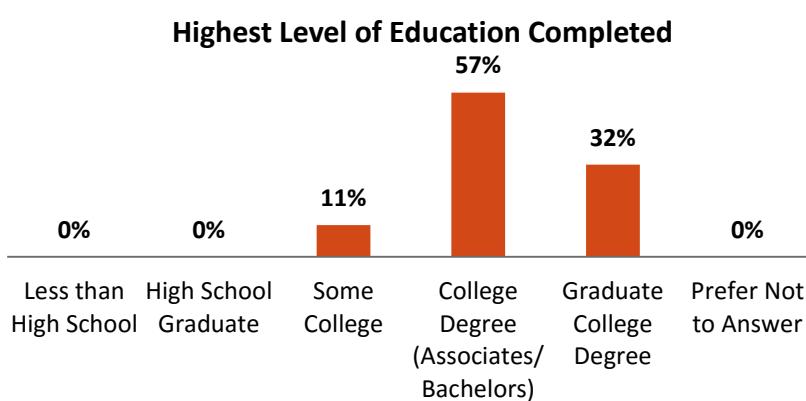
For each focus group conducted at the individual sites, participants were divided into groups based on their current job position. Administrators and supervisors represented one group, while home visitors constituted another group. Topics that were discussed included: 1) general and mental health issues 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

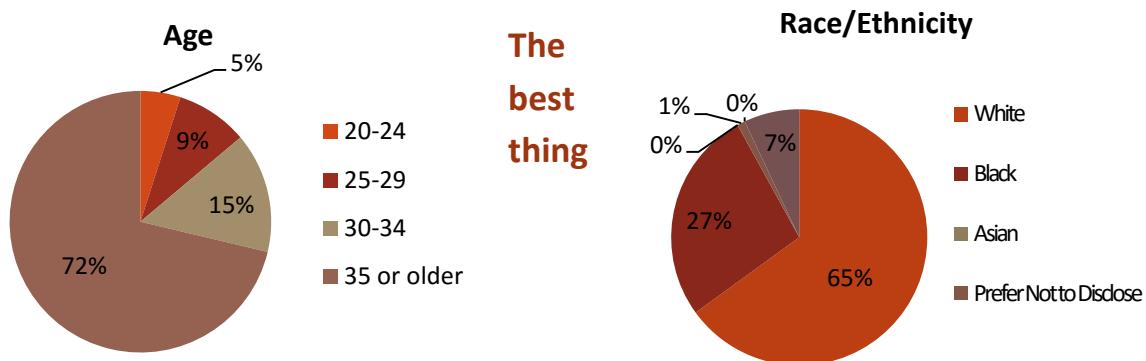
In total 82 participants were interviewed. The participants constituted 47 home visitors, 11 supervisors, 13 administrators/directors, and a few other professionals including therapists and data analysts. The length of time in which the program staff worked in their current positions ranged from less 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%).



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.



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

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.

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

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.

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

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.

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 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 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.

"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."

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

"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)

Home Visitor Groups

- Caseload/time management (required # of visits, client cancellations and attrition) (10/10)
- Client engagement and needs (unsafe home or neighborhood, chaotic or traumatic home, meeting family needs, poor birth outcomes, low engagement during visits, lack of client follow-through/apathy) (10/10)
- Paperwork & data entry (9/10)
- Time away for training and meetings (5/10)

Administrator/Supervisor Groups

- Caseload/time management (10/10)
- Paperwork/documentation (10/10)
- Client engagement and needs (lack of interest or overdependence, insufficient resources, cultural differences, poor birth outcomes) (10/10)
- Staff salary (4/10, all 3 models)
- Time away for trainings and meetings (2/10)

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 MIEHCV 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.





Work-Related Stressors Among Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Home Visitors: A Qualitative Study

Paige J. Alitz¹ · Shana Geary¹ · Pamela C. Birriel¹ · Takudzwa Sayi¹ · Rema Ramakrishnan² · Omotola Balogun¹ · Alison Salloum³ · Jennifer T. Marshall¹

Published online: 31 May 2018
© The Author(s) 2018, Corrected publication August/2018

Abstract

Background The Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program delivers evidence-based home visiting services to over 1400 families each year. Home visitors are integral in providing resources for families to promote healthy pregnancy, child development, family wellness, and self-sufficiency. Due to the nature of this work, home visitors experience work-related pressures and stressors that can impact staff well-being and retention. **Objectives** The purpose of this study was to understand primary sources of work-related stress experienced by home visitors, subsequent effects on their engagement with program participants, and to learn of coping mechanisms used to manage stress. **Methods** In 2015, Florida MIECHV program evaluators conducted ten focus groups with 49 home visitors during which they ranked and discussed their top sources of work-related stress. Qualitative analysis was conducted to identify emergent themes in work-related stressors and coping/supports. **Results** Across all sites, the burden of paperwork and data entry were the highest ranked work-related stressors perceived as interfering with home visitors' engagement with participants. The second-highest ranked stressors included caseload management, followed by a lack of resources for families, and dangerous environments. Home visitors reported gratification in their helping relationships families, and relied on coworkers or supervisors as primary sources of workplace support along with self-care (e.g. mini-vacations, recreation, and counseling). **Conclusions for practice** Florida MIECHV home visitors across all ten focus groups shared similar work-related stressors that they felt diminished engagement with program participants and could impact participant and staff retention. In response, Florida MIECHV increased resources to support home visitor compensation and reduce caseloads, and obtained a competitive award from HRSA to implement a mindfulness-based stress reduction training statewide.

Keywords Home visitation · Burnout · Work-related stress · Coping mechanisms · Social support

Significance

It is well known that home visitors balance strenuous caseloads that include families facing complex social and health related problems, but little is known about specific work-related stressors that impact staff and affect family engagement within evidence-based home visiting programs. This study identifies sources of staff stress within the Florida MIECHV program and home visitors' perceptions around how that stress directly impacts engagement with participants. A better understanding of these concepts will help programs identify effective methods to mitigate home visitor stress to ultimately improve program effectiveness.

✉ Paige J. Alitz
alitzp@health.usf.edu

¹ Department of Community and Family Health, College of Public Health, University of South Florida, Tampa, FL, USA

² Department of Epidemiology and Biostatistics, College of Public Health, University of South Florida, Tampa, FL, USA

³ School of Social Work, College of Behavioral and Community Sciences, University of South Florida, Tampa, FL, USA

Introduction

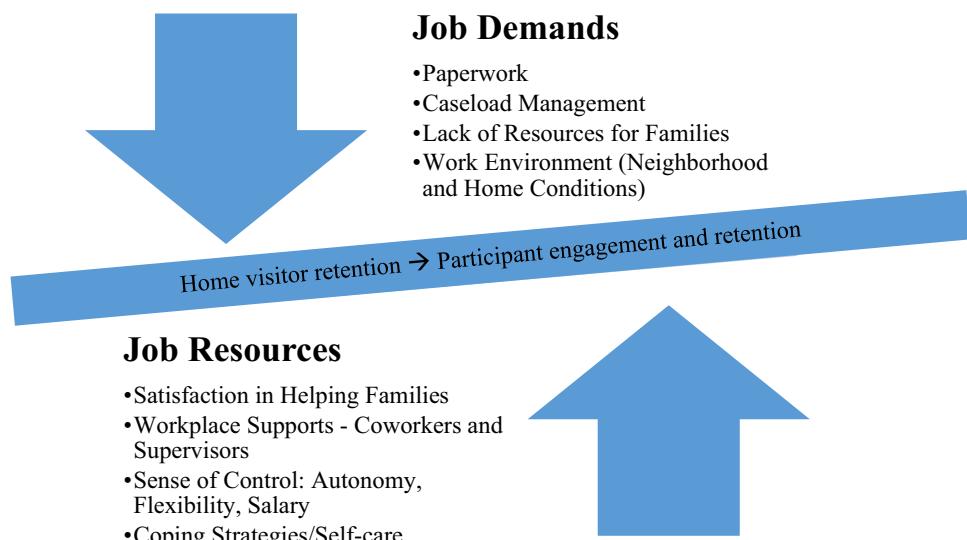
Maternal and child home visitors provide a specialized set of supports and resources to families using various program models and curricula (Gomby 2005; Sweet and Appelbaum 2004). While research shows that home care workers experience stress due to heavy caseloads, difficult clients, and safety hazards in client homes, there is scant literature on work-related stressors specifically among home visiting staff in an evidence-based program (Denton et al. 2002). The multifaceted responsibilities of home visitors in evidence-based programs contribute to work-related stress: delivering a specific curriculum; addressing multiple social determinants of health; documenting their efforts; and continuous professional development (Barak et al. 2014; Gill et al. 2007; Williams et al. 2008). Federal agencies increasingly support evidence-based models which promote rigorous evaluation of health outcomes; allocating funds to programs that make strides towards benchmark indicators (Boller et al. 2010). Sharp et al. (2003) suggested that while evidence-based models may provide more consistency and structure in program delivery, a focus on outcome measures may divert attention from some aspects of the program that may mediate these outcomes, like home visitor-parent relationships (Brookes et al. 2006; Dunst et al. 2002). Administrative burden on staff working in evidence-based programs could also be higher.

Because work-related stress can lead to burnout, reducing the quality of home visiting services, and staff turnover inhibiting client engagement and, identifying sources of these stressors among home visitors is imperative (Dickinson and Perry 2002; Khamisa et al. 2015; Lee et al. 2013; Maslach et al. 2001). This qualitative study explored

the perceptions of home visitors in Florida's evidence-based maternal, infant, and early childhood home visiting (MIECHV) programs regarding work-related stressors and coping strategies, and the potential impacts on engagement with participants and participant and staff retention. The Job Demands-Resources Model recognizes that high-demand jobs "that require sustained physical and/or psychological (cognitive and emotional) effort or skills... are therefore associated with certain physiological and/or psychological costs" which interact with personal and organizational resources, impacting motivation and causing job strain (Bakker and Demerouti 2007, p. 312; see Fig. 1).

The Florida MIECHV initiative supports the coordinated implementation of three evidence-based home visiting program models: parents as teachers, nurse-family partnership, and healthy families Florida. Across models, the maximum caseload per Florida MIECHV home visitor is 25 and the expectation is that each family receives two home visits per month. The statewide MIECHV evaluation team is housed in the Chiles Center at the University of South Florida (USF), and the evaluation has been determined exempt by the USF Institutional Review Board. As part of the evaluation, the purpose of this study was to understand the primary sources of work-related stress experienced by Florida MIECHV home visitors, how these stressors affected their engagement with participants, and the coping mechanisms home visitors used to mitigate work-related stress. Given that work-related stress may impact the retention of home visitors and program participants, staff were asked about their perceptions regarding how work-related stressors impact staff and participant retention.

Fig. 1 Themes identified related to work-related stressors and coping strategies



Methods

In Fall 2015, ten focus groups were held with Florida MIECHV home visitors on-site at each of the ten MIECHV local implementing agencies throughout the state. The 60–90 min group discussions were led by a trained facilitator and an assistant. Topics included general questions about the program, needs of families served, sources of work-related stress encountered, and coping strategies commonly used by home visitors to mitigate these stressors.

Specific questions within the focus group guide that related to stress included: What are some of the main sources of stress among home visitors? Aside from those listed, can you think of any other sources of stress among home visitors? How do you think this affects staff recruitment and retention? How do you think this affects work with families? What supports are available to home visitors in this program? and What other coping/support strategies do home visitors use to deal with work-related stress? Additionally, a pile sorting activity was conducted in which participants were provided five notecards and instructed to write one work-related stressor on each card. The group then sorted the notecards into clusters of related items and lined them up sequentially from the highest to the lowest contribution to work-related stress. The reason for using notecards was threefold. Firstly, the research team anticipated that participants may feel more comfortable writing potentially sensitive stressors on cards placed in a pile without having to directly state them in a group. Secondly, listing ideas on notecards facilitated brainstorming, which is important given the tendency of focus group discussions to follow conversational paths that may limit topics discussed. Third, ranking and grouping the cards helped participants articulate and describe why some stressors were more salient to them.

All ten focus groups were audio recorded, professionally transcribed verbatim, and reviewed by research staff for accuracy. Preliminary inductive analysis identified emergent themes from the transcripts, then coding was performed electronically with MAXQDA Version 11 (VERBI GmbH, 1989–2014) following a codebook developed by the research team based on the research questions, focus group guide, and emergent themes. A lead analyst coded each of the ten focus group transcripts, while a second analyst blind-coded three of the ten transcripts. The kappa statistic was 0.78 (95% confidence interval: 0.73, 0.83) indicating substantial inter-coder agreement. Descriptive statistics were calculated from self-reported demographics entered into Qualtrics Survey Software (2015) and stored on a secure server.

Results

Ten focus groups were conducted with 49 MIECHV home visitors (Table 1). About a third of the home visitors were under the age of 35 (34.7%), and most had worked in their current position for less than five years (84.0%). Most

Table 1 Frequency distribution of home visitor demographics

Demographics	N=49 (%)
Number of years in current position	
< 1 year	24 (49.0)
1–5 years	17 (34.7)
6–10 years	4 (8.2)
> 10 years	3 (6.1)
Prefer not to answer	1 (2.0)
Education	
High school degree	1 (2.0)
Some college	5 (10.2)
College degree (associates/bachelors)	35 (71.4)
Graduate degree (masters/doctoral)	8 (16.3)
Professional background	
Nursing	18 (36.7)
More than one discipline	10 (20.4)
Social work	7 (14.3)
Psychology/counseling	4 (8.2)
Other ^a	4 (8.2)
Education	3 (6.1)
Public health	1 (2.1)
Prefer not to answer	2 (4.1)
Age, years	
35+	32 (65.3)
30–34	7 (14.3)
25–29	7 (14.3)
20–24	3 (6.1)
Race	
White	26 (53.1)
Black	16 (32.7)
Other	6 (12.2)
Prefer not to answer	1 (2.1)
Ethnicity	
Hispanic	14 (28.6)
Non-Hispanic	34 (69.4)
Prefer not to answer	1 (2.1)
Live in community served by the program	
Yes	30 (61.2)
No	18 (36.7)
Prefer not to answer	1 (2.1)

^aOther includes social justice, business administration, health care administration, criminal justice, international studies, and communication

(87.8%) held an undergraduate or graduate college degree in nursing (36.7%), more than one discipline (20.4%), or social work (14.3%). Over half of the home visitors self-identified as non-Hispanic (69.4%), were White (53.1%), and lived in the communities in which they served (61.2%). Job demands (stressors) and resources (coping) are illustrated in Fig. 1.

Job Demands

Work-Related Stressors

Management of Paperwork In seven of the ten sites, home visitors expressed that sometimes-required documentation interfered with their ability to optimally engage with participants during their visits. One home visitor explained that excessive paperwork “really puts a barrier and monkey wrench” in their visits. Furthermore, home visitors in eight of the ten sites felt that their personal connection with families was not given the same level of importance as the outcome data captured through required documentation. As one home visitor said:

Unfortunately, the funders are not there to see, “Hey, you have a pregnant mom with twins who’s afraid to go out, and you manage to get this lady to get a job, to get her child into daycare”...What the funder is seeing is, “Are those women going to the hospital, how many times are they going to the ER? Are they going to the ER less? Are they up-to-date with immunization?” That’s what they care about, and that’s the difference.

Caseload Management In nine of ten sites, home visitors felt that travel time and other responsibilities associated with managing a caseload encroached on the time needed to engage with families. One home visitor expressed frustration with the hurriedness of her case schedule: “...if a mom needs me to stay an extra 30 min to talk, I can’t because I got another visit, I got to be there in 30 min, so I can’t help you right now.” Depending on the program model, each home visitor may be scheduled to see 20–25 clients every other week, or more frequently. The challenge was not so much the caseload size as the instability and frequency of crises among this high-risk population. As one home visitor put it, “that’s 25 problems, 25 people to try to help them in everything.”

Nearly all groups discussed how families cancel or reschedule frequently, often when they are already en route, contributing to a cyclical scheduling problem and creating additional pressure on the home visitor, who could have used the time for other work responsibilities:

This is time that you can give to another person. It is time that you can utilize working in the office. It’s a waste of time. You have too many things to do,

too many visits to accomplish...you already drive 30 minutes, 10 minutes to get there. Knock on the door, she’s not there. One hour you waste that you can use on something else.

Lack of Resources for Families Home visitors discussed difficulties in finding services for families like housing, childcare, and transportation, especially in rural MIECHV sites. One home visitor mentioned an 18-month waiting list for childcare in their community. This situation aggravates a vicious cycle of not being able to work, and thus afford housing or other bills—a common scenario that contributes to home visitors’ stress. The lack of mental health services, and long waiting lists for available services, were additional concerns expressed by many home visitors, because they are not trained as mental health providers. As one home visitor described:

I have my clients who—while referred to the [agency name] program, she was on waiting list and nobody called her. And a few weeks later she called me and she told me, “I feel like killing myself.” Who was there? So, whenever she feels depressed...10:00, 11:00 at night, who she calls? Me, while we’re waiting for [agency] to call her back.

Dangerous Environments The home visitors consistently expressed a passion for supporting families living in high-need communities, but described the stress of encountering drug dealing, crime, and gun violence in the participants’ neighborhoods. One home visitor recalled when a client’s neighbors was shot in front of her house. In addition to concerns with neighborhood safety, home visitors noted risks within some client’s homes, mentioning that often they do not know what they are “walking into” when they stop by: “If they’ve forgotten that we’re coming, we also don’t want to walk into a bad situation where we’re not invited.”

Impacts on Home Visitor-Participant Engagement

Home visitors were explicit about their skill in suppressing personal stress when engaging directly with families, though it takes an emotional toll. As explained by one home visitor, “I could be crying now and then I’ll go to my clients and whatever and then I leave—but what that makes me is more burn out, more stressed.” Said another,

When I go to 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.

Filling out paperwork/assessments during home visits was referenced as the primary work-related stressor interfering with home visitors' engagement with families during visits. One home visitor explained:

...this is my plan today, and then mom starts talking about something personal and then [I'm] listening to her I'm thinking, "oh my God, I need to do the ASQ [Ages & Stages Questionnaire]" and she's still talking. I need to do the ASQ and I need to be leaving soon because then I have another mom to see. I'm not even focusing on her!

The ability of home visitors to engage with participants is also affected when rescheduling and cancellations occur. Without meeting frequently, the level of contact needed for the home visitor to build a trusting relationship, while effectively delivering a curriculum and services that can impact positive health outcomes, is not achieved.

Managing caseloads and family engagement was also difficult for home visitors who attend beneficial, yet time-consuming, meetings and conferences for professional development. During one focus group, a home visitor explained feeling like she "had to rush sometimes with [my] clients, especially when they're in a crisis..." due to other job-related obligations. Another home visitor spoke about visiting a client in crisis, but because there was a required meeting to attend, this home visitor had to leave in the middle of the woman's emotional breakdown.

Impacts on Participant Retention

Schedule changes impact engagement, and subsequently retention of participants, as one home visitor explained, "...because unfortunately, cancellations lead to disengagement, disengagement leads to low numbers, our numbers drop." Additionally, home visitors mentioned how completion of required paperwork can intimidate clients into being less willing to proceed with the program. For example, there was one instance where a client commented on the number of pages on the intake form; the home visitor halted the visit in fear of losing the client before their first meeting was over, noting how losing clients "happens a lot," because "they're probably thinking, 'if we had to do this on day one, God only knows what they'll have me doing every day.'"

The lack of resources available in the community was perceived to impact participant retention in some MIECHV programs more than others. In one community, a home visitor felt as an "essential" part of participants' lives; even if home visitors could not connect them with transportation or another resource, the client depended on them for the personal relationship. In some communities, home visitors perceived that some families joined the program solely to obtain needed supplies such as cribs, federal aid money,

or car seats. This motive inherently affected client retention because those participants saw home visitors as a "go-between... between the different types of services that they need..." These families would leave the program once material needs were met.

Impacts on Home Visitor Retention

Staff turnover varied between sites, with some experiencing high turnover while other sites had very little; one site described their staffing as "solid." One home visitor explained:

...for me to recommend this job to someone I would have to know them very well. I would have to know that they're organized. I would have to know some things about them before I would encourage them.... I wouldn't tell them to take this job just because they need a job. This is not the job you take just because you need a job.

Job Resources

Satisfaction in Helping Families

Home visitors across all MIECHV sites expressed how helping and building relationships with families and seeing the positive changes in response to their efforts was the most gratifying aspect of their job, as one described, "Being able to help the families. Point them in the right direction where they need to go to get the help that they need." Home visitors also felt satisfaction in watching their clients become more independent, securing jobs, and following through with the referrals given to them.

...you make a referral because you know they probably need it and they agree to it then they might not follow through and then you're waiting and waiting but they eventually do. So, that progress that they have as well with their baby developing and the fact we're there helping them with letting them know how the baby should be developing and stuff. That does really make you feel good about your job.

Workplace Supports: Coworkers and Supervisors

The home visitors consistently identified each other as their greatest form of support in dealing with the work-related stressors. In seven out of ten sites, supervisors were mentioned as another form of support. These home visitors noted how the use of reflective supervision allowed them to vent their frustrations, express their feelings, and talk freely about how their job affects them personally. As one home visitor described of their site supervisor: "She'll always say, 'Is

there anything I can do for you? How can I help you?" Conversely, at one site, the lack of support from coworkers and supervisors was damaging. A few home visitors spoke of their unhappiness and stress over their job-related duties, feeling as though they had no one to turn to when they needed help with a family. In one site that was undergoing a transition in leadership, a home visitor stated, "we don't know how to work with each other anymore."

Sense of Control: Autonomy, Flexibility, Salary

Although not explicit in most discussions, home visitors' need for a sense of control over their work demands was implicit in many comments. They conveyed commitment, satisfaction, and confidence in working with families but often expressed frustration at their lack of control over their schedules, due to client cancellations or staff meetings and to balancing programmatic demands with family needs. The sentiments reflected a lower sense of control over their job demands and the subsequent strain, as one home visitor shared: "So, you feel this pressure like, I can't change my situation. If you can't change your situation, you're like, 'Why should I be here?' Because I'm doing all I can." Also, in some groups, there was discussion regarding differential rates of pay across sites and home visiting models—and even within one program that was implemented by two organizations. Some home visitors explained that they could make a higher hourly rate in other types of positions, and among staff in some programs there was concern about the low rate of pay overall. Salaried positions offered more scheduling flexibility.

Coping Strategies

Home visitors cited the use of exercise and meditation techniques such as yoga, dance, and mindfulness practices to ease their work-related stress. These activities were self-directed, and sometimes encouraged and supported by the employer. Oftentimes these strategies were utilized during employee retreats; supervisors provided time off for home visitors to attend group classes or mindfulness seminars. Home visitors also spoke of the stress-relieving effects of spending time with their own children and families; one reflected that taking her sister's grandchildren on outings (restaurant/arcade, swimming, bike riding, etc.) was the "greatest thing in the world" for stress management.

Discussion

This study identified job demands and resources contributing to home visitors' overall job stress and satisfaction. The highest reported source of stress was paperwork/

documentation required by both MIECHV and their respective program models, along with the requisite caseload and number of visits, lack of resources for families, and unsafe environments. These factors negatively influenced engagement by diluting the highly valued relationships between home visitors and families, and could ultimately impact retention of staff and participants.

The notion that a strict focus on documenting and achieving program outcomes conflicts with the home visitor-client relationship can be found elsewhere in the literature (Barak et al. 2014; Brookes et al. 2006). A study of 85 Illinois home visitors from three evidence-based models found that, while the home visitors appreciate the need for program fidelity, the amount of paperwork required undermined the importance of their relationships with clients (Barak et al. 2014). Much like those in our study, the Illinois home visitors felt that their clients were being reduced to quantifiable data points denoted as "numbers" and "results" rather than seen as human beings facing and overcoming everyday obstacles, and worried that paperwork required during each home visit interfered with the natural course of relationship building with their clients, diminishing the client-centered nature of the program (Barak et al. 2014).

The balance between training/professional development, salary and benefits, and supportive work environment with job demands impacts home visitors' job satisfaction and burnout (Gill et al. 2007). To balance the demands of home visiting as a profession, home visitors primarily relied on organizational resources (e.g., social support from coworkers and supervisors, reflective supervision) and various modes of self-care. Prior research also suggests that quality supervision and a high level of support from colleagues contribute to the effectiveness of home visitors (Gill et al. 2007; Wasik and Bryant 2001). A change in leadership has been identified as a period where home visitors may feel the most stressed and least satisfied with their jobs (Gill et al. 2007) as was evident in one program site in this study.

Home visiting as a profession requires a unique set of knowledge, attitudes, and skills in health and safety, mental health, and learning; assessment, reflective practice and supporting families/parenting; leadership, diversity/inclusion, and professionalism (Roggman et al. 2016). Training for home visitors should incorporate guidance on how to simultaneously manage their role as a support system for the families they serve while executing program requirements. While the burden of paperwork contributes to work-related stress in evidence-based programs, assessments and documentation are vital components; more efficient methods for data collection would save time, and better conveyance of the ultimate benefits of evidence-based programs to families could reduce dissonance. In addition to the logistics of caseload management, training and support for handling the emotional labor involved in home visiting while capitalizing on the satisfaction home

visitors express in helping families can reduce stress and burnout (Brotheridge and Grandey 2002; Humphrey et al. 2015).

The results of this study, conducted with Florida MIECHV staff may not be generalizable to MIECHV programs in other states. The experiences of other home visitors in Florida who are not within MIECHV (funded under different structures and reporting requirements) may also reflect different or additional stressors, supports, and coping methods. We also note that almost half of the home visitors who participated in this study were within their first year of working in the MIECHV program; stressors among home visitors working in a newly funded program, or those who are new to the profession, likely differ compared to those who are more experienced and may be more adept at or better equipped to manage program requirements.

Conclusions

Home visitors play a vital role in promoting positive outcomes for children and families. Programmatic efforts to mitigate work-related stress could increase the well-being, effectiveness, and consistency of home visitors. Following this study: Florida MIECHV increased resources to sites specifically to increase home visitor compensation, hire data entry staff, and reduce caseloads where needed. Additionally, a competitive grant from the Health Resources and Services Administration was awarded to implement a mindfulness-based stress-reduction program for home visitors statewide; and reflective supervision training is ongoing. More research is needed to compare stressors and coping among newer versus more seasoned home visitors, to understand the benefits and toll of emotional labor on home visitors, and to further dissect the intersection between caseloads, required documentation, and supporting families in evidence-based home visiting.

Acknowledgements This study was funded by the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative, Florida Association of Healthy Start Coalitions, Inc. (Grant #D90MC25705). The authors express our thanks to Carol Brady, the Project Director of the Florida MIECHV Initiative, for her support of this research.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Open Access This article is distributed under the terms of the Creative Commons Attribution 4.0 International License (<http://creativecommons.org/licenses/by/4.0/>), which permits unrestricted use, distribution, and reproduction in any medium, provided you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license, and indicate if changes were made.

References

- Bakker, A. B., & Demerouti, E. (2007). The job demands-resources model: State of the art. *Journal of Managerial Psychology*, 22(3), 309–328.
- Barak, A., Spielberger, J., & Gitlow, E. (2014). The challenge of relationships and fidelity: Home visitors' perspectives. *Children and Youth Services Review*, 42, 50–58. <https://doi.org/10.1016/j.childyouth.2014.03.023>.
- Boller, K., Strong, D. A., & Daro, D. (2010). Home visiting: Looking back and moving forward. *Zero to Three*, 30(6), 4–9.
- Brookes, S. J., Summers, J. A., Thornburg, K. R., Ispa, J. M., & Lane, V. J. (2006). Building successful home visitor-mother relationships and reaching program goals in two Early Head Start programs: A qualitative look at contributing factors. *Early Childhood Research Quarterly*, 21(1), 25–45. <https://doi.org/10.1016/j.ecresq.2006.01.005>.
- Brotheridge, C. M., & Grandey, A. A. (2002). Emotional labor and burnout: Comparing two perspectives of "people work". *Journal of Vocational Behavior*, 60(1), 17–39.
- Denton, M. A., Zeytinoğlu, I. U., & Davies, S. (2002). Working in clients' homes: The impact on the mental health and well-being of visiting home care workers. *Home Health Care Services Quarterly*, 21(1), 1–27. https://doi.org/10.1300/J027v21n01_01.
- Dickinson, N. S., & Perry, R. E. (2002). Factors influencing the retention of specially educated public child welfare workers. *Journal of Health & Social Policy*, 15(3/4), 89–103.
- Dunst, C. J., Boyd, K., Trivette, C. M., & Hamby (2002). Family-oriented program models and professional help giving practices. *Family Relations*, 51, 221–229.
- Gill, S., Greenberg, M. T., Moon, C., & Margraf, P. (2007). Home visitor competence, burnout, support, and client engagement. *Journal of Human Behavior in the Social Environment*, 15(1), 23–44. https://doi.org/10.1300/J137v15n01_02sa.
- Gomby, D. S. (2005). *Home visitation in 2005: Outcomes for children and parents*. Washington DC: Committee on Economic Development.
- Humphrey, R. H., Ashforth, B. E., & Diefendorff, J. M. (2015). The bright side of emotional labor. *Journal of Organizational Behavior*, 36(6), 749–769.
- Khamisa, N., Oldenburg, B., Peltzer, K., & Illic, D. (2015). Work related stress, burnout, job satisfaction and general health of nurses. *International Journal of Environmental Research and Public Health*, 12(1), 652–666. <https://doi.org/10.3390/ijerph120100652>.
- Lee, E., Esaki, N., Kim, J., Greene, R., Kirkland, K., & Mitchell-Herzfeld, S. (2013). Organizational climate and burnout among home visitors: Testing mediating effects of empowerment. *Children and Youth Services Review*, 35(4), 594–602. <https://doi.org/10.1016/j.childyouth.2013.01.011>.
- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology*, 52, 397–422. <https://doi.org/10.1146/annurev.psych.52.1.397>.
- Qualtrics: Online Survey Software & Insight Platform [Computer software]. (2015). Provo, UT. Available from <http://www.qualtrics.com/>.
- Roggman, L. A., Peterson, C. A., Chazan-Cohen, R., Ispa, J., Decker, B., Hughes-Belding, K., et al. (2016). Preparing home visitors to partner with families of infants and toddlers. *Journal of Early Childhood Teacher Education*, 37(4), 301–313.
- Sharp, E. A., Ispa, J. M., Thornburg, K. R., & Lane, V. (2003). Relationships among mother and home visitor personality, relationship quality, and amount of time spent in home visits. *Journal of Community Psychology*, 31(6), 591–606.
- Sweet, M. A., & Appelbaum, M. I. (2004). Is home visiting an effective strategy? A meta-analytic review of home visiting programs

- for families with young children. *Child Development*, 75(5), 1435–1456.
- VERBI GmbH. (1989–2014). *MAXQDA, software for qualitative data analysis*. Berlin: VERBI Software – Consult - Sozialforschung GmbH.
- Wasik, B. H., & Bryant, D. M. (2001). *Home visiting: Procedures for helping families*. Thousand Oaks: Sage.
- Williams, D. R., Costa, M. V., Odunlami, A. O., & Mohammed, S. A. (2008). Moving upstream: How interventions that address social determinants of health can improve health and reduce disparities. *Journal of Public Health Management and Practice*, 14(Suppl), S8–S17. <https://doi.org/10.1097/01.PHH.0000338382.36695.42>.

**Florida Maternal, Infant, and Early Childhood
Home Visiting (MIECHV) Program Evaluation**

Comprehensive Baseline PARTNER Report:
Collaboration Analysis across All Counties

2014

Prepared by:

Marshall, J., Baker, E., Birriel, P. C., Olson, L., Ramakrishnan, R., Estefan, L. F., & USF Florida MIECHV
Evaluation Team.

Chiles Center for Healthy Mothers and Babies
College of Public Health
University of South Florida

This project is supported by the the Florida Maternal, Infant and Early Childhood Home Visiting Initiative.

Introduction

In 2013, with funds authorized by the Affordable Care Act, Florida was awarded a Maternal, Infant, and Early Childhood Home Visitation Program (MIECHV) grant to enhance the infrastructure of Florida home visitation programs. In part, this grant funds an independent evaluation of the Florida MIECHV program conducted by the Lawton and Rhea Chiles Center for Healthy Mothers and Babies, located within the College of Public Health at the University of South Florida.

A main goal of MIECHV programs is to foster increased collaboration and coordination among community stakeholders to improve health and development outcomes for at-risk children. For this reason, one purpose of the MIECHV evaluation is to describe and evaluate the community coalitions that are providing home visiting services to assess their community implementation, processes, and networking.

The collaboration component of the evaluation seeks to answer the following overarching questions:

1. Does the MIECHV program contribute to collaboration and systems development at the state and community levels?
2. What does the collaboration among agencies look like? Are those collaborations facilitating program implementation?
3. How are the programs being implemented? What kinds of services are being provided?
4. Are clients receiving appropriate referrals and services?

Overall, we will collect data at multiple time points to examine the development of community collaborative over time as they relate to the research questions above.

Purpose of this Report

This report presents preliminary, baseline information on the quantitative data collected for the collaboration and social network analysis. This preliminary report focuses on all Florida MIECHV communities funded by the MIECHV grant: Alachua, Bradford, Broward, Duval, Escambia, Hillsborough, Manatee, Miami-Dade, Orange, Pinellas, Putnam, and Southwest Florida Counties. The survey included the MIECHV administrator in each community and their identified collaborative partners; a total of 131 of the 167 identified stakeholders accessed and/or completed the survey.

Methods

To quantitatively describe and measure baseline collaboration among agencies, organizations, and groups in each community, the Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER), was utilized. PARTNER is a social network analysis and collaboration tool developed by the Robert Wood Johnson Foundation that is administered by online survey.

The evaluation team modified the PARTNER Tool to meet the specific needs and goals of MIECHV. A word version of the modified survey was sent to the MIECHV state leadership team and site administrators for review and feedback. This feedback was incorporated into the survey, and the final version was revised on the PARTNER Tool website in preparation for data collection.

Once the PARTNER Tool was modified to meet the needs of MIECHV, the evaluation team identified MIECHV program administrators from each community in collaboration with the MIECHV state leadership. The administrators were asked to identify agencies with whom they collaborate around MIECHV issues in their community, and to provide contact information for a representative from each agency. Lists of collaborative agencies were developed in collaboration with the evaluation team and FAHSC, and were specific to the needs and context of each community.

Prior to sending the survey to identified respondents, the evaluation team piloted the survey and resolved any remaining issues. The evaluation team then emailed the link to the PARTNER Tool online survey to each MIECHV program administrator and their list of collaborators. Respondents were asked to answer the PARTNER Tool to assess the development of collaborations in their community. Regular reminder emails were sent from the evaluation team over several months to individuals who had not completed the survey.

Results

Participants

This preliminary report focuses on all Florida MIECHV communities funded by the MIECHV grant: Alachua, Bradford, Broward, Duval, Escambia, Hillsborough, Manatee, Miami-Dade, Orange, Pinellas, Putnam, and Southwest Florida Counties. Table 1 below describes the number of participants who responded in each county:

Table 1: Response Rates

County	Number of Participants	Response Percentage (%)
A	17/18	94.4%
B	10/13	76.9%
C	8/13	61.5%
D	5/6	83.3%
E	11/11	100%
F	20/21	95.2%
G	17/23	73.9%
H	6/7	85.7%
I	4/5	80.0%
J	13/17	76.5%
K	9/18	50.0%
L	11/15	73.3%

These participants include the MIECHV administrator in each community and their identified collaborative partners. Collaborators included representatives from early education, health, and social services programs.

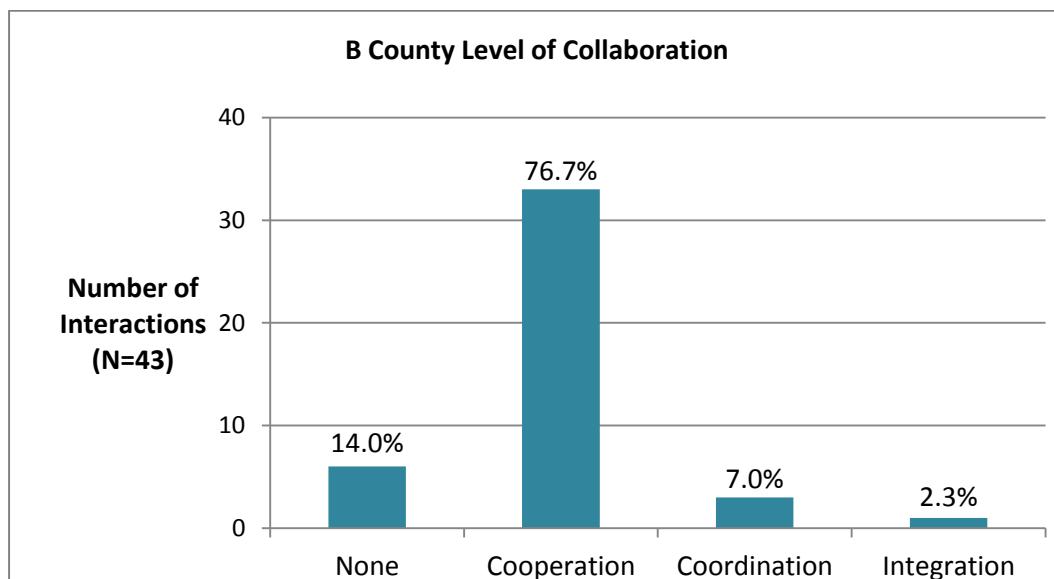
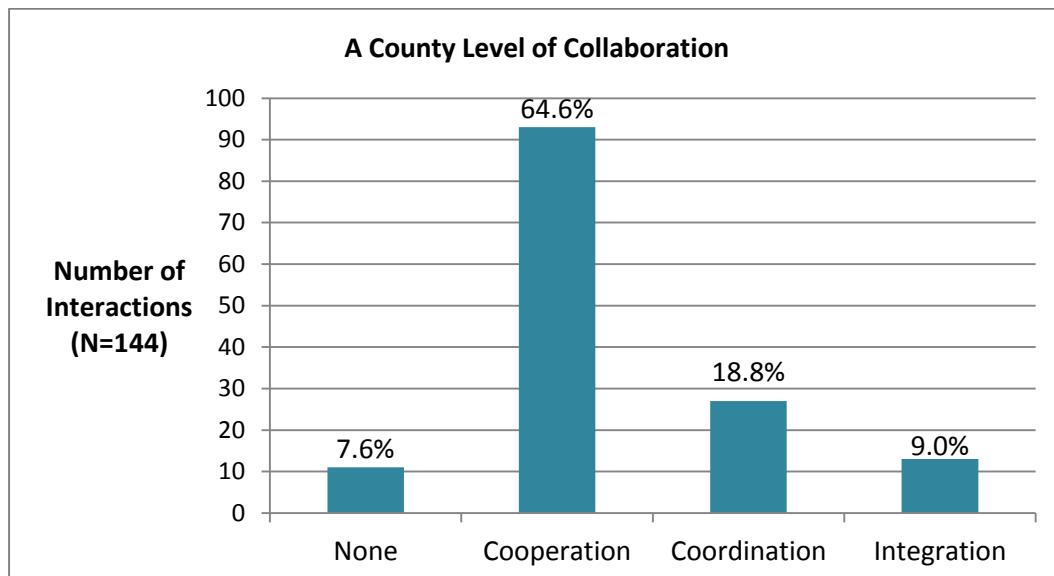
Level of Collaboration

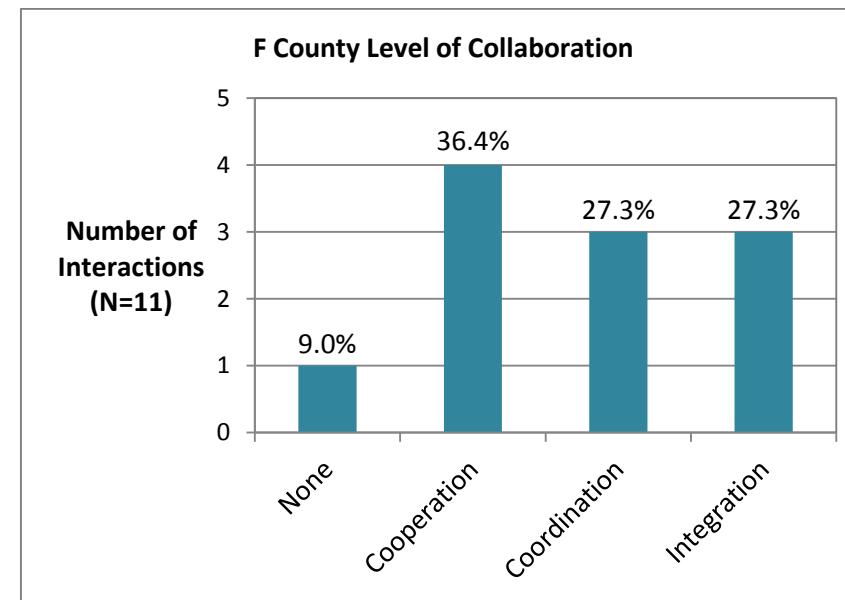
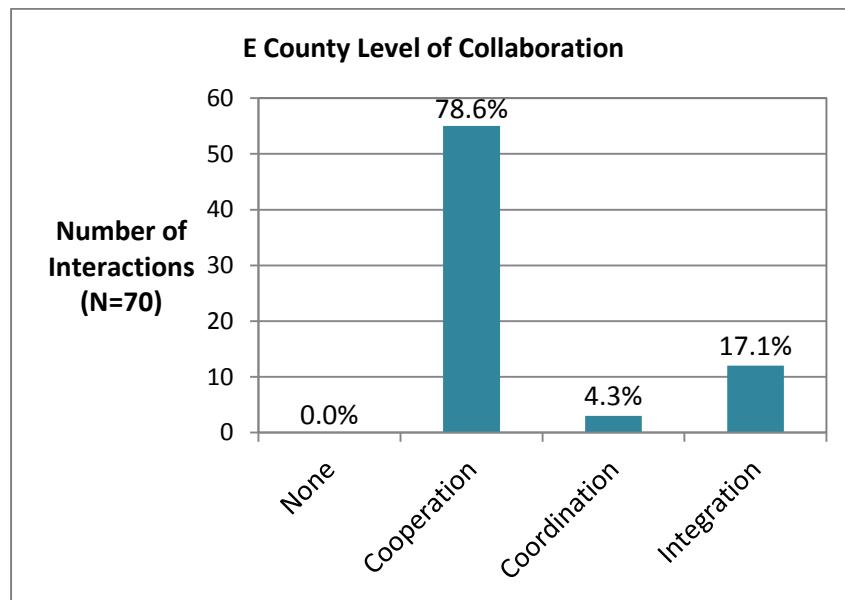
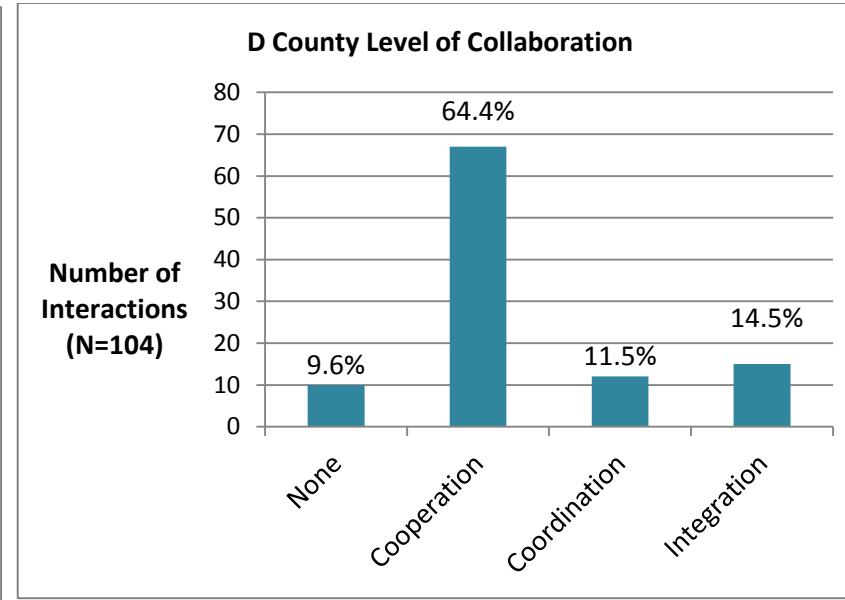
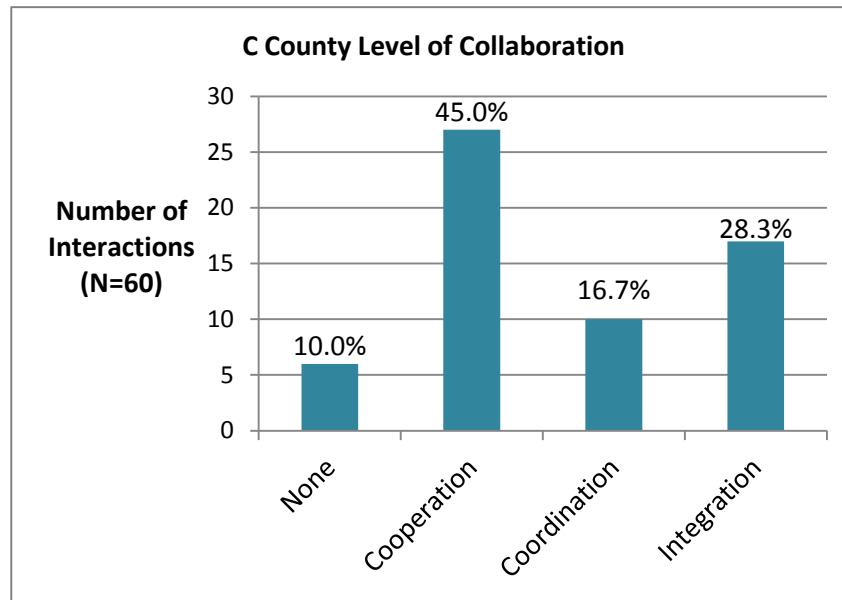
Level of collaboration between community partners was measured with a single question. For this question, survey respondents were asked to describe their organization's level of collaboration with each of their community partners. Participants could choose one of the following answers:

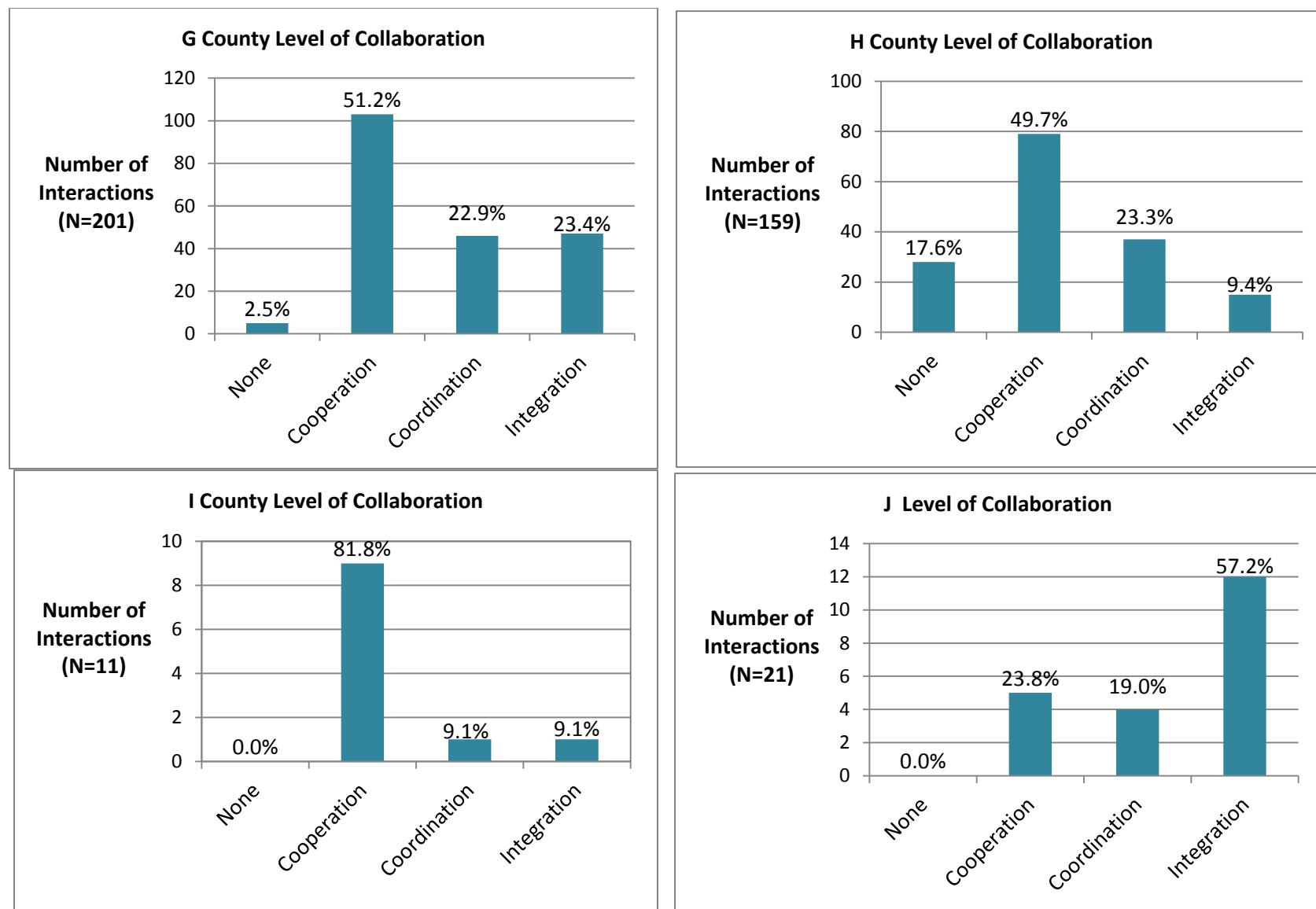
- **None**

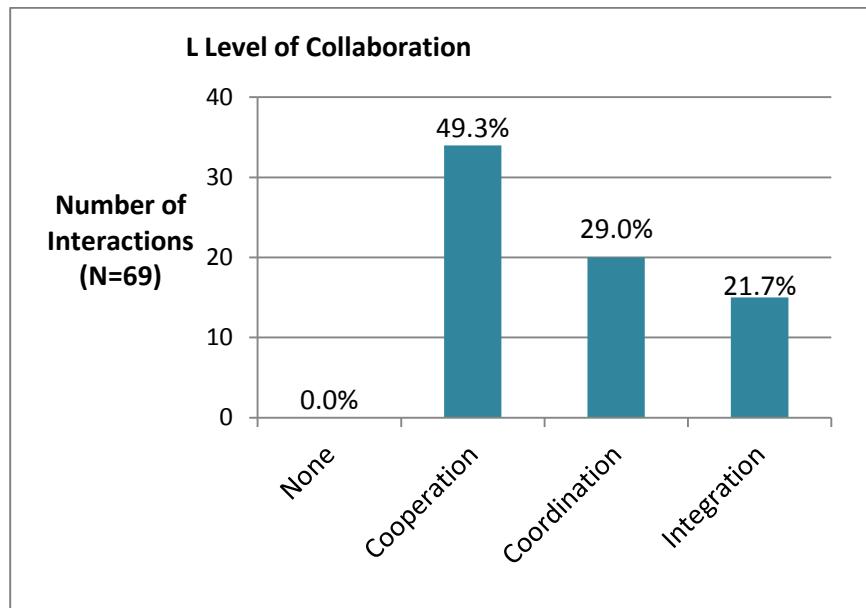
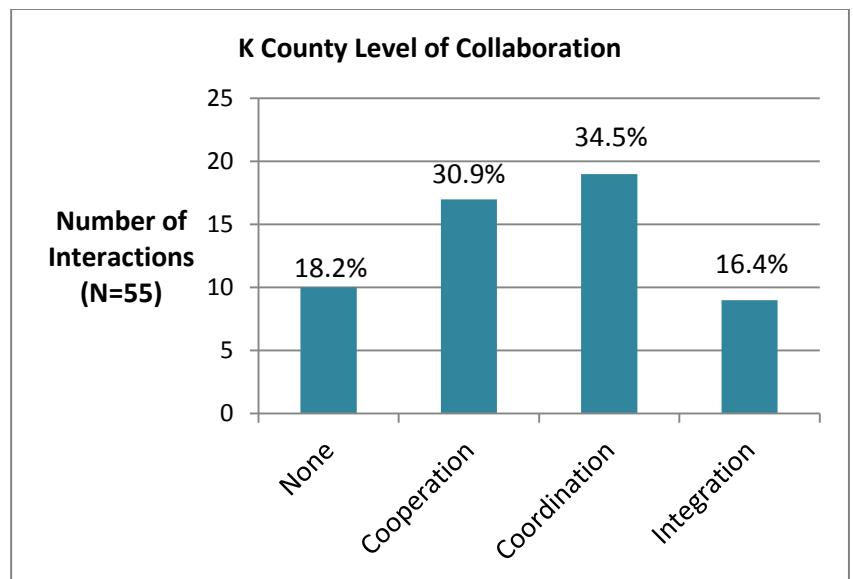
- **Cooperative Activities:** Involves exchanging information, attending meetings together, and offering resources to partners (Example: Informs other programs of RFA release).
- **Coordinated Activities:** Include cooperative activities in addition to intentional efforts to enhance each other's capacity for the mutual benefit of programs (Example: Separate granting programs utilizing shared administrative processes and forms for application review and selection).
- **Integrated Activities:** In addition to cooperative and coordinated activities, this is the act of using commonalities to create a unified center of knowledge and programming that supports work in related content areas (Example: Developing and utilizing shared priorities for funding effective prevention strategies. Funding pools may be combined).

Level of collaboration between community partners in each county is reported in the following charts.









With the exceptions of Miami-Dade and Putnam Counties, most community organizations reported *cooperative activities* with their community partners. On the other hand, in Miami-Dade and Putnam Counties, community organizations reported a range of activities with community partners. In these counties, community organizations described most of their interactions with their community partners as *integrated* or *coordinated*, respectively, meaning that, in general, the level of collaboration in these counties was higher among community partners than in Alachua, Bradford, Broward, Duval, Escambia, Hillsborough, Manatee, Orange, Pinellas, and Southwest Counties.

Community Networks

Maps that illustrate the connections between agencies in each community were developed from information provided by the respondents. Each organization that responded to the survey is

represented as a dot. The lines between each organization represent the presence of a relationship based on the responses indicating how frequently the two organizations work together around the issue of MIECHV. The number of relationships is also dependent on the number of collaborators that were identified early in the process; this differs for each county. The home visiting agency in each community is represented by the blue dot.

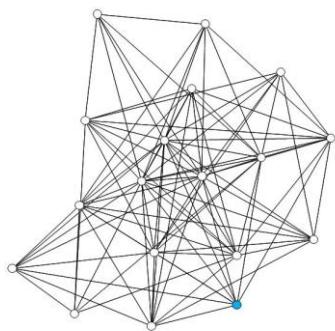
Networks can also be described by scores. A density score (displayed as a percentage) is provided for each community ranging from 31-90%. The density score represents how many network ties are present in the community in relation to the total number of possible ties in the network (i.e., if everyone was connected to everyone else). To get a 100% density score, every member would have to be connected to every other member. A trust score is also provided as a percentage ranging from 76-93%.

With baseline data and new collaborations being developed around MEICHV, it is expected that the appearance of the network maps, as well as the density and trust scores, will vary for each community. The results presented below indicate that while the maps look different from each other, the communities, in general, already have networks in place that will likely be even further strengthened by MIECHV.

MIECHV Community Network Maps

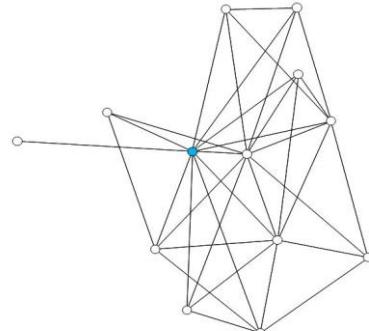
A County

Density score: 62%
Trust Score: 82%



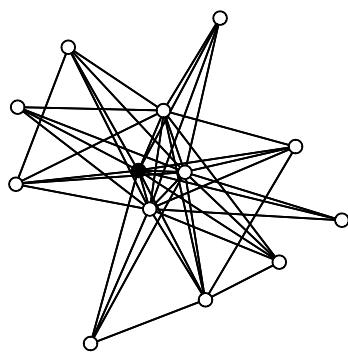
B County

Density Score: 45%
Trust Score: 79%



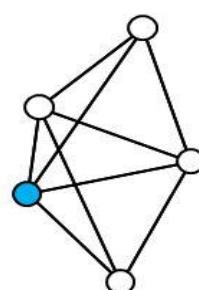
C County

Density score: 56%
Trust Score: 81%



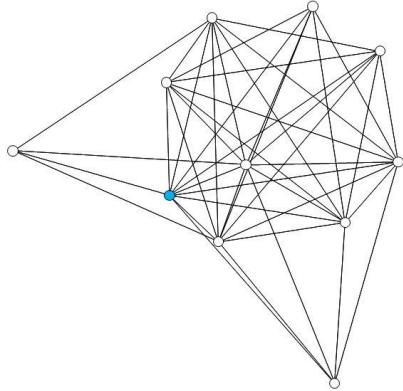
D County

Density Score: 43%
Trust Score: 96%



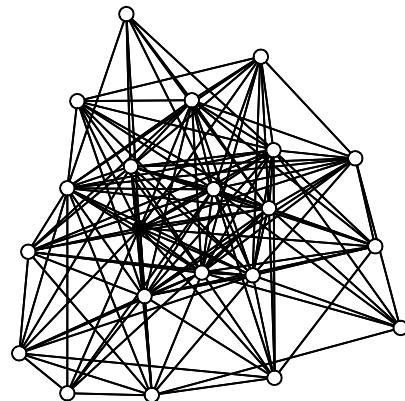
E County

Density Score: 78%
Trust Score: 92%



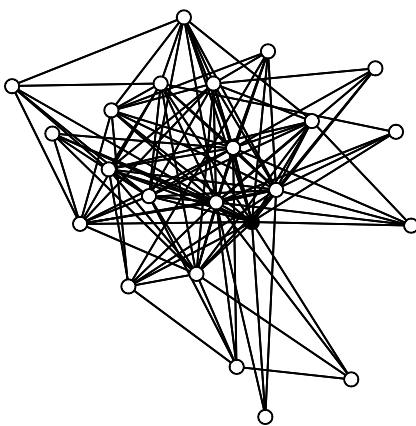
F County

Density Score: 67%
Trust Score: 76%



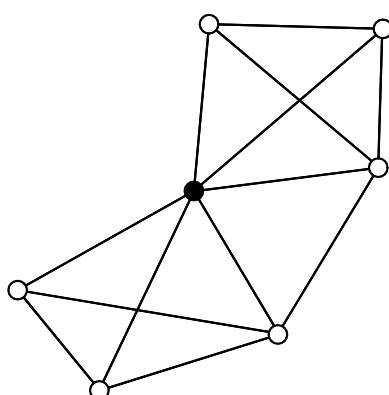
G County

Density Score: 47%
Trust Score: 75%

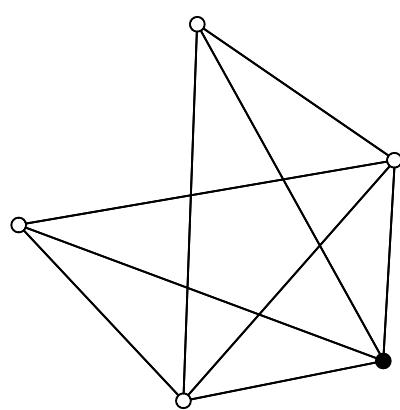


H County

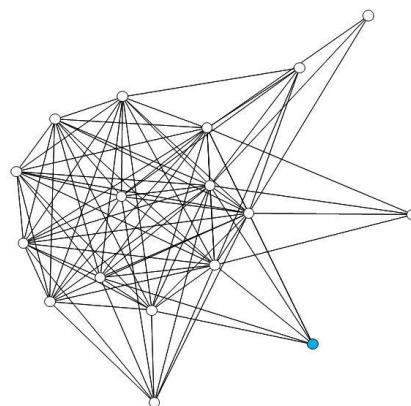
Density Score: 62%
Trust Score: 93%



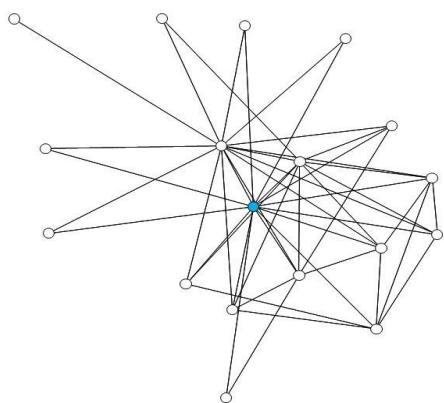
I County
Density Score: 90%
Trust Score: 76%



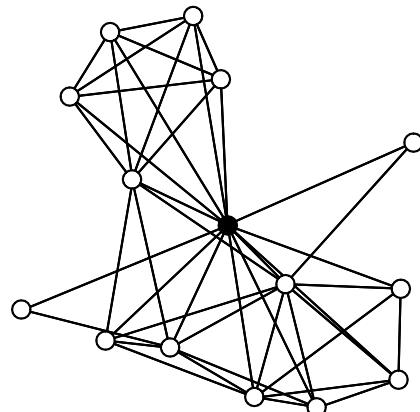
J County
Density Score: 66%
Trust Score: 81%



K County
Density Score: 31%
Trust Score: 81%



L County
Density Score: 42%
Trust Score: 78%



Aspects of Collaboration

The aspects of collaboration that contribute to MIECHV's success were measured with a single question. For this question, survey respondents were asked what aspects of community collaboration contribute to their county's MIECHV program's progress towards reaching its goals. Respondents were able to choose all that apply from the following options:

- bringing together diverse stakeholders,
- meeting regularly,
- exchanging information/ knowledge,
- sharing resources,
- informal relationships created,
- collective decision-making, and
- having a shared mission, goals.

A total of 131 of the 167 identified stakeholders accessed and/or completed the survey. Across all counties, respondents selected *exchanging information and/or knowledge* (73.3%, n=96), *having a shared mission/goals* (66.4%, n=87), and *sharing resources* (65.6%, n=86) as the most important aspects of community collaboration that contribute to MIECHV programs' progress towards reaching its goals. For this question within the survey, percentages add up to more than 100% because respondents were able to choose all that apply. The aspects of collaboration that community partners report contribute to MIECHV's success are shown in Table 2.

Outcomes of MIECHV

Potential outcomes of the MIECHV program for each county were assessed. Two questions within the survey were targeted in understanding what the potential outcomes of MIECHV's work include, as well as the most important outcome from the response options. For the potential outcomes question, respondents were able to choose all that apply, whereas for the most important outcome, respondents could only choose one answer option. The outcomes or potential outcomes of the MIECHV programs' community collaborative work for each county are reported in the following table. Respondents were able to choose all that apply for this question. The most important outcomes for each MIECHV program's community collaborative is shown in Table 3.

For the potential outcomes question within the survey, percentages add up to more than 100% because respondents were able to choose all that apply. Across all counties, respondents selected *improved services for children and families in high-need communities* (85%, n=112), *increased coordination and referrals for other community resources* (79%, n=104), and *community support for the health and well-being of children and families* (78%, n=103) as the leading three outcomes of MIECHV programs' community collaborative work.

Additionally, respondents expressed their perception of the most important outcomes of the MIECHV program for children and families (Table 4). For this second question regarding most important outcomes, respondents were only able to choose one answer option from the same list as the previous question. Across all counties, 35.5% (n=44) specified that MIECHV programs' community collaborative most important outcome was *improving maternal and newborn health*, while 29.0% (n=36) recognized it as *improving services for children and families in high-need communities*. The response options for these questions were very similar and could also be seen as overlapping and not mutually exclusive.

Table 2: Aspects of collaboration that contribute to MIECHV's success by county:

	A (n = 17)	B (n = 10)	C (n = 8)	D (n = 5)	E (n = 11)	F (n = 20)	G (n = 17)	H (n = 6)	I (n= 4)	J (n = 13)	K (n = 9)	L (n = 11)	All Counties (n = 131)
Exchanging information/knowledge	58.8% (10)	80.0% (8)	20.7% (6)	80.0% (4)	72.7% (8)	16.8% (16)	19.5% (15)	12.5% (3)	33.3% (3)	69.2% (9)	66.7% (6)	24.2% (8)	73.3% (96)
Having a shared mission, goals	70.6% (12)	60.0% (6)	20.7% (6)	60.0% (3)	81.8% (9)	16.8% (16)	16.9% (13)	20.8% (5)	33.3% (3)	15.4% (2)	33.3% (3)	27.3% (9)	66.4% (87)
Sharing resources	52.9% (9)	70.0% (7)	20.7% (6)	80.0% (4)	90.9% (10)	12.6% (12)	19.5% (15)	16.7% (4)	0% (0)	61.5% (8)	33.3% (3)	24.2% (8)	65.6% (86)
Bringing together diverse stakeholders	64.7% (11)	50.0% (5)	6.9% (2)	80.0% (4)	63.6% (7)	14.7% (14)	10.4% (8)	16.7% (4)	11.1% (1)	61.5% (8)	66.7% (6)	3.0% (1)	54.2% (71)
Informal relationships created	58.8% (10)	50.0% (5)	3.4% (1)	60.0% (3)	36.4% (4)	12.6% (12)	11.7% (9)	8.3% (2)	22.2% (2)	42.2% (6)	55.6% (5)	9.1% (3)	47.3% (62)
Meeting regularly	29.4% (5)	50.0% (5)	10.3% (3)	40.0% (2)	54.5% (6)	12.6% (12)	10.4% (8)	16.7% (4)	0% (0)	23.1% (3)	55.6% (5)	6.1% (2)	41.9% (55)
Collective decision-making	35.3% (6)	40.0% (4)	17.2% (5)	40.0% (2)	0.09% (1)	13.7% (13)	11.7% (9)	8.3% (2)	0% (0)	38.5% (5)	11.1% (1)	6.1% (2)	38.2% (50)

*Percentages add up to more than 100% because respondents were able to choose all that apply

Table 3: Outcomes of the MIECHV program's community collaborative

	A (n = 17)	B (n = 10)	C (n = 8)	D (n = 5)	E (n = 11)	F (n= 20)	G (n= 17)	H (n= 6)	I (n= 4)	J (n = 13)	K (n = 9)	Lt (n= 11)	All Counties (n = 131)
Improved services for children and families in high-need communities	100% (17)	70% (7)	87.5% (7)	60% (3)	90% (10)	85% (17)	88% (15)	83% (5)	100% (4)	92% (12)	66% (6)	81% (9)	85% (112)
Increased coordination and referrals for other community resources	82% (14)	50% (5)	75% (6)	60% (3)	81% (9)	100% (20)	82% (14)	100% (6)	100% (4)	69% (9)	77% (7)	63% (7)	79% (104)
Community support for the health and well-being of children and their families	82% (14)	80% (8)	87.5% (7)	60% (3)	81% (9)	85% (17)	58% (10)	100% (6)	100% (4)	84% (11)	77% (7)	63% (7)	78% (103)
Health education services, health literacy, educational resources	88% (15)	80% (8)	62.5% (5)	60% (3)	72% (8)	75% (15)	47% (8)	83% (5)	75% (3)	84% (11)	44% (4)	81% (9)	72% (94)
Improved maternal and newborn health	70% (12)	50% (5)	87.5% (7)	60% (3)	63% (7)	75% (15)	58% (10)	100% (6)	100% (4)	61% (8)	66% (6)	81% (9)	70% (92)
Improved resource sharing	88% (15)	50% (5)	50% (4)	40% (2)	63% (7)	90% (18)	70.5% (12)	100% (6)	100% (4)	38% (5)	66% (6)	63% (7)	69% (91)
Improved communication among agencies and organizations interested in the health and well-being of children and their families	70% (12)	60% (6)	50% (4)	40% (2)	54% (6)	80% (16)	70.5% (12)	66% (4)	100% (4)	69% (9)	55% (5)	55% (6)	66% (86)
Increased knowledge sharing	82% (14)	60% (6)	50% (4)	40% (2)	63% (7)	80% (16)	70.5% (12)	83% (5)	100% (4)	38% (5)	44% (4)	63% (7)	66% (86)
Public awareness of issues related to the health and well-being of children and their families	94% (16)	80% (8)	87.5% (7)	60% (3)	63% (7)	55% (11)	58% (10)	66% (4)	75% (3)	46% (6)	44% (4)	36% (4)	63% (83)
Increased family economic self-sufficiency	53% (9)	40% (4)	75% (6)	60% (3)	72% (8)	60% (12)	64% (11)	66% (4)	75% (3)	46% (6)	33% (3)	63% (7)	58% (76)
Reduction of health disparities	53% (9)	30% (3)	87.5% (7)	60% (3)	27% (3)	80% (16)	35% (6)	83% (5)	100% (4)	53% (7)	55% (5)	63% (7)	57% (75)
Improved school readiness and achievement	53% (9)	80% (8)	50% (4)	60% (3)	72% (8)	4.0% (8)	58% (10)	83% (5)	100% (4)	38% (5)	44% (4)	36% (4)	55% (72)
Reduced emergency department visits	47% (8)	60% (6)	75% (6)	60% (3)	18% (2)	45% (9)	53% (9)	83% (5)	50% (2)	46% (6)	44% (4)	45% (5)	49% (65)
Reduced crime and intimate partner violence	35% (6)	40% (4)	62.5% (5)	40% (2)	45% (5)	30% (6)	41% (7)	50% (3)	25% (1)	46% (6)	55% (5)	45% (5)	42% (55)
New sources of data	53% (9)	30% (3)	62.5% (5)	40% (2)	45% (5)	15% (3)	47% (8)	16% (1)	50% (2)	30% (4)	22% (2)	36% (4)	36% (48)
Policy, law, and/or regulation	23% (4)	30% (3)	12.5% (1)	-	18% (2)	10% (2)	35% (6)	16% (1)	25% (1)	7% (1)	33% (3)	18% (2)	20% (26)

*Percentages add up to more than 100% because respondents were able to choose all that apply

**Dash (-) represents zero responses

***Zero responses selected for the following option in D County: policy, law and/or regulation

Table 4: Most important outcome of MIECHV

	A (n = 17)	B (n = 9)	C (n = 8)	D (n = 3)	E (n = 11)	F (n = 20)	G (n = 16)	H (n = 6)	I (n = 4)	J (n = 12)	K (n = 8)	L (n = 10)	All Counties (n = 124)
Improved maternal and newborn health	17.6% (3)	22.2% (2)	62.5% (5)	100% (3)	9.1% (1)	40% (8)	6.3% (1)	50% (3)	25% (1)	41.7% (5)	62.5% (5)	70% (7)	35.5% (44)
Improved services for children and families in high-need communities	35.3% (6)	33.3% (3)	25% (2)	-	54.5% (6)	25% (5)	12.5% (2)	33% (2)	50% (2)	41.7% (5)	12.5% (1)	20% (2)	29.0% (36)
Community support for the health and well-being of children and their families	5.9% (1)	22.2% (2)	-	-	27.3% (3)	5% (1)	6.3% (1)	-	-	8.3% (1)	12.5% (1)	-	8.1% (10)
Improved communication among agencies and organizations interested in the health and well-being of children and their families	-	11.1% (1)	-	-	9.1% (1)	5% (1)	25% (4)	-	-	-	-	-	5.7% (7)
Improved school readiness and achievement	-	11.1% (1)	-	-	-	-	18.8% (3)	-	25% (1)	8.3% (1)	-	-	4.8% (6)
Health education services, health literacy, educational resources	17.6% (3)	-	12.5% (1)	-	-	-	6.3% (1)	-	-	-	-	-	4.0% (5)
Reduction of health disparities	11.8% (2)	-	-	-	-	15% (3)	-	-	-	-	-	-	4.0% (5)
Improved resource sharing	-	-	-	-	-	10% (2)	-	16.7% (1)	-	-	12.5% (1)	-	3.2% (4)
Increased coordination and referrals for other community resources	5.9% (1)	-	-	-	-	-	12.5% (2)	-	-	-	-	-	2.4% (3)
Public awareness of issues related to the health and well-being of children and their families	5.9% (1)	-	-	-	-	-	-	-	-	-	-	-	0.8% (1)
New sources of data	-	-	-	-	-	-	-	-	-	-	-	10% (1)	0.8% (1)
Reduced emergency department visits	-	-	-	-	-	-	6.3% (1)	-	-	-	-	-	0.8% (1)
Increased family economic self-sufficiency	-	-	-	-	-	-	6.3% (1)	-	-	-	-	-	0.8% (1)

* Participants could only select one answer option

** Dash (-) represents zero responses

Note: Not shown on this table - zero responses selected for the following options across all counties: increased knowledge sharing; policy, law, and/or regulation; reduced crime and intimate partner violence.

Discussion

Participants who were invited to complete the PARTNER Tool will be asked to again complete the survey in order to examine the development of collaborative relationships and activities in each community over time. Because the MIECHV home visiting programs in these counties in their first years of implementation, it is unsurprising that the community networks interact cooperatively, rather than reporting high levels of integration. All of the communities have partnerships and cooperative relationships with multiple agencies across service sectors. As reported by the participating agencies, these relationships facilitate important functions such as: *improving services for children and families in Florida's high-need communities; increasing coordination and referrals for other community resources; increasing community support for the health and well-being of children and their families; providing health education, health literacy, and educational resources; improving maternal and newborn health in general; improving resource sharing; and improving communication among agencies and organizations interested in the health and well-being of children and their families.*

Networks maps were generated to illustrate network connections between agencies in each community. At baseline, with new collaborations being developed around MIECHV, network maps will vary for each community. In general, the communities already have networks in place that will likely be further strengthened by MIECHV. It is expected that the size and density of community networks and the level of collaboration among community partners will increase as programs are further established.

When comparing the difference in responses between MIECHV programs' community collaborative work, versus most important outcome from the community collaborative, it is important to note the differences. Some of the reported potential outcomes from the '*choose all that apply*' question are not aligning with the most important outcomes. For example, the first most important outcome is listed as *improving maternal and newborn health*, whereas it is listed as the fifth potential outcome of MIECHV programs' work. While MIECHV stakeholders identified a number of benefits of collaboration, there was no consensus among stakeholders on the most important outcome of the MIECHV program. This may reflect the diversity of programs and the needs and priorities of the communities they serve. The greatest consensus was that the MIECHV program is *improves services for children and families in high-need communities and improves maternal and newborn health*.

Next Steps

The evaluation team also conducted 32 interviews and focus groups with MIECHV program administrators, supervisors, and home visitors. These interviews accomplished several goals, including giving greater depth and context to the results of the PARTNER Tool analysis; providing additional information about services that are being provided, received, and most needed in each community; enriching data from ETO an quarterly reporting systems; providing information on how individuals discuss the home visiting programs and their collaborations in the community; and providing important feedback on the overall MIECHV program and evaluation.

Further analysis of the PARTNER Tool data will include integration of all data one comprehensive dataset to examine overall collaboration, trust, and shared vision of MIECHV outcomes as well as a deeper examination of the community networks by service sector (e.g. early education, health, and social services, etc.). The county-specific network maps have been shared with individual MIECHV programs and can be used as a communication tool for MIECHV coalition or advisory committee planning.

Over time, the purpose of this evaluation activity is to collect information on the development of collaborative activities in each community from the perspective of multiple stakeholders. These multiple perspectives will allow the evaluation team to provide a comprehensive view of collaborative activities and the impact of MIECHV in this area.

For more information, please contact:

Jennifer Marshall, PhD, MPH
Research Assistant Professor
University of South Florida College of Public Health
Department of Community & Family Health
(813) 396-2672

MIECHV Evaluation Team

Dr. Jennifer Marshall
Pam Birriel
Leandra Olson
Rema Ramakrishnan
Deviquea Rainford
Suen Morgan
Oluyemisi Aderomilehin
Chantell Robinson
Loreal Dolar
Dr. Elizabeth Baker
Dr. Lana Yampolskaya
Dr. Sheri Eisert
Dr. Bill Sappenfield

2016 Florida MIECHV State-Level Collaboration Report

Pamela Birriel, Carolyn Heeraman, Amita Baban Patil, Amber Warren and Jennifer Marshall
Chiles Center for Healthy Mothers and Babies, University of South Florida College of Public Health

Introduction

The Affordable Care Act, Florida authorized funding for the Maternal, Infant, and Early Childhood Home Visitation Initiative (MIECHV) in 2010 to enhance the infrastructure of Florida home visiting programs. Florida MIECHV is administrated by the Florida Association of Healthy Start Coalitions (FAHSC), and provides funding, training, and technical assistance to 10 community programs throughout the state. Additionally, FAHSC is one of three nonprofits funded nationally, since all other grants are administered through state agencies. An independent evaluation of the Florida MIECHV program conducted by the Lawton and Rhea Chiles Center for Healthy Mothers and Babies, located within the College of Public Health at the University of South Florida (miechv.health.usf.edu).



The collaboration component of the evaluation seeks to answer the questions like name of organization, job title and position along with the following questions about each organization in Florida MIECHV Initiative's network:

- How frequently does your organization/ program work with each organization/ program on issues related to Florida MIECHV's goals?
- What kinds of activities does your relationship with each organization/ program entail?
- How valuable is each organization's/ program's POWER and INFLUENCE and LEVEL OF INVOLVEMENT in achieving the overall mission of Florida MIECHV?
- To what extent does the organization/ program SHARE A MISSION with Florida MIECHV's mission and goals?
- What is your organization's MOST IMPORTANT contribution to Florida MIECHV?
- What aspects of collaboration contribute to progress?
- How RELIABLE is each organization/ program?
- What are POTENTIAL outcomes of the Florida MIECHV's initiative?
- Which is the MOST IMPORTANT outcome of Florida MIECHV?
- How much progress has Florida MIECHV made towards reaching its goals?



For this analysis, the Florida MIECHV Initiative administrator identified collaborative partners at the state level, consisting of state leaders from early education, mental health, child welfare, home visiting, public health, and social services sectors. This report presents information on the quantitative data collected for the collaboration and social network analysis for the Florida state survey in 2016. A total of 32 out of 35 participants completed the survey.

Methods

The evaluation team used the Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER) to quantitatively describe and measure baseline collaboration among agencies, organizations, and groups within the state of Florida. PARTNER is a social network analysis

and collaboration tool developed by the Robert Wood Johnson Foundation that is administered by online survey (<http://www.partnertool.net/>).

We modified the PARTNER Tool to meet the specific needs and goals of the MIECHV program. A word version of the modified baseline survey was sent to the MIECHV state leadership team and site administrators for review and feedback. This feedback was incorporated into the survey, and the final version was revised on the PARTNER Tool website in preparation for data collection.

Once the PARTNER Tool was finalized, the evaluation team identified MIECHV state leadership across Florida. The administrators were asked to identify agencies with whom they collaborate around MIECHV issues within the state and to provide contact information for a representative from each agency. The evaluation team then emailed the link to the PARTNER Tool online survey to each MIECHV program administrator and their list of collaborators. Respondents were asked to answer the PARTNER Tool survey questions to assess the development of collaborations across the state of Florida. Regular reminder emails were sent from the evaluation team to individuals who had not completed the survey.

Level of Collaboration

Level of collaboration between state partners was measured with a single question that asked survey respondents to describe their organization's level of collaboration with each of their state partners. Participants could choose one of the following answers:

No Collaboration

Cooperative Activities: Involves exchanging information, attending meetings together, and offering resources to partners (Example: Informs other programs of RFA release).

Coordinated Activities: Include cooperative activities in addition to intentional efforts to enhance each other's capacity for the mutual benefit of programs (Example: Separate granting programs utilizing shared administrative processes and forms for application review and selection).

Integrated Activities: In addition to cooperative and coordinated activities, this is the act of using commonalities to create a unified center of knowledge and programming that supports work in related content areas (Example: Developing and utilizing shared priorities for funding effective prevention strategies. Funding pools may be combined).

Community Networks

A map that illustrates the connections between agencies across the state was developed from information provided by the respondents. Each organization that responded to the survey is represented as a dot. The lines between each organization represent the presence of a relationship based on the responses indicating how frequently the two organizations work together. The number of relationships is also dependent on the number of collaborators that were identified early in the process; this differs for each county. The home visiting agency is represented by a yellow star.

Networks can also be described by scores. The density score represents how many network ties are present in the community in relation to the total number of possible ties in the network (i.e., if everyone was connected to everyone else). To achieve a 100% density score, every member would have to be connected to every other member.

Aspects of Community Collaboration

The aspects of collaboration that contribute to MIECHV's success were measured with a single question. For this question, survey respondents were asked what aspects of collaboration contribute to the Florida's MIECHV program's progress towards reaching its goals. Respondents were able to choose all that apply from the following options:



Outcomes of MIECHV

Potential outcomes of the MIECHV program across the state were assessed. Two questions within the survey were targeted in understanding what the potential outcomes of MIECHV's work include, as well as the most important outcome from the response options. For the potential outcomes question, respondents were able to choose all that apply, whereas for the most important outcome, respondents could only choose one answer option. Additionally, respondents expressed their perception of the most important outcomes of the MIECHV program for children and families for which the respondents were able to choose only one answer option from the same list as the previous question.

Participants

This report describes collaborations within all Florida MIECHV state partners funded by the MIECHV grant 2015. The participants include the MIECHV administrators across the state of Florida and their identified collaborative partners who consist of representatives from early education, healthcare, home visiting, government, and social services programs. A total of 32 of the 35 identified stakeholders accessed and/or completed the baseline survey in 2016.

Results

The total number of interactions among all partners who completed the survey was 387. From Figure 3, we can see that the most common level of collaboration among all agencies was cooperation (41.3%, N=160).

Level of Collaboration

Figure 3 displays the state of Florida levels of collaboration, density and trust score as reported by the MIECHV programs and partners in 2016. The density score was 50.9% and the trust score was 82.6% among the partners and programs.

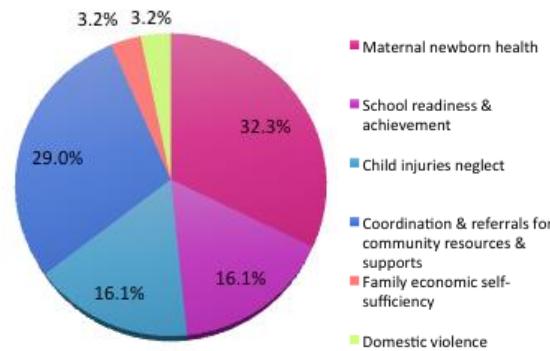


Figure 1: PARTNER Survey Response Rates by Services, Florida MIECHV, 2016

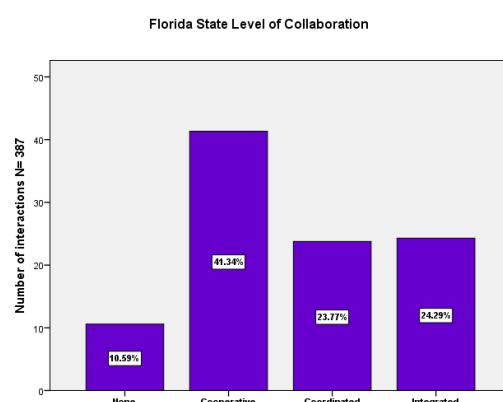


Figure 2: Florida MIECHV Partners: Level of Collaboration (2016)

Statewide Networks

Network maps were generated to describe the connections between all agencies in the statewide network. The dots (nodes) represent state agencies; service sector based on MIECHV benchmark areas are signified by color. The lines represent relationships between agencies. Scores reflect responses based on the total number of possible ties in the network. For example, the network Density score was 50.9% and average level of Trust score was 82.6% among all partners in the state-level partner network.

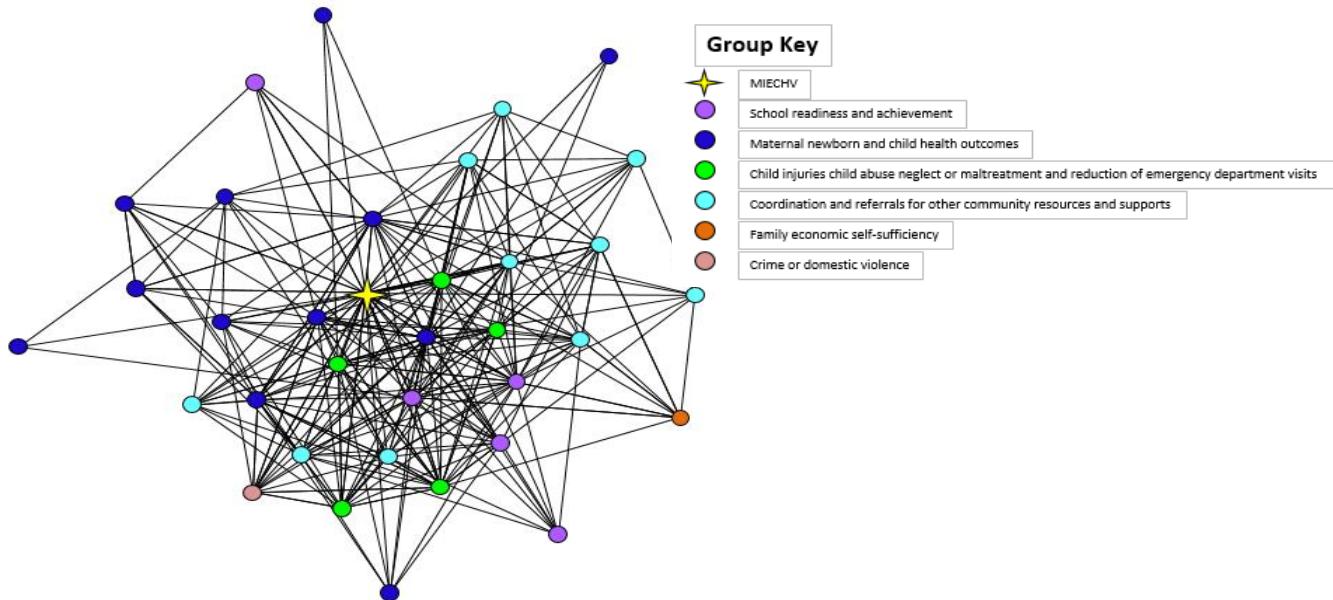
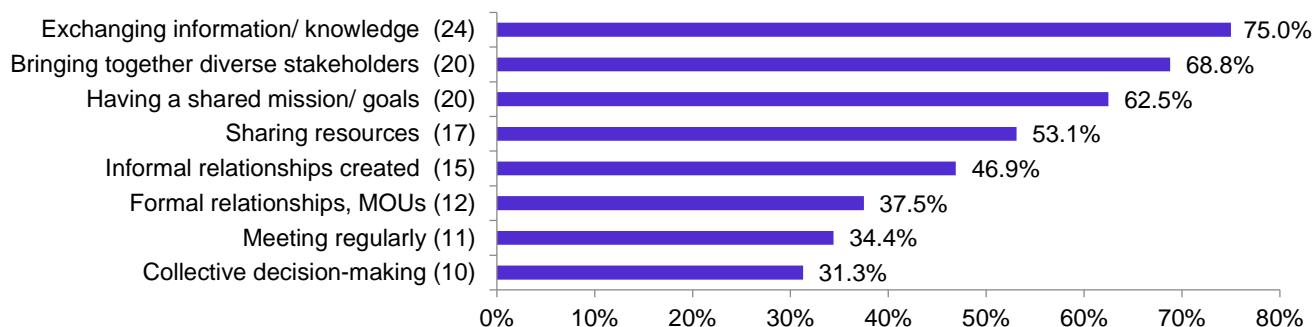


Figure 3: Network Map, State of Florida MEICHV (2016)

Aspects of Statewide Collaboration

As shown in figure 4 and table 1 below, respondents selected *exchanging information/knowledge* (75.0%, n=24), *bringing together diverse stakeholders* (68.8%, n=22), and *having a shared mission/goals* (62.5%, n=20) as the most important aspects of collaboration that contribute to MIECHV's success across the state of Florida. For this particular question, the percentages add up to more than 100% since respondents were allowed to choose all that apply.



Outcomes of MIECHV

The potential outcomes of the Florida MIECHV program across the state are shown in Table 2 and participants were allowed to select all that apply. The majority of respondents selected *Improved services for children and families in high-need communities* (84.4%, n=27), *Reduction of health*

disparities (78.1%, n=25) and *Community support for the health and well-being of children and their families* (75.0%, n=24) as the leading outcomes of MIECHV program's statewide collaborative work. The least number of respondents selected *Access to federal resources* (46.9%, n=15), *New sources of data* (46.9%, n=15) and *Reduced crime and Intimate Partner Violence* (46.9%, n=15) as outcomes for the MIECHV program's statewide collaborative.



According to respondents, potential outcomes of MIECHV were: *Improved services for children and families in high-need communities* (84.4%, n=27); *Reduction of health disparities* (78.1%, n=25); and *Experience, expertise in implementing evidence-based interventions* (75.0%, n=24) (Table 2).

Table 2: Potential Outcomes of the MIECHV Program's Statewide Collaborative (2016)

Potential Outcomes of the collaborative	Statewide (N=32)
Improved services for children and families in high-need communities	84.4% (27)
Reduction of health disparities	78.1% (25)
Experience, expertise in implementing evidence-based interventions	75.0% (24)
Community support for the health and well-being of children and their families	75.0% (24)
Public awareness of issues related to the health and well-being of children and their families	75.0% (24)
Improved communication among agencies and organizations interested in the health and well-being of children and their families	75.0% (24)
Improved maternal and newborn health	75.0% (24)
Increased coordination and referrals for other community resources	71.9% (23)
Development of local systems for coordinated intake and referral	68.8% (22)
Improved resource sharing	68.8% (22)
Increased knowledge sharing	68.8% (22)
Improved school readiness and achievement	68.8% (22)
Health education services, health literacy, educational resources	65.6% (21)
Innovation in service delivery	65.6% (21)
Support, expertise in using Continuous Quality Improvement (CQI) in program performance	59.4% (19)
Resources for professional development	59.4% (19)
Increased family economic self-sufficiency	59.4% (19)
Reduced emergency department visits	56.3% (18)
Expertise in using data to drive service delivery	53.1% (17)
Policy, law, and/ or regulation	50.0% (16)
Access to federal resources	46.9% (15)
New sources of data	46.9% (15)
Reduced crime and intimate partner violence	46.9% (15)

Percentages add up to more than 100% because respondents were able to choose all that apply

Table 3 shows respondents' ranking of the most important outcomes of the Florida MIECHV initiative. The most highly ranked outcomes include: *Improved maternal and newborn health* (35.7%, n=10); *Reduction in health disparities* (17.9%, n=5); *Improved services for children and families in high-need communities* (14.3%, n=4). Additional items selected as the most important outcome include: *Community support for the health and well-being of children and their families* (10.7%, n=3); *Health education services, health literacy, educational resources* (7.1%, n=2); *Improved communication among agencies and organizations interested in the health and well-being of children and their families* (7.1%, n=2); *Experience, expertise in implementing evidence-based interventions* (3.6%, n=1); and *Development of local systems for coordinated intake and referral* (3.6%, n=1). The MIECHV outcomes that were not selected as "the most important", are also shown on Table 3.

Table 3: Most Important Outcome of MIECHV across the state of Florida (2016)

Most important outcome of MIECHV	Statewide (N=28)
Improved maternal and newborn health	35.7% (10)
Reduction of health disparities	17.9% (5)
Improved services for children and families in high-need communities	14.3% (4)
Community support for the health and well-being of children and their families	10.7% (3)
Health education services, health literacy, educational resources	7.1% (2)
Improved communication among agencies and organizations interested in the health and well-being of children and their families	7.1% (2)
Experience, expertise in implementing evidence-based interventions	3.6% (1)
Development of local systems for coordinated intake and referral	3.6% (1)
Support, expertise in using Continuous Quality Improvement (CQI) in program performance	-
Resources for professional development	-
Access to federal resources	-
Innovation in service delivery	-
Expertise in using data to drive service delivery	-
Improved resource sharing	-
Increased knowledge sharing	-
New sources of data	-
Public awareness of issues related to the health and well-being of children and their families	-
Policy, law, and/ or regulation	-
Improved school readiness and achievement	-
Reduced emergency department visits	-
Reduced crime and intimate partner violence	-
Increased family economic self-sufficiency	-
Increased coordination and referrals for other community resources	-

*Participants could only select one answer option

*Dash (-) represents 0 responses

Respondents also selected the top three contributions /potential contributions to the MIECHV initiative (Table 4) include information or feedback (90%, N=27), community connections (80%, N=24) and opportunities from cross-sector collaboration, planning (70%, N=21).

Table 4: Organizations Contributions/Potential Contributions to the MIECHV Initiative (2016)

Contributions by the Organization	Statewide (N=30)
Information/ feedback	90.0% (27)
Community connections	80.0% (24)
Opportunities from cross-sector collaboration, planning	70.0% (21)
Coordination at state-level with programs serving at-risk families	56.7% (17)
Advocacy	56.7% (17)
In-kind resources (e.g., meeting space)	53.3% (16)
Data resources including data sets, collection, and analysis	50.0% (15)
Expertise other than in health	50.0% (15)
Facilitation/ leadership	36.7% (11)
Professional development	33.3% (10)
Providing client referrals to the home visiting program	30.0% (9)
Specific health expertise	26.7% (8)
Providing services to clients	20.0% (6)
Funding	6.7% (2)
Paid staff	6.7% (2)
Volunteers and volunteers staff	6.7% (2)
Fiscal management (e.g., acting as fiscal agent)	3.3% (1)
IT/ web resources (e.g., server space, web site development, social media)	3.3% (1)

Figure 5 shows that the majority of respondents selected that there is a fair amount of progress of the MIECHV program (51.7%, n=15), while the second most respondents selected that it is too soon to tell the progress of the MIECHV program (34.5%, n=10).

How much progress has Florida MIECHV made towards reaching its goals?

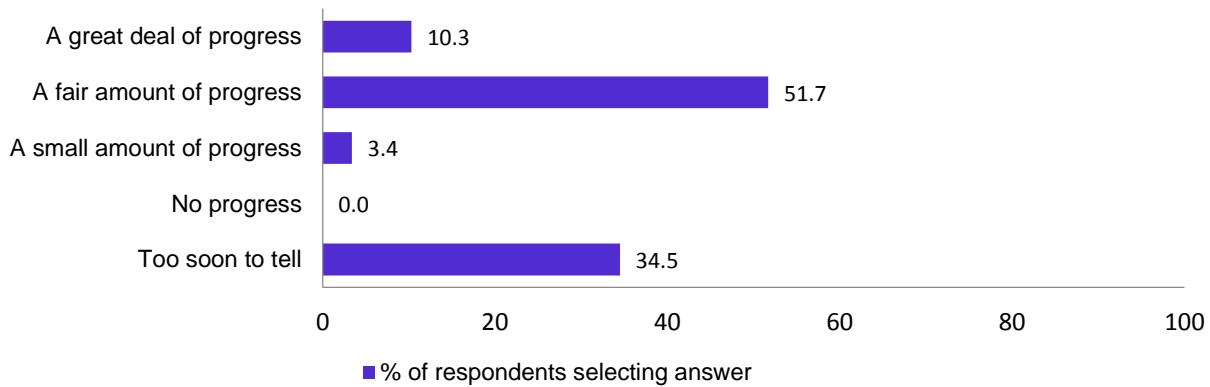
**Figure 5: Perceived Progress of Florida MIECHV (2016)**

Table 5: Comparison of Parameters for the MIECHV Program Site Community Partner Networks versus State-level Partner Network

Parameter	MIECHV Program Site Community Partner Networks Range (Average)	State-level MIECHV Initiative Partners (Average)
Density Score	23% - 90% (55%)	50.9%
Trust Score	56% - 76% (79.5%)	82.6%
Cooperation	23.8% – 81.8% (54.5%)	41.3%
Coordination	5.0% – 40.0% (19.8%)	23.8%
Integration	2.3% – 36.6% (28.5%)	24.3%

Program site statistics drawn come from the Florida MIECHV community collaboration report (2014-2015)

As seen in table 5 above, MIECHV program sites reported network density scores ranging from 23% - 90% (average = 55%), and trust score ranging from 56% - 76% (average = 79.5%). Similarly, the statewide density score was 50.9% and the statewide trust score was 82.6%. The most common level of collaboration for the program sites was cooperative (54.5%) and similar results were seen in the statewide network with cooperative relationships being the most frequently reported (41.3%, Table 5). Partner relationships that were integrated occurred, on average, in 28.5% of local site networks, and among 24.3% of state-level partners. Coordination was the least reported level of collaboration at both program sites and statewide, while integration was the middle proportion (Table 5).

Discussion

As reported by the participating agencies, a variety of state-level partnerships help to support the MIECHV Initiative's efforts to improve the health and well-being of Florida's mothers, infants, and families through home visiting programs aimed to: improve maternal and newborn health; reduce health disparities; improve services for children and families in Florida's high-need communities; and to increase coordination and referrals for community resources. These partnerships strengthen family support, health education, health literacy, and educational resources through resource sharing and interagency communication.

The network map and scores reflect a large number of partners, connected in a fairly dense network of relationships with high levels of interagency trust (82.6%). Partners identified that exchanging information/ knowledge, bringing together diverse stakeholders, and having a shared mission/ goals are the aspects of collaboration that contribute most to MIECHV's success. Indeed, there was fairly high agreement on the potential outcomes of MIECHV program's statewide collaborative work: Improved services for children and families in high-need communities; Reduction of health disparities; and Experience, expertise in implementing evidence-based interventions. Half of the network partners felt that MIECHV had made a fair amount of progress towards its goals since it began three years ago, and 10% felt that the program had made a great deal of progress. One-third of partnering agencies felt that it was still too soon to tell. The PARTNER survey will be re-distributed to state-level agencies within MIECHV's network again in 2017 to examine changes in network composition, interagency trust, collaboration, and shared vision.

Florida MIECHV Evaluation Team

Dr. Jennifer Marshall – Principal Investigator, Lead Evaluator
Pamela Birriel – Research Associate, Project Coordinator
Rema Ramakrishnan – Research Associate, Data Analyst
Ngozi Agu – Research Associate
Amber Warren – Research Assistant
Paige Alitz – Research Assistant
Esther Jean-Baptiste – Research Assistant
Abimbola Michael-Asalu – Research Assistant
Omotola Balogun – Research Assistant
Kimberly Hailey – Research Assistant
Shana Geary – Research Assistant
Carolyn Heeraman – Research Assistant
Amita Baban Patil – Research Assistant
Oluyemisi Amoda – Research Assistant
Dr. Takudzwa Sayi – Research Associate

For more information, please contact:

Jennifer Marshall, PhD, CPH
Assistant Professor
University of South Florida College of Public Health
Department of Community & Family Health
(813) 396-2672
jmarshal@health.usf.edu
miechv.health.usf.edu

This project is supported by the Health Resources and Service Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number D89MC28265, Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsement be inferred by HRSA, HHS, or the U.S. Government.

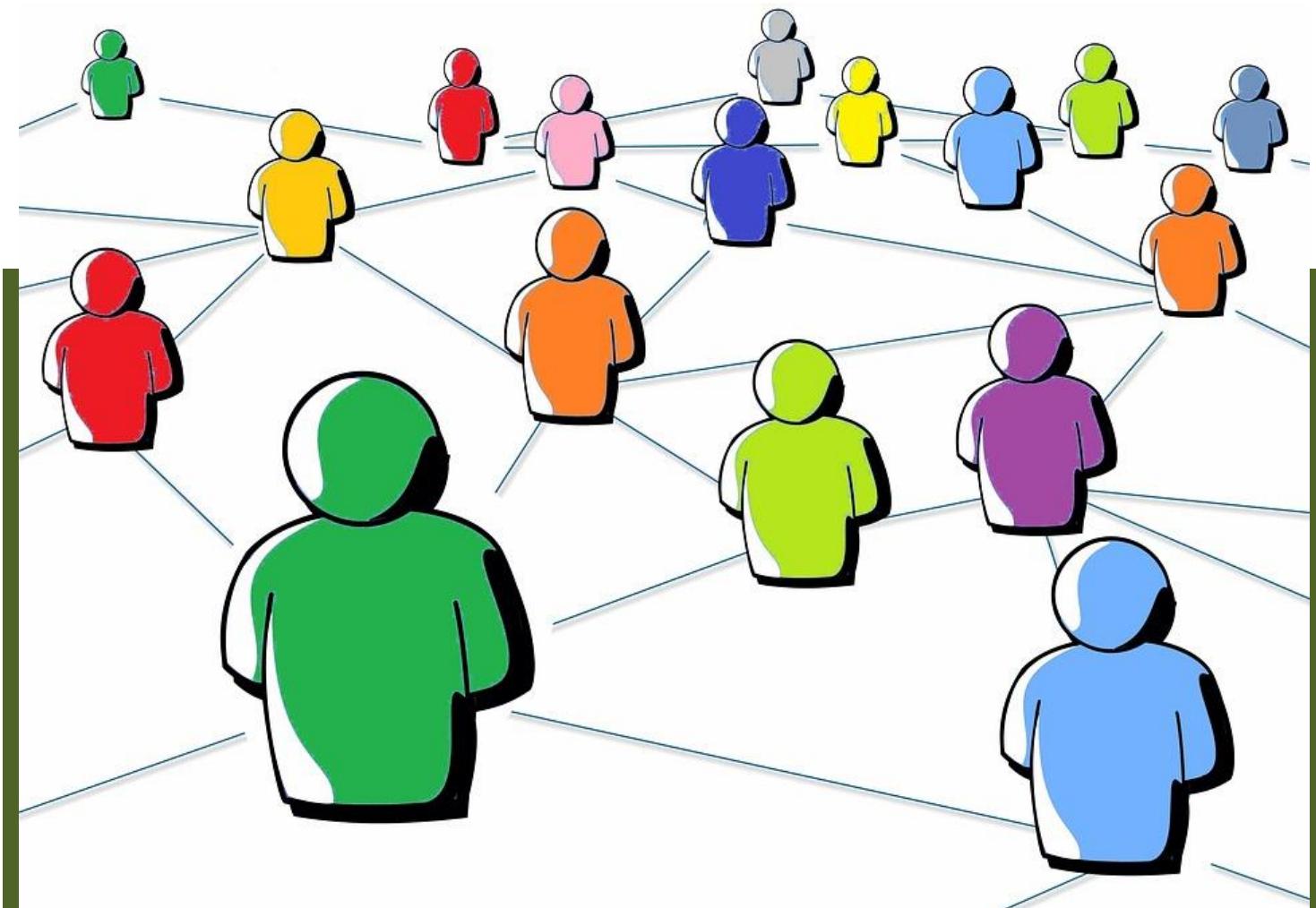


Florida
Maternal Infant & Early Childhood
Home Visiting Initiative



**Florida Maternal, Infant, and Early Childhood
Home Visiting (MIECHV) Program:
Community Collaboration Report**

2017 PARTNER SURVEY



**Vanessa Sharon, Pamela Birriel, Ngozichukwuka Agu,
Kimberly Hailey, and Jennifer Marshall**

APRIL 2018

Background

In 2010, Florida's Affordable Care Act authorized funding for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative to enhance the capacity and infrastructure of Florida home visiting programs. Florida MIECHV, administrated by the Florida Association of Healthy Start Coalitions, provides funding, training, and technical assistance to local implementing agencies throughout the state. FAHSC is one of three nonprofits funded nationally to implement MIECHV; all other grants are administered through state agencies. An independent evaluation of this initiative is conducted by the Lawton and Rhea Chiles Center for Healthy Women, Children and Families, located within the College of Public Health at the University of South Florida (miechv.health.usf.edu). This utilization-focused evaluation includes both process and outcome evaluation components. Since 2014, this collaboration and social network analysis has described agencies partnering with Florida MIECHV, as well as each partner's relationships with the others within these local Florida MIECHV networks. Questions include:

- 1) How frequently does each organization work with the others on issues related to MIECHV's goals?
- 2) What kinds of activities do relationships among organizations/programs in MIECHV networks entail?
- 3) How valuable is each organization's/program's power, influence, and level of involvement in achieving the overall mission of MIECHV?
- 4) To what extent does each organization/program share a mission with Florida MIECHV's mission and goals?
- 5) What is each organization's most important contribution to MIECHV?
- 6) What aspects of collaboration do partners perceive contribute to progress?
- 7) How reliable is each organization/program?
- 8) What do partners believe are potential outcomes of the MIECHV's initiative?
- 9) What do partners believe are the most important outcomes of MIECHV?
- 10) How much progress do partners perceive that MIECHV has made towards reaching its goals?

Community Networks to Achieve Collective Impact

Florida MIECHV aims to improve maternal, child, and family outcomes by improving coordination and collaboration among programs that provide services to families at the state and local levels. The program does this by implementing evidence-based programs in high need communities and engaging available resources and linking families to services most appropriate for their specific needs. The program is also expected to contribute to the development of the early childhood systems of care in their communities. The development and management of community networks is a complex process that is highly variable and dependent on a multitude of factors, including the broader sociopolitical context (e.g., funding and management of public and private state- and community-level programs; shifting patterns and trends in community health issues; and organizational changes, such as staff turnover or organizational restructuring). This report details findings from the 2017 evaluation of collaboration between local Florida MIECHV sites and partnering agencies. Previous reports include:

- [2016 Florida MIECHV State-Level Collaboration Report](#)
- [2014-2015 Florida MIECHV Community Collaboration Report: PARTNER Tool Survey](#)
- [2014 Florida MIECHV Program Evaluation Comprehensive Baseline PARTNER Report: Collaboration Analysis across All Counties](#)

This report builds upon previous reports by highlighting changes in indicators of collaboration over time. Specifically, changes in social network members, network scores, number and quality of relationships, and roles and contributions of network members. Assessment of outcomes were used to indicate development of the collaborative relationships over time.

Methods

Recruitment and Data Collection

To quantitatively describe and measure baseline collaboration among agencies, organizations, and groups in each community, the Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER), was utilized. PARTNER is a social network analysis and collaboration tool developed by the Robert Wood Johnson Foundation. The PARTNER Tool (<http://www.partnertool.net/>) administers an online survey to measure collaborative relationships between organizations participating in community networks. This tool was used to assess collaboration between Florida MIECHV programs and partnering agencies.

The evaluation team modified the PARTNER Tool survey to meet the specific needs and goals of MIECHV. A word version of the modified survey was sent to the MIECHV state leadership team for review and feedback. The feedback was incorporated into the survey, and the final version was revised on the PARTNER Tool website in preparation for data collection. Once the PARTNER Tool was modified for each MIECHV program site, the evaluation team identified MIECHV program administrators from each community who were asked to identify agencies with whom they collaborate around MIECHV issues within their county and provide contact information for a representative from each agency. The evaluation team then emailed the link to the PARTNER Tool online survey to each MIECHV program administrator and their list of collaborators. Identified representatives from partnering agencies were sent a unique username and password to complete the survey. Bi-weekly reminder emails were sent from the evaluation team over several months to individuals who had not completed the survey. Respondents were asked to answer the PARTNER Tool survey to assess the development of collaborations in their community.

Measures

Level of Collaboration

Collaboration between community partners was measured with a single question that asked survey respondents to describe their organization's level of collaboration with each of the network partners. Participants could choose one of the following answers:

- **None**
- **Cooperative** activities, which involve exchanging information, attending meetings together, and offering resources to partners (e.g., informing other programs of grants)
- **Coordinated** activities, which include cooperative activities, in addition to intentional efforts to enhance each other's capacity for the mutual benefit of programs (e.g., separate granting programs utilizing shared administrative processes and forms for application review and selection)
- **Integrated** activities, which include cooperative and coordinated activities, as well as the act of using commonalities to create a unified center of knowledge and programming that supports work

in related content areas (e.g., developing and utilizing shared priorities for funding effective prevention strategies, where funding pools may be combined)

Community Networks

Maps that illustrate the connections between agencies in each community were developed from information provided by the respondents. Each organization that responded to the survey is represented as a dot. The lines between each organization represent the presence of a relationship based on the responses indicating how frequently the two organizations work together. The number of relationships is also dependent on the number of collaborators that were identified early in the process; this differs for each county. Networks can also be described by scores. The density score represents how many network ties are present in the community in relation to the total number of possible ties in the network (i.e., if everyone was connected to everyone else). To achieve a 100% density score, every member would have to be connected to every other member.

Aspects of Community Collaboration

The aspects of collaboration that contribute to MIECHV's success were measured with a single question. For this question, survey respondents were asked what aspects of community collaboration contribute to their county's MIECHV program's progress towards reaching its goals. Respondents could choose all that apply from the following options: bringing together diverse stakeholders; meeting regularly; exchanging information/knowledge; sharing resources; informal relationships created; collective decision-making; and having a shared mission, goals.

Outcomes of MIECHV

Potential outcomes of the MIECHV program for each county were assessed. Two questions within the survey were targeted in understanding what the potential outcomes of MIECHV's work include, as well as the most important outcome from the response options. For the potential outcomes question, respondents could choose all that apply, whereas for the most important outcome, respondents could only choose one answer option. Additionally, respondents expressed their perception of the most important outcomes of the MIECHV program for children and families for which the respondents could choose only one answer option from the same list as the previous question.

Data Analysis

Descriptive statistics were generated for each site-level survey. Changes over time in the social network model, network scores, number and quality of relationships, roles and contributions of network members, and assessment of the outcomes were used to indicate development of the collaborative relationships over time. All collected data were analyzed using the PARTNER Tool and SPSS v.24 to determine the level of collaboration, community network, aspects of collaboration, graphic representations of the social network/collaborative model in each community, and perceptions of Florida MIECHV program outcomes. Changes over time (2014-2017) were also discussed.

Results

Participants

This report describes collaborations within Florida MIECHV communities funded in 2017: Broward, Duval, Escambia, Gadsden, Hardee/Desoto, Highlands, Hillsborough, Manatee, Miami-Dade, North

Florida MIECHV Community Collaboration Report: 2017 PARTNER Tool Survey

Central Florida, Orange, Pinellas, Polk, and Southwest (Lee, Hendry, Collier). Survey respondents include the MIECHV administrator in each community and their identified collaborative partners, consisting of representatives from early education, healthcare, home visiting, government, and social services programs. A total of 131 of the 167 stakeholders accessed and/or completed the survey in 2014 (*Time-1*, 78.4% response rate), a total of 176 of the 254 (69.3% response) in 2015 (*Time-2*), and a total of 205 out of 325 (63.1% response) in 2017 (*Time-3*). Table 1 illustrates these response rates by county across three time periods.

Table 1. PARTNER Survey Response Rates, Florida MIECHV Counties

County	Time 1		Time 2		Time 3	
	Total Participants	Response Rate (%)	Total Participants	Response Rate (%)	Total Participants	Response Rate (%)
Broward	8/13	61.5%	14/23	60.9%	18/25	72.0%
Duval	5/6	83.3%	28/56	50.0%	26/48	54.1%
Escambia	11/11	100.0%	12/14	85.7%	12/13	92.3%
Gadsden	-	-	-	-	10/11	90.9%
Hardee/Desoto	-	-	-	-	12/30	40.0%
Highlands	-	-	-	-	13/15	86.6%
Hillsborough	20/21	95.2%	19/20	95.0%	19/26	73.0%
Manatee	17/23	73.9%	26/31	83.9%	20/39	51.2%
Miami-Dade	6/7	85.7%	9/9	100.0%	9/15	60.0%
North Central	36/49	73.5%	38/59	64.4%	18/42	42.8%
Orange	4/5	80.0%	4/5	80.0%	8/8	100.0%
Pinellas	13/17	76.5%	12/17	70.6%	12/17	70.5%
Polk	-	-	-	-	11/15	73.3%
Southwest	11/15	73.3%	14/20	70.0%	17/21	80.9%
Total	131/167	79.2%	176/254	73.7%	205/235	63.1%

Level of Collaboration

The number of interactions among community networks increased from 948 at *Time-1* to 1,655 at *Time-2* to 1,803 at this current follow-up of *Time-3*. Figure 1 and Table 2 display community network levels of collaboration, density, and trust as reported by MIECHV programs and partners at *Time-1*, *Time-2*, and *Time-3*, including those programs who completed the PARTNER Tool survey for the first time in 2017 (third follow-up survey) - Gadsden, Hardee/Desoto, Highlands, and Polk. As shown in Figure 1, cooperation remains the most common level of collaboration among programs. The density scores – signifying number of relationships among agencies – was relatively stable across time points, ranging from 31-90% for the *Time-1* survey, 23-90% for the *Time-2* survey, and 27-89% for the *Time-3* survey across communities with the average score decreasing from 57% to 54% from *Time-1* to *Time-3* (Table 2). For counties participating in the survey for the first time (Gadsden, Hardee/Desoto, Highlands, and Polk), the range of density scores was 19% to 80% with an average of 48%.

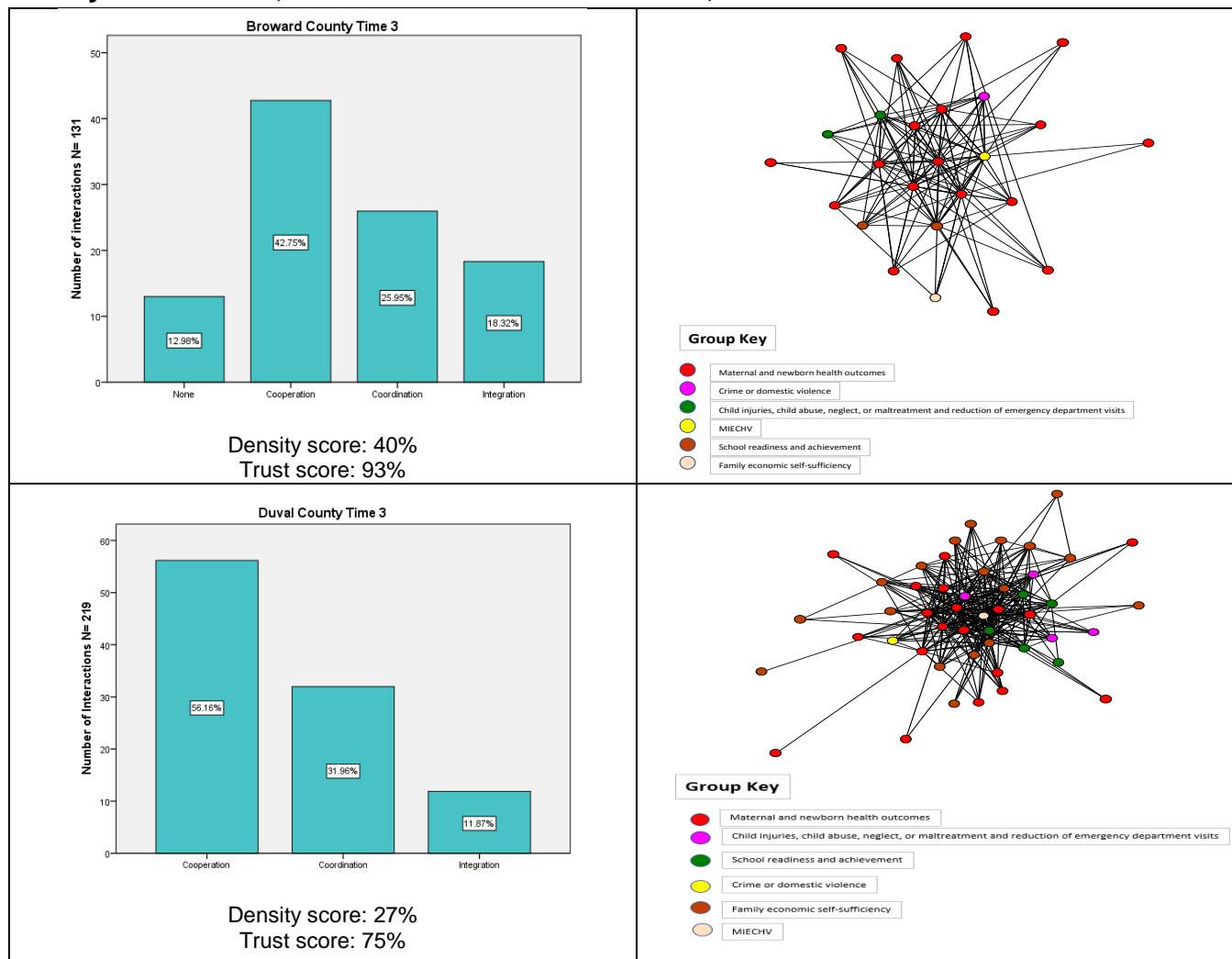
Interagency trust scores ranged from 75-96% at *Time-1*, 56-90% at *Time-2*, and 68-93% at *Time-3* (Table 2), decreasing from 83% to 76% from *Time-1* to *Time-2*, possibly due to the incorporation of 87 new or additional partners identified in Florida MIECHV networks at *Time-2*. However, at *Time-3*, the measured average trust score was 82%. For counties participating in the survey for the first time, the trust scores ranged from 60-81% with an average of 71%.

With baseline data and new collaborations continuously being developed around MIECHV, it is expected that the appearance of the network maps, as well as the density and trust scores will vary for

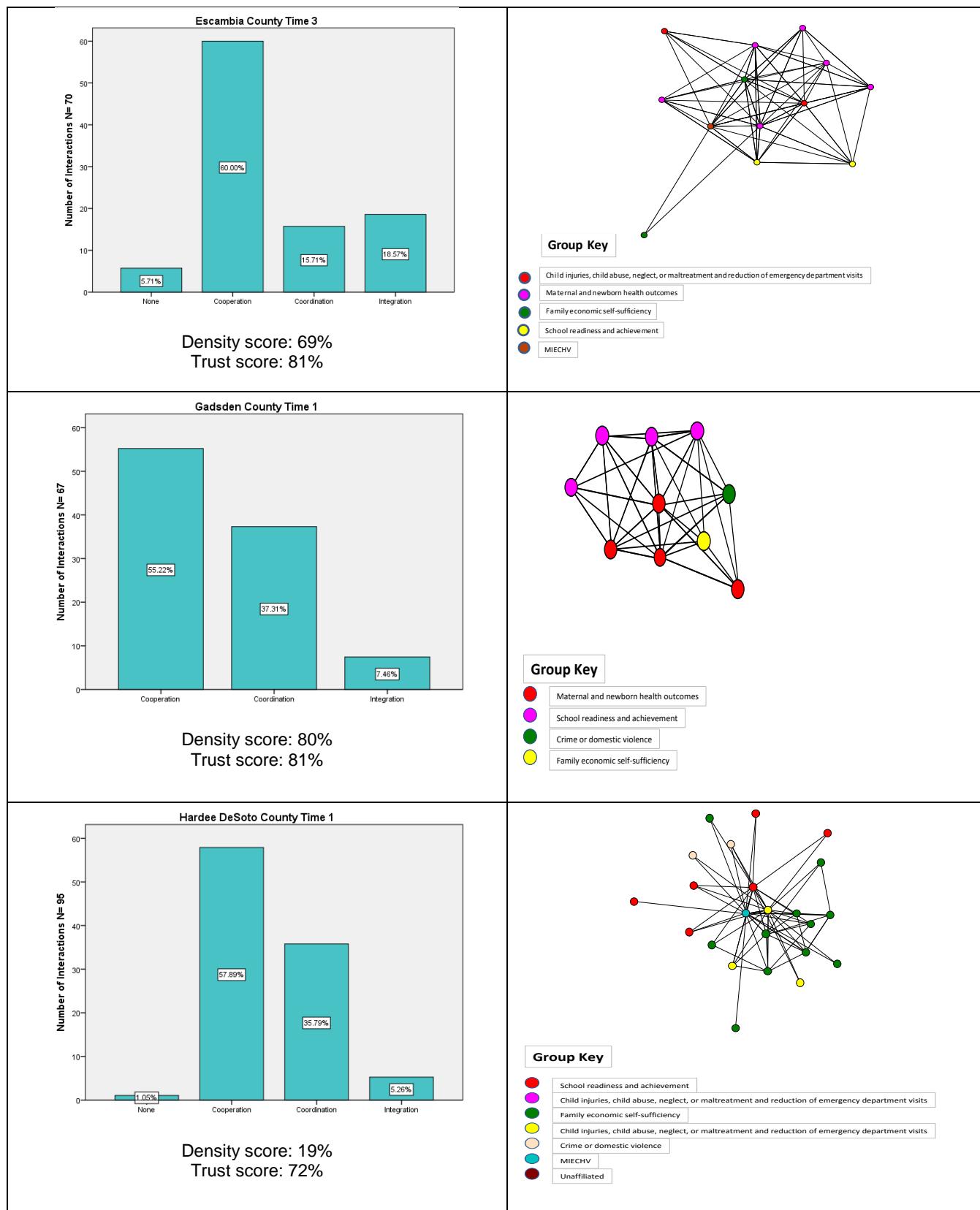
Florida MIECHV Community Collaboration Report: 2017 PARTNER Tool Survey

each community. The results presented below indicate that while the maps look different from each other, the communities, in general, already have networks in place that will likely be even further strengthened by MIECHV. The counties that fall under North Central Florida (Alachua, Bradford, Putnam, Columbia, and Hamilton) are reporting in *Time-3* as one site instead of as individual counties like in previous PARTNER Tool reports.

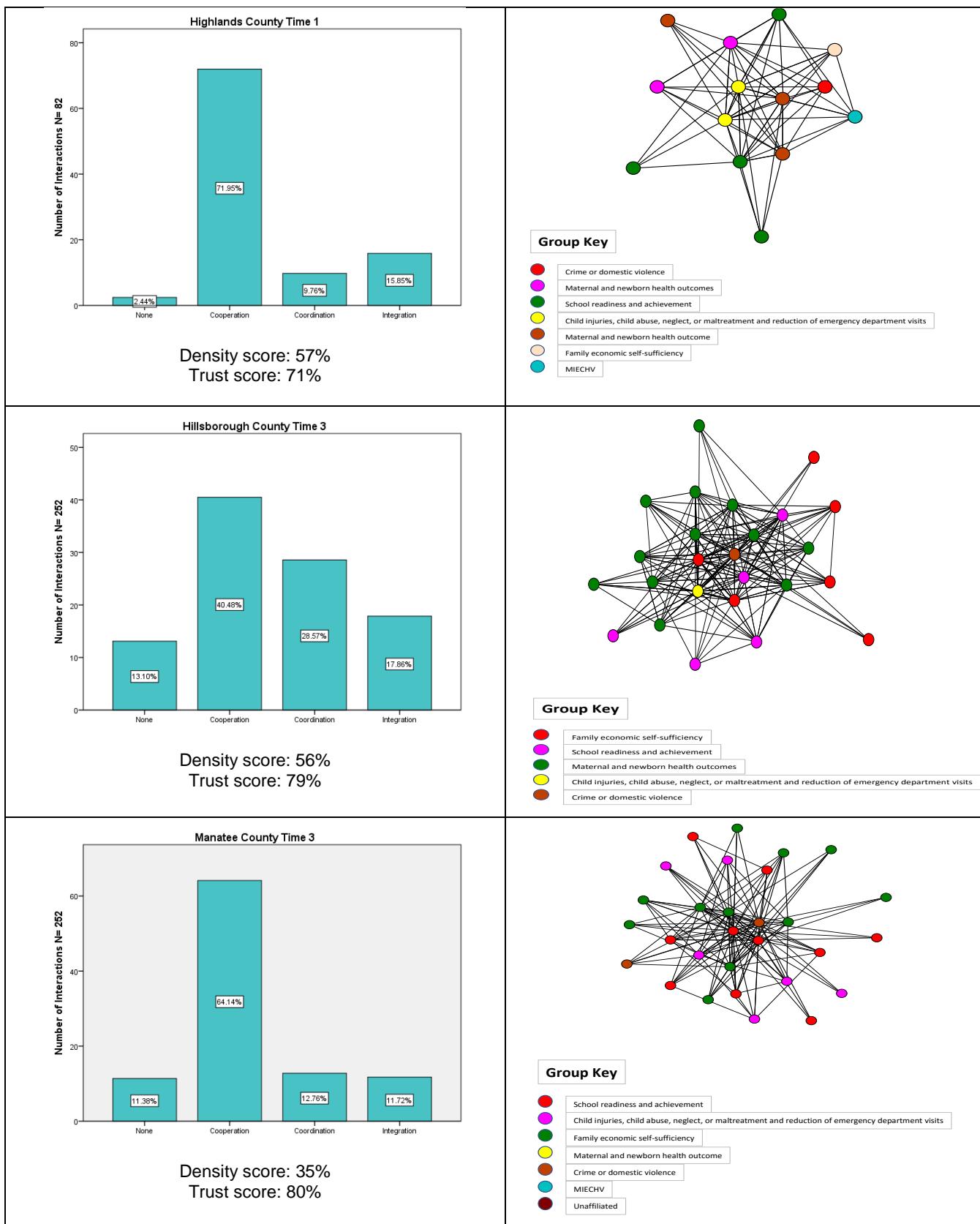
Figure 1. Levels of Collaboration among Partners and Network Maps for Counties Surveyed in *Time-3*, Florida MIECHV Communities, 2017.



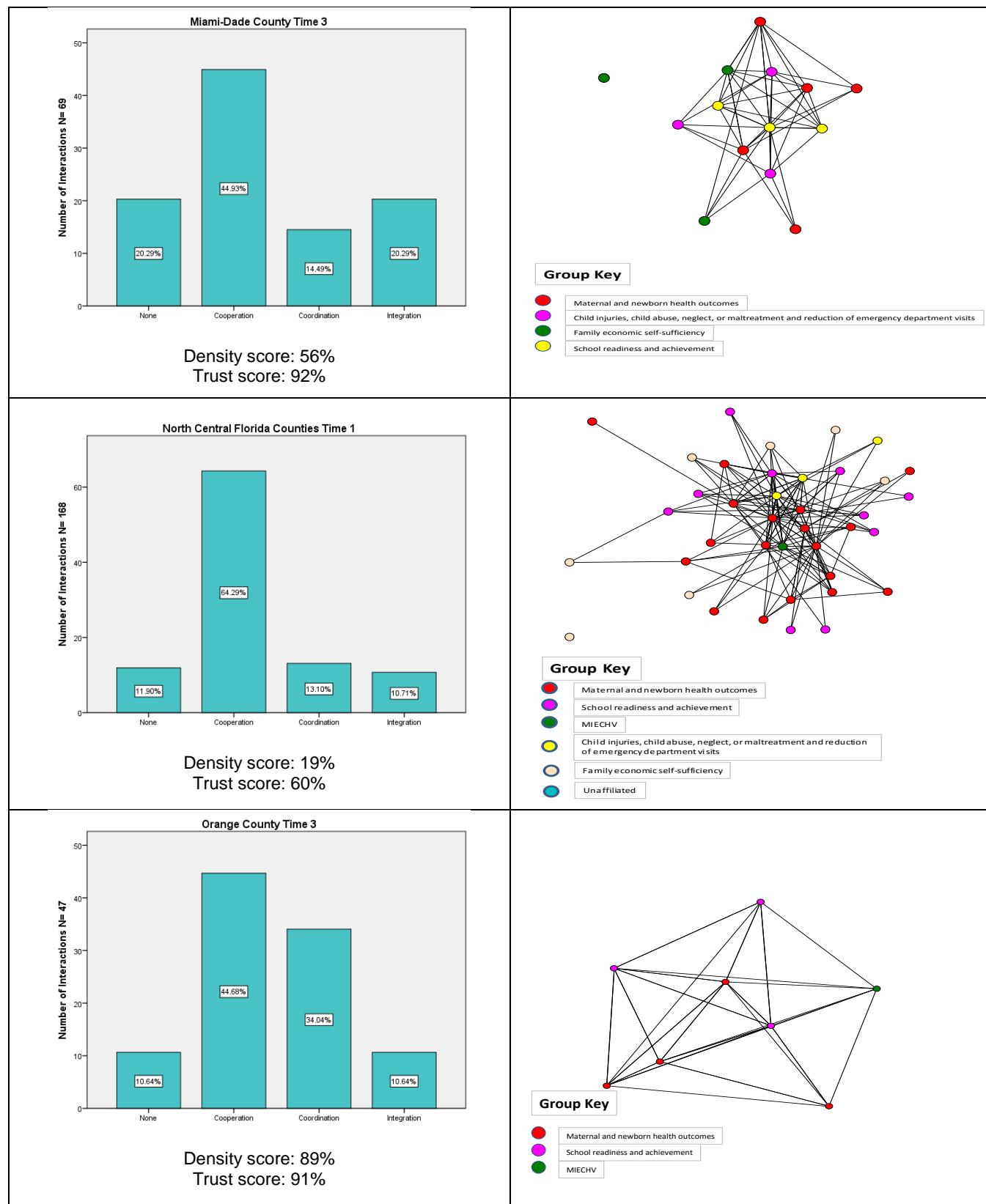
Florida MIECHV Community Collaboration Report: 2017 PARTNER Tool Survey



Florida MIECHV Community Collaboration Report: 2017 PARTNER Tool Survey



Florida MIECHV Community Collaboration Report: 2017 PARTNER Tool Survey



Florida MIECHV Community Collaboration Report: 2017 PARTNER Tool Survey

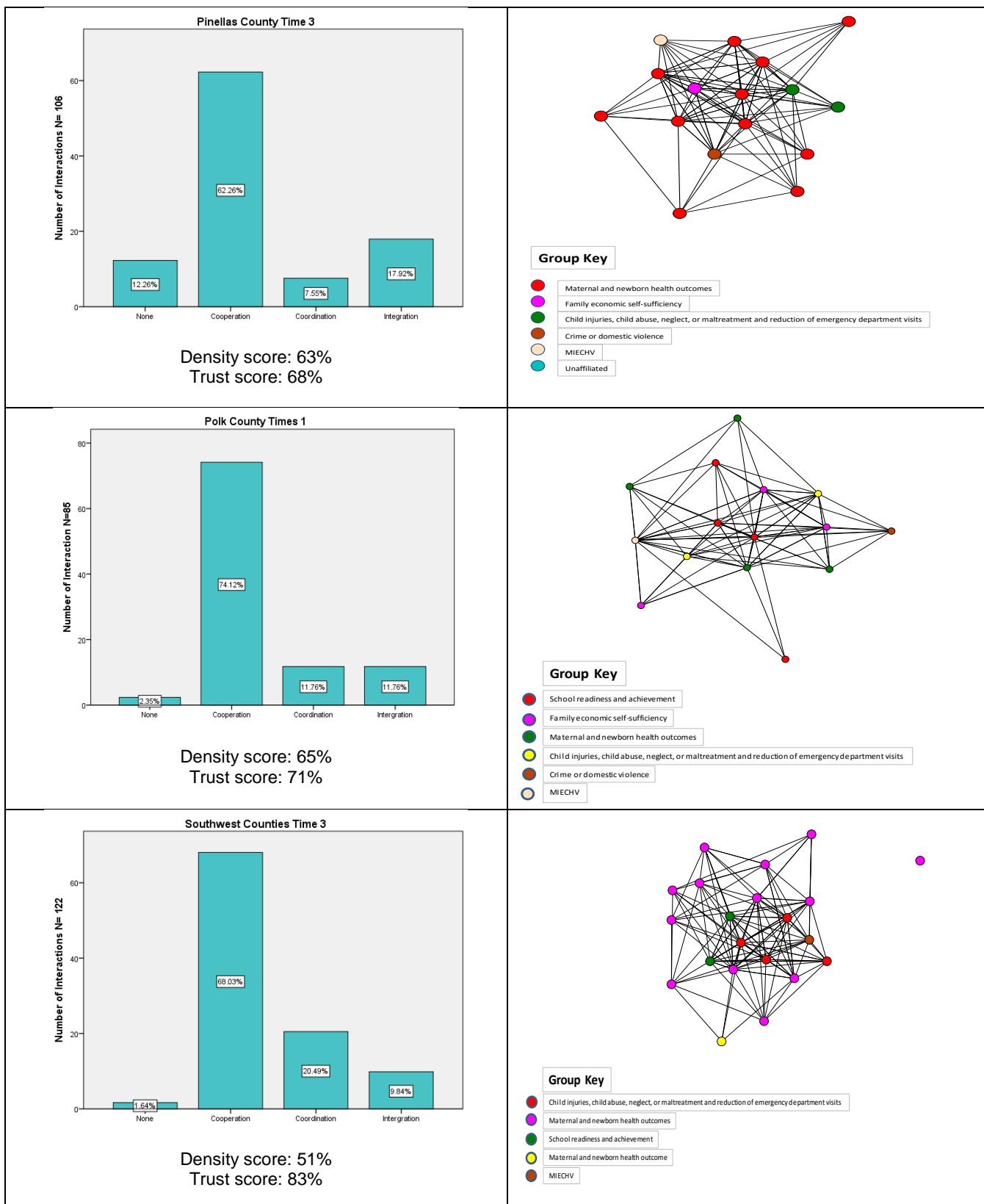


Table 2. Density and Trust Scores from Time-1, Time-2, and Time-3 Surveys

County	Density T1	Density T2	Density T3	Trust T1	Trust T2	Trust T3	# Partners T1 – T3 Difference
Alachua	62%	48%	-	82%	77%	-	-
Bradford	45%	36%	-	79%	82%	-	-
Broward	56%	41%	40%	81%	87%	93%	+10
Duval	43%	23%	27%	96%	56%	75%	+21
Escambia	78%	62%	69%	92%	84%	81%	+1
Gadsden	-	-	80%	-	-	81%	-
Hardee/Desoto	-	-	19%	-	-	72%	
Highlands	-	-	57%	-	-	71%	
Hillsborough	67%	67%	56%	76%	79%	79%	-1
Manatee	47%	51%	35%	75%	70%	80%	+3
Miami Dade	62%	72%	56%	93%	82%	92%	+3
North Central	(Avg. 46%)	(Avg. 46%)	19%	(Avg. 81%)	(Avg. 74%)	60%	-18
Alachua	62%	48%		82%	77%		
Bradford	45%	36%		79%	82%		
Putnam	31%	27%		81%	64%		
Orange	90%	90%	89%	76%	90%	91%	+4
Pinellas	66%	65%	63%	81%	71%	68%	-1
Polk	-	-	65%	-	-	71%	-
Putnam	31%	27%	-	81%	64%	-	-
Southwest	42%	56%	51%	78%	71%	83%	+6
Average	57%	53%	52% (54%*)	83%	76%	78% (82%*)	+74 (+28*)

*Averages for all counties participating in all time points time 1-3. North Central was reported separately as Alachua, Bradford, Putnam Counties at T1 and T2.

Community Networks

The density scores ranged from 31-90% for *Time-1*, 23-90% for *Time-2*, and 19-90% for *Time-3*. The average score for *Time-1* was 57%, *Time-2* 53%, and *Time-3* decreasing to 48%. The trust scores ranged from 75-93% at *Time-1*, 56-90% at *Time-2*, and 60-93% at *Time-3*. The mean trust score for *Time-1* was 83%, *Time-2* 76%, and *Time-3* is 78%, a slight increase from *Time-2*. However, it should be kept in mind that the 78% average includes new MIECHV programs and new partners participating in existing MIECHV networks.

Aspects of Community Collaboration

Results from the *Time-3* PARTNER Tool survey continued to capture the aspects of collaboration that partners perceive contribute to MIECHV's success. With the *Time-3* survey (focusing on counties who responded at all three time points), respondents selected *exchanging information and/or knowledge* (70.9%, n=100), *sharing resources* (59.6%, n=84), and *having a shared mission/goals* (58.9%, n=83) as the most important aspects of community collaboration that contribute to MIECHV's progress towards



reaching its goals.

This was similar to responses from counties participating for the first time with these respondents also selecting *exchanging information and/or knowledge* (57.8%, n=37), *sharing resources* (50.0%, n=32), and *having a shared mission/goals* (43.8%, n=28) as the most important aspects of community collaboration that contribute to MIECHV programs' progress towards reaching its goals. At *Time-2*, respondents selected *exchanging information and/or knowledge* (69.0%, n=121), *sharing resources* (59.8%, n=107), and *informal relationships created* (52.0%, n=85) as the most important aspects of community collaboration. Similarly, during *Time-1*, respondents also selected *exchanging information and/or knowledge* (73.3%, n=96) and *sharing resources* (65.6%, n=86), but *having a shared mission/goals* (66.4%, n=87) was chosen by respondents at *Time-1* instead of *informal relationships created* selected by *Time-2* respondents. For this question within the survey, percentages add up to more than 100% because respondents could choose all that apply. The aspects of collaboration that community partners reported as most contributory to MIECHV's success are shown in Tables 3 and 4.

Outcomes of MIECHV

The potential outcomes of the MIECHV program's community collaborative at *Time-3* are shown in Tables 5 and 6, while most important outcomes for each MIECHV program's community collaborative at *Time-3* are shown in Tables 7 ad 8. For the potential outcomes question in baseline survey and follow-up surveys, respondents could choose all that apply. At *Time-3*, three responses were included with the first being for those counties who participated in all three surveys, the second were counties who participated in all three surveys but utilized a previous version of the survey, and the third being those who were responding to the survey for the first time. For those who participated in all three surveys and those responding for the first time, the two leading outcomes that were selected by these groups were: *improved services for children and families in high-need communities most times* (80.2%, n=93), (81.3%, n=52); and *improved maternal and newborn health* (78.4%, n=91), (78.1%, n=50). Those who participated in all three surveys but used a previous version had the three leading outcomes as: *improved health outcomes* (48%, n=12); *improved resource sharing* (36%, n=9); and *increased knowledge sharing* (36%, n=9).

Tables 7 and 8 illustrate respondents' perception of the most important outcomes of the MIECHV program for children and families. Across all counties at baseline, 35.5% (n=44) specified that MIECHV programs' community collaborative most important outcome was *improving maternal and newborn health*, while 29.0% (n=36) recognized it as *improving services for children and families in high-need communities*. However, at follow-up, respondents chose the reverse with 38% (n=62) specifying *improving services for children and families in high need communities* as the most important outcome of MIECHV programs' community collaborative and 29.4% (n=48) selecting *improving maternal and newborn health* as the most important outcome. At *Time-3*, among counties who had participated in all PARTNER Tool surveys, 30.0% (n=33) selected *maternal and newborn health* as the most important outcome for MIECHV programs' community collaborative, and 27.3% (n=30) selected *improved services for children and families in high-need communities* as the next most important outcome. This is similar to the responses at baseline, as well as information gleaned from those who participated in the survey for the first time in which 43.1% (n=25) selected *improved maternal and newborn health* as the most important outcome followed by 22.4% (n=13) who selected *improved services for children and families in high need communities*.

The response options for these questions were very similar and could also be seen as overlapping and not mutually exclusive. Among counties who participated in all surveys, two of these responded to a previous version of the survey with slightly different outcomes. For these counties, 45.8% (n=11) selected *improved health outcomes as the most important outcome*. The previous version of the survey did not have a response for maternal and newborn health but included only improved health outcomes. These response options are also very similar in the context of the population served by these agencies.

Table 3. Aspects of Collaboration that Contribute to MIECHV's Success, Time-3

Aspect of Collaboration	Broward (n=18)	Duval (n=26)	Escan比亚 (n=12)	Hillsborough (n=19)	Manatee (n=20)	Miami-Dade (n=9)	Orange (n=8)	Pinellas (n=12)	Southwest (n=17)	All (n=141)
Exchanging information/knowledge	55.6 (10)	65.4 (17)	75.0 (9)	63.2 (12)	80 (16)	100 (9)	87.5 (7)	58.3 (7)	76.5 (13)	70.9 (100)
Having a shared mission, goals	61.1 (11)	50.0 (13)	75.0 (9)	47.4 (9)	65.0 (13)	88.9 (8)	50.0 (4)	50.0 (6)	58.8 (10)	58.9 (83)
Sharing resources	55.6 (10)	61.5 (16)	50.0 (6)	52.6 (10)	75.0 (15)	88.9 (8)	50.0 (4)	58.3 (7)	47.1 (8)	59.6 (84)
Bringing together diverse stakeholders	66.7 (12)	50.0 (13)	58.3 (7)	47.4 (9)	45.0 (9)	77.8 (7)	0.0 (0)	33.3 (4)	52.9 (9)	49.6 (70)
Informal relationships created	33.3 (6)	42.3 (11)	50.0 (6)	26.3 (5)	55.0 (11)	55.6 (5)	37.5 (3)	75.0 (9)	70.6 (12)	48.2 (68)
Meeting regularly	38.9 (7)	34.6 (9)	33.3 (4)	21.0 (4)	45.0 (9)	77.8 (7)	25.0 (2)	41.7 (5)	23.5 (4)	36.2 (51)
Collective decision-making	27.8 (5)	30.8 (8)	25.0 (3)	21.1 (4)	30.0 (6)	55.6 (5)	12.5 (1)	25.0 (3)	17.6 (3)	27.0 (38)

Table includes only those counties who were represented in Time-1, -2, and -3. Percentages add up to more than 100 because respondents could select more than one response

Table 4. Aspects of Collaboration that Contribute to MIECHV's Success: Surveyed Time-3 Only

Aspect of Collaboration	Gadsden (n=10)	Hardee (n=12)	Highlands (n=13)	N. Central (n=18)	Polk (n=11)	Total (n=64)
Exchanging information/knowledge	70.0 (7)	41.7 (5)	46.2 (6)	72.2 (13)	54.5 (6)	57.8 (37)
Having a shared mission, goals	40.0 (4)	16.7 (2)	38.5 (5)	55.6 (10)	63.6 (7)	43.8 (28)
Sharing resources	70.0 (7)	41.7 (5)	30.8 (4)	55.6 (10)	54.5 (6)	50.0 (32)
Bringing together diverse stakeholders	50.0 (5)	0.0 (0)	7.7 (1)	61.1 (11)	36.4 (4)	14.9 (21)
Informal relationships created	20.0 (2)	33.3 (4)	38.5 (5)	38.9 (7)	36.4 (4)	15.6 (22)
Meeting regularly	40.0 (4)	16.7 (2)	15.4 (2)	50.0 (9)	9.1 (1)	28.1 (18)
Collective decision-making	30.0 (3)	0.0 (0)	15.4 (2)	33.3 (6)	18.2 (2)	20.3 (13)

Counties represented here were those surveyed for the first time during Time-3 survey. Percentages add up to more than 100 because respondents could select more than one response

Table 5. Potential Outcomes of MIECHV Community Collaboratives, Time-3

Outcomes of work	Broward (n=18)	Duval (n=26)	Escambia (n=12)	Hillsborough (n=19)	Manatee (n=20)	Miami-Dade (n=9)	Pinellas (n=12)	All (n=116)
Health education services, health literacy, educational resources	61.1 (11)	76.9 (20)	75.0 (9)	73.7 (14)	85.0 (17)	88.9 (8)	75.0 (9)	75.9 (88)
Improved services for children and families in high-need communities	77.8 (14)	73.1 (19)	91.7 (11)	73.7 (14)	80.0 (16)	100.0 (9)	83.3 (10)	80.2 (93)
Reduction of health disparities	72.2 (13)	65.4 (17)	50.0 (6)	84.2 (16)	55.0 (11)	77.8 (7)	58.3 (7)	66.3 (77)
Improved resource sharing	61.1 (11)	53.8 (14)	83.3 (10)	52.6 (10)	75.0 (15)	77.8 (7)	66.7 (8)	64.7 (75)
Increased knowledge sharing	55.6 (10)	69.2 (18)	66.7 (8)	57.9 (11)	80.0 (16)	77.8 (7)	66.7 (8)	67.2 (78)
New sources of data	27.8 (5)	38.5 (10)	50.0 (6)	42.1 (8)	45.0 (9)	66.7 (6)	41.7 (5)	42.2 (49)
Community support for the health and well-being of children and their families	50.0 (9)	69.2 (18)	83.3 (10)	68.4 (13)	95.0 (19)	77.8 (7)	75.0 (9)	73.3 (85)
Public awareness of issues related to the health and well-being of children and their families	55.6 (10)	57.7 (15)	83.3 (10)	57.9 (11)	80.0 (16)	77.8 (7)	66.7 (8)	66.4 (77)
Policy, law, and/or regulation	11.1 (2)	23.1 (6)	50.0 (6)	21.1 (4)	35.0 (7)	55.6 (5)	16.7 (2)	27.6 (32)
Improved communication among agencies and organizations interested in the health and well-being of children and their families	61.1 (11)	53.8 (14)	83.3 (10)	57.9 (11)	75.0 (15)	88.9 (8)	50.0 (6)	64.7 (75)
Improved school readiness and achievement	44.4 (8)	50.0 (13)	50.0 (6)	47.4 (9)	65.0 (13)	77.8 (7)	58.3 (7)	54.3 (63)
Reduced emergency department visits	38.9 (7)	42.3 (11)	58.3 (7)	63.2 (12)	60.0 (12)	66.7 (6)	66.7 (8)	54.3 (63)
Improved maternal and newborn health	61.1 (11)	73.1 (19)	91.7 (11)	94.7 (18)	65.0 (13)	100.0 (9)	83.3 (10)	78.4 (91)
Reduced crime and intimate partner violence	33.3 (6)	23.1 (6)	50 (6)	47.4 (9)	50.0 (10)	66.7 (6)	41.7 (5)	41.3 (48)
Increased family economic self-sufficiency	38.9 (7)	46.2 (12)	66.7 (8)	78.9 (15)	65.0 (13)	66.7 (6)	50.0 (6)	57.8 (67)
Increased coordination and referrals for other community resources	55.6 (10)	73.1 (19)	75.0 (9)	78.9 (15)	80.0 (16)	88.9 (8)	75.0 (9)	74.1 (86)

Table includes only counties who were represented in Time-1 and -2 surveys. Percentages add up to more than 100 because respondents could select more than one response

Table 5 (Continued). Potential Outcomes of MIECHV Community Collaboratives, Time-3*

Outcomes of work	Orange (n=8)	Southwest (n=17)	Total (n=25)
Health education services, health literacy, educational resources	75.0 (6)	5.8 (1)	28.0 (7)
Improved services for children and families in high-need communities	75.0 (6)	11.8 (2)	32.0 (8)
Reduction of health disparities	37.5 (3)	5.9 (1)	16.0 (4)
Improved resource sharing	100.0 (8)	5.9 (1)	36.0 (9)
Increased knowledge sharing	100.0 (8)	5.9 (1)	36.0 (9)
New sources of data	25.0 (2)	0.0 (0)	8.0 (2)
Community support for the health and well-being of children and their families	50.0 (4)	0.0 (0)	16.0 (4)
Public awareness of issues related to the health and well-being of children and their families	50.0 (4)	5.9 (1)	20.0 (5)
Policy, law, and/ or regulation	12.5 (1)	0.0 (0)	4.0 (1)
Improved health outcomes	50.0 (4)	47.1 (8)	48.0 (12)
Improved communication among agencies and organizations interested in the health and well-being of children and their families	62.5 (5)	5.9 (1)	24.0 (6)

*These counties utilized the previous version of the PARTNER survey; therefore, did not respond to all questions regarding outcomes. Percentages add up to more than 100 because respondents could select more than one response

Table 6. Potential Outcomes of MIECHV Community Collaboratives, Surveyed Time-3 Only

Outcomes of work	Gadsden (n=10)	Hardee (n=12)	Highlands (n=13)	N. Central (n=18)	Polk (n=11)	Total (n=64)
Health education services, health literacy, educational resources	90.0 (9)	50.0 (6)	53.8 (7)	72.2 (13)	72.7 (8)	67.2 (43)
Improved services for children and families in high-need communities	80.0 (8)	83.3 (10)	69.2 (9)	83.3 (15)	90.9 (10)	81.3 (52)
Reduction of health disparities	90.0 (9)	16.7 (2)	61.5 (8)	66.7 (12)	72.7 (8)	60.9 (39)
Improved resource sharing	80.0 (8)	66.7 (8)	38.5 (5)	72.2 (13)	54.5 (6)	62.5 (40)
Increased knowledge sharing	70.0 (7)	33.3 (4)	46.2 (6)	66.7 (12)	54.5 (6)	54.7 (35)
New sources of data	50.0 (5)	16.7 (2)	23.1 (3)	38.9 (7)	27.3 (3)	31.3 (20)
Community support for the health and well-being of children and their families	90.0 (9)	50.0 (6)	53.8 (7)	83.3 (15)	72.7 (8)	70.3 (45)
Public awareness of issues related to the health and well-being of children and their families	70.0 (7)	33.3 (4)	53.8 (7)	55.6 (10)	54.5 (6)	53.1 (34)
Policy, law, and/ or regulation	30.0 (3)	16.7 (2)	15.4 (2)	27.8 (5)	9.1 (1)	20.3 (13)
Improved communication among agencies and organizations interested in the health and well-being of children and their families	70.0 (7)	58.3 (7)	46.2 (6)	72.2 (13)	54.5 (6)	60.9 (39)
Improved school readiness and achievement	40.0 (4)	58.3 (7)	23.1 (3)	66.7 (12)	27.3 (3)	45.3 (29)
Reduced emergency department visits	60.0 (6)	25.0 (3)	46.2 (6)	44.4 (8)	63.6 (7)	46.9 (30)
Improved maternal and newborn health	100.0 (10)	58.3 (7)	69.2 (9)	83.3 (15)	81.8 (9)	78.1 (50)

Table 7. Most Important Outcome of MIECHV, Time-3

Most important outcome	Broward (n=17)	Duval (n=22)	Escambia (n=11)	Hillsborough (n=19)	Manatee (n=20)	Miami-Dade (n=9)	Pinellas (n=12)	All Counties (n=110)
Health education services, health literacy, educational resources	0.0 (0)	4.5 (1)	18.2 (2)	0.0 (0)	15.0 (3)	11.1 (1)	16.7 (2)	8.2 (9)
Improved services for children and families in high-need communities	20.0 (3)	27.3 (6)	63.6 (7)	21.1 (4)	25.0 (5)	11.1 (1)	33.3 (4)	27.3 (30)
Reduction of health disparities	26.7 (4)	4.5 (1)	0.0 (0)	15.8 (3)	0.0 (0)	11.1 (1)	0.0 (0)	8.2 (9)
Increased knowledge sharing	0.0 (0)	4.5 (1)	0.0 (0)	0.0 (0)	5.0 (1)	0.0 (0)	0.0 (0)	1.8 (2)
Community support for the health and well-being of children and their families	0.0 (0)	4.5 (1)	0.0 (0)	10.5 (2)	10.0 (2)	0.0 (0)	25.0 (3)	7.3 (8)
Public awareness of issues related to the health and well-being of children and their families	6.7 (1)	0.0 (0)	0.0 (0)	0.0 (0)	5.0 (1)	0.0 (0)	0.0 (0)	1.8 (2)
Improved communication among agencies and organizations interested in the health and well-being of children and their families	0.0 (0)	4.5 (1)	0.0 (0)	0.0 (0)	5.0 (1)	0.0 (0)	0.0 (0)	1.8 (2)
Improved school readiness and achievement	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	15.0 (3)	0.0 (0)	0.0 (0)	2.7 (3)
Reduced emergency department visits	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	5.0 (1)	0.0 (0)	0.0 (0)	0.9 (1)
Improved maternal and newborn health	40.0 (6)	40.9 (9)	9.1 (1)	47.4 (9)	0.0 (0)	66.7 (6)	16.7 (2)	30.0 (33)
Reduced crime and intimate partner violence	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	5.0 (1)	0.0 (0)	0.0 (0)	0.9 (1)
Increased family economic self-sufficiency	0.0 (0)	4.5 (1)	9.1 (1)	0.0 (0)	5.0 (1)	0.0 (0)	8.3 (1)	3.6 (4)
Increased coordination and referrals for other community resources	6.7 (1)	4.5 (1)	0.0 (0)	5.3 (1)	5.0 (1)	0.0 (0)	0.0 (0)	3.6 (4)

Table includes only those counties who were represented in Time-1 and -2 surveys. Items that received zero responses for 'most important outcome' include: Improved resource sharing, New sources of data, Policy, law, and/or regulation,

Table 7. (Continued). Most important outcome of MIECHV, Time-3

Most important outcome	Orange* (n=8)	Southwest* (n=16)	All (n=24)
Health education services, health literacy, educational resources	0.0 (0)	6.3 (1)	4.2 (1)
Improved services for children and families in high-need communities	0.0 (0)	12.5 (2)	8.3 (2)
Reduction of health disparities	0.0 (0)	6.3 (1)	4.2 (1)
Improved resource sharing	12.5 (1)	6.3 (1)	8.3 (2)
Increased knowledge sharing	12.5 (1)	6.3 (1)	8.3 (2)
Community support for the health and well-being of children and their families	25.0 (2)	0.0 (0)	8.3 (2)
Public awareness of issues related to the health and well-being of children and their families	0.0 (0)	6.3 (1)	4.2 (1)
Improved health outcomes	37.5 (3)	50.0 (8)	45.8 (11)
Improved communication among agencies and organizations interested in the health and well-being of children and their families	12.5 (1)	6.3 (1)	8.3 (2)

*These counties utilized the previous version of the PARTNER survey so did not respond to all questions on outcomes. Items that received zero responses for 'most important outcome' include: New sources of data and Policy, law, and/or regulation.

Table 8. Most important outcome of MIECHV by Counties Only Surveyed in Time-3

Most important outcomes	Gadsden (n=10)	Hardee (n=10)	Highlands (n=11)	N. Central (n=16)	Polk (n=11)	All counties (n=58)
Health education services, health literacy, educational resources	0.0 (0)	0.0 (0)	0.0 (0)	6.3 (1)	9.1 (1)	3.4 (2)
Improved services for children and families in high-need communities	10.0 (1)	50.0 (5)	18.2 (2)	12.5 (2)	27.3 (3)	22.4 (13)
Reduction of health disparities	30.0 (3)	10.0 (1)	0.0 (0)	12.5 (2)	9.1 (1)	12.1 (7)
Community support for the health and well-being of children and their families	0.0 (0)	0.0 (0)	9.1 (1)	18.8 (3)	0.0 (0)	6.9 (4)
Improved communication among agencies and organizations interested in the health and well-being of children and their families	0.0 (0)	0.0 (0)	9.1 (1)	6.3 (1)	0.0 (0)	3.4 (2)
Improved school readiness and achievement	0.0 (0)	20.0 (2)	0.0 (0)	0.0 (0)	0.0 (0)	3.4 (2)
Improved maternal and newborn health	60.0 (6)	10.0 (1)	54.5 (6)	37.5 (6)	54.5 (6)	43.1 (25)
Increased family economic self-sufficiency	0.0 (0)	10.0 (1)	0.0 (0)	0.0 (0)	0.0 (0)	1.7 (1)
Increased coordination and referrals for other community resources	0.0 (0)	0.0 (0)	9.1 (1)	6.3 (1)	0.0 (0)	3.4 (2)

Counties represented here were surveyed for the first time in Time-3. Items that received zero responses for 'most important outcome' include: Improved resource sharing, Increased knowledge sharing, New sources of data, Public awareness of issues related to the health and well-being of children and their families, Policy, law, and/or regulation, Reduced emergency department visits, and Reduced crime and intimate partner violence.

Discussion and Conclusion

The 2017 collaboration analysis shows that the number of participating sites, and total number of community partners within those sites' networks increased. A total of 74 new partners (who responded to the survey) joined MIECHV networks statewide (including 28 new respondents to sites that had participated in previous surveys). The larger and more diverse the network, the larger the number of possible relationships and thus likely lower density of interagency partnerships. Similarly, trust may be lower if new partners are brought to the table and relationships are being developed.

As shown in Table 2, in network density and trust scores were highly variable (ranging from 19%-89% and 60%-93%, respectively) among these very diverse urban and rural counties, and remained relatively stable across time points overall (Density T1 57%, T2 53%, T3 52%, Trust T1 83%, T2 76%, T3 78%) in spite of fairly large changes in network size in some counties and the inclusion of four new sites. Based on these findings, what the sites probably need to do now that they have built their networks is strengthen existing relationships. Individualized reports are being created for each site to assist them in planning their interagency partnerships and collaboration strategies.

Most partners agreed that exchanging information/ knowledge, sharing resources, and having a shared mission and goals were aspects of collaboration that contribute to MIECHV's success. This mission congruence was high, with agreement among agencies regarding three potential and most important outcomes of Florida MIECHV: improved services for children and families in high-need communities, improved health outcomes, and improved maternal and newborn health.

The administration of the PARTNER Survey allows Florida MIECHV sites to measure, visualize, and better understand the interagency partnerships that they are fostering in their communities towards achieving collective impact on maternal, child, and family health and well-being. MIECHV program can continue to identify, develop, and strengthen partnerships with these agencies to strengthen local systems of care.

For further information on this report, please contact:

Jennifer Marshall, PhD, MPH, CPH.

Assistant Professor, Lead Evaluator

University of South Florida, College of Public Health,
Chiles Center for Healthy Women, Children & Families.

Email: jmarshal@health.usf.edu

Tel: 813-396-2672

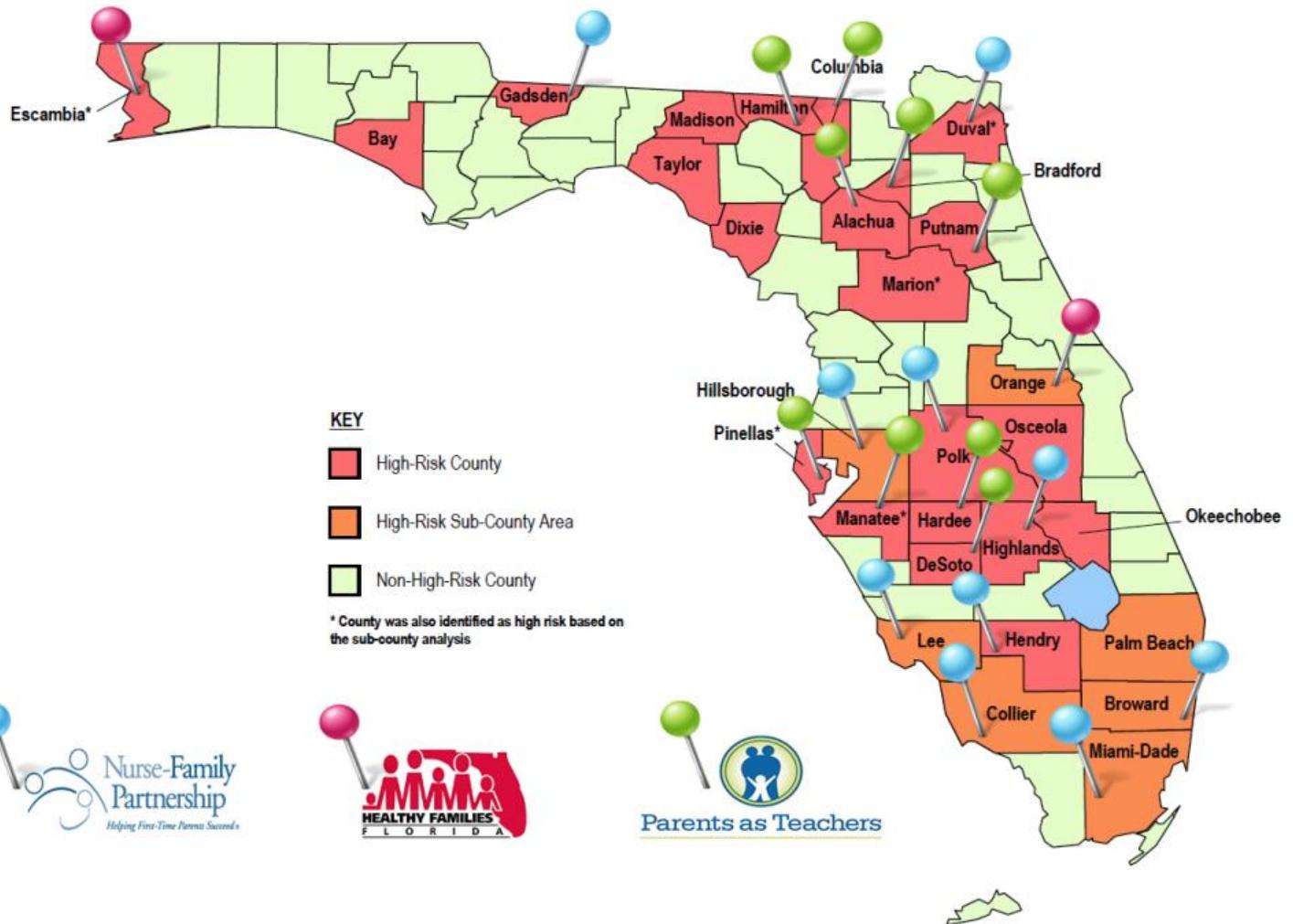


This project is supported by the Health Resources and Service Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number D89MC28265, Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsement be inferred by HRSA, HHS, or the U.S. Government.



Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Evaluation Overview

Program Profiles 2015



Pamela Birriel, Rema Ramakrishnan, Paige Alitz,
Chantell Robinson, Suen Morgan, and Jennifer Marshall

University of South Florida
Chiles Center for Healthy Mothers and Babies

Introduction

This report includes a compilation of research summaries of feedback from staff, participants, and community partners in the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. We included brief excerpts from data collected in 2014 and 2015 from 11 programs in 14 counties implementing MIECHV. In fall of 2014, there were a total of 32 interviews and focus groups conducted with 81 total MIECHV program staff, including 17 administrators (21%), 15 supervisors (19%), and 49 home visitors (60%). Additionally, we share brief insights and quotes derived from 103 total interviews with program participants representative of the ethno-racial and linguistic diversity of families participating in Florida MIECHV. The participant interviews were conducted in English (79), Spanish (15), and Haitian/Creole (9), and with 101 women and two male caregivers/parents. Forty participants identified their race as Black (39%), 19 identified as White (18%), 5 identified as Other (5%), 26 identified as Hispanic (25%), and 12 identified as Haitian-Creole (12%).

Another element of interest in the MIECHV program evaluation is the extent to which collaborative community partnerships are built between each MIECHV program and agencies in the surrounding area to meet specified benchmark goals. The benchmark sectors include: maternal and child outcomes; family economic self-sufficiency; child abuse and neglect along with reduction in emergency visits; school readiness and achievement; and crime or domestic violence. A total of 303 partners were identified by the 11 MIECHV programs in 12 communities (one program served two distinct communities); each programs' collaborative relationships were described by program partners through the PARTNER Tool Survey (<http://www.partnertool.net/>) which was administered in 2014 and again in 2015. These relationships are illustrated through social network maps in this report. A network map depicts each dot as an agency specified as a MIECHV collaborator, with lines connecting each dot representing the connections between each agency in the network. The program partners were further identified by benchmark area in 2015, allowing individual MIECHV programs to examine where partnerships are thriving in their communities, which benchmarks are being addressed, and where new partnerships may be needed.

The full reports describing the results of MIECHV staff interviews and focus groups, program participant telephone interviews, and the PARTNER survey collaboration analysis can be found on the Florida MIECHV website (<http://flmiechv.com/what-we-do/measuring-results/>) and USF MIECHV Evaluation website (<http://health.usf.edu/publichealth/chiles/miechv/state-evaluation.htm>).

The MIECHV program prides itself in offering supportive services to mothers who reside in the most high-risk communities across the state of Florida. To capture the characteristics of the communities where MIECHV program is serving families, the ArcGIS software was used to map where participants reside in comparison to specific demographic factors in the particular county per the 2010 U.S. Census data and 2013 American Community Survey. With this in mind, the summaries also contain Geographic Information System (GIS) maps that were constructed to visually depict the relationship between where MIECHV participants live with the percentage of unemployment, uninsured, and poverty of that county at the census-tract levels.

MIECHV Evaluation Overview

Broward County



Focus groups and interviews conducted with NFP staff in Broward County:

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

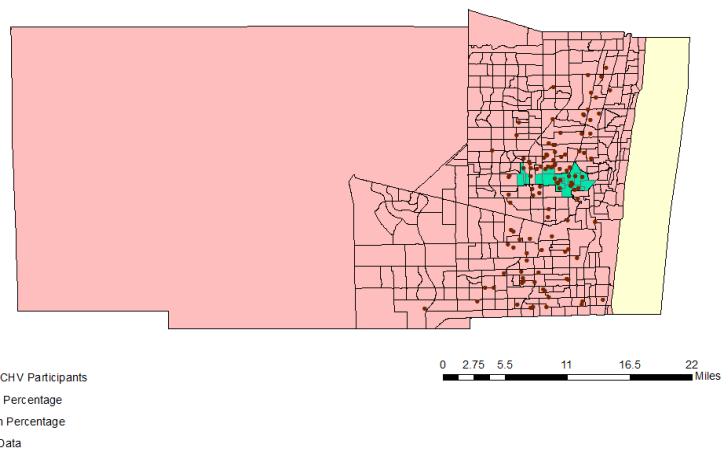
The MIECHV Program staff in Broward County expressed that being able to stay well informed on the needs of the women within their community was a critical strength of their program. The staff found further advantages in providing assistance (e.g., accessible public transportation, Healthy Start services, and prenatal risk screens) through the MIECHV Program to families with high needs who live in rural areas. With regard to the workplace environment, retaining qualified, multi-lingual, knowledgeable, and supportive colleagues were all imperative qualities discussed. Lastly, the NFP staff elaborated on how their program encourages the development of a trusting mentor-friend relationship between the nurse home visitors and the clients at each visit.

"The leveraging of the additional services that these babies can get is probably impressive." – Administrator

"Nurses are not only a trusted profession, but they're very knowledgeable about pregnancy, child development, and all that kind of thing." – Supervisor

"I believe the strength of the program for me, after all that they said, is knowing that every next visit when we have too many of the clients, there's always a change. There's always an improvement on the client quality." – Home Visitor

Broward County MIECHV Participants Mapped at the Census-Tract Level into Two Groups Based on Percentage of Unemployment, No Insurance, and Those Who Live in Poverty at the Census Tract Level



Poverty Definition: Office of Management and Budget Grouping Based on Grouping Analysis Tool of ArcGIS 9.3
High Percentage: Mean (Poverty: 22.2%, No Insurance: 4.9%, and Unemployment: 13.8%)
Low Percentage: Mean (Poverty: 31.3%, No Insurance: 24.7%, and Unemployment: 39.7%)

Author: USF MIECHV Evaluation Team
Sources: Census.gov, American Community Survey (2013)
Date: August 08/24/2015

What do you think are the most important outcomes of the program?

Broward County's MIECHV Program staff stated that the most important outcome of the program was the ability to empower women. One way they instill empowerment is through helping immigrant mothers adapt to and thrive in their new life in the United States. Other crucial outcomes of the program involved building stronger bonds between the mother and her baby, along with reducing the rates of low birthweight and preterm births.

"Well, connecting them with resources that are not available, that they're not aware of in the community..." – Administrator

"To me, it will be big one like for my clients being able to adapt to a new country and to go forward in life." – Home Visitor

What are some outcomes of the program that would be hard to measure?

The Broward County MIECHV Program staff identified themes among participants that were hard to measure, such as self-sufficiency, learning to cope, prioritizing, and taking the opportunity to change their lives. The staff also mentioned how it would be difficult to quantify the desire of the clients wanting to be mothers and wanting the best for their child.

"Hard to measure – is probably the self-efficacy kind of goals because sometimes clients go back to work and school, and then they leave the program." – Supervisor

"Because we are still a new program, sometimes it is difficult to measure like on the cost-effectiveness of the program because we have clients that are diabetic, have high-blood pressure during pregnancy, and they're having a C-section, and they're having NICU babies." – Home Visitor

Phone interviews conducted with Broward County MIECHV Program participants:

What does the home visiting program mean to you and your family?

Generally, most women voiced thanks for the informational support provided. However, the relationships (i.e., emotional support) that participants formed with their home visitors seemed to mean the most to participants.

"For a mother, especially a first time mother, this help is essential."

"They care for the first time mommies for them to be knowledgeable of things that are going on and you know."

"I think it's a really good program and it could help at least in a lot of things, from a lot of bad things from happening down the road."

"It's always good to have someone, a more experienced person to be around that you can actually talk to them, to get you ready, and prepared for what's to come."

"I think it's been really good for me and my family."

"I don't think I would be as knowledgeable as I am about certain things, and that I wouldn't know what to do sometimes."

PARTNER Tool survey 2014-2015 administered with Broward County MIECHV collaborators:

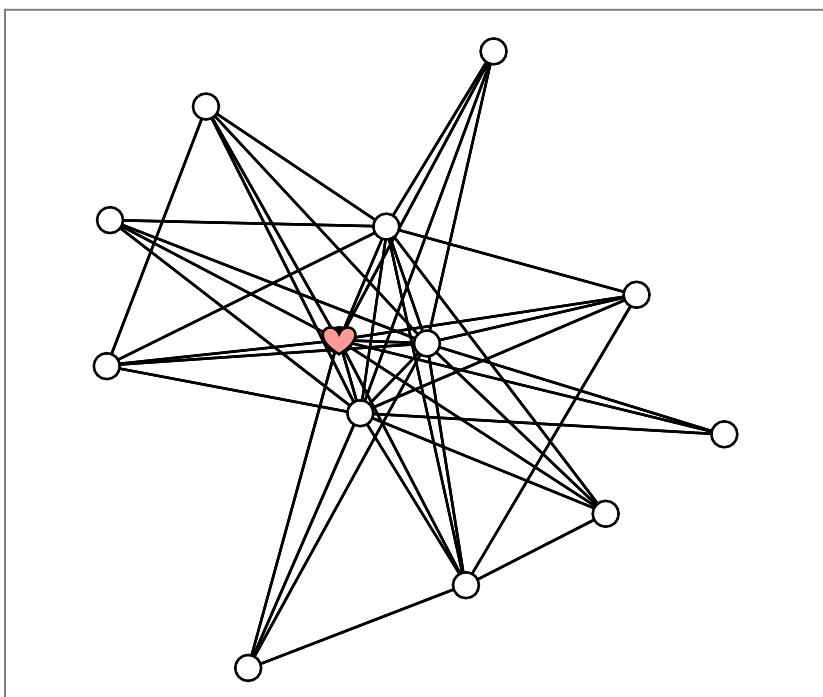
Select the organizations with which you have an established relationship (either formal or informal).

Collaboration among organizations and groups was measured through the Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER Tool) survey completed by community partners and agency representatives. Maps that illustrate the connections between organizations (represented as a dot) in each community were developed from information provided by the respondents. The lines between each organization represent the presence of a relationship based on the responses indicating how frequently the two organizations work together in the context of Nurse-Family Partnership in Broward County.

Time I Survey (Summer 2014)

Number of Participants: 8/13

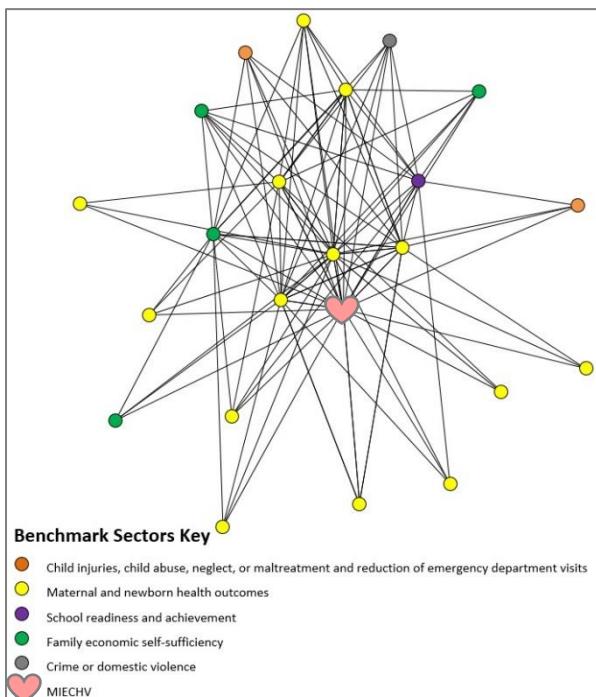
Response Rate: 52.6%



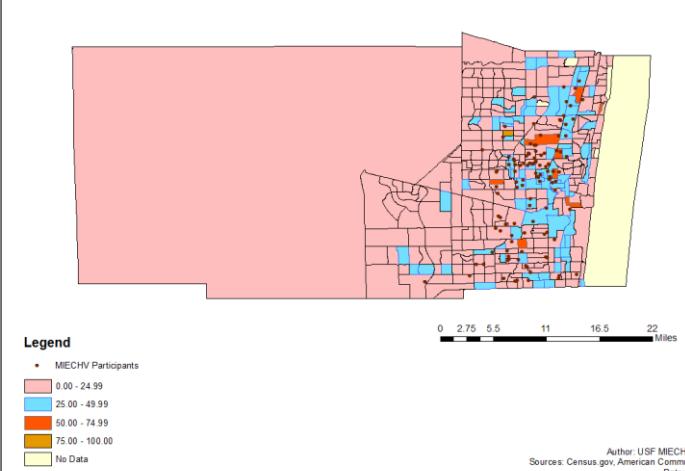
Time II Survey (Summer 2015)

Number of Participants: 13/23

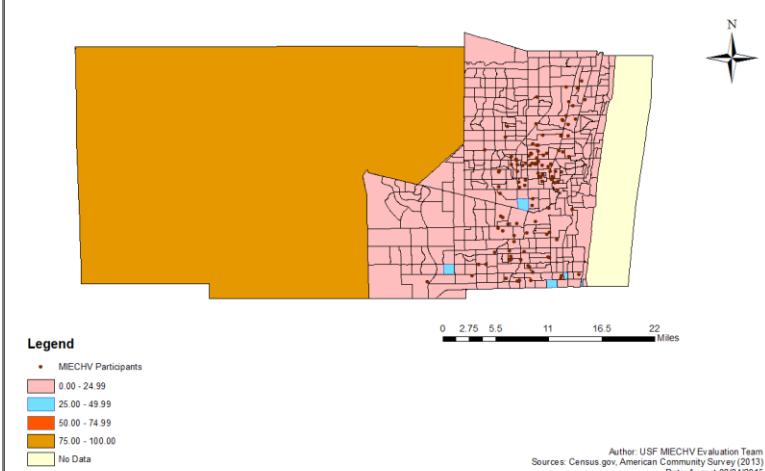
Response Rate: 46.6%



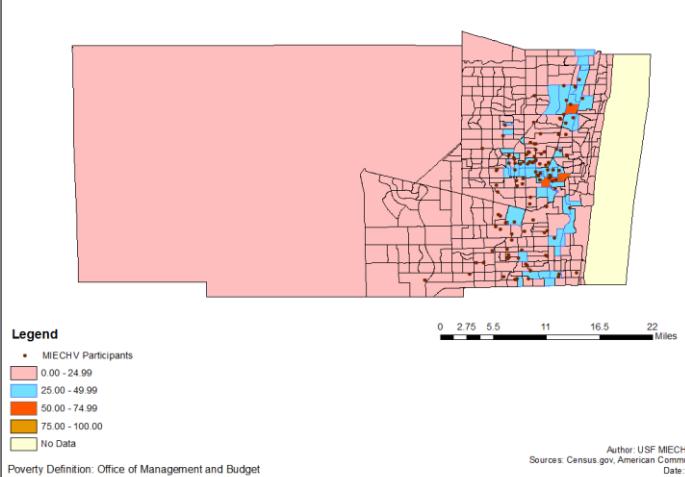
Broward County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Individuals Having Less than High School Education at the Census Tract Level



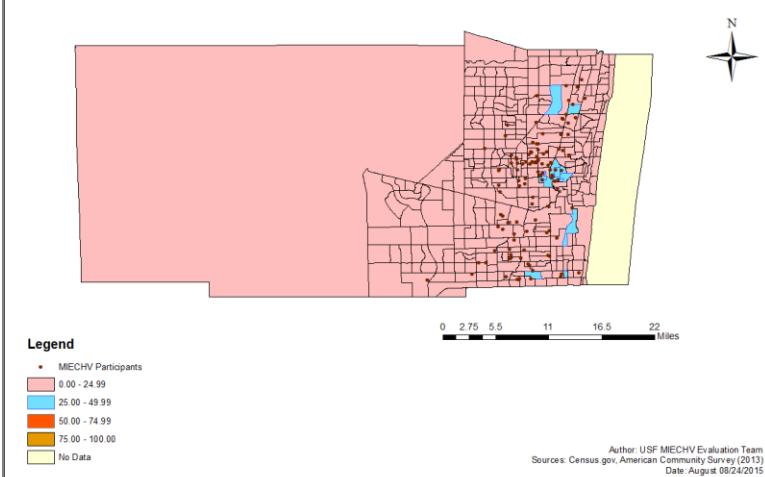
Broward County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Limited English - Speaking Households at the Census Tract Level



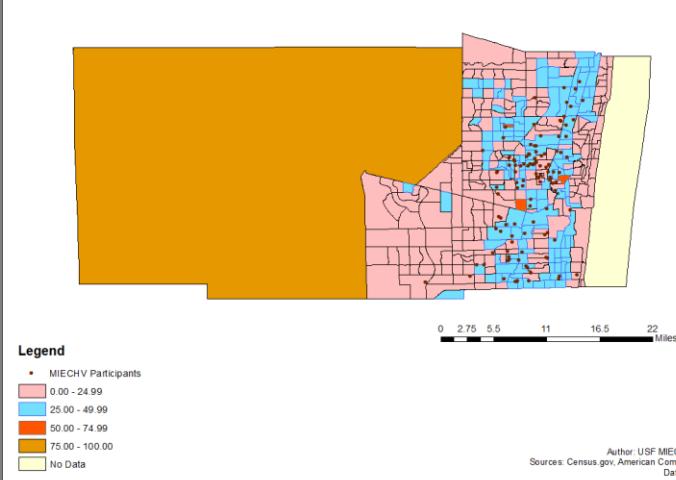
Broward County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Individuals Who Live in Poverty at the Census Tract Level



Broward County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Unemployed Individuals at the Census Tract Level



Broward County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Uninsured Individuals at the Census Tract Level



MIECHV Evaluation Overview

Duval County



Focus groups and interviews conducted with NFP staff in Duval County:

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

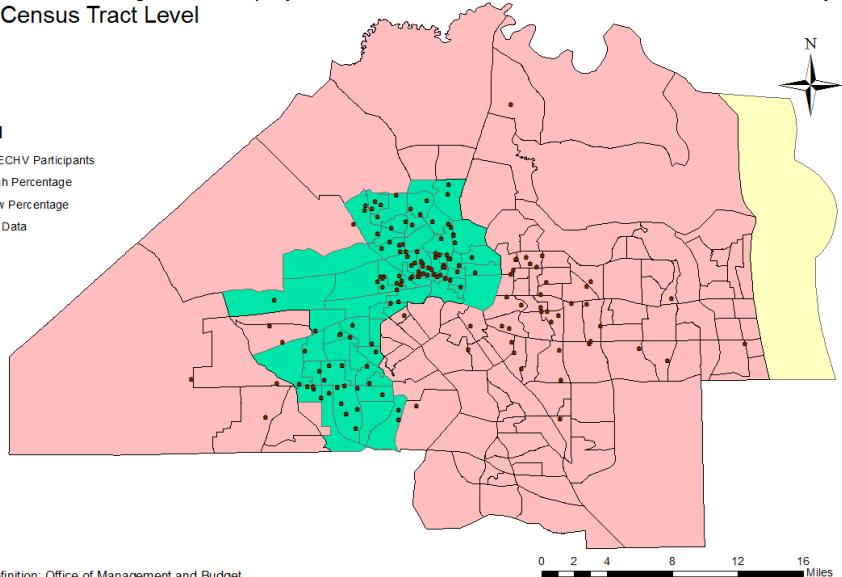
The MIECHV program staff from Duval County expressed that having the ability to retain their staff was a critical strength of their program. Additionally, the NFP staff elaborated on how their nurse home visitors were caring, committed, and invested in each of their clients. Lastly, the staff found further advantages on how the Nurse-Family Partnership curriculum builds on past lessons with each family, therefore encouraging the moms to continue to learn to take care of themselves and their children.

"I think the biggest strength for us, all of us, is the fact that we use the Healthy Start screen as one intake."

"...because of the partnerships that we have in place and the collaboration. The fact that we were able to get to capacity according to the Nurse-Family Partnership model where it's 25 women per nurse."

"I think the longevity of the program allows us to make an impact on the client's outcomes because we're in their homes for at least two and a half years."

Duval County MIECHV Participants Mapped at the Census-Tract Level into Two Groups Based on Percentage of Unemployment, No Insurance, and Those Who Live in Poverty at the Census Tract Level



Poverty Definition: Office of Management and Budget
Grouping Based on Grouping Analysis Tool of ArcGIS 9.3
High Percentage: Mean (Poverty: 31.3%, No Insurance: 24.7%, and Unemployment: 39.7%)
Low Percentage: Mean (Poverty: 22.2%, No Insurance: 11.5%, and Unemployment: 13.8%)

Author: USF MIECHV Evaluation Team
Sources: Census.gov, American Community Survey (2013)
Date: August 08/25/2015

What do you think are the most important outcomes of the program?

Duval County's MIECHV program staff stated that the most important outcome of their program was the ability to empower women. Other crucial outcomes for mothers enrolled in the MIECHV program included attaining self-efficacy and economic sufficiency. The staff also reported getting mothers ready for a healthy pregnancy and helping them develop better family planning practices. Lastly, the nurse home visitors help to strengthen parenting skills, increase family engagement, as well as build stronger bonds between the mother and her baby.

"Trying to increase breastfeeding, for moms to breastfeed."

"A big thing with us is that fatherhood involvement."

"Well even in family goals, like just seeing them graduate, they're very, very proud; and there's lots of fatherhood involvement to incorporating them, and walking across the stage, and then plans for a bigger and better future."

What are some outcomes of the program that would be hard to measure?

Duval County's MIECHV program staff identified themes among participants that were hard to measure, such as quantifying the desire of their clients to want to be better parents. The staff also mentioned how it would be difficult to measure father involvement, the development of healthy family relationships, and early learning through the provision of available books for the children within the NFP program.

"Desire to be a better parent."

"I think family engagement because it goes beyond just the client. Oftentimes, it's grandma, it's the mother."

Phone interviews conducted with Duval County MIECHV program participants:

What does the home visiting program mean to you and your family?

Generally, most women voiced thanks for the informational support provided. However, the relationships (i.e., emotional support) that participants formed with their nurse home visitors seemed to mean the most to participants.

"It means everything. We get to learn. She comes out, and we build our relationship so it's somebody new to introduce my son too that can help him and guide him, I mean – it's my life. I actually look forward to her coming – she comes tomorrow, I'm like so excited."

"A lot. I think that I'd be pretty clueless if I didn't have my nurse..."

"I recommend it to any and everybody, not only just first time moms but even parents that already have kids because I believe that it makes a big difference."

"I really don't know what I would do without her or how to be the parent that I am today, so it really means a lot."

"Exciting. Just that one word sums it all up."

"It just helps me a lot to keep level-headed when she comes every two weeks."

"We can talk and I could talk to her about what I had going on, and she just gives some of her best advice to help me get through what I'm going through."

PARTNER Tool survey 2014-2015 administered with Duval County MIECHV collaborators:

Select the organizations with which you have an established relationship (either formal or informal).

Collaboration among organizations and groups was measured through the Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER Tool) survey completed by community partners and agency representatives. Maps that illustrate the connections between organizations (represented as a dot) in each community were developed from information provided by the respondents. The lines between each organization represent the presence of a relationship based on the responses indicating how frequently the two organizations work together in the context of Nurse-Family Partnership in Duval County.

Time I Survey (Spring 2014)

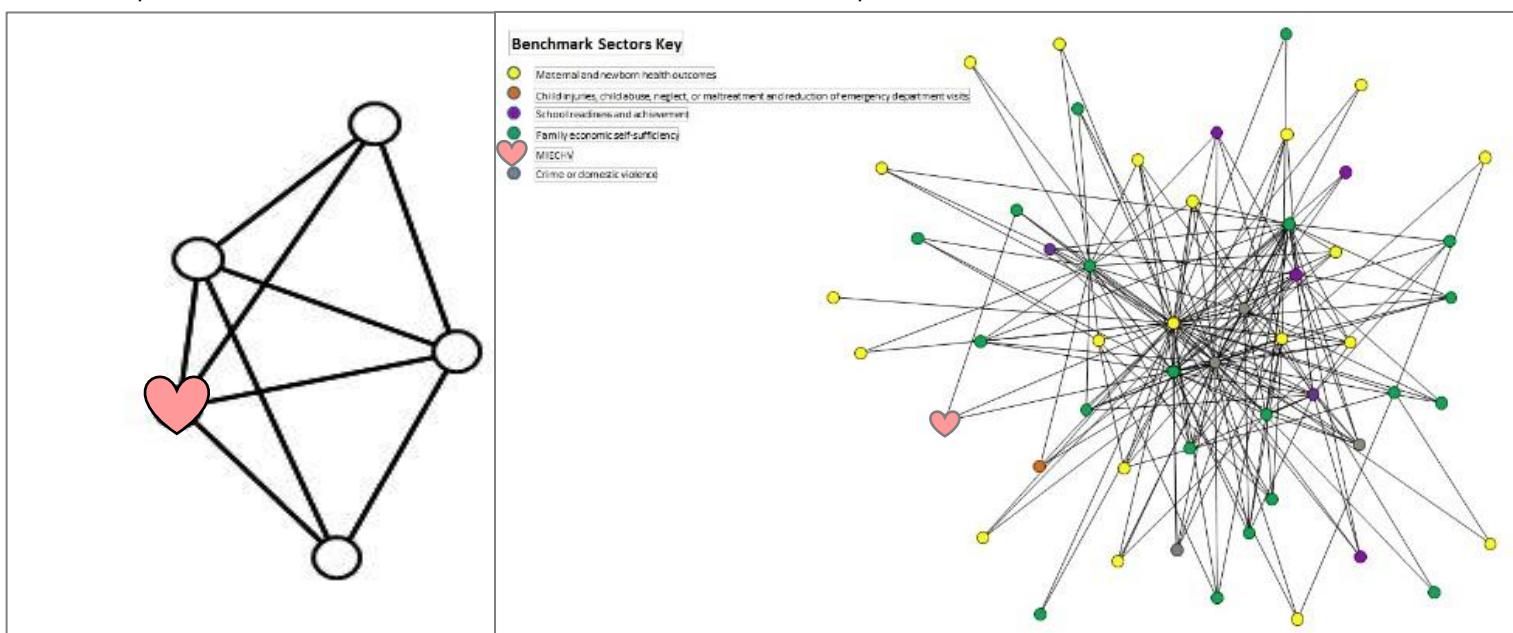
Number of Participants: 5/6

Response Rate: 61.3%

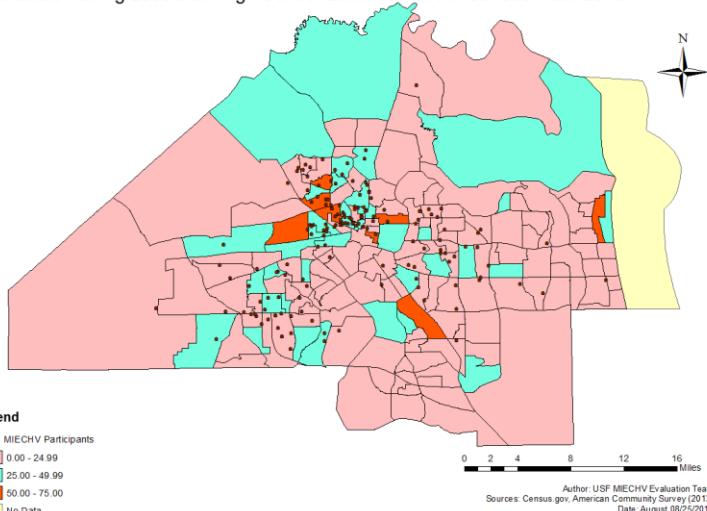
Time II Survey (Summer 2015)

Number of Participants: 26/56

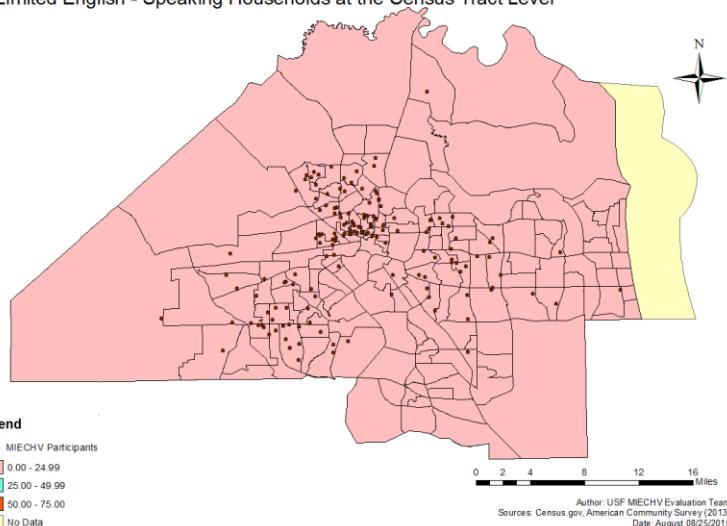
Response Rate: 38.7%



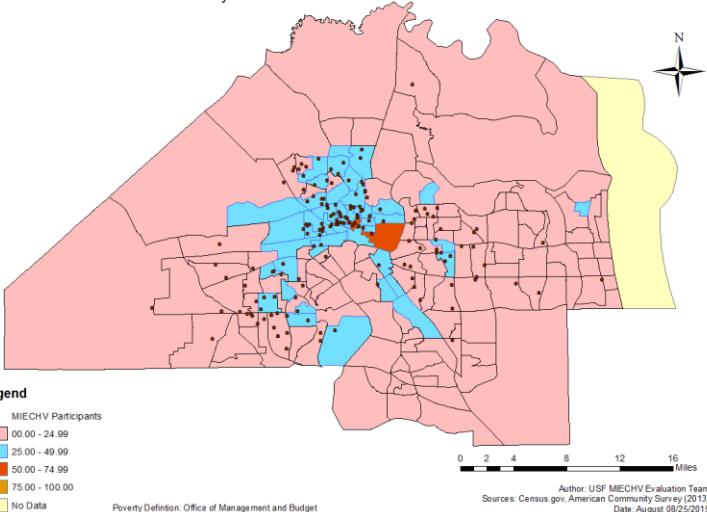
Duval County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Individuals Having Less than High School Education at the Census Tract Level



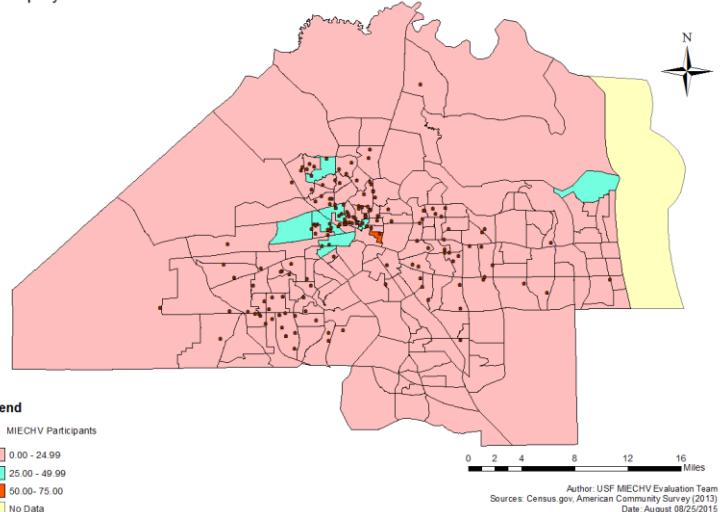
Duval County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Limited English - Speaking Households at the Census Tract Level



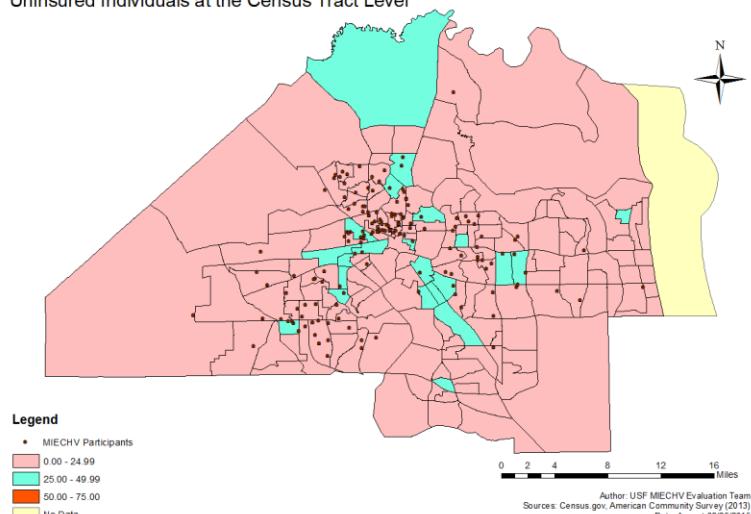
Duval County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Individuals Who Live in Poverty at the Census Tract Level



Duval County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Unemployed Individuals at the Census Tract Level



Duval County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Uninsured Individuals at the Census Tract Level

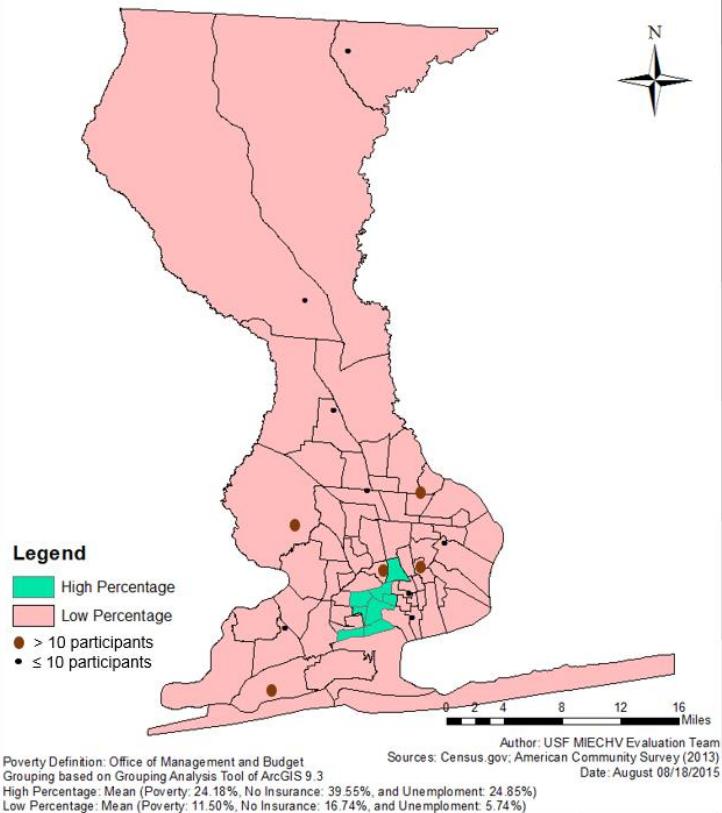


MIECHV Evaluation Overview

Escambia County



Escambia County Participants Mapped at Zip Code Level to Two Groups Based on Census Tract Level Percentage of Unemployment, No Insurance, and Those Who Live in Poverty



Focus groups and interviews conducted with staff:

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

The MIECHV Program staff in Escambia County expressed that the strengths of their program are demonstrated by their shared personal experiences with the MIECHV participants and their ability to retain their employees. The staff also found advantages in being able to provide their community with a prevention program inside of their homes and bringing resources directly to them. Along with offering parents tactics and support to help prevent child abuse, having a larger infrastructure (in place before the program began) allowed for access to a multitude of services and pre-established community partnerships.

"This community has a lot of it. I mean, this is a really poor area, and there are a lot of barriers out there. So, we're working with them so that the bigger view of their life gets better than just subsisting, just existing." – Administrator

"I think the obvious strength is that it's prevention rather than intervention." – Supervisor

"I think being able to be like their cheerleader and a supporter because I think the positive affirmation that they hear from us, they don't necessarily hear from their significant other or their family or their children or people in the community." – Home Visitor

What do you think are the most important outcomes of the program?

Escambia County's MIECHV Program staff stated that the most important outcome of the program was the ability to empower women, as well as prepping them for a healthy pregnancy, building better bonds between the mother and child, and successfully delaying repeat pregnancies. The Healthy Families Florida staff also observed outcomes such as children in safer environments, positive disciplining practices, mental health services for parents, and the availability of disability services for children in need.

What are some outcomes of the program that would be hard to measure?

Escambia County's MIECHV Program staff identified themes among participants that were hard to measure, such as self-sufficiency, learning to cope, prioritizing and taking the opportunity to change their lives, lifestyle stabilization, and building a healthy family relationship. The staff also mentioned psychological outcomes, such as breaking the cycle of generational child abuse and neglect.

"One of the hardest things to measure is the psychological benefits to that child." – Supervisor

"Mental health for the parents, for the mom that's making sure that they are able – have access whether it's through our family specialists or through some community agency about mental health to make sure they're getting those needs met." – Home Visitor

Phone interviews conducted with Escambia County MIECHV Program participants:

What does the home visiting program mean to you and your family?

Generally, most women voiced thanks for the informational support provided. However, the relationships (i.e., emotional support) that participants formed with their home visitors seemed to mean the most to participants.

"I would describe it as very helpful and it's a good program when you're new to being a parent and you don't really know much. I feel like she's very helpful. It will help you out a lot. It will teach you a lot of stuff that you really didn't know or you really wouldn't have thought of."

"I would say it's very helpful. They can involve with you during your pregnancy and after your pregnancy if you choose to do it. I highly recommend it to somebody if they're pregnant, if I know somebody that's pregnant I would recommend them to the person I know that's pregnant."

"They help set and make goals that are reachable."

"She's very understanding and she's helped me a lot with things that I go through with some personal pointers from herself and her own experiences."

"The program has given me the stability that the baby's coming and it's going to be okay."

PARTNER Tool survey 2014-2015:

Select the organizations with which you have an established relationship (either formal or informal).

Collaboration among organizations and groups was measured through the Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER Tool) survey completed by community partners and agency representatives. Maps that illustrate the connections between organizations (represented as a dot) in each community were developed from information provided by the respondents. The lines between each organization represent the presence of a relationship based on the responses indicating how frequently the two organizations work together in the context of 90Works Healthy Families Escambia.

Time I Survey (Spring 2014)

Number of Participants: 11/11

Response Rate: 99.3%

Time II Survey (Summer 2015)

Number of Participants: 11/14

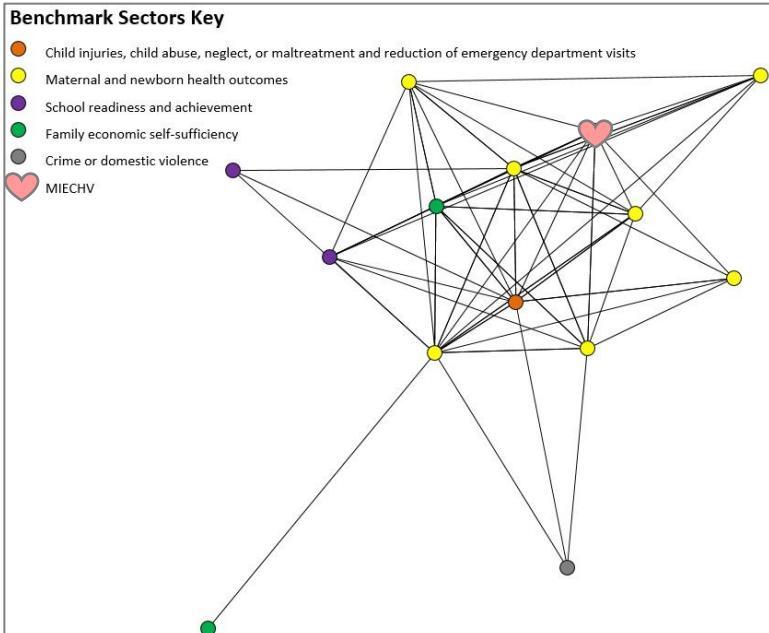
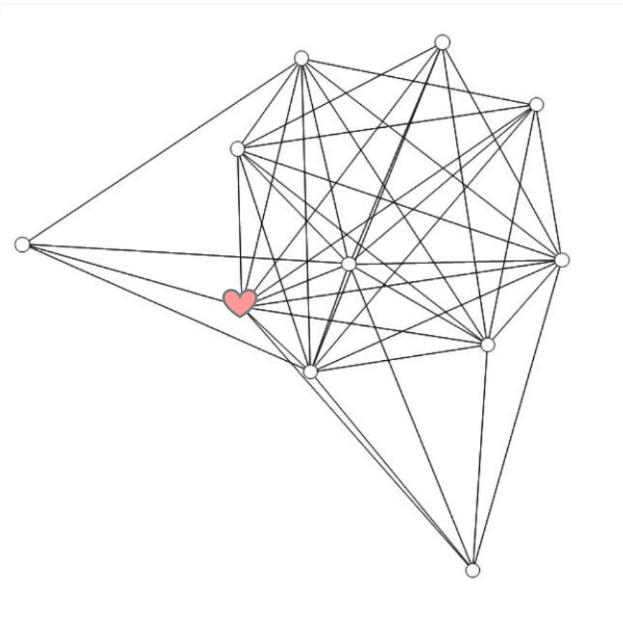
Response Rate:

2015

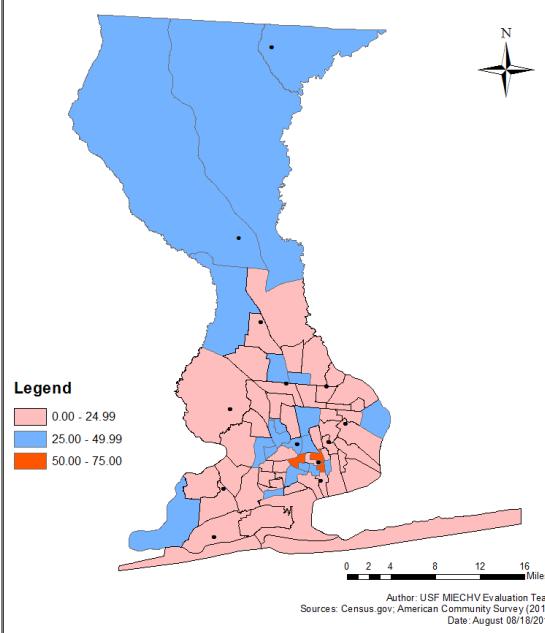
73.5%

Benchmark Sectors Key

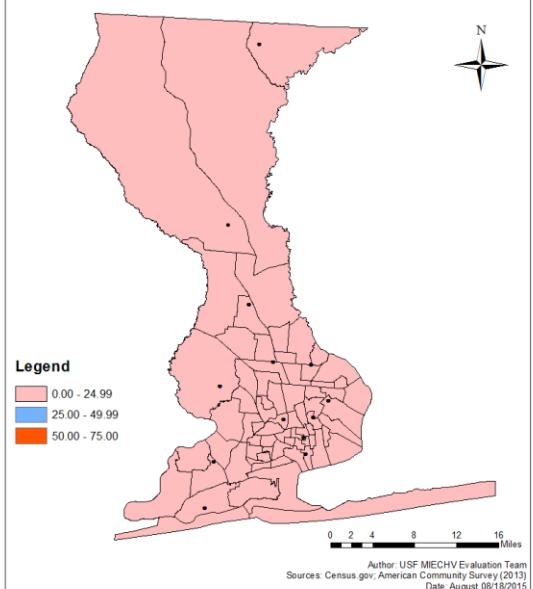
- Child injuries, child abuse, neglect, or maltreatment and reduction of emergency department visits
- Maternal and newborn health outcomes
- School readiness and achievement
- Family economic self-sufficiency
- Crime or domestic violence
- MIECHV



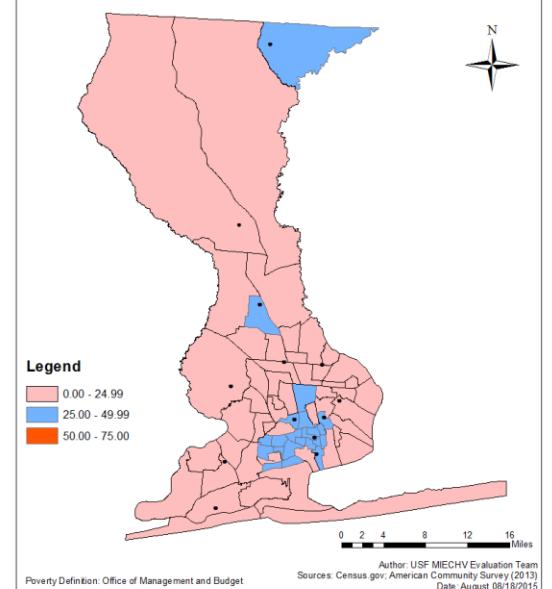
Escambia County Participants Mapped at Zip Code Level to Percentage of Individuals with Less than High School Education at the Census Tract Level



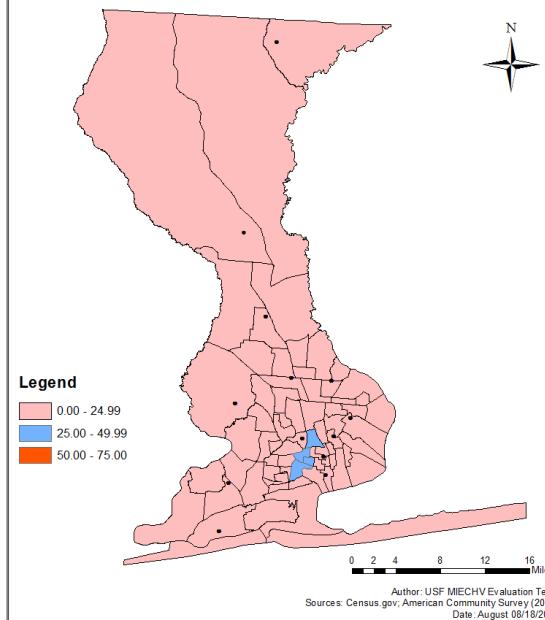
Escambia County Participants Mapped at Zip Code Level to Percentage of Limited English Speaking Households at the Census Tract Level



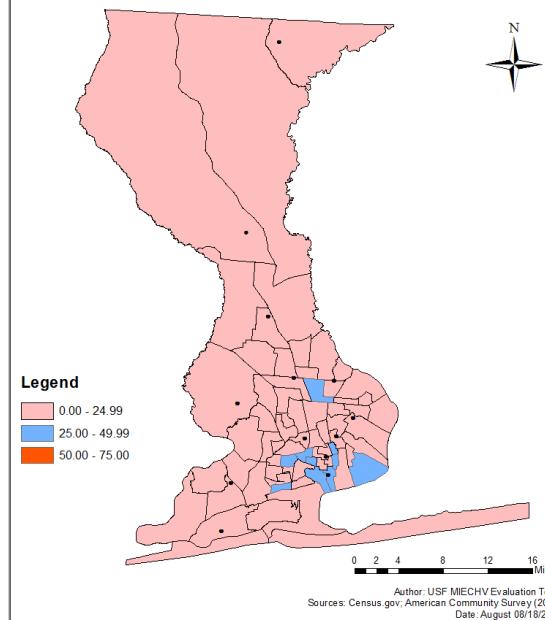
Escambia County Participants Mapped at Zip Code Level to Percentage of Individuals Living in Poverty at the Census Tract Level



Escambia County Participants Mapped at Zip Code Level to Percentage of Unemployment at the Census Tract Level



Escambia County Participants Mapped at Zip Code Level to Percentage of Individuals with No Insurance at the Census Tract Level



MIECHV Evaluation Overview

Hillsborough County



Focus groups and interviews conducted with NFP staff in Hillsborough County:

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

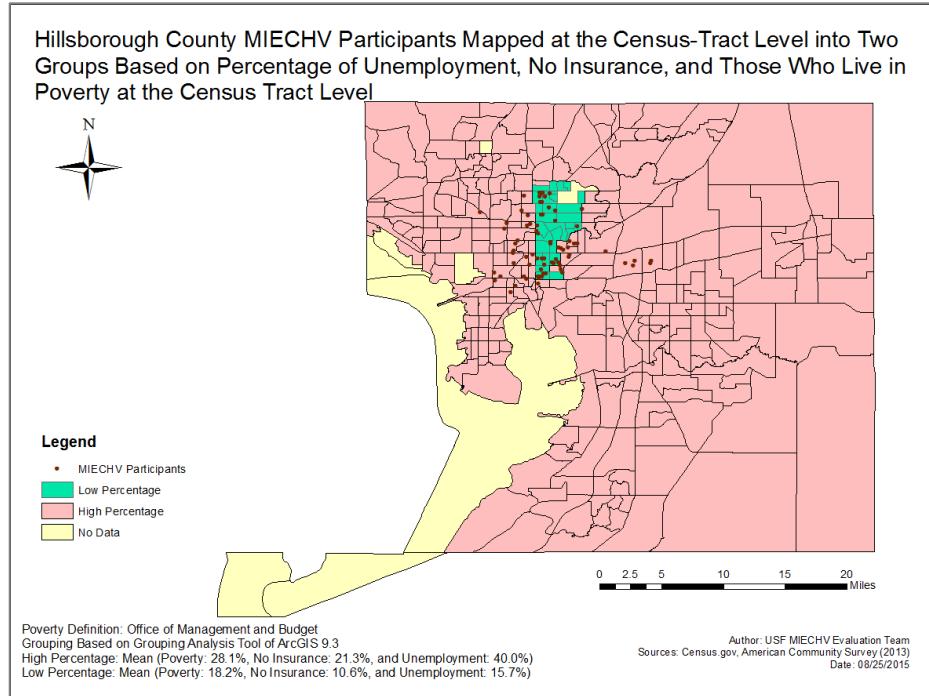
The MIECHV program staff from Hillsborough County expressed that being ingrained in the community, as opposed to in a hospital, was a critical strength of their program. The NFP staff further elaborated on the strength of having an evidence-based program, as well as having powerful community partnerships. Ultimately the NFP staff found it advantageous to have a NFP curriculum that enables nurse home visitors to provide numerous types of support, professional guidance, and a nurturing friendship with the families.

"Wow, biggest strength. It is evidence-based. It has got a proven track record by virtue of the three randomized controlled trials that David Olds conducted."

"That we can change some women lives, family, and have better outcome with their children."

"We are their mentors, educators, social support because we can also give some referrals, and we have a liaison within the community."

"I truly think it's how strong our community is and with maternal child health issues we, through Healthy Start Coalition, they've always chaired the Plan Development Committee, you know, our partnership committee, and we just have real strong community partners who've come to the table."



What do you think are the most important outcomes of the program?

Hillsborough County's MIECHV program staff stated a number of important outcomes of their program including the ability to empower women, teach self-sufficiency, and encourage responsible parenting practices. The staff also voiced how getting mothers ready for a healthy pregnancy was crucial, being that the goals of the program include helping women reach full-term birth and decreasing infant mortality rates. Other noteworthy outcomes for mothers enrolled in the MIECHV program included building stronger bonds between the mother and her baby and strengthening parenting skills, the latter of which can help with stress reduction.

"I think the self-sufficiency part, I really compare it to my family and our parents being born in a depression and all the programs that the government had to really improve the lives of so many Americans."

"...to teach them and simulate how to motivate a child to learn because their brains are growing."

"I think your outcome data would be clearer if you were also looking at the structure of the family."

What are some outcomes of the program that would be hard to measure?

Hillsborough County's MIECHV program staff identified themes among participants that were hard to measure, such as quantifying the desire of their clients to become self-sufficient. The staff also mentioned how it would be difficult to measure what impact the Nurse-Family Partnership program has on positive pregnancy outcomes.

"Self-sufficiency, a Healthy baby, a bonded child that feels secure for future relationships."

Phone interviews conducted with Hillsborough County MIECHV program participants:

What does the home visiting program mean to you and your family?

Generally, most women voiced thanks for the informational support provided. However, the relationships (i.e., emotional support) that participants formed with their nurse home visitors seemed to mean the most.

"I would say it was very, very informative for me. Especially being a first time mom, not knowing what to expect."

"Honestly, it's one of those things where you know that you're not alone, and you always have somebody there to look out for you and help you in any situations."

"It means to support us and help choose better decisions in life and think positive about things."

PARTNER Tool survey 2014-2015 administered with Hillsborough MIECHV collaborators:

Select the organizations with which you have an established relationship (either formal or informal).

Collaboration among organizations and groups was measured through the Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER Tool) survey completed by community partners and agency representatives. Maps that illustrate the connections between organizations (represented as a dot) in each community were developed from information provided by the respondents. The lines between each organization represent the presence of a relationship based on the responses indicating how frequently the two organizations work together in the context of Nurse-Family Partnership in Hillsborough County.

Time I Survey (Summer 2014)

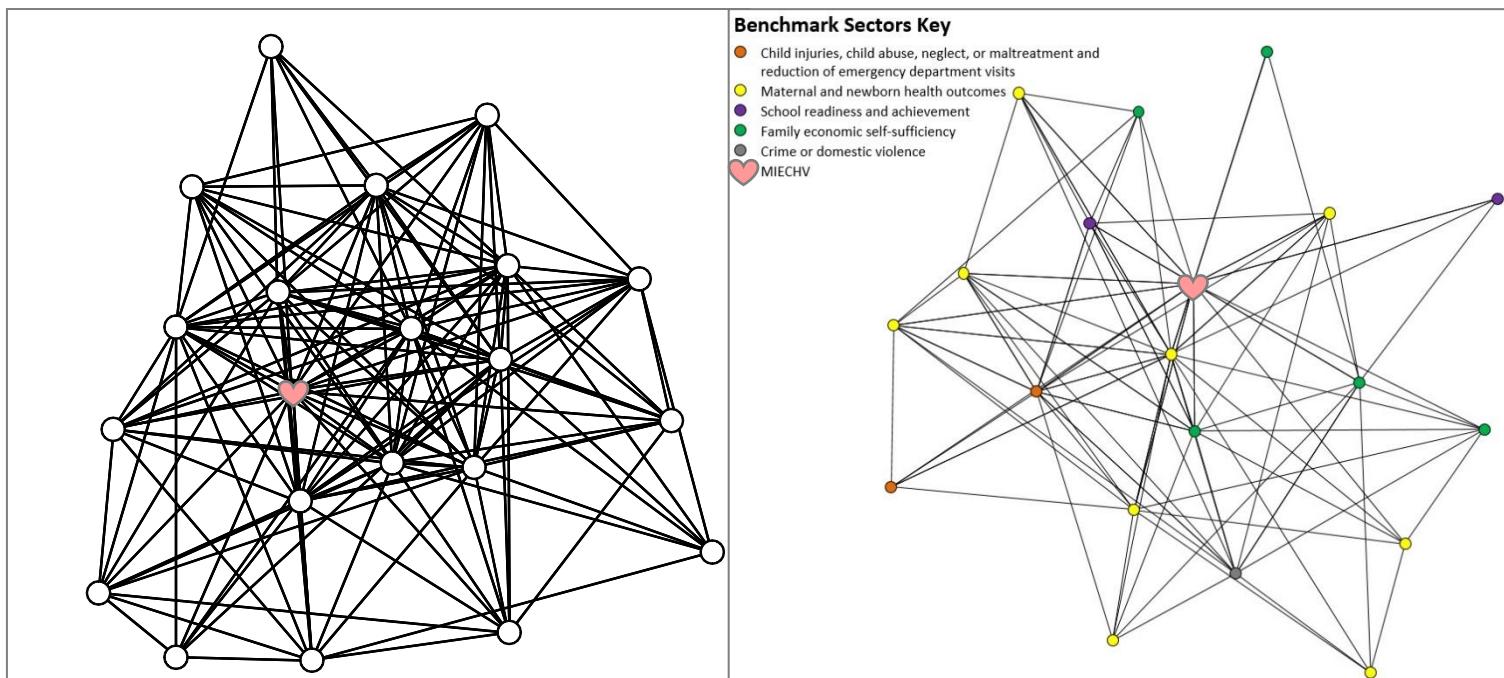
Number of Participants: 20/21

Response Rate: 89.5%

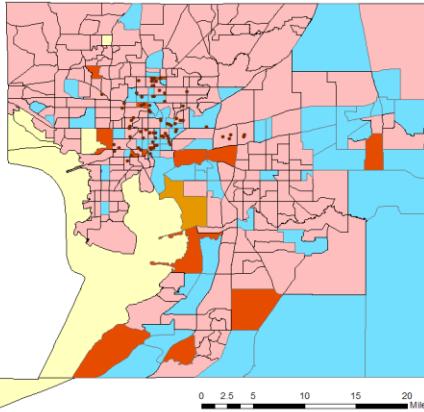
Time II Survey (Summer 2015)

Number of Participants: 19/20

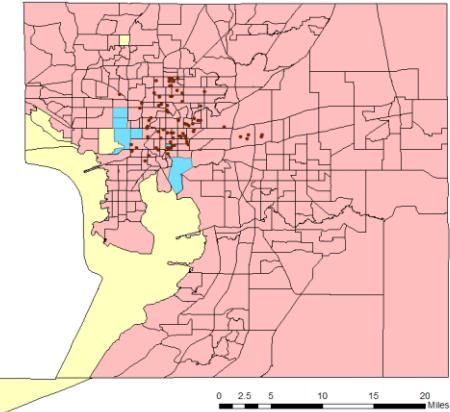
Response Rate: 83.0%



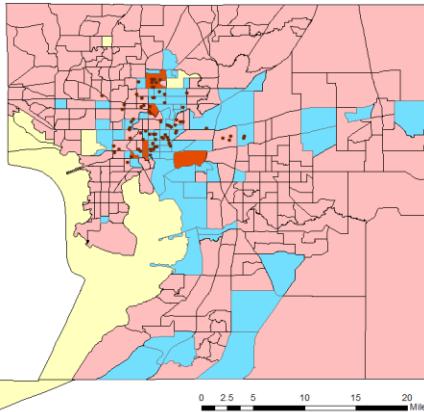
Hillsborough County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Individuals Having Less than High School Education at the Census Tract Level



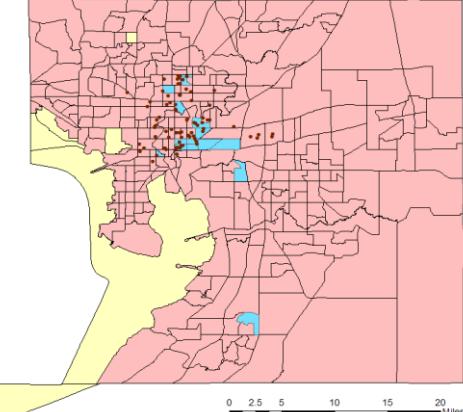
Hillsborough County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Limited English - Speaking Households at the Census Tract Level



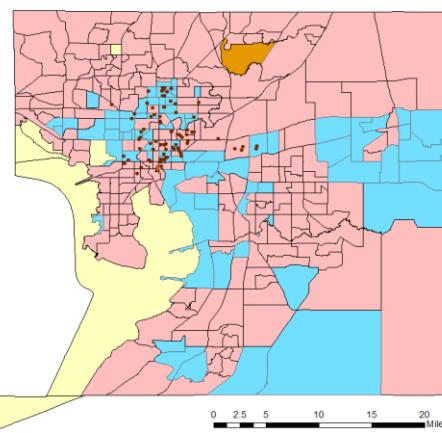
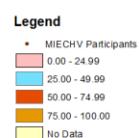
Hillsborough County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Individuals Who Live in Poverty at the Census Tract Level



Hillsborough County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Unemployed Individuals at the Census Tract Level



Hillsborough County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Uninsured Individuals at the Census Tract Level



MIECHV Evaluation Overview

Manatee County



Focus groups and interviews conducted with PAT Program staff in Manatee County:

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

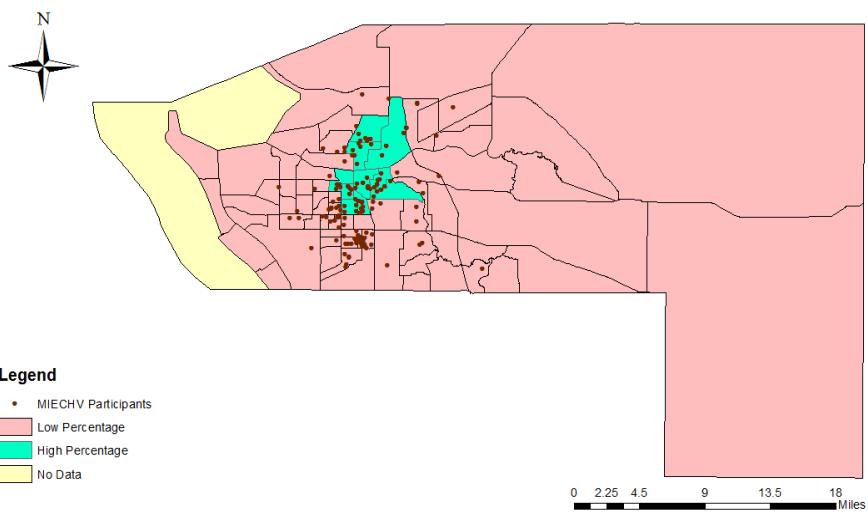
The MIECHV Program staff in Manatee County expressed that their well-educated, bilingual, and experienced parent educators were a critical strength of their program. The staff found further advantages in the skillset of the parent educators in directly providing their PAT Program participants with necessary resources. Said resources are what the PAT Program emphasized as a final strength, specifically how their program represents an avenue to access a vast amount of available resources in the community that their clients may not have otherwise been aware of.

"The PAT program funded by MIECHV really filled in that gap in the population that we could not serve."

"Definitely my staff. They have a lot of experience. Even though we only require a bachelor level, we have four masters, three bachelors."

"I think the resources is going to be in this one the biggest thing with this program; except that the people look for more than anything is resources where they can get food, where they can get clothing, homes, housing assistance, things like that."

Manatee County MIECHV Participants Mapped at the Census-Tract Level into Two Groups Based on Percentage of Unemployment, No Insurance, and Those Who Live in Poverty at the Census Tract Level



What do you think are the most important outcomes of the program?

Manatee County's MIECHV Program staff stated a number of important outcomes of the program including learning self-sufficiency, independence, and self-empowerment. They also reported changes in lifestyle and household environment, early intervention in developmental delays, and school readiness. Other crucial outcomes of the program involved building stronger bonds between the mother and her baby, along with the mothers learning how to go out and get information and different forms of support on their own.

"Improved communication among agencies and organizations interested in the health..."

What are some outcomes of the program that would be hard to measure?

The Manatee County MIECHV Program staff identified themes among participants that were difficult to measure, such as participant and community integration, mother and baby bonding, and life skill progressions. The staff also mentioned how it would be difficult to quantify outcomes that would not be apparent until after the two years of home visiting has come to an end.

"Some of the life skills progression things, some things that are not two years and – some things are never going to be achievable for some of our parents. They're undocumented, they don't speak English..."

"Taking the information that was given to them and them making the changes in their lifestyles and their household because we gave them that information and trying to make that change for their child or for their home."

Phone interviews conducted with Manatee County MIECHV Program participants:

What does the home visiting program mean to you and your family?

Manatee County MIECHV Program participants noted that some of them were first time parents and having this program and support was absolutely essential to surviving. They also mentioned the importance of having the support for their other children in the household, helping with assimilation into their new environments, learning to interact properly and positively with their children, learning new things about parenting that have changed since having earlier children, and even being able to have a place to live and the resources necessary to take care of their families.

"A very essential and important help."

"I don't even want to imagine what we would be without it, like we might be homeless right now."

"I see it as the future of my daughters."

"I think it's very good because sometimes when you're not from here, you need help to know how to do things here. You need someone to explain things to you."

PARTNER Tool survey 2014-2015 administered with Manatee County PAT Program collaborators:

Select the organizations with which you have an established relationship (either formal or informal).

Collaboration among organizations and groups was measured through the Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER Tool) survey completed by community partners and agency representatives. Maps that illustrate the connections between organizations (represented as a dot) in each community were developed from information provided by the respondents. The lines between each organization represent the presence of a relationship based on the responses indicating how frequently the two organizations work together in the context of Manatee Community Action Agency's Parents as Teachers Program.

Time I Survey (Summer 2014)

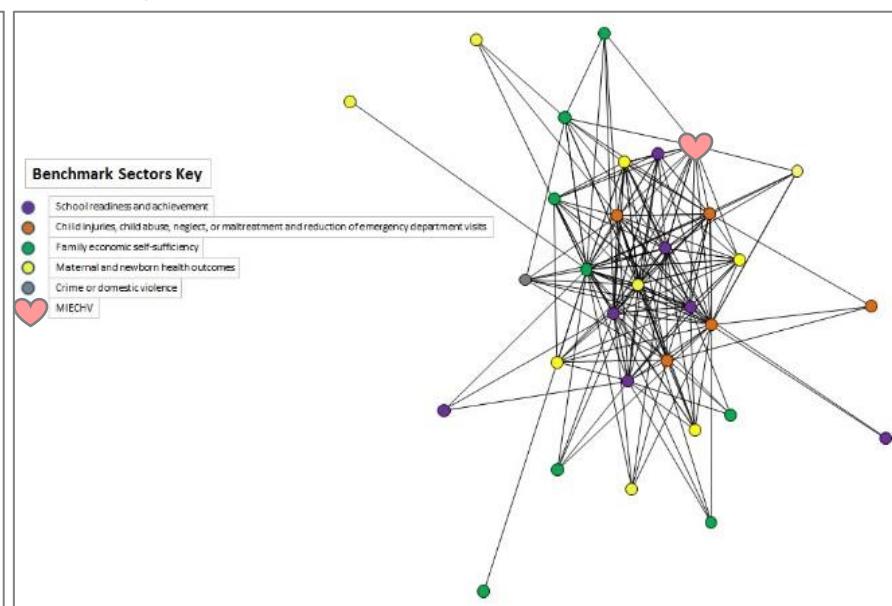
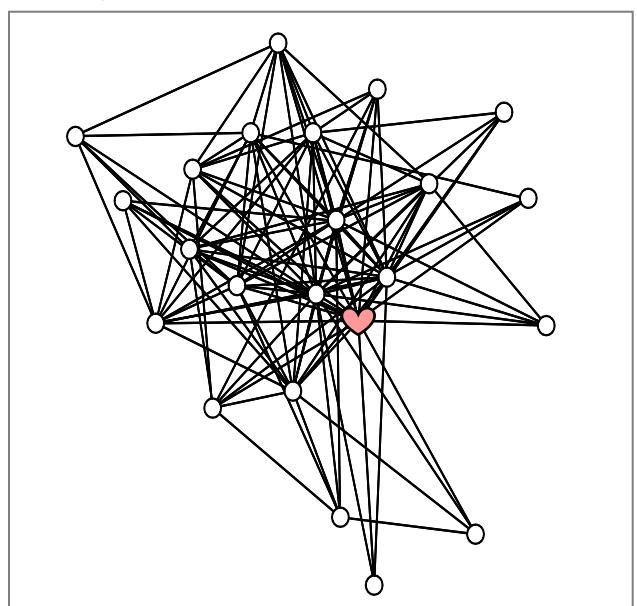
Number of Participants: 17/23

Response Rate: 65.5%

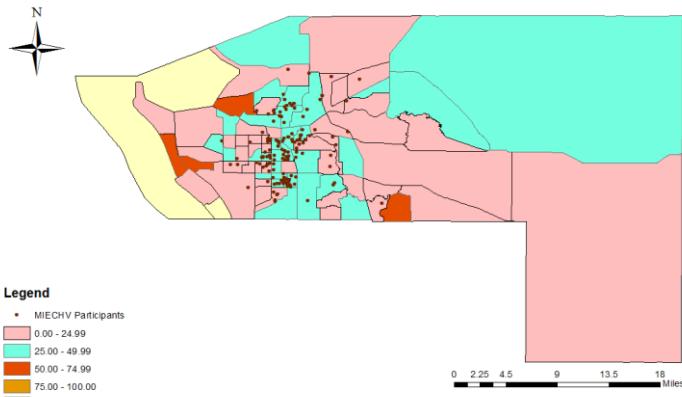
Time II Survey (Summer 2015)

Number of Participants: 20/31

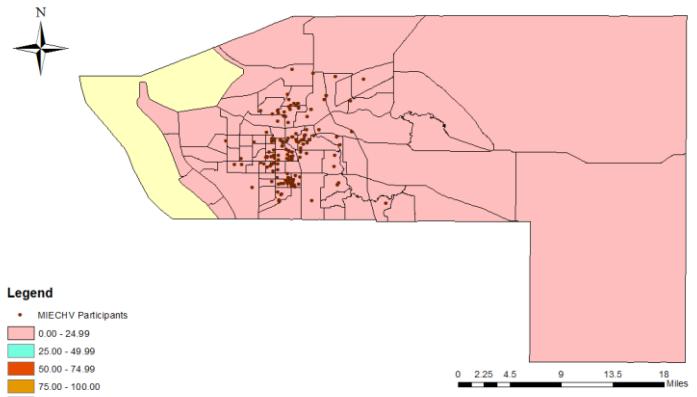
Response Rate: 50.2%



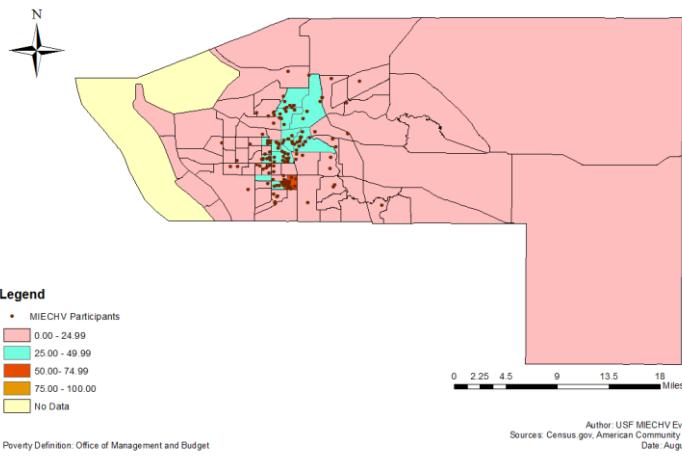
Manatee County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Individuals Having Less than High School Education at the Census Tract Level



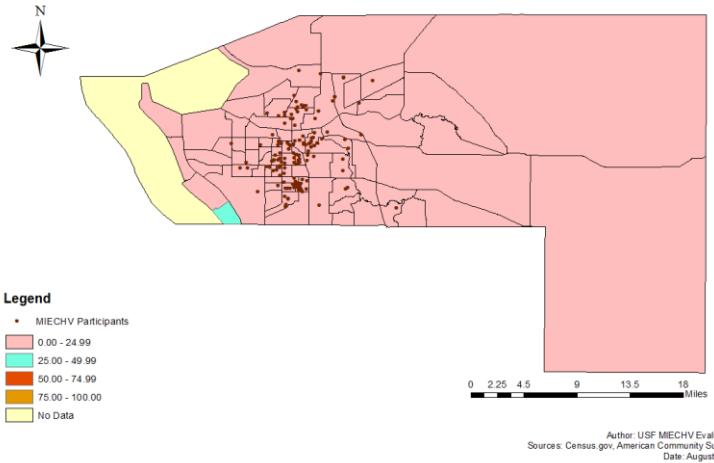
Manatee County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Limited English - Speaking Households at the Census Tract Level



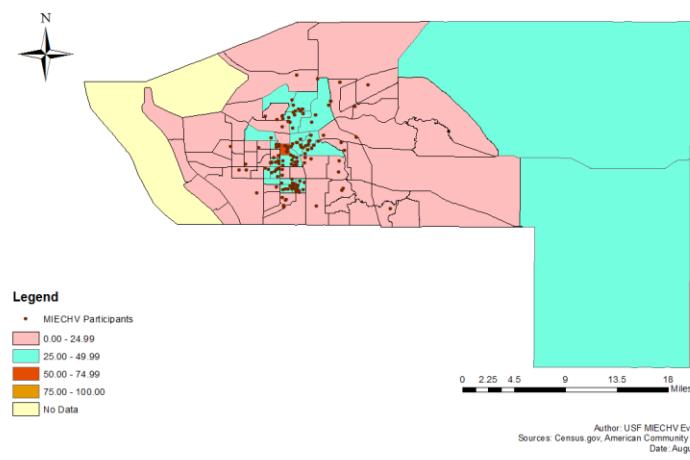
Manatee County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Individuals Who Live in Poverty at the Census Tract Level



Manatee County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Unemployed Individuals at the Census Tract Level



Manatee County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Uninsured Individuals at the Census Tract Level

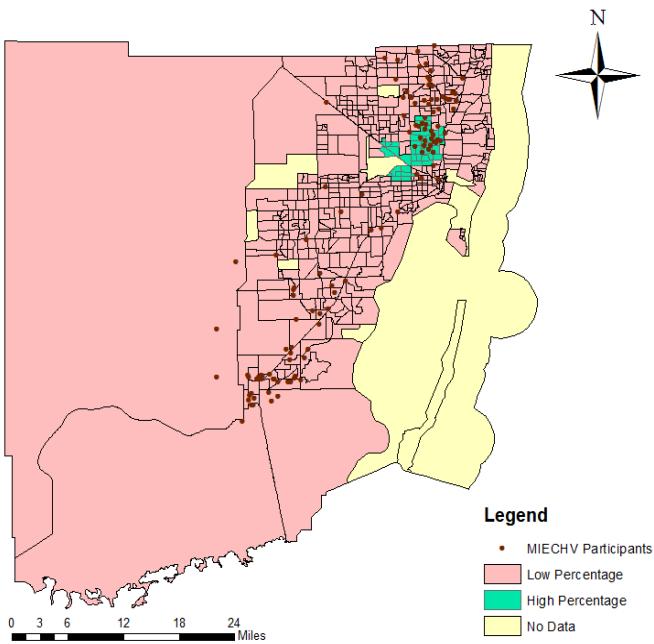


MIECHV Evaluation Overview

Miami-Dade County



Miami - Dade County MIECHV Participants Mapped at the Census-Tract Level to Two Groups Based on Percentage of Unemployment, No Insurance, and Those Who Live in Poverty at the Census Tract Level



Author: USF MIECHV Evaluation Team
Sources: Census.gov, American Community Survey (2013)
Date: August 08/25/2015

Poverty Definition: Office of Management and Budget
Grouping Based on Grouping Analysis Tool of ArcGIS 9.3

High Percentage: Mean (Poverty: 37.1%, No Insurance: 20.5%, and Unemployment: 38.6%)

Low Percentage: Mean (Poverty: 28.6%, No Insurance: 11.2%, and Unemployment: 18.8%)

Focus groups and interviews conducted with NFPAMD staff:

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

The MIECHV Program staff in Miami-Dade County were asked to identify the biggest strengths of their program. They noted the length of the program, as well as the strong internal communication and support with colleagues as powerful aspects not only for their clients but for their working environment. Along with being able to hold meetings and share information with each other, the staff found additional strength in the manner in which their team collaborates together and their ability to implement the Nurse-Family Partnership model.

"I think the fact that our RNs are part of Federally Qualified Health Centers, and therefore are linked to OB practices, makes a huge difference."

"I think we have like a really strong bond between all of us. Like the nurses that are there and myself, we communicate really well."

"...I would say the continuity of seeing that person every week or every other week, and see how they grow."

What do you think are the most important outcomes of the program?

Miami-Dade County's MIECHV Program staff stated that the most important outcomes of the program included the participants and home visitors accomplishing the goals that were made at the first home visits and the program's positive impact on child development. The NFPAMD staff also elaborated on critical outcomes, such as improvement in mother-and-baby interactions and the self-efficacy of participants.

"That I can accomplish what I promised them the first day that I saw them."

What are some outcomes of the program that would be hard to measure?

The Miami-Dade County's MIECHV Program staff were asked to think of any intangible benefits received as a result of the program. Staff members mentioned how it would be difficult to quantify the participants' feelings towards their home visitor, emphasizing the strength of the bond formed between the two parties.

"I guess how some of the mothers might feel about their relationships with their nurse home visitor, sometimes that is subjective rather than objective."

Phone interviews conducted with Miami-Dade County MIECHV Program participants:

What does the home visiting program mean to you and your family?

In general, NFPAMD participants expressed their appreciation and affinity for the Miami-Dade MIECHV Program. They also stated that they valued being able to gain knowledge from the visits, as well as have support and information provided to them.

"It means a lot. It means a lot and still does due to the fact of, you know, having a baby and the support, because I feel like have more support not just from my family but with the program and the home worker herself."

"I would say it means support and just knowledge. It's a lot of things that I didn't know since this is my first child, so very knowledgeable."

"That's a huge help."

PARTNER Tool survey 2014-2015 administered with NFPAMD collaborators:

Select the organizations with which you have an established relationship (either formal or informal).

Collaboration among organizations and groups was measured through the Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER Tool) survey completed by community partners and agency representatives. Maps that illustrate the connections between organizations (represented as a dot) in each community were developed from information provided by the respondents. The lines between each organization represent the presence of a relationship based on the responses indicating how frequently the two organizations work together in the context of NFPAMD.

Time I Survey (Summer 2014)

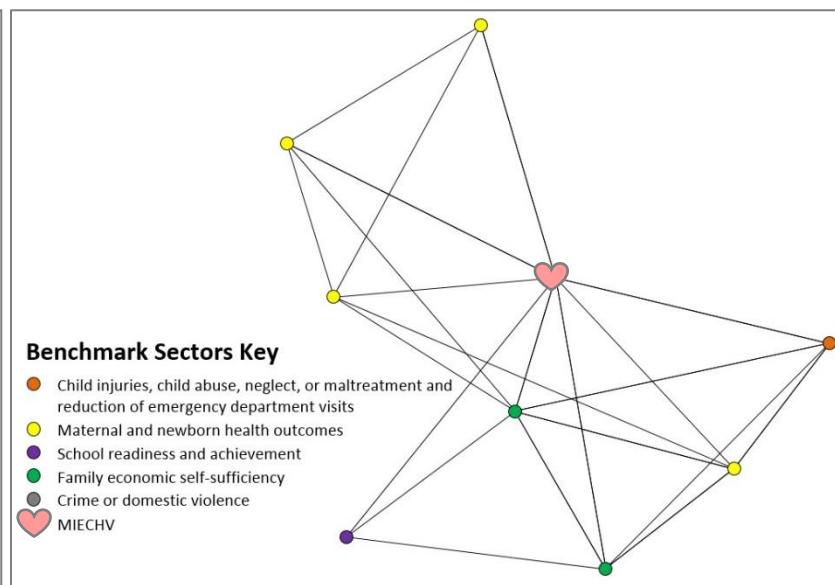
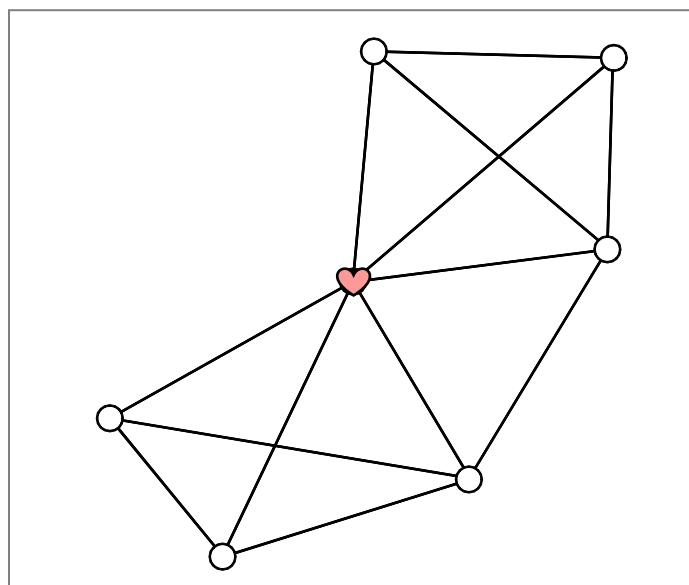
Number of Participants: 6/7

Response Rate: 85.7%

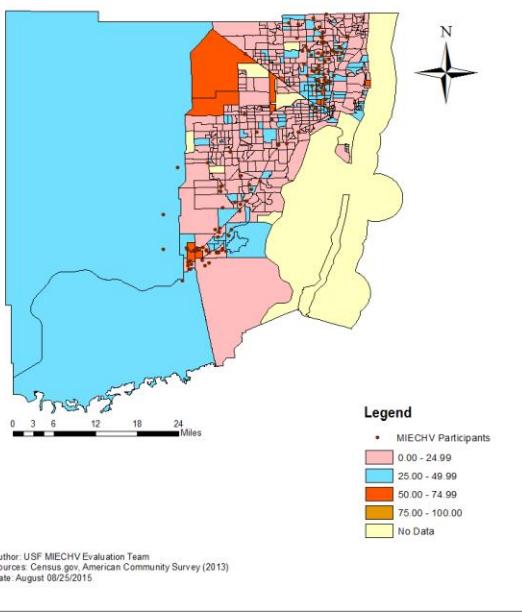
Time II Survey (Summer 2015)

Number of Participants: 8/9

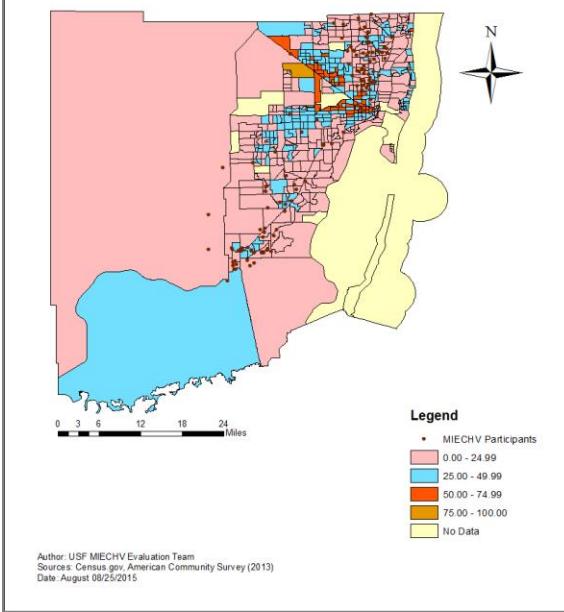
Response Rate: 86.4%



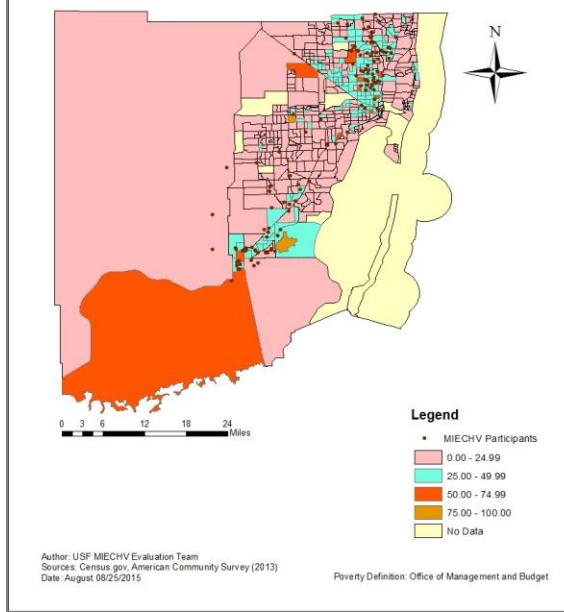
Miami -Dade County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Individuals Having Less than High School Education at the Census Tract Level



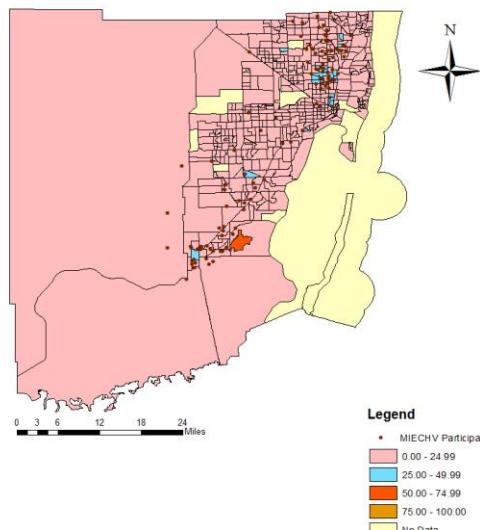
Miami - Dade MIECHV Participants Mapped at the Census Tract Level to Percentage of Limited English - Speaking Households at the Census Tract Level



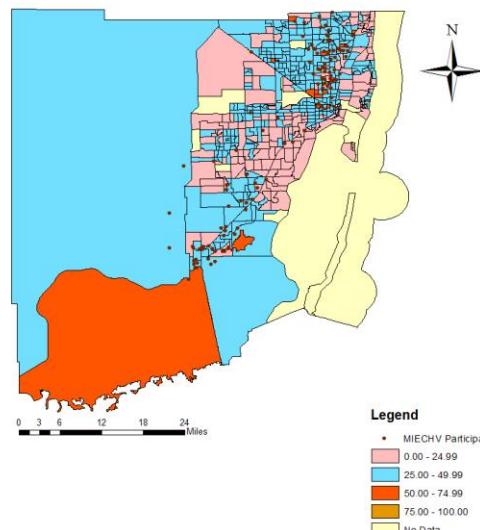
Miami-Dade County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Individuals Who Live in Poverty at the Census Tract Level



Miami - Dade County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Unemployed Individuals at the Census Tract Level



Miami -Dade County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Uninsured Individuals at the Census Tract Level



MIECHV Evaluation Overview

North Central Florida Counties



Focus groups and interviews conducted with PAT program staff in North Central Florida Counties:

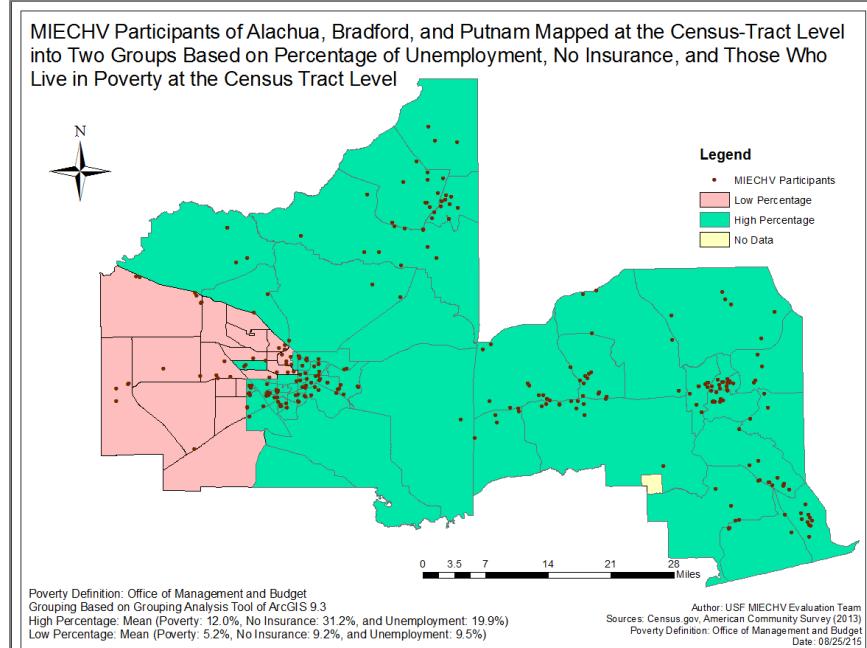
What do you consider the biggest strength(s) of your program?

The MIECHV program staff from three North Central Florida Counties expressed that they encompassed the ability to provide services to families who live in rural counties where transportation is limited and need is high. The PAT staff talked about their strengths of implementing an evidence-based program, building comfortable and more receptive relationships with their clients in their homes, and being able to dedicate as much time to a family as needed. Additionally, they found further advantages from the previous implementation of Healthy Start in the community and the connections that made it smoother for the MIECHV program to be implemented. Lastly, the PAT staff elaborated on the program's community- and family-based focus, as well as its ability for client engagement and retention.

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

"I would say the biggest strength – is that it's community-based and that it is family-focused."

"Just the building a rapport and building the trust so that they will disclose information they might not otherwise do, I think it's really a big strength because you're there and you're talking."



What do you think are the most important outcomes of the program?

North Central Florida Counties' MIECHV program staff stated that the most important outcome of their program was giving their clients the opportunity to change their lives around. Other crucial outcomes as a result of program implementation were improvements in reaching developmental milestones, school readiness, as well as receiving healthcare. Of additional importance, the PAT program staff reported children removed from abusive situations and the cessation of repeat teen births. Also, the staff expanded on how their program contributes to the empowerment of women, as well as getting mothers ready for a healthy pregnancy and helping them build stronger bonds between the mother and her baby. Lastly, the staff elaborated on the prevention of child abuse and injuries and families entering into the welfare system. The parent educators help the families to strengthen child engagement, learn family planning practices, as well as attain self-sufficiency, independence, and self-worth.

"They have so many negatives and people saying, 'You can't. You can't. You can't.' To have somebody come in and say, 'You can,' that builds their self-esteem."

"If the right person is meeting with them for the first visit and they connect with them, it could change their life forever."

"I mean, I think just like how much they learned or how much they've changed."

What are some outcomes of the program that would be hard to measure?

North Central Florida Counties' MIECHV program staff identified themes among participants that were intangible, such as measuring how they become self-efficient, learn to cope, prioritize, and take the opportunity to change their lives. The staff also mentioned that another immeasurable benefit of the PAT program was how it allowed participants to stabilize their lifestyle, which better enables them to build a healthy family relationship and decrease stress levels moving forward.

"Decreasing the stress..."

"The level of support that they got."

Phone interviews conducted with Alachua County MIECHV program participants:

What does the home visiting program mean to you and your family?

The North Central Florida MIECHV participants noted the importance of being able to have information about the different ways to interact with their children. They also mentioned the positive impact of the PAT program in providing the personal aspect of the home visits and close relationships with their parent educators, as well as getting other family members involved and being able to build a connection with their babies. Lastly, the MIECHV participants also stated that some of them were first time moms and having this program, gaining knowledge about their child's development, and receiving extra support or any support at all was essential to surviving.

"I like that they're very personal, like she gets to know our family and comes in and I can just talk to her and I can say whatever, a kid's name and she's not like, 'Oh, who are you?'"

"Extra support. Not like money support but extra moral support and maybe – I don't know a better word to say it, but like knowledge support."

"Like I told the one who comes here also, I said, 'I'm not going to let you all go for nothing in this world. I'm going to stick with you all for the rest of my life. I will stick with you all throughout the rest of my life."

PARTNER Tool survey 2014-2015 administered with Alachua County MIECHV collaborators:

Select the organizations with which you have an established relationship (either formal or informal).

Collaboration among organizations and groups was measured through the Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER Tool) survey completed by community partners and agency representatives. Maps that illustrate the connections between organizations (represented as a dot) in each community were developed from information provided by the respondents. The lines between each organization represent the presence of a relationship based on the responses indicating how frequently the two organizations work together in the context of Parents as Teachers in Alachua County.

Time I Survey (Spring 2014)

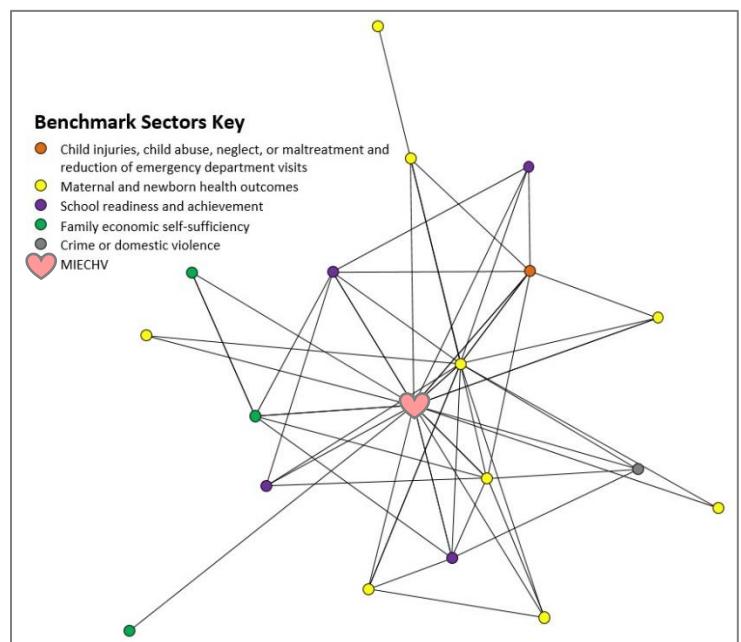
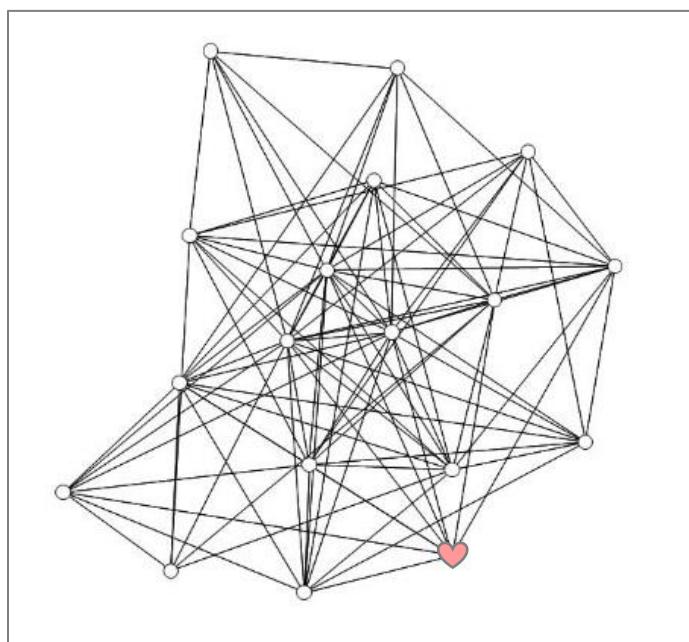
Number of Participants: 17/18

Response Rate: 84.9%

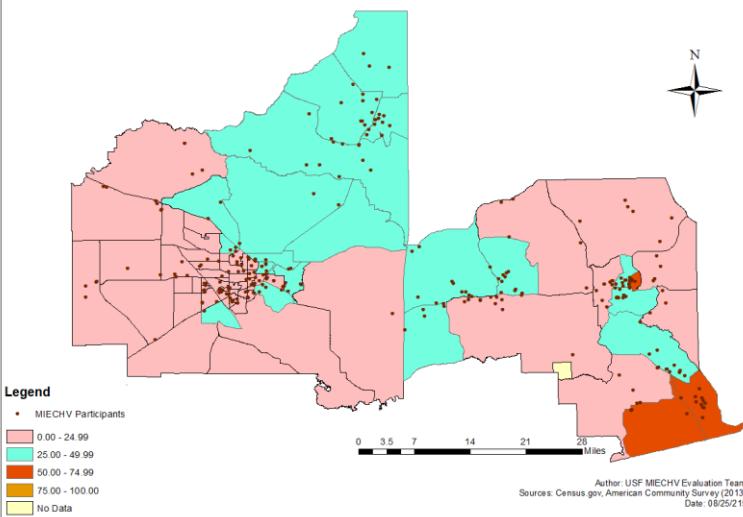
Time II Survey (Summer 2015)

Number of Participants: 17/23

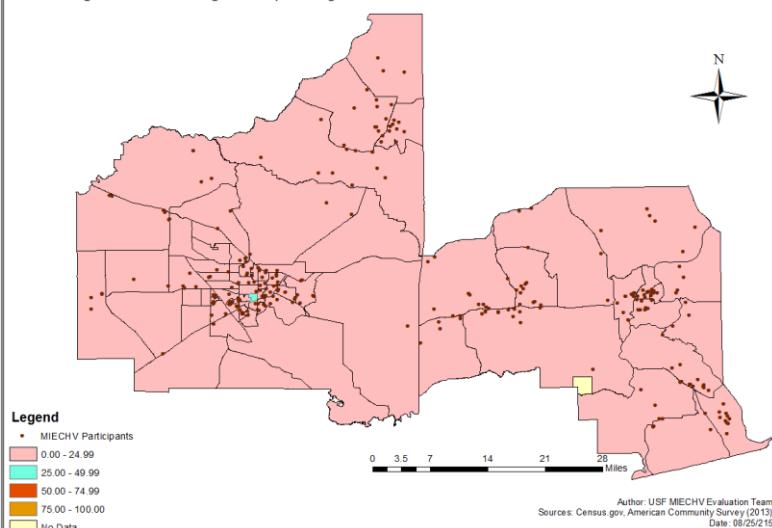
Response Rate: 67.2%



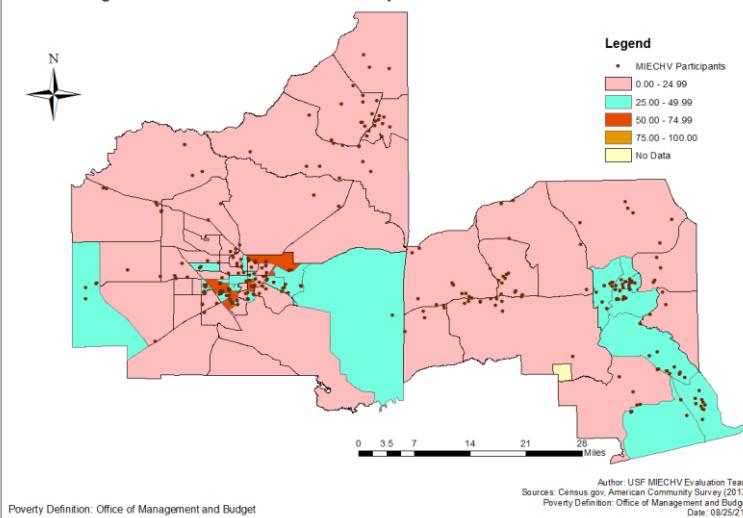
MIECHV Participants of Alachua, Bradford, and Putnam Mapped at the Census-Tract Level to Percentage of Individuals Having Less than High School Education at the Census Tract Level



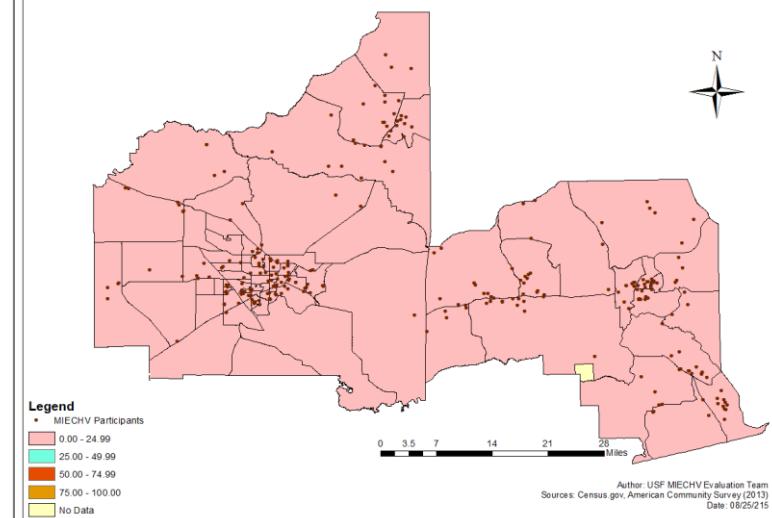
MIECHV Participants of Alachua, Bradford, and Putnam Mapped at the Census-Tract Level to Percentage of Limited English - Speaking Households at the Census Tract Level



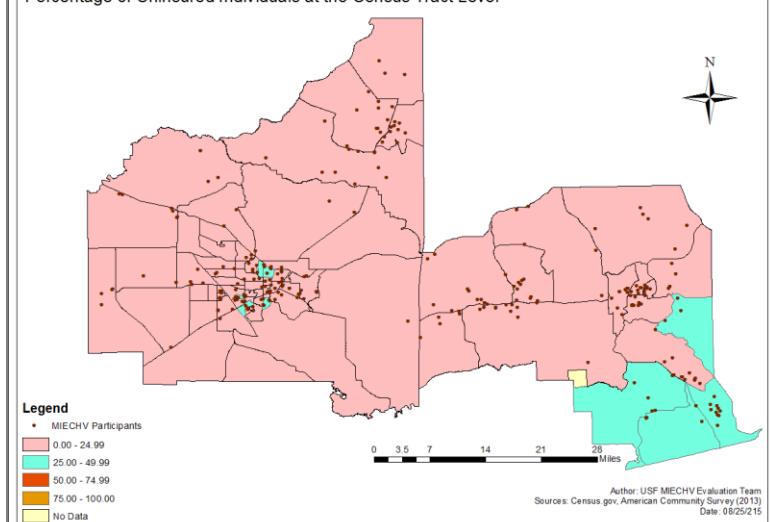
MIECHV Participants of Alachua, Bradford, and Putnam Mapped at the Census-Tract Level to Percentage of Individuals Who Live in Poverty at the Census Tract Level



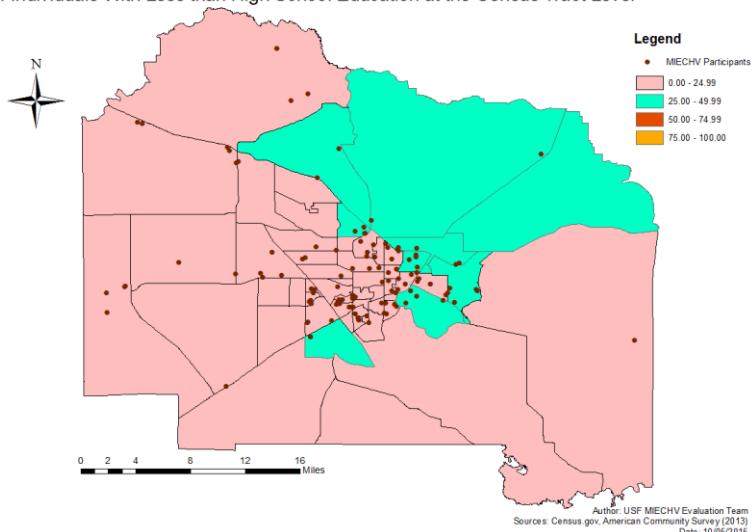
MIECHV Participants of Alachua, Bradford, and Putnam Mapped at the Census-Tract Level to Percentage of Unemployed Individuals at the Census Tract Level



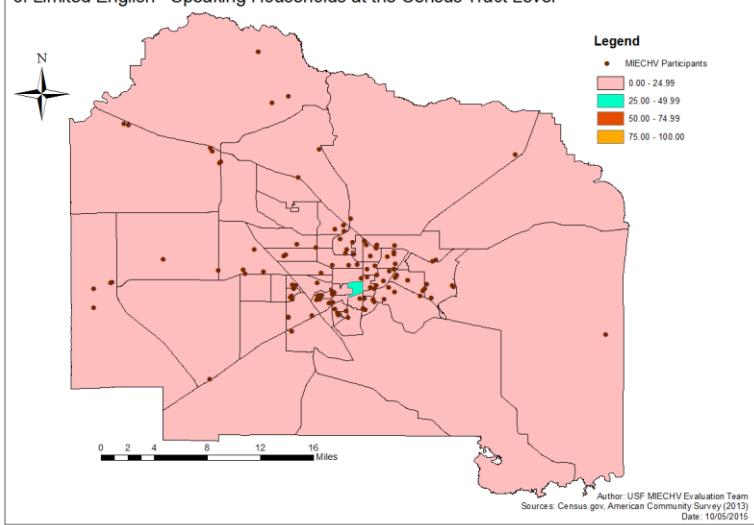
MIECHV Participants of Alachua, Bradford, and Putnam Mapped at the Census-Tract Level to Percentage of Uninsured Individuals at the Census Tract Level



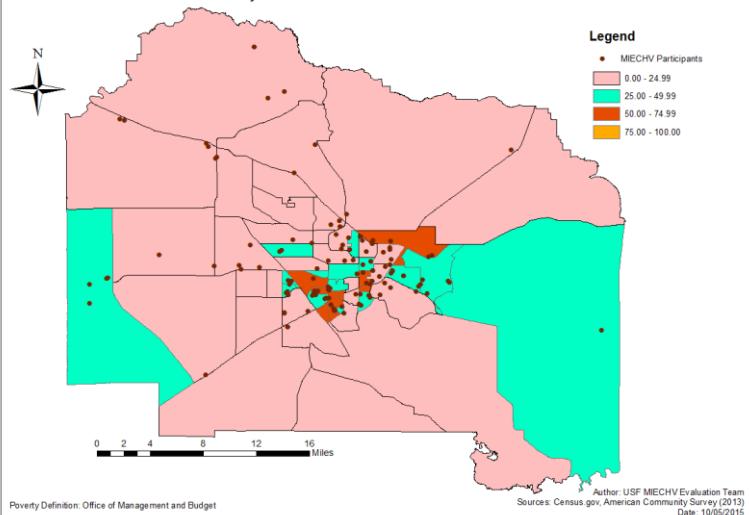
MIECHV Participants of Alachua County Mapped at the Census-Tract Level to Percentage of Individuals With Less than High School Education at the Census Tract Level



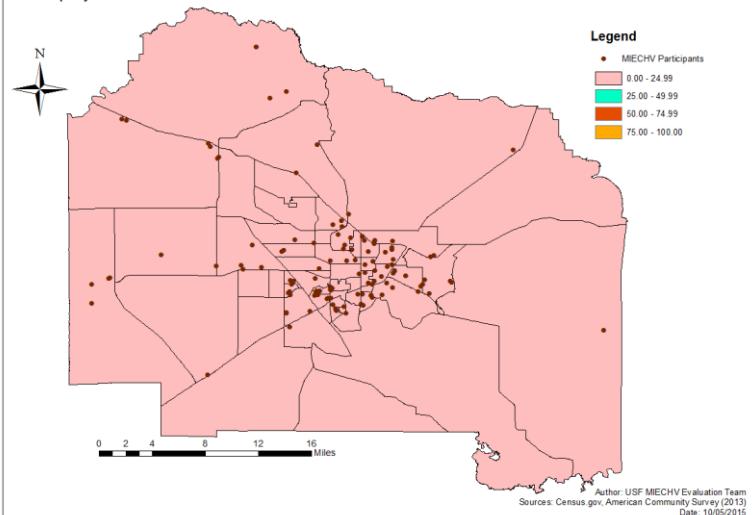
Alachua County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Limited English-Speaking Households at the Census Tract Level



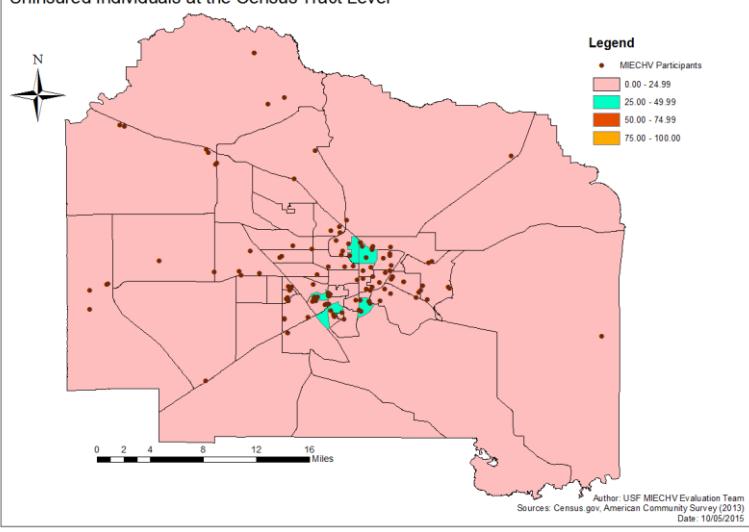
Alachua County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Individuals Who Live in Poverty at the Census Tract Level



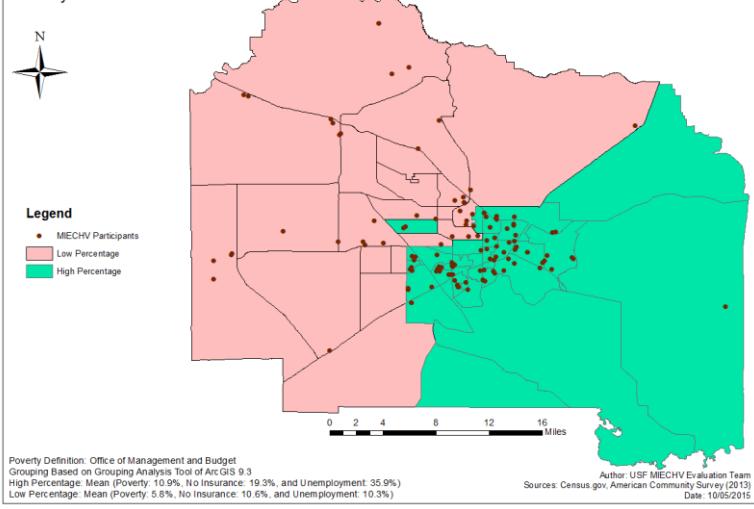
Alachua County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Unemployed Individuals at the Census Tract Level



Alachua County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Uninsured Individuals at the Census Tract Level



Alachua County MIECHV Participants Mapped at the Census-Tract Level into Two Groups Based on Percentage of Unemployment, No Insurance, and Those Who Live in Poverty at the Census Tract Level



MIECHV Evaluation Overview

Orange County



Focus groups and interviews conducted with HFF program staff in Orange County:

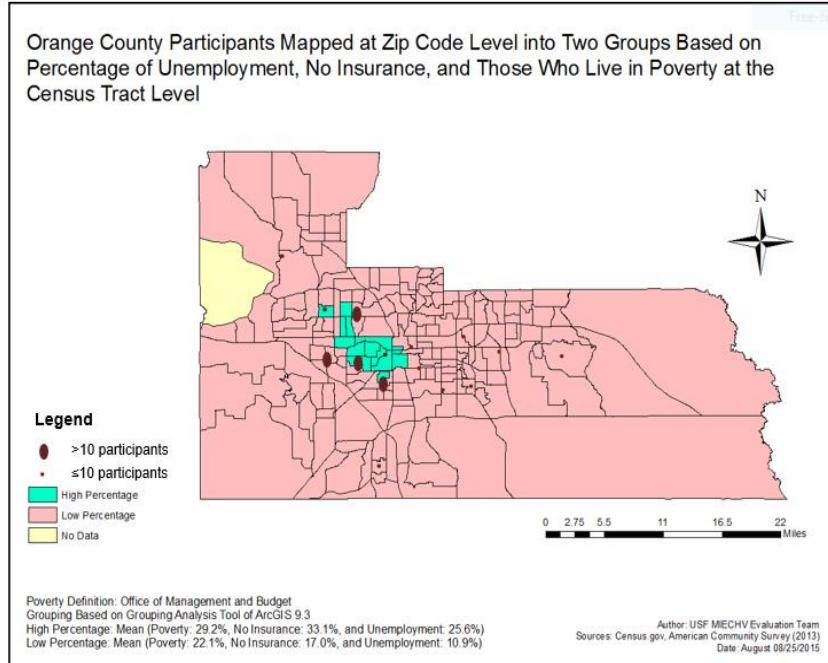
What do you consider the biggest strength(s) of your program?

The MIECHV program staff from Orange County expressed that the longevity of the program, being that their home visitors are in the clients' homes from pregnancy until the child is five years old, was a critical strength of their program. The staff further emphasized how the HFF home visitors minimize their families' crisis situations and how the program influences the prevention of child abuse and neglect, both of which are tremendously beneficial. Another advantage of the program discussed was being able to cross cultural lines, helping the families see a new perspective to parenting, and linking families to community resources. A crucial aspect of the HFF program is the guidance of clients into becoming self-sufficient and empowering them to accomplish their goals, visions, and dreams. The HFF staff elaborated on how the program is not only focused on helping mothers but also on helping participant fathers improve their relationships with their children. The HFF staff also expressed appreciation for the opportunity to attend professional development and training sessions, as well as for being among a good team environment that cares about the community. Lastly, the staff applauded how HFF implements MIECHV's strength-based model and how specialists in the program can work directly with the families instead of having to refer them to other agencies.

"I would say that it's the home visitors themselves, and that there are frequent face-to-face support of families that have lots of crisis and drama and need in their lives, and navigating the limited resources that there are."

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

"I think one of the biggest strengths of the program is that – is the way that everybody who works with Healthy Families kind of work together and collaborates together."



What do you think are the most important outcomes of the program?

Orange County's MIECHV program staff stated a number of important outcomes of their program including increased prenatal care utilization and immunizations, along with improvements in home safety. Another crucial outcome as a result of the program was reducing child maltreatment in their clients' homes; consequently, the betterment of family health and positive parent-and-child interactions. Of additional importance was the reportedly high completion rate regarding their clients' ages and stages questionnaires. Ultimately, the staff discussed how home visitors help their clients achieve a level of self-sufficiency that may not have been reached otherwise.

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

"...learning what kind of choices they've made in their past that have led them to this place, and how to think about things in a different way, in a healthy way and make healthy, positive changes so that they can be more independent in fixing things for themselves."

"I think independence is a major outcome of the program."

What are some outcomes of the program that would be hard to measure?

Orange County's MIECHV program staff identified themes among participants that were intangible, such as measuring the clients' coping and prioritization process, as well as measuring the families' ability to become stable. The staff mentioned that another immeasurable benefit of the HFF program would be to quantify the amount of effort that the home visitors put into each visit.

"I would say it is them becoming stable, and them learning how to cope and prioritize."

"I think what's difficult to measure is what – actually what we do out in the field."

Phone interviews conducted with Orange County MIECHV program participants:

What does the home visiting program mean to you and your family?

The Orange County MIECHV participants noted that the HFF program has given them useful information and taught them to reduce their stress levels. The program has enabled them to understand that taking time for themselves is crucial to being a better parent. They also mentioned the positive impact of the HFF program in checking-up on them, supporting the interaction with older children, and having someone there for them when they may not have anybody else. Lastly, the MIECHV participants stated that having the home visitors as a guide for the first five years of their child's life, in addition to receiving their professional opinions and perspectives, gave them a chance as moms to learn new things.

"I don't think I would know how to be stress free. Trying to do everything at one time, knowing that I can't. It's okay to take time out for yourself."

"Well, they have helped me with the older boy because of the problem with his not wanting to speak."

"The home visiting program means that I will always have somebody to guide me through the kids growing up the first five years."

PARTNER Tool survey 2014-2015 administered with Orange County MIECHV collaborators:

Select the organizations with which you have an established relationship (either formal or informal).

Collaboration among organizations and groups was measured through the Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER Tool) survey completed by community partners and agency representatives. Maps that illustrate the connections between organizations (represented as a dot) in each community were developed from information provided by the respondents. The lines between each organization represent the presence of a relationship based on the responses indicating how frequently the two organizations work together in the context of Healthy Families Florida in Orange County.

Time I Survey (Summer 2014)

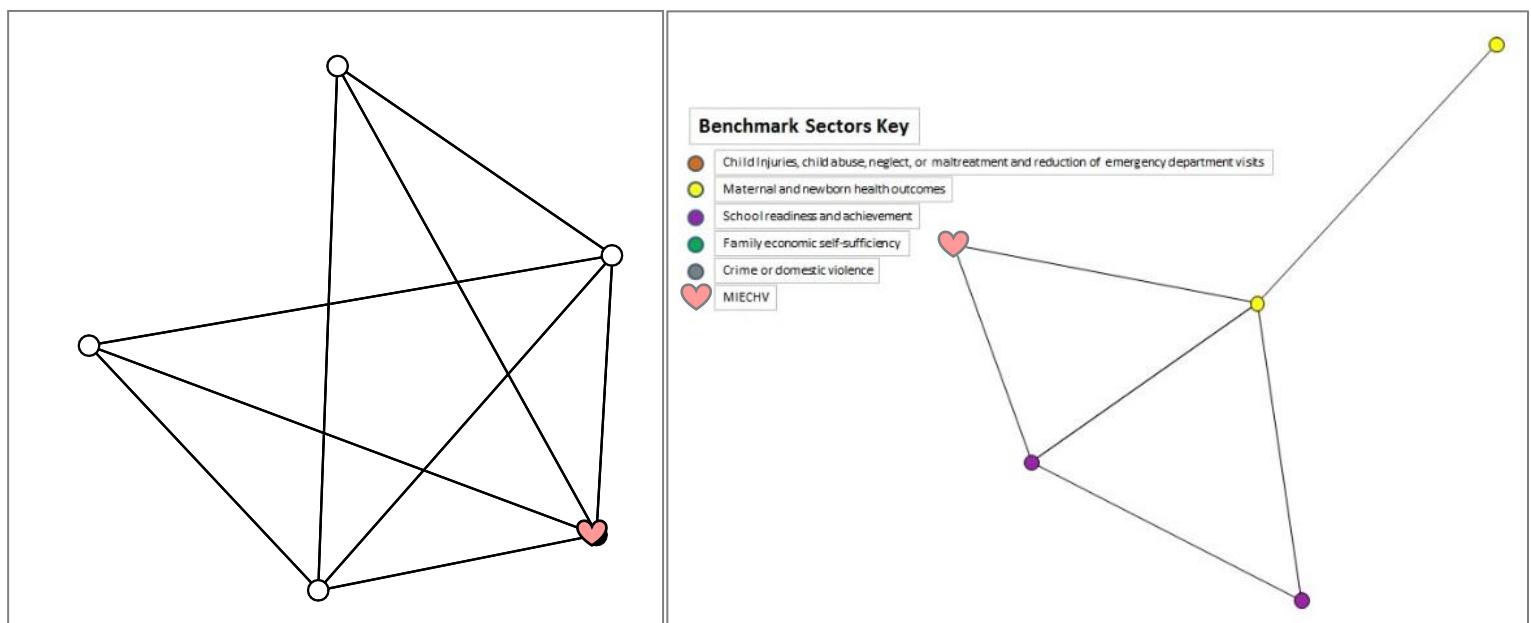
Number of Participants: 4/5

Response Rate: 66.0%

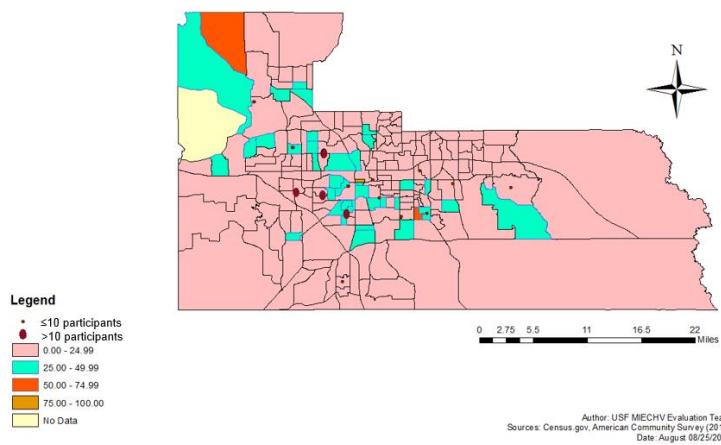
Time II Survey (Summer 2015)

Number of Participants: 4/5

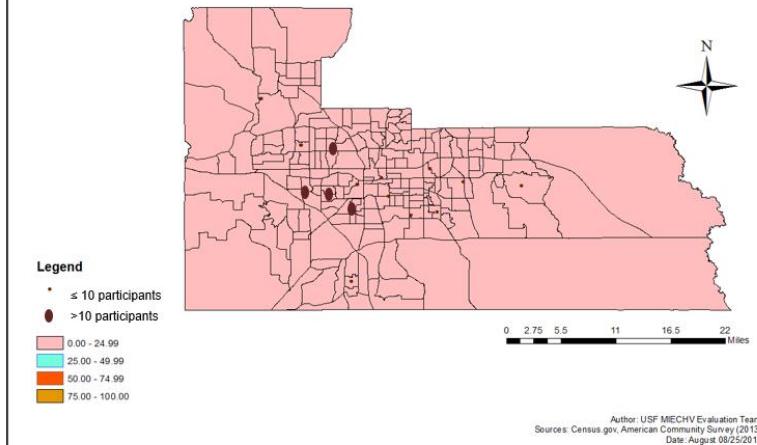
Response Rate: 80.0%



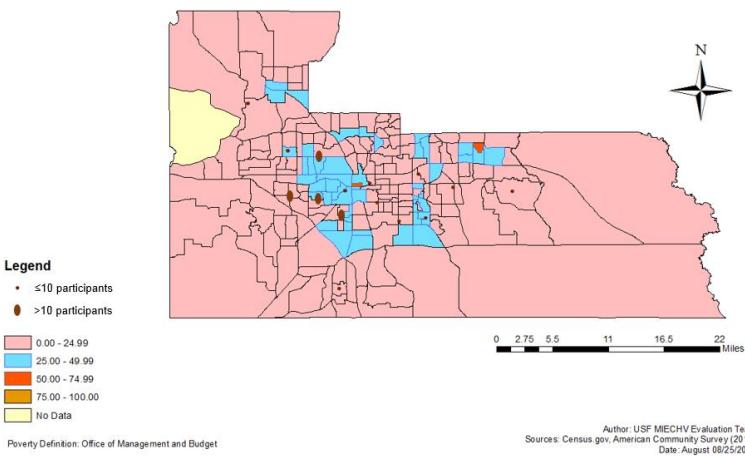
Orange County Participants Mapped at Zip Code Level to Percentage of Individuals Having Less than High School Education at the Census Tract Level



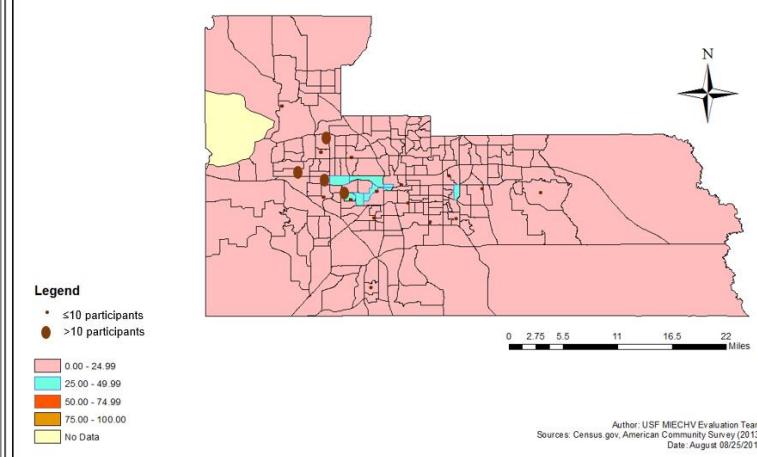
Orange County Participants Mapped at Zip Code Level to Percentage of Limited English-Speaking Households at the Census Tract Level



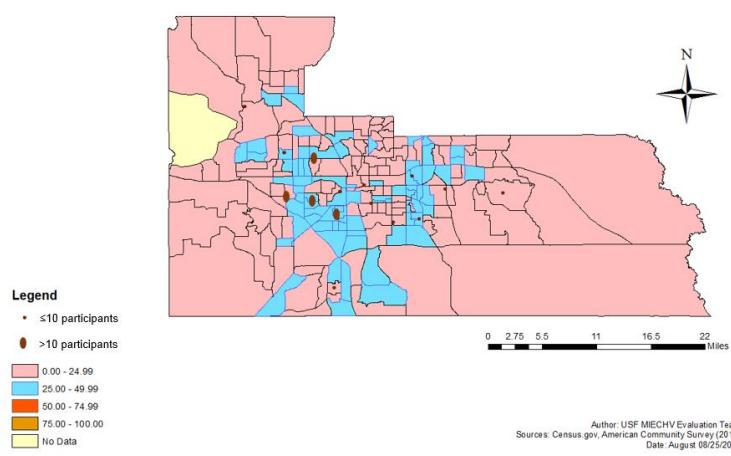
Orange County Participants Mapped at Zip Code Level to Percentage of Individuals Who Live in Poverty at the Census Tract Level



Orange County Participants Mapped at Zip Code Level to Percentage of Unemployed Individuals at the Census Tract Level



Orange County Participants Mapped at Zip Code Level to Percentage of Uninsured Individuals at the Census Tract Level

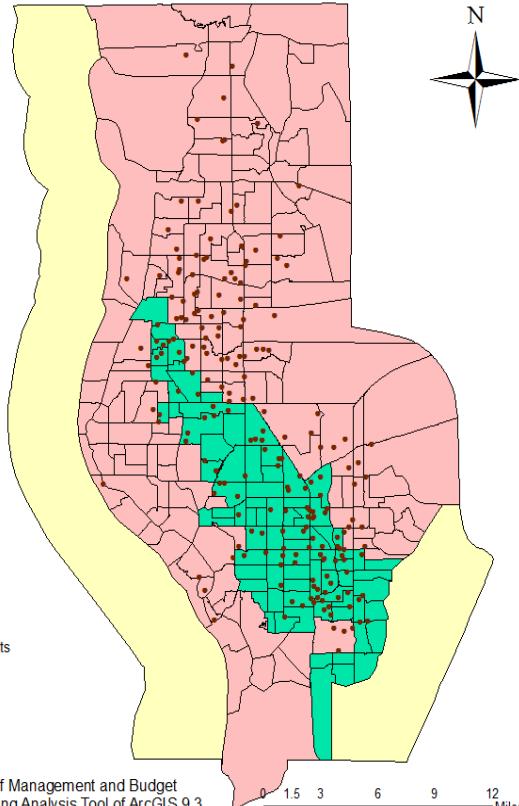


MIECHV Evaluation Overview

Pinellas County



Pinellas County MIECHV Participants Mapped at the Census Tract Level into Two Groups Based on Percentage of Unemployment, No Insurance, and Those Who Live in Poverty at the Census Tract Level



Poverty Definition: Office of Management and Budget Grouping Based on Grouping Analysis Tool of ArcGIS 9.3
High Percentage: Mean (Poverty: 12.7 %, No Insurance: 21.7%, and Unemployment: 20.5%)
Low Percentage: Mean (Poverty: 9.6%, No Insurance: 15.3%, and Unemployment: 11.5%)

Author: USF MIECHV Evaluation Team
Sources: Census.gov, American Community Survey (2013)
Date: August 08/25/2015

Focus groups / interviews conducted with staff:

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

The MIECHV staff in Pinellas County shared numerous strengths of their program, such as having experienced and well-trained staff in a variety of disciplines who are committed and dedicated to their families' progress. The staff in Pinellas are also able to provide support to families who may not be able to receive such a benefit from other service providers. PAT+ tailors services to the specific needs of participant families and helps with other issues, in addition to substance abuse, that are apparent in the families' lives.

"Probably the support that we offer families."

"I think the staff, really, and their commitment to their clients is the biggest strength."

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

"We identify the trauma that got them to this point, and we have a lot of different areas and skills within our staff that can meet those needs..."

"There are a lot of communication. They are familiar with each other's challenging cases and have suggestions."

"That was what I was going to kind of say, the consistency that we offer. Because a lot of our families, they don't have any consistency."

What do you think are the most important outcomes of the program?

The staff of the MIECHV Program in Pinellas County stated that the most important outcomes of the program included: increased knowledge, confidence, and competence, as well as better parenting, child development skills, and understanding of employment and healthcare needs. Of additional importance, the PAT+ staff elaborated on how their program contributes to the empowerment of women, the preparation of expecting mothers for a healthy pregnancy, and the establishment of stronger bonds between the mother and child.

"A strong parent-child relationship motivates a mom to work towards other things, and get up and go."

"We can get them to move forward and out of that lifestyle and create a good, quality atmosphere for that child."

"Well, I just think a well-functioning parent-child relationship is what our ultimate goal is because I think that solves a lot of the other problems like the drug abuse, the developmental delays."

What are some outcomes of the program that would be hard to measure?

Pinellas County's MIECHV Program staff identified numerous intangible benefits among their participants, such as measuring how they become self-efficient, learn to cope, prioritize, and take the opportunity to change their lives. Pinellas County staff mentioned that another immeasurable benefit of the PAT+ Program was how it allowed participants to stabilize their lifestyle, which better enables them to build a healthy family relationship moving forward.

Phone interviews conducted with Pinellas County MIECHV Program participants:

What does the home visiting program mean to you and your family?

Generally, most women voiced thanks for the informational support provided. However, the relationships (i.e., emotional support) that participants formed with their home visitors seemed to mean the most to participants.

"Since I'm not from here, this help has really been good."

"It means that she is showing me the way that [I] don't know, I guess maybe the difference and possibly then keeping this child, being able to know what to do with her."

"Really getting up on the right track."

"Taught us so much about communicating with each other and stuff, and it brought us more together for that reason."

"It's like a safety net."

"One of our goals is to become self-sufficient all the way around the board, and she's making that possible."

PARTNER Tool survey 2014-2015 administered with PAT+ collaborators:

Select the organizations with which you have an established relationship (either formal or informal).

Collaboration among organizations and groups was measured through the Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER Tool) survey completed by community partners and agency representatives. Maps that illustrate the connections between organizations (represented as a dot) in each community were developed from information provided by the respondents. The lines between each organization represent the presence of a relationship based on the responses indicating how frequently the two organizations work together in the context of PAT+ in Pinellas County.

Time I Survey (Spring 2014)

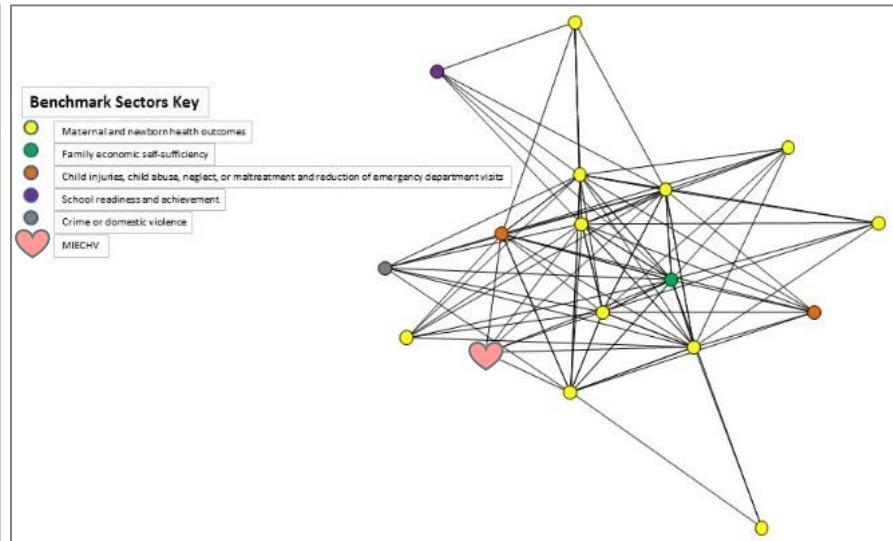
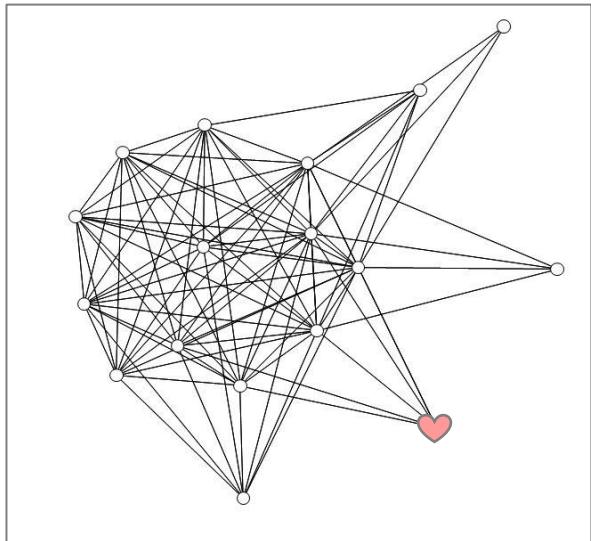
Number of Participants: 13/17

Response Rate: 53.1%

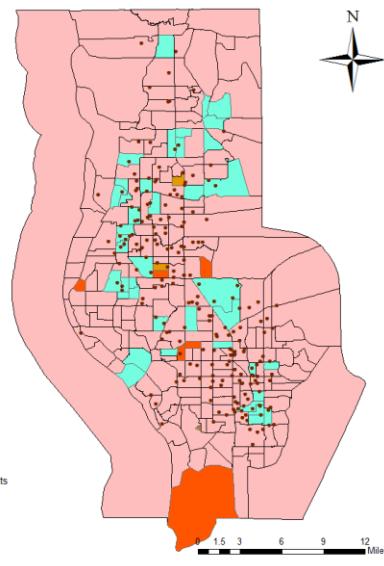
Time II Survey (Summer 2015)

Number of Participants: 10/17

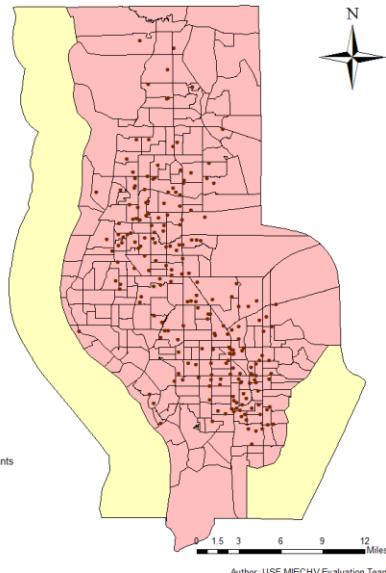
Response Rate: 47.2%



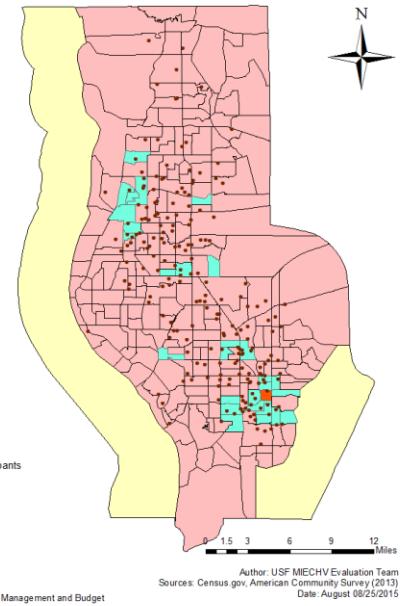
Pinellas County MIECHV Participants Mapped at the Census Tract Level to Percentage of Individuals Having Less than High School Education at the Census Tract Level



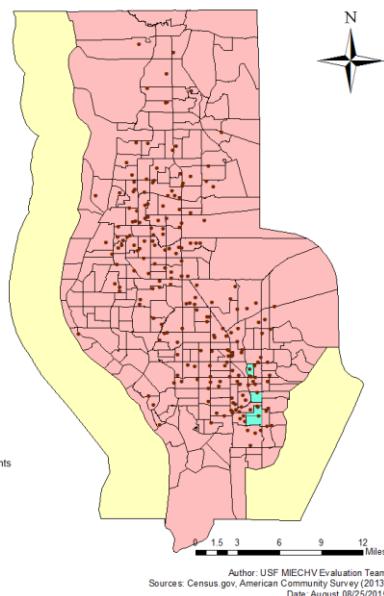
Pinellas County MIECHV Participants Mapped at the Census Tract Level to Percentage of Limited English - Speaking Households at the Census Tract Level



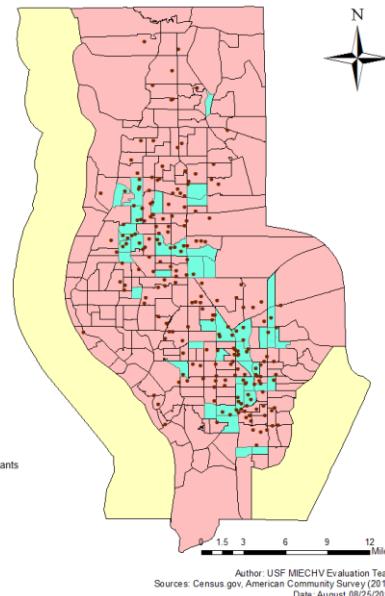
Pinellas County MIECHV Participants Mapped at the Census Tract Level to Percentage of Individuals Who Live in Poverty at the Census Tract Level



Pinellas County MIECHV Participants Mapped at the Census Tract Level to Percentage of Unemployed Individuals at the Census Tract Level



Pinellas County MIECHV Participants Mapped at the Census Tract Level to Percentage of Uninsured Individuals at the Census Tract Level



MIECHV Evaluation Overview

Southwest Florida Counties



Focus groups and interviews conducted with NFP staff in Southwest Florida Counties:

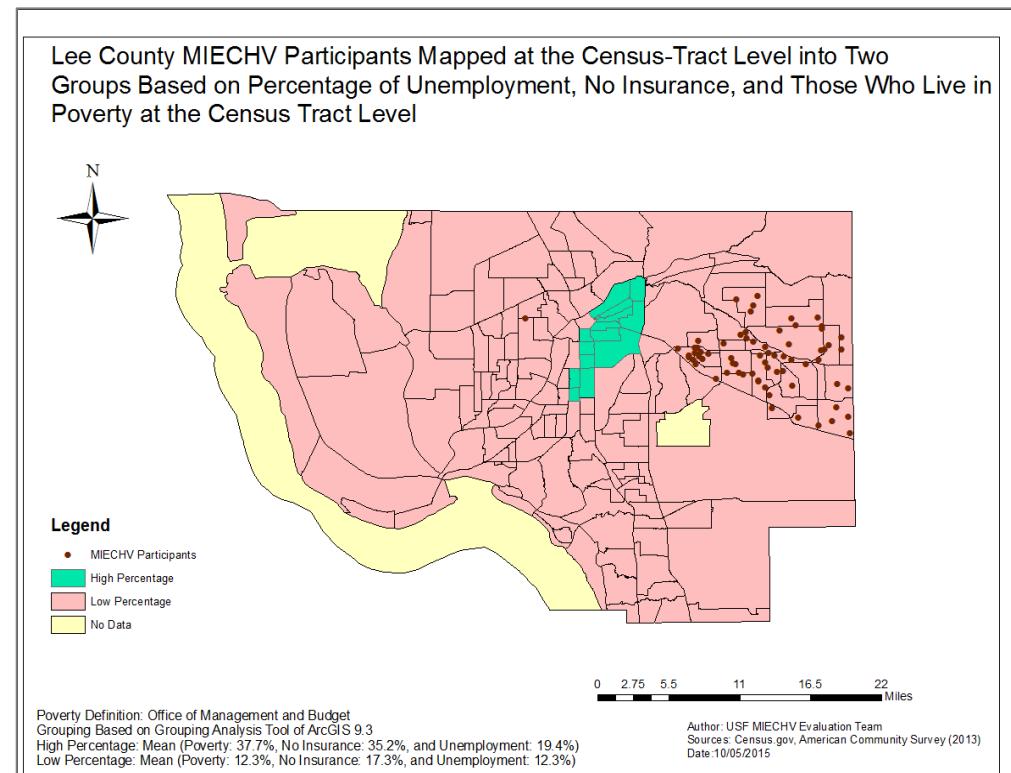
What do you consider the biggest strength(s) of your program?

The MIECHV program staff from three Southwest Florida Counties expressed that having a great infrastructure already in place for them to operate and being able to provide the best services to their clients were critical strengths of their program. The staff found further advantages in providing their families with individual access to a nurse home visitor through their Nurse-Family Partnership program. Lastly, the NFP staff elaborated on how their nurse home visitors were caring, committed, and invested in each of their clients.

"I think the biggest one is just the importance of teaching these mothers how to take care of themselves and preparing them to take care of their own babies."

"My nurse home visitors. They're caring, they're committed, and they have an invested interest in the clients."

"...hiring nurses too that were familiar with the area and maternal and child health, we still have quite a few of them."



What do you think are the most important outcomes of the program?

Southwest Florida Counties' MIECHV program staff stated that the most important outcome of their program was the ability to empower women. Other crucial outcomes of the program involved getting mothers ready for a healthy pregnancy and helping to build stronger bonds between the mother and her baby.

"That they get their prenatal care. That they learn how to take care of their infants and toddlers emotionally and to break some vicious cycles."

"I think everybody's making an impact on the breastfeeding rates, too."

What are some outcomes of the program that would be hard to measure?

Southwest Florida Counties' MIECHV program staff identified themes among participants that were hard to measure, such as quantifying the desire of their clients wanting to be mothers and wanting the best for their child. Another intangible outcome was the hypothetical comparison of what mothers in the program would have done versus what they actually did because of their nurse home visitor. The staff also mentioned how it would be difficult to measure the healthier choices that the clients are making as a result of the NFP program.

"When you talk to them about nutrition and making healthier choices, that is intangible because you can't really measure that, like how many vegetables did they eat before?"

"I think the intangible is what they would have done versus what they do. We only get what they do."

Phone interviews conducted with Southwest Florida MIECHV program participants:

What does the home visiting program mean to you and your family?

Generally, most women voiced thanks for the informational support provided. However, the relationships (i.e., emotional support) that participants formed with their nurse home visitors seemed to mean the most to participants.

"It's helped us a lot."

"It's been very important and with a lot support."

"It was very helpful with child birthing, and breastfeeding, and in helping me with the Apgar score when she was born, and what did they do to her, and giving her shots, and what did they put in her eyes."

"I wouldn't know anything. I'd be stuck on Google."

"Just peace of mind, honestly."

"It's important. It's helpful in supporting."

PARTNER Tool survey 2014-2015 administered with Southwest Florida MIECHV collaborators:

Select the organizations with which you have an established relationship (either formal or informal).

Collaboration among organizations and groups was measured through the Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER Tool) survey completed by community partners and agency representatives. Maps that illustrate the connections between organizations (represented as a dot) in each community were developed from information provided by the respondents. The lines between each organization represent the presence of a relationship based on the responses indicating how frequently the two organizations work together in the context of Nurse-Family Partnership in Southwest Florida Counties.

Time I Survey (Spring 2014)

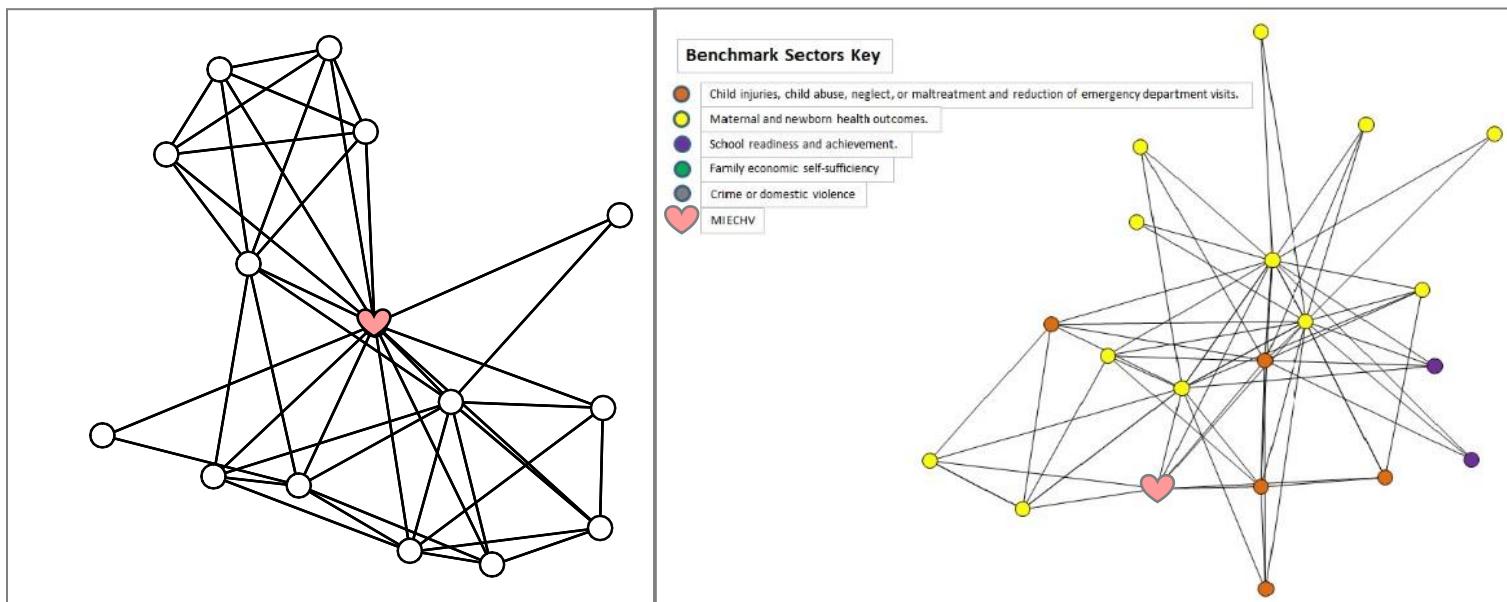
Number of Participants: 11/15

Response Rate: 64.7%

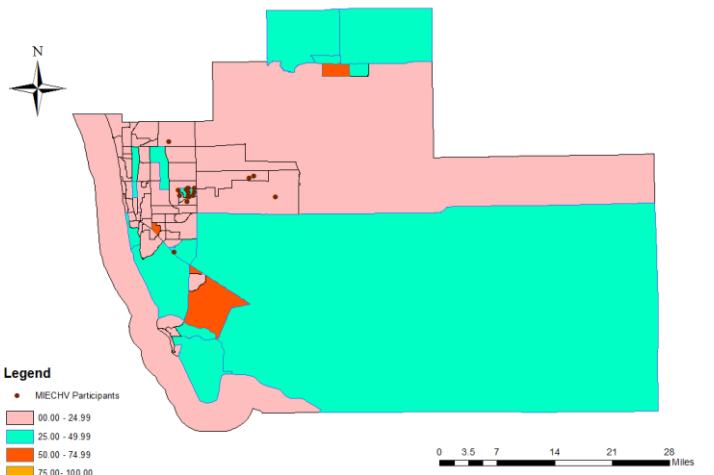
Time II Survey (Summer 2015)

Number of Participants: 14/20

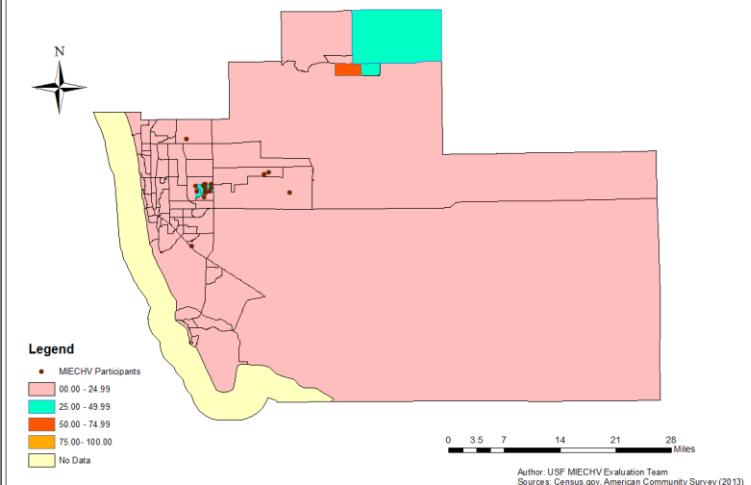
Response Rate: 61.1%



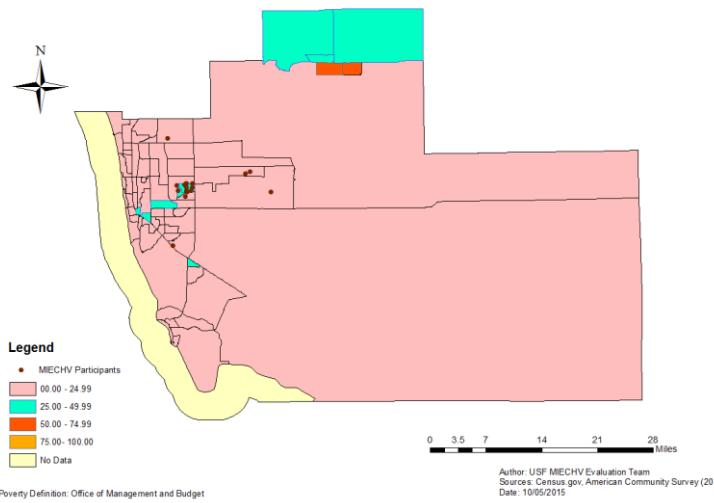
MIECHV Participants of Collier County Mapped at the CensusTract Level to Percentage of Individuals Having Less than High School Education at the Census Tract Level



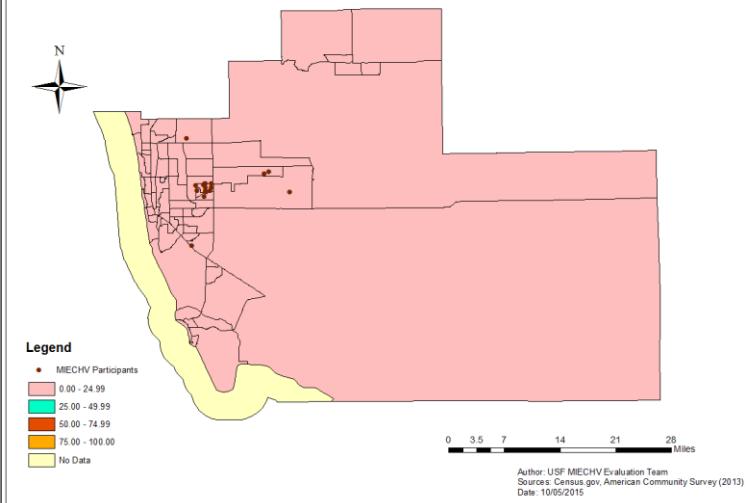
MIECHV Participants of Collier County Mapped at the CensusTract Level to Percentage of Limited English - Speaking Households at the Census Tract Level



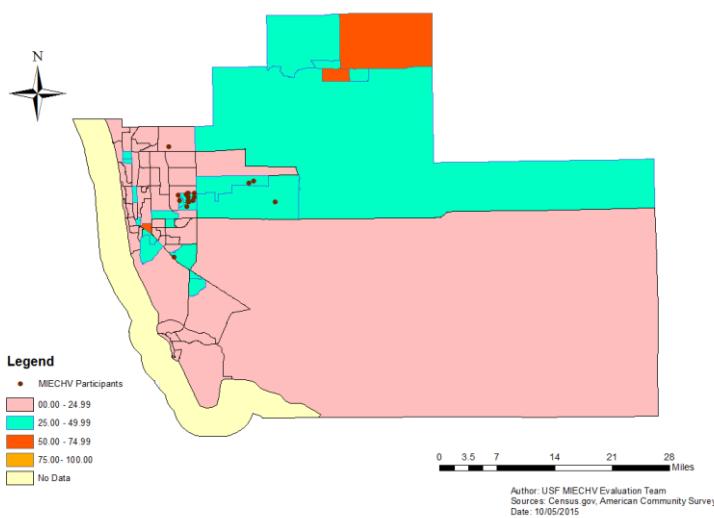
MIECHV Participants of Collier County Mapped at the Census Tract Level to Percentage of Individuals Who Live in Poverty at the Census Tract Level



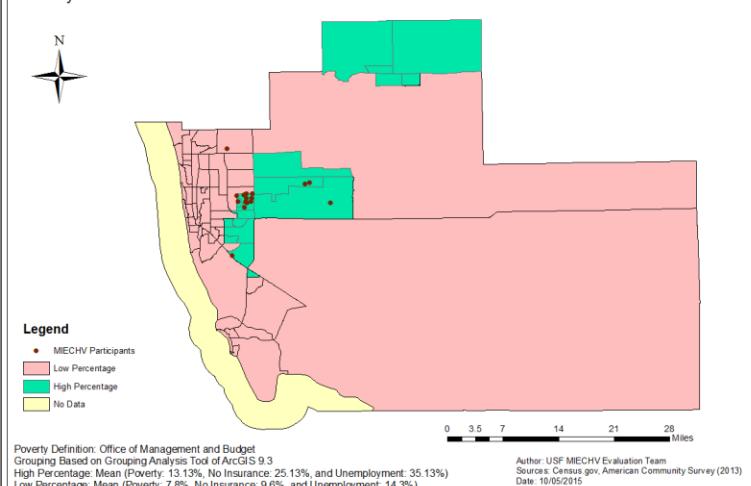
MIECHV Participants of Collier County Mapped at the CensusTract Level to Percentage of Unemployed Individuals at the Census Tract Level



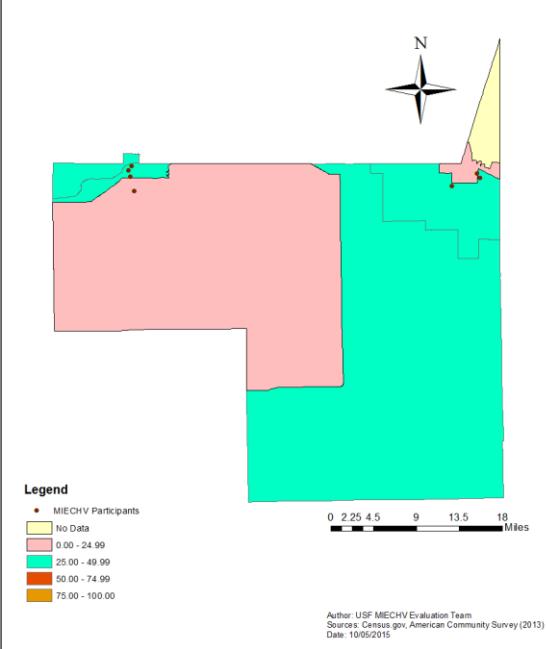
MIECHV Participants of Collier County Mapped at the CensusTract Level to Percentage of Uninsured Individuals at the Census Tract Level



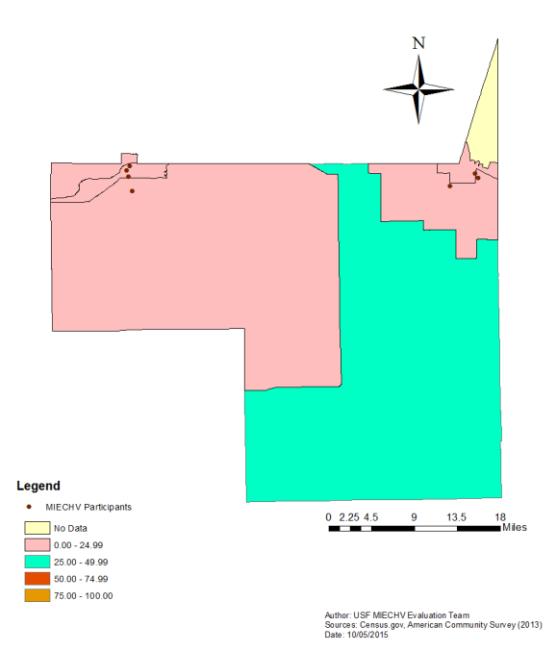
MIECHV Participants of Collier County Mapped at the Census Tract Level into Two Groups Based on Percentage of Unemployment, No Insurance, and Those who Live in Poverty at the Census Tract Level



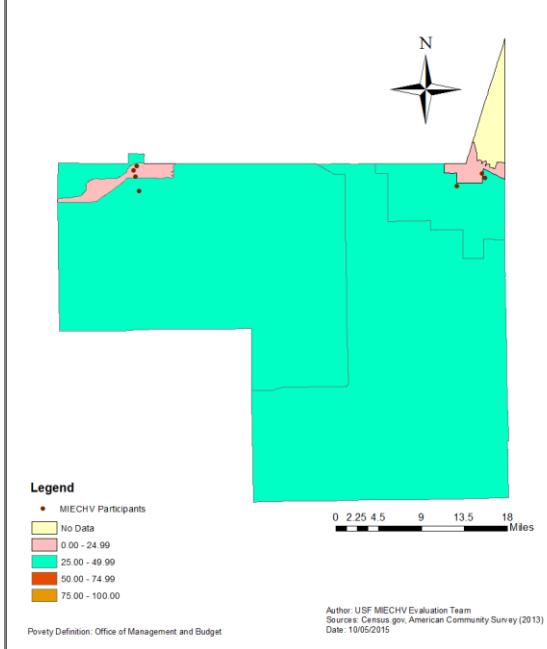
Hendry County MIECHV Participants Mapped at the Census Tract Level to Percentage of Individuals Having Less than High School Education at the Census Tract Level



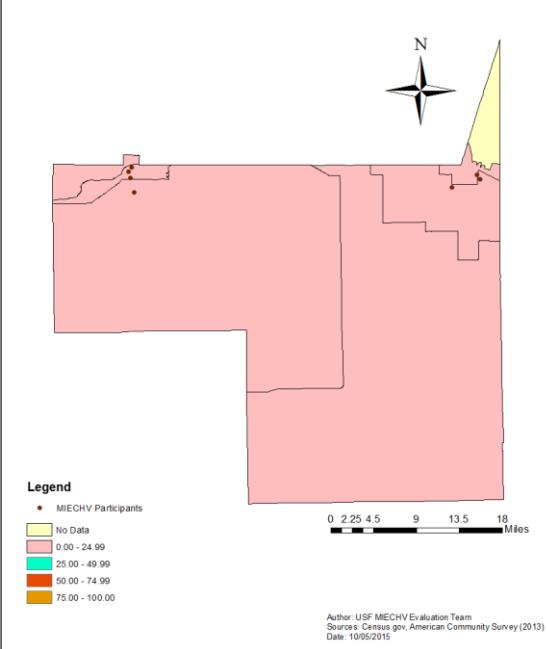
Hendry County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Limited English-Speaking Households at the Census Tract Level



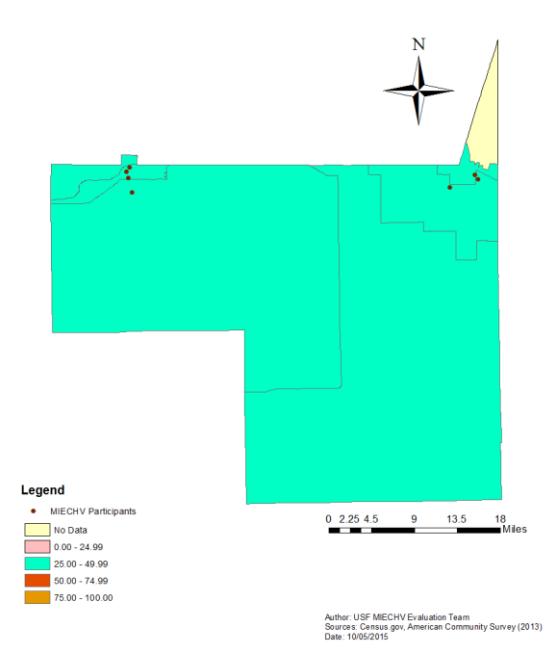
Hendry County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Individuals Who Live in Poverty at the Census Tract Level



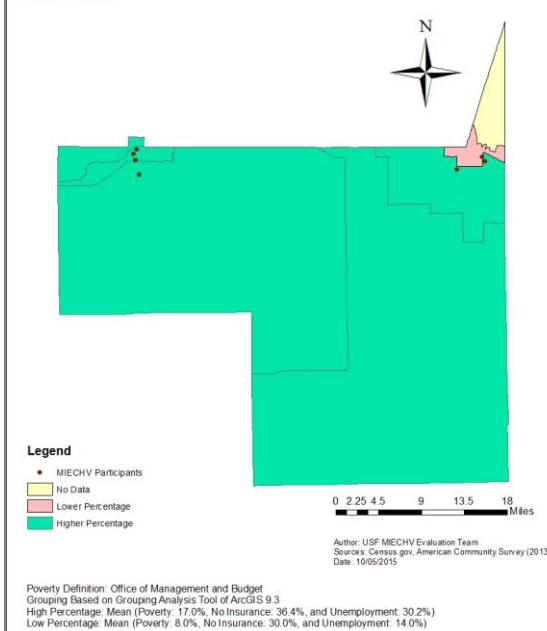
Hendry County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Unemployed Individuals at the Census Tract Level



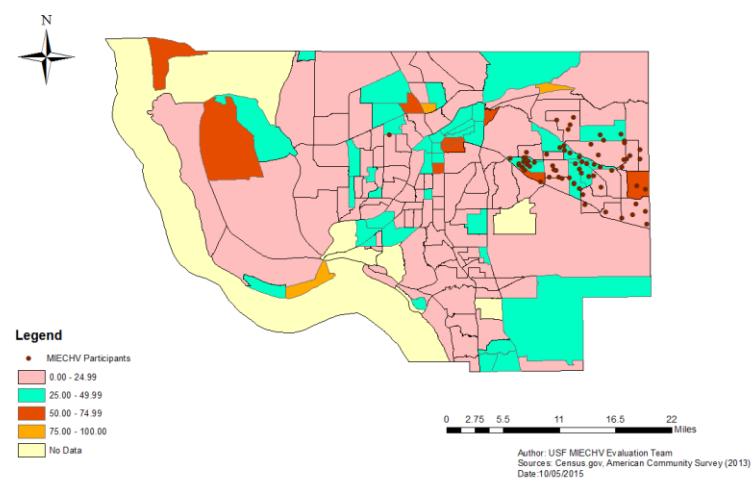
Hendry County MIECHV Participants Mapped at the Census-Tract Level to Percentage of Uninsured Individuals at the Census Tract Level



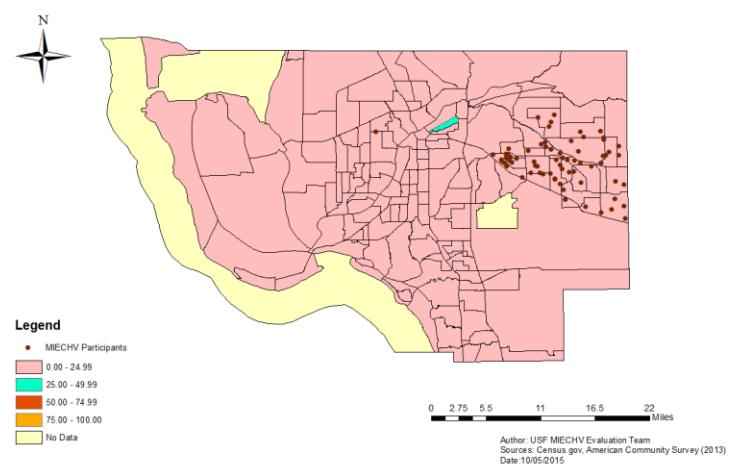
Hendry County MIECHV Participants Mapped at the Census-Tract Level into Two Groups Based on Percentage of Unemployment, No Insurance, and Those Who Live in Poverty at the Census Tract Level



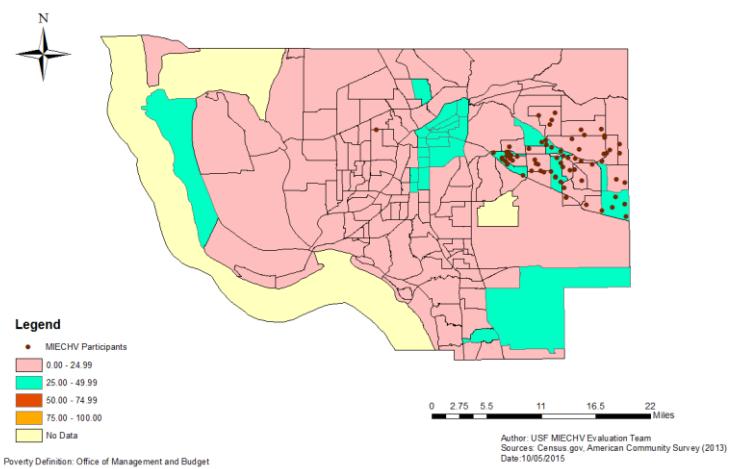
MIECHV Participants of Lee County Mapped at the Census Tract Level to Percentage of Individuals Having Less than High School Education at the Census Tract Level



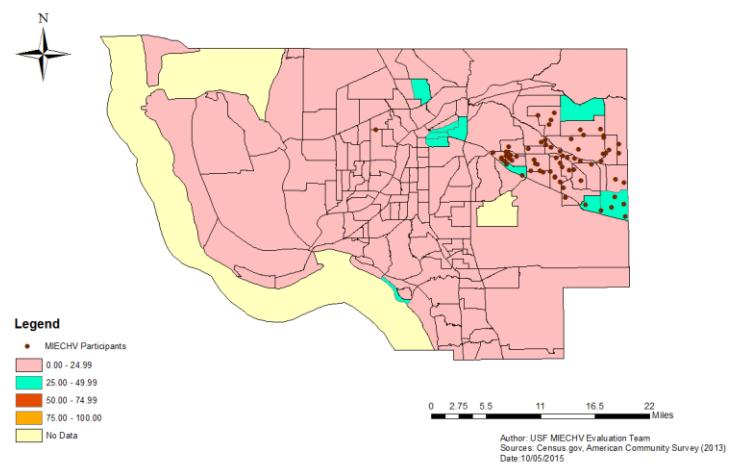
MIECHV Participants of Lee County Mapped at the Census Tract Level to Percentage of Limited English - Speaking Households at the Census Tract Level



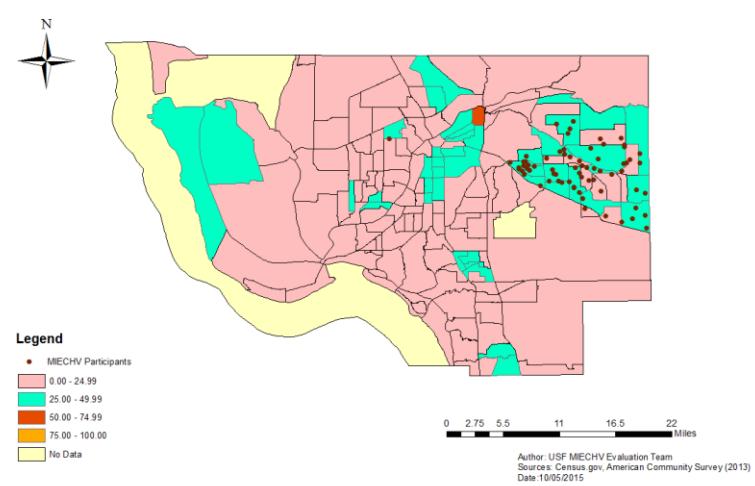
MIECHV Participants of Lee County Mapped at the Census Tract Level to Percentage of Individuals Who Live in Poverty at the Census Tract Level



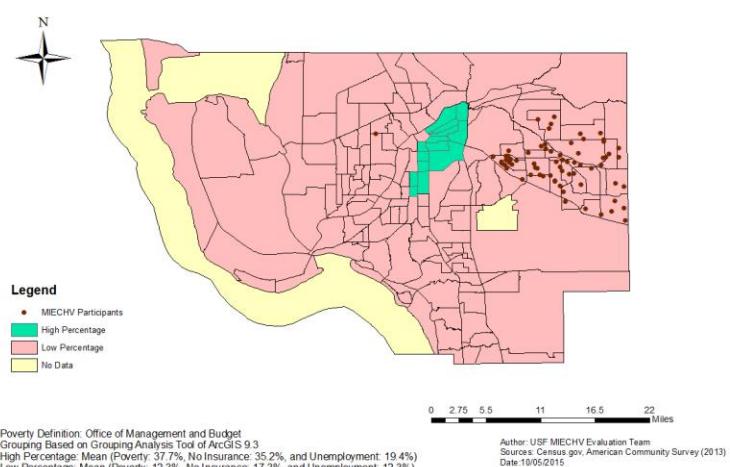
MIECHV Participants of Lee County Mapped at the Census Tract Level to Percentage of Unemployed Individuals at the Census Tract Level



MIECHV Participants of Lee County Mapped at the Census Tract Level to Percentage of Uninsured Individuals at the Census Tract Level



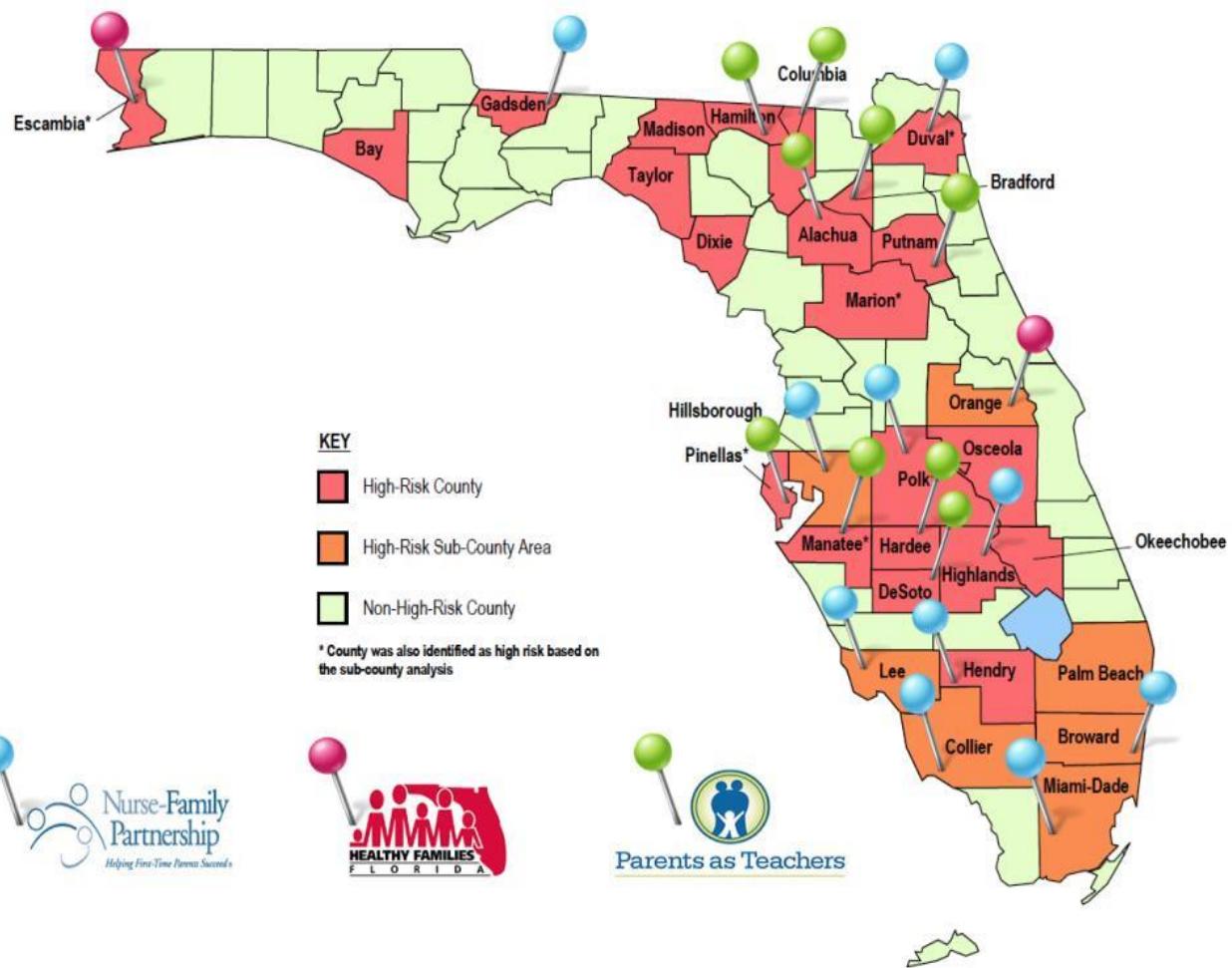
Lee County MIECHV Participants Mapped at the Census-Tract Level into Two Groups Based on Percentage of Unemployment, No Insurance, and Those Who Live in Poverty at the Census Tract Level



Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Evaluation

Community PARTNER Survey Program Profiles

2017



**Priyashi Manani, Vanessa Sharon, Pamela Birriel, Ngozichukwuka Agu
Kimberly Hailey, & Jennifer Marshall
University of South Florida**



Florida
Maternal
Infant &
Early
Childhood
Home
Visiting
Initiative



Chiles Center
Women, Children & Families

our
practice
is
our
passion.TM
University of South Florida
College of Public Health

Introduction

In 2010, Florida's Affordable Care Act authorized funding for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative to enhance the capacity and infrastructure of Florida home visiting programs. Florida MIECHV, administrated by the Florida Association of Healthy Start Coalitions, provides funding, training, and technical assistance to local implementing agencies throughout the state. An independent evaluation of this initiative is conducted by the Lawton and Rhea Chiles Center for Healthy Women, Children and Families, located within the College of Public Health at the University of South Florida (miechv.health.usf.edu). This utilization-focused evaluation includes both process and outcome evaluation components. Since 2014, this collaboration and social network analysis has described agencies partnering with Florida MIECHV, as well as each partner's relationships with the others within these local Florida MIECHV networks.

This report is a compilation of 2017 community collaboration survey results collected from Florida Maternal, Infant, Early Childhood Home Visiting (MIECHV) site program administrators and community collaborators. The social network analysis and collaboration tool, Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER), developed by Robert Wood Johnson Foundation was utilized to measure collaboration among agencies, organizations and groups within each community (<http://www.partnertool.net/>). The USF evaluation team modified the PARTNER tool to align with the goals of MIECHV. The evaluation team then sent the modified PARTNER tool to the program administrators and their list of collaborators via email. The full report describing the results of 2015-2017 evaluations of collaboration among local Florida MIECHV sites and partnering agencies can be found on the Florida MIECHV website (<http://health.usf.edu/publichealth/chiles/miechv/state-evaluation>).



Florida
Maternal
Infant &
Early
Childhood
Home
Visiting
Initiative



Chiles Center
Women, Children & Families

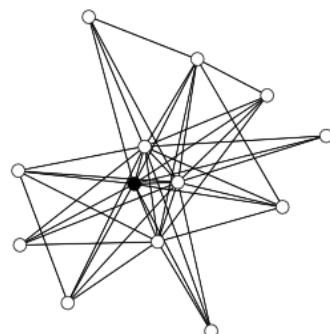
our
practice
is
our
passion.[®]
University of South Florida
College of Public Health

MIECHV Community Partnerships

Broward County

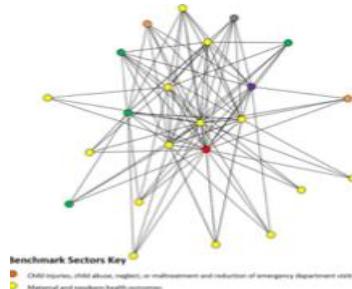
Network Maps

2014



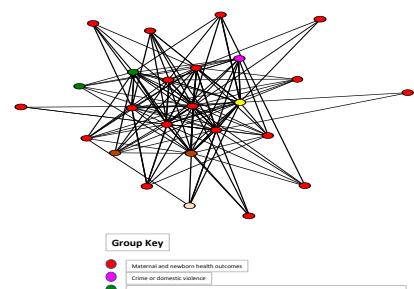
Number of Participants: 8/13

2015



Number of Participants: 14/23

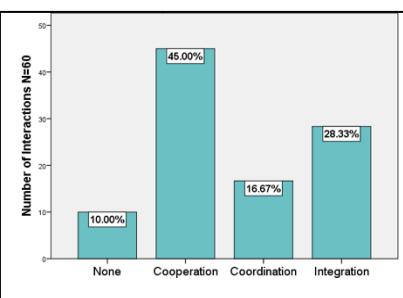
2017



Number of Participants: 18/25

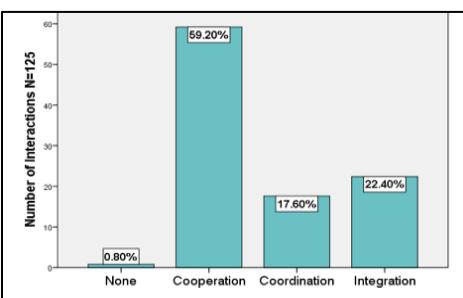
Levels of Collaboration

2014



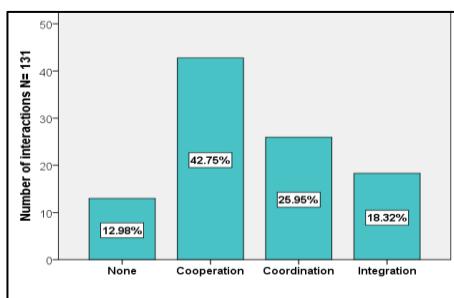
Density Score: 56%
Trust Score: 81%

2015



Density Score: 41%
Trust Score: 87%

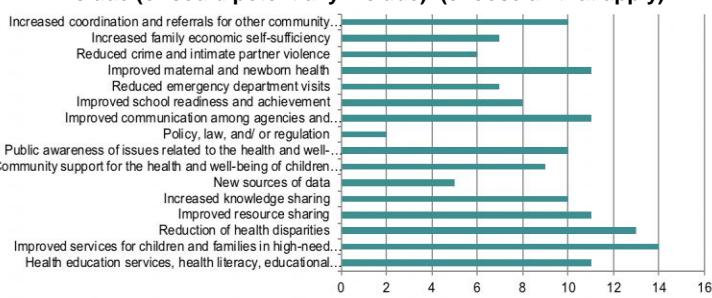
2017



Density Score: 40%
Trust Score: 93%

Outcomes

Outcomes of Nurse-Family Partnership in Broward County's work include (or could potentially include): (choose all that apply).

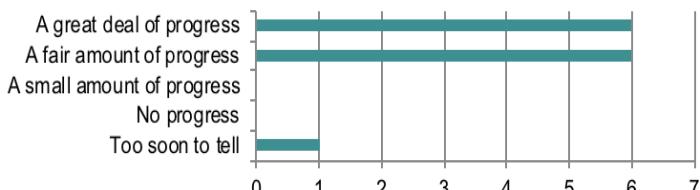


The **MOST IMPORTANT** outcomes of Nurse Family Partnership in Broward County

1. Improved Maternal and newborn health.
2. Reduction in health disparities
3. Improved services for children and families in high-need communities.

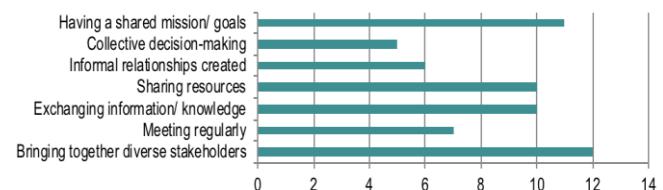
Perceptions of Success

How much progress has Nurse Family Partnership in Broward County made towards reaching its goals?



Contribution

What aspects of collaboration contribute to this progress? (Choose all that apply).



Florida
Maternal
Infant &
Early
Childhood
Home
Visiting
Initiative



Chiles Center
Women, Children & Families



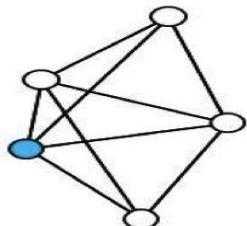
our
practice
is
our
passion.
University of South Florida
College of Public Health

MIECHV Community Partnerships

Duval County

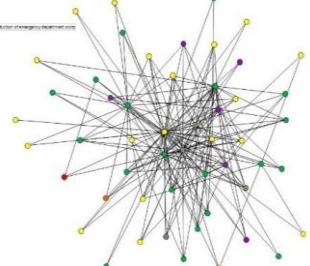
Network Maps

2014



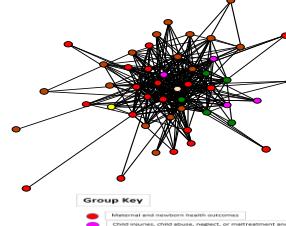
Number of Participants: 5/6

2015



Number of Participants: 28/56

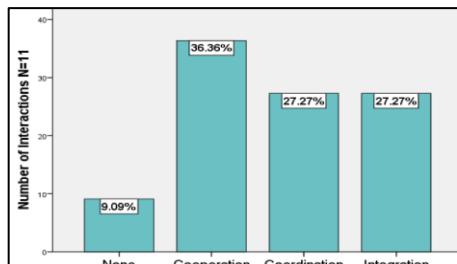
2017



Number of Participants: 26/48

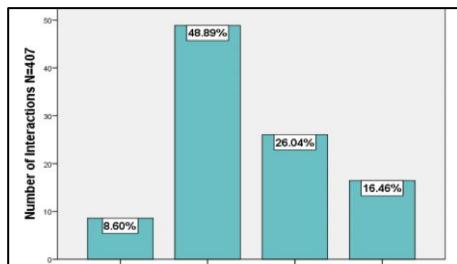
Levels of Collaboration

2014



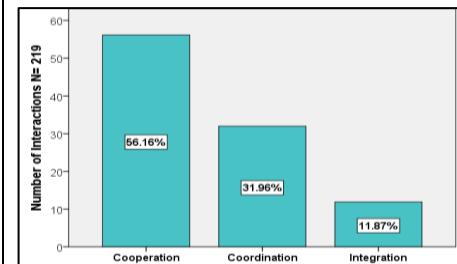
Density Score: 43%
Trust Score: 96%

2015



Density Score: 23%
Trust Score: 56%

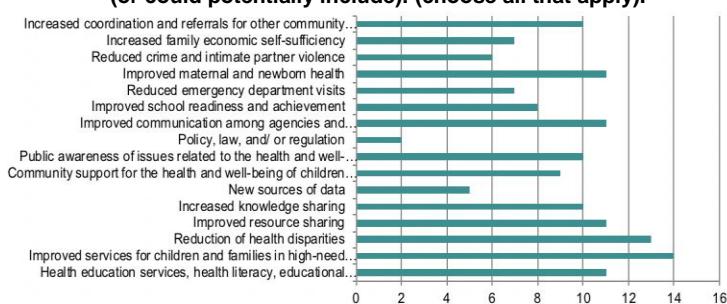
2017



Density Score: 27%
Trust Score: 75%

Outcomes

Outcomes of Nurse-Family Partnership in Duval County's work include (or could potentially include): (choose all that apply).

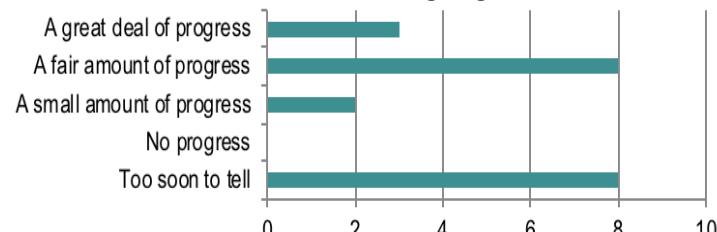


The **MOST IMPORTANT** outcomes of Nurse Family Partnership in Duval County

1. Improved Maternal and newborn health.
2. Improved services for children and families in high-need communities.

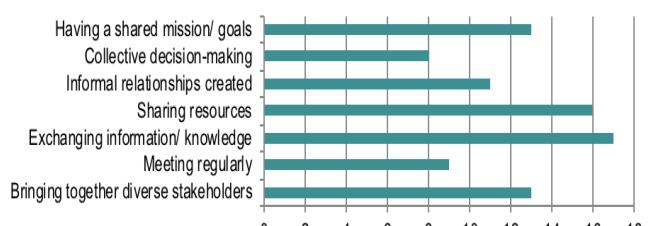
Perceptions of Success

How much progress has Nurse Family Partnership in Duval County made towards reaching its goals?



Contribution

What aspects of collaboration contribute to this progress? (Choose all that apply).



Florida
Medicaid
Infant &
Early
Childhood
Home
Visiting
Initiative



Chiles Center
Women, Children & Families

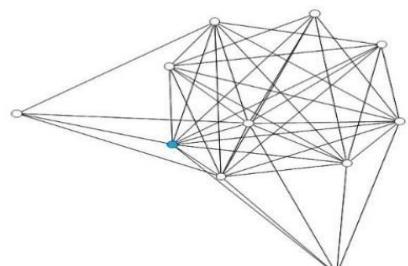
our
practice
is
our
passion.
University of South Florida
College of Public Health

MIECHV Community Partnerships

Escambia County

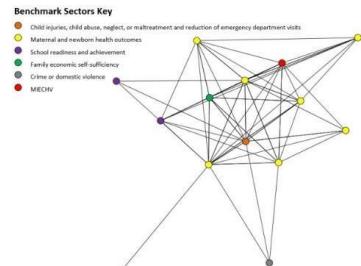
Network Maps

2014



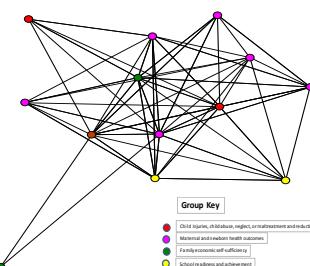
Number of Participants: 11/11

2015



Number of Participants: 12/14

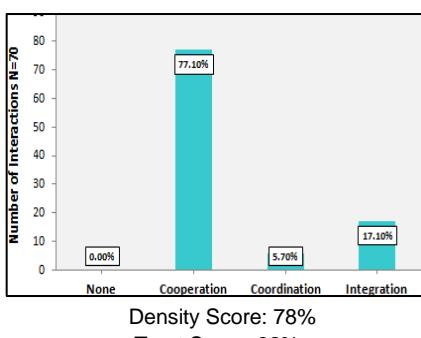
2017



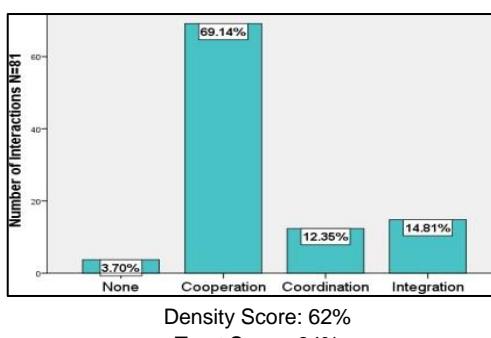
Number of Participants: 12/13

Levels of Collaboration

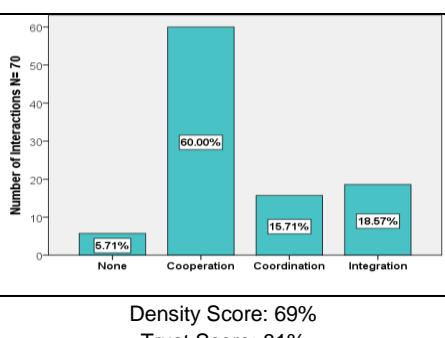
2014



2015

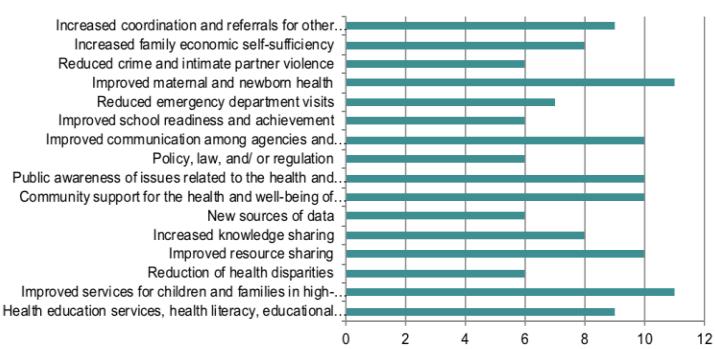


2017



Outcomes

Outcomes of 90Works Healthy Families in Escambia County's work include (or could potentially include): (choose all that apply).

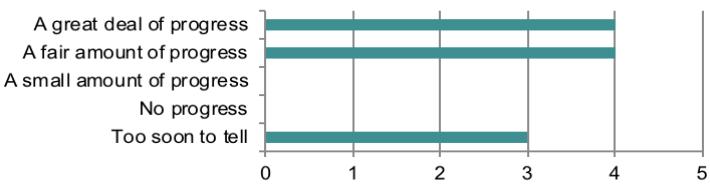


The **MOST IMPORTANT** outcomes of 90Works Healthy Families in Escambia County

1. Improved services for children and families in high-need communities.
2. Health education services, health literacy, and educational resources.

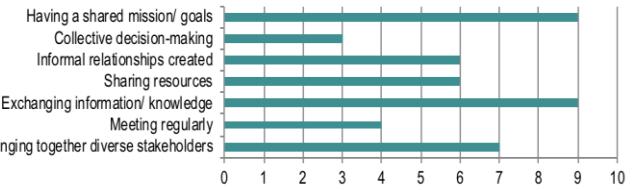
Perceptions of Success

How much progress has 90Works Healthy Families in Escambia County made towards reaching its goals?



Contribution

What aspects of collaboration contribute to this progress? (Choose all that apply).



Florida
Maternal
Infant &
Early
Childhood
Home
Visiting
Initiative



Chiles Center
Women, Children & Families



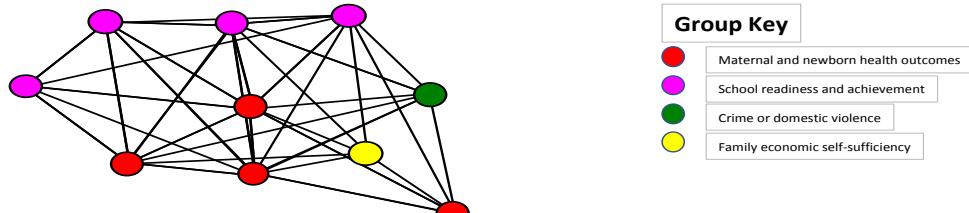
MIECHV Community Partnerships

Gadsden County

*Completed the PARTNER tool survey for the first time in 2017

Network Maps

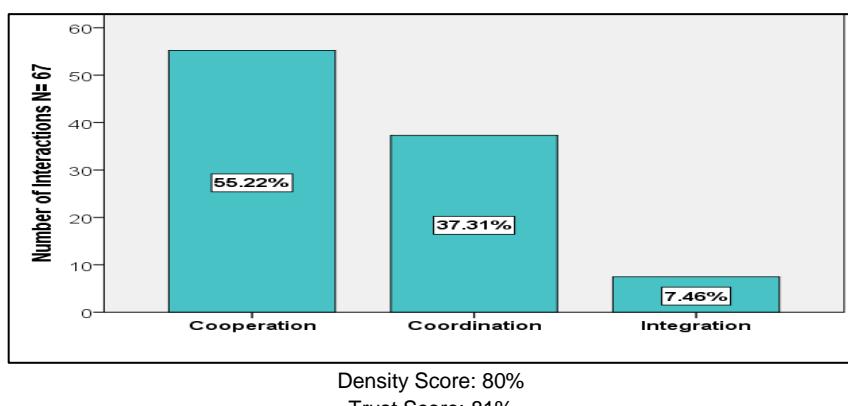
2017



Number of Participants: 10/11

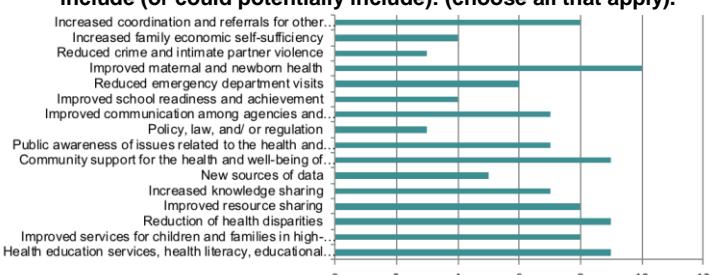
Levels of Collaboration

2017



Outcomes

Outcomes of Nurse-Family Partnership in Gadsden County's work include (or could potentially include): (choose all that apply).

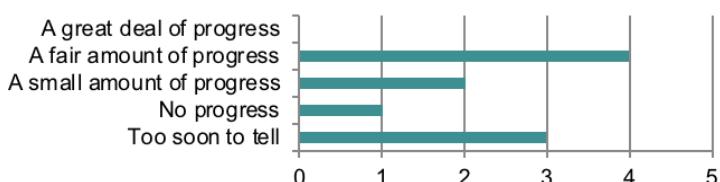


The **MOST IMPORTANT** outcomes of Nurse-family partnership in Gadsden County

1. Improved services for children and families in high-need communities.
2. Reduction in health disparities.
3. Health education services, health literacy, and educational resources.

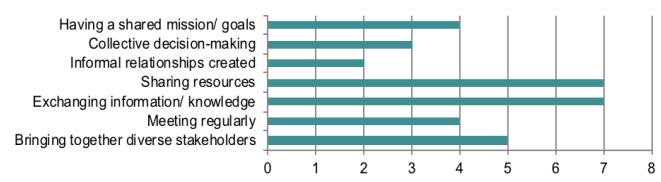
Perceptions of Success

How much progress has Nurse Family Partnership in Gadsden County made towards reaching its goals?



Contribution

What aspects of collaboration contribute to this progress? (Choose all that apply).



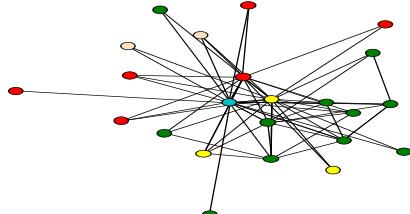
MIECHV Community Partnerships

Hardee/Desoto County

*Completed the PARTNER tool survey for the first time in 2017

Network Maps

2017



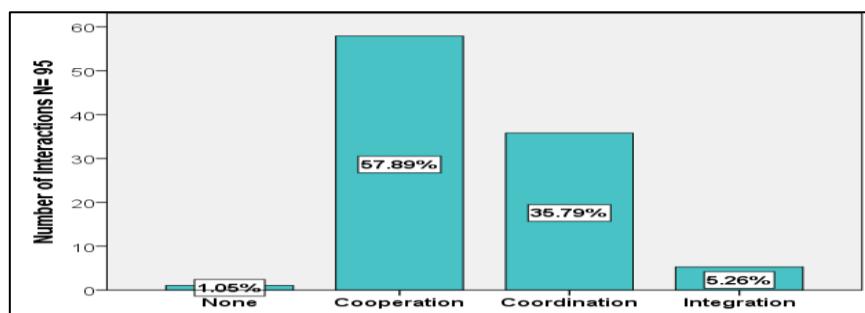
Group Key

- School readiness and achievement
- Child injuries, child abuse, neglect, or maltreatment and reduction of emergency department visits
- Family economic self-sufficiency
- Child injuries, child abuse, neglect, or maltreatment and reduction of emergency department visits
- Crime or domestic violence
- MIECHV
- Unaffiliated

Number of Participants: 12/30

Levels of Collaboration

2017

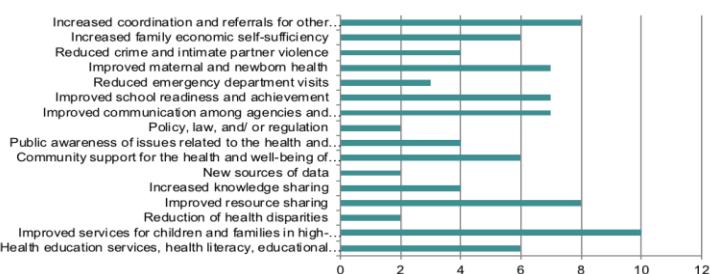


Density Score: 19%

Trust Score: 72%

Outcomes

Outcomes of Parents as Teachers in Hardee/Desoto County's work include (or could potentially include): (choose all that apply).



The **MOST IMPORTANT** outcomes of Parents as Teachers program in Hardee/Desoto County

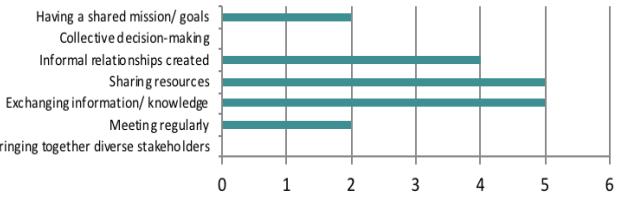
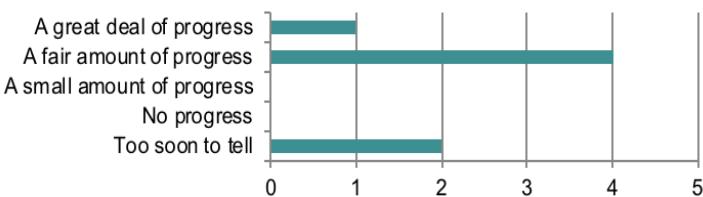
1. Improved services for children and families in high-need communities.
2. Improved school readiness and achievement.

Perceptions of Success

Contribution

How much progress has Parents as Teachers in Hardee/ Desoto County made towards reaching its goals?

What aspects of collaboration contribute to this progress? (Choose all that apply).



Florida
Medicaid
Infant &
Early
Childhood
Home
Visiting
Initiative



Chiles Center
Women, Children & Families

our
practice
is
our
passion.
University of South Florida
College of Public Health

MIECHV Community Partnerships

Highlands County

*Completed the PARTNER tool survey for the first time in 2017

Network Maps

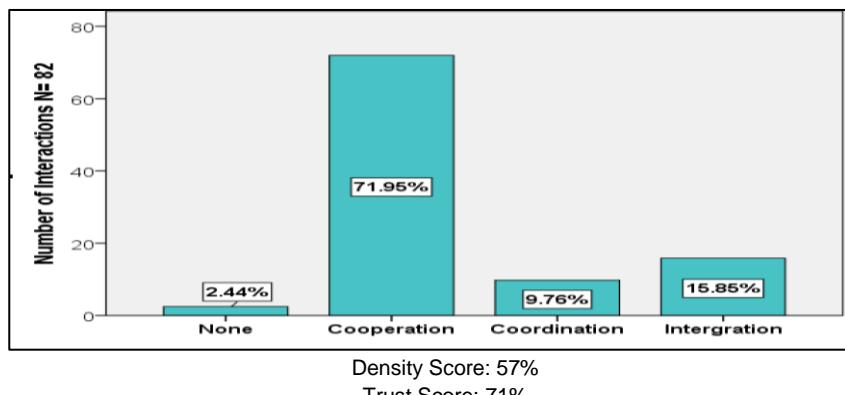
2017



Number of Participants: 13/15

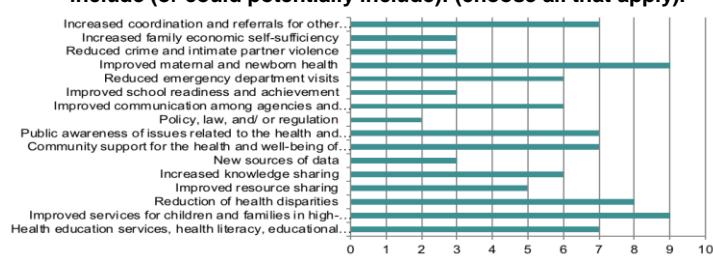
Levels of Collaboration

2017



Outcomes

Outcomes of Nurse-Family Partnership in Highlands County's work include (or could potentially include): (choose all that apply).

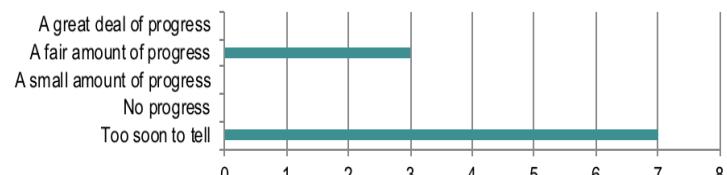


The **MOST IMPORTANT** outcomes of Nurse Family Partnership in Highlands County

- Improved maternal and newborn health.
- Improved services for children and families in high-need communities.

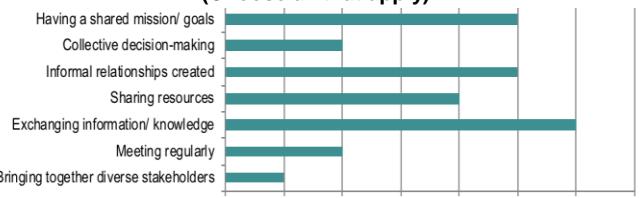
Perceptions of Success

How much progress has Nurse Family Partnership in Highlands County made towards reaching its goals?



Contribution

What aspects of collaboration contribute to this progress? (Choose all that apply).



Florida
Maternal
Infant &
Early
Childhood
Home
Visiting
Initiative



Chiles Center
Women, Children & Families



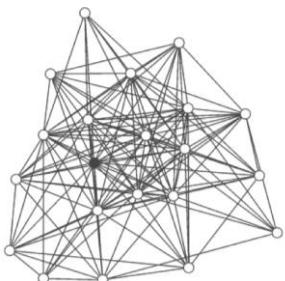
our
practice
is
our
passion.
University of South Florida
College of Public Health

MIECHV Community Partnerships

Hillsborough County

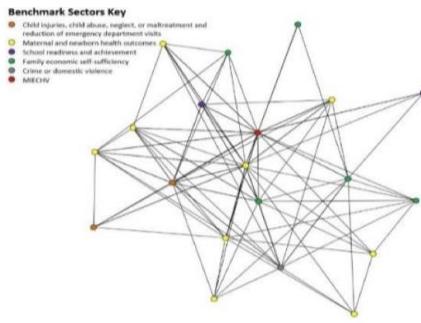
Network Maps

2014



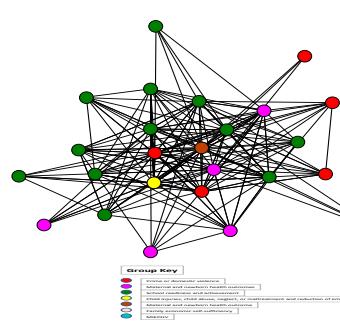
Number of Participants: 20/21

2015



Number of Participants: 19/20

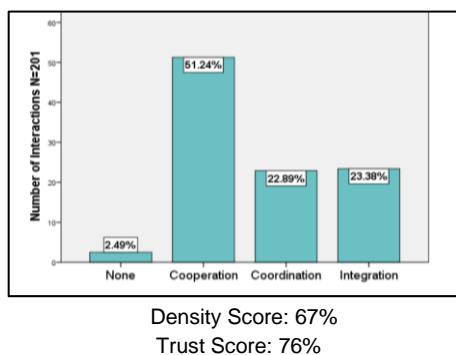
2017



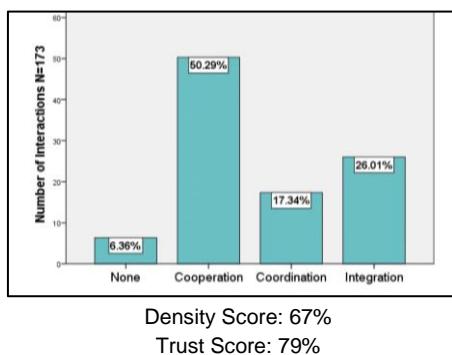
Number of Participants: 19/26

Levels of Collaboration

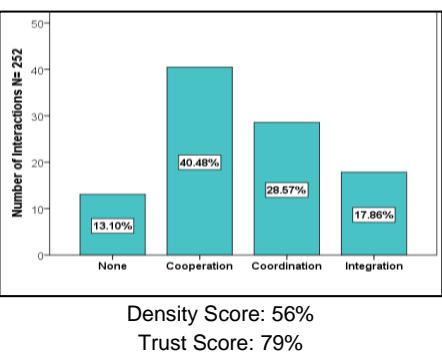
2014



2015

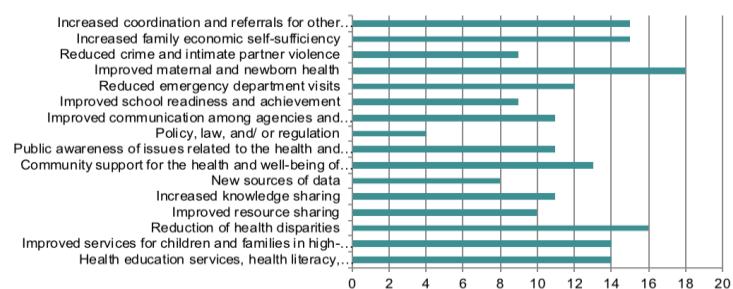


2017



Outcomes

Outcomes of Nurse-Family Partnership in Hillsborough County's work include (or could potentially include): (choose all that apply).

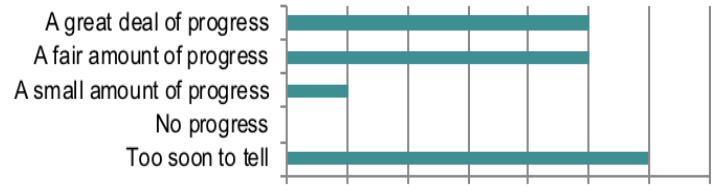


The **MOST IMPORTANT** outcomes of Nurse Family Partnerships in Hillsborough County

1. Improved maternal and newborn health.
2. Improved services for children and families in high-need communities.
3. Reduction in health disparities.

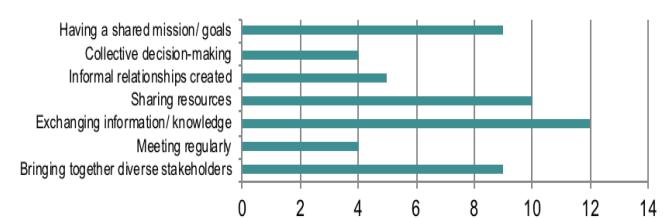
Perceptions of Success

How much progress has Nurse Family Partnership in Hillsborough County made towards reaching its goals?



Contribution

What aspects of collaboration contribute to this progress? (Choose all that apply).



Florida
Maternal
Infant &
Early
Childhood
Home
Visiting
Initiative



Chiles Center
Women, Children & Families

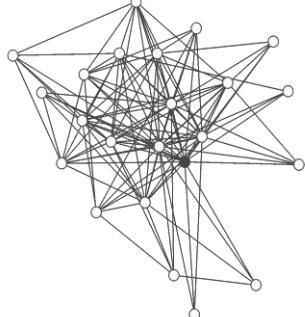
our
practice
is
our
passion.
University of South Florida
College of Public Health

MIECHV Community Partnerships

Manatee County

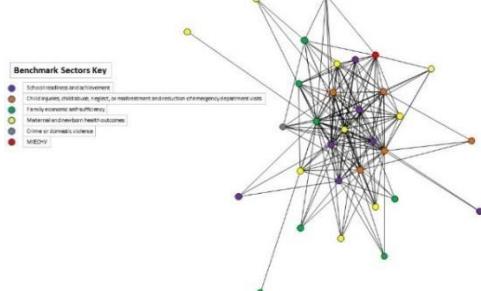
Network Maps

2014



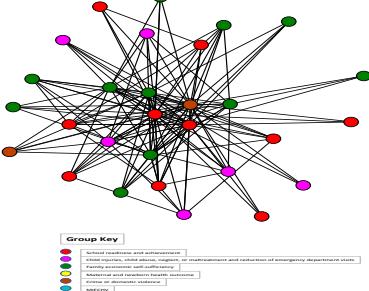
Number of Participants: 17/23

2015



Number of Participants: 26/31

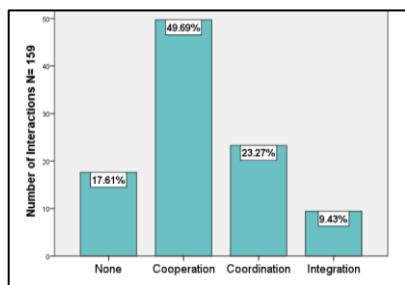
2017



Number of Participants: 20/39

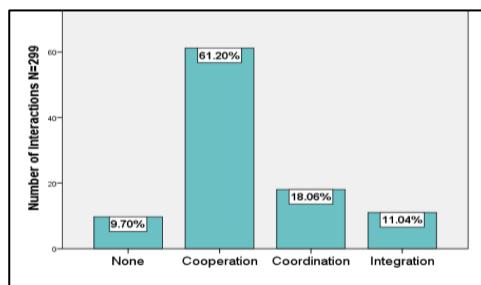
Levels of Collaboration

2014



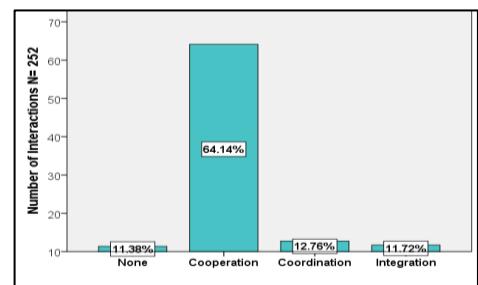
Density Score: 47%
Trust Score: 75%

2015



Density Score: 51%
Trust Score: 70%

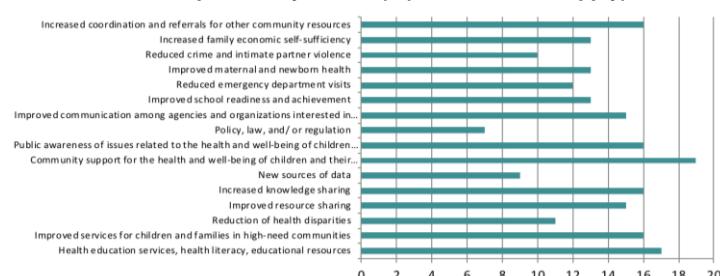
2017



Density Score: 35%
Trust Score: 80%

Outcomes

Outcomes of Parents as Teachers in Manatee County's work include (or could potentially include): (choose all that apply).

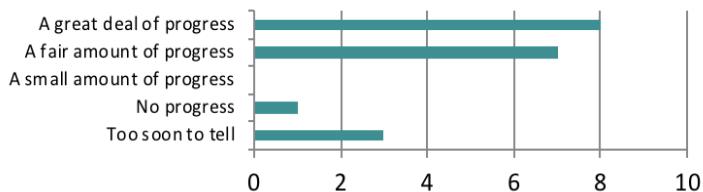


The **MOST IMPORTANT** outcomes of Parents as Teachers program in Manatee County

1. Improved school readiness and achievement.
2. Community support for the health and well-being of children and their families.

Perceptions of Success

How much progress has Parents as Teachers in Manatee County made towards reaching its goals?



Contribution

What aspects of collaboration contribute to this progress? (Choose all that apply).



Florida
Migrant
Infant &
Early
Childhood
Home
Visiting
Initiative



Chiles Center
Women, Children & Families

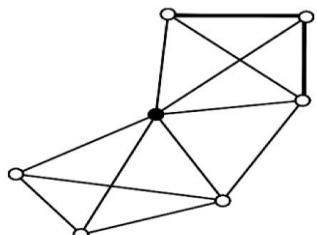
our
practice
is
our
passion.TM
University of South Florida
College of Public Health

MIECHV Community Partnerships

Miami-Dade County

Network Maps

2014



Number of Participants: 6/7

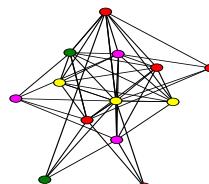
2015

Benchmark Sectors Key
 ● Child injuries, child abuse, neglect, or maltreatment and reduction of emergency department visits
 ○ Maternal and newborn health outcomes
 □ School readiness and achievement
 ■ Family economic self-sufficiency
 ▲ Crime or domestic violence
 ● MIECHV



Number of Participants: 9/9

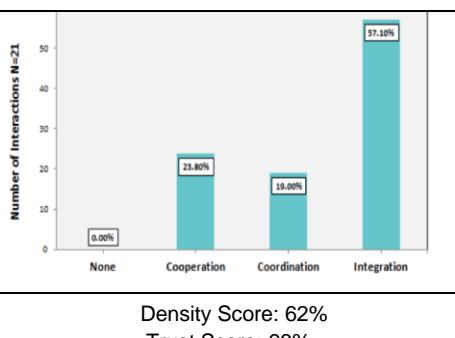
2017



Number of Participants: 9/15

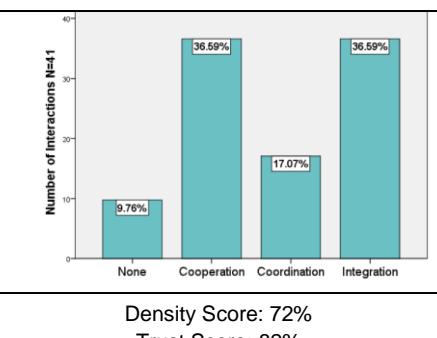
Levels of Collaboration

2014



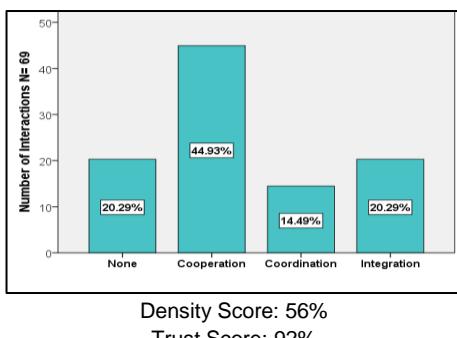
Density Score: 62%
 Trust Score: 93%

2015



Density Score: 72%
 Trust Score: 82%

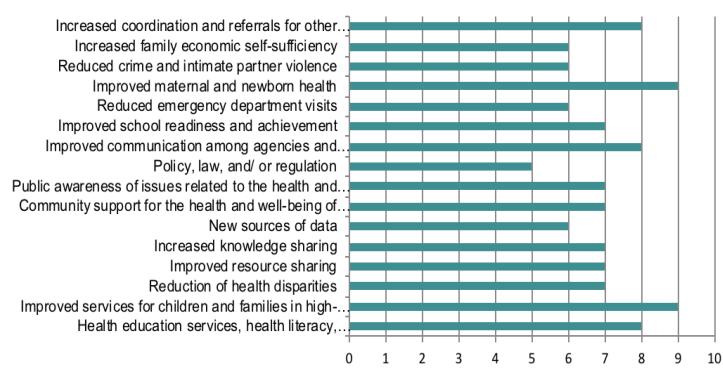
2017



Density Score: 56%
 Trust Score: 92%

Outcomes

Outcomes of Nurse-Family Partnership in Miami-Dade County's work include (or could potentially include): (choose all that apply).

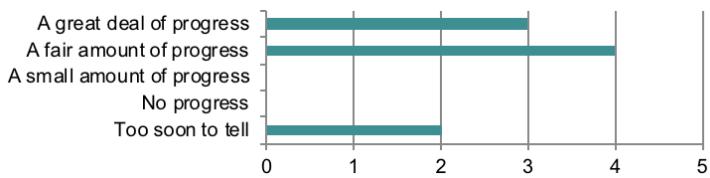


The **MOST IMPORTANT** outcomes of Nurse Family Partnership in Miami-Dade County

1. Improved maternal and newborn health.
2. Reduction in health disparities.
3. Health education services, health literacy, and educational resources.

Perceptions of Success

How much progress has Nurse Family Partnership in Miami-Dade County made towards reaching its goals?



Contribution

What aspects of collaboration contribute to this progress? (Choose all that apply).



Florida
Medicaid
Infant &
Early
Childhood
Home
Visiting
Initiative



Chiles Center
Women, Children & Families



our
practice
is
our
passion.
University of South Florida
College of Public Health

MIECHV Community Partnerships

North Central (Alachua, Bradford, Columbia, Hamilton, and Putnam) Florida Counties

*Completed the PARTNER tool survey for the first time in 2017

Network Maps

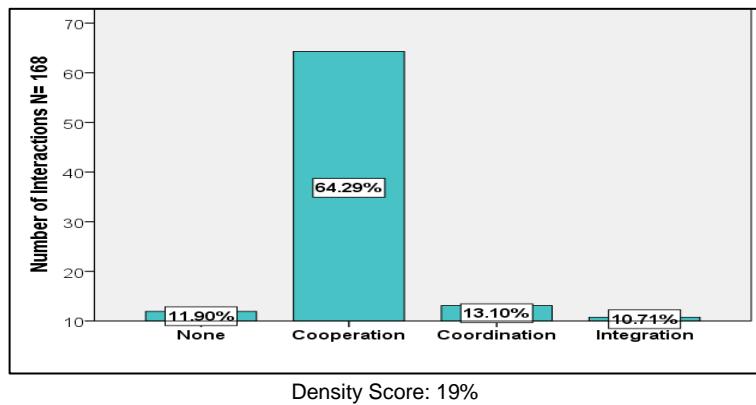
2017



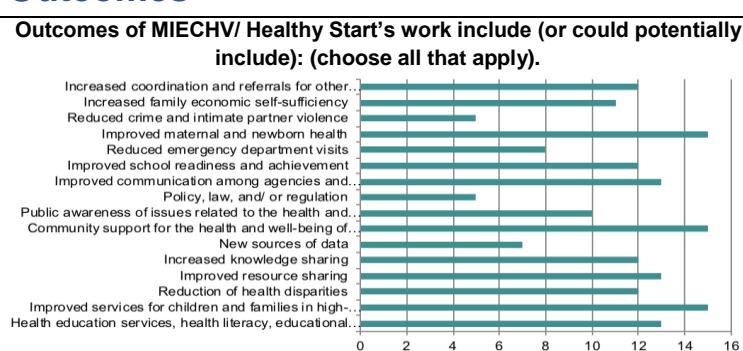
Number of Participants: 18/42

Levels of Collaboration

2017



Outcomes

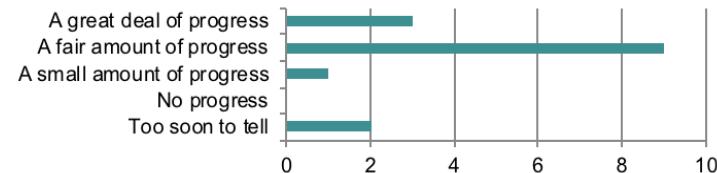


The **MOST IMPORTANT** outcomes of MIECHV in North Central Florida Counties

1. Improved maternal and newborn health.
2. Community support for health and well-being of children and their families.
3. Reduction of health disparities.

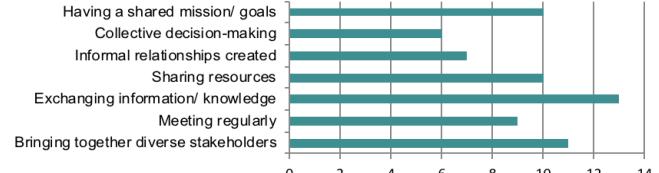
Perceptions of Success

How much progress has Nurse Family Partnership in North Central Florida Counties made towards reaching its goals?



Contribution

What aspects of collaboration contribute to this progress? (Choose all that apply).



Florida
Maternal
Infant &
Early
Childhood
Home
Visiting
Initiative



Chiles Center
Women, Children & Families



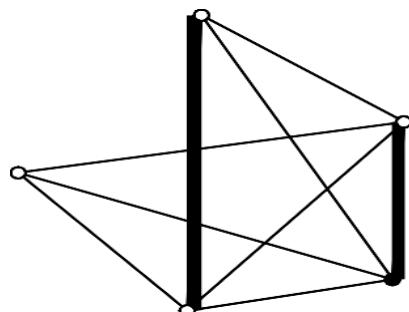
our
practice
is
our
passion.
University of South Florida
College of Public Health

MIECHV Community Partnerships

Orange County

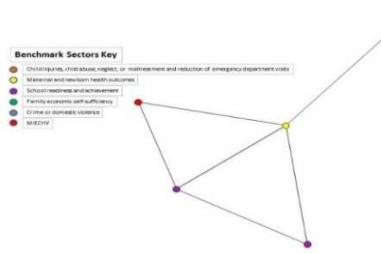
Network Maps

2014



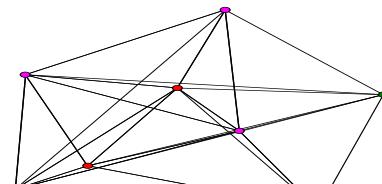
Number of Participants: 4/5

2015



Number of Participants: 4/5

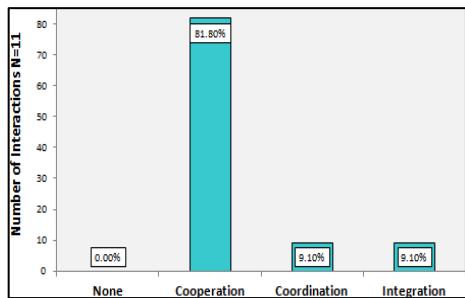
2017



Number of Participants: 8/8

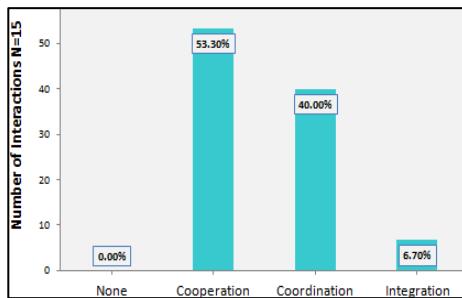
Levels of Collaboration

2014



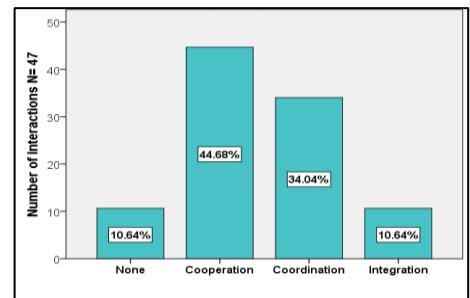
Density Score: 90%
Trust Score: 76%

2015



Density Score: 90%
Trust Score: 90%

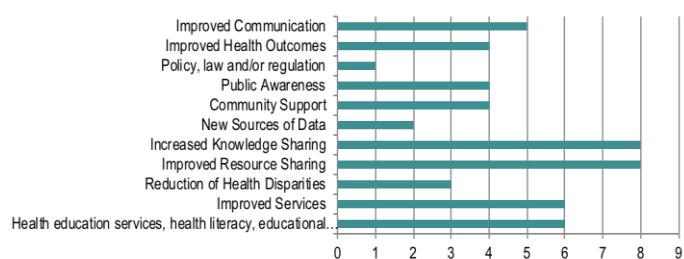
2017



Density Score: 89%
Trust Score: 91%

Outcomes

Outcomes of MIECHV in Orange County's work include (or could potentially include): (choose all that apply).

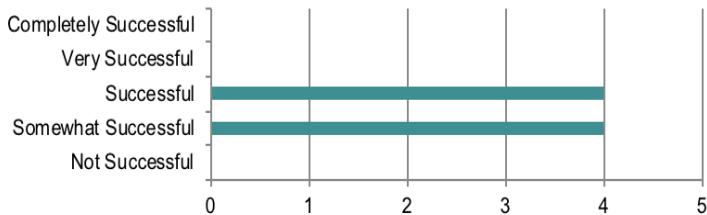


The **MOST IMPORTANT** outcomes of MIECHV in Orange County

1. Improved health outcomes.
2. Community support.
3. Increase knowledge sharing, improved resource sharing and communication.

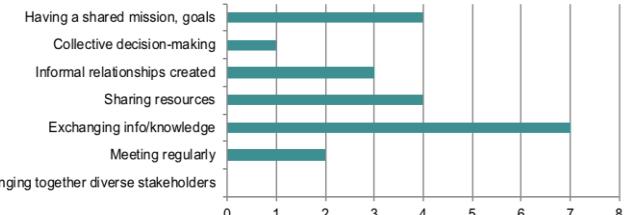
Perceptions of Success

How successful has this community collaborative in Orange County been towards reaching its goals?



Contribution

What aspects of collaboration contribute to this progress? (Choose all that apply).



Chiles Center
Women, Children & Families

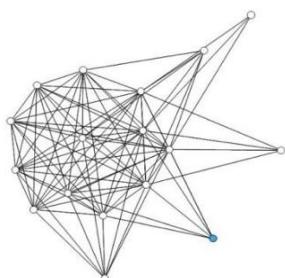
our
practice
is
our
passion.
University of South Florida
College of Public Health

MIECHV Community Partnerships

Pinellas County

Network Maps

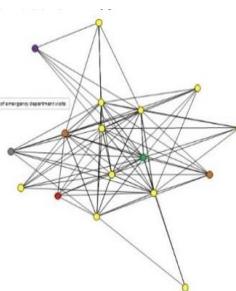
2014



Number of Participants: 13/17

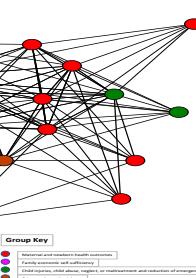
2015

Benchmark Sectors Key



Number of Participants: 12/17

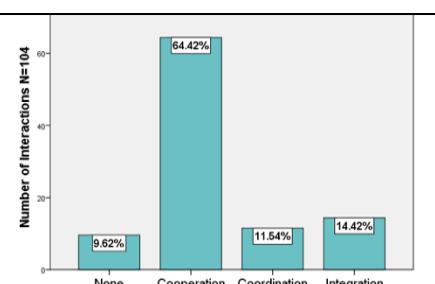
2017



Number of Participants: 12/17

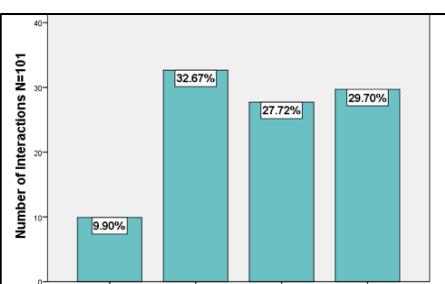
Levels of Collaboration

2014



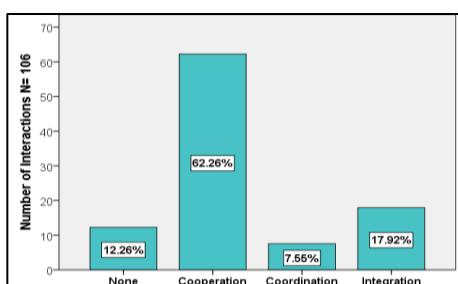
Density Score: 66%
Trust Score: 81%

2015



Density Score: 65%
Trust Score: 71%

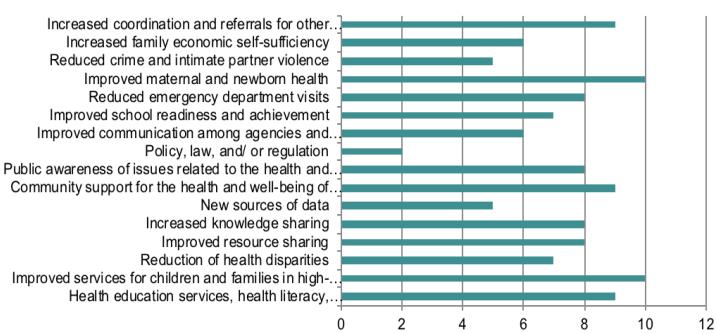
2017



Density Score: 63%
Trust Score: 68%

Outcomes

Outcomes of Parents as Teachers in Pinellas County's work include (or could potentially include): (choose all that apply).



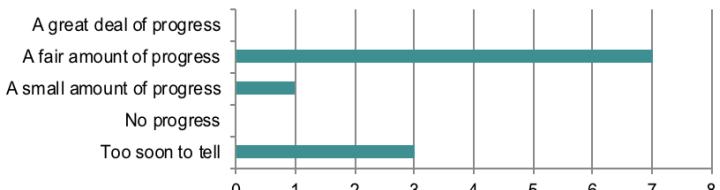
The **MOST IMPORTANT** outcomes of Parents as Teachers Program in Pinellas County

1. Improved services for children and families in high-need communities.
2. Community support for health and well-being of children and their families.
3. Improved maternal and newborn health.

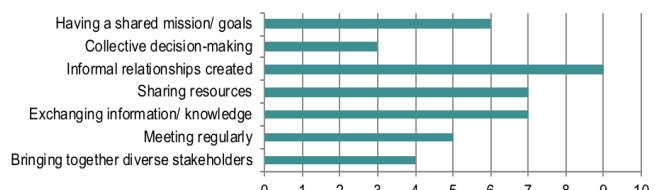
Perceptions of Success

Contribution

How much progress has Parents as Teachers in Pinellas County made towards reaching its goals?



What aspects of collaboration contribute to this progress? (Choose all that apply).



Florida
Migrant
Infant &
Early
Childhood
Home
Visiting
Initiative



Chiles Center
Women, Children & Families



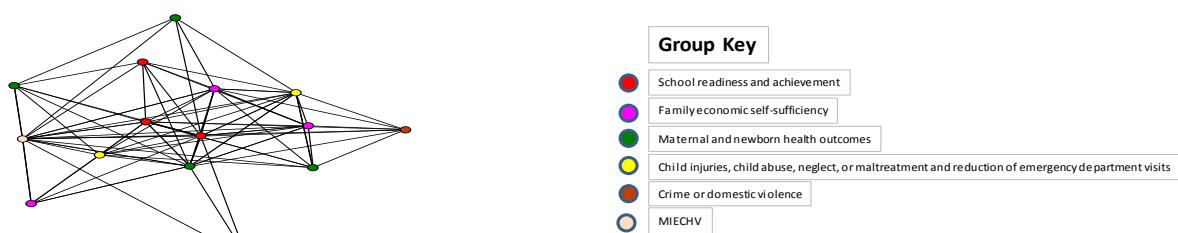
MIECHV Community Partnerships

Polk County

*Completed the PARTNER tool survey for the first time in 2017

Network Maps

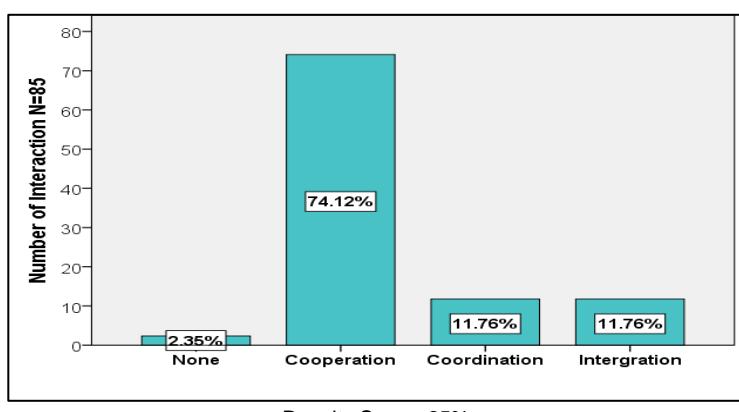
2017



Number of Participants: 11/15

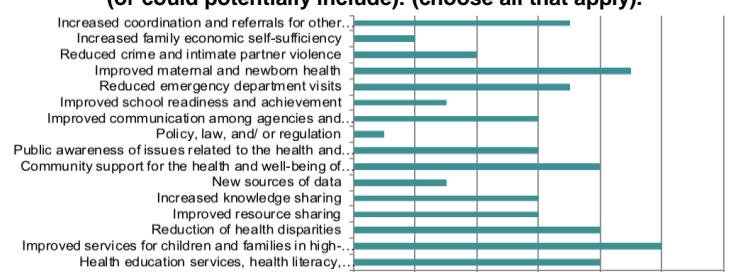
Levels of Collaboration

2017



Outcomes

Outcomes of Nurse-Family Partnership in Polk County's work include (or could potentially include): (choose all that apply).

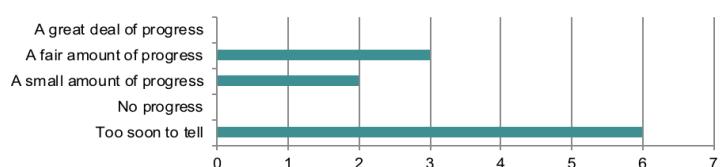


The **MOST IMPORTANT** outcomes of Nurse Family Partnership in Polk County

1. Improved maternal and newborn health.
2. Improved services for children and families in high-need communities.
3. Reduction of health disparities.

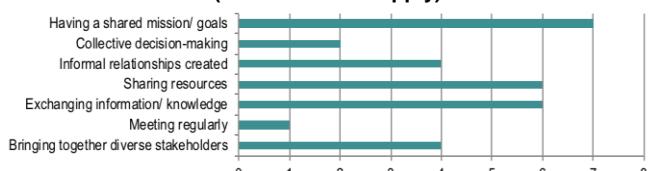
Perceptions of Success

How much progress has Nurse Family Partnership in Polk County made towards reaching its goals?



Contribution

What aspects of collaboration contribute to this progress? (Choose all that apply).



Florida
Maternal
Infant &
Early
Childhood
Home
Visiting
Initiative



Chiles Center
Women, Children & Families



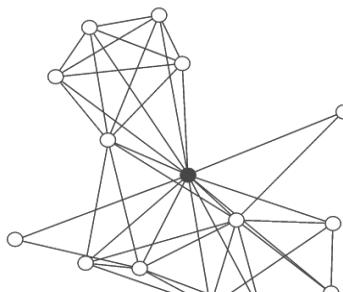
our
practice
is
our
passion.
University of South Florida
College of Public Health

MIECHV Community Partnerships

Southwest Florida (Lee, Hendry, and Collier) Counties

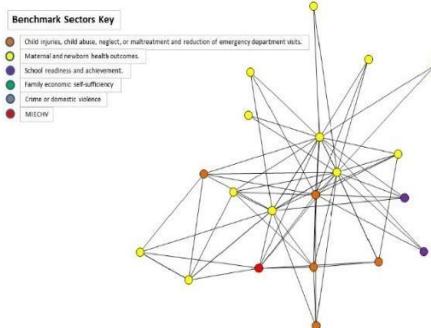
Network Maps

2014



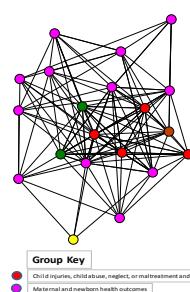
Number of Participants: 11/15

2015



Number of Participants: 14/20

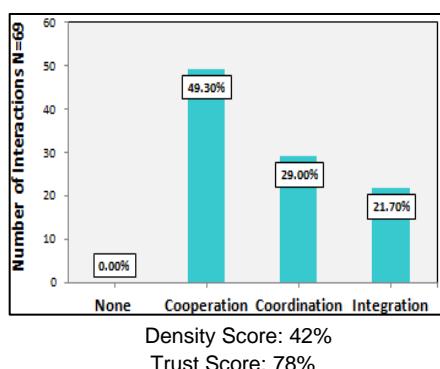
2017



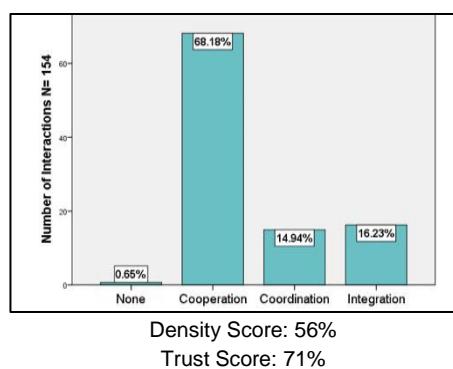
Number of Participants: 17/21

Levels of Collaboration

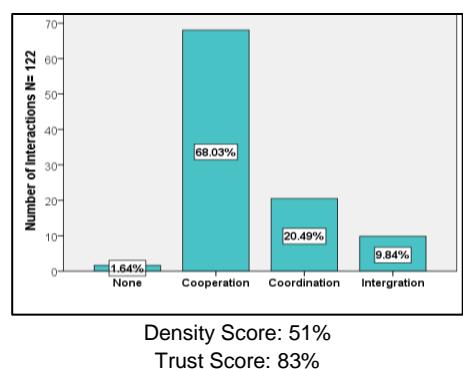
2014



2015

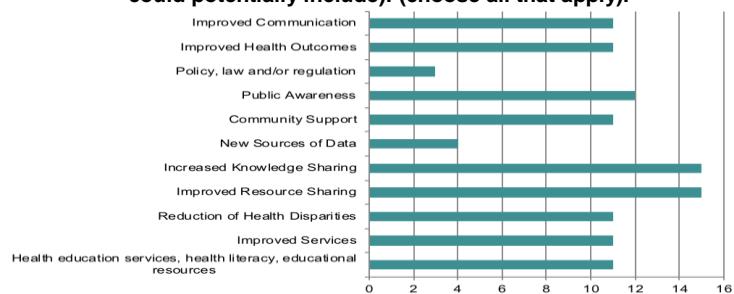


2017



Outcomes

Outcomes of MIECHV in Southwest Florida Counties' work include (or could potentially include): (choose all that apply).

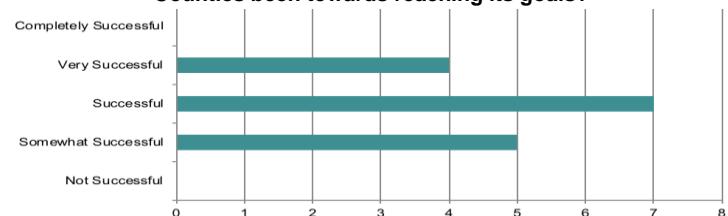


The **MOST IMPORTANT** outcomes of MIECHV in Southwest Florida Counties

1. Improved health outcomes.
2. Improved services.

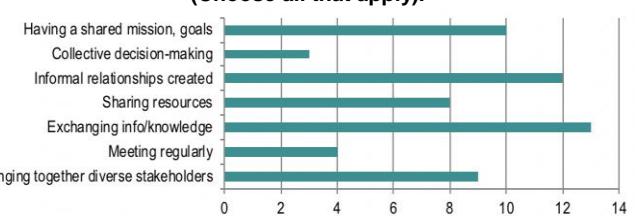
Perceptions of Success

How successful has this community collaborative in Southwest Counties been towards reaching its goals?



Contribution

What aspects of collaboration contribute to this progress? (Choose all that apply).



Florida
Maternal
Infant &
Early
Childhood
Home
Visiting
Initiative



Chiles Center
Women, Children & Families

our
practice
is
our
passion.TM
University of South Florida
College of Public Health

FLORIDA MATERNAL, INFANT, & EARLY CHILDHOOD HOME VISITING (MIECHV) PROGRAM EVALUATION

COORDINATED INTAKE & REFERRAL LEARNING COLLABORATIVE, SPRING 2016



Paige Alitz, Amber Warren, Pamela Birriel, Omotola Balogun,
Takudzwa Sayi, & Jennifer Marshall



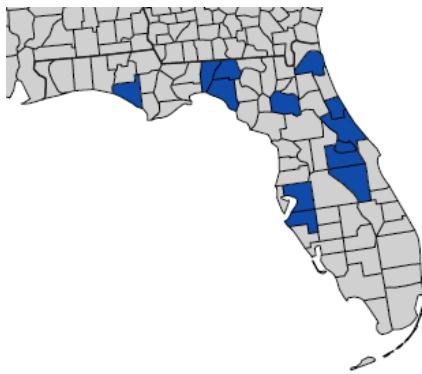
our practice
is our passion.
University of South Florida
College of Public Health

The Lawton and Rhea
Chiles Center
for Healthy Mothers and Babies

INTRODUCTION

THE COORDINATED INTAKE & REFERRAL LEARNING COLLABORATIVE

During the Spring of 2016, the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative partnered with the State Title V agency to develop and test Coordinated Intake and Referral (CI&R) models with a group of Florida's Healthy Start Coalitions using the state's universal prenatal and infant risk screens. The prenatal and infant risk screens provide a foundation for local maternal and child health systems, affording universal access to appropriate care and services. The purpose of a CI&R system is to streamline an oftentimes complex process by minimizing duplication of services, utilizing community resources effectively, determining the best services for the needs of families, and following what family participation and referrals collectively. Community collaborations are integral to this process because they form the foundation and extent to which services are available to families and may also help to expedite community referrals.

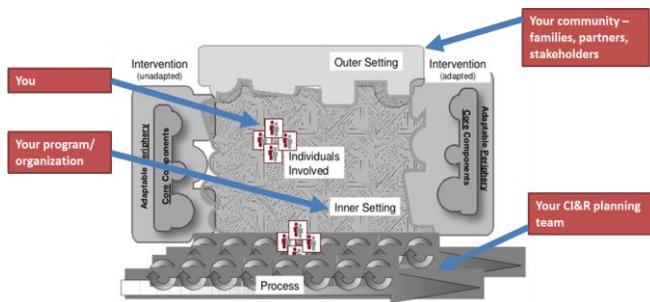


This project was implemented using a learning collaborative approach with participation from eight Healthy Start Coalition teams who self-selected in response to a request for proposals (RFP) sent to all of the 32 coalitions. Per the RFP participating coalitions were required to include specific organizations on their local teams, including at a minimum: Healthy Start Coalition, local Health Department responsible for processing screening forms, Healthy Families Florida, Federal Healthy Start, Early Head Start, MIECHV-funded project, Early Steps, additional care coordination, education and support programs, and other key stakeholders. They had the flexibility of selecting any five members to serve on the travel team to attend in-person learning sessions. Florida MIECHV Initiative provided the participating coalitions with financial support (\$90,000 - \$120,000 for the 21-month project period, depending on number of births in their area) to design and implement system changes as part of the learning collaborative. These eight coalition teams all started in different places - from no CI&R experience to implementing CI&R in some fashion – and all are early adopters, with leadership that sees the value added by participating in this learning collaborative.

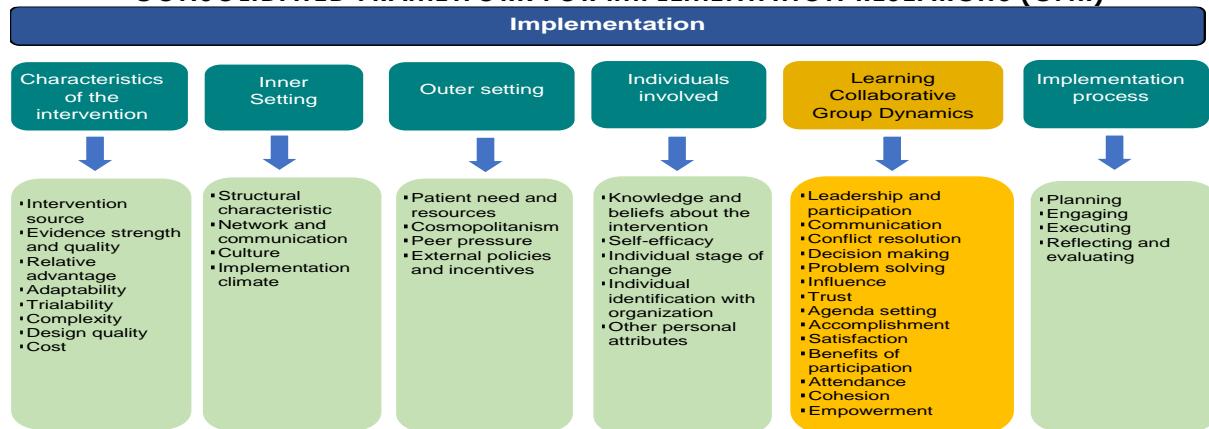
PARTICIPATING HEALTHY START COALITION (HSC)	COUNTY/ COUNTIES	ANNUAL NUMBER OF BIRTHS 2014-2015
HSC of North Central Florida	Alachua	2,914
Bay, Franklin, Gulf HSC	Bay	2,389
HSC of Flagler & Volusia	Flagler, Volusia	5,609
HSC of Hillsborough	Hillsborough	17,238
HSC of Jefferson, Madison & Taylor	Jefferson, Madison, Taylor	558
Northeast Florida HSC	Duval	12,761
HSCs of Orange, Osceola & Seminole	Orange, Osceola, Seminole	25,067
HSC of Manatee	Manatee	3,549
Total	13 Counties	70,085

EVALUATION FRAMEWORK

The University of South Florida (USF) evaluation team utilizes the Consolidated Framework for Implementation Research (CFIR) to describe the characteristics of the learning collaborative and will document the successes and challenges faced by the learning collaborative in integrating CI&R models into local systems of care, particularly in the context of Florida's universal prenatal and infant risk screens. This framework is a useful guide for formative evaluation research, as it provides an organizational framework for synthesizing and building knowledge about what works in multiple settings.¹ As explained by Kilbourne et al., this model is useful for implementation research, "Adaptive implementation designs consisting of a sequence of decision rules that are tailored based on a site's uptake of an effective program may produce more relevant, rapid, and generalizable results by more quickly validating or rejecting new implementation strategies, thus enhancing the efficiency and sustainability of implementation research and potentially leading to the rollout of more cost-efficient implementation strategies."² The evaluation primarily focuses on the organizational-level (community teams) collaborative characteristics, perceptions, and processes.



CONSOLIDATED FRAMEWORK FOR IMPLEMENTATION RESEARCH³ (CFIR)



CI&R LEARNING SESSIONS

The first meeting of the learning collaborative took place in Jacksonville, Florida March 10-11, 2016. Representatives from each of the eight participating Healthy Start Coalitions attended the event. The two-day meeting included guest speakers, break-out sessions, and team poster presentations. These activities were designed to encourage information sharing among the different Healthy Start Coalition travel teams regarding their community CI&R systems and provide an opportunity for networking.

As part of the MIECHV program evaluation, a baseline comprehensive CI&R readiness survey was distributed to all learning collaborative participants electronically before the meeting to examine: their respective community's CI&R system characteristics and perceptions of system changes; the inner setting of the organization; the outer setting and community partners; their involvement in their community's CI&R system changes; group dynamics of their CI&R teams; and their impressions of the CI&R implementation process in their community. There were open-ended questions in the survey for

participants to enter their responses regarding their personal/professional CI&R knowledge, as well as their organization's CI&R knowledge.

Three separate focus groups were then conducted by the MIECHV evaluation team during the second day of the learning collaborative meeting. Focus group discussions were based on CFIR constructs: perceptions of opportunities and challenges of CI&R system change within the context of individual, organizational, and community characteristics; perceptions of system changes; and learning collaborative group dynamics. Discussions were audio recorded and professionally transcribed verbatim. Transcripts were reviewed for accuracy by the MIECHV evaluation team.

CI & R TEAM MEMBER DEMOGRAPHICS

BASELINE READINESS SURVEY – INDIVIDUAL TEAM MEMBER DEMOGRAPHICS

51 CI&R team members completed the baseline survey. Most survey respondents (66%) described their organization as a home visiting program, 12% did not identify a predetermined category, and 4% and 1% described their organizations as healthcare and early childhood care/ education, respectively. Almost half of all team members identified as administrators or directors in their organizations. Respondents' experience in their professional field ranged from 0 to 46 years, averaging 17 years of experience. A minority (10%) of respondents identified as Hispanic, while the majority (72%) were White and 20% Black. The largest group of participants (56%) had professional or graduate degrees, and 26% had a bachelors, 6% an associate degree, and 10% some college without a degree.

BASELINE PRE-COLLABORATIVE READINESS SURVEY

CI & R SYSTEM CHARACTERISTICS

In the pre-collaborative readiness survey distributed before the meeting, CI&R team members were asked to rate the strength of evidence that is available in implementing CI&R systems changes. When asked how they perceived the strength of evidence in the CI&R system to meaningfully impact family outcomes, 38% felt there was very strong evidence, 48% felt there was slightly strong evidence, 10% felt neutral, and 2% there was slightly or very weak evidence. Team members responded similarly when asked how they thought that respected officials within the organization would rate the strength of evidence for CI&R systems change to meaningfully impact family outcomes; 18 (38%) felt officials would rate the evidence as very strong and 23 (48%) as slightly strong, four (8%) neutral, two (4%) as slightly weak, and one (2%) who felt officials would rate the evidence as very weak.

INNER SETTING OF THE ORGANIZATION

Team members were posed a series of statements in the survey that dealt with how they perceived that the inner setting of their organization might have an influence on the CI&R system changes. Most agreed or strongly agreed when asked if: CI&R system changes within the organization take into account the needs and preferences of families; management/leadership have clearly defined areas of responsibility to implement CI&R system changes; management/leadership promote communication among community partners to implement CI&R system changes; communication will be maintained with regular project meetings; and staff members are receptive to the CI&R system changes. Most participants however strongly disagreed/disagreed that the current CI&R system is intolerable and needs to be changed. Nonetheless, about 21% of participants agreed that the current system was either intolerable or needed to be changed.

Additional comments on the organizational setting were:

"Our CI&R is still in the planning phase. I will be going to Jacksonville this Thursday to learn more."

"We are still in the formative stage of our C I & R project and many of the previous questions were not applicable at this time. We have not yet begun the work to develop our design and implementation plan."

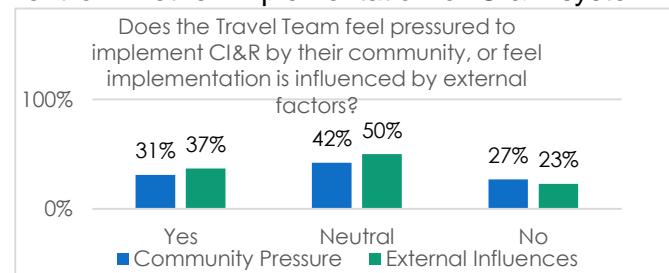
"I am sure there are areas of improvement and opportunities to take it to the next level."

"The lead is very knowledgeable and capable to move forward with CI & R."

"I'm concerned that historical animosity may impact our ability to move forward as quickly as could be possible."

OUTER SETTING - COMMUNITY PARTNERS

Team members were presented with six different statements to gauge their insights on how community partners might influence the CI&R system changes. For the statements rating the extent to which their community took into consideration the needs and preferences of families, and of partner agencies, a large proportion - 72% and 79% team members agreed with the statements, respectively. Regarding whether they felt that those on the CI&R system change team were networked with other community organizations, 81% agreed, 13% felt neutral, and 8% disagreed. Regarding whether team members felt that there was peer pressure by their respective communities to implement CI&R system changes, the responses were somewhat evenly distributed. There were 15 (31%) who agreed that there was peer pressure, 20 (42%) who felt neutral, and 13 (27%) who disagreed. Responses followed a similar pattern when team members were presented with the statement of whether implementation of CI&R system changes was influenced by external policy and incentives. There were 13 (37%) who agreed that their CI&R system changes were influenced, 24 (50%) who felt neutral, and 11 (23%) who disagreed. There was no difference, based on whether the respondents felt pressured, in whether they felt that the current system was intolerable or needed to be changed.



INVOLVEMENT IN CI&R SYSTEM CHANGES

Team members were also asked about the extent of their personal involvement in CI&R system changes. Nearly all team members agreed that their attitude towards the value placed on CI&R system changes was positive, with 96% agreeing and only 4% reporting neutral. Similarly, all team members (100%) felt that their degree of commitment to the CI&R system changes was positive. Regarding whether team members believed in their own capabilities to execute courses of action to achieve implementation goals for the CI&R system changes, 90% agreed this was true and 10% were neutral.

Two statements were posed to team members with respect to the planning and implementation process of CI&R system changes. For the first statement of whether team members were *actively planning* to implement CI&R changes, there were 43 (90%) who agreed, three (6%) who felt neutral, and two (4%) who disagreed. The second statement inquired whether team members were *already working* on CI&R system changes. There were 34 (71%) who agreed that they were already working on changes, 11 (23%) who felt neutral, and three (6%) who disagreed, meaning they were not already working on the changes. Ten respondents (71%) of those not currently working on or neutral are actively planning to implement system changes.

CI&R team members were also asked if they had any additional comments about their personal/professional centralized intake & referral knowledge or practices:

"Beginning stage - Need time." "We are just beginning this process." "... just recently developed our team."

"We are just beginning and haven't delved into the details yet. We were waiting for the initial meeting in order to gage a better idea of action steps."

"We are still in the early formative stage of our CI&R project and many of the previous questions were not applicable at this time. Our organization is extremely committed to working to develop community minded thought and effective change to our CI&R system."

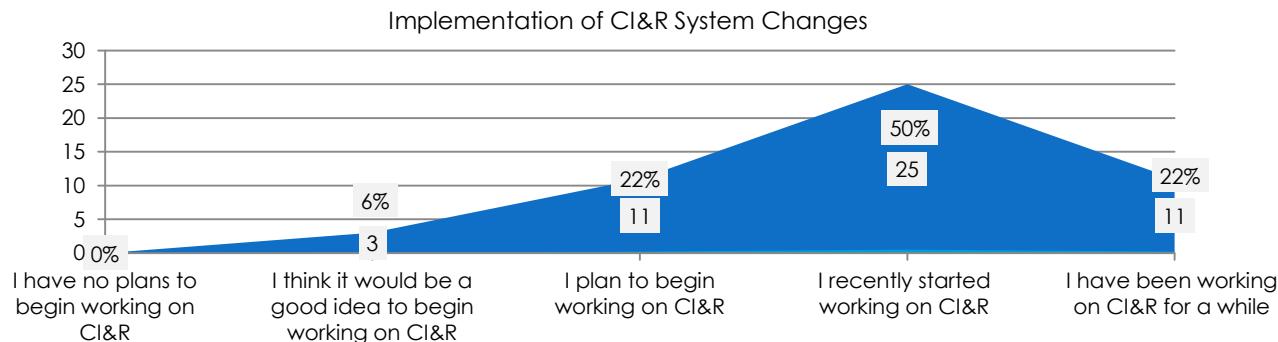
"I am willing to be a part of local community team that will be using CI&R. I was recently introduced to the system and looking forward to receive more knowledge."

"We have been implementing a centralized I&R for a while in [our county] and have a fluid process."

"We are past the planning stage and we are in our second year after implementation."

"Integrating assessment processes and data collection have been key for the progress we have made so far. We would really like to use technology more to our advantage by giving participants more access to services through 'apps' and self-assessment/screening."

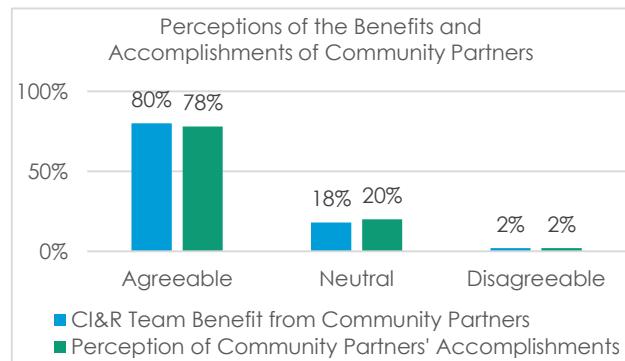
"I do believe that our involvement and participation with the CI&R learning collaborative will assist us in enhancing our processes and improve services for families in our community."



CI&R GROUP DYNAMICS

A series of statements were posed to team members to evaluate the group dynamics of their respective CI&R teams. There were 41 (85%) team members who believed that there was leadership and participation among community partners, whereas 4 (8%) and 3 (6%) felt neutral and disagreed respectively. Similarly, there were 42 (88%) team members who felt that there was communication between community partners, with 3 (6%) who felt each neutral and 3 (6%) who disagreed with the statement, and 39 (80%) reported acceptable levels of decision making capabilities among community partners. Regarding whether there was adequate conflict resolution among community partners, 32 (67%) team members who agreed, 13 (27%) felt neutral, and 3 (6%) disagreed. Finally, 39 (80%) team members felt that there was trust among community partners, with 7 (14%) team members reporting neutral and 3 (6%) who disagreed.

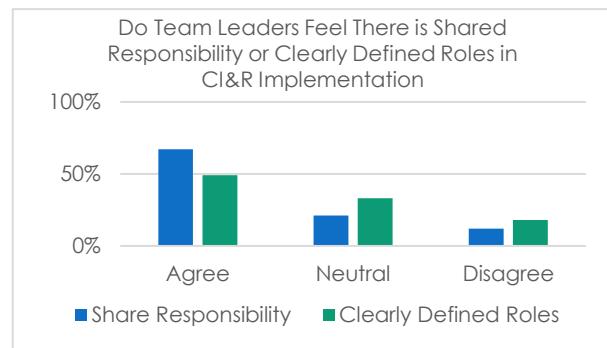
Team members were also asked whether their CI&R teams benefit from their participation with community



partners. There were 39 (80%) team members who agreed, 9 (18%) who reported neutral, and 1 (2%) who disagreed. Their perception of the accomplishments of community partners followed a similar trend, with 38 (78%) feeling as though the level of accomplishments were agreeable, 10 (20%) feeling neutral, and 1 (2%) who reported the level was disagreeable. Satisfaction among community members was found agreeable by 32 (65%) and neutral by 16 (33%) team members, with 1 (2%) team leader finding it disagreeable.

CI&R IMPLEMENTATION

Team members validated statements related to the implementation process for CI&R system changes. Statements indicated whether the organization had a staff participation/satisfaction survey (51% agreed) or a dissemination plan in place (47% agreed) for performance measures as the CI&R system changes unfold. There were 6 (12%) who answered each question by disagreeing, indicating that neither surveys nor a dissemination plan were part of the CI&R system changes. Regarding provider buy-in, 28 (57%) team members indicated that they had provider buy-in, and 5 (10%) team members reported they did not. Statements were presented as to whether team members were expected to share the responsibility of the CI&R system changes leading to success of the program; and whether team members have clearly defined roles and responsibilities. 67% of team members agreed that team members share the responsibility, but only 49% identified that team members have clearly defined roles and responsibilities. There were 6 (12%) and 9 (18%) who indicated that their teams did not have shared responsibility and clearly defined roles and responsibilities, respectively. Additionally, 33 (67%) believed they had a systems team in place and 4 (8%) indicated they did not, with the remainder feeling neutral. Those who disagreed or were neutral about clearly defined roles were more likely to feel that the system needed to be changed or was intolerable than those who agreed. There however is not a linear relationship between low values of agreement on most of the implementation variables with feelings about the need to change the system.



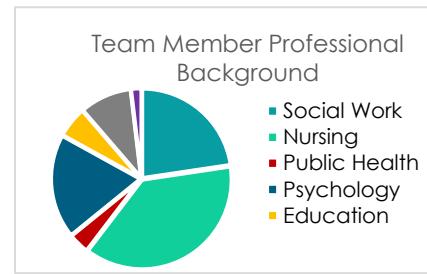
FOCUS GROUP RESULTS

Three separate, simultaneous focus groups were moderated by members of the USF evaluation team during the learning collaborative. CI&R travel team members were asked a series of questions to gain insight into: how their teams came into fruition; the decision process for taking part in the CI&R intervention; determining the informal leaders or champions taking the lead in the CI&R initiatives; reasons for deciding to implement the CI&R system changes in their communities; and how essential the CI&R intervention is to families in their communities.

TRAVEL TEAM MEMBER DEMOGRAPHICS

In total, 31 CI&R travel team members attended the learning collaborative in Jacksonville. The characteristics of the group who attended the learning collaborative were fairly representative of the baseline readiness respondents. The representation at the meeting was nearly balanced: of the participants, Alachua and Volusia/Flagler counties each had five leaders in attendance; Bay, Duval, and Hillsborough counties each had four; and Jefferson/Madison/Taylor, Manatee, and Orange/Osceola/Seminole counties had three each. In terms of service sectors of the organization, 55% of travel team

members identified their organization as maternal and/or newborn health focus, 35% identified as a home visiting organization, 6% as a school readiness program, and 3% as a child maltreatment program. Within these organizations, most individuals (58%) self-identified as an administrator/director, 10% as a family support worker, and 3% as a supervisor. The remaining nine participants (29%) selected 'other,' which included: community relations, Healthy Families program manager, a program coordinator or program specialist, a CI&R project manager, a training specialist, program improvement, and a peer breastfeeding specialist. Experience in the current role ranged from zero to 18 years, with an average duration of 4.8 years (standard deviation of 5.5 years). Additionally, 40% of participants and 16% of participants had more than five and ten years of experience in the current role, respectively.



The majority of travel team members self-identified as 35 or older (77%), non-Hispanic (90%), and White (61%). Educational background was quite diverse; 17 (55%) participants held a graduate degree, 10 (32%) held a college degree, and 3 (10%) had some college experience, with public health (29%), social work (16%), and education (16%) being the most common fields. The selection of 'other' was selected 35% of the time, and included a wide range of answers such as sociology, English, economics, and recreation/tourism.

HOW WAS THIS CI&R LEADERSHIP GROUP OR TEAM FORMED?

When asked how their respective CI&R leadership group formed, some of the travel team members responded that most of the group was already in place before the CI&R initiative, having to add a few people to the team when they found out about the CI&R grant opportunity. Other travel team members reflected on the team recruiting and building process because there was no prior team in place.

"For [our county], since we're so large, we've actually had a kind of meeting going for the last couple of years that we've called [name] and it was our one place to come once a month. We'd invite Healthy Families, any other potential partners in the community. So, it's developed prior to – even with coordinated intake."

"A lot of the folks on our team have been working together on other collaborative initiatives. So, basically, I just called everybody... 'We have another opportunity to apply for some funding. We'd like you at the table. It's really important to have the whole continuum.' Pretty much everybody said yes."

"We've only really had one collective team meeting where all the members came to the table. There's been e-mails, different things like that, that just kind of the understanding. We weren't sure; our thing was basically when you get to this meeting. These guys are going to bring back what we're really supposed to do. So, there wasn't like a road map."

"In [our county], we already had a home visiting coalition that met monthly with all the home visiting programs in the county. This was something that we had talked about wanting to do before this RFP ever came out."

HOW WAS IT DECIDED TO PARTICIPATE IN THE CI&R INTERVENTION?

Much like the formation of teams, the decision to participate in the CI&R intervention varied between already having an ad hoc CI&R system in place, and making the decision with little previously

established. One sentiment that was shared among all teams, however, was how the decision was made based on what they perceived as the best choice for the families they served.

"Since for the last couple of years we've been meeting and we realized that there needs to be a process put into place within our community...We're in like a – working [on the] fly because it's something that we had been wanting to do, but it takes time, it takes money, it takes commitment, and it takes guidance, and that's kind of what we're all here together...versus trying to do our own things."

"We do have the advisory board, we just meet quarterly and we probably need to meet more often - so we have a structure in place but know that we're at the point where we could really provide services to many more families."

"The part I'm looking forward to is just to having one system where each agency can go in and look up and see what they provided for each family, so there won't be a duplication of services; because you can very well get a car seat for one service, come over to another and get another car seat, and we just need to have that. All the agencies needs to be viewing one thing ."

"I think what really stood out for me is when [partner agencies] talked about families having to share their story over and over. It's not respectful to them..."

WHO ARE THE INFORMAL LEADERS IN THE CI&R INTERVENTION?

Travel team members were asked to identify those who were the informal leaders, or champions of the CI&R intervention. These were people or organizations who leaders reported had gone above and beyond in their support efforts. In every focus group, Healthy Families identified as a key leader in the respective community's intervention. Other leaders that the teams mentioned ranged from MIECHV, non-profit organizations, the government, to the parents who use the CI&R services.

"I would say for us it's all the leadership and staff at the Community Coalition and are also managers at the health departments that do use services."

"I think the leaders of all the home visiting programs are really involved and really onboard to really create this collaborative approach. So, I think we're kind of ahead of the curve just because the provider meetings and the relationships we've established..."

"Yes. I think that's been the key for us, as really – I think as we've been really discussing this, we've been trying to figure out who exactly do we have to have buy-in from, which is really everybody, but really, key is actual parents that would use our services."

"I think that's the thing I'm taking away from this [learning collaborative] the most is that we think we know best...and we've been doing this and so of course, why wouldn't we be the best. But I think we do lose sight sometimes of that [family] and we need to actually be thinking the most about what their input could be in this process."

WHAT ARE THE DRIVING FACTORS FOR A CI&R INTERVENTION?

Travel team members were asked to explain why they thought the CI&R intervention was being implemented in their respective communities. In every focus group, leaders expressed similar notions of how much easier it is for the organizations in a community to be quite literally coordinated so that services are streamlined for families. Oftentimes there are overlaps in services provided to families, and there are also different qualifications for different services that organizations may not be aware of upon

referral. Travel team members talked about how both of these situations can be discouraging for families and their organizations alike because it creates extra barriers to resource delivery.

"Competing against each other, too, has led to negative outcomes. I mean if we have multiple programs coming into a home, it overwhelms the family sometimes. They don't want any of us there. So, maybe coordinating those efforts helps us all to better serve the families."

"I think just having us get to know the programs so we don't send people on a witch hunt because we'd love to tell families, 'Oh girl, can I help you?', and then we give them a number and then they found out that they didn't wear the red shoes so they can't participate in the program. If we knew that they had to wear red shoes we could have told them up front."

"Actually, we have both. We have families where two and three agencies are coming in to do home visits and not coordinating."

"So, when we looked at that data a few years back and saw the disparity in certain communities we said we have to do something. So, it's been a conversation for a really, really, really long time and this was an opportunity that allowed us to start where we should be starting, at the beginning."

HOW ESSENTIAL IS CI&R IN MEETING THE NEEDS OF FAMILIES?

Travel team members were asked how essential they felt that the CI&R intervention would be in meeting the needs of the families served. The responses from leaders ranged from the intervention being so essential that it would change the community forever and that it should be legislatively mandated in all states, to the intervention being essential although communities cannot possibly know what they need if they are not aware of the particular needs of their families.

"So, they're [communities] unassuming as a whole right now. They don't know what they don't know. So, we have bits and pieces that we'll have to educate them that this could work, oh, so much better if we all came together."

"...meaningful services and the outcomes of moving because the needs of family is met. Those families that just need a little bit of services or help them to through health outcomes. The really low birth weight children or the babies that have other medical issues and they don't have all these risk factors that is associated with child abuse".

"...because how many times have we given someone a referral and then you saw them in the street. They call back and say, 'That lady never called me', and you think all this time that she's getting these services over here at ABC and no one has ever called her."

"So, their family's support, we'll meet moms that – they're just nervous because they don't have a sister here, or a mama here, or a mother-in-law here. They had been sent to our area with their husband who's deployed many times or TDY and they're kind of by themselves. So, we call them sometimes. They just want help with breastfeeding or education that just somebody that I can call that knows the area, kind of thing"

"We have strong participation from all the home visiting programs within our community. All of them are represented and there's a buy-in from everybody that it would be the best for the families. We've talked about being able to track the families; if they graduated from one program or like some of the programs that we have in there are short term programs but they may feel like they need continued support so the we can refer them back, and they can go into like a parent-teacher program or something else that continues with that care."

CONCLUSION

Both the CI&R readiness survey and the three separate focus groups unveiled predominantly positive feedback from the CI&R team leaders regarding how helpful they perceive the intervention will be for their communities. Many of the leaders who participated in the learning collaborative had already been involved in CI&R implementation for some time in their respective communities; however, there were also some leaders whose communities had not yet started implementation activities. This mix of experienced and inexperienced participants in CI&R learning collaborative proved to be instrumental in the exchange of information and knowledge of how to approach the implementation of such a complex intervention. The next CI&R learning collaborative will be held in September 2016. With each subsequent learning collaborative, the USF evaluation team will continue to assess the perceptions of team members and their communities with respect to CI&R implementation in their communities.

MIECHV EVALUATION TEAM

Dr. Jennifer Marshall – Principal Investigator, Lead Evaluator
Pamela Birriel – Research Associate, Project Coordinator
Rema Ramakrishnan – Research Associate, Data Analyst
Ngozi Agu – Research Associate
Paige Alitz – Research Assistant
Amber Warren – Research Assistant
Esther Jean-Baptiste – Research Assistant
Abimbola Michael-Asalu – Research Assistant
Omotola Balogun – Research Assistant
Kimberly Hailey – Research Assistant
Shana Geary – Research Assistant
Oluyemisi Amoda – Research Assistant
Dr. Takudzwa Sayi – Research Associate

For more information, please contact:

Jennifer Marshall, PhD, CPH
Assistant Professor
University of South Florida College of Public Health
Department of Community & Family Health
(813) 396-2672
jmarshal@health.usf.edu
miechv.health.usf.edu

REFERENCES

- ¹ Damschroder, L. J., & Hagedorn, H. J. (2011). A guiding framework and approach for implementation research in substance use disorders treatment. *Psychology of Addictive Behaviors*, 25(2), 194.
 - ² Kilbourne, A. M., Abraham, K. M., Goodrich, D. E., Bowersox, N. W., Almirall, D., Lai, Z., & Nord, K. M. (2013). Cluster randomized adaptive implementation trial comparing a standard versus enhanced implementation intervention to improve uptake of an effective re-engagement program for patients with serious mental illness. *Implementation Science*, 8(1), 1-14.
 - ³ Adapted CFIR-Model: Damschroder, et al., 2009, in Ament et al. BMC Health Services Research 2012 12:423. doi:10.1186/1472-6963-12-423.
- Group dynamics adapted from Schulz, Amy J., Barbara A. Israel, and Paula Lantz. "Instrument for evaluating dimensions of group dynamics within community-based participatory research partnerships." *Evaluation and Program Planning* 26.3 (2003): 249-262

Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Evaluation

Time 1 and Time 2 results for the Coordinated Intake and Referral Initiative, 2016

Takudzwa Sayi, Oluwatosin Ajisope, Pamela Birriel, Rema Ramakrishnan,
Deborah Cragun, Cheryl Vamos, and Jennifer Marshall



This project is supported by the Health Resources and Service Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number D89MC28265, Affordable Care Act, Maternal, Infant, and Early Childhood Home Visiting Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsement be inferred by HRSA, HHS, or the U.S. Government.



Florida Maternal, Infant & Early Childhood Home Visiting Initiative

our
practice
is our
passion.

University of South Florida
College of Public Health

The Lawton and Rhea
Chiles Center
for Healthy Mothers and Babies

Introduction

The Coordinated Intake and Referral Learning Collaborative

The Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program is an evidence-based home visiting program that aims to improve health and developmental outcomes for families living in at-risk communities. The Florida MIECHV, in partnership with the state Title V agency developed coordinated intake and referral (CI&R) models with a group of Healthy Start Coalitions in the spring of 2016. The CI&R system is a community-based and a collaborative process which utilizes the statewide prenatal and infant risk screens to help connect at-risk families to services that best meet their needs and preferences through better utilization of community resources, reduction in duplication of services, and appropriate follow up of families' involvement and referrals. This was intended to be achieved through utilization of the state's prenatal and infant screen as a single point of entry for various home visiting, care coordination, education, and support services.

In August 2015, a request for application for a CI&R action learning collaborative project was sent to the 32 Healthy Start Coalitions in Florida, out of which eight elected to participate. Application requirements included the inclusion of particular organizations on teams, such as: Healthy Start Coalitions, Healthy Families Florida, Early Head Start, Early Steps, Federal Healthy Start, local Health Department responsible for processing screening forms, MIECHV funded projects, education and support programs, additional care coordination, and other relevant stakeholders. This 21 - month project (January 2016 – September 2017) is supported financially and technically by the MIECHV initiative. Based on the annual births of the counties/ participating coalitions, the Florida MIECHV initiative provided \$90,000 to \$170,000 grant support to the participating coalitions. This was to enable them to design, implement, and test CI&R system changes as part of the learning collaborative. The MIECHV evaluation team was tasked to evaluate the participating coalitions at different stages of implementation, from no knowledge to some knowledge, while documenting the challenges and successes faced by the participating coalitions in their implementation of CI&R system changes.

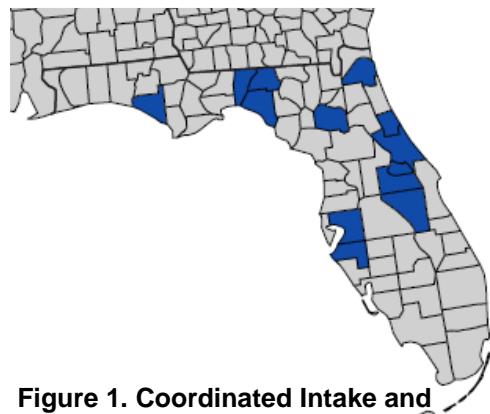


Figure 1. Coordinated Intake and Referral Learning Collaborative: Participating Healthy Start

Table 1: Healthy Start Coalitions that Participated in the Coordinated Intake and Referral Learning Collaborative

Participating Healthy Start Coalition (HSC) Teams	County/COUNTIES	Annual Number of Births: 2014	Annual Number of Births: 2015
HSC of North Central Florida	Alachua	2,916	2,885
Bay, Franklin, Gulf HSC	Bay	2,328	2,396
Northeast Florida HSC	Duval	12,514	13,041
HSC of Flagler & Volusia Counties	Flagler, Volusia	5,600	5,736
HSC of Hillsborough	Hillsborough	16,846	17,570
HSC of Jefferson, Madison & Taylor	Jefferson, Madison, Taylor	535	583
HSC of Manatee	Manatee	3,545	3469
HSC of Orange, Osceola & Seminole	Orange, Osceola, Seminole	24,931	25,455
Total	13 Counties	69,215	71,135

Source: Florida Charts (<http://www.flhealthcharts.com/charts/default.aspx>)

Evaluation Framework

The Consolidated Framework for Implementation Research (CFIR) framework was utilized by the University of South Florida (USF) MIECHV evaluation team to describe the characteristics of the learning collaborative focusing on the coalitions' perceptions and processes with regards to implementing the CI&R system changes.

The CFIR framework, developed by Damschroder et al. (2009, 2011), consists of 25 constructs across five major domains influencing implementation and implementation effectiveness. CFIR serves as a useful guide in formative evaluation research. This framework is beneficial in various diverse and multiple settings, as it aids in analyzing and organizing findings from implementation research. It also increases knowledge on the effectiveness of the various strategies used in the implementation process. A sixth domain, "Learning Collaborative Group Dynamics", consists of 14 constructs adapted from Schulz, Israel, and Lantz (2003) (Figure 3). This domain can be considered as a subset of the inner setting domain of the CFIR framework.

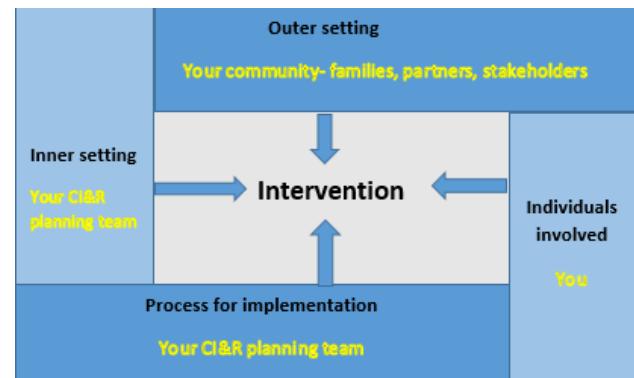


Figure 2. Adapted CFIR showing interacting domains in implementation research (Henao-Martínez, Colborn, & Parra-Henao, 2016).

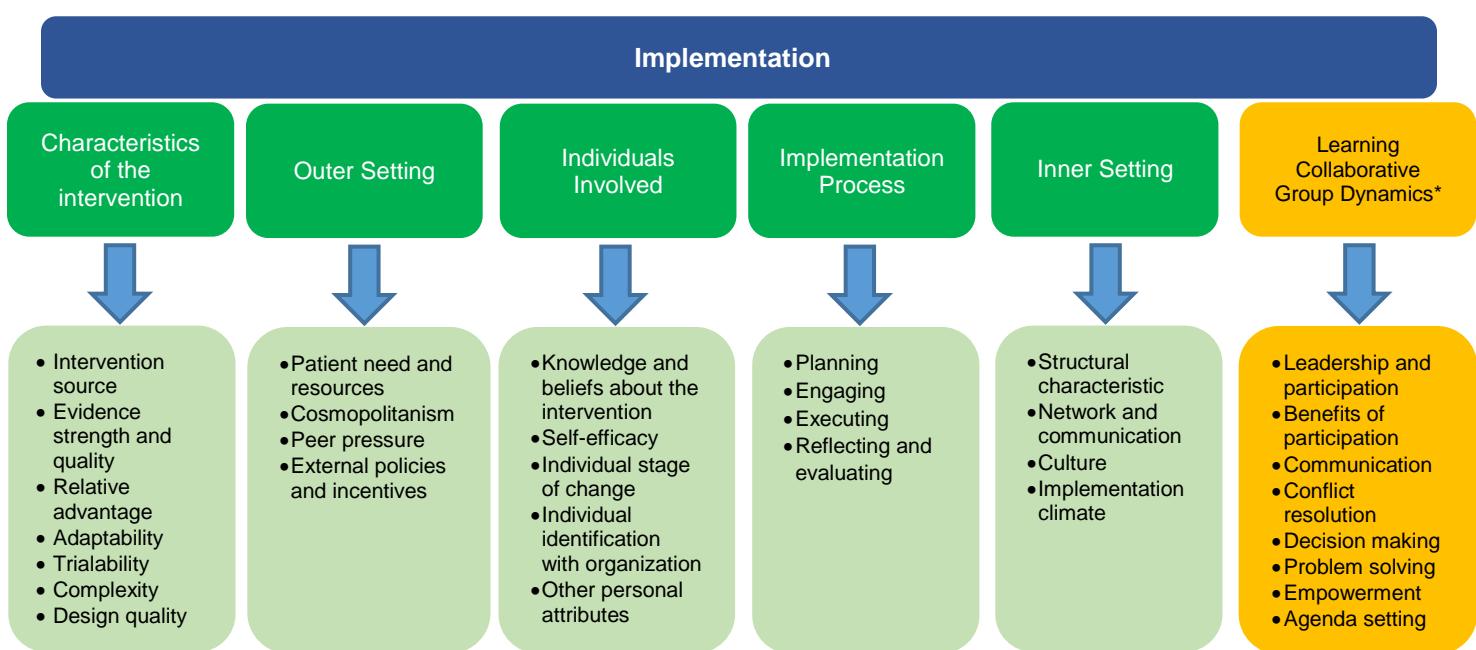


Figure 3. Domains and constructs of the Consolidated Framework for Implementation Research and Group Dynamics (Adapted from Damschroder et al., 2009 and *Schulz, Israel, & Lantz, 2003)

The MIECHV team used this modified framework to evaluate characteristics of teams, coalitions, and system changes, methods of incorporating the CI&R framework into their various sectional systems of care, and accomplishments and barriers encountered during their various implementation processes.

CI&R Learning Sessions

Two face-to-face learning sessions of this collaborative have occurred to date. The baseline learning session took place March 10-11, 2016, in Jacksonville, and the second one occurred at the Children's Board of Hillsborough County in Tampa September 29-30, 2016. Both sessions were similar in structure and format, consisting of a two-day event with various activities such as lectures from guest speakers, poster presentations, and breakout sessions with representatives from each of the ten participating Healthy Start Coalitions comprising eight teams (Table 1, Figure 1). The purpose of these activities was to promote networking and knowledge sharing among the participating Healthy Start Coalition teams with regards to their local CI&R systems and implementation processes.

Prior to convening at each two-day collaborative learning session, the evaluation team distributed a comprehensive CI&R readiness survey electronically to all the learning collaborative participants. The surveys included multiple choice and open-ended questions assessing: 1) participants' individual, professional and organizations' CI&R knowledge; 2) their personal involvement in their community's CI&R system changes; 3) inner setting and group dynamics of their CI&R teams; 4) the outer settings of their organizations; 5) their impressions of the CI&R implementation process in their community; and 6) their respective community's CI&R system characteristics and perceptions of system changes.

On the second day of each learning session, focus groups were conducted with all attendees divided into three smaller discussion groups. These discussions were based on the CFIR constructs and group dynamics. All of the focus group discussions were audio recorded and professionally transcribed verbatim. Each focus group transcript was then reviewed with accompanying audio recordings by the MIECHV evaluation team members to ensure accuracy.

This report documents the process evaluation, participant and organization characteristics and perspectives at baseline (LS1) and at a follow-up period about six months later (LS2). It also describes changes in various CFIR domains and selected constructs from LS1 to LS2. The detailed description of Learning Session 1 and the baseline collaborative survey including participant demographics and organizational-level collaborative characteristics, perceptions, and processes can be found at the evaluation website (<http://miechv.health.usf.edu>).

Demographic Characteristics of Participants at Learning Session 2

Out of the 53 respondents who completed the CI&R readiness survey prior to the meeting, 38 attended the session at the Children's Board of Hillsborough County. Most of the survey respondents identified their role in their organization as administrator/director (40%), supervisor (21%), or program manager (8%), and the rest were divided among other roles. Most respondents described their service sector as home visiting (53%), early childhood or education (12%), or both (6%); 8% as health care; and the remainder as other service sectors. Respondents had worked for an average of 15 years in their professional field. Half (49%) had a professional/graduate degree, 48% Bachelor's or Associate degree, and 4% some college education. Nearly all (98%) identified as non-Hispanic; 60% identified as White, 31% Black/African American, 4% Asian, and the remaining 5% as other racial groups.

Integrating CI&R Models into Local Systems of Care

Intervention Characteristics

The various CI&R teams described system changes being planned, namely implementing a system to link families with the best services for their needs, improving community-wide system of care, while

minimizing duplication of services. However, activities through which the common goal is being achieved varied by team.

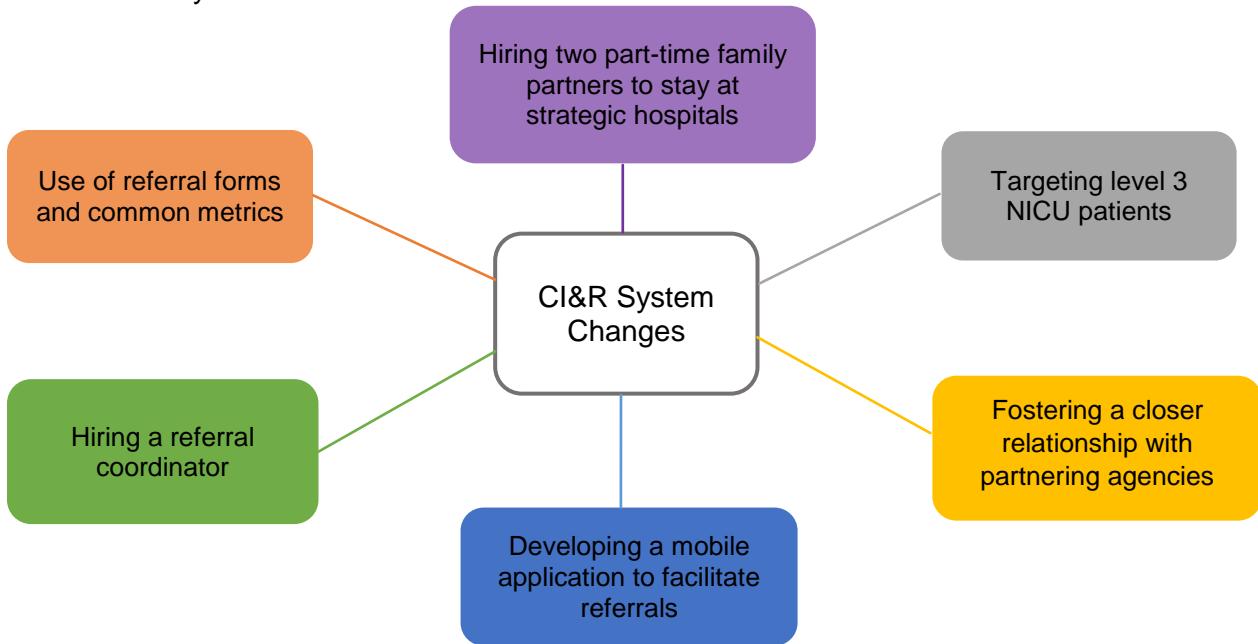


Figure 4: CI&R system change activities by different teams.

Participants indicated that these interventions generally fit in with existing processes and practices within their organizations, such that they were mainly expanding and refining similar existing systems, adding more partners and agencies to their referral system, while making them more formal and beneficial to clients and community partners. In addition, having preexisting connections and communications with certain organizations made it easier to implement the system changes.



As teams compared the existing system with ideas for system improvements, they identified several advantages and disadvantages. The advantages of the change/intervention were that: 1) it was population-based; 2) it gave the ability to coordinate with different agencies thereby preventing counties from hoarding knowledge; and 3) receipt of appropriate feedback enabled them to reassess and make relevant changes. One team reported that the proposed change would be the first in their community as it will integrate a lot of services, provide help to families by connecting them to organizations that meet

their needs, educate counties on choices of different programs available to families, understand the curriculum of other programs, and leverage community resources to build better programs. The teams felt that this process increased interconnectedness between organizations through relationship-building and sharing of resources that would benefit communities. They hoped to increase awareness about how their programs work together and sustain the involvement of all agencies already involved so as to have greater reach for better outcomes regarding the health of their communities.

However, lack of follow up of referrals was cited among many as a disadvantage due to programs tending to stay within their niche. They also reported the need to understand why some families who needed a program were rejecting those programs.

"What program they want to, and also how to change the program because they're going to get the family's input on, what they wanted from out of this program. Everything is done to meet each family's need."

"That's really the main purpose of why this work is important to us, it's because we want to get the client where each family is getting served individually what they need or co-served what they need."

"We hope to be able to link them to support and services. We've created a little getting-to-know-your-family forum, kind of another intake, so that we can make sure that we're referring them to the right services and support."

"I think less confusion for the community in general, because if we have a unified message and a unified referral form or whatever, it's not going to be – somebody in the community is thinking, "Where do I need to refer those families?"

Despite these disadvantages, most participants in both LS1 and LS2 perceived that there was strong evidence that strategies to improve CI&R systems will meaningfully impact family outcomes, as shown in Figure 5. Most also agreed that respected officials within their organization would rate the strength of evidence as strong. In addition, there was an increase in participant perceptions over time, with little change in perceptions related to respected officials.

I believe there is strong evidence that CI&R system changes to our program have the potential to meaningfully impact family outcomes.

Respected officials in my organization believe there is strong evidence that CI&R system changes can meaningfully impact family outcomes.

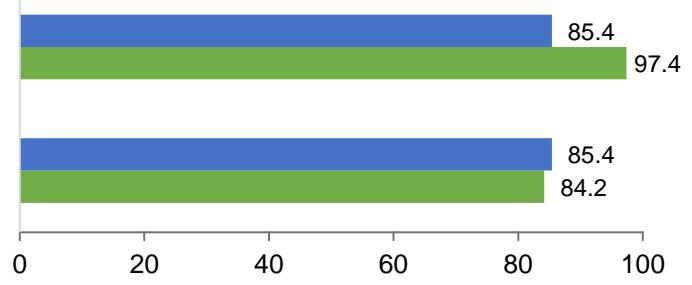


Figure 5: Perceptions on strength of evidence.

Characteristics of Individuals

Individual characteristics that the evaluation explored were related to each team member's perceived self-efficacy, knowledge and beliefs about the intervention, and their stages of change, as shown in Figure 7. Between the two learning sessions, there was great

- ↑ Individual Characteristics
 - Working on system changes (+11.2%)
 - Actively planning to implement changes (+6.3%)
 - Self-efficacy (+4.8%)
 - Familiarity with facts & principles of system changes (+14.8%)
 - Positive system change (+6.1%)
- ↓ Individual Characteristics
 - Commitment to system changes (-2.8%)

Figure 6: Individual Characteristics' Changes Time 1-Time 2

improvement in indicators related to individual participants' involvement in system changes (Figures 6 & 7). By the second learning session, most participants: 1) believed system changes would be positive; 2) were familiar with facts, truths, and principles related to CI&R system changes; 3) believed in their own capabilities to execute courses of action to achieve implementation goals; and 4) were committed to and actively planning to make system changes. The greatest increase was for the perception that the participants were familiar with the facts and principles related to CI&R system changes (Figures 6 & 7). However, one fifth of participants had not started working on system changes by the second meeting. There was also a slight (2.8%) decline in commitment to making system changes.

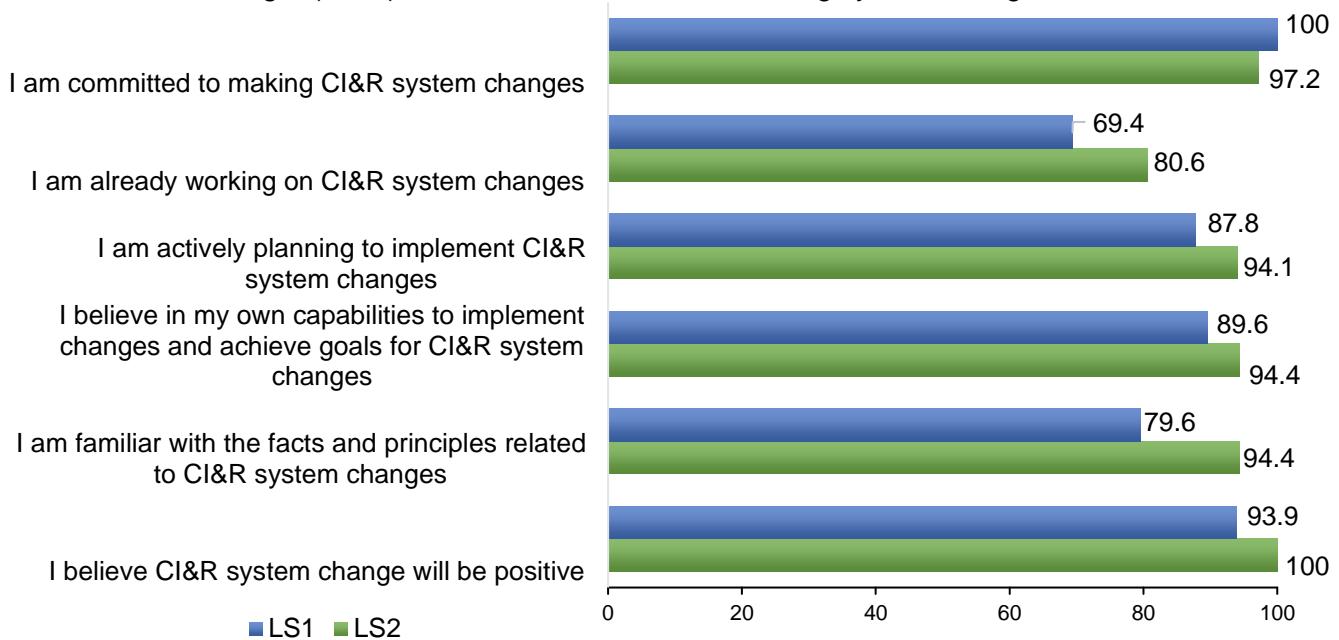


Figure 7: Individual characteristics

Inner Setting (CI&R Team)

Most of the inner setting perceptions increased over time. For example, most participants continued to agree that regular project meetings were held, that leadership promotes team building to solve problems, system changes take into account needs and preferences of families, and that leadership have clearly defined areas of responsibility to implement changes (Figures 8 & 9).

Between the two sessions, the largest increase was in the perception that the current system was intolerable or needed to be changed (9.3 percentage points), indicating a larger proportion (about one third) of participants expressing motivation to make these changes (Figures 8 & 9). By LS2, participants also increased in their reporting that there is a need for the system to take into account needs and preferences of families, and that within their team there are regular project meetings, team-building activities, clearly defined areas of responsibility and authority for staff. However, there was a reduction in the percentage of individuals who

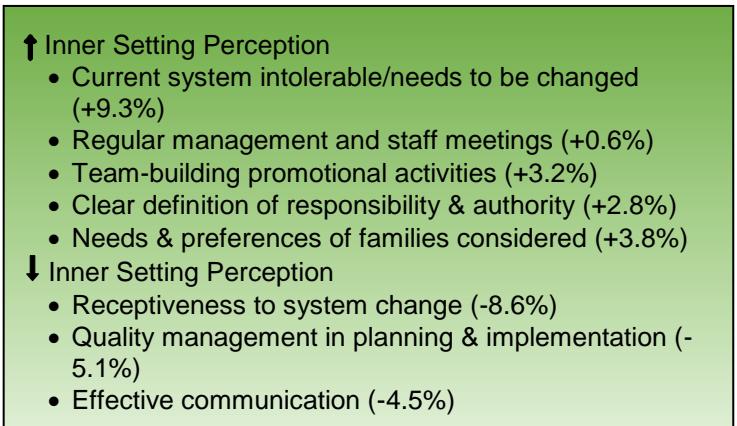


Figure 8: Inner Setting Changes Time - Time 2

believed that staff members were receptive to system change, quality management staff were involved in planning and implementation, and individuals in the system communicate effectively (Figures 8 & 9).

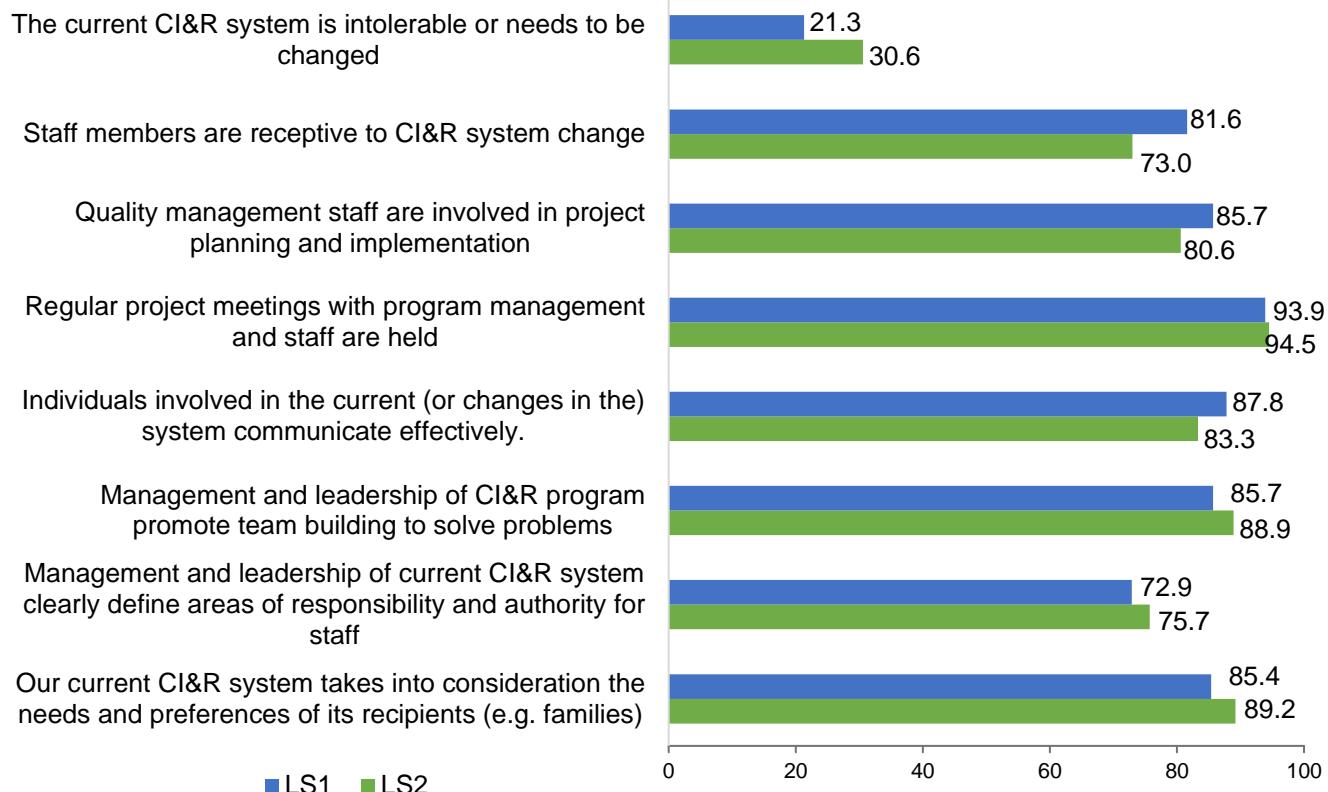


Figure 9: Perceptions of inner setting (CI&R Team).

In the focus groups, the teams identified several barriers to compatibility of these system changes with their current/past approach, such as: finding the right people for the job and retaining them; inadequate communication and inconsistency of information shared between agencies; discomfort with the amount of data shared with other agencies in light of HIPAA regulations; and time constraints. Some teams, however, planned to address these issues based on their assessment after implementation.

Outer Setting (Broader Community)

The change in outer setting perceptions over time was ambivalent (Figures 10 & 11). The majority of participants agreed that system changes take into consideration needs and preferences of recipients (e.g., families), and participants (e.g., community partners, other agencies). This perception increased slightly between LS1 and LS2. Smaller proportions of participants in LS2 compared with LS1 agreed that patient/family awareness/need was available to make changes work, and that the CI&R system was networked with other external organizations that could help or provide resources for making changes. Additionally, the perception that there was peer pressure or external incentives in the community to implement CI&R changes remained quite low.

- ↑ Outer Setting Perception
 - Implementation influenced by external incentives (+4.1%)
 - Preferences of community partners taken into account (+3.0%)
 - Needs & preferences of families considered (+4.3%)
- ↓ Outer Setting Perception
 - Peer pressure to implement system change (-3.6%)
 - Networking with external organizations for resources (-4.6%)
 - Patient awareness/need available (-3.8%)

Figure 10: Outer Setting Changes Time 1 - Time 2

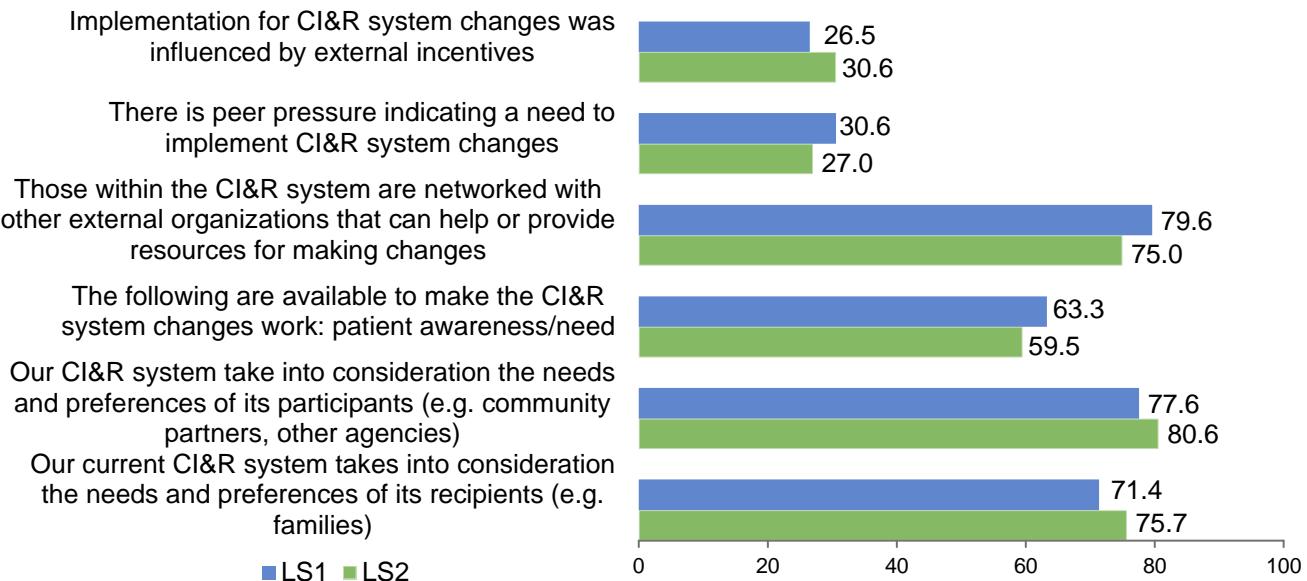


Figure 11: Outer setting

In focus groups, CI&R teams mentioned communicating with stakeholders about the initiatives and system changes through various avenues such as joint meetings involving all partners or representatives of the different agencies involved. During these meetings, they held discussions on progress, impact, and goals though use of tools such as power point, handouts, and sometimes problem-solving exercises. They also communicated via use of progress reports, monthly newsletters, and distribution of fliers to relevant agencies.

"Little nuggets until we get ready to really solidify and implement... but we want them to be hearing about it monthly to know that this is coming down the pipeline."

"So our Tri-County Partnership, we have a lot of conflict goals to go over. A lot of the information that we're working on and then the face-to-face we share through PowerPoint, through handouts. Also, sometimes we do exercise solving."

Additionally, in focus group discussions, most CI&R team members were confident they could successfully implement the intervention due to high stakeholder buy-in once stakeholders heard about the concept, and were confident that the system changes would be sustainable. Other teams were, however, concerned about sustainability, and noted the importance of listening to other people's concerns, avoiding internalization, getting agencies to be engaged and trust in the program, and acknowledging, where present, lack of fit with client needs and sending them to appropriate agencies more appropriate for those needs.

Implementation Process

Most measures of implementation process increased between LS1 and LS2 (Figures 12 & 13), although the level of agreement within teams was generally lower than in the other domains. By the second meeting, 80% and 74%, respectively, indicated that progress in system changes would be measured by collecting feedback from program recipients and from agency staff regarding proposed/implemented changes. Most agreed that the changes would be implemented according to plan, with a majority indicating that there was a clearly defined team in place to make system changes. However, 64% of participants agreed that there was provider buy-in. About four out every five participants agreed that team members shared responsibility for project success, while 60% agreed

that the implementation plan identified specific roles and responsibilities. Less than half of participants (46%) indicated the presence of a plan for providing feedback using performance measures to evaluate the program and about 20% were given a satisfaction survey to evaluate the current program.

Focus group discussions revealed that team members believed active involvement and positive commitment of those involved were essential for successful implementation. They expected stakeholders to be clear in the goals of their respective programs for easy referrals, provide relevant information, fully buy-in and adequately utilize the changes. They mentioned that trainings of the staff undertaken by the involved organizations will be beneficial as it will help to improve services and retention.

- ↑ Implementation Perception
 - Progress measured by program recipients' feedback (+12.7%)
 - Progress measured by agency staff feedback (+7.0%)
 - Implemented according to plan (11.5%)
 - Provider buy-in available (+6.8%)
 - Clearly defined team available (+13.3%)
 - Clearly defined roles and responsibilities for members (+23.2%)
 - Shared responsibility (+13.3%)
 - Specific roles and responsibilities identified (+6.9%)

- ↓ Implementation Perception
 - Clear plan for feedback (-1.4%)
 - Satisfaction survey provided for program evaluation (-30.4%)

Figure 12: Implementation Process Changes Time 1- Time 2

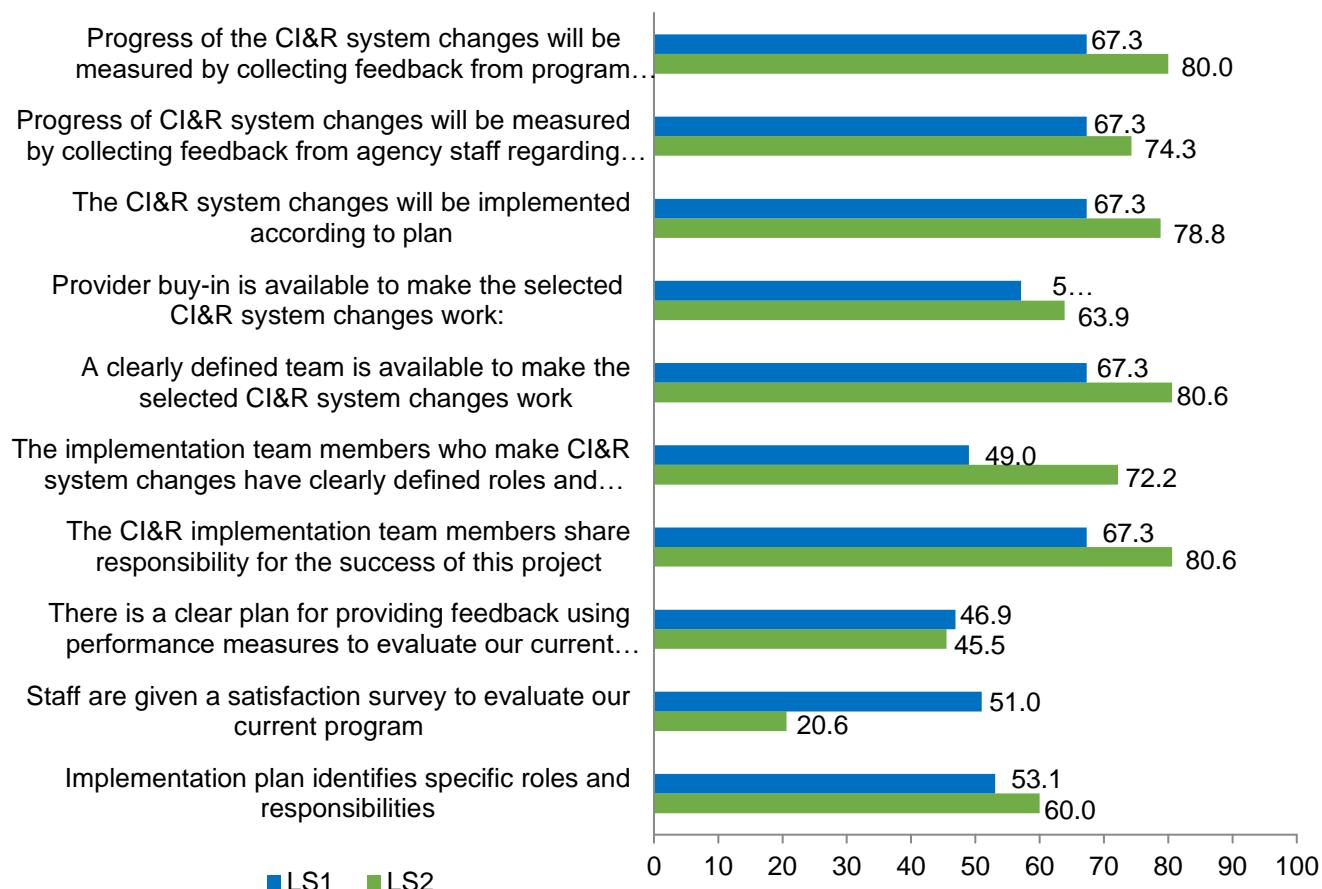


Figure 13: Implementation

"Also to be able to explain what their program is all about, and what they do, and how they would want to receive a referral, and how they will serve them."

"I think the trainings from the different organizations will help our staff and of us, that would be an opportunity... If we have augmented support, compassion, and training for our home visitors – that kind of will complete the circle."

"I think that they just support when they come across a woman that is in need, and that's our target population."

"Using that and then not going through our process then – all our stakeholders fully buying in, all of it contingent upon all of our staff really buying in and wholeheartedly doing the process."

Barriers to implementation of system changes identified through focus group discussions include: 1) unwillingness of some organizations to partner with others; 2) change of leadership in the organization of any of the partners; 3) ineffective communication to stakeholders on what CI&R is; 4) lack of support and resources; 5) double data entry for some of the partnering agencies which requires more time, energy and money as a result of a new database system in place; 6) issues with regulations that govern interagency information sharing; and 7) problems with communication between systems. They also mentioned other barriers such as poor progress in implementation of programs due to different organizations involved, increase in the volume of work without a corresponding increase in the staff due to inadequate funding, and stakeholders who are focused on personal interests.

"Helping them see the buy in and the benefit because nobody wants to go to another meeting or do – add one more item to their plate on a daily basis."

"Some of the root causes will be ineffective communication of what really our mission and our vision is, or the CI&R. Just making sure that we effectively communicate to the stakeholders or any of the entities that we are engaging with."

"I also think one of our challenges is to see how we can support. We're putting all this on our Intake Unit that has not increased in size."

"To see that as our goal, you must do duplication data entry. It's just a big barrier, for sure. We need to figure out a way to handle that around and have our systems talk to each other."

"Some that we're seeing already, and I'm sure we'll continue to see is, that it's going to require double data entry for some of the aid partnering agencies. We all have our own Well Family system or whatever each one is using, and now we have this additional system that's going to require more time and energy and money because time is money, and I think that's a barrier."

CI&R staff reported that they assessed progress towards their goals by use of tools such as: surveys; timelines which enable them to accomplish things at certain points as it ensures they meet the deadlines; group meetings where progress updates are given and followed up; participation in webinars and group sites; and the use of reports and HMIS data system. Some also stated that they have received positive feedback from centers that have agreed to have their family partners there and reported progress with certain administrative processes such as HIPAA clearance as regards to confidentiality and access to patient information.

Conclusion

The findings from the first and second learning CI&R collaborative sessions indicate that there has been a general improvement in positive feedback from participants between the two sessions. In the second session, the most positive feedback was in the domains of individual characteristics of participants, inner setting within the CI&R team, and implementation measures. These findings indicate increased participant awareness of the CI&R intervention and the facilitators and barriers of implementation measures. However, work needs to be done to improve networking with external community organizations to leverage resources for implementing CI&R. In addition, some areas of concern identified included need for follow-up referrals, identification of families' needs to increase their participation, sustainability, ineffective communication to stakeholders, and low staff: work ratio due to inadequate funding. However, perception of greater buy-in by stakeholders and increased interconnectedness between organizations through relationship building and sharing of resources are encouraging factors for successful implementation of CI&R within the eight Healthy Start Coalitions.

The barriers and facilitators identified in these domains will help to provide feedback to participants, which can be discussed within and across teams to enable improvement of the implementation of CI&R system changes. Learning Session 3 will take place in June 2017. Prior to that session, participants will complete the Readiness Survey for the final time, including perceptions of the inner and outer settings; individual, organizational, and community characteristics; and learning collaborative team dynamics such as leadership, participation, communication, conflict resolution, leadership, decision-making capabilities, problem-solving skills, trust, agenda-making capabilities, accomplishments, satisfaction, benefits of participation, cohesion, perceived empowerment, consistency with attendance at meetings, and perceived level of influence on CI&R system changes.

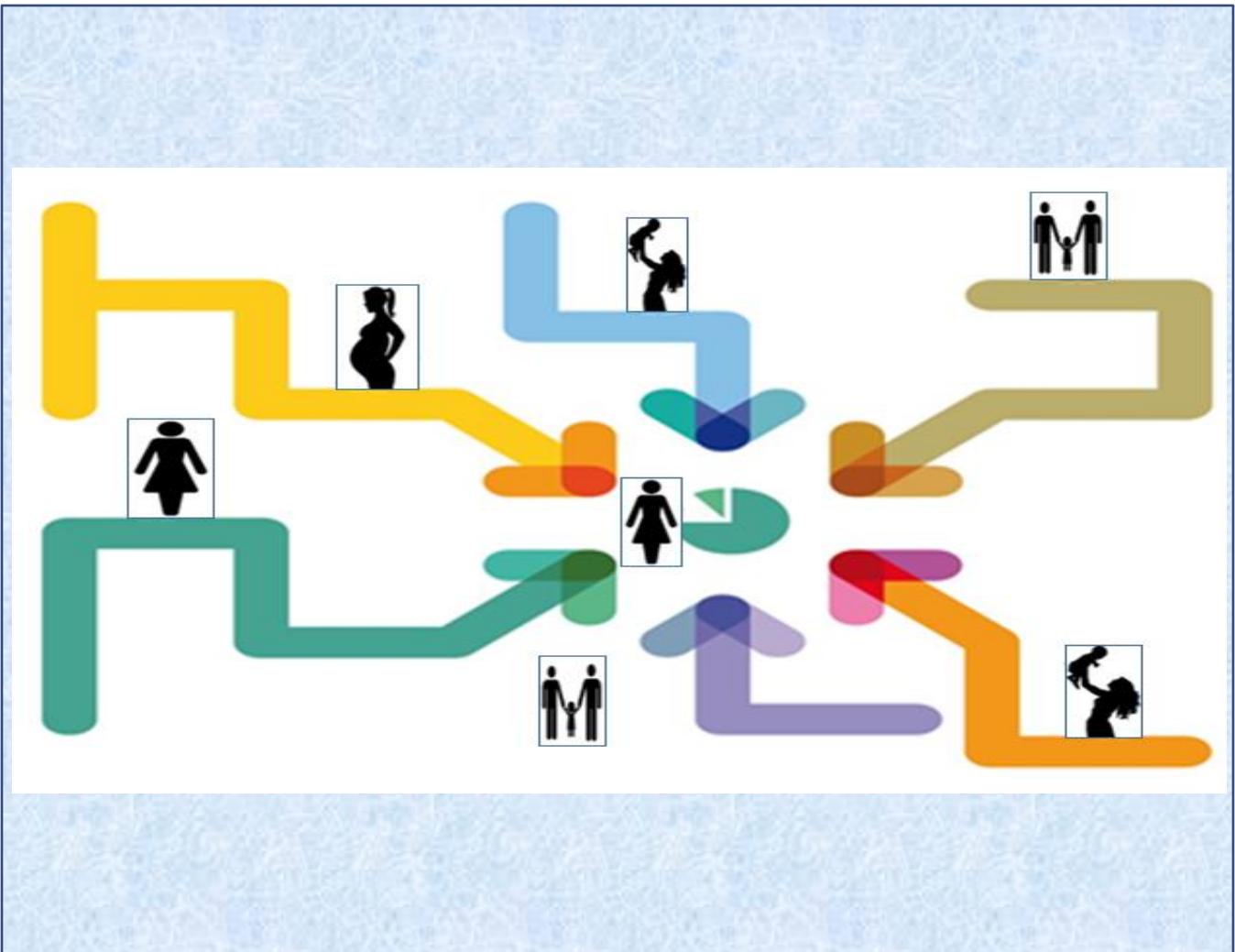


For more information, please contact:

Jennifer Marshall, PhD, CPH
Assistant Professor, Lead Evaluator
University of South Florida College of Public Health
Department of Community and Family Health
Tel: (813) 396-2672 Email: jmarshal@health.usf.edu Website: <http://miechv.health.usf.edu>

References

- Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science*, 4, 50. doi:10.1186/1748-5908-4-50
- Damschroder, L. J., & Hagedorn, H. J. (2011). A guiding framework and approach for implementation research in substance use disorders treatment. *Psychology of Addictive Behaviors*, 25(2), 194.
- Damschroder, et al., (2009). Adapted CFIR-Model. In Ament et al. *BMC Health Services Research*, 12, 423. doi:10.1186/1472-6963-12-423
- Henao-Martínez, A. F., Colborn, K., & Parra-Henao, G. (2016). Overcoming research barriers in Chagas disease—designing effective implementation science. *Parasitology Research*, 1-10. doi:10.1007/s00436-016-5291-z
- Schulz, A. J., Israel, B. A., & Lantz, P. (2003). Instrument for evaluating dimensions of group dynamics within community-based participatory research partnerships. *Evaluation and Program Planning*, 26(3), 249-262



FLORIDA MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING (MIECHV) PROGRAM EVALUATION

FINDINGS FROM THE COORDINATED INTAKE AND REFERRAL LEARNING COLLABORATIVE, 2015-2017

Takudzwa Sayi, Oluwatosin Ajisope, Rema Ramakrishnan, Amita Patil, Deborah Cragun, & Jennifer Marshall, University of South Florida College of Public Health, Chiles Center for Healthy Women, Children, and Families.

Introduction

The Florida MIECHV initiative, in collaboration with the State Title V agency developed a new MIECHV learning collaborative in the spring of 2016, with the aim of implementing and testing Coordinated Intake & Referral (CI&R) models with eight Florida's Healthy Start Coalitions (Figure 1 & Table 1), using the state's universal prenatal and infant risk screens. The CI&R system, which is a collaborative process, aims to ensure that at-risk families are linked with the best services available that address their needs, through better utilization of community resources, minimizing duplication of services, and appropriate follow up of families' involvement and referrals. By using the state's universal prenatal and infant risk screening process, women and infants who are at risk of poor birth outcomes and developmental outcomes will be identified, thus aiding in universal access to appropriate care and services. Through the learning collaborative approach, the CI&R models were tested by various coalitions and their strategies of implementation were examined, thus aiding in the improvement of community coordination and collaborations. This is essential as community collaborations are integral to maximize community resources and referral services.

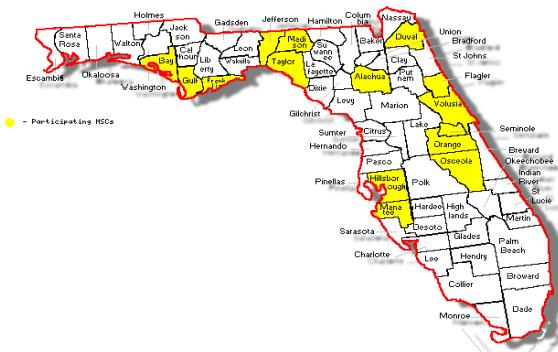


Figure 1. Healthy Start Coalitions which participated in the Coordinated Intake and Referral Learning Collaborative

The MIECHV evaluation team assessed the participating coalitions at different stages of implementation while documenting the challenges and successes faced by the participating coalitions in their implementation of CI&R system changes.

Table 1: Participating Healthy Start Coalitions

Participating Healthy Start Coalition (HSC)	County/Counties	Annual Number of Births 2014	Annual Number of Births 2015
HSC of North Central Florida	Alachua	2,916	2,885
Bay, Franklin, Gulf HSC	Bay	2,328	2,396
Northeast Florida HSC	Duval	12,514	13,041
HSC of Flagler & Volusia	Flagler and Volusia	5600	5736
HSC of Hillsborough	Hillsborough	16,846	17,570
HSC of Jefferson, Madison & Taylor	Jefferson, Madison, Taylor	535	583
HSC of Manatee	Manatee	3,545	3469
HSCs of Orange, Osceola & Seminole	Orange, Osceola, Seminole	24,931	25,455
Total	13 Counties	70,085	71,135

Source: Florida Charts (<http://www.flhealthcharts.com/charts/default.aspx>)

Evaluation Framework

The Consolidated Framework for Implementation Research (CFIR) model was utilized by the USF MIECHV evaluation team to describe the characteristics of the learning collaboratives. The teams implemented various interventions to improve the system of care in their community. These include the development of a mobile app, utilization of family partners to improve referrals, hiring of a referral coordinator, and use of referral forms and common metrics, to mention a few. The CFIR model, which was developed by Damschroder et al in 2009, comprises a list of constructs across five major domains, the interaction of which influences implementation of interventions, in this case, the implementation of CI&R systems improvements. The CFIR model was adapted by the MIECHV team by adding the ‘learning collaborative group dynamics’ category (Figure 2 & 3), to ensure that team dynamics such as CI&R members’ perceptions and interactions

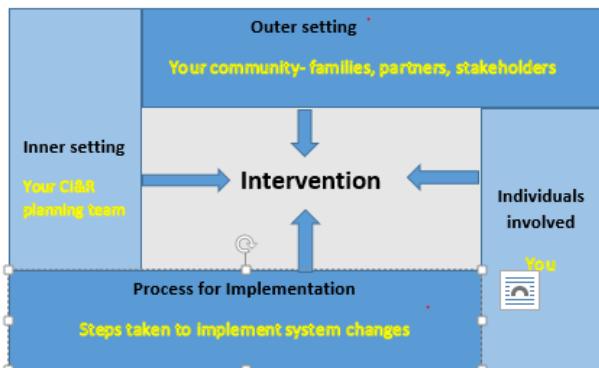


Figure 2: Adapted CFIR showing interacting domains in implementation research (Henao-Martínez, Colborn, & Parra-Henao, 2016).

within their respective groups were assessed. This is essential in order to evaluate the influence of the partnership itself on the attainment of the outcome objectives of the group (Schulz, Israel, & Lantz, 2003). The MIECHV team used this framework to evaluate coalition system changes while utilizing the prenatal and infant risk screens, their methods of incorporating the CI&R model into their various systems of care, and the accomplishments and barriers encountered during their various implementation processes.

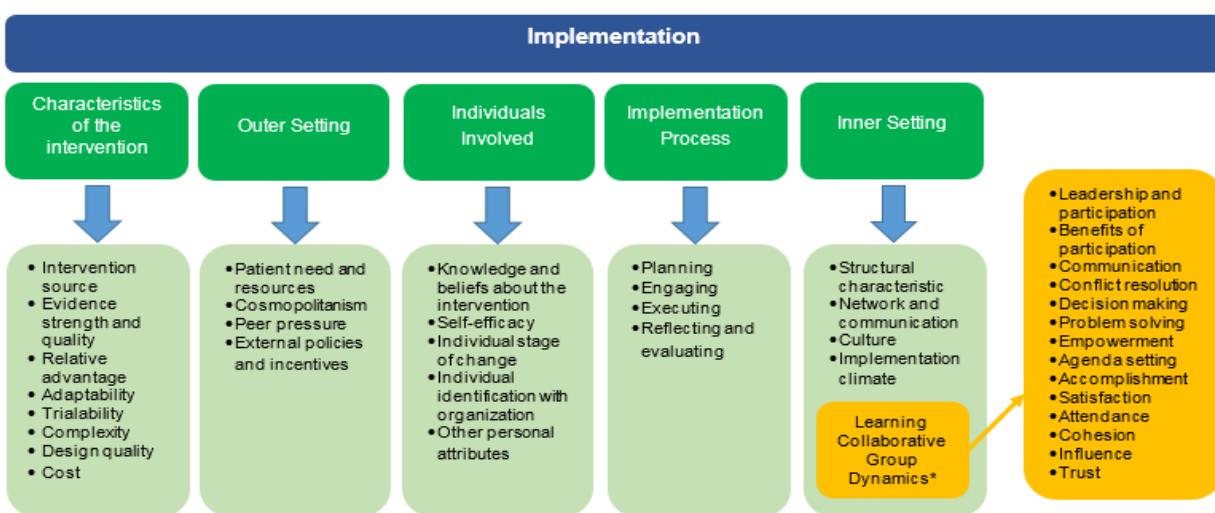


Figure 3: Domains and Constructs of the Consolidated Framework for Implementation Research

CI&R Learning Sessions

Three face-to-face learning sessions of this collaborative have occurred to date. At the conclusion of the second learning collaborative, there was a positive change especially in the domains of individual characteristics of participants, inner setting within the CI&R team, and measures of the implementation process. Areas of concern that were identified were - need for follow-up referrals, identification of families' needs to increase their participation, sustainability, ineffective communication to stakeholders, and low levels of staffing due to inadequate funding.

The third and final learning session occurred in Daytona Beach from June 13 – 14, 2017. Similar to the first two learning sessions in 2016 (in Jacksonville and at the Children's Board of Hillsborough County in Tampa, respectively), participants from eight participating Healthy Start Coalitions attended the two-day learning session. Similarly, learning activities included poster presentations, presentations from guest speakers, and breakout sessions.

As in the first two learning sessions, a survey was distributed to participants online prior to the meeting, and also at the learning session to attendees. The survey, which used a five-scale system (strongly disagree, disagree, neutral, agree, strongly agree), assessed participants' perceptions of CI&R system changes within the communities, as well as their experiences. The questions asked in this survey were based on the CFIR framework described above and on learning collaborative group dynamics. The evaluation team conducted focus group discussions separately with participants from each Healthy Start Coalition on the second and final day of the learning session. The aim of the focus groups was to elicit information on strategies used by the coalitions to improve the CI&R systems of care in their communities, their teams' definition and rating of success, and facilitators and barriers to teams and community success. Focus groups were audio recorded, transcribed verbatim, and reviewed for accuracy by the evaluation team. Themes from these focus group were extracted and summarized.

Demographic Characteristics of Participants Who Attended the Third Learning Session

Forty-seven participants from the eight CI&R planning teams completed a survey to evaluate their respective CI&R system changes. The majority of respondents described their organizations to be primarily associated with home visiting (85%), while 4%, 2%, and 9% of respondents described their organizations to be associated with healthcare, early childhood care and/or education, or other services, respectively. Regarding the respondents' roles within their organizations, 34% identified as administrators, 21% as supervisors, 11% as home visitors, and 34% as other (e.g. program managers, project coordinators, intake specialist, and family partners). Work experience among respondents ranged from four months to forty years (with a mean of 15 years and a standard deviation of 12 years). All respondents reported having some level of college education, of which 37% held a professional/graduate degree, 54% a bachelor's or associate's degree, and 9% no degree. Fifty-seven percent of respondents

identified as White, 29% as Black, 8% as Asian or Pacific Islander, and 6% as belonging to another racial group; of these respondents, 6% identified as Hispanic/Latino.

Change in Readiness over Time

At all three time points, the vast majority of participants (>85%) agreed that they personally, as well as respected officials, believe there is strong evidence for the CI & R system changes to meaningfully impact family outcomes (Figure 4).

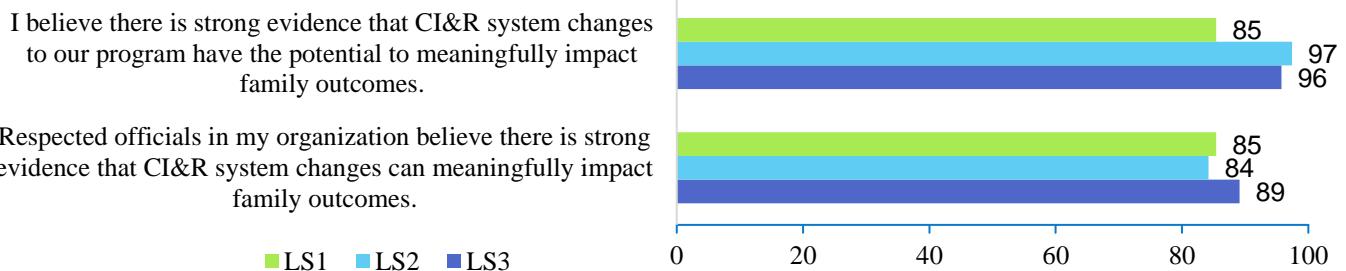


Figure 4: Perceptions on Strength of Evidence

Change in CFIR Domains over Time

Characteristics of Individuals

Across all three learning sessions, over 97% of participants were committed to making CI&R system changes, over 93% believed that the changes would be positive, and over 89% believed in their ability to achieve their CI&R goals. Between the first and final sessions, there was an increase in: those already working on and those actively planning to implement CI&R system changes; those who believed in their own capabilities to implement changes and achieve goals; and those familiar with system change facts and principles (Figure 5).

↑ Individual Characteristics

- Working on system changes (+24.2%)
- Familiarity with facts & principles of system changes (+13.6%)
- Actively planning to implement changes (+7.9%)

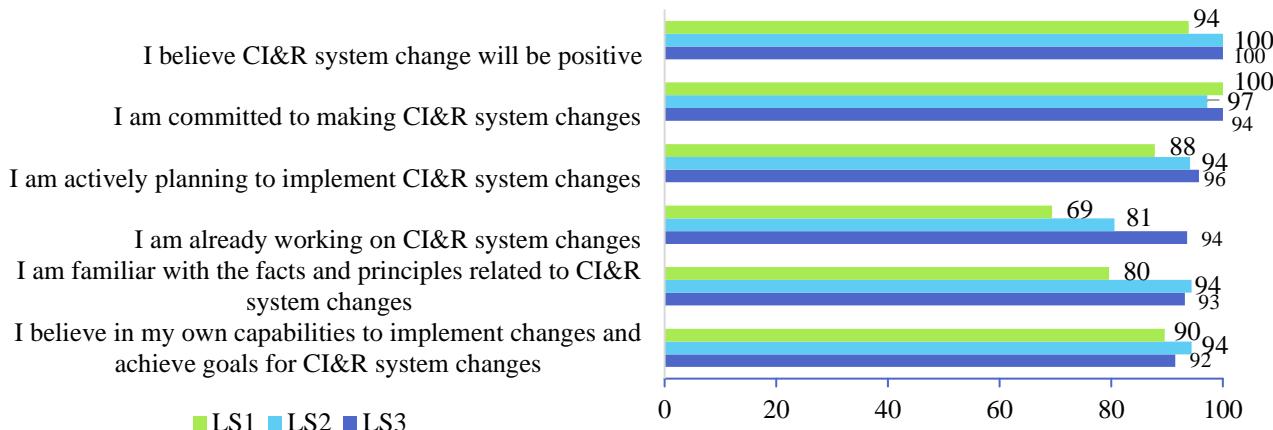


Figure 5: Individual Characteristics

Inner Setting (CI&R Team)

There was a modest increase in participant ratings of their CI&R planning team and CI&R system between the first and third learning sessions. In the third session, over 90% of participants agreed that regular project meetings with management and staff were held, CI&R team members communicated effectively, leadership promoted problem-solving through team building, and their CI&R system took into consideration needs and preferences of the recipients.

In contrast, there was a negligible decrease in the proportions who perceived that staff members were receptive to CI&R changes and those who agreed that quality management staff were involved in the planning and implementation process. On a positive note, at time three, only 13.3% of the participants believed that the current system is intolerable/needs to be changed, an 8% decrease from the first session and 17% decrease from the second session (Figure 6).

- ↑ Inner Setting Perception
 - Needs & preferences of families considered (+10.3%)
 - Clear definition of responsibility & authority (+9.7%)
 - Effective communication (+7.9%)

- ↓ Inner Setting Perception
 - Current system intolerable/needs to be changed (-8.0%)
 - Receptiveness to system change (-3.8%)
 - Quality management in planning & implementation (-0.9%)

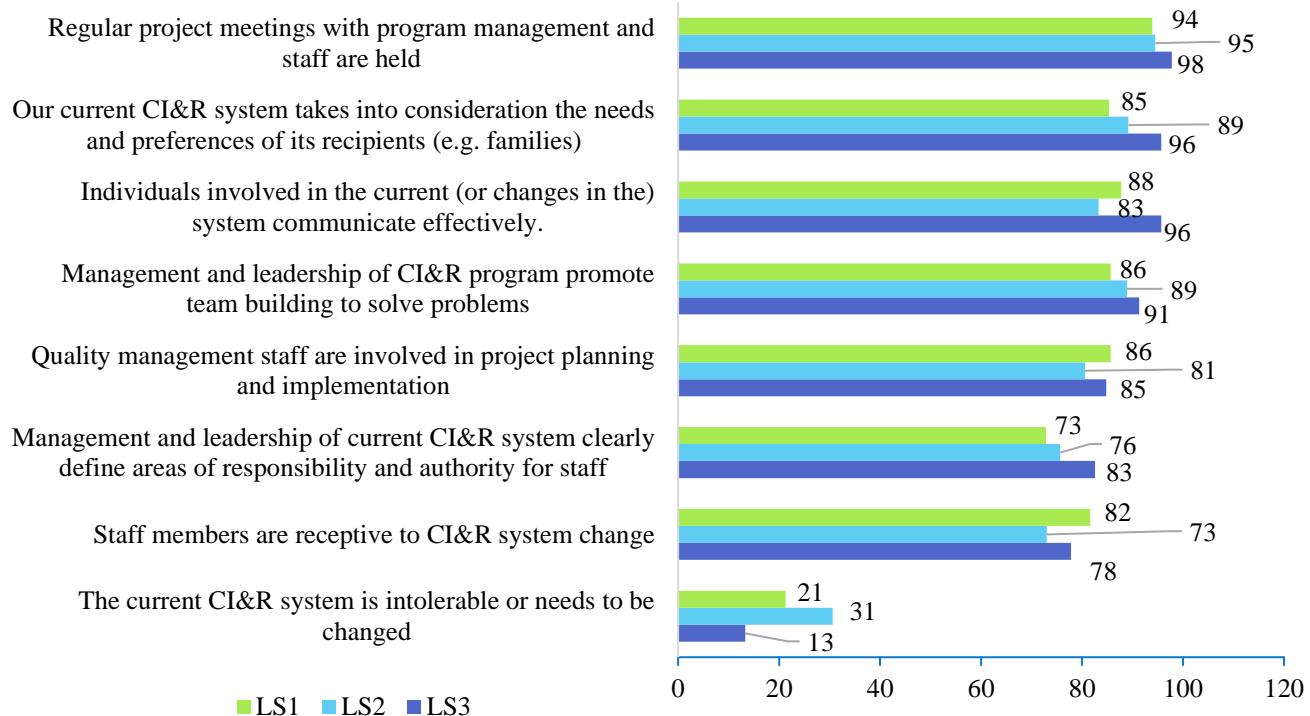


Figure 6: Perceptions of Inner Setting (CI&R Team)

Figure 7 shows other aspects related to the inner settings of the CI&R teams that were investigated only at the third learning session. More than 90% of participants rated the benefits to participating in the learning collaborative, team members' problem-solving skills, and communication and leadership among team members as good or excellent. Over three-quarters of participants thought perceived empowerment

among team members, team members' consistency with attending meetings, and their level of influence on system changes to be good or excellent. The majority (over 80%) of participants rated satisfaction, accomplishment, trust, decision-making and agenda-making capabilities, and conflict resolution among team members as good or excellent.

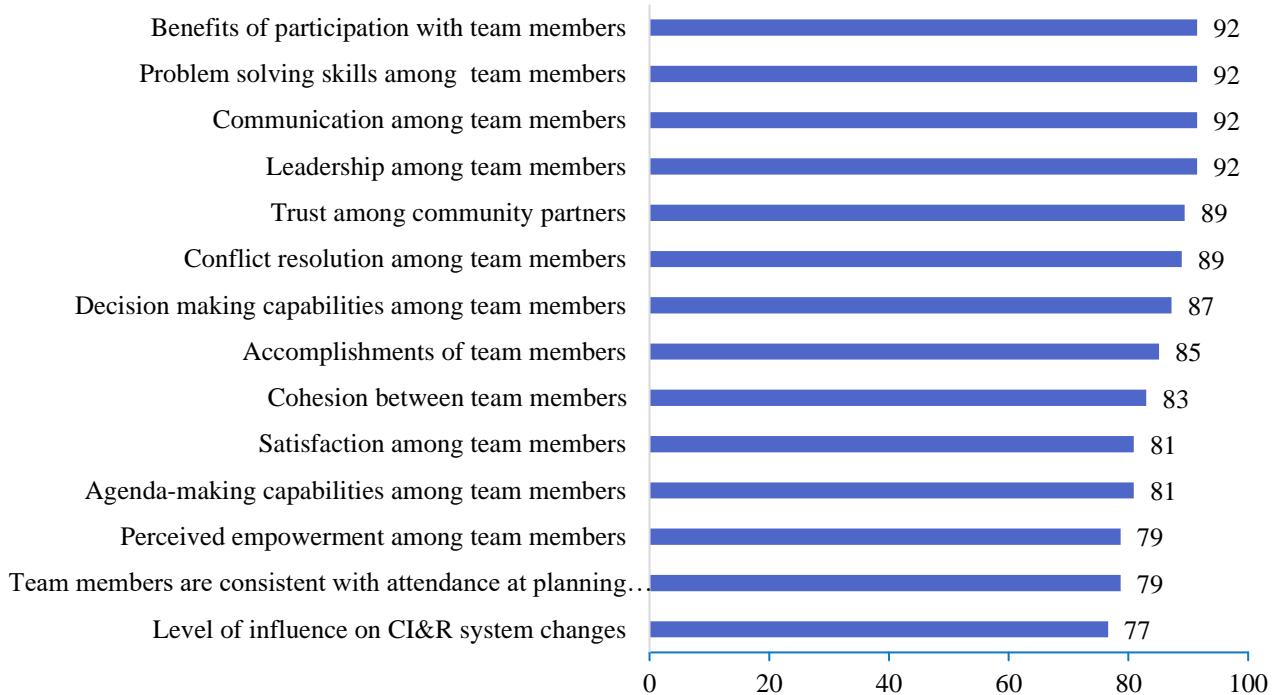


Figure 7: Other aspects of CI&R Group Dynamics

Outer Setting (Broader Community)

Most measures of perception of the CI&R team's outer setting improved over time since the first learning session (Figure 8). The largest improvement of 19.9% was in how participants agreed that the needs and preferences of families were being considered in the CI&R system, with more than 90% of participants in agreement by the third session. More than 80% of participants agreed that their CI&R team members were networked with external organizations, and that their system took into consideration needs and preferences of participants. Lower proportions – slightly less than 70% – agreed that patient awareness or need was available to make the CI&R system changes work. There was an increase in participants agreeing that system changes were influenced by external incentives, and similar proportions that agreed that there was peer pressure to implement system changes.

- ↑ Outer Setting Perception
 - Needs & preferences of families considered (+19.9%)
 - Implementation influenced by external incentives (+14.8%)
 - Networking with external organizations for resources (+7.4%)
- ↓ Outer Setting Perception
 - Peer pressure to implement system change (-2.3%)

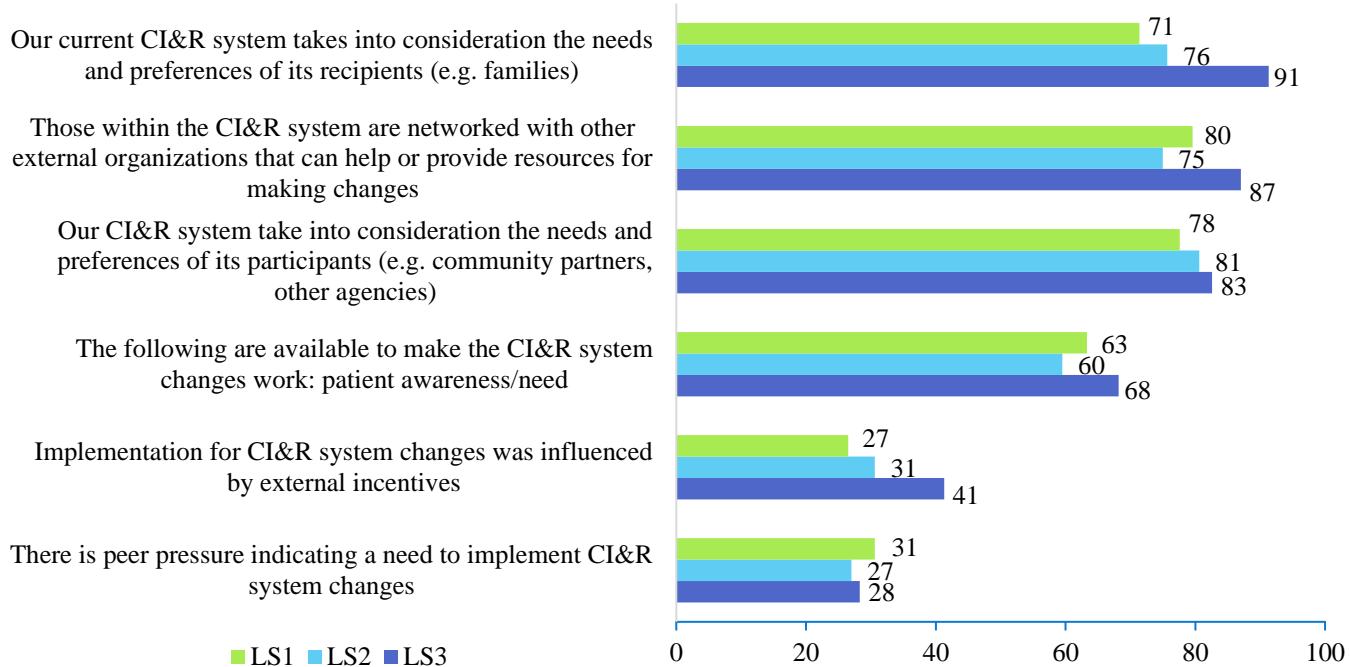


Figure 8: Outer Setting

Implementation Process

There was an increase in almost all measures of implementation perception among participants between the first and last learning sessions (Figure 9). The largest increases (more than 20 percentage points) were in agreement that the system changes would be implemented according to plan, that there was a clearly defined team and roles and responsibilities, in shared responsibility for the success of the project, and that the implementation plan identified roles and responsibilities well. The only decline was a sharp reduction from the first to third sessions in participants agreeing that a satisfaction survey was used to evaluate their current program.

- ↑ Implementation Perception
 - Implementation plan has specific roles and responsibilities (+29.9%)
 - Shared responsibility (+24.2%)
 - Implemented according to plan (+24.2%)
- ↓ Implementation Perception
 - Satisfaction survey provided for program evaluation (-29.3%)

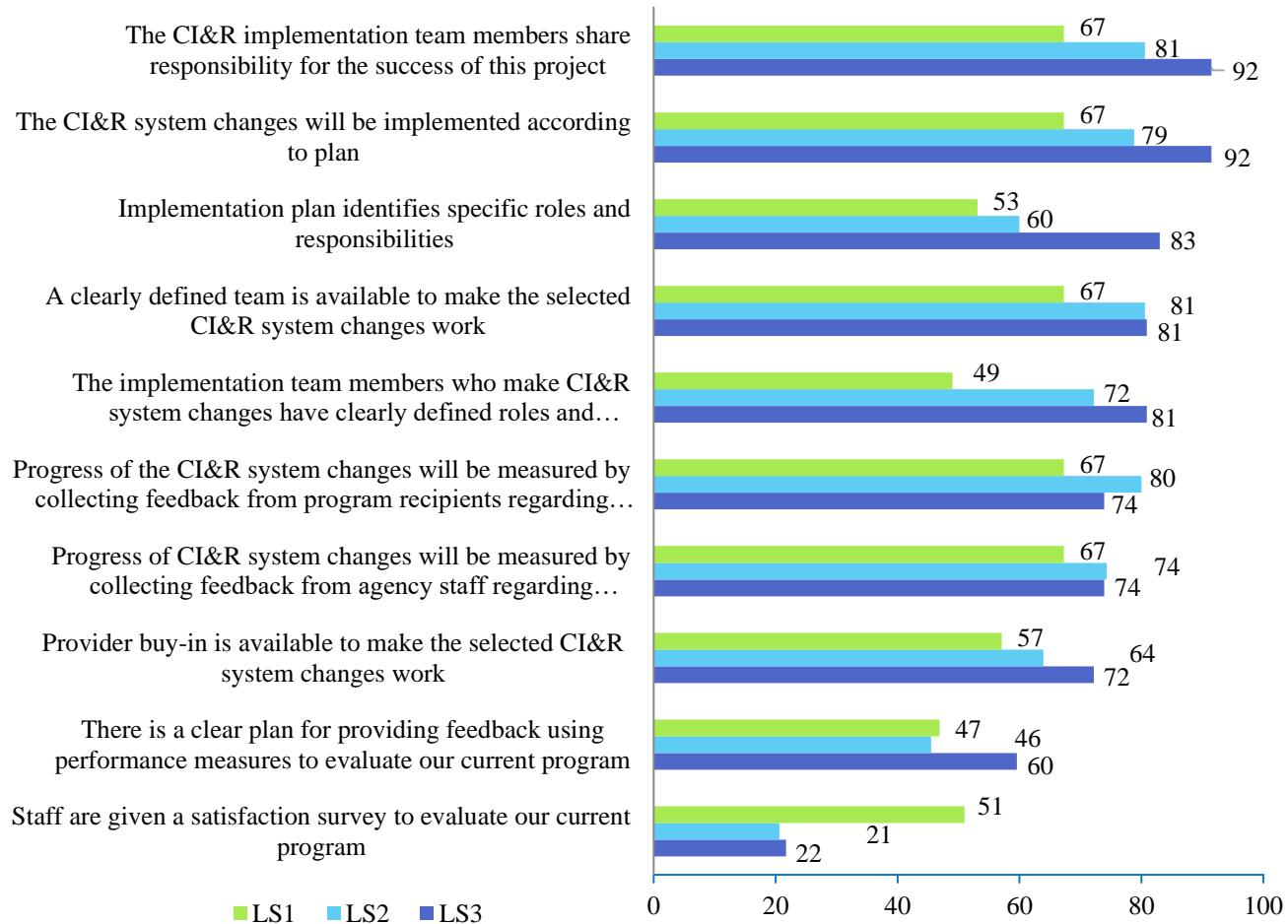


Figure 9: Implementation

Defining and Measuring Success in Focus Group Discussions

To complement the information from the readiness survey, eight separate focus groups were moderated by members of the USF evaluation team during the learning collaborative. CI&R planning team members were asked a series of questions to gain insight into ways in which they are improving the CI&R systems of care in their communities, definitions and rating of success in their teams, and facilitators and barriers to team and community success. The specific questions asked were:

- What is this team doing to improve the (CI&R) system in your community?
- How would this team define success?
- How would you qualitatively rate this team's success at this time?
- What has hindered this team's success thus far?
- What unique qualities of this team make this CI&R project especially easy/difficult?
- What unique qualities of this community make this CI&R project especially easy/difficult?

Strategies to Improve CI&R System of Care

The CI&R team members reported various methods they employ to improve coordination and ease of referring families served. The teams focused on different target populations, such as newborns and mothers exposed to substance abuse, moderate to high-risk pregnant mothers, and teens.



"I think we're trying to track families and make sure that they're engaging in services that they need, and making sure more families can be served by making sure that two agencies aren't serving the same one or we're not duplicating as much effort."

"Well also to collaborate with community partners. So trying to make sure that – we, you know, include everyone, different home visiting programs that are involved, and keeping the communication in developing and continuing the good relationship."

Strategies to Improve CI&R System of Care

- Plan-Do-Study-Act analyses of CI&R system
- Development of a mobile app that will direct more families to CI&R services
- Tracking and managing programs in order to prevent duplication of services
- Gathering feedback from partner agencies on what does and does not work
- Reflecting on ways to expand resources to families
- Maintaining communication and strong relationships between home visiting programs
- Provision of training to empower home visitors
- Contact with families to streamline process and reduce their stress

Teams' Definitions of Success

The team members described success in various ways, which centered on the CI&R system of care, the staff, the families served, and community involvement.

"I mean, I think just being a part of this process has been a success, the teamwork and I think the wholehearted effort that's been put forth need."

Success related to CI&R System Changes

- ⊕ Families referred to services
- ⊕ Families enrolled with services that fit their needs
- ⊕ Community involvement
- ⊕ Retention rates for families enrolled
- ⊕ Families staying engaged with program even after services are officially over
- ⊕ Families showing independence and increased advocacy after participation
- ⊕ Full implementation of refined CI&R system that makes referral process simple and expands reach – care provided

Success related to CI&R Team & Staff

- ⊕ Having a diverse and collaborative staff that recognizes families' needs
- ⊕ Staff's understanding of the programs offered so that the proper care can be assigned to each family
- ⊕ Self confidence in staff's abilities to provide care
- ⊕ Effective intra-agency communication
- ⊕ High degree of collaboration and cooperation rather than competition among agencies
- ⊕ Supportive team with diverse skill sets among members

Teams' Rating of their Success

The team members when asked to rate their respective teams' success on a scale of one to ten, gave various ratings backed with different reasons. The ratings across all focus groups ranged from four to nine with the majority of the participants rating their teams a score of seven. This led to additional information about successes (already described above) and areas for improvement in the process. Lack of collaborations between agencies, lack of engagement and retention of families, and a CI&R system that was not fully developed were some reasons stated by those with lower ratings. Nearly all groups further explained that they are continually working to develop and improve the system and suggested ways of improvements in order for them to achieve the highest rating.

"I probably would say a nine because I feel like we're doing a great job. We have room for improvement but we work very well together and we definitely seeing results from that work on each level, not just the planning level but also the implementation and amongst the other agencies and we're reaching the families."

"It's just going to take time because this is a new process. It's new for all of us. Some of us that have been doing things a certain way for a long time, just learning how to integrate this new system into it, and I think the longer we do it, the closer we'll get to it because every time we add a new target, we find other little things that we need to tweak or to get better."

Barriers to Success

The team members further discussed reasons why they had not yet achieved the highest level of success and mentioned factors that hindered their respective teams' success. Some of the factors mentioned include lack of engagement and retention of some staff and families, and inadequate funding/resources which limited opportunities. One of the teams reported that due to the lack of resources, most of the programs were at capacity as inadequate funding has led to an undersized staff and limited opportunities. Structural factors such as the ambiguity of certain aspects of the program e.g. the enrollment process and the inability of some medical providers to recognize the CI&R system were discussed. These made it difficult for the programs to reach out to families that would benefit from services offered. Other barriers mentioned include confidentiality issues when sharing data interagency, limited options for families that do not mesh well with CI&R services, families unaware that there are services available to them irrespective of their socioeconomic status, families declining services, language barriers, and a high rate of attrition as families move out of the area in search of better opportunities.

“And I think some of our hardship too is been keeping people engaged that don’t necessarily understand “How does this apply to me and my job and what I’m doing?” So keeping them to see that it’s good for all of us and just engaging and I guess sustaining.”

- | Barriers to Success |
|---|
| <ul style="list-style-type: none"> ■ Lack of retention of staff ■ Lack of engagement of families ■ Inadequate funding/resources – can lead to understaffing ■ Lack of clarity in terms of how programs differ (overlap of services) ■ Lack of awareness of CI&R systems among medical providers in particular ■ Ambiguity in enrollment process ■ Confidentiality issues limiting ability to share certain data across agencies ■ Lack of family awareness of services (irrespective of socioeconomic status) ■ Limited options if families don’t fit well with CI&R services ■ Families declining services ■ Language barriers ■ High rates of family mobility/attrition |

“I think one of our biggest challenges is that like some of the areas, we don’t fall under the same umbrella. So, having to be mindful that we’re not oversharing information in unsecure ways and that we’re trying to communicate as efficiently and effectively as possible with having to use outdated means is a challenge.”

Unique Qualities of the Teams

The team members were asked about the unique qualities possessed by their teams that made the CI&R project easy or difficult. They explained that intrinsic factors such as positive staff qualities contributed to a positive team functioning. Some of the qualities mentioned include: a wide range of skills sets among staff members, both social and technical; healthy communication among team

members; prior and close relationships among staff members which made the process run smoothly due to an intrinsic confidence in each other's judgment; trust and openness between team members; and a shared determination/goal to make the CI&R system successful and flawless. One team also reported that empowering leaders made the process easier as it allowed staff members to perform at their best.

I think we really have a very eclectic group that everyone brings so many different gifts to the table that it really lets us cook a really good meal, if that makes sense. From our leadership...MIECHV giving us the full reign to think creatively and throw ideas out there and test them, and the partnership that [a teammate] and I have created is fluid and it flows and we throw things in the air and they give us permission in a way and say, "Run it."

I think what makes it easy is the buy-in, everybody has the same buy-in. We don't really have anybody on our team that's territorial, that is reluctant to the process, and that's why we all work together well.

Despite these positive qualities, they shared other team qualities that made the CI&R project difficult. For instance, factors such as different working backgrounds and differences in various programs expected outcomes made information transfer somewhat difficult

Unique Qualities of the Communities or Settings

The teams identified unique qualities in their communities which either made the CI&R process difficult or easy. One of the teams explained that they had adequate funding through a separate funding source which made the process to progress relatively unhindered. They also reported interagency factors that aid in their success, such as healthy relations among agencies which allow for the opportunity to test creative ideas through MIECHV, widespread compassion of the particular community being serviced, and willingness of individuals within partner agencies to coordinate and collaborate, which makes care more accessible to families.

Teams also mentioned community factors that made the process difficult, including inaccuracies in the depiction of areas in need of CI&R services (due to a large size of community), leading to some areas being underserved, economic and racial barriers which led to some deficiencies in community involvement, and the inability of the community to fully recognize the value of the CI&R system, or the programs within it. Other barriers are highlighted in the table below.

"I think that our community is, from what I experienced, really giving and they all are working towards some more goals but are all in their own silos or in their own ... but we all need to come together to work towards that same goal."

"As diverse as [our community] is, there are a lot of racial barriers, economic barriers, and people that aren't as willing to help and do different things. So there are definitely some challenges with that like where you live matters [here] ... especially with community involvement."

Community Factors as Facilitators

- Strong relationships among people at the various agencies and proximity to each other
- Available funding through separate funding source (one team)
- Compassion from community being served
- Willingness of partner organizations to collaborate

Community Factors Creating Challenges

- Lack of resources or competition for resources and families across agencies
- A lack of collaboration among organizations
- Deficient transportation services which limit access of families to care
- Political leaders choosing to ignore populations that are in greatest need of CI&R services – resulting in lack of resources
- Difficulty in communicating with people in some organizations due to a lack of alignment in perspectives re: certain circumstances (e.g. viewing drug addiction as a choice instead of a disease)
- Economic and racial barriers which impacted community involvement

Improving the Process

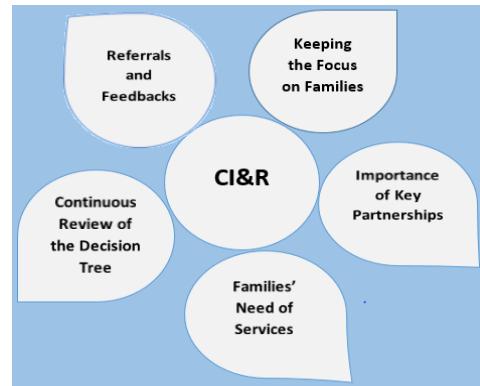
The focus group discussions revealed advantages of the CI&R process as the participants shared their opinions on why other teams should adopt a similar process. They explained that CI&R system allowed team members and their respective programs to become more motivated to provide the best services for families. It also promoted improved recognition of families in need of services, better interagency understanding and collaborations in the services rendered, and greater understanding of internal processes that maintained programs, thus leading to a more efficient program. Some teams also recognized the large number of people requiring care coordination in their systems, acknowledged the strength of interagency collaborations, and appreciated the different programs within their CI&R systems. The participants, shared various strategies that could help improve the CI&R process such as:

- Expansion of the program so that resources are more readily accessible to families
- Standardized data entry program that would allow for continuous improvement of care
- A shared database that will help streamline the CI&R process
- A universal screening tool that allows agencies to understand patients' situation prior to their arrival and not require them to repeat their situations before providing services
- The development of an Advisory Board that contains voices from different backgrounds and perspectives

Figure 10: Strategies that could help improve the CI & R process

Lessons from the Field

Excerpts were drawn from the CI&R sites final reports and posters to provide more insight into the process of the CI&R system changes by the various coalitions. The major lessons identified that aided system changes include the: importance of key partnerships; continuous need to update decision trees; importance of referrals and participant feedback; and keeping the focus on families while meeting their needs.



Conclusions

This report tracks CI&R system changes in eight Healthy Start Coalitions in Florida through three learning sessions, as well as focus group discussions, to understand how participants view their successes and challenges. The findings show general improvement in perceptions in all domains between the first and the final learning sessions. Though varying by teams, the areas which need further attention (i.e. with < 80% agreement in the third learning session) are:

- team building (perceived empowerment among team members, consistency with planning meeting attendance by team members, and level of influence on CI&R system changes);
- participant teams' evaluation of their outcomes (giving satisfaction surveys to evaluate current programs, establishing clear plans for providing feedback using performance measures to evaluate current programs, collecting feedback from agency staff regarding proposed/implemented changes so as to progress of CI&R system changes, and collecting feedback from program recipients regarding proposed/implemented changes so as to progress of CI&R system changes); and
- participant buy-in (increasing staff receptiveness to CI&R system changes, provider buy-in, and patient awareness/need).

These go hand-in-hand with some of what was revealed in focus group discussions of barriers and recommendations. Strategies that increase awareness of the CI&R system among team members and agencies, providers, and families will likely increase buy-in at these different levels of participation. Emphasizing the importance of collecting data to evaluate each team's implementation of system changes will help improve team's ability to track their own efforts and outcomes. The teams themselves, no matter how they rated the success of the system changes in their community, agreed that they would continually work to improve on their progress thus far.

The very process of coming together in teams to communicate and reflect upon the services they provide, find common goals, and build relationships across organizations was successful across the coalitions that elected to participate. Notably, these sites scored high on the baseline survey indicators that suggest a relatively high level of readiness to implement changes in CI&R processes. This is critical to be aware of because scaling this up to coalitions that are not volunteering may present some new challenges related to getting buy-in and increasing their

readiness to take actions. Furthermore, the individuals involved began with a relatively high level of commitment to implementing CI&R changes or they were already working on it. Nevertheless, many of the challenges and successes they faced may serve as lessons learned for other sites. We recommend considering some of the differences in the inner and outer settings and differences in barriers in moving forward with the plan to pair coalitions up as mentors for new learning collaborative groups in order to assign mentor groups that are most similar.

For more information, please contact:

Jennifer Marshall, PhD, CPH
 Assistant Professor, Lead Evaluator
 University of South Florida College of Public Health
 Department of Community and Family Health
 Tel: (813) 396-2672
 Email: jmarshal@health.usf.edu
 Website: <http://miechy.health.usf.edu>

This project is supported by the Health Resources and Service Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number D89MC28265, Affordable Care Act, Maternal, Infant, and Early Childhood Home Visiting Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsement be inferred by HRSA, HHS, or the U.S. Government.



Florida Maternal, Infant & Early Childhood Home Visiting Initiative



References

- Adapted CFIR showing interacting domains in implementation research: Henao-Martínez, A. F., Colborn, K., & Parra-Henao, G. Overcoming research barriers in Chagas disease—Designing effective implementation science. doi: 10.1007/s00436-016-5291-z
- Adapted CFIR-Model: Damschroder, et al., 2009, in Ament et al. BMC Health Service Research 2012 12:423. doi:10.1186/1472-6963-12-423. Group dynamics adapted from Schulz, Amy J., Barbara A. Israel, and Paula Lantz. "Instrument for evaluating dimensions of group dynamics within community-based participatory research partnerships." Evaluation and Program Planning 26.3 (2003): 249-262
- Damschroder, L. J., & Hagedorn, H. J. (2011). A guiding framework and approach for implementation research in substance use disorders treatment. *Psychology of Addictive Behaviors*, 25(2), 194.
- Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A. and Lowery, J. C.(2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science* 2009, 4:50. doi:10.1186/1748-5908-4-5

STAFF STRESS AND BURNOUT IN THE FLORIDA MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING (MIECHV) PROGRAM

Alitz, P., MPH¹, Birriel, P., MPH, CHES², Ramakrishnan, R., MPH², Robinson, C., BS², & Marshall, J., PhD, CPH²

¹University of South Florida, College of Public Health, Department of Epidemiology & Biostatistics

²University of South Florida, College of Public Health, Department of Community & Family Health

PROJECT OVERVIEW

The Florida Maternal, Infant and Early Childhood Home Visiting (MIECHV) program is an evidence-based home visiting program that serves high-need, expecting and new mothers until their child is up to five years of age in 14 communities across the state. Three evidence-based program models are implemented, including Nurse-Family Partnership, Parents as Teachers, and Healthy Families Florida. As part of an independent, ongoing evaluation of Florida MIECHV, the University of South Florida (USF) evaluation team conducted...

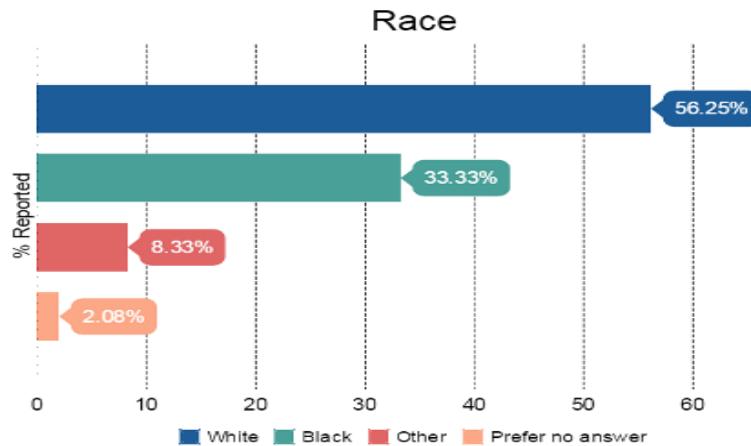
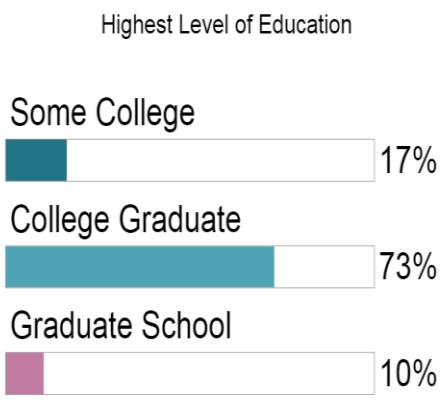
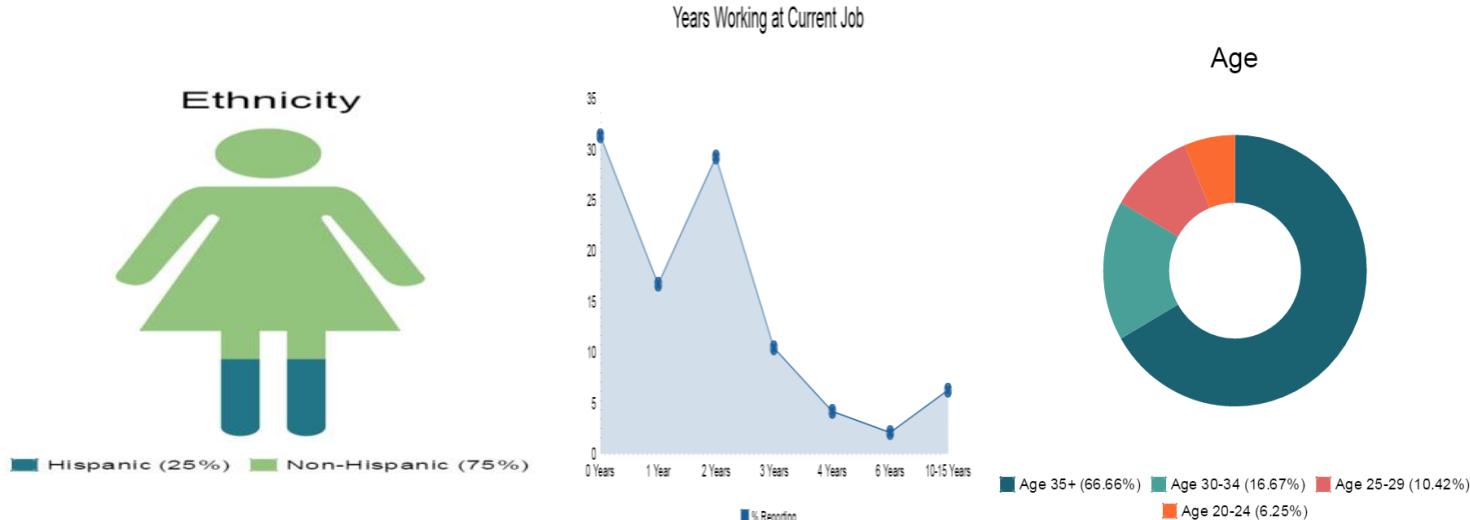
METHODS

Ten separate focus group interviews with 47 home visitors, 11 supervisors, 13 administrators/directors, which included discussions focusing on staff stressors. During the focus group interviews, the USF evaluation team conducted a pile sorting activity. The experience of these professionals in home visiting ranged from less than one year to two decades, with the majority being within their first five years in their position.



The majority of home visitors were White, non-Hispanic women above the age of 35 years old, who had earned a 4-year college degree. Additionally, most home visitors had between 0-2 years of experience in their current position.

PARTICIPANT DEMOGRAPHICS



RESULTS



Required Paperwork

- Home visitors at every MIECHV site named completing required paperwork as their number one job-related stressor. Not only did they cite the amount of time that it takes to complete paperwork, but the program's emphasis on completing paperwork over having genuine relationships with the families.

• ...it doesn't matter how you do your job as long as the paperwork is right. Like everything is about the numbers. Everything is about the studies. But here's the thing, paperwork is not everything because the numbers could be there but your relationship is what's going to affect the outcomes in the long run."

Caseload Management

- In 9 of 10 focus groups, home visitors voiced concern regarding their caseloads. Each home visitor is required to see between 20-25 families on a weekly basis, which can be cumbersome with juggling the required paperwork and engaging with mothers who are often facing dire circumstances that require extra time.
- *"It's the caseload...I have six families to see so if I have to see you at 2:00 and I've got another I need to see at 2:15, I can only give you this amount of time...something may come up where she needs more time, and even though we want to be there and spend time with their family, we're thinking about our home visit rate."*

Cancelations and Rescheduling

- The stress of managing a high caseload is compounded by frequent, last minute cancelations and rescheduling by the family.
- *"This is time that you can give to another person. It is time that you can utilize working in the office. It's a waste of time. You have too many things to do, too many visits to accomplish...you already drive 30 minutes, 10 minutes to get there. Knock on the door, she's not there. One hour you waste that you can use on something else."*



Lack of Resources for Families

- In 8 of 10 focus groups, home visitors reflected on the stress of their families not having enough resources available in their communities. Housing, child care, transportation, and mental health services were merely a few resources discussed that were lacking for families.
- *"As mental health care is concerned, I have my clients who – while referred to the MOMS [Mothers Overcoming Maternal Stress] program she was on the waiting list, and nobody called her."*

Client Engagement

- Due to the job-related stressors such as paperwork completion, case management, and lack of resources for families, client engagement is hindered.
- *"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...The moment you push their needs off, especially if they're having a crisis, you deteriorate that relationship..."*

Coping Mechanisms

- Yoga, dance, and mindfulness practices were used by many home visitors as coping strategies. Other stress-reduction activities included job retreats with supervisors, and spending time with their families.
- *"I take the babies out. My sister has – her two grandchildren live with us and that's the greatest thing in the world for me. I love to – we go to Chucky Cheese. We go to the pool. We go swimming. We go bike riding. I love to do things with them."*

DISCUSSION

The current study examined job-related stressors in the MIECHV program. Because the Florida initiative was less than 3 years old, the majority of home visitors who participated in the focus group interviews were newer; thus, our findings may not be representative of the diverse experiences of home visiting professionals. In response to these findings, Florida MIECHV increased resources to support home visitor compensation, reduce caseloads, and hire data entry staff. Additionally, a competitive award from HRSA was obtained to implement a mindfulness-based stress reduction program for home visitors statewide in 2017.



Florida
Maternal Infant & Early Childhood
Home Visiting Initiative



COLLEGE OF PUBLIC HEALTH
UNIVERSITY OF SOUTH FLORIDA



The Lawton and Rhea
Chiles Center
for Healthy Mothers and Babies

Florida Maternal, Infant, & Early Childhood Home Visiting Initiative Evaluation

Qualitative Report: Perceptions of the *Mindful Caring Pro* course among Florida MIECHV Home Visiting Staff

Kimberly Hailey, Esther Jean-Baptiste, and Jennifer Marshall

In Spring 2017, Florida home visiting staff were invited to participate in the *Mindful Caring Pro*(MCP) retreat and subsequent web-based series. The eight-week intervention was offered twice; initially in March (Cohort 1) and again in May (Cohort 2).



Participants voluntarily enrolled into the programs, which began with a retreat conducted to equip home visitors, administrators, and supervisors with the tools for stress management skills. Program activities were selected with an expectation that participants could apply these newfound strategies in both their personal and professional domains.

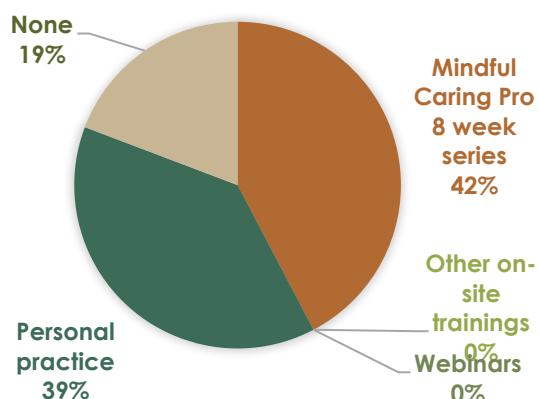
The qualitative data in the below report were obtained from the responses of those that completed at least one question from the surveys distributed by the University of South Florida Evaluation Team. Potential survey participants were invited via email to complete an online Qualtrics survey; responses were recorded, and later analyzed through the same software tool.

Of the 59 people invited to participate in the survey following the first MCP retreat (Cohort 1), 29 responses were gathered. Sixty-one people were invited to the Cohort 2 follow-up survey and 21 responses were collected from this group. Respectively, 43% and 50% of respondents in Cohort 1 and 2 surveys participated in the MCP series.

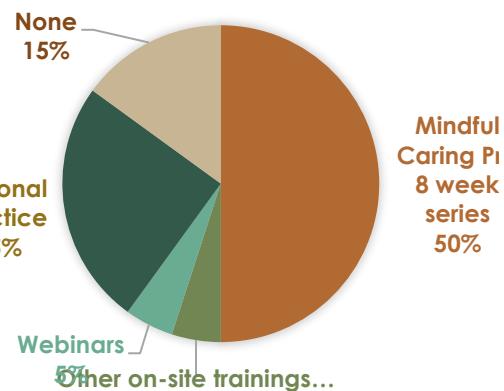
What mindfulness activities have you participated in within the last 4 months?

While the majority (42%; 50%) of respondents indicated participating in the MCP series within the last four months , personal practice was also commonly chosen (39%; 25%) as another mindfulness activity.

Cohort 1- Mindfulness Activities



Cohort 2- Mindfulness Activities



How has mindfulness practice positively impacted you and your work?

Below are the testimonies of several program participants; detailing how being mindful has impacted them or their work:

It has helped me to slow down and listen to listen rather than listen to respond. To take a moment to be in the moment.

I was already familiar with mindfulness practices and employ them several times a week, it has been helpful to reinforce/ validate the positive practices.

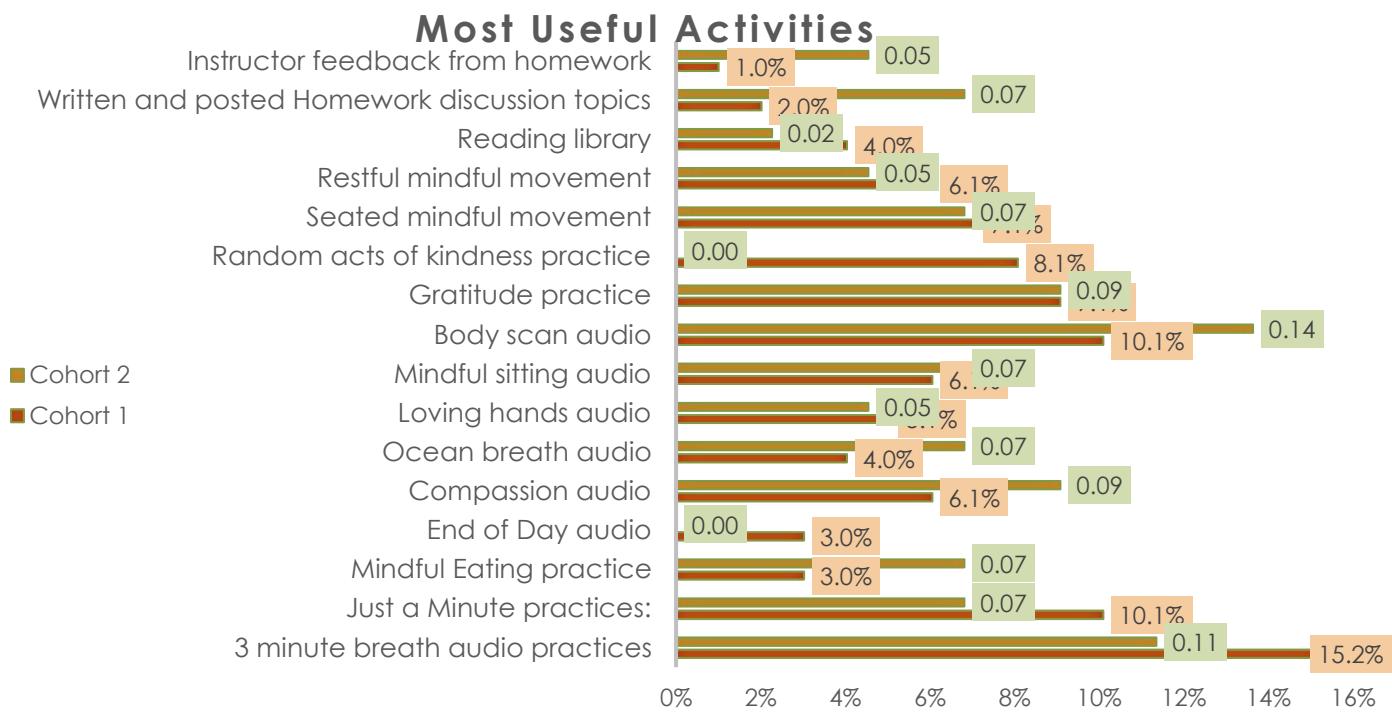
I find myself less reactive, more curious, more reflective, listening more and speaking less.

I feel more relaxed and confident that I can use it as I need it to alleviate stress and induce sleep.

Improved my work and private life by reducing stress and better handling stressful situations.

Which mindfulness activities/practices did you find most useful?

Participants in Cohort 1 found the '3-minute breath audio practices' (15%), 'Just a minute practices' (10%), 'body scan audio' (10%), and 'gratitude practice' (9%) to be the most useful among the practices described in the program. While Cohort 2 respondents perceived the 'body scan audio' (14%), '3-minute breath audio practices' (11%), 'compassion audio' (9%) and 'gratitude practice' (9%) in order as the most useful practices.



Among the least reported activities from Cohort 1 were the 'instructor feedback from homework' (1%) and 'written and posted homework discussion topics' (2%). Cohort 2 reported utilizing those two activities more often than Cohort 1 and listed 'random acts of kindness' (0%) and 'end of day audio' (0%) as the least useful activities.

Which of the following Just a Minute techniques did you find most useful?

Participants were asked to rank Just a Minute techniques from 1 to 7, in order of most to least useful. In both Cohorts, 'waiting' was identified as the most useful technique. 44% of participants in Cohort 1 and 67% of respondents in Cohort 2 reported 'waiting' as their most useful strategy. The ranking of the other techniques differed based on the cohort, with Cohort 1 favoring 'morning meditation' over their Cohort 2 counterparts.

Cohort 1 activity ranking:

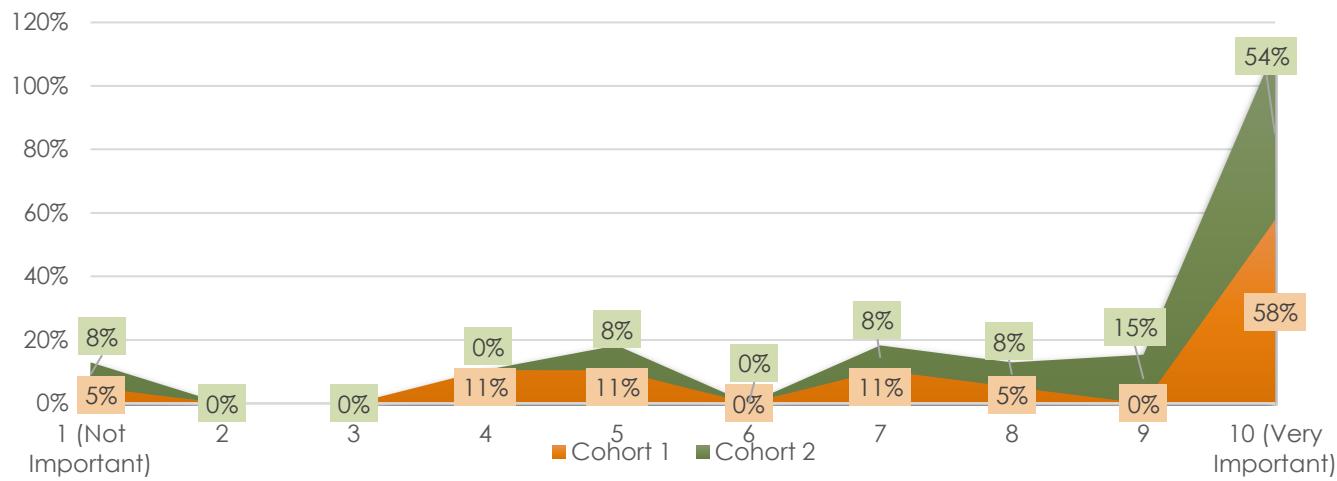


Cohort 2 ranking:



How important were the retreats in informing you about mindfulness & the MCP course?

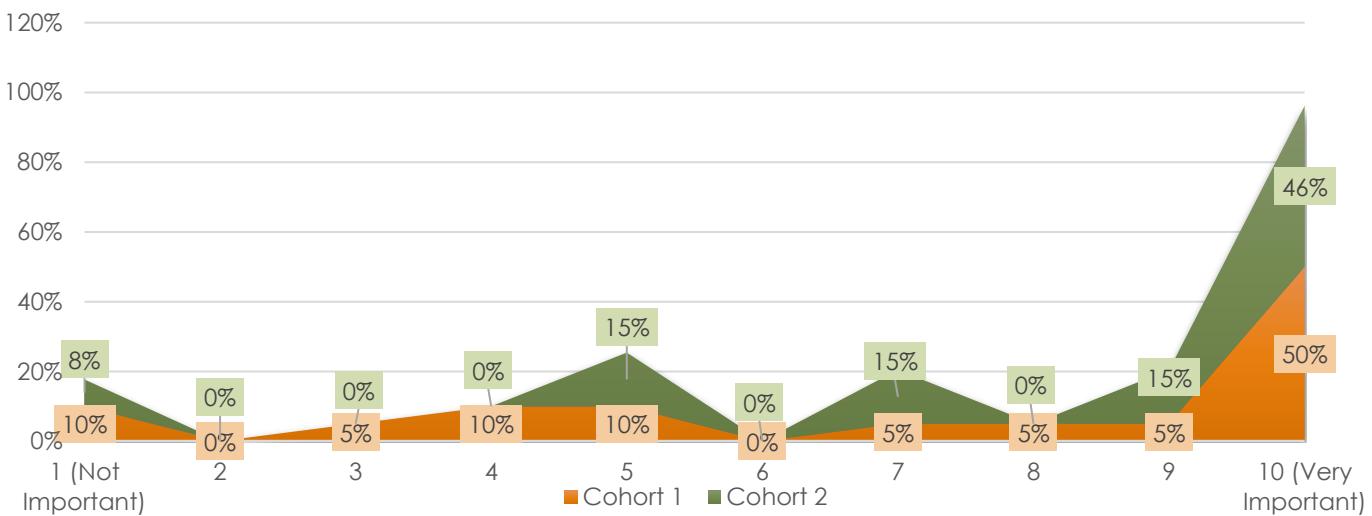
Importance of retreat in informing about mindfulness



Overall, the majority (58%; 54%) of participants in both cohorts believed the retreats were 'very important' in informing them of mindfulness and the web-based series.

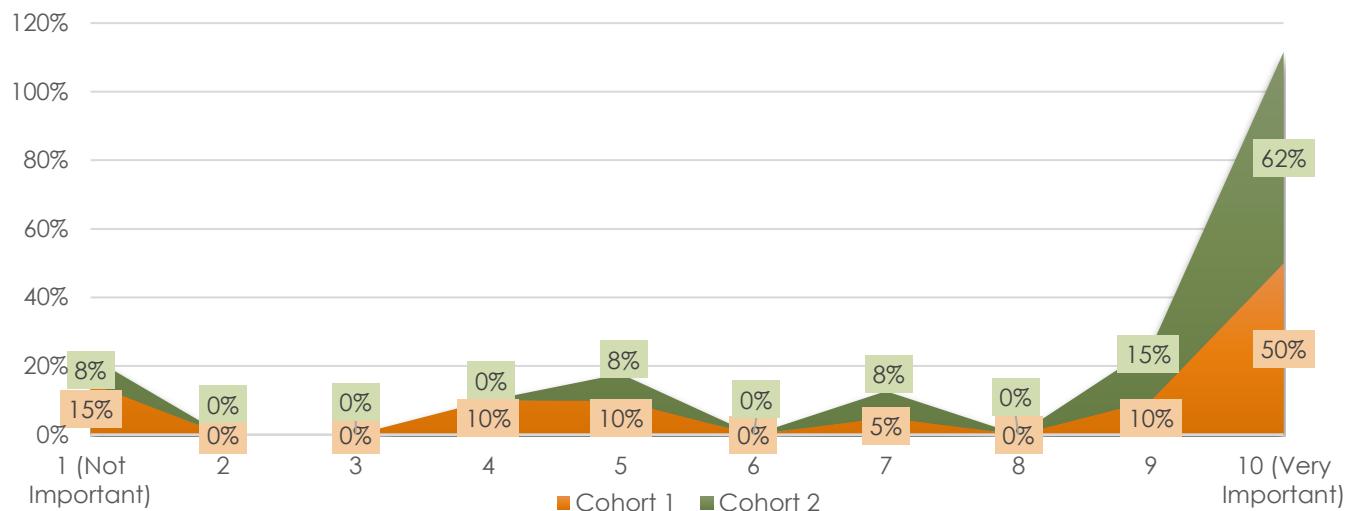
How important were the retreats in creating greater connection with the instructors?

Importance of retreat in creating greater connection with instructors



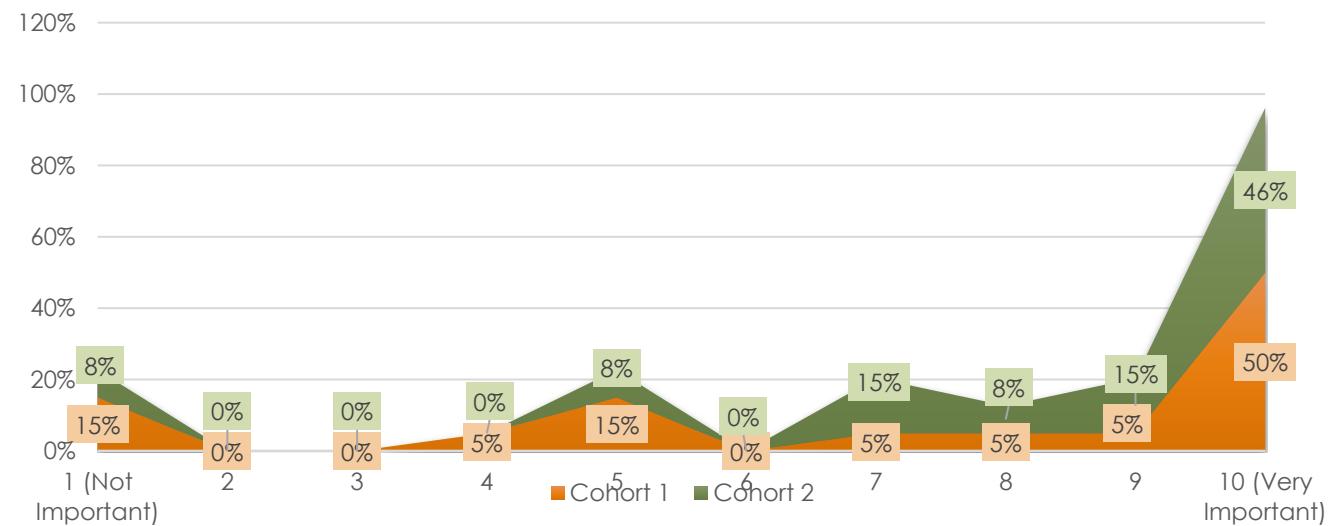
How important were the retreats in providing basic instruction on the practices?

Importance of retreat in providing basic instruction on practices



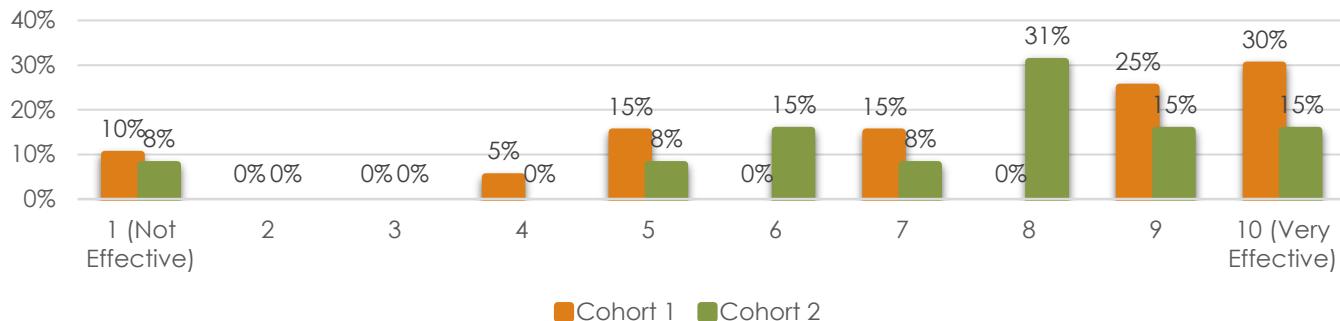
How important were the retreats in helping to motivate and support your mindfulness practices?

Importance of retreat in helping to motivate mindfulness practices



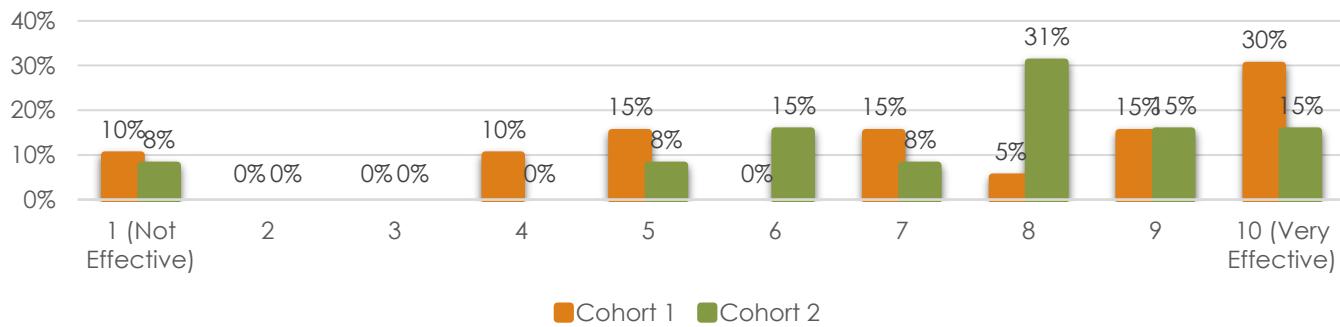
How effective was the *Mindful Caring Pro* series in reducing personal stress?

Effectiveness of MCP in reducing personal stress



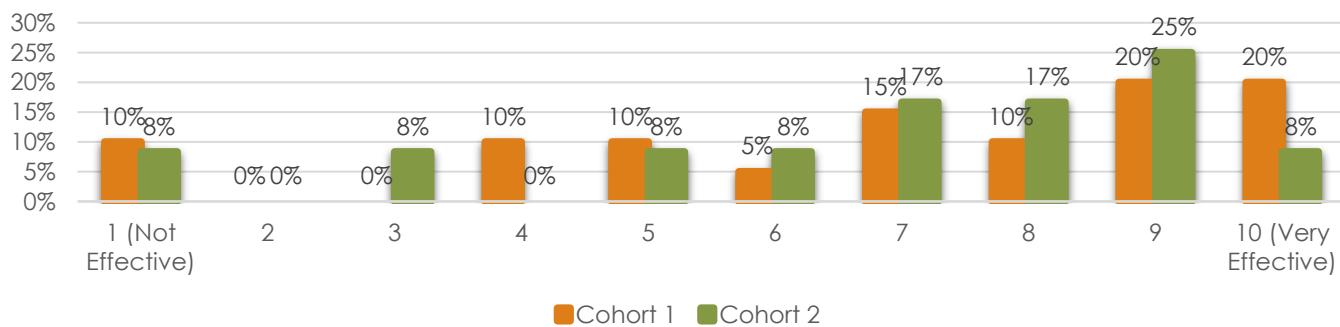
How effective was the *Mindful Caring Pro* series in reducing work-related stress?

Effectiveness of MCP in reducing work-related stress



How effective was the *Mindful Caring Pro* series in improving your engagement with clients/families?

Effectiveness of MCP in improving your engagement with families



Participants in Cohort 1 were more likely (20% vs 8%) to report MCP as contributing to the improvement of their client engagement.

What did you like BEST about the Mindful Caring Pro series?

- Having interaction with the instructors
- Experiencing the peaceful setting and connection Attending the retreats
- Learning new mindfulness activities
- Using personal practice activities to complete in the comfort of home



"The audio mindfulness practices. Her voice is heaven, I loved listening to the audio practices they enhance relaxation."

"Being guided or coached through it was nurturing and motivating to do it for myself. This is the only thing so far that actually helped me feel better. Talking about trauma and secondary trauma and recognizing it is valuable but it is intellectual and does nothing for the actual feeling part of it. Mindfulness addresses and helps with the experience and emotions of secondary trauma."

Do you have recommendations for improving the Mindful Caring Pro series?

While most participants reported 'loving' the experience of MCP, a few recommendations were noted:

- Receiving a certificate after completion
- Extending the retreat for a weekend
- Having the retreat more often at a closer proximity
- Creating a local practice community for further support
- Making it easier to log into the system and to access the website
- Finding ways to balance work/caseloads with MCP homework and activities

"It is too much commitment for those carrying a full case load, and it would have been better to have day of learning, and retreat, then coming back in 3 to 4 weeks to discuss what worked and the challenges that were faced incorporating mindfulness practices into each day, with a refresher retreat."

For more information, please contact:

Jennifer Marshall, PhD, CPH

Assistant Professor

University of South Florida College of Public Health

Department of Community & Family Health, Chiles Center

(813) 396-2672

jmarshal@health.usf.edu

Florida MIECHV Evaluation <http://miechv.health.usf.edu>

Florida ECCS Evaluation <http://health.usf.edu/publichealth/chiles/eccs>

Florida Maternal, Infant, & Early Childhood Home Visiting

Program 2015 Maternal Depression Analysis Report

Kristen Ross, Rema Ramakrishnan, Abimbola Michael-Asalu, Ngozi Agu, Jennifer Carter, Pam Birriel, Paige Alitz & Jennifer Marshall, University of South Florida Chiles Center for Healthy Mothers & Babies

Background

Depression is an illness that varies on levels of severity, but is reported to affect an estimated 6.7% of adults in the United States at least once in a time span of 12 monthsⁱ. Adults do not collectively experience depression at the same rate, however, being that depression has a significantly higher prevalence rate in women (11.7%) versus men (5.6%).ⁱ Postpartum depression, a significantly common depression amongst women, is defined as “a major depressive episode occurring either during pregnancy or postpartum.”ⁱⁱ Women are most commonly diagnosed with postpartum depression when their symptoms occur within three to six months after delivery and occasionally last up to the first year.ⁱⁱⁱ Against popular belief, depression affects more than just the individual. As a steadily increasing public health issue, it is now understood that depression also has a negative impact on individuals in close proximity to the person suffering from the condition.



Because depression is significantly more prevalent in women, several studies have examined the relationship between maternal depression and impacts on the child. These impacts include, but are not limited to: behavioral problems, lack of sufficient mother-infant bonding, delayed developmental milestones, and consequently child and adolescent mental health problems.^{ivvviivviii} The mother may also experience anxiety and lack of confidence in her ability to possess and carry out parenting skills, which also affects child outcomes.^{ix}



The risk factors for maternal depression are wide and varied but may include several socio-demographic factors (unemployment, low educational attainment, low socioeconomic status), drug and alcohol abuse, family violence, or illnesses and stressors experienced prior to or during pregnancy.^x Despite the exact cause of postpartum depression, many studies conclude that interaction between child and depressed mother is significantly different than that of women who don't suffer from depressive symptoms^{xi} which can negatively impact family well-being, attachment, and child development.

Therefore, the purpose of this study was to describe possible risk factors for maternal depression among participants in Florida's MIECHV program and to contribute to the general body of information about maternal depression. The Florida MIECHV program (<http://flmiechv.com/>) is led by the Florida Associations of Healthy Start Coalitions, Inc. which focuses on the goal of

improving health and developmental outcomes for families in high-risk communities through evidence-based home visiting programs. By implementing MIECHV home visiting program, trained professionals work exclusively with parents towards the goal of promoting wellness within the home and preventing negative outcomes.

Methods

The data for this study came from the Florida Home Visiting Information System. The sample of the study consisted of mothers enrolled in Florida MIECHV anytime between April 1, 2013 and June 30, 2015 who were screened for depression using the Edinburgh Postnatal Depression Scale (EPDS) and Perceived Stress Scale (PSS) under the measures of socio-demographic variables (income, age, level of education, ethnicity) as well as psychosocial variables (history of substance abuse and child abuse). All measures are described in the Florida MIECHV Data Plan.^{xii}

Statistical analyses were performed using IBM's Statistical Package for the Social Sciences (SPSS) version 22 and SAS 9.4. The depression variable was analyzed both as continuous as well as categorical. For creating the categorical depression variable, a participant having an EPDS score ≥ 10 was considered "depressed" and those < 10 as "not depressed."^{xiii} Participant characteristics were described using means and standard deviations for continuous variables and frequencies and percentages for categorical variables. T-tests were conducted to determine the nature of the relationships between categorical risk factors and depression score and chi-square test for categorical risk factors and the categorical depression variable. Both linear and logistic regression analyses were performed using EPDS total scores and the categorical depression variable as dependent variables, respectively. The risk factors included were: age, race, ethnicity, education, employment, income, history of substance abuse, history of childhood abuse, and PSS. All tests were two-tailed, with P-values of less than 0.05 considered statistically significant.

Results

A total of 715 participants in this sample ranged between 14 and 55 years (Mean=27.2; SD=6.17). Most of the participants were White (60.2%), with Black participants being the second largest group represented (33.2%), and 21.9% were Hispanic. More than half of the participants (54.7%) were unemployed and 34.7% had less than high school education. Income level of participants was low, with approximately three-quarters of the sample earning less than \$20,000 per year (73.2%). More than a third of participants reported a history of childhood abuse (33.5%) and current or past substance abuse (36.3%). About a quarter of respondents (24.6%) were classified as being depressed based on results of the Edinburg Depression scale (score ≥ 10) with a mean score of 6.3 (SD 5.5).

Participant characteristics that were found to be associated with depression in the crude analysis included race, ethnicity, employment status, income, childhood abuse, and stress. However, in the adjusted model, only perceived parental stress remained significantly associated with depression (OR 1.26; CI: 1.21-1.31). This implies that stress plays a strong role on the mental health status of

women in our sample. Interventions that address stress may lead to an improvement in rates of maternal depression.

Table 1. Crude and adjusted odds ratios for depression with socio-demographic variables

Characteristic	Total N (%)	COR	95%CI	AOR	95%CI
Depression					
Score <10	539 (75.4)	-	-	-	-
Score ≥ 10	176 (24.6)				
Race					
White	236 (33.2)	ref		ref	
Black	428 (60.2)	0.96	0.66 – 1.39	1.19	0.66 – 2.16
Others	46 (6.5)	0.95	0.46 – 1.93	1.94	0.74 – 5.09
Ethnicity					
Non-Hispanic	556 (78.1)	ref		ref	
Hispanic	156 (21.9)	0.61	0.39-0.96	1.33	0.68-2.62
Employment					
Unemployed	387 (54.7)	ref		ref	
Employed	320 (45.3)	0.53	0.37-0.76	0.62	0.36-1.06
Education					
Less than high school	247 (34.7)	ref		ref	
High School/more	464 (65.3)	1.00	0.70-1.44	1.11	0.66-1.88
Household Annual Income					
Less than \$20,000	517 (73.2)	ref		ref	
\$20,000/more	189 (26.8)	0.54	0.36-0.83	0.88	0.47-1.63
Increased Maternal Age (Mean, SD)	27.2 (6.2)				
		0.98	0.96-1.01	0.99	0.95-1.04
Mother Experienced Physical or Sexual Childhood Abuse					
No	453 (66.5)	ref		ref	
Yes	258 (36.3)	1.77	1.25-2.51	1.07	0.62-1.87
Current/Past Maternal Substance Abuse					
No	473 (66.5)	ref		ref	
Yes	238 (33.5)	1.39	0.97-1.98	1.16	0.63-2.11
Perceived Stress* (Mean, SD)	13.7 (7.6)				
No		ref			
Yes		1.27	1.22-1.32	1.26	1.21-1.31

Note: Odds ratios in bold typeface were statistically significant

*Statistically significant controlling for other factors.

Education status did not appear to be associated with higher or lower levels of depression; however in the crude model, women who were employed experienced lower likelihood of depression (COR 0.53; CI 0.37-0.76) as did those with household annual incomes of more than \$20,000 (COR 0.54;

0.36-0.83). Among MIECHV participants, women who identified as White race were not significantly more or less likely to be depressed as Black women (COR 0.96; CI: 0.66-1.39) or those who identified their race as “Other” (COR 0.95; CI: 0.46-1.93). In terms of ethnicity, in the crude analysis Hispanic women were less likely to report depression (COR 0.61; CI: 0.39-0.96). Study participants who reported current or past use of substances were found to be more likely to be depressed than women who did not use (OR 1.16; CI: 0.63-2.11) and those who reported experiencing childhood abuse were also more likely to report depression (COR 1.77; CI 1.25-2.51). Women with higher perceived stress scores were more likely to experience higher rates of depression (COR 1.27; CI: 1.22-1.32).

In this sample, STRESS was the highest risk factor for depression, regardless of the mother's socio-demographic factors, experience of childhood abuse or current/past substance abuse.

However, with the exception of stress, none of these factors were significantly related to higher rates of depression when controlling for other factors in the adjusted model. When controlling for all other factors (maternal race, ethnicity, education and employment status, age, abuse history or substance abuse) only perceived stress remained a significant factor in higher depression scores (AOR 1.26; CI 1.21-1.31).

Summary and Implications

The results showed that among MIECVH participants, perceived stress was one of the highest risk factors for depression, regardless of the individual’s sociodemographic factors, drug and alcohol abuse, domestic partner violence, or the mother’s history of childhood abuse. The strong positive relationship between stress and depression in the analyses conducted suggests that the more stress a person feels in their life increases their chances of developing depressive symptoms. Additionally, previous studies emphasized that women with a history of substance abuse and childhood abuse were more likely to be stressed, depressed, challenged in coping with the stressors of daily life, and in turn may demonstrate difficulty in attending to their child.^{xivxxvvi}



At the state level, in 2010 the Pregnancy Risk Assessment Monitoring System (PRAMS) found that 58.8% of mothers experienced postpartum depression symptoms after giving birth.^{xvii} This rate is much higher than the 24.6% found among MIECHV participants in this study. Our findings of lower prevalence than in PRAMS may indicate that women participating in MIECHV have lower than average levels of depression, or that depression was underreported. Nonetheless, risk factors found in this study were similar to those found among PRAMS respondents. In PRAMS, the prevalence of postpartum depression was found to be associated with mothers who were younger than 19 years old, receiving Medicaid, earning less than \$15,000 per year, and of non-

Hispanic Black race. In 2012, PRAMS also measured the level of maternal stress which was defined as having at least one stressor during the 12 months before giving birth. Of the women surveyed, 76% reported having at least one stressor.^{xviii} This variable was similarly higher among women who were non-Hispanic Black race, earned less than \$15,000 per year, and who received Medicaid as their primary form of insurance. Depressive symptoms have additionally been linked to adverse childhood experiences (ACES) in low-income women. In a 2008 peer-reviewed study it was found that among nearly 1500 expecting mothers the majority (70%) had experienced at least one ACE.^{xix} Furthermore, the researchers observed a dose-response relationship between the number of ACES experienced and the level of depressive symptoms in that an increased number of ACES simultaneously increased the symptomology of depression.

This analysis highlights the prevalence of self-reported depression among one in every four Florida MIECHV participants, as well as a history of childhood abuse and current or past substance abuse among one-third of participants. In light of this study's findings, awareness of the risk factors of maternal depression may help the MIECHV home visiting program develop training for staff related to depression, stress, substance abuse, and trauma-informed care, as well as to develop programs for MIECHV participants focused on stress management, while continuing to work improving socioeconomic conditions that contribute to stress. Prevention, early identification and treatment of depression will improve both maternal and child outcomes.

MIECHV home visiting programs should consider the relatively high prevalence of adverse childhood experiences, substance abuse history, and depression in their clients. To prevent depression, MIECHV may consider developing and implementing stress management programs in addition to working towards improving socioeconomic conditions.

For more information contact:

Jennifer Marshall, PhD, CPH

Research Assistant Professor, Lead Evaluator

USF College of Public Health, Department of Community & Family Health

(813) 396-2672

jmarshal@health.usf.edu

miechv.health.usf.edu

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



Baseline Individual and Organizational Readiness Assessment for Parental Mental Health Intervention Implementation among Florida MIECHV Program Staff

FLORIDA MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING INITIATIVE - 2017



Abimbola Michael-Asalu, Kimberly Hailey, Jennifer Delva,
Esther Jean-Baptiste, Pamela Birriel, Oluwatosin Ajisope,
Cynthia Horwitz, Oluyemisi Amoda, & Jennifer Marshall
UNIVERSITY OF SOUTH FLORIDA COLLEGE OF PUBLIC HEALTH,
CHILES CENTER FOR HEALTHY MOTHERS & BABIES

INTRODUCTION

The Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative supports evidence-based home visiting programs across the state with the aim of improving health and developmental outcomes for families living in at-risk communities. Home visitors provide education, social support, and linkage to community agencies for pregnant women and families with young children. These home visitors help to ameliorate family stress, offer resources and guidance, and identify and address risk factors associated with poor birth outcomes or child developmental issues.

Mental health issues can cause varying degrees of interference in thought processes and behaviors, leading to difficulties in coping with ordinary life experiences, and consequently negative effects on the family (Leinonen, Solantaus, & Punamäki, 2003; Reupert & Maybery, 2007). Parents with mental health issues may contribute to marital friction with increased risk of divorce, inability to develop or maintain positive relationships with children, poor judgment, and poor parenting practices. Depression is the most studied form of mental illness (Leinonen et al., 2003; Reupert & Maybery, 2007) and aside from the effect on the parents, children of mothers with depression are more likely to experience problems with school performance, peer relationships, substance abuse, psychological adjustment, and are at an increased risk of developing depression themselves (Leinonen et al., 2003; Reupert & Maybery, 2007). Parenting practices and interpersonal relationships improve when mental health issues are addressed (Smith, 2004). Prior research with the Florida MIECHV population found that about a quarter (24.6%) of 715 sample participants were at high risk for maternal depression based on the Edinburgh Depression Scale (score ≥ 10), with a mean score of 6.3 (SD 5.5) (Ross et al., 2015). The most significant factor associated with the depressive symptoms was perceived parental stress (OR: 1.26, CI: 1.21-1.31) (Ross et al., 2015).

The implementation of Parental Mental Health (PMH) intervention programs throughout Florida MIECHV sites are one focus of an initiative funded by a Federal Competitive Grant awarded to the Florida Association of Healthy Start Coalitions, Inc. from the 2016-2018 cycle. The PMH intervention aims to incorporate mental health service delivery into current home visiting services for Florida MIECHV participants. This initiative includes implementation of *Moving Beyond Depression* (Moving Beyond Depression, n.d.) in selected sites, and *Mothers and Babies Program* (Mothers and Babies, n.d.) statewide. The PMH-focused curricula, with topics such as prevention and psycho-social education, along with counseling and intensive therapy, support families experiencing depression or other mental health issues.

To assess the baseline individual and organizational readiness for PMH intervention implementation, all Florida MIECHV staff were provided with a “Parental Mental Health Implementation Readiness Survey” by the University of South Florida MIECHV Evaluation Team. The Florida MIECHV evaluation uses a mixed-methods approach to evaluate various activities of the program to inform program design, implementation, and policy as a part of the federal funding agreement. The PMH baseline survey serves as a reference to assess readiness across sites for future implementation, and to determine if improvements occurred after the PMH intervention programs were implemented in late spring of 2017.

METHODS

Quantitative

Diffusion of Innovation (DOI) Theory was introduced as the foundation for understanding adoption of PMH practice among staff within their organizations (MIECHV sites). The DOI theory describes how an innovation or new practice “diffuses” throughout a particular population. The adoption of innovation typically happens in five stages: initial knowledge of the innovation; persuasion to readily incorporate new knowledge into deciding whether or not to adopt the innovation; decision to adopt or reject the innovation; implementation of the innovation; and confirmation to agree or disagree with the decision made (see Figure 1).

DOI theory was used to measure both the individual and organizational readiness to employ PMH practices. The 56-item questionnaire assessed participant characteristics, knowledge, attitude, individual and organizational practices, and self-efficacy/effectiveness concerning PMH implementation. The survey was available both online through Qualtrics software, and hard-copy format distributed by members of the evaluation team during the 2016 annual site visits. Program staff not present at the time of site visits were invited to complete the survey online.

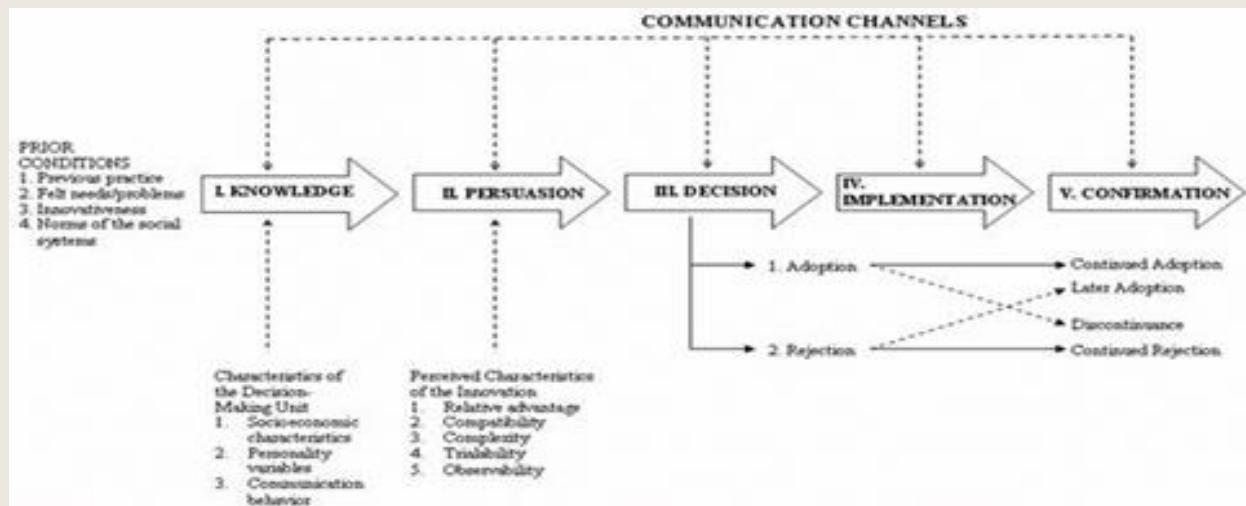


Figure 1. Diffusion of Innovation Stages of Adoption

Qualitative

To explore additional attitudes on the organizational processes of implementing a new program, focus groups were conducted with home visiting staff members in four sites. Several administrators, supervisors, and home visitors from Alachua, Duval, Hillsborough, and Miami-Dade counties participated in three focus groups, typically for an hour with members of the MIECHV Evaluation team. These group sessions aimed to explore the impact of the intervention on participants' mental health and parenting, as well as the participants' engagement, collaboration, and retention in the MIECHV home visitation program. The focus groups/conference calls were recorded, transcribed, and reviewed to identify major themes of the process of implementation, specifically the perceived challenges/barriers, successes, and expectations in the preliminary stages of the *Moving Beyond Depression* (MBD) intervention.

RESULTS

Quantitative

A total of 45 survey participants completed the survey or accessed it online. The participants included 29 home visitors (64.4%), 12 administrators/directors/supervisors (26.7%), and ‘other’ roles such as therapist, office operations manager, and program manager (8.9%). The majority of the survey participants were female (93.3, n=42), with most identifying as White (71.1%, n=32), versus Black (20.0%, n=9), Asian (4.4%, n=2), and ‘other’ (8.9%, n=4). Respondents also mostly identified as non-Hispanic (77.8%, n=35). The mean age of respondents was 42.3 years (range from 25 to 67 years), with the highest level of education ranging from Bachelor’s degree (51.1%, n=23) to Master’s/Doctoral/Professional degree (31.1%, n=14). About half of respondents were already familiar with the term “parental mental health” (56.1%, n=23).

Table 1: Characteristics of Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Staff, Participants of the Parental Mental Health Survey, 2016

PMH Survey Participants Characteristics	Respondents (N=45)
Characteristics	N (%)
AGE (Mean, SD)	42.3(11.05)
GENDER	
Female	42(93.3)
Male	2(4.4)
Prefer not to Answer	1(2.2)
RACE (N=47)	
White	32(68.1)
Black/African American	9(19.1)
Asian	2(4.3)
Other	4(8.5)
ETHNICITY	
Non-Hispanic	35(77.8)
Hispanic	10(22.2)
EDUCATION	
Some College	1(2.2)
Associate Degree	7(15.6)
Bachelor’s Degree	23(51.1)
Masters/Doctoral/Professional Degree	14(31.1)
ROLE IN ORGANIZATION	
Administrator/Director	4(8.9)
Supervisor	8(17.8)
Home Visitor	29(64.4)
Others	4(8.9)
FAMILIARITY WITH THE TERM ‘Parental Mental Health’	
Strongly Agree/Agree	21(56.8)
Neutral	12(32.4)
Strongly Disagree/Disagree	4(10.8)
WORK IN A PMH INTERVENTION SITE	
Yes	13(32.5)
No	27(67.5)

Abbreviations: SD = standard deviation; PMH = Parental Mental Health

INDIVIDUAL READINESS

In assessing readiness for PMH implementation, survey respondents were asked questions relating to their individual current PMH practices. Approximately one-third (30.0%, n=12) of respondents have been using PMH strategies for a while (more than 1 year), while 35.0% (n=14) reported that they “think it would be a good idea to begin” using PMH strategies. Six respondents (15.0%) planned to begin using PMH strategies as opposed to three (7.5%) who have recently started using PMH strategies.

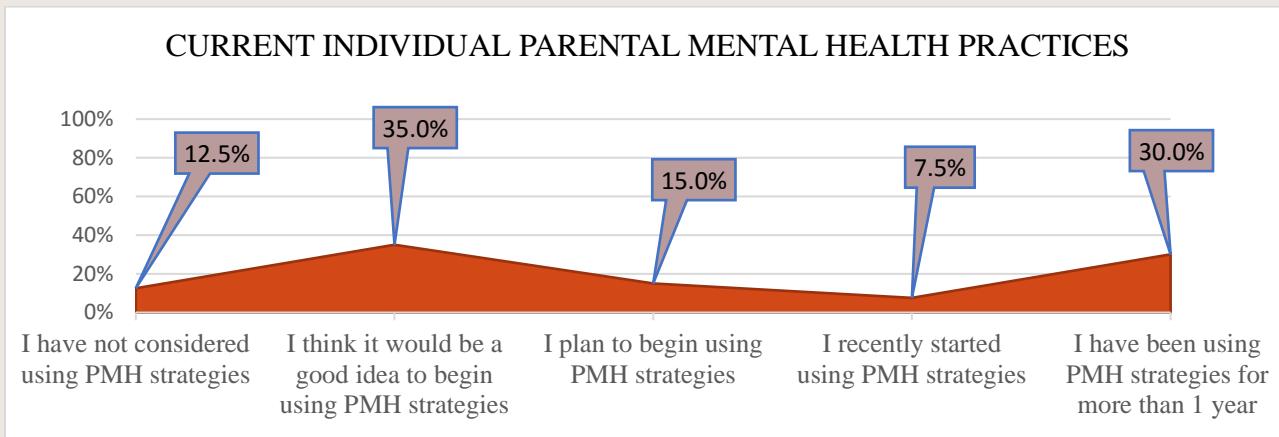


Figure 2: Description of current individual Parental Mental Health practices

Knowledge, Attitudes and Practices

While just over half (56.1%) of the survey participants were familiar with term ‘parental mental health’, most reported knowing the importance of involving an entire family in PMH programs/services (85%, n=34). Many respondents reported knowing what to do if a child needed mental health services (72.5%, n=29), and about half (48.8%, n=20) had observed how incorporating PMH improved practices for others in their field. Overall, participants (70%, n=28) were motivated to implement PMH programs/services. Similarly, majority of survey respondents perceive that PMH services were compatible with the services they currently provide (76.3%, n=29). A majority of staff felt that they play an important role in improving community’s ability to address PMH by promoting PMH programs/services (67.5%, n=27).

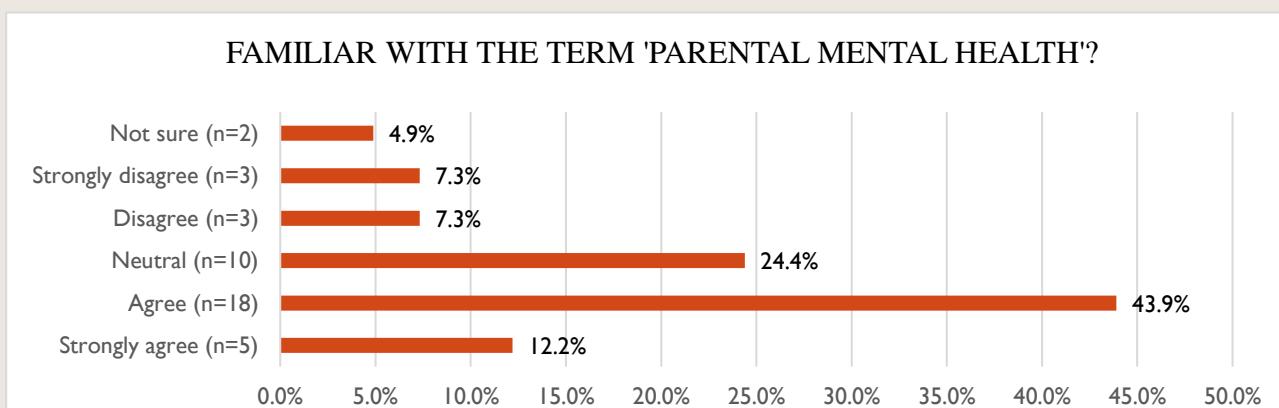


Figure 3: Participant familiarity with the term Parental Mental Health

About half of participants (50%, n=17) felt that incorporating PMH into their practice was something they could try out before fully committing, and less than half reported that their position allows enough time to implement PMH (46.2%, n=18). In terms of skill set and practices, while a little above half of the respondents strongly agreed/agreed to having confidence in their ability to implement PMH practices (53.7%, n=22), 17 participants (42.5%) find it easy to locate current local, state and national resources on PMH. About a quarter (26.8%, n=11) felt that their current PMH practices are effective. Less than half (48.8%, n=20) have the skills to assess PMH and connect those at risk to appropriate services.

Perceived Need

When asked if PMH was an important issue for the families with whom respondents worked, the vast majority indicated that they strongly agreed/ agreed (82.9%, n=34), while 7 respondents (17.1%) were either not sure or neutral. Participants strongly agreed/ agreed (75.7%, n=28) that incorporating PMH into current practices would improve the services they currently provide. No participants disagreed on the importance of PMH or its ability to improve services provided.

Facilitators/Barriers

As previously mentioned, the majority of the respondents stated they play an important role in improving their community's ability to address PMH by promoting PMH programs/services. 73.2% (N=30) of participants indicated that it is not only important for someone in their position to engage in PMH practices, but also to advocate for PMH (80%, n=32), and to partner with others in the community who are interested in promoting PMH (82.5%, n=33). No barriers to implementing PMH were mentioned and just one individual (2.6%) agreed that it would be too complicated to incorporate PMH into his/her current practices.

ORGANIZATIONAL READINESS – MIECHV SITES

Following an assessment of individual PMH readiness, survey respondents were also asked questions related to their organization's PMH practices. About half of participants reported that their organization had been using PMH practices for more than 1 year (50%, n=16); other organizations planned to begin (21.9%, n=7), or thought it would be a good idea to begin (21.9%, n=7) using PMH strategies.

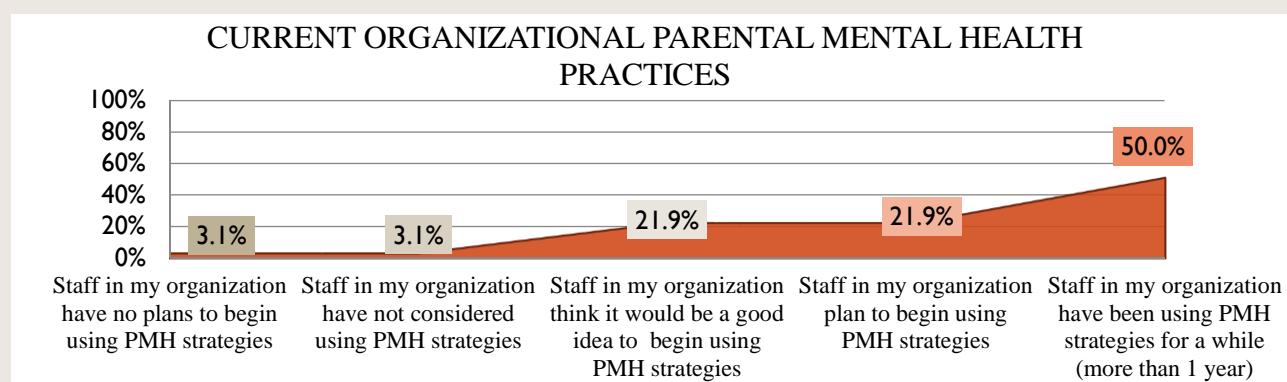


Figure 4: Description of current organizational practices of Parental Mental Health

Organizational Awareness and Attitudes

In terms of the MIECHV sites' awareness, necessity, and compatibility: almost half of participants (48.1%) strongly agree/agree that their organization was familiar with the term "Parental Mental Health"; the vast majority reported that incorporating PMH into the current practices of staff in their organization would improve the services currently provided (79.2%); PMH is compatible with services currently provided by their organization (82.6%).

Half of participants (50%) strongly disagreed/disagreed that it would be too complicated to incorporate PMH into current practices in their organization, similar to 57.9% reporting on their individual practice. Similarly, reports were mixed regarding the trialability of incorporating PMH in their organizations: 52.2% of participants strongly agreed/agreed, 43.5% were neutral/not sure, and 4.4% disagreed/strongly disagreed that incorporating PMH into their organization's current practices would be something they could try before fully committing. Most participants (69.6%) strongly agreed/agreed that incorporating PMH into their organization's current practices would be something that could be learned by watching others; that PMH is an important issue for families served in their organization (84%), and that staff in their organization should be trained to assess PMH and connect those at risk to appropriate services (85.2%).

Organizational Leadership, Capacity, and Interagency Linkage:

More than two-thirds (69.2%) of participants strongly agreed/agreed that their organization places importance on promoting or providing PMH programs/services in the community and partners with community members to promote PMH (61.5%). However, fewer than half of participants reported that key leaders in their organization are actively involved in PMH practices (46.2%). Participants also report their organization and that community organizations participate in joint planning and decision-making about PMH (42.2%).

Translation of these activities into practice is reported at a lower rate. As shown in the figures above, approximately half (51.8%) of survey participants reported that most members in their organization know where to go to find resources or information regarding PMH. A similar proportion reported that organizations in their community share information with each other (55.6%) and share money or personnel (23.1%) to implement and promote PMH.

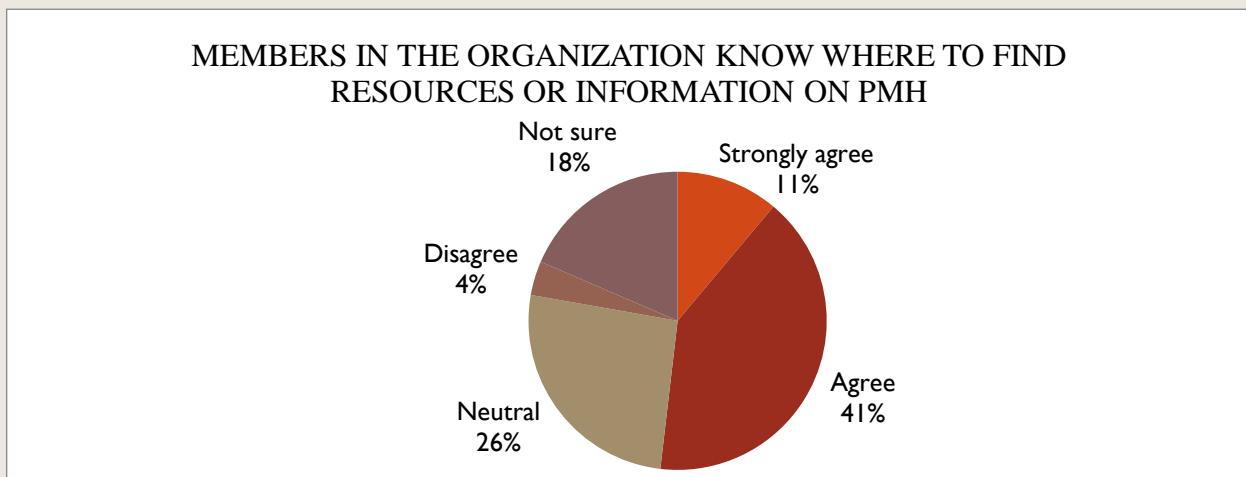


Figure 5: Participant perception of organizational awareness/ knowledge on resources for PMH

In terms of organizational capacity, 34.6% of participants strongly agreed/agreed that their organization has adequate funding; 46.2% strongly agreed/agreed that their organization has sufficient staff; 46.2% strongly agreed/agreed that their position permits enough time; and 33.3% of participants strongly agreed/agreed that their organization receives adequate technical assistance and support to educate staff on PMH practices.

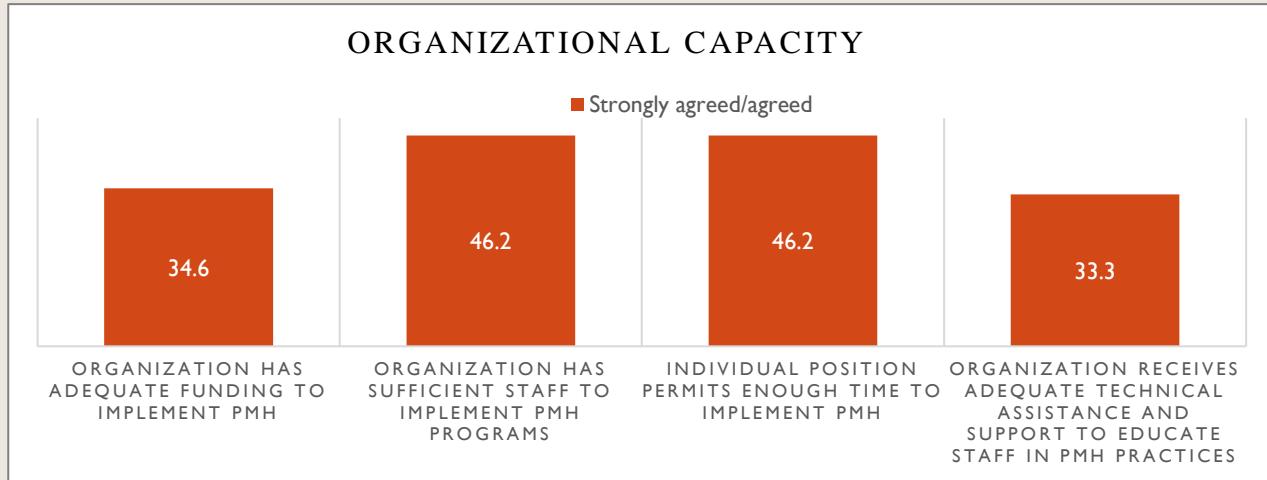


Figure 6: Participant perception of organizational capacity for implementing PMH practices

IMPLEMENTATION PROCESS

Qualitative Results

From the information gathered during the focus groups, the implementation process of *Moving Beyond Depression* has been a success so far. Many of the sites have referred parents to receive mental health services. The number of referrals across the four sites ranged from three to forty-seven referrals. Mental health providers, home visitors, care coordinators, data specialist, Healthy Start and Nurse Family Partnership program managers, and other stakeholders played an important role in ensuring the success of the implementation process. Although some sites experienced difficulties initially implementing the program, they were able to alleviate any further challenges by inviting a mental health provider to facilitate further staff training.

In addition to the involvement of a mental health provider, the launch of MBD can be directly linked to the level of engagement among current stakeholders. Staff members are encouraged to participate in scheduled meetings intended to evaluate the planning process demands, and discuss necessary adjustments. Participating in training sessions prior to and during program implementation, maintaining constant communication with various stakeholders, and sharing a communal understanding of the importance of the intervention provides a stable foundation for the current achievements of MBD.

Strengths

Acknowledgement of program significance

Stakeholders discussed that MBD recognized the limited, yet urgent need of mental health services for at-risk parents in our communities. Conducting in-depth screenings has identified more parents who are likely to benefit from receiving counseling services, thus, increasing program demand. The program has also been beneficial in targeting groups where previous programs' reach and interest were extremely limited. At a specific site, MBD received particular enthusiasm from the local Hispanic community; a group previously lacking engagement in mental health services.

Prior to the implementation of the MBD program, home visitors had to refer parents to different agencies, and then expected them to receive another referral to a mental health provider. MBD removes the additional step and allows home visitors to directly refer their clients to counseling services. For parents who are eligible, MBD has improved the timeliness of parents to receive services. For example, a stakeholder in one of the counties noted that a mother who scored 23 on the Edinburgh test received mental health services within forty-eight hours. In addition to the timely referral rates, meeting at the parents' home rather than having to schedule clinic visits was also a positive attribute of this program. Removing the barrier of having reliable transportation, as well as the promise of receiving needed services has influenced parents to participate and improves receptiveness to the program.

"The more we can get to the finish line, the better the overall results are going to be for the mom and the family." – Site B

"She's very new to it but she was really excited to have someone come to her. She doesn't have any other transportation than the bus and was just talking about how difficult it is to take the stroller and the car seat. They yelled at her the other day because she didn't have it broken down when they got there." Site B

"I've been pleasantly surprised of the engagement of our so-called Latin-Hispanic population that traditionally, this is taboo. As I recall, recent immigrants that I thought we were going to have more of a challenge, but it had not been, because have enjoyed being on the monthly calls with the therapists. " - Site A

Stakeholder communication

The level of stakeholder engagement and communication among all four sites greatly contributed to the successful attributes of MBD. In one of the implementation sites, a mother who scored high

on the Edinburgh test, as a result of MBD and the high level of collaboration, discharged from Nurse-Family Partnerships after her last visit and easily transitioned into the Healthy Start and MBD program to begin mental health services. As reported from all sites, MBD makes it possible for home visitors, nurses, therapists, and other providers to be in constant communication with one another to form a relationship and provide the best coordination of care for the parent.

"I think that is a real testament of how close these programs have grown together and built relationships because I don't think that this would've happened before Moving Beyond Depression began in Florida." – Site A

"Amazing. Yes, it is a great story. It also really shows how sort of doing this with multiple programs that are all kind of connected is really a smart idea. If you think of people falling between the cracks, you kind of fill the cracks so she couldn't fall through them. So that's a nice story. Wow" Site C

"We have monthly phone calls to talk about how MBD is going, what we need to do better, what can we change, how can we do this differently and everyone is on the call together."

– Site A

Challenges

Parent eligibility issues

The process of referring parents who exhibit elevated risk factors of depression made it possible for many to receive counseling services but presented a challenge to others. Participants who had pre-existing conditions such as bipolar disorder, a history of substance use, or possibly exposure to intimate partner violence may be ineligible to receive services through the MBD program. Parents who score at or below the cut off level of 12 on the Edinburgh test are also ineligible. Stakeholders across sites discussed their concerns that if referred, MBD ineligible parents would then have to seek counseling services elsewhere, prolonging the process to receive services.

"Even when they are accepting referrals, it takes much longer for them to initiate that referral. By then, some of our girls are moved, have different phone numbers." - Site B

"History or current use of substance...they're already coming in with substance issues. So, they cannot be referred to your program. That's a barrier." - Site C

Waiting time

Multiple concerns were raised among stakeholders when the home visitor visitation requirement

"Sometimes it's hard finding those clients that are 13 or above with no bipolar or the other qualifiers. I have lots of people I refer to [the therapist] but very few fit that criteria." - Site B

"The only problem that's coming up is having to wait for the home visitor to start meeting with a mom if the mom really needs services... therapy services, having to wait a month is a challenge for us. Just ethically, if we know she needs services and we have the referral, having to wait that month..." - Site A

was discussed. To begin counseling services, parents must participate in a home visiting program for a minimum of one month. The home visitor enrollment requirement is an obstacle for parents to begin to receive services, especially for parents who can particularly benefit from treatment.

One stakeholder noted that this waiting period runs the risk of parents moving or switching their contact information before connecting to needed services.

Parent retention issues

Some MBD sites experienced the challenge of low numbers of parents who complete the treatment plan in its entirety. Staff members reported several parents who start the program deciding to end treatment early due to a premature sense of resolution or completion, priority changes such as: enrolling in school or becoming employed, or a change in insurance. As in the case of many parents in a particular county, when a parent loses their Medicaid coverage, they are unable to complete services. Completion of the treatment is vital to ensure the well-being of the parent and the family. Another issue regarding program retention is the participants that are lost to follow-up. In one of the counties, housing was mentioned several times by home visitors as a dire problem. Lack of stable living situations in many MIECHV communities makes it difficult for home visitors to locate families after many calls are unreturned and doors unanswered. Unfortunately, many participants who initially show interest are not responsive to follow-up phone calls, texting, or drive-by attempt to begin the enrollment process.

“I had a client that was receiving TANF services and then she lost her Medicaid which happens a lot with our clients, and then she could no longer receive services through them.”

- Site B

Privacy concerns

Stakeholders shared that parents who participate in the MBD program are initially hesitant to share information to someone besides their normal home visitor, with whom they have built trust and rapport. A stakeholder mentioned that while the relationship with the home visitor is stable enough to disclose personal information, the parent is cautious to share due to concerns of family members who may listen in. Parent resistance to being videotaped was also mentioned as a challenge.

“We describe them as they couch-surf a lot. So their housing is very unstable. So our nurses are having to try to sort of track them down, find out where they are.” – Site C

“So that we have more moms consenting to be [video] taped, but they have been finding a lot of resistance from our client. I know that part of it is some of our clients – quite a few of them may be illegal immigrants or there are legal issues, things like that where they don’t want to be taped...” – Site A

“With the home visitors but whenever I’ll go to a home that is so crowded that sometimes they have issues that they don’t want to share with all the family members. And it’s really difficult because these are tiny home environments, crowded and most of the time that is like an impairment for the services to continue.” – Site B

“...has the same issues with trying to find a client who maybe has decided that she wants services but then after you know several attempts of phone calls or texting or drive by, you can’t find your client” – Site B

Impact on MIECHV

The impact of MBD on the home visiting program is positive. Home visitors mentioned that with the introduction of MBD to the parent, it strengthened an already established relationship. Despite the proposal of potentially removing the initial home visitation requirement and presenting the MBD and home visitation program as a team approach, enrollment in MIECHV would still be encouraged. Stakeholders in one of the participatory counties also noticed that those who received treatment had additional home visits and remained in the home visitation program longer than those who did not accept treatment.

“The first is that we found that mothers who were receiving the treatment through MBD had an additional 3.2 home visits during the treatment phase. We also found that among those mothers who completed the treatment, they stayed in the home visiting program in additional 4½ months over those who did not get the treatment.” - Site A

“If they trust their nurse home visitor and their nurse home visitor is telling them about this wonderful counseling program that they would qualify for, would they be interested in finding out more about it and having our therapist come out to speak to them? They trust that we have their best interest at heart.” - Site B

DISCUSSION

The evaluation of the implementation of PMH reveals that most staff responding to the Readiness Survey perceived PMH to be of great value and should be incorporated into current practices. Respondents also reported a general shift towards implementation, if they had not been already implementing PMH. However, over 40% of the participants did not agree with utilizing PMH, on the basis of not having enough knowledge about PMH practices and the importance of including the whole family in the program. Less than half of the participants felt that they could easily implement the program or connect clients in need of the program services to appropriate resources. While no barrier to program implementation was stated, having a professional role associated with PMH was identified as a facilitator among the survey participants. Upcoming state-wide training may increase awareness of parental mental health and more the resources available for families requiring mental health services.

After assessing staff perceptions of organizational readiness, more than half of the survey respondents did not believe that other members in their organizations were familiar with PMH.

“I think with this client’s case, she was amazed that we could assist with therapy. That she could get that opportunity to have someone come into your house. She was really grateful. She’s like, “Oh, you can do that? That’s great.” She was so excited. We already had our relationship built, but I think that that helped to strengthen it.” – Site B

Additionally, half of the respondents believed that incorporating the program into the current practices at their organizations would be too complicated and were not sure they could test PMH before making a full commitment to PMH practices. Most of the organizations partner with community members to provide PMH services, but reported inadequate translation of the program into real-life practice. Problems with funding, staffing, time, and lack of technical assistance and support to educate staff were identified as barriers to implementation.

While most individual survey participants exhibit readiness to learn more about PMH and incorporate it into their current practices, these participants did not report the same level of readiness within their organizations. Using the DOI theory, most of the participants implied that there was necessary knowledge emphasized in the PMH programs, at both individual and organizational levels, and believed that it should be made a part of current practice. Although the majority of the individual participants have accepted the innovation and are ready for implementation, the organizations are still in the stage of making a decision to accept implementation of the program. From the baseline assessment, a large number of the individual participants viewed the program as compatible with current practice, not entirely difficult to implement, and are ready to try implementing the program while a few want to observe first.

To overcome some of the barriers encountered by organizations for program implementation, a plausible option could be towards enhancing community organization skills. Communities may have resources that can be built upon, reducing the amount of funding required (i.e. appropriate resource allocation), and members of the community may be willing to offer voluntary services when necessary. Training programs should also be organized for staff to increase content knowledge of PMH practices. These aforementioned recommendations ensure the utilization of best practices while working with families with parental mental health issues (Darlington & Feeney, 2008). Other factors that have the ability to influence program implementation include supporting organizational structures and promoting client readiness for service-delivery adjustments. Previous research provides adaptable measures to assess organizational and client readiness towards implementation of a new program (Chaudoir, Dugan & Barr, 2013). Organizational readiness can be measured using the Organizational Readiness for Implementing Change (ORIC) Framework, which assesses respondents' willingness and commitment to structural changes. This theory also considers how these factors affect implementation of innovation or if implementation can occur without or at various stages of organizational readiness (Shea et al., 2014).

There are increased risks associated with the rates of abuse and maltreatment of children living with parents who have a history of mental health issues (O'Donell et al., 2015). Hence, it is paramount to improve access to resources that will help enhance parental mental health practices. Through the current proposed efforts of PMH program implementation, state-level goals have emphasized: increased knowledge and awareness of the PMH practices, improved sustainability of the services provided, and increased access to resources that would facilitate optimal mental health among the families participating in the home visiting services.

Focus groups with sites illustrated how implementing a strong evidence-based mental health program such as MBD through the home visitation program facilitates access to mental health services. Although several sites have experienced low completion rates for this 18 session intervention, as well as difficulty with parent follow-up, and issues referring ineligible parents to

alternate services, the process identified more parents who may benefit from the intervention and improved the referral process for at-risk clients receiving those needed services. Staff report that parents express concern about their lack of privacy during counseling sessions and the long waiting time to initiate sessions, but are excited about the option to receive quality mental health services. In order to encourage participation in a parental mental health intervention, several staff members recommended presenting the home visitation program and MBD as an interdisciplinary- team approach. By removing the requirement of being in the home visitation program for a month, parents can receive mental health services in a shorter timeframe. With the continuance of stakeholder collaboration and addressing the concerns of the parents, MBD can have a positive impact on participant and infant mental health, parenting strategies, and commitment to the MIECHV home visiting program.

CONCLUSION

The Florida MIECHV program supports families experiencing higher risks by providing education, support, and referrals to optimize healthy physical, social and emotional development. Home visiting programs should incorporate interventions that meet the mental health and social-emotional needs of the populations they serve. Knowledge and attitude of program staff towards PMH implementation is generally favorable but gaps identified from this baseline survey should be addressed for proper implementation of PMH services such that the goal of improving health and developmental outcome is met. MIECHV should be strengthened in terms of funding, staffing, and adequate access to technical assistance made available to program staff. Challenges such as eligibility and time issues identified from the evaluation of the initial stages of PMH program intervention should also be addressed to ensure an efficient transition of the program from implementation to the confirmatory stage of adoption.

References

- Chaudoir, S. R., Dugan, A. G., & Barr, C. H. (2013). Measuring factors affecting implementation of health innovations: a systematic review of structural, organizational, provider, patient, and innovation level measures. *Implementation Science*, 8(1), 1.
- Darlington, Y., & Feeney, J. A. (2008). Collaboration between mental health and child protection services: Professionals' perceptions of best practice. *Children and Youth Services Review*, 30(2), 187-198.
- Leinonen, J. A., Solantaus, T. S., & Punamäki, R.-L. (2003). Parental mental health and children's adjustment: the quality of marital interaction and parenting as mediating factors. *Journal of Child Psychology and Psychiatry*, 44(2), 227-241. doi: 10.1111/1469-7610.t01-1-00116
- Mothers and Babies (n.d.). Research. Retrieved from
<http://www.mothersandbabiesprogram.org/research/efficacy/>
- Moving Beyond Depression (n.d.). Proven results. Retrieved from
<http://www.movingbeyonddepression.org/>
- O'Donnell, M., Maclean, M. J., Sims, S., Morgan, V. A., Leonard, H., & Stanley, F. J. (2015). Maternal mental health and risk of child protection involvement: mental health diagnoses associated with increased risk. *Journal of epidemiology and community health*, 69(12), 1175-1183.

- Reupert, A., & Maybery, D. (2007). Families Affected by Parental Mental Illness: A Multiperspective Account of Issues and Interventions. *American Journal of Orthopsychiatry*, 77(3), 362-369. doi: 10.1037/0002-9432.77.3.362
- Ross, K., Ramakrishnan, R., Michael-Asalu, A., Agu, N., Carter, J., Birriel, P., ... Marshall, J. (2015). Florida maternal, infant, & early childhood home visiting program 2015 maternal depression analysis report. Retrieved from <http://flmiechv.com/wp-content/uploads/Maternal-Depression-12-10-15.pdf>
- Shea, C. M., Jacobs, S. R., Esserman, D. A., Bruce, K., & Weiner, B. J. (2014). Organizational readiness for implementing change: a psychometric assessment of a new measure. *Implementation Science : IS*, 9, 7.
- Smith, M. (2004). Parental mental health: disruptions to parenting and outcomes for children. *Child & Family Social Work*, 9(1), 3-11. doi: 10.1111/j.1365-2206.2004.00312.x

For further information on this report, please contact:

Jennifer Marshall, PhD, MPH
Assistant Professor, Lead Evaluator
University of South Florida, College of Public Health
Department of Community and Family Health
(813) 396-2672
<http://miechv.health.usf.edu>

This project is supported by the Health Resources and Service Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number D89MC28265, Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsement be inferred by HRSA, HHS, or the U.S. Government.

FLORIDA MATERNAL, INFANT, & EARLY CHILDHOOD HOME VISITING INITIATIVE EVALUATION

QUALITATIVE REPORT: PERCEPTIONS OF SAFE SLEEP PRACTICES AMONG FLORIDA MIECHV HOME VISITING STAFF, 2016

Omotola Balogun, Pamela Birriel, Vanessa Sharon, Oluwatosin Ajisope, Marshara Fross, Amita Patil, Carolyn Heeraman, Kimberly Hailey, & Jennifer Marshall

INTRODUCTION

Sleep is a vital aspect of a child's development, yet during infancy unsafe sleep environments can cause life-threatening complications¹. Each year, 3,500 infants in the United States die due to unsafe sleeping environments² with accidental suffocation, strangulation in bed, and smothering among the most commonly reported circumstances³. In Florida alone, Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death (SUID) is identified as a leading cause of death among infants, and the leading cause of neonatal deaths⁴. To combat this, the American Academy of Pediatrics recommends that safe sleep practices be used to reduce the incidence of infant sleep-related deaths⁵.

One of the goals of Florida Maternal, Infant and Early Childhood Home Visiting (MIECHV) initiative is to promote infant health, including prevention of SUID and through the promotion of safe infant sleep practices. To learn more about MIECHV program interventions, the Florida MIECHV evaluation team organized focus groups among MIECHV staff during fall 2016 to elicit their perspectives on safe sleep education, caregiver practices, successes and challenges.

METHODS

A qualitative approach was utilized to understand the perceptions of safe sleep promotion activities among Florida MIECHV staff. Six focus groups were held with three Florida MIECHV sites (Escambia, Manatee and Hillsborough counties) implementing: *Healthy Families Florida*, *Nurse Family Partnership*, and *Parents as Teachers* programs. Administrators/supervisors and home visitors were interviewed separately at each site regarding the definition of safe sleep, factors contributing to unsafe sleep practices, populations of focus, and the overall facilitators and barriers of promoting safe sleep practices. Identifying these factors helps to inform Florida MIECHV about effective interventions to reduce the overall occurrence of sleep related deaths. A semi-structured focus group guide was developed, and flip charts were used to engage staff and facilitate conversations. These discussions were audio recorded, transcribed verbatim, and thematic analysis was conducted.

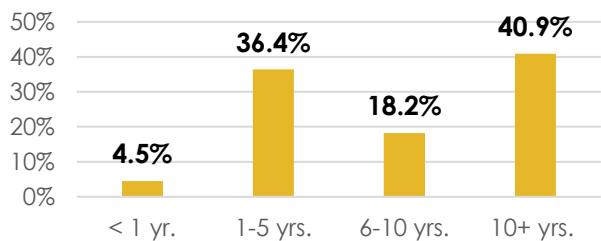
PARTICIPANT CHARACTERISTICS

A total of 23 staff members participated in the focus group, including two administrators, one supervisor, 16 home visitors, and 4 other staff members. Most were female (95.7 %), with the greatest percentage of participants within the ages of 36-45 (34.8%). Most had been in their profession for at least 6 years (56.5%, with 39.1% at 10+ years), while 34.7% had worked for 1-5 years. Participants were also ethnically

Staff Focus Groups: Safe Sleep 2016

and racially diverse, with 21.7% identifying as Hispanic, and 65.2% White, 17.4% Black, 4.4% Asian and 3% other. Most had received a bachelor's or professional degree (78.2%, n=18).

NUMBER OF YEARS IN PROFESSION



HIGHEST LEVEL OF EDUCATION

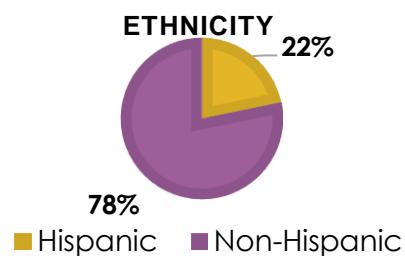
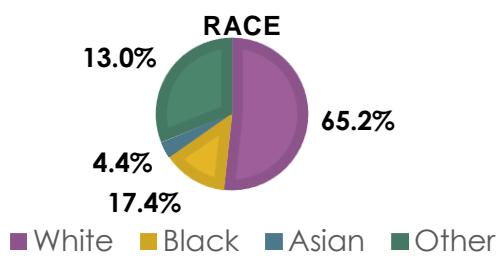
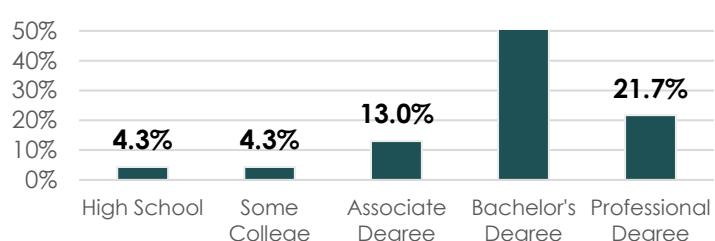


Table 1: Participant characteristics

Staff Characteristics	N (%)
Age (years)	
18-25	2 (8.7)
26-35	6 (26.1)
36-45	8 (34.8)
46-55	3 (13.0)
56-65	2 (8.7)
66-75	2 (8.7)
Gender	
Male	1 (4.4)
Female	22 (95.7)
Race	
White	15 (65.2)
Black	4 (17.4)
Asian	1 (4.4)
Other	3 (13.0)
Ethnicity	
Hispanic	5 (21.7)
Non-Hispanic	18 (78.3)
Organizational Role	
Administrator/Director	2 (8.7)
Supervisor	1 (4.4)
Home visitor	16 (69.6)
Others	4 (17.4)
Number of years in profession*	
< 1 year	1 (4.3)
1-5 years	8 (34.7)
6-10 years	4 (17.4)
10+ years	9 (39.1)

*One respondent did not provide information.

PERCEPTIONS OF SAFE AND UNSAFE SLEEP PRACTICES

SAFE SLEEP DEFINITION

Safe sleep was defined by participants in a variety of ways. All definitions given included a reference to the infant lying on his/her back alone in a designated sleeping area. Participants' definitions included: "babies sleeping on their backs", "not having anything in the sleep area", and "not co-sleeping with parents or caregivers." Other definitions of safe sleep referred to providing a safe place for a baby to sleep without harm, the absence of bedding materials within close proximity of a sleeping infant, the proximity of the baby's crib to a window, and the temperature of the baby's room.



"Yes. Alone, back, crib, nothing else in there. No co-sleeping. We do like room sharing and we're advocates of that but not bed sharing preferably". - Home visitor

UNSAFE SLEEP PRACTICES

Home visitors observed and identified unsafe sleep environments in participants' homes. These often included items such as pillows, blankets, bumper pads, and stuffed animals in an infant's sleep area. Infant sleep areas described were bassinets, cribs, and Pack 'n' Plays. Further unsafe sleep practices identified by participants included bed-sharing with the infant, putting the bassinet top over the baby, placing an infant to sleep on their stomachs, the use of old cribs, sleeping on a parent or caregiver's chest, being propped against the corner of a sofa or couch, and sleeping in car seats. Several home visitors specifically mentioned some parents/caregivers do not allow their babies to sleep in the crib for fear of "crib death", thus resulting in more unsafe sleep practices.

"I was at a meeting just last week where they talked about several cases of infants either sleeping in the bed with the parent and smothering, because somebody rolled over on them or they got caught between the bed and the wall, that type of thing." - Administrator/Supervisor

BARRIERS TO SAFE SLEEP PRACTICES

MIECHV staff observed barriers within homes that prevent safe sleep practices, and identified several risk factors for unsafe sleep practices. These include alcohol and substance abuse in the home, child abuse or neglect, lack of adequate space for infant furnishings, cultural norms that promote co-sleeping, and convenience of tending to the baby in the same bed. All aforementioned scenarios impact the mindset and perception of the mother, and affect what she believes to be the most ideal sleeping situation for her child. For some caregivers, safe sleep practices may be perceived as impacting comfort and convenience, and thus are challenging to promote. For example, staff explained that some families report that they like the mobility of the portable cribs, but worry that they are not soft enough for their infants to sleep in. Staff also report that some breastfeeding mothers they work with

"We've had situations where there has been substance abuse or alcohol that it has impacted the caregiver's ability to really sense what's going on". - Administrator

Staff Focus Groups: Safe Sleep 2016

feel that co-sleeping was an important way to bond with their baby, and that they prefer co-sleeping due to the convenience of breastfeeding their infants in bed.

All sites linked the difficulties experienced with changing or encouraging safe infant sleep practices to generational and cultural preferences, especially regarding co-sleeping; for example some caregivers resist safe sleep promotion because they strongly believe in co-sleeping, or caregivers from older generations co-slept with their babies and continue to encourage this practice. Two sites specifically mentioned cultural norms as barriers to safe sleep. In another site, it was similarly reported that certain populations of parents participating in the program, such as those with developmental disabilities and those of certain cultural backgrounds are more likely to resist changes to current sleeping practices. Also, some parents were convinced by other agencies or programs, doctors within their community, and the Internet that co-sleeping is good for the infant. Staff report that parents have been taught by others that co-sleeping is a safe practice so long as certain guidelines are followed (e.g. no alcohol, drugs, obesity, etc.). Because caregivers are given conflicting advice on the best sleep practices for their infant, uncertainty about this often occurs. Multiple supervisors and administrators specifically mentioned that mixed messages act as a barrier to safe sleep promotion.

"We had a grandfather who had a child on his chest and he was sleeping on the couch, but he was inebriated and he wasn't aware that the child rolled off of him in between the couch and him, and then the couch back."

- Administrator/ Supervisor

"Culturally with Hispanic families, it's a family bed. I mean... those are some of the barriers that you have, too. It's just the cultural norm or it's just the way they've always done it."

- Administrator/Supervisor

"We get a lot of resistance there is a whole group of people that just, they say co-sleeping is the best. They're like, other countries do it, and they go into all that. They have their research and their facts."

- Administrator/ Supervisor

"I have a sense from my nurses that the Pack 'n Plays are number one, they're grateful to receive them, and because they are mobile, they feel like they can take the baby in all the rooms that they're in."

- Home Visitor

STRATEGIES

Some of the strategies used for promoting safe sleep included educating the caregivers about the importance of safe sleep, explaining risks of unsafe sleep practices, and demonstrating correct practices. The conversations with parents included sharing of stories, anecdotes, news, and videos of real life experiences that resulted in poor outcomes. Parents were also referred to specific resources on the Internet and to their physicians for more information on safe sleep practices.

When educating parents, staff noted that just presenting and reading information to the parents, even if it is evidence-based, or just handing them a flyer, does not have the same impact as parents seeing the risks for themselves. Staff commented further that many parents in the program accept and incorporate their teachings, but face pressure from grandmothers and other relatives who did not practice safe sleep themselves.

Staff Focus Groups: Safe Sleep 2016



ADDITIONAL SUGGESTIONS

Other strategies utilized to address safe sleep risk factors include educating parents on the immediate and long-term benefits of safe sleep, the consequences of unsafe sleep, provision of portable cribs or safe sleep boxes, the use of positive messages, and reference to specific online videos. Staff find that involving others in the household and babysitters also increases appropriate safe sleep outcomes.

Provision of resources such as the portable crib (Pack 'n Play) can influence the level of engagement. Some of the parents and caregivers who use these resources are highly engaged in the program. According to MIECHV supervisors and administrators, there are pilot programs underway where hospitals receive funding to purchase and distribute Pack 'n Plays to families in need. Because Pack 'n Plays are easy to assemble and transport, and are cheaper than cribs, they have showed positive results for the safe sleep initiatives. However, manufacturer guidelines do not recommend Pack 'n Plays for overnight sleep. "Onesies" or "sleep sacs" were also mentioned by respondents as being helpful in promoting safe sleep practices. This clothing is produced with a message that reads "This side up," serving as a convenient reminder for the parents to place the baby on their back to sleep. MIECHV supervisors and administrators also referenced recent promotion of baby boxes used in Australia and Finland, and have shown interest in using them as a safe sleep promotion strategy.

"Trying to educate them too that when they go to sleep like that, they are going to increase risk of spitting up and then they can aspirate the more reason they need to be on their back in a safe sleep position."

- Home visitor

"I have a sense from my nurses that the Pack 'n Plays are number one, they're grateful to receive them, and because they are mobile, they feel like they can take the baby in all the rooms that they're in."

- Administrator/Supervisor

"We have a lot of videos and then even we'll find stuff here, but we have some videos specifically, the Back to Sleep from the Healthy Start Coalitions and some of those back to sleep videos."

- Home visitor

"You know what works too, their doctors, their pediatrician telling them when the pediatrician tells them and he's adamant about it, they listen... 'Yes, you're right because my pediatrician just told me that.'"

- Home visitor

CONCLUSION AND RECOMMENDATIONS

MIECHV staff reported that the majority of parents respond positively to safe sleep messages. To continue to promote infant health through the prevention of SUIDs, messages about safe sleep should remain consistent and continue to be publicized. The MIECHV program staff have expressed knowledge, awareness, and commitment to promotion of the AAP safe sleep guidelines. They also acknowledge the numerous challenges in delivering this piece of their educational program to the populations that they work with. In response, the Florida MIECHV Initiative and Healthy Families Florida are instituting universal Safe Baby® training (healthysafebaby.org) for all staff beginning in fall 2017.

Additionally, in 2017 the Florida MIECHV evaluation will interview mothers, fathers, and other caregivers involved in the MIECHV program and in 2018, will conduct a comparative assessment of safe sleep furnishings and other strategies used in Florida MIECHV sites to promote safe sleep and an evaluation of the Safe Baby program implementation.

References

1. Task Force on Sudden Infant Death Syndrome. (2011). SIDS and other sleep-related infant deaths: expansion of recommendations for a safe infant sleeping environment. *Pediatrics*, 28(5), 1030-1039. doi:10.1542/peds.2011-2284.
2. Klingenbjergr, P. M. T. (2017). Risk Factors for Sleep-Related Infant Deaths in In-Home and Out-of-Home Settings. *Journal of Emergency Medicine*, 52(1), 125-126.
3. Bartick, M., & Smith, L. J. (2014). Speaking out on safe sleep: evidence-based infant sleep recommendations. *Breastfeeding medicine*, 9(9), 417-422. doi:10.1089/bfm.2014.0113
4. Florida Department of Health (2015). Florida Community Health Assessment Resource Tool Set (CHARTS). <http://www.floridacharts.com/charts/chart.aspx>. Published 2015. Accessed July, 2017.
5. Sauber-Schatz, E. K., Sappenfield, W. M., & Shapiro-Mendoza, C. K. (2015). Comprehensive review of sleep-related sudden unexpected infant deaths and their investigations: Florida 2008. *Maternal and child health journal*, 19(2), 381-390.

For further information on this report, please contact:

Jennifer Marshall, PhD, MPH,
Assistant Professor, Lead Evaluator
Department of Community and Family Health,
University of South Florida, College of Public Health
(813) 396-2672, <http://miechv.health.usf.edu>

This project is supported by the Health Resources and Service Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number D89MC28265, Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsement be inferred by HRSA, HHS, or the U.S. Government.



**Florida Maternal, Infant, and Early Childhood Home Visiting
Program Evaluation (MIECHV)**

Baby's Best Sleep Evaluation Focus Groups Report 2017-2018



**Marshara Fross, Dogeli Rojas, Amanda McMahon, Ngozichukwuka Agu,
Igbagbosanmi Oredein, Jordan Stofan, Joanne Gomez, and Jennifer Marshall
University of South Florida, College of Public Health**

Executive Summary

The Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative serves families in high-need communities across 29 counties. The initiative works towards improving health and development outcomes of at-risk families and children. In 2016, the Florida infant mortality rate was slightly higher than the national average at 6.1 and 5.9 per 1,000, respectively. Florida MIECHV staff and home visitors provide safe sleep education and support for program participants and their families. The Baby's Best Sleep Evaluation has been ongoing since 2016 and aims to assess the process and achievements Florida MIECHV has made in promoting safe infant sleep practices. This segment of the infant sleep evaluation assessed MIECHV staff and home visitors' safe sleep education delivery, observations of MIECHV participant's implementation practices, concerns for families and infants regarding safe sleep, and suggestions for future education and organizational level improvements in the area.

The MIECHV evaluation team conducted 12 focus groups with a total of 86 participants, 54 of which were representatives of Florida MIECHV. Discussions were semi-structured in an effort to foster risk-discussions identifying gaps in services, potential improvements in home visiting services, education and resources, and to help identify promising strategies to promote safe sleep and the prevention of SUID. In addition, staff were asked to rate the level of which the families they serve would be interested in receiving and likely to use a Pack N' Play and Baby Box; they also rated their perceived level of comfortability, safety, and helpfulness of these furnishings.

These professionals expressed that despite the delivery of safe sleep education provided to families, not all families implement recommended infant sleep practices. Some reasons for parental noncompliance perceived by staff included convenience of proximity to the infant while sleeping, lack of perception of risk susceptibility or severity, limited space or resources for separate sleep areas, pre-established practices and traditions, and concerns for infant safety (e.g. worries about choking due to reflux). Social circumstances such as crowded living conditions, substance abuse, and additional caregivers also influenced parents' practices. Home visiting programs should work towards maintaining strong community networks to assist participants in addressing social conditions that may lead to adverse health and developmental outcomes. Furthermore, participants expressed that mixed messaging from the internet, healthcare providers, family, and the media is a major concern and barrier to successful education and implementation. Participants suggest that efforts should be made to embrace the use and influence of the media and social media to spread accurate, consistent messaging and to encourage safe sleep practices. This messaging should aim to address the advertisement of aesthetically pleasing, yet potentially harmful crib decorations, and encourage the ABC's of safe sleep.

Introduction

The Florida Maternal, Infant and Early Childhood Home Visiting (MIECHV) initiative consists of seventeen local sites implementing three models in 29 high-need counties across the state of Florida. Last year, 11 of these 29 counties served by Florida MIECHV had Infant Deaths from Unintentional Suffocation and Strangulation-in-Bed rates that were more than twice the Florida average (0.5 per 1000 live births). In 2017, Florida MIECHV added safe infant sleep as a benchmark aiming to promote infant health through the promotion of safe infant sleep and prevention of Sudden Unexpected Infant Death (SUID).

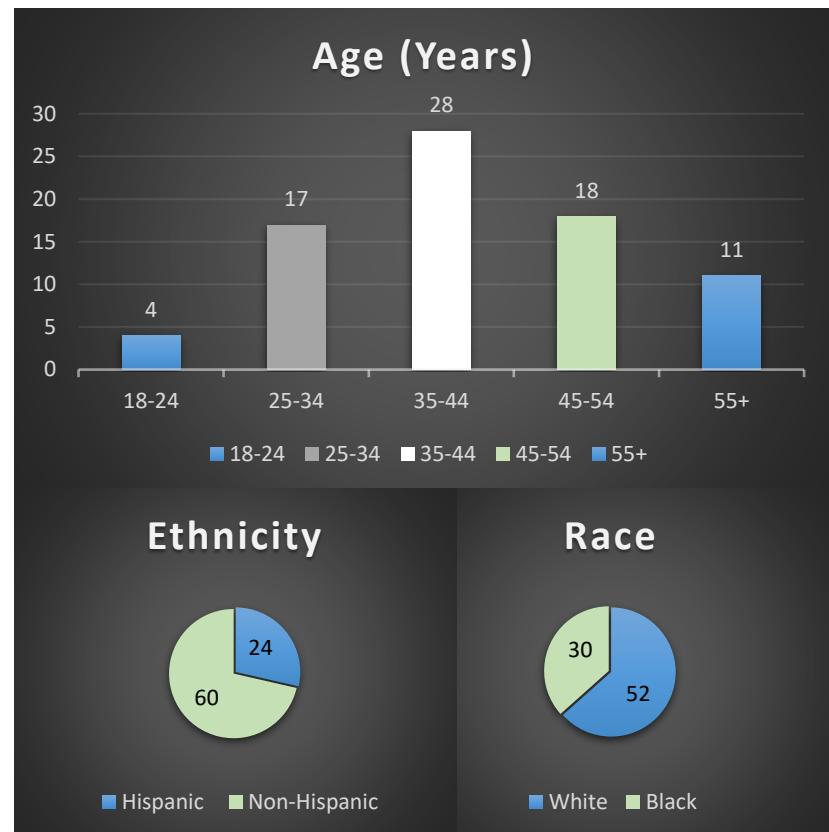
MIECHV staff assist underserved populations and families with characteristics that place them at an increased risk for sleep related deaths by providing comprehensive safe sleep education, necessary resources and support for program participants. The Baby's Best Sleep Evaluation assesses current infant sleep practices among program participants, knowledge of education, attitudes and other influences on infant sleep practices. The evaluation also assesses intervention approaches used by MIECHV sites, remaining gaps in services and identifies potential innovative strategies.

Methods

The Baby's Best Sleep Evaluation utilized a qualitative research design in effort to understand the current state of infant sleep within Florida MIECHV. Twelve focus groups were conducted with representatives from MIECHV, Healthy Start Coalitions, and other community agencies across the state of Florida. There were 86 participants in these focus groups, 54 of which were representatives of Florida MIECHV. Discussions were conducted in English in varying locations across the state of Florida. All discussions were digitally recorded, transcribed verbatim, and reviewed for accuracy. Coding and thematic analysis was conducted, in addition to demographic analysis. Participants completed a survey tool designed to capture perceptions of infant sleep furnishings and quantitative analysis was conducted on resulting data.

Participants

In addition to three focus groups conducted in 2016 with a total of 38 Hillsborough, Escambia, and Manatee County MIECHV staff (demographics not included here), 12 focus groups were conducted in 2017-2018 with representatives from MIECHV, Healthy Start Coalitions, and other community agencies across the state of Florida. Focus groups were held at Safe Baby curriculum trainings (completed before the training began) or at local MIECHV offices. There were a total of 86 participants including home visitors, program administrators, and staff who were involved in providing safe sleep education to home visiting participants. The 2017-2018 participants represented 15 of the 17 Florida MIECHV sites, serving 24 counties. Of the 86 participants, 54 (63%) were MIECHV staff and 25 (29%) were non-MIECHV (partnering home visiting organizations and Healthy Start Coalitions). There were 48 (60%) home visitors, 17 (21%) site administrators, and 15 (19%) case managers. More than half of the participants completed a Bachelor's Degree (57%), one-fifth ($n=17$) completed an advanced degree, and about 5% completed some college or less. All participants were female.



American Academy of Pediatrics (AAP) Guidelines/Safe Sleep Information

These professionals provide safe sleep information to mothers during pregnancy and reinforce the information at each visit after the baby is born. Home visitors deliver comprehensive education on safe infant sleep practices that include:

- Preferred sleep position
- Information on recommended furnishing and optimal sleep area
- Information on bed sharing and co-sleeping
- Breastfeeding and safe sleep
- Triggers for unsafe sleep practices such as maternal exhaustion

Participants expressed that their preferred mode of delivery was in-person as it enabled the use of supplemental methods of reinforcement such as demonstration and/or the provision of furnishings. They used personal stories, accounts of individuals in the community who have been affected by Sudden Unexpected Infant Death (SUID), and examples of harmful practices and potential barriers to practicing safe sleep to supplement the education on AAP guidelines. In general, focus group respondents believed that their clients are saturated with safe sleep information.

Home visitors encouraged mothers to provide safe sleep information to other caregivers. Facilitators to receiving safe sleep information included enrollment in a home visiting program, advanced maternal age (older mothers perceived to be more receptive), and first-time mothers. Barriers to receiving safe sleep information were maternal mental health issues such as depression, parents and caregiver's unreceptiveness to new information, and the need for convenience.

Perceptions and Beliefs

Home visitors observe that although most clients are aware of the guidelines, adherence among MIECHV participants varies for several reasons. These reasons included:

- culture
- family support systems providing contradicting information
- baby factors e.g., reflux
- maternal anxiety
- convenient practices for caregivers
- low risk perception of negative outcomes
- perception of being able to limit harm to infant such as mom being a "light sleeper"
- structural barriers e.g., small living spaces
- limited finances
- transient lifestyle

Respondents perceive that parents' practices stem from the belief that their decisions and actions the safest for their infant based on the environment, previous experiences, and traditions. Examples of safety practices include the use of bumpers to protect babies from getting limbs stuck between crib slates, using objects (e.g., pillows, foam noodles, dividers) to prevent babies from falling, and placing babies to sleep on their stomachs or their side due to perceived increase of choking from reflux. In addition, parents place a large emphasis on baby's comfort while sleeping and the need for convenience – even if it interferes with infant safety. Participants expressed that parents and caregivers prioritize increasing the comfortability of the infant's sleep area to increase infant sleep duration. Measures taken to increase comfort include:

- using blankets to prevent baby from feeling cold
- not swaddling
- using towels, blankets, and pillows to create a softer sleeping area

Additional items that influence a clients' adherence to AAP guidelines include:

- Low perceived susceptibility to potentially negative outcomes
- Positive outcomes with previous children while employing non-recommended practices
- Lack of knowledge and education about biological mechanisms for SUID
- Beliefs and previous practices of other caregivers (e.g. maternal grandmother)

Mixed Messaging

Mixed messaging was of concern to home visitors and considered to influence caregiver sleep practices. Examples of mixed messaging include contradicting information on the internet, from other health care providers, from daycare providers, from family support systems, the media's promotion of the use of bumpers, blankets, and crib decorations, and some hospital practices. Previous safe sleep recommendations were also determined to contribute to mixed messaging message. Home visitors addressed this by informing clients that the recommendations have changed over time because of new information and research findings. In addition, participants expressed that having multiple sources of information can sometimes be overwhelming for clients and could lead to them to practicing whatever works best for them, despite AAP recommendations. Aside from home visitors, other sources of sleep information for clients included the pediatrician, OB/GYN, the internet/online sources and social media, specifically mom groups on Facebook. Since mothers also rely on the internet for sleep information, home visitors discuss how to find reputable sources of safe sleep information during visits.

Sleep Practices/Behaviors

Participants surmised that despite parents and caregivers' intentions to adhere to guidelines, the interaction of infant temperament and client circumstances greatly impact the implementation of safe sleep practices. Circumstances vary on a case-by-case basis, thus sleep practices vary widely. Convenience, tradition, societal norms, and cultural influence are all factors identified by focus group participants that influence MIECHV participant's daily decisions on sleep practices. Home visitors asserted that consistent night time routines, infant massage, bath time before bed and coping with crying exercises increase the caregiver's ability to adhere to AAP Guidelines, as well as aid in improving sleep for parents and caregivers.

Current Trends & At-Risk Populations

- African-Americans, Hispanics, parents using illicit substances or alcohol , adolescents, single mothers, families with low income, and migrant workers or other immigrant populations have increased instances of unsafe infant sleep practices
- Substance abuse has always been a risk factor, but it is now reaching new communities and populations
- Parents embracing a more holistic lifestyle and parenting approaches that are trending in communities and online that promote practice or breastfeeding and co-sleeping (the family bed) affects adherence
- Marketing of aesthetically pleasing, extravagant nurseries encourages MIECHV participants to purchase unsafe sleep items

Furnishings being used	Places furnishing can be found
• Cribs	• Nursery
• Pack-N-Plays	• Living Room
• Bassinets	• Caregiver's room
• Beds	• Garage
• Couches	• Basement
• Boppy Pillows	• General living areas in group homes
• Moses Baskets	
• Swings	

Sleep Area/Location

Infants within the MIECHV program are sleeping in a variety of places depending on living circumstances, infant temperament, available resources, and the beliefs/opinions of parents and caregivers. Home visitors observe that some of the program participants have infant furnishings filled with items unrelated to sleep (clothes, laundry, toys), suggesting that they are not used for infant sleep. In addition, parents and caregivers often use pillows to increase comfortability of firm surfaces and blankets to keep babies warm, despite home visitors informing them that they are not necessary and increase risk of SUID.

Sleep Position: According to staff, the program participants are practicing some safe sleep recommendations at slowly increasing rates. However, infants sleeping on their stomach and side remain common practice. Sleeping prone is known among mothers and caregivers as helpful increasing infant sleep duration and was previously encouraged by the medical community. This limits the successful promotion of the supine position for infant sleep. According to discussions, program participants are also propping their infants on their side to prevent choking.

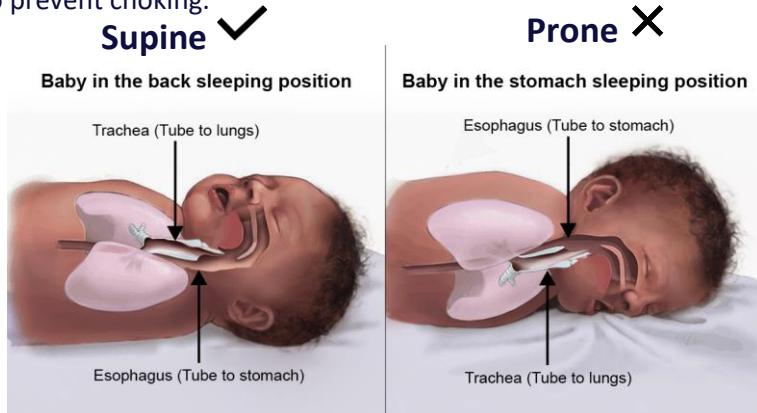


Image courtesy of the Safe to Sleep® campaign, for educational purposes only; Eunice Kennedy Shriver National Institute of Child Health and Human Development, <http://www.nichd.nih.gov/sids>; Safe to Sleep® is a registered trademark of the U.S. Department of Health and Human Services.

Co-Sleeping

The majority of MIECHV home visitors and staff expressed frustrations with the constant battle against co-sleeping. Mixed messaging seemed to be the most recent source of frustration as the internet provides unlimited resources such as Mommy Support groups, articles, and information that are not always fact based. Furthermore, the lack of consistency between health and wellness practitioners makes promoting safe sleep more complex. According to the discussions, there are differences in the education provided by home visitors, doctors, nurses, and lactation consultants.

Many of the home visitors agreed that the choice to co-sleep is a matter of convenience. According to the discussions, MIECHV participants find co-sleeping to be the easiest and most

effective way to increase sleep duration for both the mother and the infant. Program participants are aware of the education, however, the risk perception and threat to the health of their baby is not present. Mothers express lowering their baby's risk of injury by using pillows or other form of barriers to prevent the baby falling asleep or rolling over on them; however, these measures still present a danger to the baby. Although women with lower resources are more likely to co-sleep, women with adequate space and furnishings also practice co-sleeping. Home visitors express that new inventions and furnishings encourage the practice by creating additional options to utilize without research or evidence to prove the safety.

Concerns

Home visitors voiced numerous concerns in relation to infant sleep among MIECHV program participants. Seemingly, the most common concern of home visitors was that despite knowing and understanding the education and providing all the necessary resources, clients continue to practice unsafe sleep. Numerous home visitors and staff expressed frustration with the lack of behavior change. Furthermore, continuing to provide education for recommended safe sleep practices during visits often resulted in clients tuning out of the visit. Additionally, home visitors observed that some clients are not truthful about their infants sleep practices. For example, the client may say the infant always sleeps on their back, but the home visitor finds the infant asleep on their stomach. In addition, some MIECHV participants may enroll for services because they are in need for resources such as a car seat or a Pack N' Play but discontinue participation after receiving the items.



BREASTFEEDING

Breastfeeding is an agreeably highly encouraged practice among MIECHV home visitors and staff. Home visitors continue to strive for increased rates of breastfeeding among their clients; however, it remains a major concern in relation to safe sleep.

Focus group participants explained that breastfeeding greatly increases the likelihood of co-sleeping and it remains a struggle to combat the numerous factors impacting this practice. Home visitors share that clients often find exclusive breastfeeding to be exhausting. Co-sleeping is a convenient method for breastfeeding the baby that allows the mother to increase sleep duration for both her and the baby. In an effort to combat this, home visitors practice creating plans with clients to deal with expected influential circumstances such as exhaustion. According to discussions, the concept of "safe co-sleeping" is extremely popular among breastfeeding mothers and lactation consultants, which requires seven steps to safely co-sleeping. MIECHV home visitors explained that mixed messaging makes it difficult to encourage safe sleep practices among breastfeeding program participants.

Home visitors were also concerned with some of the circumstances in which their clients were living that made it difficult to practice safe sleep. Many clients have limited, crowded, or cluttered spaces. This limits the furnishing options, adds additional individuals influencing behavior, and creates additional barriers. Home visitors also struggle with client's need for privacy and the impact of the perception of community and government entities. Some clients believe that circumstances within the home will result in the infant being removed or necessary services being lost. A concern specific to teen clients and young mothers is their dependence on their parents or other people which may limit the home visitor's ability to work with the participant. Additionally, access to other caregiver's is limited, therefore home visitors stress the importance of conveying education to other caregivers and siblings to avoid negative outcomes. In addition, marketing of potentially hazardous items such as bumpers, blankets, and baby pillows makes it difficult for home visitors to justify their safe sleep education.

Infant Sleep Furnishings

Crib and Bassinets

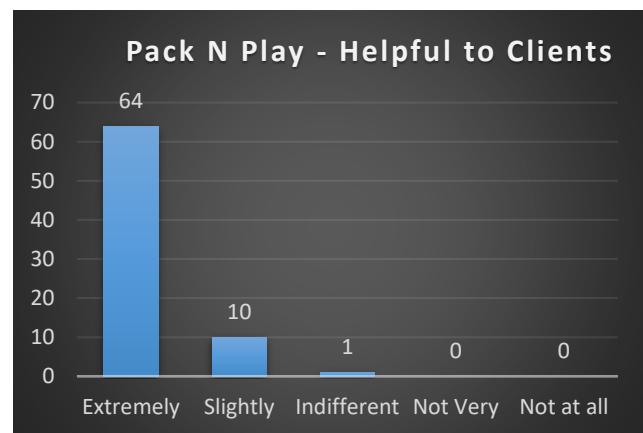
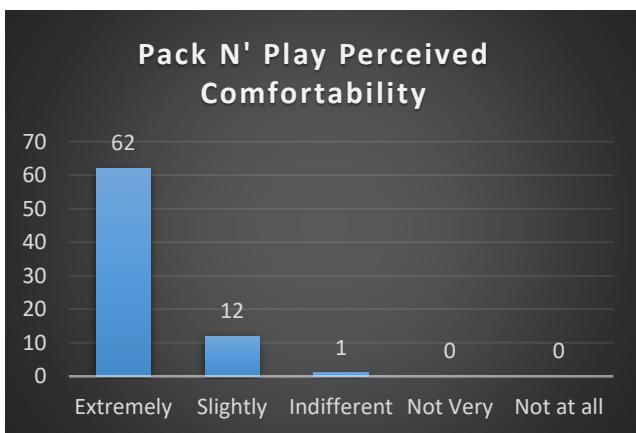
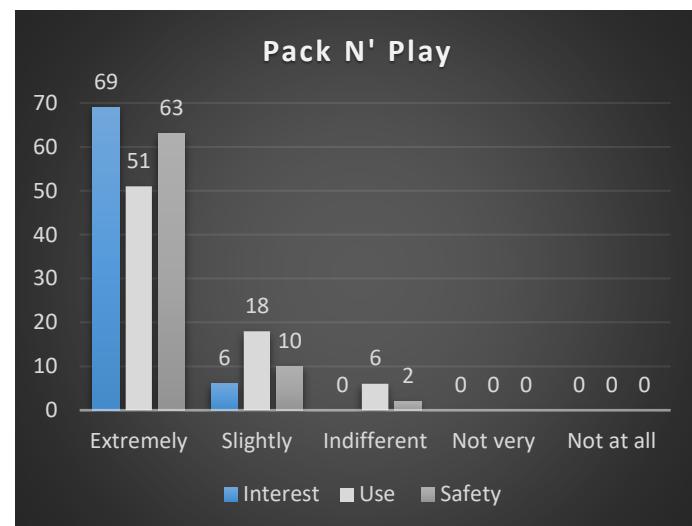
Some home visitors report that their clients are more likely to purchase bassinets and Pack N' Plays than they are to purchase cribs due to mobility and space. Still, though, some visitors have found that parents that had bassinets were still co-sleeping. While some parents follow through with the instructions and guidelines, many home visitors find that parents tend to adjust the guidelines to meet their needs, such as co-sleeping to make breast feeding more convenient.

Regarding cribs, home visitors had positive and negative experiences with their clients and their infants. Home visitors reported observing the use of bumpers in cribs due to parents reporting that their infant gets their feet or leg stuck in slats of the crib. Another challenge that home visitors voice is the use of hand-me-down cribs that have moving/sliding side rails which present the risk of injury if infants get their hands and fingers stuck. It was also reported that when home visitors go to their client's home, they see the use of the crib for storage instead of using it as the infant's bed. Home visitors continue to encourage caregivers that own cribs to place their infants to sleep in them.



Pack N' Play

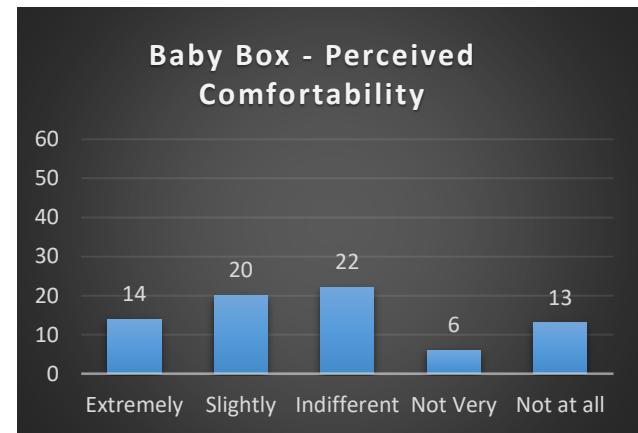
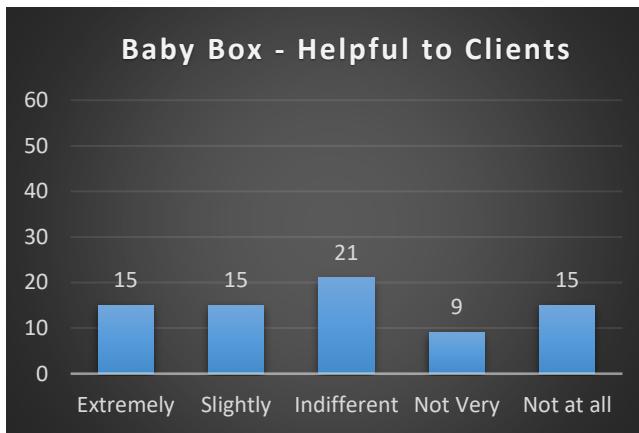
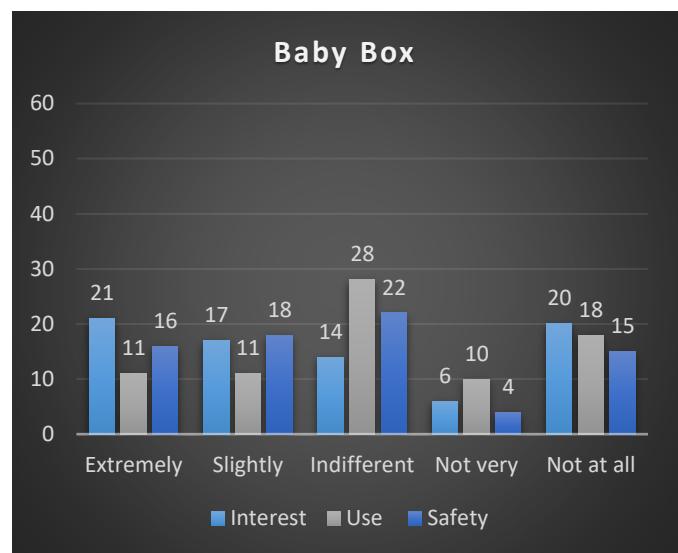
Discussions revealed that many MIECHV program participants own Pack N' Plays, which was the most popular furnishing, due to the product's versatility, affordability, and mobility. Some home visitors and staff explained that their site/agency has resources in place to provide Pack N' Plays in the case that a client does not have a place for their infant to sleep. However, not all sites and agencies have the resources to do this or may have very limited resources. Other sites and agencies have Pack N' Plays available to eligible parents. Home visitors educate parents and caregivers on how to properly assemble and use Pack N' Plays. Although Home visitors do their best to assist their clients by providing them with a Pack N' Play and to help them create a safe environment for their infants, several home visitors have observed that some parents do not use the Pack-N-Play for its intended purpose – instead they are used for the storage of toys, diapers, clothes, etc. In addition, home visitors also observe that families may only use their Pack N' Plays for naps or play time and choose to co-sleep during other times.



Other Sleep Furnishings

Home visitors reported other locations or furnishing items that infant sleeping in including couches, bouncers, car seats, and Baby Boxes among others. There were mixed opinions regarding the appropriateness of an infant sleeping in their car seat and swings with some home visitors suggesting that infants sleeping in these items were napping not sleeping throughout the night. It was explained that Moses Baskets often ultimately used for storage and as laundry baskets. Participants also discussed the potential distribution of Baby Boxes and some felt that their clients would not be interested because of the idea of the furnishing being an actual cardboard box.

Furthermore, there were additional questions about the stability and safety of the Baby Box with some believing an infant would be able to roll it over. Additionally, it was discussed that the possibility that the Baby Box could be placed on the floor close to the parent's bed could pose a risk to the infant. Some home visitors believed that Baby Boxes would be unsuccessful among certain groups due to cultural norms. For example, in some cultures, a cardboard box is commonly used as a coffin in the case of infant death. Thus, it is believed that among some cultures the Baby Boxes will not be appealing because of what the box symbolizes. Some of the study participants had questions about some of the new innovative furnishings such as side-bed co-sleepers that are now available for purchase and their safety.



Intervention Strategies

Home visitors identified many factors that present as barriers to practicing safe sleep behaviors among their clients. The two major factors home visitors identified that influenced current infant sleep practices were clients' culture and inter-generational advice on infant sleep. Home visitors also identified these factors as some of the most difficult to tackle because of cultural sensitivity and the large influence that generational advice plays in upbringing. Other factors that were observed by home visitors were the lack of safe sleep education among family and other caregivers that contribute to the care of the infants, lack of trust with home visitors and healthcare providers, less than ideal housing situations (i.e., small and/or crowded spaces and housing instability), perceived inconvenient or impractical recommendations, and lack of resources to provide safe sleep environments.

While identifying major factors, home visitors also shared intervention strategies that they utilized and encouraged others to implement to tackle these issues. Home visitors agreed that every client and family was unique and should be approached accordingly. The most commonly used strategy was sharing stories with clients about personal accounts with SUID experienced by their own co-workers, family members or friends. Several home visitors expressed that when clients heard these stories, they often reacted with bewilderment because while they knew of the importance of safe sleep, they were not aware that it could truly end in an infant death. Even then, home visitors mentioned that there were a few clients that acknowledged the stories but still did not believe that it could happen to them. Another

intervention strategy that home visitors counted as effective was the provision of Pack-N-Plays and sleep sacks. Pack-N-Plays allowed families to provide infants with a safe place to sleep, and for some families, the only place to sleep alone. Sleep sacks were particularly helpful in addressing the issue of using blankets in sleep areas for families that were worried about their infants feeling cold. With their experience, they were able to share techniques that could not only help guide other home visitors, but also guide researchers and policy-makers.

Home visitors brainstormed intervention strategies that were not necessarily widely used but that they believed would be worthwhile in attempting to implement safe sleep practices and provided suggestions for future improvement. Some strategies included more presence and use of social media outlets to spread the safe sleep messages and dispel myths, continuously reinforcing the message equally to caregivers and their families in a culturally respectful manner, building a trusting bond with clients so that they do not feel compelled to recite what they believe home visitors want to hear, and follow-up and follow-through with safe sleep education. In addition, home visitors identified systemic barriers that made it difficult to present families with the most effective and efficient safe sleep education and resources. Those barriers include an extensive referral process for provision of Pack-N-Plays and other resources, limited supply of resources, lack of accessible informational material (especially for clients with low literacy levels), and language barriers.

Recommendations and Conclusion

Infant safe sleep continues to be an important curriculum topic in home visiting programs. Interviews with caregivers and home visitors in the Baby's Best Sleep Evaluation have shown that while primary MIECHV caregivers – the majority of who are mothers – are receiving safe sleep education there continues to be a gap in knowledge and practice. While many mothers claim to implement the AAP safe sleep practices, others acknowledge the recommendations, but choose not to implement them for several reasons including: convenience of proximity, lack of risk susceptibility or severity, lack of resources for separate sleep areas, previous practices and traditions, and concerns for infant safety especially when it comes to choking due to reflux. Of the mothers that claim to implement the AAP safe sleep practices, home visitors reveal that their observations of practices and sleep environments contradict some of those claims.

Home visitors express various concerns for the families they serve that they believe contribute to inconsistencies in implementation practices. Social conditions such as crowded living conditions, substance abuse, and illiteracy were some factors that stood out among home visitors. Home visitors acknowledge that every family they serve is unique and must be treated as such, this should be reflected in the safe sleep curriculum and delivery. Home visiting programs should build and maintain community networks that assist in providing families with necessary referrals to address social determinants such as living conditions and education. In addition, as home visitors claim that substance abuse has always been a concern, it is necessary for home visitors and community networks to identify resources that effectively address substance abuse.

Across the Baby's Best Sleep Evaluation, mixed messaging has come to light as one of the most concerning factors in safe sleep education and implementation practices. Home visitors discuss that the internet, other healthcare providers, family, and the media all play a role. Some home visitors mentioned that they take the time to discuss with their families how to find reputable online sources for personal reference. While this is a worthy skill to review with families, efforts must be made from public health entities to assure that accurate information is reaching the necessary recipients. This can be done by creating consistent messaging across health disciplines and agencies. In addition, further efforts must be made to saturate the media to discourage the use of bumpers, blankets, and other crib decorations that may be aesthetically pleasing, but potentially present increased risk of SUIDs. Connecting with families through media and social media outlets can not only serve as refreshing the safe sleep message, but may also serve as an outlet to reach families that may not otherwise seek out or have access to needed services and education.

2018 | Florida Maternal, Infant, and Early Childhood Home Visiting Initiative



Baby's Best Sleep Evaluation Participant Interview Report

Marshara Fross, Amanda McMahon, Dogeli Rojas &
Dr. Jennifer Marshall

Baby's Best Sleep 2017

Executive Summary

The Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative supports home visiting programs that serve families with characteristics that place them at a higher risk for Sudden Unexpected Infant Death (SUID) in 25 counties throughout the state. Sleep-related death is the largest preventable cause of infant mortality after the first month of life. In the United States, there were more than 3,600 Sudden Unexpected Infant Deaths (SUID) and 203 in Florida in 2016. There were 239 SUID deaths in Florida in 2017. In Florida, the infant mortality rate of 6.2 per 1,000 is slightly higher than the national average of 6.0/1,000. Florida MIECHV staff and home visitors provide safe sleep education and support for program participants and their families. This infant sleep evaluation, Baby's Best Sleep, assesses participants' knowledge, attitudes, beliefs, and other factors that influence infant sleep practices and environment.

The MIECHV evaluation team randomly selected and conducted phone interviews of 50 program participants, consisting of parents and other caregivers (i.e., fathers/partners, grandmothers, and aunts) of infants up to seven months old. Participants were interviewed in their native/pREFERRED language, (i.e., English, Haitian-Creole, or Spanish). Participants were asked about their current infant sleep practices, knowledge of recommended infant sleep guidelines, and their use and perception of infant sleep furnishings (e.g., cribs, bassinets, Baby Boxes, Pack-N-Plays, and Moses Baskets). In addition, for Baby Boxes and Pack-N-Plays, participants were asked to rate their perception of safety, comfort, and helpfulness; level of interest in receiving the product; and their likelihood to use it.

Nearly all MIECHV participants reported being aware of infant sleep guidelines: alone, on their back and in a crib (n=40). However, there was mixed success with conveying of recommendations from MIECHV participants to other caregivers with almost all participants being unaware of the recommendations (n=5). Despite reporting being aware of the recommended infant sleep guidelines, participants reported practicing co-sleeping (n=23), infants sleeping on their side or stomach (n=15), and having stuffed animals or blankets in the infant's sleep area (n=13). Use of a variety of sleep furnishings were reported in interviews including, but not limited to, Boppy Pillows, co-sleepers, and bouncers. Pack-N-Plays were largely accepted and perceived to be safe, comfortable, and helpful; in comparison to Baby Boxes where participants' acceptance and perceptions varied greatly.

Compliance with infant sleep guidelines were influenced by factors such as breastfeeding, proximity to infant, convenience, safety concerns and traditions. In addition, use of sleep furnishings was influenced by factors such as perceived safety, perceived quality, infant response, and ease of use. This report provides a better understanding of MIECHV participants' infant sleep practices, infant sleep furnishing use and perceptions, and barriers to compliance with recommended infant sleep guidelines. Recommendations include continued education of all caregivers on the importance of compliance with recommended infant sleep guidelines and delivery of consistent messages across health disciplines regarding co-sleeping.

Introduction

Unsafe sleep practices place infants and newborns at increased risk for infant mortality. Sleep-related death is the largest preventable cause of infant mortality after the first month of life. In the United States, there were more than 3,600 Sudden Unexpected Infant Deaths (SUID), including 203 in Florida in 2016. There were 239 SUID deaths in Florida in 2017. The Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program strives to improve health outcomes in pregnant women and infants by providing evidence based interventions to families with characteristics that place them at a higher risk for SUID and reaching underserved populations in 25 counties. Florida MIECHV promotes infant health by providing education and resources and preventing SUIDs within program participants to high need and at-risk families.

The Florida MIECHV staff and home visitors provide safe sleep education and support for program participants. The Florida MIECHV infant sleep evaluation (Baby's Best Sleep) assesses participants' practices, knowledge, attitudes, beliefs, and other influences on infant sleep environments, as well as intervention approaches used by MIECHV sites to promote safe infant sleep practices as recommended by the American Academy of Pediatrics. The evaluation also aims to examine participant perceptions of sleep furnishings such as Baby Boxes, Pack N' Play, and Moses Baskets; which have been used in recent years as strategies to promote, demonstrate, and provide education and potential alternative sleep furnishing for infants.

Methods

The Baby's Best Sleep Evaluation utilized a qualitative research design to understand current infant sleep practices among program participants. In efforts to better understand the critical issue of safe sleep practices within Florida MIECHV, this evaluation aims to capture infant sleep knowledge and practices from multiple perspectives. In this study, 50 in-depth interviews were conducted with parents and caregivers involved in the infant's sleeping regimen. Stratified random quota sampling was used to create a list of eligible program participants with infants 0-4 months old. The interviews were conducted in the participants preferred language (i.e., English, Spanish or Haitian-Creole). Semi-structured interviews were conducted to foster rich discussions aiming to identify gaps in care, improve home visiting services, education and resources, promote safe sleep and prevent SUID. Discussions were digitally recorded, transcribed verbatim, and reviewed for accuracy. Coding and thematic analysis was conducted, in addition to demographic analysis.

Participants

A total of 50 interviews were conducted with parents and caregivers of infants enrolled in the home visiting program representing 10 of the 17 MIECHV sites. Of those 50 interviews, 43 interviews were conducted with the mother of the infant and 7 with another caregiver (i.e., father, grandmother, aunt). The infants were aged one to seven months old. More than half of the participants were single (60%), about a quarter were married (24%), 8% reported being divorced, and 4% were separated. The employment status for the one third of the respondents was unemployed – looking for work (36%), followed by homemaker (26%), employed full-time (18%) and employed part-time (8%). Eighteen participants reported having a high school diploma/GED (37%), 11 completed some college (22%), 10 completed less than a high school education (20%), two reported having a two-year college degree (4%), and eight reported having a four-year college degree (16%). None of the women reported being pregnant at the time of the interview. Table 1 further displays participant characteristics.

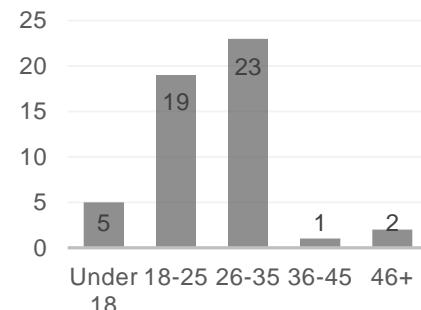
Table 1: Participant Characteristics

Participant Characteristics		N (%)
Gender	Male	2 (4)
	Female	48 (96)
Relationship to Baby	Mother	43 (86)
	Other caregiver	7 (14)
Education*	Less than high school	10 (20.41)
	High school graduate/GED	18 (36.73)
	Some college	11 (22.45)
	2 year degree	2 (4.08)
	4 year degree	8 (16.33)
	Professional degree	0

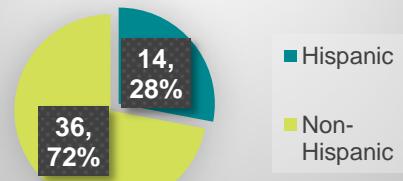
*Some participants preferred not to answer.

DEMOGRAPHICS SNAPSHOT

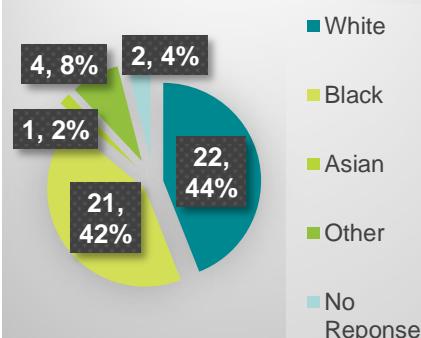
Age (Years)



Ethnicity



Race*



Sleep Practices & Behaviors

Participants shared their various experiences with infant sleep and methods utilized to successfully get their infant to sleep. Some of the most common challenges respondents expressed were:

- having an infant that prefers to be held and that requires proximity to a parent in order to sleep
- having infants who wake frequently during the night and require frequent attention

On the contrary, some participants explained that their infant does not wake frequently enough and subsequently misses feedings. Successful routines for infant sleep included:

- bath time before bed
- swaddling/zip-up blankets
- infant sleep furnishings placed at an incline (for infants with GERD)
- white noise machines



Nighttime bath



Swaddle



White Noise Machine=

Sleeping Position

Majority of parents and caregivers (70%) reported that their infant consistently slept on their backs. Of the 50 participants, 30% (n=15) reported that their infants either consistently or on some occasions slept on their sides (n=9) or on their stomachs (n=6). Several respondents also reported their infants rolling from their backs after being placed to sleep.

"She normally sleeps on her back, but now that she's turning, she sometimes turns on her side, but she [is] placed on her back."

Sleep Area

Most respondents reported that infants slept in an infant sleep furnishing that was empty with only a fitted sheet or a thin blanket covering the mattress. Only 13 (26%) of the participants reported that their infants slept with a stuffed animal or blanket. Three parents reported their infants have a mobile above their cribs. There were no reported uses of bumpers or crib decorations. Almost all of the parents and caregivers had

separate set sleep areas for their infants and many of the participants practice room sharing. Some reported having multiple set sleep areas.

[We co-sleep] because we put him in the crib when he was two months old and he wasn't happy. So, then I put him in the bed with me because he doesn't like to sleep alone. He wants to be where he can nurse when he wants to."

Co-Sleeping

Nearly half of participants reported co-sleeping despite being in the program and receiving ample education about its risks. There were 23 (46%) parents and caregivers who reported that their babies co-slept with them or with another caregiver either occasionally or on a regular basis. Some

respondents emphasized that they only co-slept with their babies when they felt it necessary (e.g., when breastfeeding, for soothing, to prevent GERD/reflux, or if baby simply fell asleep in their arms). Another common reason cited for co-sleeping with the baby was to bond and build a close relationship. Almost all of these participants were aware of the risks of co-sleeping and could recite the American Academy of Pediatrics (AAP) guidelines and recommendations.

Some of the parents/caregivers alluded to the concept of 'safe co-sleeping' and claimed that they created a safe co-sleeping environment by sleeping lightly, avoiding soft or plush bedding, refraining from drug and alcohol use, and using objects such as pillows as dividers. A proportion of caregivers were adamant about the benefits of sleeping with baby. However, most caregivers had attempted to mitigate the risks by:

- staying alert when baby falls asleep
- keeping infant sleep furnishings in close proximity
- moving the baby to their own furnishing before the caregiver begins to feel tired

Breastfeeding

Many of the parents/caregivers agreed that co-sleeping with the baby in the bed facilitates breastfeeding and helped them to maintain consistent feeding. Having to leave their beds to feed baby in the middle of the night was described as very difficult and inconvenient for the mothers; some felt as though the expectation was unrealistic. They explained that breastfeeding often helps soothe baby to sleep, therefore some breastfeeding caregivers kept the baby in the bed with them during the night. According to respondents, lactation consultants encouraged breastfeeding mothers who co-slept to do so safely by using recommended safe bedding and avoiding drugs



and alcohol for anyone in the sleep area. Most caregivers were aware of the risks of sleeping with baby but claim they were “more aware” with baby in the bed.

Reasons behind Sleep Practices

Respondents expressed various reasons for their infant sleep practices and behaviors. Many agreed that education and infant behaviors, health, and temperament were primary reasons for sleep practices. Program participants also highlighted the influence of friends, family and peer support groups on their actions. Specifically, a small proportion of the breastfeeding mothers explained their choice to co-sleep after attending breastfeeding support groups and receiving support from their peers and the facilitator. On the contrary, other peer support groups encouraged AAP guideline adherence. Additionally, the needs of parents and family members in the residence also impacted sleep practices. A small number of program participants explained that one of the primary influences on their sleep practices was knowledge of a personal friend or colleague who lost their infant to Sudden Infant Death Syndrome (SIDS).

Participant Concerns



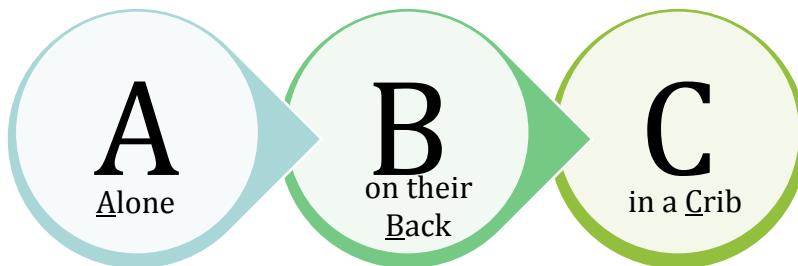
“I ALSO HAVE CONCERNS ABOUT MY DAUGHTER BECAUSE OF HER ACID REFLUX THAT I AM CONCERNED SHE WOULD END UP SPITTING UP WHILE SHE’S SLEEPING. BECAUSE SHE’S SO LITTLE, I’M SCARED THAT SHE COULD ASPIRATE AND END UP CHOKING, DYING BECAUSE SHE CAN’T BREATHE.”

Many of the parents and caregivers interviewed expressed sleep-related concerns they had for their infant, despite receiving education through the program. The largest concern of the respondents was the risk of the baby choking due to reflux, GERD and gas during sleep time. Safety was a concern both in regard to the reflux and the perceived risk of baby sleeping alone in cribs. These caregivers also cited the need to sleep with the babies to either monitor these issues or to safeguard against mishaps in their cribs or bassinets. Few caregivers expressed their apprehension about the infant’s continued breathing throughout the night and sleep habits such as the infants’ frequent waking/lack of sleep or tendency to oversleep and missing feedings. Participants also expressed concern about their infants’ warmth without the use of blankets. Crib safety was also a concern; some parents stated that their infants’ limbs were getting caught between crib slats or mentioned the possibility of the infant falling

“[he] likes to put his foot in between them [crib slats] and then he’ll fall asleep and roll over, and he gets stuck occasionally. I’ve had to use lotion to try to get his leg out. So I feel like they should be closer together.”

from the sleep area.

American Academy of Pediatrics (AAP) Guidelines/Safe Sleep Information



The respondents understood and could recite, when asked, the infant sleep AAP guidelines or the ABC's of safe sleep, regardless of adherence. Only a few ($n=2$) program participants were unaware of the guidelines and few required additional prompting. However, program participants relayed this information to other caregivers with mixed success. Almost all of the caregivers (5 out of 7) were unaware of the existence of 'safe sleep guidelines'. Caregivers who were unknowingly adhering to the safe sleep guidelines were unaware their actions were an effort to prevent SIDS. While respondents found the safe sleep awareness information to be helpful, though majority of respondents felt they had received more than enough information on this topic.

Although a large proportion of program participants were aware of AAP guidelines, there was mixed adherence to these guidelines. All infant sleep practices were influenced by the guidelines in some way, even if the participant was not adhering to all of them. This was especially emphasized for co-sleeping respondents who attempted to make co-sleeping as safe as possible via positioning and bedding adaptations. Some respondents felt that adhering to all the guidelines on a consistent basis was unrealistic and that sleep practices are greatly influenced by the infant.

Twelve of the study participants specifically mentioned receiving safe sleep information from their home visitors. Those who mentioned their home visitors explained the home visitors' vital role in explaining and helping them to implement safe sleep practices. Other providers mentioned were pediatricians, OB/GYNs, midwives and lactation consultants.

"Pretty much everybody that you meet along the way after having a baby, you hear it constantly. Nothing in the crib, no bumpers, babies on their back, no blankets. You hear it everywhere."

Traditions & Previous Practices

A few of the respondents concluded that their traditions either stem from previous experiences with their older children or from what they have learned from family members. For some, practices with their previous children resulted in indifference toward infant sleep recommendations. Furthermore, previous practices of close family members and friends were also influential. A few ($n=3$) of the caregivers based sleep practices on previous practices instead of recommendations provided by the mother. A small minority of the respondents reported having traditions that align with the recommended guidelines from the AAP.

Perceptions and Beliefs

The respondents recognized the overall benefits of the safe sleep practices, but also conveyed that they could be difficult to implement. Numerous parents described inconveniences that safe sleep practices presented for late night feedings and/or baby soothing. Alternatives that were mentioned as a way to observe the safe sleep practices, but also to make the late-night feedings easier on the caretaker included using flat bassinets, placing the infant's sleep furnishings (i.e., Pack N' Play, crib, bassinet, etc.) in the caregivers' bedrooms (room sharing), and 'safe co-sleeping'. However, these choices were heavily influenced by whether or not the infant cooperates, thus causing the caretakers to adjust accordingly. Participants had varied responses for their decisions regarding infant sleep practices, citing either their spatial awareness while sleeping or unwillingness to place their infant at risk as reasons for their routines.

"I'M DOING WHAT I THINK IS BEST FOR MY BABY. I MEAN, ANYBODY ELSE CAN DO 'SLEEP THE BABY BY HIMSELF' BUT I FEEL LIKE THERE'S NO RISK WITH ME. I'M A VERY LIGHT SLEEPER. I JUST FEEL MORE COMFORTABLE WITH HIM THERE WITH [...]. THAT'S MY OPINION."

"I BELIEVE THAT THAT IS ABSOLUTELY THE SAFEST WAY TO SLEEP. [...] EVEN AT A YOUNG AGE, THEY ARE CAPABLE OF GRABBING A BLANKET AND COVERING THEIR FACE WITH IT. SO I ABSOLUTELY DO TRUST AND BELIEVE THAT AN INFANT IS PLACED SAFEST ON THEIR BACK, ALONE."

Sleep Furnishings

Participants were asked about their opinions on different sleep furnishing options for their infant. The most popular items were bassinets, cribs, and Pack n' Plays; though a few parents also mentioned having a Rock n' Play. Parents' and caregivers' responses varied regarding why they believed that a certain item was best for their children. Many parents and caregivers reported that they had more than one of these

items. Most felt that the item they chose for their babies to sleep in was safe whether it



Pack-n-Play

- A piece of furniture in which an infant or young toddler is placed to provide a safe place



Baby Box

- A box filled with safety information and necessities, which is lined with a mattress and is used as temporary sleep space for newborns.



Moses Basket

- A basket for holding a newborn; a kind of bassinet, often set upon a stand.

was the bassinet, crib, or Pack n' Play.

Crib/Bassinet

Cribs were largely accepted by respondents as the best infant sleep furnishing, with some participants indicating that they preferred bassinets. Some participants identified convertible cribs as a worthwhile investment because they are made to change along with growing children. These cribs can be transformed into toddler beds and then to full-sized beds as the children grow. Size was also identified as a factor for lack of preference for bassinets. While some participants expressed that they like bassinets because they are small and portable, others stated that the small size of the bassinet is limiting as it can only be used for a short period of time.

Despite participants' preferences in furnishings, many explained that their use of a particular furnishing was dependent on their infants' comfort and response to sleeping in the space; often determine by whether the infant easily fell asleep in it or awoke often. Safety was another factor that affected furnishing preference with several participants indicating that the space between crib slats were of concern since their infants put their arms and legs between them. Almost all participants that discussed bassinets found them to be a safe and secure option.

Moses Basket

Most parents were previously unaware of a Moses Basket, and for the majority of those that were aware, they reported that they were unlikely to use one. In general, most respondents were reluctant to use the Moses Basket primarily

"[I]nfants that I know would outgrow it very quickly because of their length or their weight. Moses baskets are very flimsy. Yes, there's no draw to the Moses basket for me. That'll be the least choice I'd choose from any of these."

due to safety concerns; they feared that the basket is too small to protect an infant. Some parents simply did not like the idea of putting their child in a “basket”, while others felt the Moses Basket was not worth the investment due to the fact that the infants would outgrow it quickly. However, other parents stated they would be willing to use the Moses Basket if their child was small enough (i.e., newborns).

Other Sleep Furnishings

Parents and caregivers were asked to identify other sleep furnishings they use in addition to bassinets, cribs, and Pack-n-Plays. A wide variety of sleep furnishings or devices that infants slept in were mentioned by participants, including:

- Rock-N-Plays
- Swings
- Bouncers
- Boppy Pillows
- Sleeping mats
- Cradles, strollers
- Car seats
- Co-sleepers
- Side sleepers
- Rocking chair
- Parent’s bed

It is worth noting that parents and caregivers expressed that they may not place the infant in these places/items with the intention for them to sleep, but that the infant would simply fall asleep while in them. Parents and caregivers also reported that they do not want to disturb their sleeping baby and will allow them to stay wherever they may have fallen asleep – even if it is not their set sleep areas.



Rock-N-Play

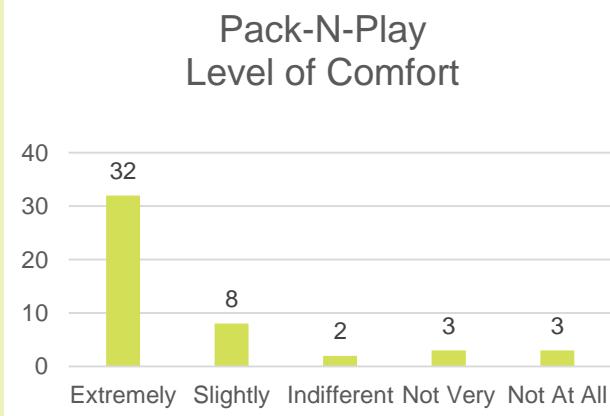
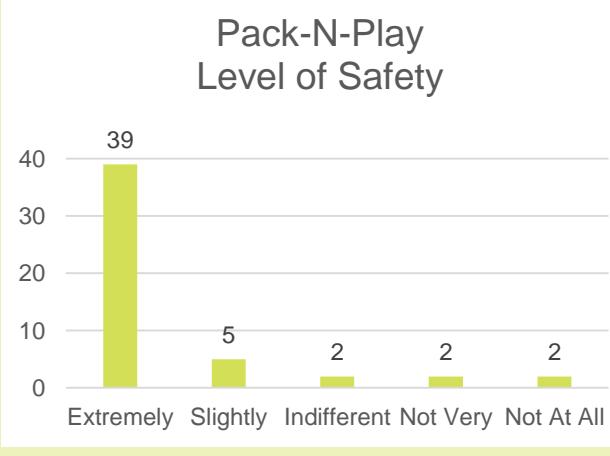
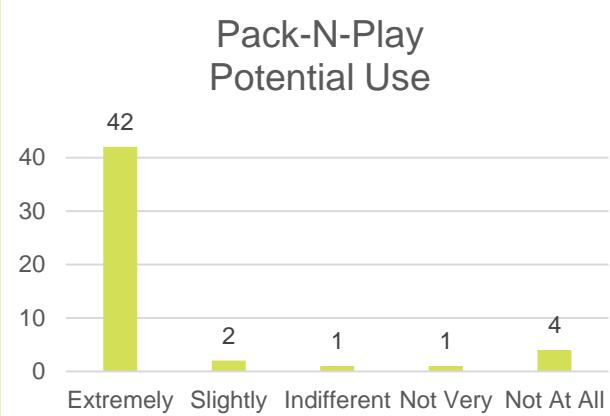
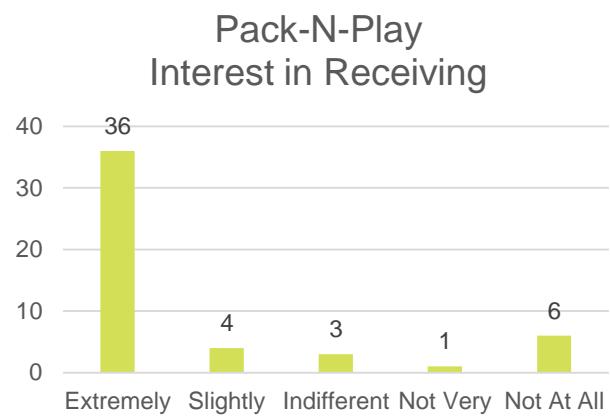


Co-Sleeper



Boppy Pillow

Pack-N-Play Ratings



Pack-N-Play

Many participants reported having positive experiences and opinions regarding Pack-N-Plays. Parents and caregivers stated that they like that the Pack-N-Play is:

- practical
- useful
- easy to move around the house and travel with
- safe and sturdy
- made with mesh/netting which prevents their baby from getting an arm, leg, or foot stuck compared to a crib with slats
- convenient because it comes with a Newborn Napper and changing table that sits on top of the Pack-N-Play which is useful as their baby grows

"Pack-N-Plays are so easy to just pack up and bring with you. When I go to family functions, to park. I think that Pack-N-Plays are awesome."

Though most parents and caregivers had positive opinions about the Pack-N-Play, some have concerns regarding the portable crib. Common concerns and issues that parents and caregivers had regarding the Pack-N-Play included:

- Feeling that cribs would be safer
- Too low to the ground
- Mattress was too hard and not comfortable for their baby

Most participants reported that they

"I don't like the Pack-N-Play just because it's low to the ground when you put them all the way in and then I don't feel like it's safe enough to have them in the little top portion so I personally don't like it."

had heard of the Pack-N-Play, even if they have not used one yet or own one. Both parents and caregivers were open to trying the Pack-N-Plays and expressed interest in them. Most participants reported that they had previously used a Pack-N-Play or would be likely to use it if they had one. Participants expressed interest in using them for when their baby napped during the day, but some were less likely to place their baby to sleep in one at night. While many parents and caregivers stated that they were comfortable allowing their baby to sleep in a Pack-N-Play, others felt that a crib would be safer. Furthermore, some parents reported that the frequency of Pack-N-Play use has increased now that their baby is getting older, while others reported using them more when their baby was a newborn. Overall, the Pack-N-Play was positively received by participants.

Baby Box

While the majority of participants were unfamiliar with Baby Boxes, many expressed interest in learning more about them. Of the several parents and caregivers that were aware of Baby Boxes, some had received one or knew of them. When asked how likely participants thought they were to use a Baby Box, parents and caregivers reported a high level of uncertainty.

Many reported that they would like to see the Baby Box and evaluate its safety, before using one. It is clear that parents and caregivers wanted to familiarize themselves with the Baby Box before allowing their baby to sleep in one. Additionally, some stated that if left with no other furnishing options they would use a Baby Box; but was not their preference. However, many were curious about them and reported feeling open to the idea of having their baby sleep or nap in one.

After explaining what Baby Boxes were to participants, some parents and caregivers stated that the Baby Boxes seemed:

- convenient because it sounded practical and easy to move around
- safe
- comfortable because of the foam mattress, as compared to a Pack-N-Play, which may not be included a mattress or cushion
- comforting for an infant seeing as it is not as large as a crib

“Versatility, I don’t know if that would be the best way to describe it. I can use it as she grows, because when I first decided to buy a crib or a bassinet [over] a playpen, I reviewed the Pack-N-Play, it was almost like a three-in-one. So, in her newborn stage, the bassinet area worked well and then flip it over, you can utilize this changing pad. As she gets older, I’m able to use it as a regular crib and days where she just wants to jump around. As she grows older, I can also use it as a playpen.”

"It seems very useful, especially for parents who don't have a place in the house yet set up for the baby. If they didn't have anything ready, I think this could be a solution."

Respondent's interest levels varied based on their concerns regarding the Baby Boxes. Some parents believed that a crib was ultimately the safest location for their baby to sleep. While some participants reported that they were simply not interested, others mentioned they had concerns such as:

- safety and comfort
- mixed or negative feelings about placing their baby to sleep in a box
- the baby potentially tipping the box over

"I don't know because I have to see how [they are] – I guess seeing one might understand the concept, but it still kind of scares me because she's rolling now, so if she's on her side, she could easily just flip herself."

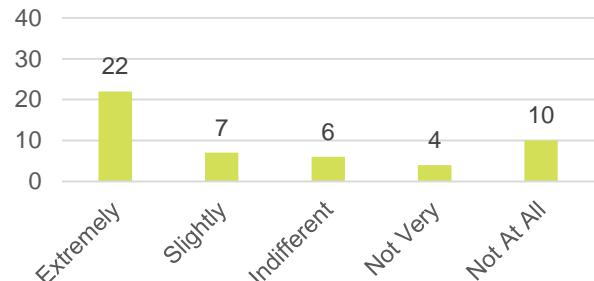
"If it has a small mattress, I expect it would be a little more comfortable because I saw that it looked small. [...] since it's smaller than the crib, the baby wouldn't feel so lost. So, if it had a surface that wasn't so hard, like the pack 'n play, I expect babies would like it better than the crib because they would feel more snuggled. I think it would be more stable than a bassinet because it doesn't have legs, and because you can put it directly in the crib. I would try one."

Baby Box Ratings

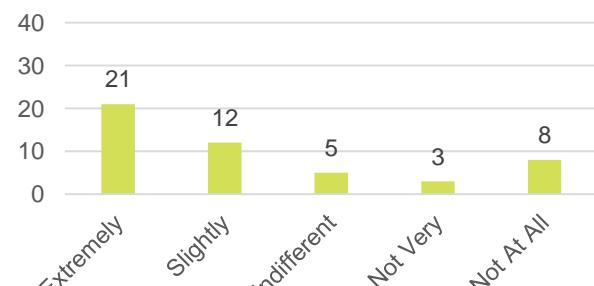
Baby Box Interest in Receiving



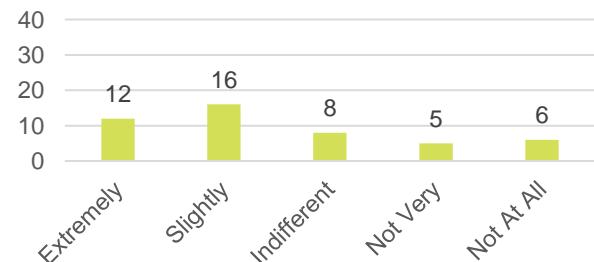
Baby Box Potential Use



Baby Box Level of Safety



Baby Box Level of Comfort



Recommendations

While this evaluation revealed that caregivers are aware of AAP infant sleep guidelines, it is important to note that many believe the guidelines to be unrealistic in practice. It would be beneficial to further explore practical ways in which to implement the guidelines so that it works best for both caregivers and infants. In addition, the discrepancy between the information that some caregivers are receiving from the program and other providers must be addressed. Furthermore, the education of all caregivers and siblings involved in the infants' sleep regimen is encouraged. The notion of "co-sleeping" continues to be interpreted in many ways, and the encouragement of "safe co-sleeping" challenges the recommended sleep practices. Ideally, providers, agencies, and programs that address infant sleep should coordinate the messages they are disseminating in efforts to provide consistent information and education to caregivers. Caregiver concerns regarding their infants health and safety (e.g. concerns regarding choking when reflux/GERD was present) and sleep patterns and comfort call for continued and improved education regarding infant sleep cycles as the infant develops along with strategies for promoting sleep hygiene and safety while maintaining attachment and responsiveness to infants' needs.

Furniture safety and proximity were some of the most common concerns expressed by caregivers. Cribs with slates should continue to be monitored and manufactured with the safety of babies in mind. That is, caregivers concern for the distance between slates on cribs should be further explored to determine whether the concern is of substance and truly presents a safety hazard for babies. Co-sleepers, such as those like the picture previously provided, which allow for the baby to sleep alone should be further explored to determine whether they are a safe alternative to cribs. These allow for the baby to sleep near their caregiver while adhering to AAP guidelines, and may help decrease the rate of in-bed co-sleeping due to breastfeeding routines and safety concerns. In all, there are still many areas to further study in the area of infant sleep.

Future Directions

In 2016, the Florida Healthy Babies Initiative conducted a statewide evaluation of safe sleep interventions including a Florida SUID epidemiologic analysis, health education and policy analysis, literature review, and focus groups with community program staff. The statewide evaluation resulted in recommendations for unifying community efforts to promote safe sleep while tailoring education to the culture, environments, and needs of families. One program that was implemented in several counties was the Safe Baby program (healthysafebaby.org). Due to targeted efforts towards promoting safe sleep practices within MIECHV, the Safe Baby curriculum has been adopted by MIECHV, Florida Healthy Start and Healthy Families Florida statewide. Moving forward, the MIECHV evaluation team plans to examine the program

implementation of Safe Baby and the resulting impact on program participant infant sleep practices. Additionally, the evaluation team plans to further study infant sleep furnishings and education strategies through comparative effectiveness analysis.

Evaluation Team

Marshara Fross, Project Coordinator

Amanda McMahon, Research Assistant

Dogeli Rojas, Research Associate

Vasthi Ciceron, Research Assistant,

Elba Campos, Research Assistant

Tochukwu Obioha, Research Assistant

Igbagbosanmi Oredein, Research Assistant

Dr. Jennifer Marshall, Principal Investigator, Lead Evaluator



Chiles Center
Women, Children & Families

For further information on this report, please contact:

Jennifer Marshall, PhD, CPH, Assistant Professor

University of South Florida, College of Public Health, Chiles Center

(813) 396-2672

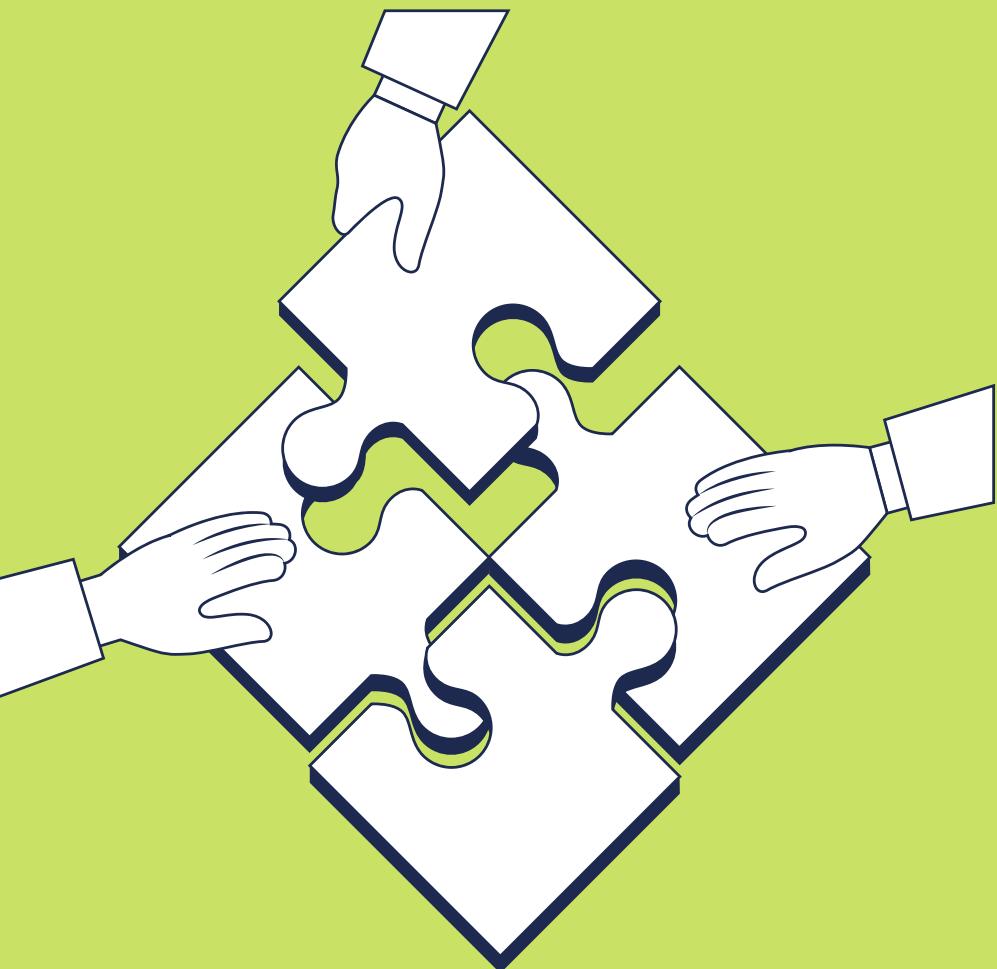
jmarshal@health.usf.edu

This project is supported by the Health Resources and Service Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number D89MC28265, Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsement be inferred by HRSA, HHS, or the U.S. Government.

Engagement & Retention

Evaluation objectives in engagement and retention were to:

- To understand family needs through the perspective of the MIECHV initiative administrators, staff and participating families.
- To assess patterns of engagement, home visit completion and enrollment/retention among MIECHV initiative participants.
- To gauge staff, current participating family and alumni family perceptions of engagement and retention.



Florida Maternal, Infant, and Early Childhood Home Visiting Program Evaluation

Staff Perception of Engagement and Retention: 2016 Site Visit Report



Ngozi Agu, Pamela Birriel, Omotola Balogun, Ajisope Oluwatosin,
Amita Patil, Carolyn Heeraman, and Jennifer Marshall

*University of South Florida College of Public Health
Chiles Center for Healthy Mothers and Babies*



Florida
Maternal
Infant &
Early
Childhood
Home
Visiting
Initiative



The Lawton and Rhea
Chiles Center
for Healthy Mothers and Babies

our
practice
is our
passion.[™]
University of South Florida
College of Public Health

EXECUTIVE SUMMARY

Engagement and retention of enrolled families is important for success in a home visiting program; thus it is essential to understand the multitude of factors that can affect these indicators of participation. Through on-site focus group discussions with Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs in 2016, program staff shared their views and experiences related to participant engagement and retention.

Engagement was defined by staff as having a good rapport and connection with program participants; participants being actively involved in all aspects of the program; and participants meeting the expectations of the different home visiting models (Nurse-Family Partnership, Parents as Teachers, and Healthy Families Florida). Characteristics of engaged home visitors and participants were positive communication, commitment, active participation, and having positive outcomes. Participants were said to be retained when they stayed in the program up until completion, as defined by the program model.

Promoting factors that were common to both engagement and retention included commitment, positive and effective communication, active participation, timing of enrollment, and a length of time in the program that is conducive. Promoting factors that were unique to engagement included the use of teaching aids/props and utilizing an individualized approach. Unique facilitators for retention were engagement; staff retention; use of incentives; having a positive, supportive relationship; and the higher level of education among participants.

Challenges to both engagement and retention included staffing issues, conflicting priorities, change in the participant's relationship status, loss of contact with the participant, and housing instability. Barriers that emerged that were unique to engagement included issues with mental health, substance abuse, and intimate partner violence, and the existence of high-pressure situations. Challenges to retention included low level of connectedness between the home visitor and participants, paperwork demands, and situations where participants felt they were not learning anything new.

Strategies home visitors discussed that they used to address these barriers/challenges included conducting unscheduled visits, providing resources and referrals to tackle housing issues, meeting in public places when the home environment was not conducive, flexible scheduling, and giving participants personal time. Discussions provided insight into specific factors that facilitate or inhibit engagement and retention of MIECHV participants. There is a need to enhance facilitators, such as relationship-building skills and tailoring programs to participants' interests and needs, as well as identify ways to reduce barriers, including staff turnover, family crises, and competing demands, to increase the overall effectiveness of the program.

INTRODUCTION

Successful participation and engagement in home visiting programs can lead to increased program retention and program effectiveness (Ammerman et al., 2006). However, achieving and sustaining participant engagement is one of the greatest challenges that home visiting programs face (Ammerman et al., 2006). In 2016, Florida MIECHV recorded an average of 1.2 completed monthly visits per family while the program target is two visits per month. The participant retention rate was 70% in 2015 and 89% in 2016 (Florida MIECHV Program, 2016 & Florida MIECHV Program, 2017). Identifying factors that impact engagement and retention can inform modifications to better meet the needs of program participants.

METHODS

To explore perceptions of home visiting staff regarding participant engagement and retention, MIECHV site visits were conducted during August and September of 2016 in 3 of 11 MIECHV sites – Hillsborough, Manatee, and Escambia. Six focus groups were conducted in total, with separate home visitor groups and staff/administrator groups in each site. Flip charts were used to facilitate conversations. All discussions were audio recorded and transcribed verbatim. Each transcription was reviewed for accuracy, and common themes that were related to definitions, characteristics, facilitators, and barriers to engagement and retention were identified.

RESULTS

Staff Characteristics

There was a total of 23 participants, including 16 home visitors, 2 administrators/directors, 1 supervisor, and 4 staff who specified another role within the program (e.g., manager, therapist, or assistant) (Table 1). A diverse group of program staff were present at the focus groups with participant's age ranging between 25-67 years. Most participants were female (95.7%) with a bachelor's degree (56.5%) and were White (65.2%), non-Hispanic (78.3%).

Table 1. Characteristics of Program Staff.

Staff Characteristics	N (%)
Age (years)	
18-25	2 (8.7)
26-35	6 (26.1)
36-45	8 (34.8)
46-55	3 (13.0)
56-65	2 (8.7)
66-75	2 (8.7)
Gender	
Male	1 (4.4)
Female	22 (95.7)

Race	
White	15 (65.2)
Black	4 (17.4)
Asian	1 (4.4)
Other	3 (13.0)
Ethnicity	
Hispanic	5 (21.7)
Non-Hispanic	18 (78.3)
Organizational role	
Administrator/Director	2 (8.7)
Supervisor	1 (4.4)
Home visitor	16 (69.6)
Other	4 (17.4)
Number of years in profession*	
< 1 year	1 (4.3)
1-5 years	8 (34.7)
6-10 years	4 (17.4)
10+ years	9 (39.1)

*One respondent did not provide information.

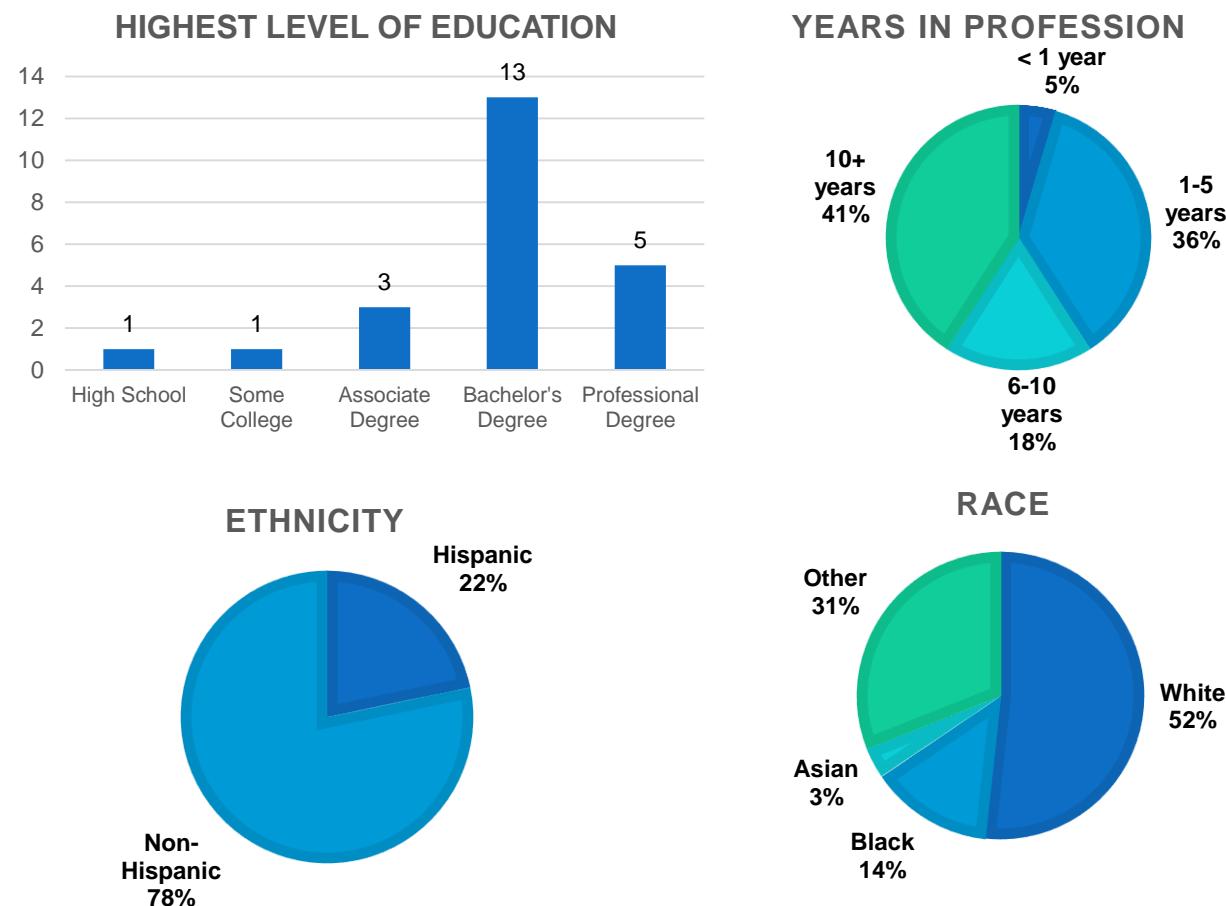


Figure 1. Characteristics of Program Staff.

Definition of Engagement

Staff defined engagement as connectedness between the home visitors and program participants, participants actively participating in the program, and the degree to which participants meet the expectations of the different home visiting models.



In terms of connectedness, program staff discussed having a good rapport with the families and letting them know that the home visiting program is there to support them and work with them. Another key element in the definitions of engagement was the family's active participation, as demonstrated by participants being involved in all aspects of the program such as: home visits, attending group events, completing surveys, the involvement of the fathers, completing tasks/homework, and asking questions. Engagement was also defined in terms of participants' ability to meet the program expectations, for example, if the program requires twice monthly meetings, participants were engaged when they met this expectation. Furthermore, program staff recognized that engagement is fluid or changing, that the quality of visits is important, and that trust remains a significant element.

"They act excited and then after you've done a visit, they will call you on something that you said or repeat it... Like, they want you to be in their home when you go to home visits."

Definition of Retention

"Being able to get them to stay... Continue and finish out the program."

Retention was described as keeping visits and not rescheduling or canceling visits, staying with the program, and graduating from the program; additionally, being able to get participants to begin, engage, and complete the program. Most agreed that retention and engagement are interrelated. Retention was further described by program staff as when participants stay actively involved in the program until graduation (i.e., for a duration of two years). Furthermore, retention was described as when participants complete the leveling system when the child is between 3-5 years old. Home visitors check that their participants have attained stability at home, that the child's immunization is up-to-date, and that the child has consistent well-child care.

FACILITATORS AND BARRIERS

Facilitators and barriers/challenges to engagement and retention were discussed by program staff. Because engagement and retention are closely related, some of the facilitators and barriers described by program staff overlapped for both engagement and retention.

Facilitators

Several factors that promote both engagement and retention were discussed by home visitors, supervisors, and administrators. These factors were categorized into commitment, communication, active participation, and timing and length of enrollment.

Commitment: Commitment on behalf of both the program participant and home visitor was identified as a facilitator for engagement and retention. Participant commitment was demonstrated by rarely or never cancelling appointments with their home visitors and preparing for scheduled home visits. Committed home visitors were described as those who went the extra mile to find resources for their families and talked with their peers to get advice and recommendations for a specific participant. Additionally, showing up to visits prepared and having good work attendance, as well as ensuring they make out time and are flexible when scheduling visits with a participant, were features of committed home visitors. When a home visitor was committed, they followed up with their families and fulfilled promises made to their participants leading to participant engagement and subsequently retention.

Communication: Two-way communication was identified as an important factor to promote engagement, and subsequently retention, in the program. For program participants, positive communication included initiation of contact with their home visitor outside of the home visits, as well as contacting the home visiting supervisor/administrators when they had additional questions about the program. On the part of home visitors, communication was aimed at remaining in touch with the participant – calling outside of visits, checking in on them, texting, and sending letters in a manner that is consistent and positive without overstepping boundaries.

Active Participation: Another key facilitator for engagement was active participation of program participants and home visitors. According to staff, during the visit the family members' and home visitors' body language shows that they are both actively involved and engaged. Program participants also participated actively by asking questions; carrying out recommended activities; modeling taught activities; utilizing information, resources, and referrals provided by their home visitor; and attending various group meetings and events separate from the home visit.

"So, like your facial expression, the tone of your voice, really be interested in what they're interested in."

Timing and Length of Enrollment: Timing of enrollment was found to be a factor that influences participant engagement, depending on the families' other priorities. Additionally, length of enrollment is a factor. Program staff discussed that even though engagement starts to wane after six months of being in the program, participants who remained in the program up to a year after enrollment were more likely to remain engaged and complete the program.

Facilitators of Engagement

Although some of the facilitators of engagement were also discussed as facilitators of retention, some factors were discussed as facilitators of engagement alone. These factors are the use of teaching props and having an individualized approach.



Use of Teaching Props: Staff discussed that using aids during their visits with program participants helped to promote learning and increase engagement. These aids were mostly used when teaching parenting skills or facilitating activities between program participants and their children. Participant engagement was facilitated by using these aids, such as brochures and videos, as well as props, including dolls and pictures.

"I use a lot of props [laughter] with my teachings, like baby dolls and pictures of things and things like that. I think the fact that I'm thinking about them and thinking about their learning styles and bringing videos and things, and it's showing that I'm engaged with you. I'm bringing things to help you understand things, so I'm thinking about you."

Individualized Approach: Staff also talked about how an individualized approach helps to increase engagement among program participants. Individualization shows that a home visitor attends to a particular participant's needs and preferences. Furthermore, when utilizing an individualized approach, home visitors were able to identify program participants who were not engaged and to identify strategies they could use in engaging them. Discussions on individualization also included that home visitors were able to remember information that is specific to certain program participants without relying on notes.

Facilitators of Retention

Factors that were discussed as facilitators of engagement alone were staff retention, incentives, positive supportive relationship, and the participant's educational level. Both home visitors and supervisors/administrators talked about staff retention, incentives, and a positive supportive relationship.



"...because if they're not engaged, they're not going to meet with you, and then good luck with keeping them in the future retaining them."

Engagement: Being engaged in the first place affects participant retention. Program staff discussed that when a participant was engaged and receptive to program activities, it usually led to retention. A participant who was not engaged will be difficult to retain in the program.

Staff Retention: Staff retention was another factor that program staff perceived as a facilitator to retention. Having a high staff retention can reduce the need to rebuild trust with new staff. When a home visitor takes the time needed to connect and build relationships with a family, that participant naturally becomes more attached, making transitions to new staff difficult when there is turnover in home visiting staff.

Incentives: Incentives were discussed as a factor that could promote retention among program participants. These incentives were given to program participants as a reward for certain achievements in the program. These incentives ranged from tangible resources, such as diapers to certificates demonstrating accomplishments.

"I think that's a way to retain them. Pampers, wipes-- because some of them, they can't afford that, so they wait for that visit, so they can get their pampers."

Regardless of the type of incentive used, program staff discussed that this reward system helped to make program participants feel fulfilled, gave them a sense of accomplishment, and retained them in the program.

Positive Supportive Relationship: A positive and supportive relationship between the home visitor and participant was also discussed as a facilitator of retention. Staff discussed that it is important for program participants to have a good relationship with their home visitor – a positive rapport and a feeling that their home visitor will always be supportive. Staff described numerous examples of when home visitors attend appointments or other activities with program participants and situations where the family receives additional wraparound support from the home visiting team (both home visitors and supervisors).

Participant's Educational Level: Program staff discussed that they noticed that program participants with higher levels of education were more likely to complete the program.

Barriers/Challenges

Barriers/challenges to engagement and retention included staffing issues, conflicting priorities, change in participant's relationship status, loss of contact, housing issues, and involvement with the Child Welfare System.

Staffing Issues: One important theme that emerged in most focus groups was the effect that staffing issues, such as high employee turnover and home visitor workload and stress, had on both engagement and retention. Staff discussed that it interfered with the ability to form a

rapport with the program participants, and this could affect engagement and retention. There was one exception to this, a situation where a participant stayed in the program despite having had four different home visitors. She was referred to as the longest retained participant.



"They have to empower themselves, and then back to empower the family."

Competing Priorities: The families' other commitments and priorities presented an additional challenge to engagement and retention of participants in the program. These priorities included employment, income and housing situation, and the birth of the baby. While it is positive that participants are able to find gainful employment and earn an income, this dynamic leads to changes in their schedule or even a situation where they do not have a set schedule and a resulting decrease in their ability to meet up with their home visitor. A busier schedule following the birth of their baby could also limit the amount of time that participants have to meet with their home visitors. A change in priority could even mean a situation where things are going so great that participants do not believe they need their home visitor anymore.

"[Program participant remarked] 'I don't think I can be in the program because I'm working five days a week'... So, I offered the weekend just so she would stay in the program."

Relationship Dynamics: Relationship changes, such as a divorce or break-up, reuniting with an ex-husband or partner, or having a new person in their life can also interfere with participants' engagement or retention. Staff explained how breaking up with a previous partner can lead to a feeling of embarrassment which prevents participants from meeting up with their home visitor. Sometimes, the partner the participant reunites with could be abusive or an otherwise unhealthy partner; a controlling partner may discourage the mother from seeing the home visitor, or she may feel that the home visitor will judge her negatively for the decision to reunite and thus pull away from the program.



Loss of Contact: Another common challenge that exists is loss of contact with the program participant. Disconnected phone lines, change in phone contact, change in living situation, and moving out of town are all situations which lead to a loss of contact with the participant and subsequent decrease in engagement and retention.

Housing Issues: Issues with housing was another factor that has a negative impact on engagement and retention. These issues included unstable housing where participants did not have a consistent living arrangement or living with relatives and/or friends.

"Our visit sometimes... it gets personal and sometimes they don't want their other family members knowing how they feel or what's going on inside their brain. I mean just that, can interact with the engagement of you and mom."

Involvement with the Child Welfare System: Another determining factor is made through which participants were enrolled in the program. Being referred through Child Protective Services or Department of Children and Families, or having contact with those agencies, usually result in poor engagement or non-completion of the program.

Barriers to Engagement

Some barriers were specific to engagement, such as issues with mental health, substance abuse, and intimate partner violence, and high-pressure or crisis situations.



Issues with Mental Health, Substance Abuse, and Intimate Partner Violence: Staff described many situations in which mental health, substance use, or intimate partner violence issues affect participant engagement. Mental health issues can impact the parent's participation in conversations and interactions with the home visitor and with their child. Additionally, staff expressed that home visitors routinely bringing up certain topics, such as substance use or intimate partner violence, may make the participant uncomfortable in situations where it is present, and can interfere with their engagement in the program.

"We can definitely go into mental health, substance abuse, intimate partner violence. Things can be great and then all of a sudden, maybe mom relapses and she pulls away."

High-Pressure Situations: Staff explained that when participants are living in high-pressure conditions – which is frequently the case – their engagement in the home visiting program can be negatively impacted. Examples of these high pressure conditions included economic or community stressors, personal or family crises, and lack of a sufficient support system for the parent or family.

Barriers to Retention

Some barriers to retention for the full duration of the program identified by program staff included low levels of connectedness, static knowledge/saturation, and paperwork demands.

Low Level of Connectedness: Low levels of connectedness between home visitor and program participant could occur due to participant expectations not being met, lack of connection and trust between home visitor and participant, and issues around respecting boundaries. Some home visitors expressed the opinion that there needs to be clear boundaries with the participant. While some home visitors earlier had discussed constant communication outside of the job as a facilitator of engagement and retention, one home visitor said that contacting participants when the home visitor was off work was overstepping boundaries and could affect retention. “We’re not there to be their best friend.” Furthermore, discussing personal issues with the participant was also identified as overstepping of boundaries.

“Calling them when you’re off, talking to them about your personal life, all that is boundary issues when you do leave this job, you are not to contact them. Some people still do [such] boundary issues, and it hurts the rest of us that get those [participants] also because they are also going to be, ‘So and so did this with me.’ ‘Well, that’s not part of the program.’”

Static Knowledge/Saturation: It was expressed during the focus groups, that static knowledge/saturation can occur in some instances where the home visitor feels like the program

participants are not learning anything new from the curriculum. This can also occur where participants maybe have had their baby for a couple of months and feel that they have a handle on things, and as such, believe they do not need home visiting services anymore.

“I think, like, knowledge level of some because for some [participants] that they do their own studying of reading books and using other resources to educate themselves on things.”

Paperwork Demands: Staff discussed that paperwork demands can also be a burden to program participants. Having different forms and questionnaires that the participant has to fill out at different time points sometimes take away from the visit and could affect participants’ continued participation. Sometimes, paperwork demands interact with the stage at enrollment. For example, participants who enroll in pregnancy are able to complete a lot of paperwork at that time and tend to have less paperwork after the baby comes, which is a really busy time for the family.

“It becomes a burden to the [participant]. It’s no longer seen as a fun program. It’s seen as homework or a chore because it’s lacking in activities.”

Strategies to Address Barriers

During discussions, staff identified various strategies that they already used to address some of the challenges to engagement and retention described above. These strategies included conducting unscheduled visits, providing resources and referrals, scheduling visits to fit the family's unique situation, and giving participants some personal time.

Unscheduled Visits: When a lack of commitment was identified (e.g., participants canceling visits and not showing up for a scheduled visit), home visitors explained that they may stop by the home to check in with the participants. This “drive-by” refers to stopping by and checking in on a participant when there has not been adequate contact. Home visitors discussed that a “drive-by” could result in a visit if the program participant is available, and in cases where the participant is not there they leave information for the participant. Despite the benefits of unscheduled visits, it was explained that this strategy also has a downside because it could lead to home visitors walking in on a less than ideal situation like a fight in the home.

“They’re cancelling every once in a while is one thing, but some of them cancel almost every visit... we do drive-bys. Sometimes you can stop by randomly [laughter] and catch them, and they’re willing to do a visit which works.”

Providing Resources and Referrals: Home visitors provide a multitude of resources and referrals to support the families they work with. Specifically, they mentioned multiple situations where there was a problem with housing issues or living arrangement; home visitors helped by providing resources and referrals for housing, or financial assistance for rent during difficult times.

Flexible Scheduling and Location: One theme that was mentioned across all focus groups was flexibility in scheduling visits. Most home visitors work around their participants’ schedules to ensure that they implement the minimum recommended number of visits for that participant. This was seen as a particularly useful strategy in cases where there are conflicting priorities. Sometimes, family members within the home could interfere with home visiting by acting as a gateway to the participant; home visitors found that engaging those gatekeepers helped to

“Sometimes they might live with some relative and they don’t want us to go to the house, so we’ll have to meet somewhere else...”

smoothen provision of services to the program participant. Home visitors are also flexible and sometimes meet up with participants in public places in situations where the home environment is not conducive for the visit.

Giving Participants Personal Time: For individuals with substance abuse, mental health issues, and intimate partner violence, besides providing resources for these particular issues, program staff mentioned sometimes giving the participant time to process their situation after an intense discussion or intervention. After providing this brief period of time, the home visitor “re-engages” with the program participant.

CONCLUSION AND RECOMMENDATIONS

Home visiting staff discussed their perceptions of engagement and retention, as well as facilitators and barriers to engaging and retaining participants in the Florida MIECHV program. Additionally, strategies that were already being implemented to facilitate participant engagement and retention were also shared. The use of various strategies to engage and support participants shows a certain level of commitment to keeping participants in the program and subsequently improving family outcomes. Engagement and retention are crucial aspects of home visiting programs, and it is necessary to enhance facilitators and minimize barriers to engagement and retention of participants in the program. Specifically, it is recommended that MIECHV programs promote:

1. Relationship-building skills to foster a connected and trusting relationship between home visitors and participants by increasing positive and effective communication and facilitating active participation.
2. A supportive environment (i.e., available resources and supervisor/administrator support) that enables home visitors to provide individualized services to participants.
3. Ways to address factors that affect staff retention to minimize turnover or disruption in participant-staff relationships.
4. Effective crisis management strategies and provisions made so home visitors are trained and empowered to support parents during periods of stress or crises.

References

- Ammerman, R. T., Stevens, J., Putnam, F. W., Altaye, M., Hulsmann, J. E., Lehmkuhl, H. D., ... & Van Ginkel, J. B. (2006). Predictors of early engagement in home visitation. *Journal of Family Violence*, 21(2), 105-115.
- Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. (2016). Florida MIECHV census report. Retrieved online at <http://flmiechv.com/wp-content/uploads/January-2015-MIECHV-Census-Report-Summary.pdf>
- Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. (2017). Florida MIECHV census report. Retrieved online at <http://flmiechv.com/wp-content/uploads/CDQR-Summary-January-2017.pdf>

Individual- and Program-Level Characteristics and Participant Retention in the Florida Maternal, Infant, & Early Childhood Home Visiting Initiative Programs



Rema Ramakrishnan, Cynthia Horwitz, & Jennifer Marshall
University of South Florida College of Public Health, Department of Community & Family Health, Chiles Center for Healthy Mothers and Babies

SUMMARY

The objectives of this study were to examine program- and participant- level characteristics associated with participant retention (survival) in the Florida MIECHV programs and determine if the retention of participants differed by time of enrollment, the home visiting model, and across program sites. Data for 2,348 women enrolled in the program from April 2013 - September 2016 from 12 MIECHV sites were retrieved from the Florida Home Visiting Information System. Analyses included descriptive statistics and multilevel survival analyses using shared frailty model for clustered survival data*.

Fifty percent of the participants remained in the program for 366 days during the study period. More than half of the participants disenrolled from the program before completion. The primary reason for attrition of participants from the Florida MIECHV program was lost to follow up (57.6%). Among Healthy Families Florida (HFF) participants, **maternal age** (hazard ratio [HR] = for 25-29 years = 0.46 (95%CI: 0.22, 0.98), 30-34 years = 0.20 (95%CI: 0.06, 0.68) compared to maternal age <20 years) was protective of and **current/history of substance abuse** was a risk factor (HR = 2.40, 95%CI: 1.36, 4.25) for participant attrition from the program. Like HFF, advanced maternal age and current/history of substance abuse were predictors for attrition for Parents as Teachers (PAT) participants. Besides these factors, **part-time employment** compared to being unemployed was a risk factor (HR = 2.41, 95%CI: 1.03, 5.64), whereas an **average of more than one home visit/month** was protective of participant attrition from the program (HR for >1.0 – 1.5 average home visits/month = 0.44, 95%CI: 0.33, 0.59, >1.5 – 2.0 average home visits/month = 0.35, 95%CI: 0.25, 0.49, > 2.0 average home visits/month = 0.61, 95%CI: 0.42, 0.88 compared to an average of ≤1.0 home visit/month). Among Nurse-Family Partnership (NFP) participants only, **maternal education** (HR for ≥ high school education = 1.95, 95%CI: 1.07, 3.53 compared to <high school education) was also predictive of attrition.

The multilevel survival analysis of participant- and program- level characteristics and participant survival found several factors predictive or protective for attrition from the program. Specifically, **enrollment during pregnancy** (HR = 0.74, 95%CI: 0.56, 0.98 compared to enrollment after birth), **advanced maternal age** (HR for 25-29 years = 0.63 (95%CI: 0.45, 0.87), 30-34 years = 0.47 (95%CI: 0.33, 0.69), 35+years = 0.52, (95%CI: 0.34, 0.80) compared to age <20 years), and an **average of more than one home visit/month** (HR for >1.0 – 1.5 average home visits/month = 0.45, 95%CI: 0.35, 0.58, >1.5 – 2.0 average home visits/month = 0.32, 95%CI: 0.24, 0.42, > 2.0 average home visits/month = 0.49, 95%CI: 0.36, 0.68 compared to ≤1.0 average home visit/month) protective factors. Additionally, **current/history of substance abuse** (HR = 1.84, 95%CI: 1.34, 2.52) was a risk factor for participant attrition.

The multilevel analysis examining attrition at three months post – enrollment also found **maternal depression** (HR= 0.14, 95%CI: 0.03, 0.73) and receipt of **> 2.0 average home visits/month** (HR= 9.58, 95%CI: 1.93, 47.46 compared to ≤1.0 average home visit/month) protective of and **perceived parental stress** as a risk factor (HR= 1.10, 95%CI: 1.01, 1.20) for attrition at three months post - enrollment.

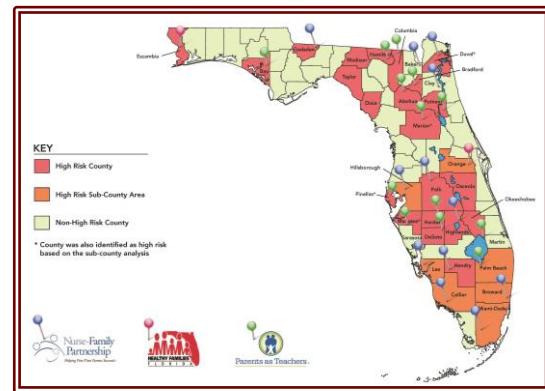
Furthermore, multilevel survival analysis by time of enrollment found factors significant for those enrolled during pregnancy versus after the child was born. For those enrolled during pregnancy or after birth, **Advanced maternal age** compared to age <20 years (during pregnancy: HR for age 25-29 years = 0.44, 95%CI: 0.25, 0.78; after birth: HR for age 30-34 years = 0.42, 95%CI: 0.26, 0.67 and age 35+ years = 0.50, 95%CI: 0.30, 0.85) and an **average of more than one home visit/month** (during pregnancy: HR for >1.0 – 1.5 average home visits/month = 0.55, 95%CI: 0.34, 0.88, >1.5 – 2.0 average home visits/month = 0.26, 95%CI: 0.15, 0.46, > 2.0 average home visits/month = 0.47, 95%CI: 0.27, 0.83 compared to ≤1.0 average home visit/month; and after birth: HR for >1.0 – 1.5 average home visits/month = 0.43, 95%CI: 0.32, 0.58, >1.5 – 2.0 average home visits/month = 0.34, 95%CI: 0.24, 0.49, > 2.0 average home visits/month = 0.53, 95%CI: 0.37, 0.78 compared to ≤1.0 average home visit/month) were protective. Also, only for participants enrolled during pregnancy, **Maternal employment** (HR of part-time employment compared to unemployed= 0.57, 95%CI: 0.36, 0.91) and having **public insurance** (HR = 0.62, 95%CI: 0.42, 0.91 compared to having no insurance) were protective, i.e. significant predictors of participant retention in the

Florida MIECHV program. For participants enrolled during pregnancy or after birth, a **current/past history of substance abuse** was a significant risk factor for attrition (HR = 2.00, 95%CI: 1.17, 3.44 and after birth: HR = 1.97, 95%CI: 1.35, 2.87). Results of this study may enable MIECHV stakeholders to focus on the predictors of participant survival in the program. The results also indicate that these predictors may differ by time of enrollment and type of home visiting model.

*[Note: Hazard ratio >1 indicates increased risk of attrition from the program; hazard ratio <1 corresponds to decreased risk of participant attrition from the program. Confidence interval implies precision of the estimated risks (narrow interval = more precise, wide interval = less precise)]

BACKGROUND

The Florida MIECHV initiative currently serves 25 high-need communities and four contiguous areas across Florida through three evidence-based home visiting models, Nurse-Family Partnership (NFP), Healthy Families Florida (HFF), Parents as Teachers (PAT). Improving participant completion rates is vital for achieving the goals of the Florida MIECHV, as those who drop out do not receive the intended number of home visits thereby potentially reducing the positive impacts and cost-effectiveness of the program.¹ However, participant engagement and retention may be a two-edged sword since the predictors of low participant retention may be identical to MIECHV target population characteristics (maternal and child health risk factors). For example, retention rates in previous studies have found individual - level characteristics including maternal age ≤ 18 years, African-American race, being unmarried², lower maternal education, maternal smoking during pregnancy,³ postnatal depression, residential instability, and limited English language proficiency⁴ as risk factors for early attrition and low engagement of participants in a home visiting program.



Program - level factors like increased staff turnover⁴ and shorter length of home visitor employment² may lead to increased participant attrition rates whereas increased rapport with the home visitors and linkage of families to community resources such as mental health services, housing assistance, and child care may lead to increased retention of these participants in the program.⁵ In addition, families are more likely to remain engaged when they need resources and the home visitor can provide resources that the family perceives as beneficial. In contrast, when families perceive that the benefits and resources do not outweigh their time investment in the program they are more likely to drop out.⁶ Additionally, it has been found that participants who experience a bond with their home visitor are more motivated to remain engaged, especially when the home visitor allows for collaboration and input.¹ An experienced home visitor is more likely to uphold a relationship with participants and tailor programs to their individual needs.⁷ In addition to the above factors that may influence participant retention in a home visiting program, provision of culturally modified programs with family systems' factors,^{1,4-6,8} and the ability of the home visitor to modify and adapt the curriculum to be more culturally sensitive may lead to increased retention and rapport of participants.^{4,5,8}

The purpose of this study was to answer the following questions:

Does the retention of participants in the Florida MIECHV program vary by time of enrollment, home visiting model, and across program sites?	Which participant- and program-level characteristics determine participant overall retention in the program?	Which participant- and program- level characteristics determine 3-month and 12-month survival of participants in the program?	Do participant- and program-level characteristics that determine participant retention in the program vary by time of enrollment?	Which participant characteristics determine retention in the program for each home visiting model in the Florida MIECHV?
---	--	---	---	--

METHODS

Data for 2,348 women enrolled in the program from April 2013 – September 2016 from 12 MIECHV sites were retrieved from the Florida Home Visiting Information System using the database, Efforts to Outcome (ETO). Participants were included in the study if they were enrolled in sites that had information for program - level characteristics. Consequently, 16 counties from 12 sites were included in the study. Participants were included in the study if they had received at least one home visit during the study period. Additionally, only female participants were included in the study as there were only 12 male participants enrolled during the study period and they were not evenly distributed across program models.

Variables for Analysis

Program – level variables



- Age of the program in days (how long the program was in existence)
- Home visiting model (HFF, NFP, and PAT)
- Median days of staff employment

Participant – level variables

- Maternal age
- Maternal race/ethnicity
- Maternal education
- Maternal employment
- Marital status
- Household poverty
- Primary language spoken at home
- Current/history of maternal substance abuse
- Maternal depression
- Health Insurance
- History of childhood abuse/neglect
- Outcome of screening for intimate partner violence
- Perceived parental stress
- Average number of home visits received/month

Some participant characteristics were measured only at specific time points. For example, the Perceived Stress Scale (PSS) was completed at two and 12-months post - enrollment for those who enrolled after the birth of their child and at child age two and 12 months for those enrolled during pregnancy. Therefore, those who enrolled during pregnancy but had not given birth at the end of the study period did not have measurements for the PSS. Similarly, variables like maternal depression and intimate partner violence (IPV) were measured at specific time points that varied between models.

Maternal age was categorized in years as <20, 20-24, 25-29, 30-35, and 35+; maternal race/ethnicity was categorized into White Non-Hispanic, Black Non-Hispanic, Hispanic, and other; maternal education was dichotomized into less than high school and \geq high school; maternal employment was classified into unemployed, part-time, and full- time; maternal marital status was dichotomized into single/separated/widowed and married/co-habitation; primary language spoken at home was categorized into English, Spanish, and other; and health insurance was categorized into uninsured, public, private, and other. Household poverty was expressed as living below the 100% Federal Poverty Level (FPL), current/history maternal substance abuse, history of childhood abuse/neglect, and outcome of screening for IPV were each dichotomized into no and yes. Maternal depression was based on the results of the Edinburgh Postnatal Depression Scale and a score ≥ 10 was defined as being positive for depression. Parental stress was measured by the 10 - item version of the PSS. The scores for this variable were obtained by reversing the responses to the four positively stated items (items 4, 5, 7, & 8) and then summing all ten scale items.⁹ It was retained as a continuous variable for the analysis. The average number of home visits per month was categorized into four levels (≤ 1.0 , $> 1.0 - 1.5$, $> 1.5 - 2.0$, and > 2.0) that approximately corresponded to the quartiles of frequency of home visits observed in this sample. The initiative requires an average of 2 home visits per month. In addition to the participant - and program - level

variables described above, we also obtained data about dates of program enrollment and termination, and the reason for dismissal from the program. Reason for dismissal from the program was categorized into: lost to follow-up, missed appointments, program-related, infant death, legal, dropout due to other reasons (that is, reasons other than lost to follow-up, missed appointments, program-related, infant death, and legal), and unknown reasons.

Statistical Analysis

Univariate descriptive statistics were computed for all the variables. Then, bivariate statistics were computed by time of enrollment and home visiting model; chi-square or Fisher's exact statistic for categorical variables and two-sample/ANOVA or Mann-Whitney U/Kruskal Wallis test was used for continuous variables.

Only participants with data for all variables were included in the survival analyses. The survival patterns were examined using Kaplan-Meier survival curves. We plotted survival curves for the entire sample and then stratified by time of enrollment, home visiting model, and program sites. We then plotted separate survival curves for each of the 12 sites. Cox proportional hazard regression models (with modified code for left truncated data) were then used to calculate hazard ratios of selected participant characteristics by the type of home visiting model. Multilevel survival analyses were then conducted to examine participant - and program - level characteristics for the entire sample as well as by time of enrollment. For this purpose, a shared frailty model was used. Shared frailty models are mixed proportional hazard models that account for within-group correlations.¹⁰

Participants within each site are more likely to share certain characteristics due to the similarity in the way the program is delivered at that site. For the analyses, we also accounted for left-truncated data. The frailty model survival estimates were computed for the entire study period and at three and 12 months post-enrollment. The event of interest was dropout from the program. For the entire sample, any participant who completed the study or remained in the program on September 30, 2016 was considered censored (not considered 'dropout'). For 3-month, 6-month, and 12-month survival analyses, any participant who remained in the program at three, six, and 12 months post-enrollment was considered censored. All analyses were conducted using the SAS 9.4 statistical software (SAS Institute Inc., Cary, NC, USA).

RESULTS

Descriptive data and survival curves were available for 2,348 participants; however, for multivariable survival analyses we had full data only on 1,033 participants. Table 1 (at the end of the report) demonstrates results of univariate statistics of participant and program characteristics. The majority of participants had enrolled during pregnancy (53.7%), had ≥ high school education (61.9%), public insurance (77.2%), lived below 100% FPL (71.1%), were unemployed (73.0%), single/widowed/separated (81.0%), Black Non-Hispanic (42.3) and Non-Hispanic (69.8%), did not have a history of substance abuse (80.0%) and childhood abuse/neglect (75.6%), screened negative for IPV (88.7%) and maternal depression (80.2%), and reported speaking English as the primary language spoken at home (79.1%). About 29% of the participants received on an average > 2.0 home visits/month. The mean perceived stress score was 12.2 (standard deviation [SD] = 7.6). The median age of the Florida MIECHV programs was 972 days and median number of days that the staff was employed was 653. The home visiting model that had the largest number of participants in this study was PAT (40.9%) closely followed by NFP (40.1%), then HFF (19%).

Enrolled during pregnancy (53.7%)	≥ High school education (61.9%)	Public insurance (77.2%)	Below 100% FPL (71.1%)	Unemployed (73.0%)
Single (81.0%)	No maternal depression (80.2%)	No reported history of substance abuse (80.0%)	No reported childhood abuse/neglect (75.6%)	No reported IPV (88.7%)
Black Non-Hispanic (42.3%)	Non-Hispanic (69.8%)	English as the primary language spoken at home (79.1%)	Mean perceived stress score (12.2)	Average home visits/month ≤1.0 (25.7%) >1.0–1.5 (23.6%) >1.5–2.0 (22.1%) > 2.0 (28.6%)

When stratified by time of enrollment, the characteristics of the participants were similar to the overall sample with few exceptions. There were significant differences in all individual - and program - level characteristics between participants who were enrolled during pregnancy and after delivery/birth except for maternal depression, IPV, and average home visits/month. The mean PSS score was higher among participants who enrolled after delivery compared to those who enrolled during pregnancy (12.9 versus 11.3). Not surprisingly, most of the participants who enrolled during pregnancy (74.2%) were from NFP programs whereas the majority who enrolled after delivery were from programs implementing the PAT model (79.4%) (Table 2).

Table 3 demonstrates the results of participant characteristics by the type of home visiting model. All the associations followed a similar trend as for the overall sample except that women who identified as Black Non-Hispanic formed a majority for HFF (52.9%) and NFP (57.0%), but not for PAT (24.4%). In addition, compared to the overall sample, PAT participants reported a higher percentage of current/history of substance abuse (37.0%). When one examined the average home visits per month, more than half of HFF participants received >2/month whereas, for NFP and PAT, no specific trends were observed for average home visits/month.

Rates of Participant Retention

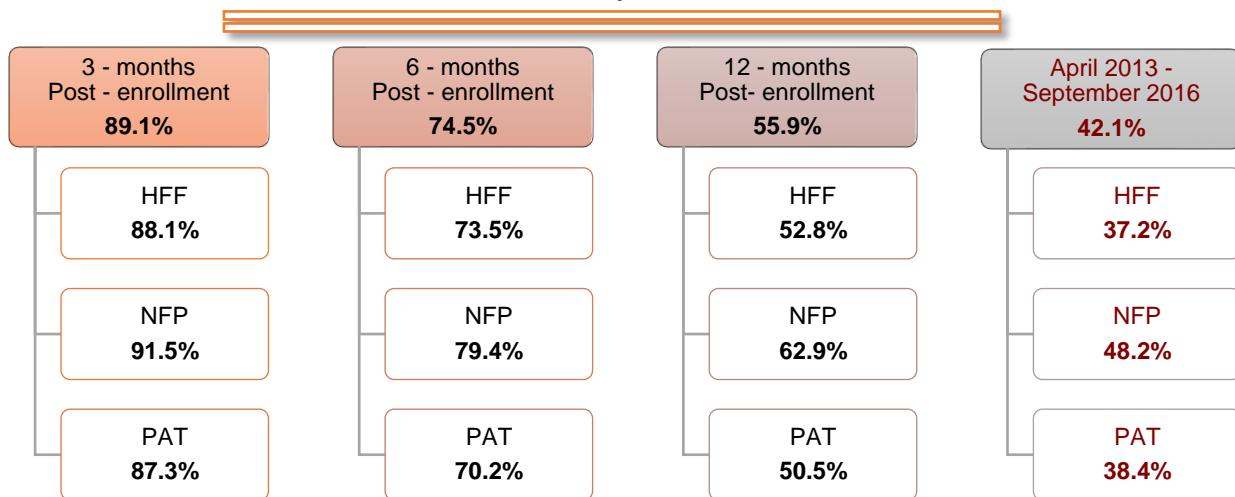


Figure 1. Participant Retention Rates in the Maternal, Infant, and Early Childhood Home Visiting Program at Various Time Points, Overall and by Type of Home Visiting Model

At all time points, participant retention rates were highest for NFP followed by HFF except when examined by the period, April 2013 – September 2016 when the retention rate for PAT was 1.2 percentage points higher than that for HFF.

Reasons for Participant Attrition

Out of 1,362 (57.9%) participants who dropped out of the program, the leading reasons were: lost to follow up (57.6%), repeated missed appointments (11.5%), and dropped due to unknown reasons (11.5%) (Figure 2). An interesting finding was that 3.1% were dropped due to reasons that were program-related; for example, home visitor safety, inability to accommodate requested schedule, and participant's refusal of new home visitor (note: one participant had no information for dismissal from the program). When the reasons for participant attrition were examined by type of home visiting model, lost to follow up remained the primary reason for program attrition for all models. However, for HFF lost to follow up (48.7%) was followed by dropout due to other reasons (32.7%). For NFP, lost to follow up (61.3%) was followed by missed appointments (17.2%); whereas, for PAT, lost to follow up (58.6%) was followed by dropout due to unknown reasons (21.5%) (Table 4).

HFF: Lost to follow up (48.7%)
Dropout due to other reasons (32.7%)

NFP: Lost to follow up (61.3%)
Missed appointments (17.2%)

PAT: Lost to follow up (58.6%)
Dropout due to unknown reasons (21.5%)

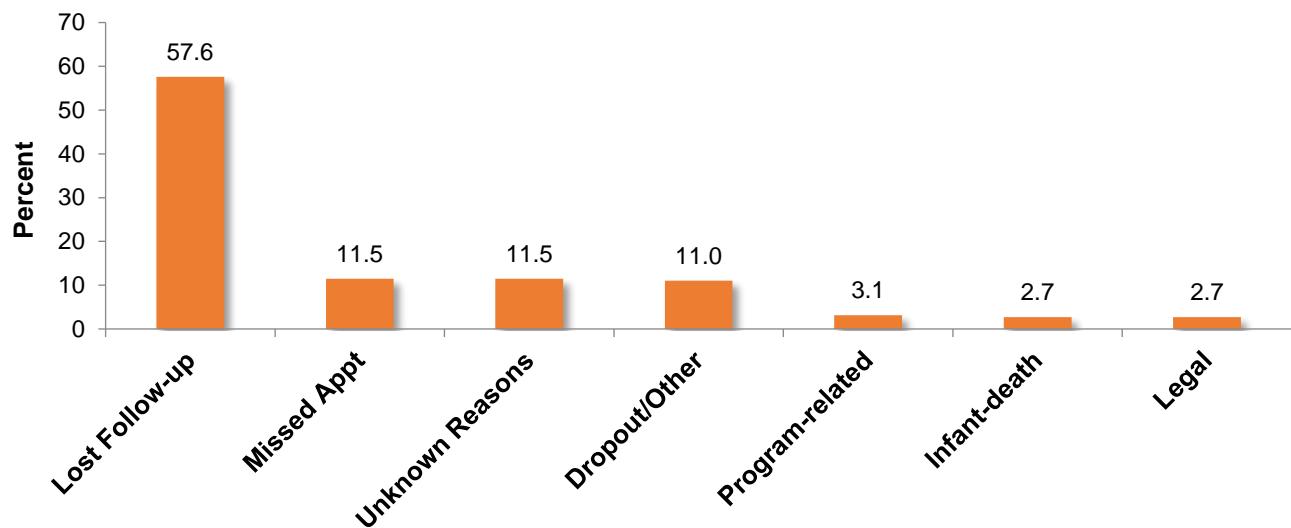


Figure 2. Reasons for Participant Attrition from the Maternal, Infant, and Early Childhood Home Visiting Program, 2013-2016

Survival Patterns of MIECHV Participants: Retention Factors

Overall Survival Curve

Figure 3 illustrates the survival [retention] rate of participants and the median survival time [length of enrollment/retention]. As noted above and in this figure, 42.1% of participants either completed or remained in the program for their respective model's intended duration. The median survival was 366 days (95% confidence interval [CI]: 347, 386) indicating that 50% of the participants remained in the program for 366 days.

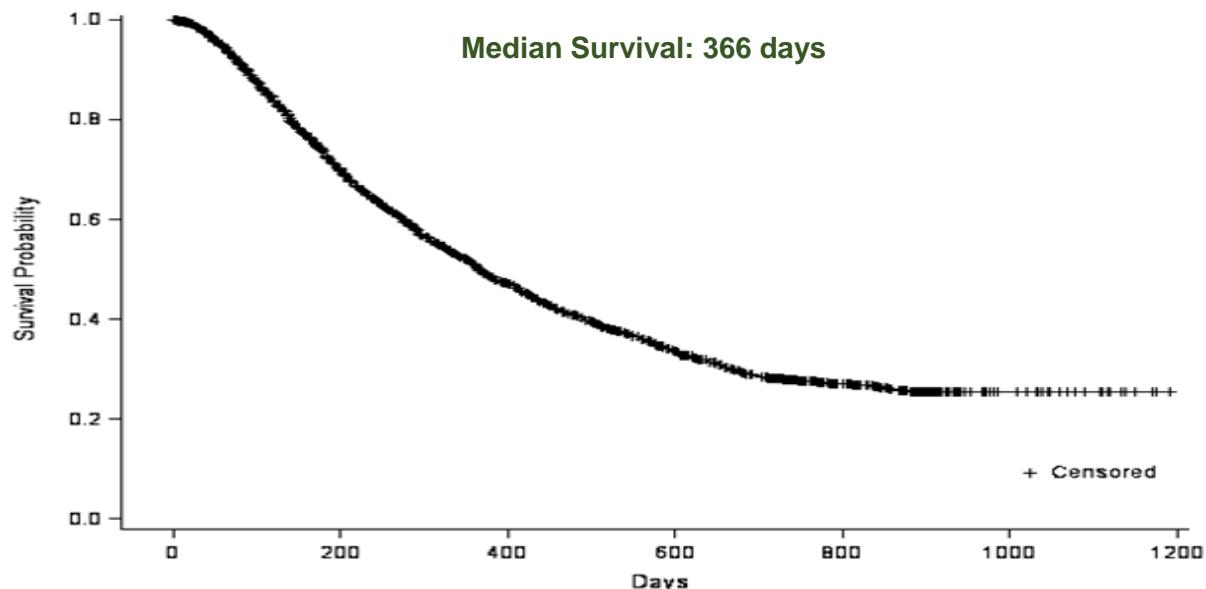


Figure 3. Crude Survival Curve of Participants in the Maternal, Infant, and Early Childhood Home Visiting Program, 2013-2016

Survival Curves by Time of Enrollment

Figure 4 demonstrates survival rates of participants and the median survival time by time of enrollment. Among participants who enrolled during pregnancy, 43.5% either completed or remained in the study whereas, among participants who enrolled after delivery/birth, 40.5% either completed or remained in the study and this difference in survival rates was significant (p -value =0.03). The median survival time was higher among women who enrolled during pregnancy compared to women who enrolled after delivery/birth (408 days (95% CI: 369, 436) versus 325 days (95%CI: 293, 357)).

During pregnancy
Retention rate: 43.5%
Survival time for 50% participants: 408 days
After delivery/birth
Retention rate: 40.5%
Survival time for 50% participants: 325 days

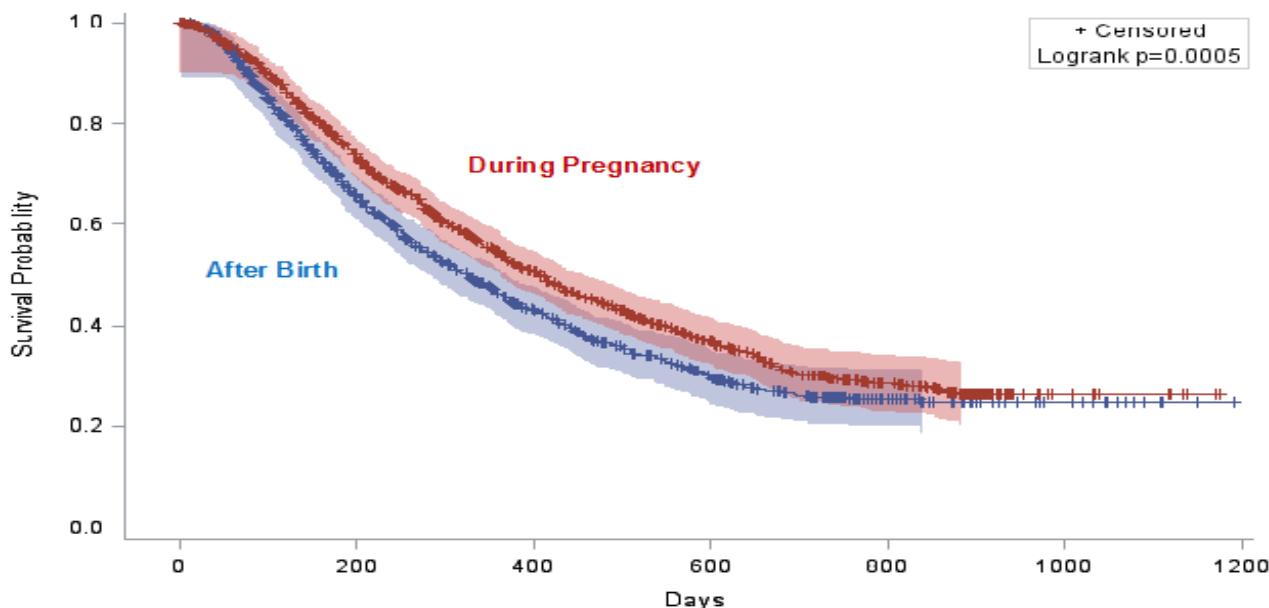


Figure 4. Crude Survival Curves (with 95% Confidence Interval Bands) of Participants in the Maternal, Infant, and Early Childhood Home Visiting Program, 2013-2016, by Time of Enrollment

Survival Curves by Home Visiting Model

HFF
Retention rate: 37.2%
Median survival time: 333 days
NFP
Retention rate: 48.2%
Median survival time: 462 days
PAT
Retention rate: 38.4%
Median survival time: 308 days

(462 days, 95%CI: 419, 510) followed by HFF (333 days, 95%CI: 292, 381) and PAT (308 days, 95%CI: 279, 341).

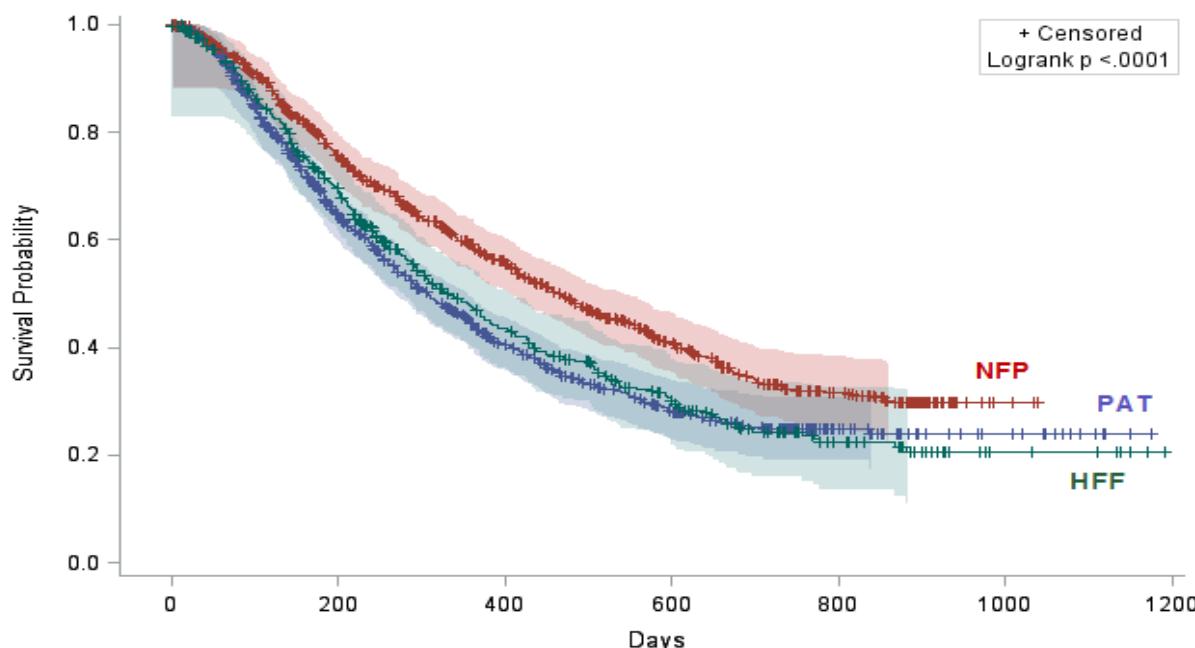


Figure 5. Crude Survival Curves (with 95% Confidence Interval Bands) of Participants in the Maternal, Infant, and Early Childhood Home Visiting Program, 2013-2016, by Home Visiting Model

Survival Analysis by Home Visiting Model

Increased Retention

- Advanced maternal age (HFF& PAT)
- An average of more than one home visit/month (NFP and PAT)

Increased Attrition

- Current/history of substance abuse (HFF & PAT)
- ≥ high school education (NFP)
- Part-time employment (PAT)

The Cox proportional hazard regression results by home visiting model revealed **advanced maternal age** (HFF and PAT), **current/history of substance abuse** (HFF and PAT), an **average of more than one home visit/month** (NFP and PAT), **employment** (PAT), and **maternal education** (NFP) to be associated with participant retention in the Florida MIECHV program (Table 5). Among HFF participants, women aged 25-29 years and 30-34 years had 54% and 80%, respectively, lower risk of leaving the program before completion compared to women who were <20 years.

Among PAT participants, the risk was 51% and 42% lower among women aged 30-34 years and 35+ years respectively, compared to younger women (aged <20 years). Among women who were enrolled in HFF, those with current/history of substance abuse had 2.40 times as high risk as women who did not have a current/history of substance abuse to leave the program whereas among PAT participants, this risk was 2.02. A finding noted only among PAT participants was that, mothers who had part-time employment were 2.41 times more likely to leave the program compared to mothers who were unemployed. Maternal education was predictive of participant attrition from the program only among NFP participants, with mothers with \geq high school education 1.95 times more likely to leave the program compared to mothers who had less than high school education.

In addition to these factors, increased frequency of home visits was associated with increased retention of participants among NFP and PAT participants. Among NFP participants, the greatest protective effect was women who received on an average 1.5 - 2.0 home visits/month were 88% less likely to leave the program compared to those who received \leq 1.0 average home visits/month. For PAT participants, also, the greatest protective effect was observed for receipt of 1.5 – 2.0 average home visits/month as these women were 65% less likely to leave the program compared to those who received \leq 1.0 average home visits/month. However, for HFF participants there was no evidence for an association between average monthly home visits and participant attrition from the program. All analyses were recalculated after removing the data for PAT+ in Pinellas County (which had a high percentage of women with substance abuse) and results overall and by model were the same.

Multilevel-Survival Analysis for 2013-2016

Increased Retention

- Enrollment during pregnancy
- Mothers aged 25+ years
- An average of more than one home visit/month

Increased Attrition

- Current/history of substance abuse

The multilevel survival analysis of participant - and program - level characteristics and participant survival using the shared frailty model revealed **enrollment during pregnancy, advanced maternal age, current/history of substance abuse, and an average of more than one home visit/month** to be associated with participant retention in the Florida MIECHV program (Table 6). Women who enrolled during pregnancy had 36% lower risk of leaving the program compared to women who enrolled after delivery/birth. Women aged 25-29 years and 30-34 years had 37% and

53% lower risk, respectively, of leaving the program in comparison to women <20 years old. Likewise, women who were more than 35 years of age had 48% lower risk of leaving the program compared to women who were <20 years old. For average home visits/month, an average of more than one home visit/month was associated with participant retention in the program. The highest protective effect was observed for receipt of >1.5 – 2.0 average home visits/month with participants who received on an average 1.5-2.0 home visits/month 68% less likely to leave the program compared to those who received on an average \leq 1.0 home visits/month. In contrast to this, women with a current/history of substance abuse were 1.84 more likely to leave the program prematurely as women without a current/history of substance abuse.

Predictors of 3-Month Survival

Increased Retention

- Maternal Depression

Increased Attrition

- Increased perceived parental stress
- An average of more than two home visit/month*

The 3 – month survival analysis revealed **maternal depression, perceived parental stress, and an average of more than two home visits/month** as significant predictors of attrition at three months post-enrollment (Table 7). In the first three months post-enrollment, maternal depression was associated with 86% lower risk of dropout from the program. Every unit increase in the PSS score was associated with a 10% increase in risk of dropout from the program in the first

three months. In addition to perceived parental stress, women who received on an average more than two home visits/month had 9 times as high a risk of leaving the program compared to women who received an average of ≤ 1.0 home visits/month (this finding should, however, be interpreted with caution due to the small sample size for this category at 3-months post-enrollment).

Predictors of 12-Month Survival

At 12 months post-enrollment, the only predictors of participant attrition from the program were **advanced maternal age** and an **average of more than one home visit/month** received. Women aged 30-34 years had a 41% lower risk of leaving the program compared to women <20 years old. Women who received on average $>1.0 - 1.5$ and $1.5 - 2.0$ home visits/month were at 31% and 52%, respectively, lower risk of leaving the program compared to women who received an average ≤ 1.0 home visits/month (Table 8).

Increased Retention

- Advanced maternal age
- An average of more than one but less than two home visits/month

*Should be interpreted with caution due to small sample size for this category

on

Multilevel-Survival Analysis for 2013–2016 by Time of Enrollment

The multilevel survival analysis of participant – and program – level characteristics and participant survival by time of enrollment revealed **advanced maternal age, public insurance** (only for participants enrolled after delivery/birth), **current/history of substance abuse**, and an **average of more than one home visit/month** to be associated with participant retention in the Florida MIECHV program (Table 9). Among participants who enrolled during pregnancy, maternal age 25–29 years (compared to maternal age <20 years) was associated with a 56% lower risk of leaving the program whereas among participants who enrolled after delivery, maternal age 30-34 years and 35+ years had 58% and 50%, respectively, lower risk of leaving the program.

DURING PREGNANCY

Protective Factors

- Maternal age: 25- 29 years (compared to age <20 years)
- An average of more than one home visit/month
- Part time employment compared to unemployed

Risk Factor

- Current/history of substance abuse

AFTER BIRTH

Protective Factors

- Maternal age: ≥ 30 years (compared to age <20 years)
- Public insurance (compared to no insurance)
- An average of more than one home visit/month

Risk Factor

- Current/history of substance abuse

Among women who enrolled after delivery/birth, compared to women who had no insurance, women who had public insurance had 38% lower risk of leaving the program. An average of more than one home visit/month was associated with participant retention in the program. The highest protective effect for average home visits/month was observed for $>1.5 - 2.0$ average home visits/month. Women who received on an average 1.5 - 2.0 home visits/month during pregnancy and after delivery/birth were 74% and 66%, respectively, less likely to leave the program compared to women who received on an average ≤ 1.0 home visits/month. Irrespective of the time of enrollment, women who reported current/history of substance abuse had about two times as high a risk of leaving the program as women who reported no current/history of substance abuse.

DISCUSSION & IMPLICATIONS

This study of the Florida MIECHV participants from 12 sites and enrolled during April 2013- September 2016 found that advanced maternal age, enrollment during pregnancy, and receipt of more than one home visit/month on an average was associated with increased retention of participants in the program.

Additionally, current/history of substance abuse was found to be a risk factor for participant attrition, even when removing one site that almost exclusively serves this population.

Specifically, for three-month survival, maternal depression was associated with increased early retention of participants whereas perceived parental stress and receipt of more than two average home visits/month were risk factors for early attrition. The finding that maternal depression is protective for participant attrition from the program is important for stakeholders and researchers because this is something that may need to be further investigated. Connecting women experiencing depression with supports early and frequently may be a critical area of intervention for MIECHV programs, as these services may be otherwise difficult to access for MIECHV populations.

There are several important considerations for cross-model comparisons. Firstly, MIECHV-funded programs comprise a fraction of the populations served in Florida's HFF, NFP and PAT programs. For example, Healthy Families Florida (HFF) is Florida's largest voluntary home visiting program serves nearly 9,960 families and their 18,313 children. The program is available in all 67 Florida counties from Pensacola to Key West: county-wide in 42 counties and in select high-risk zip codes in 25 counties. HFF is a multi-site system of 38 local sites managed by a central administration, which sets policy, provides training and ensures fidelity to the HFA model through technical assistance and quality assurance. There are two HFF MIECHV sites, and only their retention rates for those sites were included in the analysis. While some findings of this report are consistent with the findings from the annual statewide HFF evaluation, some are not. This may be due to the sample size or the consideration of other programmatic or model-specific differences. Secondly, while all Florida MIECHV programs work towards shared benchmarks, and serve families in high-risk communities, models may focus on specific populations (e.g. first time mothers beginning early in pregnancy, parents of infants and toddlers, or parents with substance abuse history, etc.). The expectation of two home visits per month is shared across sites, however there are model-specific practices (dosage, etc.) in place to address early engagement, retention, and expectations for program completion or thresholds for dismissal from the program. Using HFF as an example, the intensity, duration and depth of services also make HFF unique among other home visiting programs in Florida. Newly enrolled participants receive home visits that begin weekly and decrease in frequency as their family makes progress in providing safe, stable and nurturing environments for their children. Families move through levels of service intensity based on their stability and unique needs. Service levels determine the frequency of home visits, ensuring that less-stable families receive more ongoing support.

The predictors of retention of participants during the study period also varied by the type of home visiting model and time of enrollment. In contrast to a study of NFP participants, the current study did not find being African-American and unmarried as risk factors.² Similarly, unlike previous studies^{2,4} the current study did not find program-level factors to be associated with retention of participants in the program. It was notable that lack of English language proficiency was not a barrier to retention. Florida MIECHV serves a linguistically diverse population, with services provided in English, Spanish, and Haitian-Creole.

The strength of this study was that we examined individual- and program-level characteristics associated with participant retention instead of having home visiting dosage as an outcome. The multilevel analyses accounted for the clustering effect (sharing of certain characteristics and experiences due to the participants being enrolled at a particular site) within each site. One of the study limitations was that a more detailed description for dismissal reasons like "dropout" was not available that could have been more informative. A qualitative study completed in 2016 with Florida MIECHV staff explored these dismissal reasons in depth.¹¹ Inclusion of an indicator variable for housing stability would also be useful in future analysis. A weakness of this study is that, since it is based on data from a single state, it could have limited generalizability. In addition, self-reported measures including maternal depression, perceived parental stress, and IPV could all have been underestimated due to social desirability bias. This could have led to non-differential misclassification of the covariates that could have biased the results toward the null.

To increase participant retention, Florida MIECHV may need to focus on engagement and retention of the younger women (particularly those <20 years of age) who are enrolled in the program, and also ensure

that participants receive an average of more than one home visit/month. Recognizing the importance of sufficient dosage, Florida MIECHV requires at least two home visits per month and sites continue to work on increasing participant engagement to meet this threshold, with an average of 1.8 visits/month. Additionally, the initiative may need to concentrate on women with a history of substance abuse, especially among HFF and PAT participants. It is essential to focus on differential predictors of participant attrition between participants enrolled during pregnancy and those enrolled after delivery/birth of child and also by type of home visiting model.

For more information, please contact:

Jennifer Marshall, PhD, CPH, Assistant Professor, Lead Evaluator
University of South Florida College of Public Health, Department of Community & Family Health
Tel: (813) 396-2672 Email: jmarshal@health.usf.edu
Florida MIECHV Evaluation: <http://miechv.health.usf.edu>

This project is supported by the Health Resources and Service Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number D89MC28265, Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsement be inferred by HRSA, HHS, or the U.S. Government.



REFERENCES

1. Ingoldsby, E. M. (2010). Review of Interventions to Improve Family Engagement and Retention in Parent and Child Mental Health Programs. *J Child Fam Stud*, 19(5), 629-645. doi: 10.1007/s10826-009-9350-2
2. O'Brien, R. A., Moritz, P., Luckey, D. W., McClatchey, M. W., Ingoldsby, E. M., & Olds, D. L. (2012). Mixed methods analysis of participant attrition in the nurse-family partnership. *Prev Sci*, 13(3), 219-228. doi: 10.1007/s11121-012-0287-0
3. Latimore, A. D., Burrell, L., Crowne, S., Ojo, K., Cluxton-Keller, F., Gustin, S., . . . Duggan, A. (2017). Exploring Multilevel Factors for Family Engagement in Home Visiting Across Two National Models. *Prev Sci*, 18(5), 577-589. doi: 10.1007/s11121-017-0767-3
4. Maternal, Infant, and Early Childhood Home Visiting. (2015). MIECHV Issue Brief on Family Enrollment and Engagement. In T. A. C. Center (Ed.).
5. Azzi-Lessing, L. (2011). Home visitation programs: Critical issues and future directions. *Early Childhood Research Quarterly*, 26(4), 387-398.
6. Brand, Tilman, & Jungmann, Tanja. (2014). Participant characteristics and process variables predict attrition from a home-based early intervention program. *Early Childhood Research Quarterly*, 29(2), 155-167. doi: <http://dx.doi.org/10.1016/j.ecresq.2013.12.001>
7. Girvin, H., DePanfilis, D., & Daining, C.. (2007). Predicting program completion among families enrolled in a child neglect preventive intervention. *Research on Social Work Practice*, 17(6), 674-685.
8. Korfmacher, J., Green, B., Staerkel, F., Peterson, C., Cook, G., Roggman, L., . . . Schiffman, R.. (2008). Parent involvement in early childhood home visiting. Paper presented at the Child & Youth Care Forum.
9. Cohen, S., & Williamson, G. (1988). Perceived stress in a probability sample of the United States. *The social psychology of health: Claremont Symposium on applied social psychology*. Edited by: Spacapan S, Oskamp S. 1988: Newbury Park, CA: Sage.
10. Van den Berg, G. J., & Drepper, B. (2016). Inference for shared-frailty survival models with left-truncated data. *Econometric Reviews*, 35(6), 1075-1098.
11. Agu, N., Birriel, P. C., Balogun, O., Ajisope O., Patil, A., Heeraman, C. & Marshall, J. (2017). The Florida Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Staff Perception of Engagement and Retention 2016 Site Visit Report. Available at <http://flmiechv.com/what-we-do/measuring-results/>

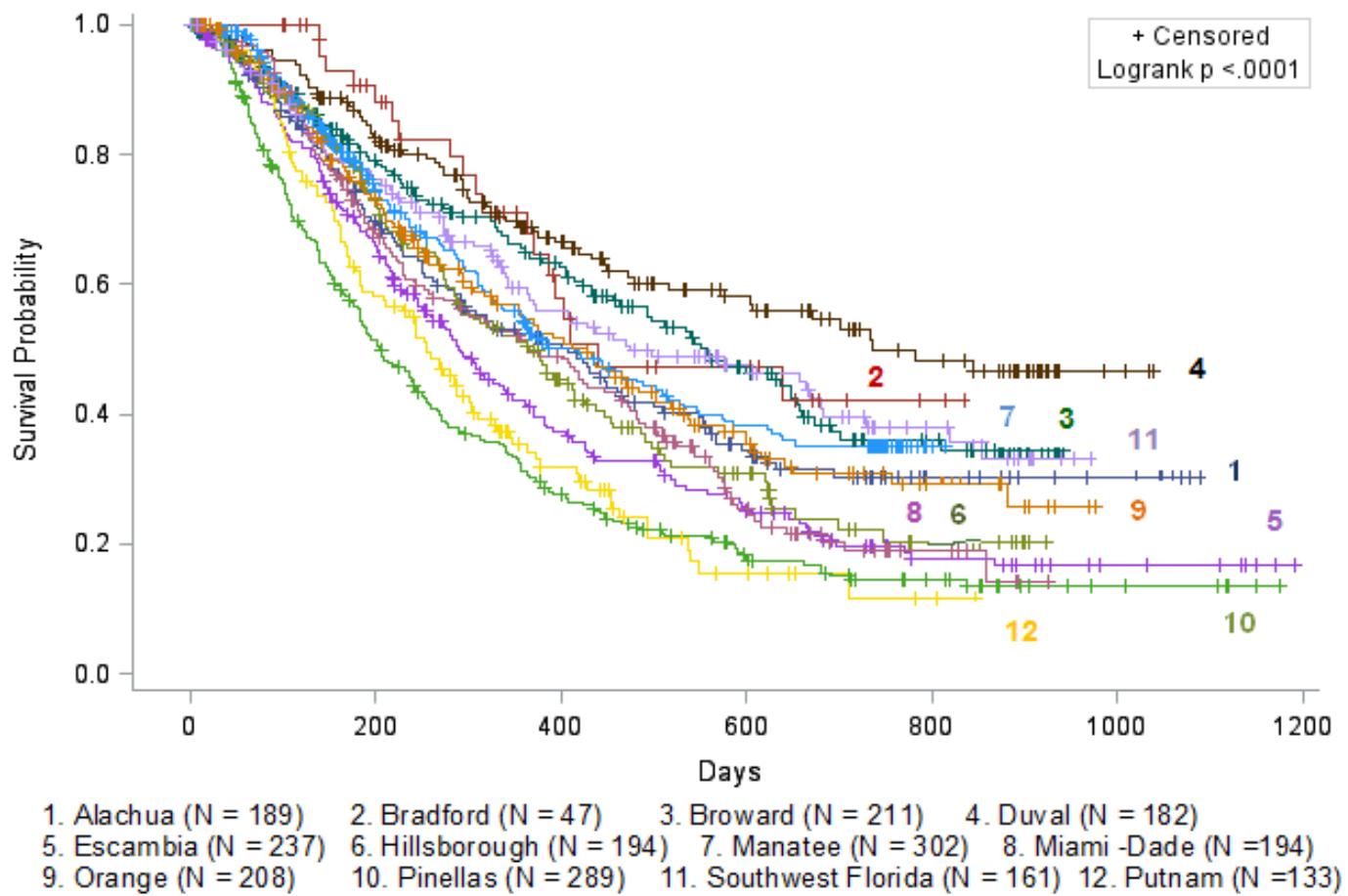
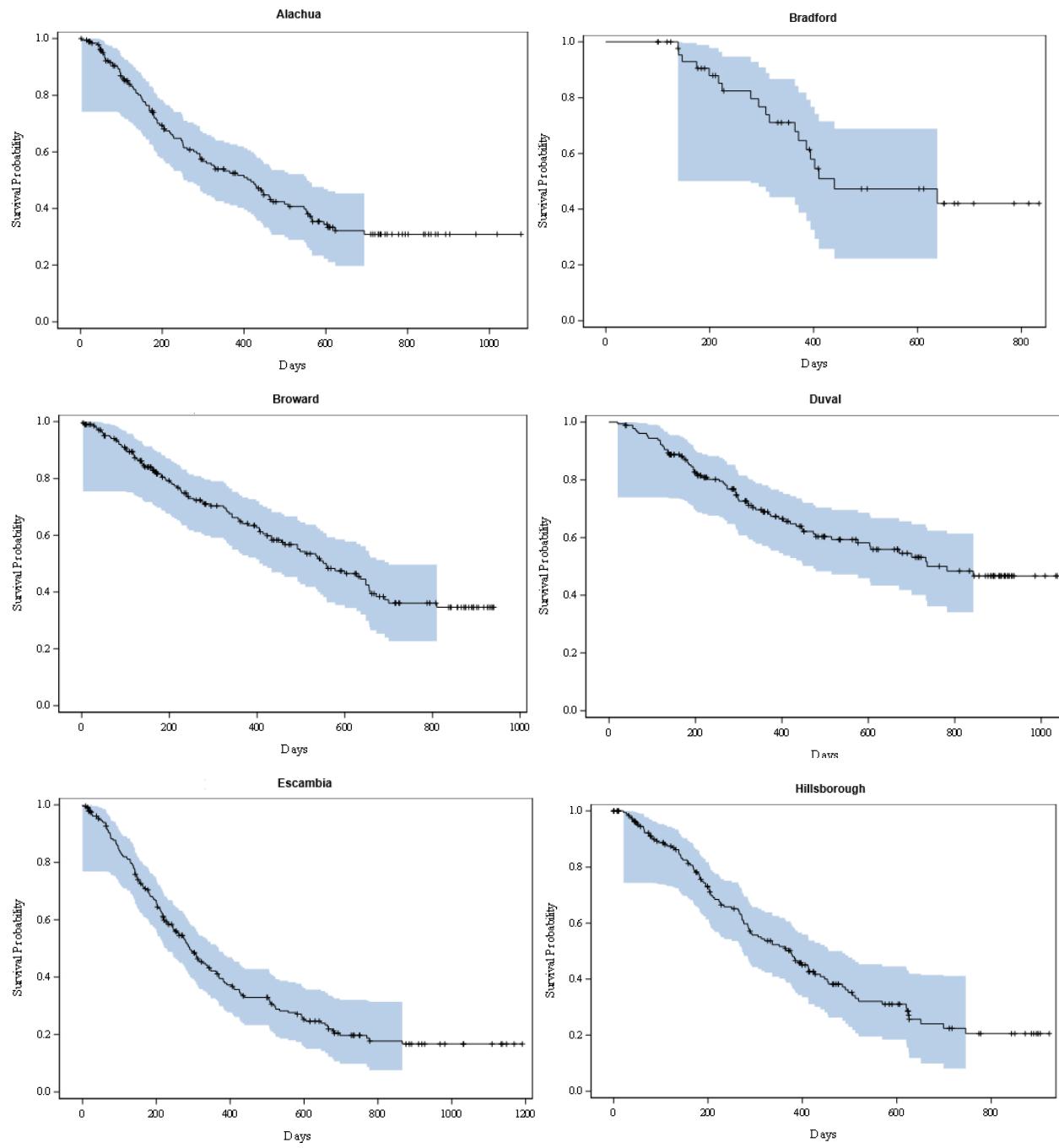


Figure 6. Comparison of Crude Survival Curves (of Participants in the Maternal, Infant, and Early Childhood Home Visiting Program, 2013-2016, by Program Sites



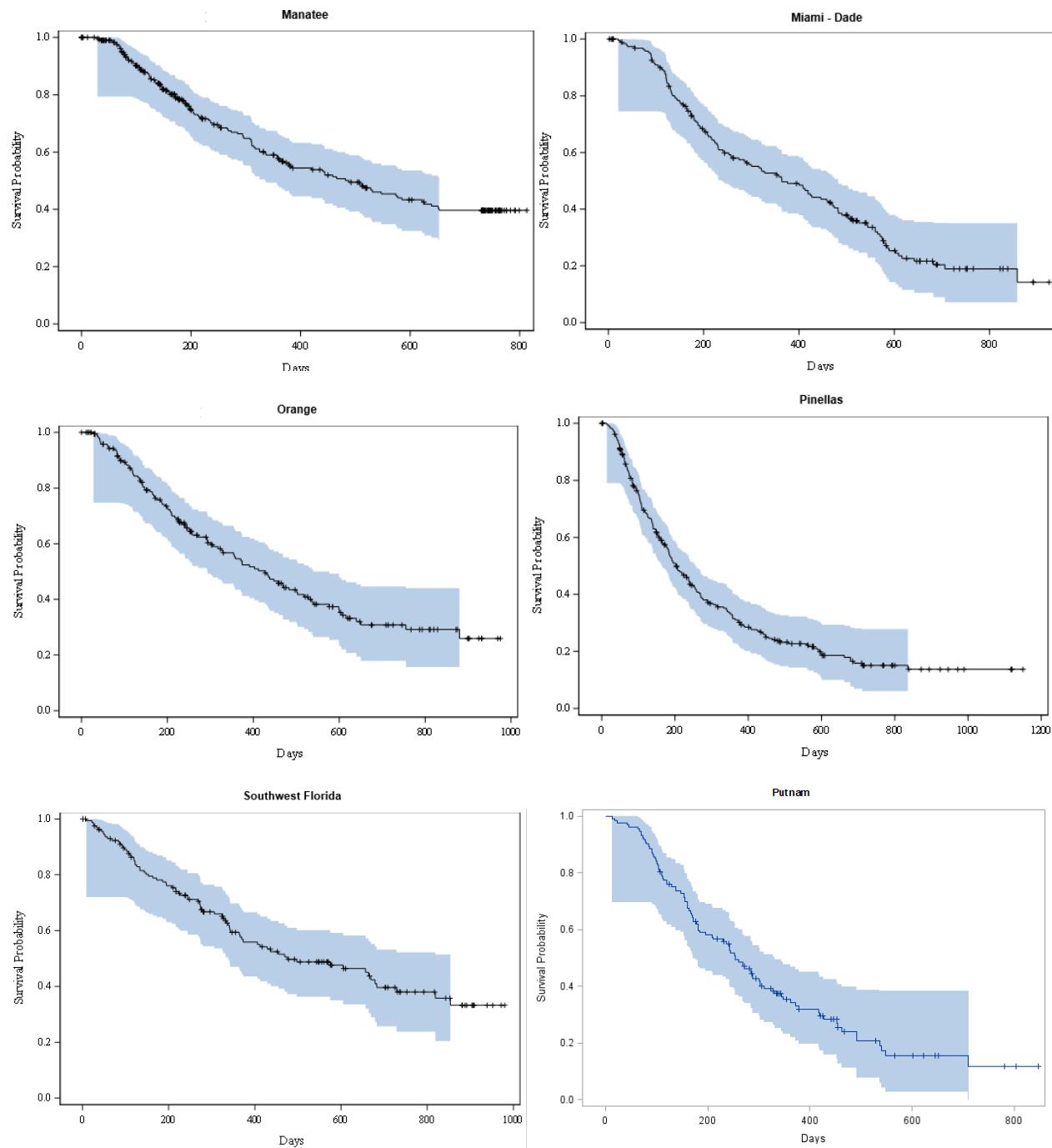


Figure 7. Crude Survival Curves (with 95% Confidence Interval Bands) of Participants in the Maternal, Infant, and Early Childhood Home Visiting Program, 2013-2016, for each Program Site

Table 1. Selected Participant- and Program-Level Characteristics: Florida Maternal, Infant, and Early Childhood Home Visiting Initiative, 2013-2016

Characteristic	N (%) ^a
Participant-Level	
Enrolled during Pregnancy	
No	1,088 (46.3)
Yes	1,260 (53.7)
Maternal Age (years)	
<20	524 (22.3)
20-24	742 (31.6)
25-29	562 (23.9)
30 – 34	344 (14.7)
35 +	176 (7.5)
Maternal Race/Ethnicity	
White Non-Hispanic	645 (27.5)
Black Non-Hispanic	993 (42.3)
Hispanic	643 (27.4)
Other	67 (2.8)
Maternal Education	
Less than high school	764 (38.1)
≥ high school	1,240 (61.9)
Maternal Employment	
Unemployed	1,713 (73.0)
Part-time	376 (16.0)
Full-time	259 (11.0)
Maternal Marital Status	
Single/separated/widowed	1,880 (81.0)
Married/co-habitation	441 (19.0)
Household Poverty (Below 100% FPL)	
No	679 (28.9)
Yes	1,669 (71.1)
Primary Language Spoken at Home	
English	1,858 (79.1)
Spanish	375 (16.0)
Other	115 (4.9)
Health Insurance	
Uninsured	337 (14.3)
Public	1,812 (77.2)
Private	186 (7.9)
Other	13 (0.6)
Current/Past Maternal Substance Abuse	
No	1,858 (80.0)
Yes	469 (20.0)
Maternal Depression ^b	
No	1,276 (80.2)
Yes	315 (19.8)
Current/History of Childhood Abuse/Neglect	
No	1,769 (75.6)
Yes	570 (24.4)
Intimate Partner Violence (Screened Positive)	
No	1,566 (88.7)
Yes	200 (11.3)
Average Home Visits/month	
≤1.0	603 (25.7)
>1.0 – 1.5	554 (23.6)
>1.5 – 2.0	519 (22.1)
> 2.0	672 (28.6)
Perceived Parental Stress (mean score) ^{c,d}	12.2 (7.6)
Program – Level	

Age of the Program (median number of days) ^e	972 (245.0)
Staff Employment (median number of days) ^e	653 (300.0)
Home Visiting Model	
Parents-As-Teachers	960 (40.9)
Nurse-Family-Partnership	942 (40.1)
Healthy Families Florida	445 (19.0)

Abbreviations: FPL = Federal Poverty Level

^aFrequencies may not add to the total due to missing data and percentage may not add to 100% due to rounding.

Column percentages displayed.

^bResults of the Edinburgh Postnatal Depression Scale, score ≥10 was defined as being positive for depression

^cMean and standard deviation

^dMeasured by the10 - item version of the Perceived Stress Scale

^eMedian and interquartile range

Table 2. Selected Participant – and Program – Level Characteristics by Time of Enrollment: Maternal, Infant, and Early Childhood Home Visiting Program, 2013-2016

Characteristic	During Pregnancy (N= 1,260) ^a	After Birth of Child (N=1,088) ^a	P-Value
Participant-Level			
Age (years)			
<20	406 (32.1)	119 (10.9)	
20-24	447 (35.4)	295 (27.1)	
25-29	232 (18.4)	330 (30.3)	<0.001
30-34	115 (9.1)	229 (21.1)	
35 +	61 (4.8)	115 (10.6)	
Maternal Race/Ethnicity			
White Non-Hispanic	205 (16.5)	407 (37.9)	<0.001
Black Non-Hispanic	657 (52.9)	336 (31.3)	
Hispanic	338 (27.2)	305 (28.4)	
Other	41 (3.3)	26 (2.4)	
Maternal Education			
Less than high school	379 (40.7)	385 (35.9)	0.03
≥ high school	553 (59.3)	687 (64.1)	
Maternal Employment			
Unemployed	848 (67.3)	865 (79.5)	
Part-time	349 (27.7)	27 (2.5)	<0.001
Full-time	63 (5.0)	196 (18.0)	
Maternal Marital Status			
Single/separated/widowed	1,064 (85.3)	816 (76.0)	<0.001
Married/co-habitation	183 (14.7)	258 (24.0)	
Household Poverty (Below 100% FPL)			
No	393 (31.2)	286 (26.3)	0.01
Yes	867 (68.8)	802 (73.7)	
Primary Language Spoken at Home			
English	1,018 (80.8)	840 (77.2)	
Spanish	170 (13.5)	205 (18.8)	0.001
Other	72 (5.7)	43 (4.0)	
Insurance			
Uninsured	93 (7.5)	220 (20.5)	<0.001
Public	1,062 (85.0)	750 (70.0)	
Private	87 (7.0)	99 (9.2)	
Other	7 (0.6)	6 (0.6)	
Current/Past Maternal Substance Abuse			
No	1,112 (89.6)	746 (68.7)	<0.001
Yes	129 (10.4)	340 (31.3)	
Maternal Depression ^b			
No	570 (82.0)	706 (78.8)	0.11
Yes	125 (18.0)	190 (21.2)	
Current/History of Childhood Abuse/Neglect			

No	1,077 (86.1)	692 (63.6)	<0.001
Yes	174 (13.9)	392 (36.4)	
Intimate Partner Violence (Screened Positive)			
No	870 (89.8)	696 (87.3)	0.11
Yes	99 (10.2)	101 (12.7)	
Average Home Visits/month			
≤1.0	315 (25.0)	288 (26.5)	0.06
>1.0 – 1.5	321 (25.5)	233 (21.4)	
>1.5 – 2.0	284 (22.5)	235 (21.6)	
> 2.0	340 (27.0)	332 (30.5)	
Perceived Parental Stress (mean score) ^{c,d}	11.3 (7.5)	12.9 (7.6)	<0.001
Program-Level			
Median Staff Employment (days) ^e	637 (348)	686 (282)	<0.001
Age of the Program (median number of days) ^e	972 (273)	1034 (245)	<0.001
Home Visiting Model			
Parents-As-Teachers	96 (7.6)	864 (79.4)	<0.001
Nurse-Family-Partnership	934 (74.2)	8 (0.7)	
Healthy Families Florida	229 (18.2)	216 (19.9)	

Abbreviations: FPL =Federal Poverty Level

^aFrequencies may not add to the total due to missing data and percentage may not add to 100% due to rounding.
Column percentages displayed.

^bResults of the Edinburgh Postnatal Depression Scale, score ≥10 was defined as being positive for depression

^cMean and standard deviation

^dMeasured by the10 - item version of the Perceived Stress Scale

^eMedian and interquartile range

Table 3. Selected Participant Characteristics by Home Visiting Model: Maternal, Infant, and Early Childhood Home Visiting Program, 2013-2016

	HFF (N =445)	NFP (N =942)	PAT (N=960)	P-Value
	N (%) ^a	N (%) ^a	N (%) ^a	
Age (years)				
<20	96 (21.6)	331 (35.1)	97 (10.1)	<0.001
20-24	184 (41.4)	337 (35.7)	220 (22.9)	
25-29	84 (18.9)	161 (17.1)	317 (33.0)	
30-34	48 (10.8)	76 (8.1)	220 (22.9)	
35 +	33 (7.4)	37 (3.9)	106 (11.0)	
Maternal Race/Ethnicity				
White Non-Hispanic	105 (23.6)	76 (8.2)	431 (45.6)	<0.001
Black Non-Hispanic	235 (52.9)	527 (57.0)	231 (24.4)	
Hispanic	93 (20.9)	290 (31.4)	259 (27.4)	
Other	25 (2.6)	31 (3.4)	25 (2.6)	
Maternal Education				
Less than high school	150 (33.8)	251 (41.2)	363 (38.2)	0.05
≥ high school	294 (66.2)	358 (58.8)	587 (61.8)	
Maternal Employment				
Unemployed	291 (76.8)	588 (62.4)	476 (71.2)	<0.001
Part-time	2 (0.5)	354 (37.6)	20 (3.0)	
Full-time	86 (22.7)	0 (0.0)	173 (25.9)	
Maternal Marital Status				
Single/separated/widowed	382 (85.8)	782 (84.5)	715 (75.3)	<0.001
Married/co-habitation	63 (14.2)	143 (15.5)	235 (24.7)	
Household Poverty (Below 100% FPL)				
No	103 (23.2)	312 (33.1)	263 (27.4)	<0.001
Yes	242 (76.8)	630 (66.9)	697 (72.6)	
Primary Language Spoken at Home				
English	372 (83.6)	733 (77.8)	752 (78.3)	<0.001
Spanish	51 (11.5)	145 (15.4)	179 (18.7)	
Other	22 (4.9)	64 (6.8)	29 (3.0)	

Insurance				
Uninsured	48 (10.9)	76 (8.2)	189 (19.9)	<0.001
Public	353 (80.0)	793 (85.0)	665 (70.1)	
Private	37 (8.4)	60 (6.4)	89 (9.4)	
Other	3 (0.7)	4 (0.4)	6 (0.6)	
Current/Past Maternal Substance Abuse				
No	356 (82.2)	896 (96.0)	605 (63.0)	<0.001
Yes	77 (17.8)	37 (4.0)	355 (37.0)	
Maternal Depression ^b				
No	262 (74.2)	403 (89.4)	610 (77.6)	<0.001
Yes	91 (25.8)	48 (10.6)	176 (22.4)	
Current/History of Childhood Abuse/Neglect				
No	310 (70.0)	855 (91.6)	603 (62.8)	<0.001
Yes	135 (30.0)	78 (8.4)	357 (37.2)	
Intimate Partner Violence (Screened Positive)				
No	172 (75.4)	737 (92.7)	656 (88.4)	<0.001
Yes	56 (24.6)	58 (7.3)	86 (11.6)	
Average Home Visits/month				
≤1.0	57 (12.8)	270 (28.7)	276 (28.8)	<0.001
>1.0 – 1.5	51 (11.5)	255 (27.1)	248 (25.8)	
>1.5 – 2.0	94 (21.1)	201 (21.3)	224 (23.3)	
> 2.0	243 (54.6)	216 (22.9)	212 (22.1)	
Perceived Parental Stress (mean[standard deviation]) ^c	13.1 (8.3)	10.6 (7.2)	12.9 (7.4)	<0.001

Abbreviations: FPL =Federal Poverty Level, HFF = Healthy Families Florida, NFP = Nurse Family Partnership, PAT = Parents as Teachers

Results of chi-square tests except for the variables, maternal employment and insurance for which the Fisher's exact test was used and Perceived Parental Stress for which ANOVA was used

^aFrequencies may not add to the total due to missing data and percentage may not add to 100% due to rounding. Column percentages displayed.

^bResults of the Edinburgh Postnatal Depression Scale, score ≥10 was defined as being positive for depression

^cMeasured by the10 - item version of the Perceived Stress Scale

Table 4. Reasons for Dismissal of Participants in the Florida Maternal, Infant, and Early Childhood Home Visiting Initiative, 2013-2016, by Type of Home Visiting Model

Reasons	HFF	NFP	PAT
Lost to Follow up	134 (48.7)	302 (61.3)	347 (58.6)
Dropout/Other	90 (32.7)	46 (9.3)	13 (2.2)
Missed appointments	0 (0.0)	85 (17.2)	71 (12.0)
Program- related	16 (5.8)	26 (5.3)	0 (0.0)
Infant death	3 (1.1)	29 (5.9)	5 (0.8)
Legal	6 (2.2)	1 (0.2)	29 (4.9)
Unknown reasons	26 (9.5)	4 (0.8)	127 (21.5)

Abbreviations: HFF = Healthy Families Florida, NFP = Nurse Family Partnership, PAT = Parents As Teachers

Table 5. Individual – Level Characteristics of Participant-Survival in the Maternal, Infant, and Early Childhood Home Visiting Program by Home Visiting Model, 2013 - 2016

Characteristics	HFF	NFP	PAT
	Hazard Ratio (95%CI)	Hazard Ratio (95%CI)	Hazard Ratio (95%CI)
Enrolled during Pregnancy			
No	1.00	1.00	1.00
Yes	1.14 (0.65,2.00)	NA	0.85 (0.59,1.22)
Age (years)			
<20	1.00	1.00	1.00
20-24	0.63 (0.32,1.25)	0.72 (0.33,1.55)	0.74 (0.49,1.12)
25-29	0.46 (0.22,0.98)	0.74 (0.31,1.79)	0.66 (0.43,1.01)
30-34	0.20 (0.06,0.68)	0.99 (0.37,2.66)	0.49 (0.31,0.78)
35 +	0.42 (0.14,1.25)	0.59 (0.18,1.97)	0.58 (0.34,0.98)
Maternal Race/Ethnicity			
White Non-Hispanic	1.00	1.00	1.00
Black Non-Hispanic	0.70 (0.36,1.33)	1.18 (0.38,3.71)	0.96 (0.70,1.32)
Hispanic	1.25 (0.51,3.06)	1.95 (0.53,7.22)	1.03 (0.68,1.58)
Other	3.96 (0.87,17.99)	0.73 (0.11,5.04)	1.20 (0.64,2.26)
Maternal Education			
Less than high school	1.00	1.00	1.00
≥ high school	0.73 (0.41,1.29)	1.95 (1.07,3.53)	0.91 (0.69,1.19)
Maternal Employment			
Unemployed	1.00	1.00	1.00
Part-time	NA	0.82 (0.48,1.39)	2.41 (1.03,5.64)
Full-time	1.09 (0.58,2.04)	NA	0.87 (0.65,1.18)
Maternal Marital Status			
Single/separated/widowed	1.00	1.00	1.00
Married/co-habitation	0.84 (0.35,2.06)	0.64 (0.30,1.37)	1.18 (0.88,1.57)
Household Poverty (Below 100% FPL)			
No	1.00	1.00	1.00
Yes	0.96 (0.53,1.75)	1.00 (0.55,1.81)	1.25 (0.96,1.64)
Primary Language Spoken at Home			
English	1.00	1.00	1.00
Spanish	0.59 (0.22,1.59)	0.78 (0.30,2.05)	0.66 (0.38,1.16)
Other	1.10 (0.30,4.03)	0.92 (0.41,2.06)	0.73 (0.32,1.64)
Insurance			
Uninsured	1.00	1.00	1.00
Public	0.44 (0.19,1.00)	1.52 (0.53,4.36)	0.73 (0.48,1.12)
Private	0.36 (0.11,1.15)	1.05 (0.30,3.71)	0.67 (0.38,1.17)
Other	NA	NA	1.96 (0.44,8.85)
Current/Past Maternal Substance Abuse			
No	1.00	1.00	1.00
Yes	2.40 (1.36,4.25)	NA	2.02 (1.46,2.79)
Maternal Depression ^a			
No	1.00	1.00	1.00
Yes	0.81 (0.43,1.50)	0.62 (0.21,1.84)	1.07 (0.79,1.46)
Current/History of Childhood Abuse/Neglect			
No	1.00	1.00	1.00
Yes	0.94 (0.51,1.73)	0.89 (0.25,3.14)	1.12 (0.84,1.49)
Interpersonal Violence (Screened Positive)			
No	1.00	1.00	1.00
Yes	0.86(0.49,1.50)	2.12 (0.70,6.40)	0.78 (0.52,1.15)
Average Home Visits/month			
≤1.0	1.00	1.00	1.00
>1.0 – 1.5	1.67 (0.27,10.33)	0.69 (0.37,1.28)	0.44 (0.33,0.59)
>1.5 – 2.0	1.35 (0.21,8.67)	0.12 (0.05,0.29)	0.35 (0.25,0.49)
> 2.0	1.08 (0.18,6.32)	0.29 (0.11,0.74)	0.61 (0.42,0.88)
Perceived Parental Stress ^b	1.04 (1.00,1.07)	1.01 (0.97,1.05)	0.99 (0.97,1.01)

Abbreviations: CI = Confidence Interval, FPL =Federal Poverty Level, HFF = Healthy Families Florida, NFP = Nurse Family Partnership, PAT = Parents As Teachers, NA = Not Available (due to few observations)

^aAssessed by the Edinburgh Postnatal Depression Scale, score ≥10 was defined as being positive for depression

^bMeasured by the 10 - item version of the Perceived Stress Scale

BOLD indicate significant results

Table 6. Participant and Program – Level Characteristics Predicting Participant- Survival in the Maternal, Infant, and Early Childhood Home Visiting Program, 2013-2016

Characteristic	Hazard Ratio (95%CI)	P-Value
<i>Participant-Level</i>		
Enrolled during Pregnancy		
No	1.00	
Yes	0.74 (0.56,0.98)	0.04
Age (years)		
<20	1.00	
20-24	0.75 (0.55,1.02)	0.07
25-29	0.63 (0.45,0.87)	0.01
30-34	0.47 (0.33,0.69)	<0.001
35 +	0.52 (0.34,0.80)	0.003
Maternal Race/Ethnicity		
White Non-Hispanic	1.00	
Black Non-Hispanic	0.93 (0.71,1.20)	0.56
Hispanic	1.06 (0.75,1.50)	0.75
Other	1.24 (0.73,2.10)	0.43
Maternal Education		
Less than high school	1.00	
≥ high school	0.99 (0.79,1.22)	0.89
Maternal Employment		
Unemployed	1.00	
Part-time	0.91 (0.60,1.38)	0.66
Full-time	0.90 (0.69,1.17)	0.44
Maternal Marital Status		
Single/separated/widowed	1.00	
Married/co-habitation	1.03 (0.80,1.32)	0.85
Household Poverty (Below 100% FPL)		
No	1.00	
Yes	1.21 (0.97,1.50)	0.09
Primary Language Spoken at Home		
English	1.00	
Spanish	0.73 (0.48,1.10)	0.13
Other	0.94 (0.57,1.56)	0.82
Insurance		
Uninsured	1.00	
Public	0.72 (0.52,0.99)	0.05
Private	0.72 (0.47,1.10)	0.13
Other	1.17 (0.28,4.96)	0.83
Current/Past Maternal Substance Abuse		
No	1.00	
Yes	1.84 (1.34,2.52)	<0.001
Maternal Depression ^a		
No	1.00	
Yes	0.93 (0.72,1.21)	0.59
Current/History of Childhood Abuse/Neglect		
No	1.00	
Yes	1.02 (0.81,1.30)	0.85
Intimate Partner Violence (Screened Positive)		
No	1.00	
Yes	0.87 (0.64,1.17)	0.36
Average Home Visits/month		

≤ 1.0	1.00	
>1.0 – 1.5	0.45 (0.35,0.58)	<0.001
>1.5 – 2.0	0.32 (0.24,0.42)	<0.001
> 2.0	0.49 (0.36,0.68)	<0.001
Perceived Parental Stress ^b	1.00 (0.99,1.02)	0.71
Program-Level		
Median Staff Employment (days)	1.00 (1.00,1.00)	0.52
Age of the Program (days)	1.00 (1.00,1.00)	0.97

Abbreviations: CI = Confidence Interval; FPL =Federal Poverty Level

^aAssessed by the Edinburgh Postnatal Depression Scale, score ≥ 10 was defined as being positive for depression

^bMeasured by the 10 - item version of the Perceived Stress Scale

BOLD indicate significant results

Table 7. Participant and Program – Level Characteristics Predicting 3 – month Participant- Survival in the Maternal, Infant, and Early Childhood Home Visiting Program

Characteristic	Hazard Ratio (95%CI)	P-Value
Participant-Level		
Enrolled during Pregnancy		
No	1.00	
Yes	0.70 (0.12,4.04)	0.69
Age (years)		
<20	1.00	
20-24	0.65 (0.11,3.73)	0.63
25-29	0.27 (0.04,2.07)	0.21
30-34	0.24 (0.03,2.12)	0.20
35 +	0.39 (0.04,3.68)	0.41
Maternal Race/Ethnicity		
White Non-Hispanic	1.00	
Black Non-Hispanic	0.12 (0.02,0.75)	0.02
Hispanic	0.09 (0.01,1.00)	0.05
Other	1.10 (0.14,8.48)	0.93
Maternal Education		
Less than high school	1.00	
\geq high school	0.46 (0.11,1.93)	0.29
Maternal Employment		
Unemployed	1.00	
Part-time	4.17 (0.37,47.09)	0.25
Full-time	1.72 (0.44,6.77)	0.44
Maternal Marital Status		
Single/separated/widowed	1.00	
Married/co-habitation	3.22 (0.70,14.89)	0.13
Household Poverty (Below 100% FPL)		
No	1.00	
Yes	0.86 (0.24,3.15)	0.82
Primary Language Spoken at Home		
English	1.00	
Spanish	0.55 (0.02,13.17)	0.71
Other	NA	
Insurance		
Uninsured	1.00	
Public	0.30 (0.04,2.40)	0.25
Private	0.11 (0.00,5.08)	0.26
Other	NA	
Current/Past Maternal Substance Abuse		
No	1.001	
Yes	0.53 (0.11,2.67)	0.44
Maternal Depression ^a		
No	1.00	
Yes	0.14 (0.03,0.73)	0.02

Current/History of Childhood Abuse/Neglect			
No	1.00		
Yes	2.74 (0.68,11.01)	0.16	
Intimate Partner Violence (Screened Positive)			
No	1.00		
Yes	0.71 (0.12,4.22)	0.71	
Average Home Visits/month			
≤1.0	1.00		
>1.0 – 1.5	0.64 (0.11,3.76)	0.62	
>1.5 – 2.0	0.37 (0.04,3.43)	0.38	
> 2.0	9.58 (1.93,47.46)	0.01	
Perceived Parental Stress ^b	1.10 (1.01,1.20)	0.02	
Program-Level			
Median Staff Employment (days)	1.00 (1.00,1.00)	0.99	
Age of the Program (days)	1.00 (1.00,1.00)	0.99	

Abbreviations: CI = Confidence Interval; FPL =Federal Poverty Level

^aAssessed by the Edinburgh Postnatal Depression Scale, score ≥10 was defined as being positive for depression

^bMeasured by the 10 - item version of the Perceived Stress Scale

BOLD indicate significant results

Table 8. Participant and Program – Level Characteristics Predicting 12 – Month Survival of Participants in the Maternal, Infant, and Early Childhood Home Visiting Program

Characteristic	Hazard Ratio (95%CI)	P-Value
Participant-Level		
Enrolled during Pregnancy		
No	1.00	
Yes	0.69 (0.47,1.02)	0.06
Age (years)		
<20	1.00	
20-24	0.93 (0.61,1.42)	0.74
25-29	0.79 (0.51,1.24)	0.31
30-34	0.59 (0.36,0.97)	0.04
35 +	0.66 (0.38,1.16)	0.15
Maternal Race/Ethnicity		
White Non-Hispanic	1.00	
Black Non-Hispanic	1.01 (0.71,1.44)	0.94
Hispanic	0.88 (0.55,1.41)	0.60
Other	1.36 (0.63,2.92)	0.43
Maternal Education		
Less than high school	1.00	
≥ high school	0.80 (0.60,1.06)	0.12
Maternal Employment		
Unemployed	1.00	
Part-time	1.02 (0.53,1.98)	0.94
Full-time	1.00 (0.72,1.39)	0.98
Maternal Marital Status		
Single/separated/widowed	1.00	
Married/co-habitation	1.01 (0.72,1.42)	0.94
Household Poverty (Below 100% FPL)		
No	1.00	
Yes	1.01 (0.76,1.34)	0.96
Primary Language Spoken at Home		
English	1.00	
Spanish	0.77 (0.44,1.36)	0.37
Other	0.61 (0.26,1.43)	0.26
Insurance		
Uninsured	1.00	
Public	0.76 (0.49,1.18)	0.22

Private	0.78 (0.43,1.41)	0.41
Other	1.07 (0.14,8.20)	0.95
Current/Past Maternal Substance Abuse		
No	1.001	
Yes	1.61 (1.07,2.43)	0.02
Maternal Depression ^a		
No	1.00	
Yes	0.89 (0.64,1.25)	0.50
Current/History of Childhood Abuse/Neglect		
No	1.00	
Yes	0.99 (0.73,1.35)	0.97
Intimate Partner Violence (Screened Positive)		
No	1.00	
Yes	0.98 (0.67,1.45)	0.93
Average Home Visits/month		
≤1.0	1.00	
>1.0 – 1.5	0.69 (0.49,0.97)	0.03
>1.5 – 2.0	0.48 (0.32,0.72)	<0.001
> 2.0	0.72 (0.47,1.09)	0.12
Perceived Parental Stress ^b	1.00 (0.98,1.02)	0.89
Program-Level		
Median Staff Employment (days)	1.00 (1.00,1.00)	0.87
Age of the Program (days)	1.00 (1.00,1.00)	0.87

Abbreviations: CI = Confidence Interval; FPL =Federal Poverty Level

^aAssessed by the Edinburgh Postnatal Depression Scale, score ≥10 was defined as being positive for depression

^bMeasured by the 10 - item version of the Perceived Stress Scale

BOLD indicate significant results

Table 9. Characteristics of Participant- Survival in the Maternal, Infant, and Early Childhood Home Visiting Program by Time of Enrollment

Characteristic	During Pregnancy		After Birth	
	Hazard Ratio (95%CI)	P-Value	Hazard Ratio (95%CI)	P-Value
Participant-Level				
Age (years)				
<20	1.00		1.00	
20-24	0.62 (0.38,1.01)	0.05	0.75 (0.50,1.13)	0.17
25-29	0.44 (0.25,0.78)	0.01	0.68 (0.45,1.03)	0.07
30-34	0.62 (0.32,1.19)	0.15	0.42 (0.26,0.67)	<0.001
35 +	0.61 (0.30,1.26)	0.18	0.50 (0.30,0.85)	0.01
Maternal Race/Ethnicity				
White Non-Hispanic	1.00		1.00	
Black Non-Hispanic	0.93 (0.58,1.49)	0.76	0.90 (0.66,1.23)	0.52
Hispanic	1.40 (0.72,2.70)	0.32	1.01 (0.66,1.54)	0.97
Other	0.69 (0.25,1.89)	0.47	1.11 (0.59,2.10)	0.75
Maternal Education				
Less than high school	1.00		1.00	
≥ high school	1.45 (0.98,2.45)		0.87 (0.67,1.14)	0.31
Maternal Employment				
Unemployed	1.00		1.00	
Part-time	0.57 (0.36,0.91)	0.02	2.27 (0.97,5.31)	0.06
Full-time	0.58 (0.29,1.15)	0.12	1.03 (0.77,1.38)	0.84
Maternal Marital Status				
Single/separated/widowed	1.00		1.00	
Married/co-habitation	0.71 (0.40,1.26)	0.24	1.13 (0.84,1.51)	0.42
Household Poverty (Below 100% FPL)				
No	1.00		1.00	
Yes	1.03 (0.69,1.55)	0.88	1.27 (0.97,1.67)	0.08
Primary Language Spoken at Home				

English	1.00		1.00	
Spanish	0.90 (0.45,1.81)	0.77	0.63 (0.38,1.05)	0.08
Other	1.01 (0.49,2.10)	0.97	1.07 (0.51,2.23)	0.86
Insurance				
Uninsured	1.00		1.00	
Public	1.08 (0.52,2.23)	0.84	0.62 (0.42,0.91)	0.01
Private	0.97 (0.39,2.45)	0.95	0.62 (0.37,1.05)	0.07
Other	NA		1.89 (0.42,8.41)	0.40
Current/Past Maternal Substance Abuse				
No	1.00		1.00	
Yes	2.00 (1.17,3.44)	0.01	1.97 (1.35,2.87)	0.001
Maternal Depression ^a				
No	1.00		1.00	
Yes	0.86 (0.52,1.43)	0.56	0.99 (0.73,1.34)	0.94
Current/History of Childhood Abuse/Neglect				
No	1.00		1.00	
Yes	1.12 (0.66,1.88)	0.68	1.03 (0.78,1.36)	0.86
Intimate Partner Violence (Screened Positive)				
No	1.00		1.00	
Yes	1.11 (0.65,1.91)	0.70	0.80 (0.55,1.16)	0.23
Average Home Visits/month				
≤1.0	1.00		1.00	
>1.0 – 1.5	0.55 (0.34,0.88)	0.01	0.43 (0.32,0.58)	<0.001
>1.5 – 2.0	0.26 (0.15,0.46)	<0.001	0.34 (0.24,0.49)	<0.001
> 2.0	0.47 (0.27,0.83)	0.01	0.53 (0.37,0.78)	0.001
Perceived Parental Stress ^b	1.03 (1.00,1.06)	0.02	0.99 (0.98,1.01)	0.47
Program-Level				
Median Staff Employment (days)	1.00 (1.00,1.00)	0.003	1.00 (1.00,1.00)	0.87
Age of the Program (days)	1.00 (1.00,1.00)	0.94	1.00 (1.00,1.00)	0.64

Abbreviations: CI = Confidence Interval; FPL =Federal Poverty Level

^aAssessed by the Edinburgh Postnatal Depression Scale, score ≥10 was defined as being positive for depression

^bMeasured by the 10 - item version of the Perceived Stress Scale

BOLD indicate significant results

Florida Maternal, Infant, and Early Childhood Home Visiting Program Evaluation

Journey Mapping Report



Ngozichukwuka Agu, Esther Jean-Baptiste, Dogeli Rojas, Omotola Balogun, Temitope Bello, Pamela Birriel, Rema Ramakrishnan, Paige Alitz, & Jennifer Marshall

*University of South Florida, College of Public Health,
Lawton and Chiles Center for Healthy Mothers and Babies*

EXECUTIVE SUMMARY

Journey mapping was used as a tool to explore perceptions of engagement and retention in the Florida Maternal, Infant, and Early Childhood Home Visiting program. This process involved research team members/observers shadowing volunteer home visitors, throughout a typical home visiting work day. The Home Visiting Rating Scale Adopted and Extended tool (HOVRS-A+) was used to measure home visitor and participant engagement during visits; and interviews with the home visitor, participant, and observer led to rich discussions about the home visiting process.

The key touch points during shadowing were at the home visitors' offices, on the way to a home visit, and leaving a home visit. During these touch points, interviews revealed factors regarding engagement and retention, logistics, family and friend involvement, social support, positive experiences, and negative experiences. For engagement and retention, how and at what

point the participant was enrolled in the program, and factors that could potentially influence engagement and retention in the program, were discussed. These factors included the stage at which the participant was in the program, home visitor/participant relationship, support that was received, home environment, and socioeconomic factors. A positive home visitor/participant relationship helped to promote engagement along with support provided by the home visitor, while financial instability and housing instability were viewed as factors that negatively impacted engagement.

The involvement of family and friends during visits was mainly positive and supportive. The most frequent form of social support provided by home visitors was informational support on a variety of topics including safe sleep, breastfeeding, parenting, child development, labor and delivery, and nutrition. Aspects of logistics included scheduling, driving, and documentation. Overall, most of the experiences of participants in the journey mapping were positive. Specifically discussed as positive were interactions between the home visitors and the participant, the participant and her baby, and the home visitor and the baby. Very few negative experiences were discussed among which were distractions during visits and concern about safety of the baby in one instance.

Findings from this journey mapping process emphasize the importance of building positive and supportive home visitor/participant relationships and the need for taking steps to reduce factors that negatively impact engagement and retention to increase program benefits.



Journey mapping examines an experience through the eyes of the participant.

INTRODUCTION

The engagement and retention of families enrolled in a home visiting program are essential for its success. Previous discussions with home visiting staff in the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program revealed staff perceptions of engagement and retention, as well as perceived facilitators and barriers to engagement and retention within the program (see <http://health.usf.edu/publichealth/chiles/miechv/state-evaluation>). To further understand engagement and retention in the program, an observation of the home visiting process was done to view engagement and retention from multiple points of view, including perspectives of the home visitors and participants.

METHODS

Journey mapping aims to develop an understanding of an individual's experience across all touch points in their interactions with a program or organization in order to identify gaps and subsequently improve services. For this evaluation, journey mapping was used to understand the experiences of both the participants and home visitors of the Florida MIECHV program with the researcher serving the role of the observer. The aim of this journey mapping project was to evaluate

the program using participants' experiences as a yardstick to assess engagement and retention in the program. Assessing positive and negative experiences of participants helps to determine the functionality of the program and identify gaps or shortcomings, with the sole purpose of optimizing participants' experiences.

Journey mapping took place through August-September 2016 in three Florida MIECHV communities – Hillsborough, Manatee, and Escambia. Home visitors were contacted and informed about the proposed journey mapping project. Home visitors were then invited by the research team to participate in the journey mapping research project if they were interested. Subsequently, families receiving services from interested home visitors were contacted about the study. Informed consent was obtained for all those who agreed to participate in the study. After consent was obtained, the researcher (observer) and the home visitor visited the participants' homes. Five home visitors and seven program participants were included in this study.

Data Collection

Four forms of data were collected for the project: 1) a demographic self-report survey administered to the participants by the home visitors; 2) the home visit observation assessment from the perspective of the researcher (observer); 3) interviews with home visitors, program participants, and observers; and 4) observational notes and photographs. The demographic self-report survey included questions about age and educational qualification of the participants. The home visit experience included an assessment of the quality of the home visit, field notes pertaining to the home visit, and pictures recorded by the observer. Roggman *et al.*'s Home Visiting Rating Scale Adopted and Extended (HOVRS-A+) tool tailored for the development of infants and young children was used to assess the quality of the home visit. This tool measures home visitor/parent educator practices that support developmental parenting approaches while respecting family's strengths and cultures. Three out of the seven HOVRS-A+ scales (described below) were completed by the observer. Notes were collected by the observer on touchpoints and personal reactions of the participants and home visitors, and photographs (taken by the observer with the participants' permission) captured their perspective of the visit and home visiting program in general.

While shadowing, the observer interviewed the home visitor at different touch points. Since the observer was with the families during one session and the home visitors during the entirety of the workday, the protocol and timing of questions was adapted to fit the visit. Following the visit, interviews with the participant and observers were also conducted. Interviews with home visitors and program participants identified factors associated with engagement and retention, logistical issues, and positive and negative experiences. Observer interviews by a research team member identified strengths, weaknesses, and perceptions of home visitor and participant relationships and interactions.

Data Analysis

Demographic data were entered into the Qualtrics software, which generated descriptive characteristics of study participants. The HOVRS-A+ form was analyzed utilizing Microsoft Excel to generate means and ranges for each of the subscales assessed. All interviews were audio recorded and transcribed verbatim by a professional transcription service. The evaluation team research assistants reviewed the transcribed documents to ensure accuracy. The transcripts were qualitatively analyzed for emergent themes utilizing the MAXQDA Software program. A codebook was developed including *a priori* and emergent codes from reading through the

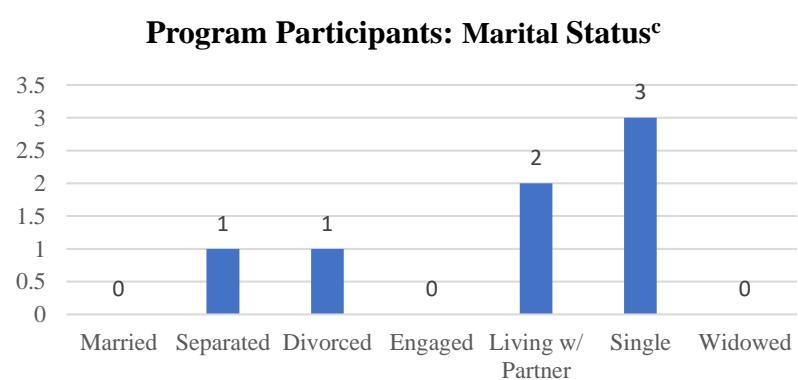
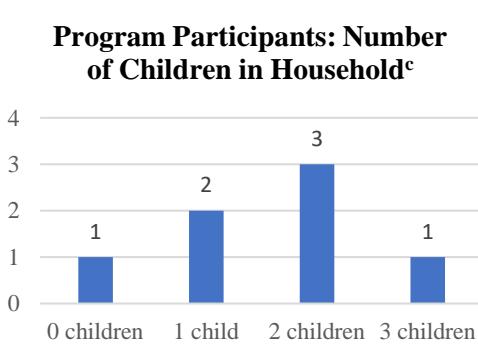
transcripts. Two members of the research team coded five transcripts until agreement was reached. The remaining transcripts were then coded by the primary coder. Because of the unique design of the journey mapping process, credibility was established by triangulating the findings from the interviews with participants, home visitors, and observers. Additionally, field notes were analyzed to identify similarities and to compare findings or thoughts of observers during the journey mapping process. These findings were also triangulated with findings from other evaluation studies that explored participant engagement and retention (e.g., participant retention data analysis, home visitor focus groups, program participant interviews, etc.).

RESULTS

Demographic Information

A total of 16 individuals including home visitors (n=5), program participants (n=7, all mothers), and observers (n=4) were interviewed. Demographic data are reported for program participants and home visitors. Participants were residents of Hillsborough County (home visitors n=2; program participants n=4), Escambia County (home visitors n=2; program participants n=2), and Manatee County (home visitors n=1; program participants n=1). Of participating home visitors, three currently lived in the specific community they worked in, and two did not. All home visitors were full-time employees with one working for less than a year in her current role and four working between one to five years in their current role. Program participant employment status included: part-time (n=1), stay-at-home mother (n=5), and unemployed due to disability (n=1). Demographics for years in current role, educational background, and work location in reference to residence were only asked of home visitors. Demographics for marital status and number of children in household were only asked of program participants. Detailed demographics can be found in Tables 1-4 and Figures 1-3.

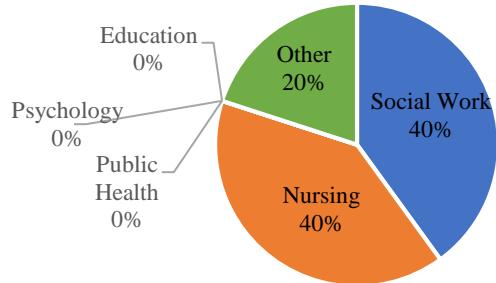
Tables 1-4 and Figures 1-3. Journey Mapping Participant Characteristics.



Age ^a			Race			Education ^a		
	Home Visitors	Program Participants		Home Visitors	Program Participants		Home Visitors	Program Participants
<20	0	1	White	5	2	Less than high school	0	1
20-24	0	2	Black	0	4	High school graduate	0	2
25-29	3	1	Asian	0	0	Some college	3	1
30-34	1	0	Pacific Islander	0	0	College graduate	1	0
≥35	1	2	Other	0	1	Graduate degree	1	2

Ethnicity ^a		
	Home Visitors	Program Participants
Hispanic	2	5
Non-Hispanic	3	1

Home Visitor: Educational Background^b



^a One program client did not participate in the follow-up interview

^b Only asked of home visitors

^c Only asked of program clients

HOVRS-A+

The HOVRS-A+ tool assessed three main factors summarized in Table 5: 1) the home visitor responsiveness to the family, 2) the relationship between the home visitor and the family, and 3) parent engagement during the home visit. In the home visitor responsiveness to family scale—which measures planning with parents and identifying family strengths to support child development—home visitors received an average overall rating of 6.43 on a scale of 1 (inadequate) to 7 (excellent), with a range from 5 (good) to 7 (excellent). A rating of 5 indicated that the home visitor was prepared for the visit, asked questions, and provided information according to the observation of parent and child needs. A rating of 7 indicated that the home visitor was prepared for the visit and also prepared for future visits with the input of the parents. It also indicated that the home visitor provided parents with feedback on interactions and child development.

In the home visitor-family relationship scale—which measures home visitor interaction with family members through warmth, positive emotions, and respect—home visitors received an average overall rating of 6.43 on a scale of 1 (inadequate) to 7 (excellent), with a range from 4 (between adequate and good) to 7 (excellent). A rating of 4 indicated an adequate familiarity with

the family and family system but a lack of intention to further learn of the family structure and current situations. In addition, it indicated a cordial relationship between the home visitor and parent but little to no social interaction (i.e., discussion outside of home visit topics). A rating of 7 indicated an open and relaxed relationship of respect and appreciation between the home visitor and parent. It also indicated comfortability of the parent to initiate discussions and of the home visitor to ask questions about familial situations.

In the parent engagement during home visit scale—which measures parent interest, participation, and initiation of interactions, discussions, and activities—parent(s) received an average overall rating of 6.57 on a scale of 1 (inadequate) to 7 (excellent), with a range from 5 (good) to 7 (excellent). A rating of 5 indicated that the parent(s) were active participants in the activities and discussions and remained in close proximity to their child and the home visitor. A rating of 7 indicated that the parent(s) were actively engaged and participated in the activities and discussions and also initiated discussions through providing information on the child's development and behavior. In addition, the parent(s) were in close proximity to their child and the home visitor and interacted enthusiastically with both.

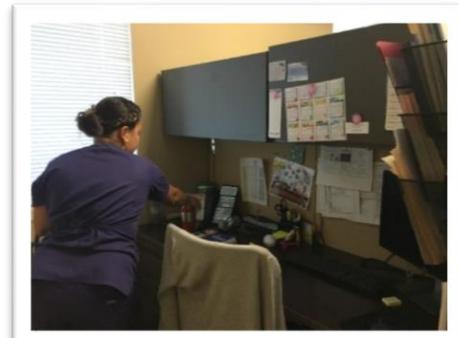
Table 5. HOVRS-A+ Tool Assessment.

Scales	Indicators Measured	Range	Mean
Home Visitor's Responsiveness to Family	<ul style="list-style-type: none"> • Plans activities and topics of home visits with parent • Prepares for home visit using parent-selected activities • Gets information about the family's strengths and child's development • Provides feedback on the family's interests and needs • Adapts activities to the family's interests and needs • Responds to family input for the agenda and activities of the home visit 	5 – 7	6.43
Home Visitor's Relationship with Family	<ul style="list-style-type: none"> • Interacts sociably with parent(s), focusing on child development • Sets the tone for positive interactions • Expresses positive emotions about the home visit • Engages other family members if present during home visit • Reflects on family's life and activities in relation to child's development • Shows respect and acceptance of the family, home, culture, and lifestyle • Discusses sensitive issues respectfully and reflectively 	4 – 7	6.43
Parent Engagement During Home Visit	<ul style="list-style-type: none"> • Shows interest in materials and activities • Participates and focuses on home visit topics and activities • Engages in play and activities with child • Initiates activities and conversations • Discusses questions and topics relevant to child and family • Is ready to interact with both child and home visitor 	5 – 7	6.57

Journey Mapping Interviews

Channel

Interviews were held at different points in time with all journey mapping participants, to reflect the touchpoints of their experiences. For example, the home visitors were interviewed at the office preparing for a home visit, on the way to a home visit, and/or leaving a home visit (Figure 4). The channel (setting for the interview) set the stage for the conversations that the observer had with the home visitor. At the office, conversations were mostly regarding the home visitors' preparation for the home visit(s) through gathering informational materials and needed items (e.g., diapers) and completing documentation after a previous visit. When heading to a new visit, the observer and the home visitor talked more about the goals the home visitor had for the visit and their expectations for the participant. As the home visitor leaves the participant's home, conversations with the observer were aimed at understanding how the home visitor perceived the visit and thoughts regarding the experience. Participants and observers were interviewed after the journey mapping home visits had taken place. Interviews with participants took place by telephone, while observers were interviewed at the research office.



Home visitor prepares for upcoming visit.

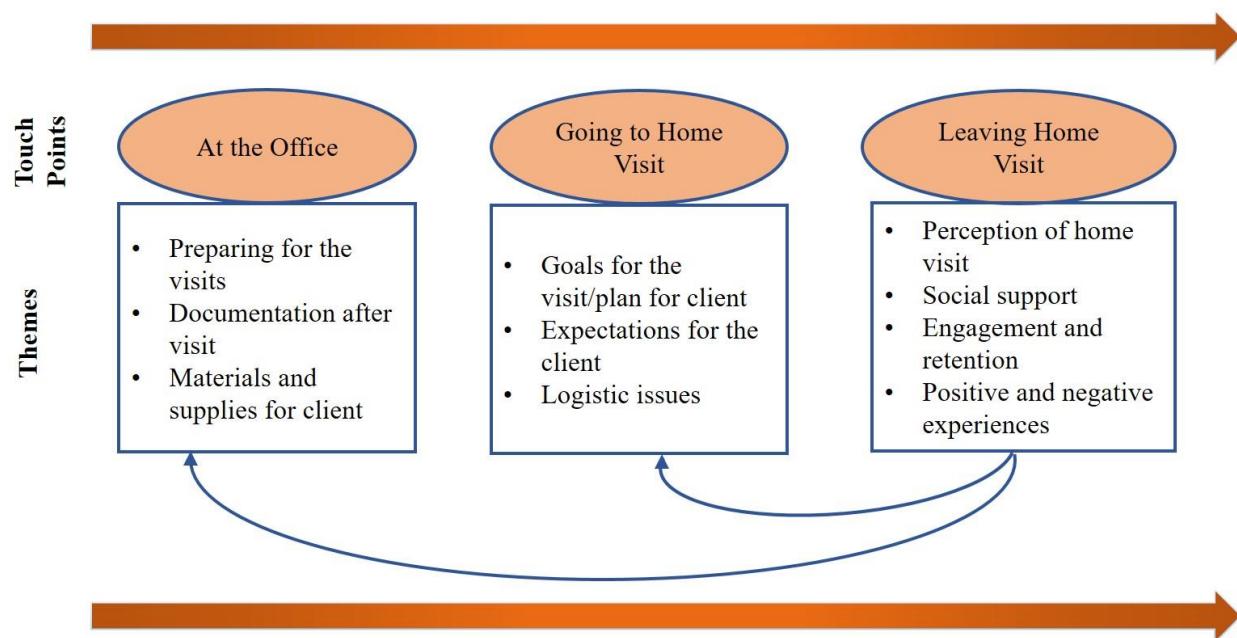


Figure 4. Touch Points and Emergent Key Themes.

Engagement and Retention

All journey mapping participants discussed factors that were associated with their engagement and retention in the home visiting program. Home visitors discussed how the participant came to be enrolled in the program, at what point in time the participant was enrolled (during pregnancy or otherwise), how long the participant had been enrolled in the program, as well as factors that could potentially influence engagement and retention in the program. These factors included the stage in which the participant was in the program, various aspects of the relationship with the home visitor, support that was received, home environment, and socioeconomic factors. The stage at which the participant enrolled could influence their engagement based on perceived benefits of the program. Some participants were described as having been initially unengaged and cancelling visits but later becoming more engaged closer to the time of having the baby. However, another home visitor discussed an instance where a participant disengaged after the baby's birth.

The relationship between the home visitor and the participant was another factor that played a role in engagement and retention. Participants discussed being engaged when they have a good relationship with their home visitors. The level of connectedness/rapport between the home visitor and participant was one aspect of this relationship, and communication was discussed as another aspect of the home visitor/participant relationship. The more rapport and trust are built, the more the participant relies on the home visitor for information. Having bilingual home visitors was said to be helpful for engagement with Spanish-speaking participants. Home visitors also found it helpful to wait until a connection had been established before broaching certain topics, such as the mental health assessment. A few first-time mothers enrolled in the program found it helpful to have someone they could speak with about their pregnancy concerns and to receive the appropriate information.

"I noticed that the home visitor and you [...] both like talking like friends, and you were quite... are quite interested in what the home visitor had to say. But, I also noticed that the TV was on, but you seemed to focus only on the home visitor and not on the TV." ~Observer

"If you're going to talk in public about people joining the program, I'd say please do that. The program is truly spectacular. It's great to have somebody, a nurse, come to your house, weigh the baby, check the baby out. It's wonderful that they have this program for mothers. And people who don't have money to pay for something like this are very grateful that the government helps. So, please, don't stop promoting the program because it is spectacular for mothers and babies. As human beings, we need this, and it's good, too if fathers get involved. I mean, fathers have to be interested first, but it's great. The program is spectacular. Please don't even think of stopping the program. Thank you for coming." ~Participant



Home visitor engages with parent during the visit.

The stage at which the participant enrolled could influence their engagement based on perceived benefits of the program. Some participants were described as having been initially unengaged and cancelling visits but later becoming more engaged closer to the time of having the baby. However, another home visitor discussed an instance where a participant disengaged after the baby's birth.

The relationship between the home visitor and the participant was another factor that played a role in engagement and retention. Participants discussed being engaged when they have a good relationship with their home visitors. The level of connectedness/rapport between the home visitor and participant was one aspect of this relationship, and communication was discussed as another aspect of the home visitor/participant relationship. The more rapport and trust are built, the more the participant relies on the home visitor for information. Having bilingual home visitors was said to be helpful for engagement with Spanish-speaking participants. Home visitors also found it helpful to wait until a connection had been established before broaching certain topics, such as the mental health assessment. A few first-time mothers enrolled in the program found it helpful to have someone they could speak with about their pregnancy concerns and to receive the appropriate information.

"I noticed that the home visitor and you [...] both like talking like friends, and you were quite... are quite interested in what the home visitor had to say. But, I also noticed that the TV was on, but you seemed to focus only on the home visitor and not on the TV." ~Observer

"If you're going to talk in public about people joining the program, I'd say please do that. The program is truly spectacular. It's great to have somebody, a nurse, come to your house, weigh the baby, check the baby out. It's wonderful that they have this program for mothers. And people who don't have money to pay for something like this are very grateful that the government helps. So, please, don't stop promoting the program because it is spectacular for mothers and babies. As human beings, we need this, and it's good, too if fathers get involved. I mean, fathers have to be interested first, but it's great. The program is spectacular. Please don't even think of stopping the program. Thank you for coming." ~Participant

Perceived benefits of the program, such as the support received from the home visitor (e.g., receiving information regarding their child's development, referrals for housing, and food resources) were also promoters of engagement. Home visitors also discussed the home environment and how this impacted their interactions with the participant. Distractions were mentioned as sometimes impacting engagement; common sources of distraction during visits included televisions, phone calls, visitors, and household activities.

"I like that she turned off the TV. She doesn't always do that [...]. Something negative about the [observed] visit is sometimes the dad will sit in with us if he is there and I noticed he didn't during this visit, but I thought she was communicating with me well. She was open." ~Home visitor



Caregiver participates in activity with child during the home visit.

Home visitors discussed varying levels of engagement among the participants that they were currently serving. Engagement was demonstrated by parent's participation in activities and utilization of programs that the home visitor recommended. However, home visitors believed that participants always learned something despite how actively they do or do not participate in the activities. The responsiveness of participants also influenced the way their home visitor approached interactions with that participant, and one home visitor discussed sending reminders based on participants' past responsiveness to these reminders.

"...and she told me that her mother-in-law, which I think she's going to be there on our visit today, told her, 'Don't pay attention to the nurse. Don't do everything she says. I'm a mother. I have four kids, and I know what I'm doing. Listen to me, not her.' After that visit, I was like, 'It's your option. I just bring you the information that is based on researches, and it's been proven, and it's up to you to decide what you're going to do with that.' I left the visit, and I will say 20 minutes after, she's like, 'Should I give my baby water?' I was like, 'No, the baby is a newborn. He's only 10 days old, so you're not supposed to give him water.' 'Oh no, my mother-in-law told me that it's about time that I start giving him water.' So, that kind of thing. And I was like, 'No.' So, she's asking me more questions. She wants to be more in the program because of that." ~Home visitor

Other factors that could negatively impact participant engagement include an inconsistent relationship or intermittent communication between the home visitor and participant. There could also be awkwardness in the first home visiting session, which could potentially affect engagement. Not participating in regular home visits, financial instability, housing instability, and low-income were also mentioned as things that affected engagement.

Negative Experiences

In general, there were few to no negative experiences from the perspectives of all participants. Observers perceived distractions during the visits, such as noise from the television, poor living conditions, living with people in a less than ideal situation, and children misbehaving as negative experiences. Program participants did not divulge any negative experiences, instead

stated that they had enjoyed the program and would recommend it to other participants. Very few home visitors had any negative experiences. Factors mentioned were concerning observations in the home, such as unsafe sleep conditions, factors that interfered with the home visit completion (e.g., no-shows), potential distractions during the visit, and unforeseen encounters (e.g., unsafe neighborhoods or problematic family situation).

"Her being in there with us for the visit and the baby waking up, she could've possibly fell off that bed. So yes, it concerns me." ~Home visitor

Involvement of Family and Friends

Aside from the home visitor, other individuals who were a source of support in the participants' lives emerged in discussions. These included family members such as mothers, mothers-in-law, partners, and friends. A few participants reported that their mothers and significant others were interested in the program, and some mothers of the participants participated during the home visiting sessions to learn more about how to take care of the baby.

Home visitors discussed that family and friends—mostly family members—were sometimes involved in the visit. There were varying levels of others' involvement, ranging from just being present without engagement during the visit to actively participating or having discussions during the visits. Overall, most involvement of family and friends was neutral to positive, and home visitors would usually find a way to encourage family involvement while at the same time ensuring that the right information regarding child care was still passed on to the participants. However, family involvement sometimes limited the ability to conduct visits, especially when it was a situation where the participant had to attend to other family responsibilities and as a result was too busy to participate in the visits. Home visitors also felt that there was a potential that the presence of family members limited the interaction and engagement with the participant, although, in some cases where there was family present, the home visitor discussed that it did not affect the interaction with the participant. Lastly, some involvement of family required additional informational support from the home visitor. For example, a participant's cousin wanted information on family planning, so the home visitor brought the corresponding information for both the participant and her cousin.

"Interviewer: Okay, so we just finished the second site visit. It was at the mother-in-law's house. Do you always have her involvement to come in and give her experiences and really chime in on what you're trying to teach her? Respondent: Yes. She always comes in the middle of the conversation and she gets involved on it and try to give her experience and how she's been raising kids and she'd tell her what to do, stuff like that." ~Home visitor

Social Support

Different types of social support were provided by the home visitors. These included informational, appraisal, instrumental, and emotional support.

Informational support was the most common type of social support that the home visitors discussed during the interactions. Using the model's curriculum, home visitors provided a lot of research-based information for participants. Although the curriculum included a structure for

providing information, participants also had an input regarding information they received choosing certain topics they wanted information on. Rapport was necessary as a basis to providing information for certain topics and home visitors were sensitive in the way they shared information so as not to overwhelm the participant. Sharing personal experiences helped home visitors connect with the participants. The home visits were mainly interactive sessions with the mother and baby and encouraged involving other family members. Provision of information was enhanced by using facilitators (i.e., visual and audio aids), as well as engaging them through interactive activities with the children. Specific topics discussed with participants during the journey mapping process included information on labor and delivery, language skills, parenting, discipline, nutrition, safe sleep, child development, breastfeeding, and birth control.

Some participants reported that they had experienced a lot of benefits from the program through the information provided to them by their home visitors. Some participants in particular who had established relationships with their home visitors were provided with various educational materials, information on what to expect during pregnancy, and information on safe sleep practices. One participant mentioned how she was taught how to feed her newborn when she had difficulties with lactation. Overall, participants felt that the program had been very helpful in providing information. Observers noted participants were generally receptive of information provided and, in some instances, referred family members and friends to the program as a result.

"I choose, and she brings it. She provides a list and I choose the one that interests me the most and she normally brings one or two, always brings something planned, and then she lets me choose something from other topics she brings info. about" ~Participant

"The information she gives me. All the information. They come to my house to help and give information. If I have an emergency, I can call, and they will help me be there to answer me. Yes, the benefits are spectacular." ~Participant

"My breastfeeding... wasn't just right for the baby's mouth. He couldn't latch properly. He wasn't able to latch on to the breast but to just the tip a bit of the nipple. So, it wasn't working for me or the baby. And she was going to bring her supervisor so I could learn how to help the baby latch on better by opening his mouth more so he could eat better and so he wouldn't hurt me." ~Participant

Appraisal support included the home visitor helping the mother evaluate her progress, set goals, and achieve those goals. Specifically, home visitors appraised the baby's progress developmentally and otherwise. Using recommended evaluation tools and tests, including weighing the baby, enabled provision of feedback and recommendations.

"So, at first I came and talked about language skills because the last time I came she told me that she was concerned that her child might be behind in his language skills because he didn't pronounce very



Home visitor takes measurements during the visit.

clearly. I gave him a little test and he came out a little low, you know. But, in any case, the fact is that he is working with two languages—the mother speaks to him in... brother speaks to him in English and the father parents in Spanish.” ~Home visitor

Other forms of support that the home visitor provided included **emotional support** and **instrumental support**, including referrals that home visitors provided. The home visitor's established rapport, trust, and an emotionally supportive environment with the participant through active listening, demonstrating verbal and nonverbal warmth, acceptance, and openness, and by responding to participants' feelings and needs. Instrumental support often came in the form of materials that reinforce the curriculum/information given during the home visits, such as books, were supplied by the home visitor. Additional supports received by participants included diapers or other household items.

“She gives me books. She’s brought diapers. It’s very good. I have all the information in a folder she gave me, so I can sit down and read anytime. Or after discussing a topic with her, I can read more in the folder. The only thing is that in this folder... Me, as a mother, should have an agenda. I have one. But I have thought it would be good to have a paper or a little notebook for keeping track of the dates for the visits, the baby’s weight each time... Do you understand? The program was very good, and knowledge was passed across whenever the home visit took place.” ~Participant

“Yes, we have a program called PRP: [Parents as Teachers] Reading Program. It’s a reading program we have for parents to read to their children. We give them five books.” ~Home visitor

Logistics

Logistics of the visit were also discussed. This included the timing of the visits and other tasks that home visitors were required to perform. The frequency of visits varied based on the participants time of enrollment but was usually two visits a month. These visits typically lasted about an hour to 90 minutes; after which home visitors were required to write a report of the visit within 48 hours. Home visitors discussed how they coordinated and/or kept track of tasks.

A key theme that emerged had to do with scheduling and being able to keep the scheduled home visiting appointment. It was agreed that scheduling a suitable meeting time that was convenient for both the participant and home visitor was key. Most participants reported that their home visitors were flexible and always kept to time when meetings were scheduled except on days when home visitors encountered traffic issues. Home visitors said that they would usually let participants know if something changed for them regarding the time—if they were running late or early—and offer them the option to reschedule if that would be inconvenient.



Home visitor approaches the participant’s home.

"Yes, and if I can't do it on the day planned, I asked if she could do it the next day, and she said 'of course.' So that's how we coordinate it. If I can't one day, we change the date or if she has to change. But that hardly ever happens. She always comes as planned. And I think I've only said twice that I couldn't meet on Wednesday as planned. So, we postpone it to the next week if she can't on Thursday." ~Participant

"If it's going to be more than like 10 minutes, I just let my client know but and I always, like, offer the option if I were to be running behind like that, for me I'm going to be 15 minutes late if they like to reschedule. I really... We always offer that option." ~Home visitor

"It's necessary to make room for contingencies. I know some things always happen like traffic and things. So, it doesn't really bother me. I don't do anything but stay in the house all day anyway." ~Participant

"Typically, our visits are anywhere from an hour to an hour and a half but sometimes they went over. If I know I'm running behind or something, I'll let the client know" ~Home visitor

Despite flexible scheduling, and appointment reminders via text, appointment cancellations still occurred. These cancellations were described as frustrating and when they occurred, home visitors tried to reschedule visits. Driving was seen as a part of the job and the driving time varied between home visitors with driving times of 15-20 minutes, or as long as an hour or more. The more visits they have with a participant, they get used to the route and no longer need help navigating. However, when driving a lot was described as being exhausting although a necessity. Home visitors utilized their personal cars to make these trips but were reimbursed for mileage.

Other logistic issues that were discussed include job requirements, such as meetings and training sessions which could interfere with home visitors' ability to schedule appointments with their participants. Paperwork and documentation were also discussed, including paperwork completed with the participants during home visits.

"I have some paperwork that has to be done which I'm going to try to do at the end. It just seems like the one visit that I end up getting with her is when we have to do all the paperwork and I'm sure that she's sick of it. So, I'm going to do minimum as possible as paperwork." ~Home Visitor

Persona

Different aspects of the persona (aspects of their character, motivations, thoughts, and feelings) of the home visitors and participants were captured during the journey mapping process. The observer noticed positive loving relationships between the participants and their children, with participants eager to learn things that would help them parent. Participants and observers discussed a generally positive relationship between the home visitor and participants. Participants felt comfortable around their home visitors and looked forward to the visits.

"Umm because this is my first pregnancy, so I don't know too much. [...] She makes me feel very comfortable. From the very beginning, even when we didn't know each other very well, she made me feel comfortable. She doesn't just come and give me information, and if I have any questions, I always feel quite

relaxed about asking her. She always leaves papers with me, which I read, and when she comes back I ask her about any questions I have, how I can resolve any problem, or any questions. It's very comfortable working with her. And maybe the fact that she is a Latina has something to do with it because I think some workers are American and/or speak English. When I first started, they asked me if I wanted my home visits in English or Spanish, and I explained that Spanish would be easier for me. But, I could have gotten the service in English if I had wanted without a problem. Anyway, visits with [the home visitor] are very comfortable." ~Participant

Aspects of home visitors' personas were apparent from the interviews. Most of the emotions that the home visitors had about their job and engagement with families were positive as they discussed different aspects of the home visit that made them feel excited and gratified in their work. These included observing parenting and family well-being with other children in the family and seeing how well the baby is developing and how well the mother is doing in her role. Some negative emotions were also evident, and these mostly included frustrations about not being able to see the participant due to cancellations and instances where they felt the participant was not being open with them about what is happening in their lives that could interfere with their ability to make visits (e.g., not being open enough to let them know that or why they were not satisfied with the program or wanted to discontinue). Another emotion identified was exhaustion associated with having to drive around for the home visits; however, home visitors also discussed that they did not mind this as it was part of their jobs.

Other aspects of their persona such as experiences and the home visitor's background seemed to influence their relationship with the participant. Having prior experience with a home visiting program or having a family member that had been involved in home visiting seemed to foster a stronger connection with their participant. Similarly, having things in common with the participant or discussing personal experiences with them was also a factor that improved the participant's level of connectedness and relatability with the home visitor.

"Interviewer: Do you usually bring experiences in? Respondent: A lot. I always—because that way, they can feel identified. They look at me as the nurse, like a coach and all of that, and by them seeing that I make mistakes too like, 'I didn't know this but now that I know, I would do it differently,' kind of thing. They're like, 'Oh.' And sometimes you can see it in their face like, 'Really, you did that?' that kind of thing. It makes them—giving you a little bit of your personal information, it connects with them and they listen more to you. That's what I see, and it's been effective until now somehow." ~Home visitor

Personal Safety

Observers noted a disparity between home visitors' accounts about dangerous home environments they encounter during the visits and what they observed. Some of the neighborhoods appeared somewhat run down to the observers, but they did not perceive threats to personal safety during their visits. However, this is likely due to a possibility that the home visitors selected specific locations for journey mapping visits with observers' comfort and safety in mind.

"...they had said that all the neighborhoods are dangerous, they had to call cops, and there are a lot of challenging things in this county. This was nothing." ~Observer

Home visitors had various perceptions regarding personal safety during the home visits. Some home visitors divulged that they felt safe in most of the areas that they had the visits. This perceived safety in some cases was because they had become accustomed to those particular areas. On the other hand, some home visitors felt they had to be on alert and cautious when they were visiting certain homes due to safety concerns.

"This is going to be my third time going there. I mean, the place is not that bad, but I'm always like—I don't know, alert, I will say." ~Home visitor

Positive Experiences

Overall, the experiences during the visits were positive. Home visitors had many positive feelings about the experiences, such as enjoying the interaction they had with the participant. Situations where the participant showed that they valued the visit was demonstrated by being present and reducing distractions during the visit, such as turning off the television; and home visitors' observations of how much progress the participant had made while in the program.

"She's very attentive to her [daughter] which I really do love. She has more of a bonding with her. I know the history with the first child. So, I feel that she's bonding a lot more well [laughter] than she did with the first one. She's doing a fantastic job." ~Home visitor

Participants were asked about their positive experiences being in the program and whether they would rather do something else. A majority of participants reported that the program is very good and that they enjoy the program. Participants reported a positive increase in knowledge—lessons on how and what to expect in caring for their babies. Participants noted that they were provided with resources like books and articles.

Observers found the interactions particularly positive. Interactions between the mother and the baby, the mother and the home visitor, and the home visitor and the baby were described by observers as "awesome." The support that home visitors provided were also a positive factor from the perspective of the observers.

"I feel the mom is receiving a lot of positive information, so being able to be there for two hours to talk about nutrition, talk about safe sleep, talk about breastfeeding is super positive..." ~Observer

CONCLUSION AND RECOMMENDATIONS

The journey mapping approach shows multiple perceptions of engagement and retention in the home visiting program. Participants' emotions and thoughts, as well as experiences they perceived to be positive or negative were captured by this process. Specific factors that affected engagement and retention included distractions during the visit, financial and housing instability, and less than ideal home visitor/participant communication or relationship. Social support, specifically informational support, provided by the home visitors was reported to be beneficial.

Furthermore, conversations around involvement of family and friends also emphasize the importance of fostering additional supportive relationships of families being served by the program. Recommendations include:

1. Consciously including activities and strategies to enable home visitors provide other forms of social support for participants.
2. Including activities that help to engage other caregivers between visits as a way to strengthen the participants' social support systems and to reinforce curricula.
3. Addressing barriers to engagement, including facilitating conversations, that will encourage participants to minimize distractions during the home visit.

Acknowledgement: We wish to extend our sincerest gratitude to the families who welcomed us into their homes for observations and participated in the interviews and to the home visitors who took the time to spend their busy workday with the observers while openly sharing their experiences.

Evaluation Team

Dr. Jennifer Marshall – Principal Investigator, Lead Evaluator
Vanessa Sharon – Research Associate/Project Coordinator
Ngozichukwuka Agu – Research Associate/Project Coordinator
Dogeli Rojas – Research Associate/Project Coordinator
Dr. Takudzwa Sayi – Postdoctoral Fellow
Omotola Balogun – Research Assistant
Oluwatosin Ajisope – Research Assistant
Temitope Bello – Research Assistant
Dr. Pamela Birriel – Research Associate
Kimberly Hailey – Research Assistant
Dr. Rema Ramakrishnan – Research Associate, Data Analyst

For further information on this report, please contact:

Jennifer Marshall, PhD, MPH, CPH
Assistant Professor, Lead Evaluator
University of South Florida, College of Public Health
Phone: (813) 396-2672
Email: jmarshal@health.usf.edu
Website: <http://health.usf.edu/publichealth/chiles/miechy>

This project is supported by the Health Resources and Service Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number D89MC28265, Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsement be inferred by HRSA, HHS, or the U.S. Government.



Florida Maternal, Infant, & Early Childhood Home Visiting Initiative Evaluation: 2017 Alumni Interviews/Discussion Groups Summary



Vanessa Sharon, Priyashi Manani, Ngozichukwuka Agu, & Jennifer Marshall

Introduction

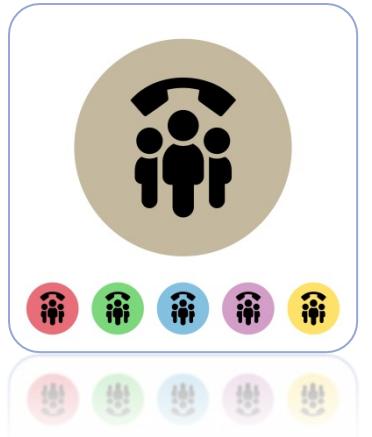
The Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative aims to improve health outcomes for children and families living in high-risk communities. Home visitors provide social support, education and resources to expectant mothers and to families with young children through three evidence-based home visiting models (Nurse-Family Partnership, Parents as Teachers, and Healthy Families Florida). Because positive program outcomes are tied to engagement and retention of participants, a recent focus of Florida MIECHV is to increase recruitment, engagement, and retention of participants by improving services through professional development and by fostering a culture of continuous improvement. Thus, the MIECHV evaluation team recruited a cohort of Florida MIECHV alumni to gather feedback and to better understand their 1) perceptions about the program and the services provided, 2) experiences and challenges encountered during enrollment in the program, 3) factors that play a role in increasing retention and 4) challenges, if any, faced while transitioning out of the program. Engaging alumni who completed the full duration of the program (graduated) as well as those who did not complete the program, provides a range of perspectives that may be different from those who are currently enrolled. We sought to understand former participants' perspectives and experiences with particular emphasis on their individual qualities (e.g. resilience, interest, expectations, commitment, etc.) associated with participation, engagement, and retention in MIECHV in order to generate recommendations for engaging and retaining current and future program participants.

Methods

The target population for the 2017 Alumni Group was mothers who were enrolled in the Florida MIECHV program for at least six months and left the program between May 2016 and April 2017. Participant information was retrieved from Florida Home Visiting Information System (FLOHVIS); those who met eligibility criteria were contacted by telephone and invited to participate in focus group calls. Upon agreeing to participate in the evaluation, participants completed a brief demographic survey by phone and listed their preferred days/times for scheduling focus group calls. Focus group phone calls were set up each month (July, August, and October) with 2-3-time options; one call during the weekend and the other during a weekday (morning and evening) to accommodate participant preferences. Semi-structured interview guides were used to elicit information on 1) enrollment and engagement, 2) engagement and retention, and 3) retention and

transitioning out of the program. Discussions were facilitated by the Lead MIECHV Evaluator and Graduate Research Assistants trained and experienced in qualitative research methods. Participants were compensated with a \$25 gift card for each call in which they contributed.

All calls were conducted in English and research team members fluent in Haitian-Creole and Spanish were included in the call to provide any translation needed. Separate group discussions were offered in Haitian-Creole and Spanish, however all participants preferred to join the English calls. Some translation was provided. Following participants' verbal consent, discussions were audio recorded and transcribed verbatim. Transcripts were reviewed by team members for accuracy and thematic analysis was conducted.



Results

Participant Characteristics

A total of 330 former participants who met inclusion criteria were called. Majority had disconnected telephone numbers (128) or did not answer or return calls (110). Of the remaining 92 participants, 34 agreed to participate, and ultimately 5 joined at least one of the calls. Table 1 summarizes the participants according to call, MIECHV site, and model. These participants represent four counties, all three home visiting models, and speak English, Spanish (1), and/or Haitian-Creole (3) had either dropped or graduated from the program. For calls where there was one participant, an individual interview was conducted.

Table1: Participant characteristics

	Call #1 7/25/17 10:00 am	Call #2 7/25/17 5:00pm	Call #3 8/27/17 2:00 pm	Call #4 8/31/17 5:00 pm	Call #5 10/26/17 10:00 am	Call #6 10/26/17 5:00 pm
Total Participants	2	1	3	2	1	2
Site	Broward DeSoto	Duval	Broward DeSoto	Orange Broward	Broward	Broward DeSoto
Model	NFP PAT	NFP	NFP NFP PAT	HFF NFP	NFP	NFP PAT
Age of children	1 & 2 yrs. old 6 mos. & 1 yr.	2 yrs.	3 & 4 yrs. 1.5 yr. 18 mos.	1.5 yrs. 1 & 2 yr.	18 mos.	1 & 2 yrs. 6 mos. & 1 yr.

Enrollment

During the first (July) calls, participants discussed how they came to be enrolled in the program including sources of referral, the process of enrollment, reasons why they enrolled, facilitators to enrollment and challenges to enrollment. Sources of referral into the program included other providers such as their ob-gyn/nurse and other

programs. Participants reported that the enrollment process was relatively easy, although one participant did mention reticence at first:

Because they don't know the beneficial [benefit] of it... When I first started, I'll be honest with you, I've missed like a few meetings in the beginning. I don't know if she'll meet with me [...] and then let's say she'll reach out and when I visit, I got to wait for next visit [...] I don't know, honestly, what I was thinking at that time or the whole situation at that time, but then I actually noticed, 'Hey, I have this issue with my baby. I have this question.' I've got to call her more because I'm missing out the meetings that we have or the visits that we're supposed to have. I realized that. 'Oh yes. I do need her. It is beneficial.'"

Most of the reasons for enrolling in the program centered around participants' expectations of potential benefits from participating in the program along with having time to invest in participation. Perceived benefits/expectations included a desire to obtain more information about parenting (especially for first time mothers) and child development, a need for support, ease of obtaining services, material support, activities (as one parent said, "doing things like going places") with the home visitor, learning for both participant and the child, an interest in having the home visitor teach and conduct activities with the child.

"At the time, I think I needed – I thought it would be best for me to get some type of a support system. So, it fits since I didn't have really any family here to even really talk to and communicate what I was going through or, you know, what choices. I thought that it will be best if I – now, I can't say if I would have taken the same steps if I was back in my home state. I think just knowing that there are programs available, I just took it upon myself to find something and become active."

"The only reason why I actually gave it a try was because I'm not afraid to try things for the first time and what the heck, maybe I will enjoy it, you know? Maybe I'll like it and it's something that I'll benefit from. So, I went ahead and took the chance."

In discussing how their expectations were met by the program, responses varied between the groups. In one of the groups, responses were positive as participants agreed that the program had met their specific needs or expectations which prompted them to recommend the programs to others. Participants who had positive responses regarding how the program met their expectations discussed a trusting relationship with their home visitor and being able to rely on them for information and other forms of support. Their positive perception of the program led to them referring other mothers to the program.

"I think it went above my expectations. Because whenever I had a question or concern, I can always turn to my nurse. She came to work like a confidante. She always shares things with me that would make me kind of consider broadening my horizons; considering maybe going back to school. Those kinds of personal conversations that you might have with a friend, I was able to have with my nurse. As I continue to determine am I going to continue to be a homemaker? Am I going to decide to go back in the work field or continue to do small entrepreneurship? We had those consultations also which I think is important especially for a new mom. For me a new mom and in the state, I have a lot of other things to consider. She was very helpful in providing some information that may actually be a part of my growth process on the top of becoming a mom."

Unmet expectations were also discussed in one group, including the realization that the home visitor was there to facilitate the parent teaching the children versus teaching her children directly. Another felt that the level of information received did not add significantly to what she could find on her own. However these participants agreed that they would recommend the program to others.

"I'm like, this is going to be helpful because I'm going to save time, and they have they have these experiences with other families that have children, so they will know what kind of words or they can tell all these kids are not going to learn this way, you got to learn that way. Since it didn't happen like that, yes, I was disappointed. Like, okay, no. I'm left where I started. I got to find a way to teach him myself."

Challenges to enrollment included the wait times to begin the program, with a participant discussing that the initial delay of the contact call may discourage potential participants:

"The amount of time it might take for someone to call you that might be the only thing that sometimes may discourage someone if you don't hear or get a phone call and you are expecting to try and be a part of the program. That will be the only thing"

Other challenges were concerns over potential difficulty in communication or having to change home visitors during the program. One participant discussed how she was initially concerned about understanding the home visitor's accent, but found that there were no difficulties with communication as initially feared. Also, in the case of staff turnover, a participant found that she transitioned smoothly to a new home visitor with the aid of the supervisor. Another challenge that was mentioned was difficulty in canceling the program; a participant wanted to discontinue but felt pressured to complete a certain number of visits. Another participant felt unprepared for the visit because the home visitor had not given her prior notice about household materials needed to carry out activities. Participants shared their perceptions of individuals who enrolled in the home visiting program versus those who do not:

Characteristics of mothers who enroll	Characteristics of mothers who are not enrolled
<ul style="list-style-type: none">• Like to be prepared• Willing to take a chance• Organized	<ul style="list-style-type: none">• Do not realize the need to prepare for parenting• Do not know the benefits of the program• Have busy schedules

Engagement

Participants described the benefits of being engaged in the program and factors that enhanced or impeded engagement. Benefits included the helpfulness of the program in navigating motherhood, receipt of useful

information, and instrumental support (e.g. books for the children). One participant shared how the provision of “random” information was really useful in parenting and was a benefit they enjoyed as a result of being engaged in the program. This reinforces the adage that “you don’t know what you don’t know”. Participants were asked to describe the program in one word:

Caring

Beneficial

Interesting

Learning

Early engagement in the program was best when clients were receptive, open, and available to the home visitor. Home visitor factors that facilitated engagement included connection with the children, demonstrating for parents how to perform activities, and home visitors being involved in ways which served to provide additional support to the parent and family. For example, home visitors sometimes involved other family members (e.g. parent, in-laws, or partner/husband). There were varying levels of involvement from family members that ranged from limited participation (sometimes due to language barriers), to sitting in on visits as an observer, to actively learning from the home visitor. One client shared how the home visitor helped to pass along information to her mother regarding safe sleep that was contrary to the grandmothers’ previous knowledge and experiences.

He [husband] was also enjoying [home visits] because we are... for more information. Because he was like me, he was like me all the time, he would be with the baby. We didn't – we just got married and have a baby and we are excited we have a baby but we didn't know we what to expect.

The foremost challenge to engagement experienced by participants was time and scheduling conflicts. Other challenges included a mismatch between information needed versus offered/provided. The program competed with other time-consuming priorities such as work hours, or household chores. Another challenge that emerged was inconvenience of visits especially in situations where the home visitor showed up without prior notice or earlier than planned; in these cases the client felt they did not have enough time to prepare for the visit. Below are quotes that capture some of these challenges from the participants.

“But what I didn't like was that she would come, the person who was in charge, first, would come and she would be like, “Okay, today we're going to do this activity, and this helps with his coordination,” or whatever. But then she was like, “Do you have a rope? Do you have this? Do you have that?” Half of the time, of course, I wasn't prepared. I didn't know it beforehand”

“When she would show up an hour earlier when I wasn't expecting her, I was like, ‘Oh my gosh.’ I had to pardon this one like, ‘I'm sorry for my mess.’ Then she'd be like, ‘It's okay. It's okay.’ But to me, it made me feel uncomfortable.”

“Well, I'll be honest with you. At first, in the beginning, I thought I didn't really need the program so I tried to avoid setting up appointments with the nurse and we have to have... So some people may think they may not need it, but in my scenario, it was actually scheduling, keeping up with the program.”

In terms of program design, most participants felt that the number of home visits was adequate and appropriate. Another design factor was communication; having the home visitor call frequently was seen as

useful and a sign that the home visitor cared. Participants agreed that the amount of communication should be individualized and tailored to the family's schedule once rapport was built. Acceptable forms of communication included calls, texting, and potentially some visits via phone or videoconferencing (facetime, skype) to continue to provide support to parents who are unable to complete in-home visits.

"I had to go back to work... business hours is 9:00 to 5:00, I think I actually got off a little after, so what she would do, sometimes she would just drop off some things off to my mother, write down a little note or she's providing the information that I would need. Sometimes, I would text her and if I have a question-if my baby is weeping, coughing in a certain way. If she's using a particular soap that I've seen and I noticed the difference, I'll text her and she'll reply. She just told me, 'Hey, if you want to meet up on Saturday' ...we met up on Saturdays."

Retention

The facilitators and barriers to retention were also discussed. Facilitators of retention were related to characteristics of the home visitor, such as her ability to make the participant feel comfortable and to answer any questions the participant had. Another factor was the caring nature of the home visitor.

"That's what I think of the program. I really didn't care too much for it, but I think there's the nurse that helped was the reason why I stayed in the program for so long because she became like a part of my family, but then she left."

Challenges to retention were time constraints and a change in home visitors. The time commitment can be burdensome and frustrating when the scheduled visits were changed by staff as one parent explained, "Yes. It was an inconvenience to me a lot of time actually."

"I guess for me, it would have been schedule being more constant. No random showing up. It would have been a little more, I guess for me, helpful. [...] being more concern that they do show up on their scheduled appointment."

"Yes. She changed it up. She showed up –this is the first one [home visitor]. She would show up at random times or she would tell me, 'If you let me come in this week, I'll come next week and I don't have to come to the next two next weeks.' And then I felt like she was coming on a Friday and she's coming on Tuesday and I was just like [...] After a while I was like, 'Okay. This is too much. I feel like she's in my house almost every week..'"

Some participants mentioned experiencing discomfort with dealing with and building trust with a new home visitor after their previous home visitor left. On the other hand, some participants had positive relationships with two or more home visitors. Another challenge that was mentioned was a difficulty in getting back into the program if a participant changes their mind after having dropped out.

Transition

In terms of transitioning out of the program, participants were asked if they enrolled in other programs, what their current needs are, their sources of help and support after the program, and if they maintained contact with their home visitor. Most participants were not in any program after graduating or dropping out of the MIECHV program. Reasons for this included that they felt all the other programs will be similar or they had tried to get into another program and hadn't yet been successful (due to cost, eligibility, or waitlist). One participant mentioned that she wanted to re-enroll with her second baby, but the program was for first-time mothers, so

she utilized the handouts and materials from her MIECHV home visitor that had been shared when she had her first baby.

My son was two when he graduated and [the home visiting program] only do first-time mothers and I got pregnant immediately with a second baby so they're both 15months apart. Because I was already a stay at home mom with the first baby, it was harder for me to maybe potentially find any other programs. Then, I was able to adjust because the children were so close in age. We utilize a lot of the materials that I had from the first baby. I would more than likely try to find programs such as Healthy Moms, Healthy Babies or Healthy Families. They actually called not too long after I had the second baby but they didn't follow up after the initial phone call."

Current needs of participants included child care, housing, and other resources. One participant mentioned that their child doesn't qualify for preschool subsidies and daycare is expensive, so she teaches the child at home but has concerns that child may not be prepared for preschool/kindergarten and that the situation offers little interaction with other children. Others expressed continued need for information about child development and developmental screening. Affordable housing and living expenses continued to be a challenge for some participants, and a crisis for one in particular.

"Because of financial reasons that's why she's [my child is] home. If it wasn't for that, yes, she'll actually be in daycare. I'm actually having a living issue right now"

"I've actually called different programs before I even became homeless with my daughter, and this is actually emotional. I called and he told me that in order for them to accept me, I have to actually be homeless-homeless. So now, I'm actually homeless. Every day I pay for a motel room and a hotel room, that's \$90.00 a day."

[Note: This parent was put in touch with her former home visiting program and connected to housing resources]

After leaving the MIECHV program, sources of help participants mentioned included their pediatrician, family and friends (e.g. husband, child's father, mother, husband's coworker who helped with childcare). One participant discussed that their sister-in-law helps with informational support with regards to their child's learning needs. Other sources of help that were mentioned by some were specific programs such as WIC and housing assistance. When discussing continued relationship with home visitor, several participants discussed that they were not in touch with their home visitor following the program. Reasons given for this were a lack of bonding with the home visitor, or for some it was the awareness of home visitors' busy schedules. One participant discussed remaining in touch with their home visitor and continuing to rely on them for information about programs and services.

Other Suggestions

During the discussions, participants had some suggestions for improving enrollment and engagement in the home visiting program. Advertising the program to new mothers who may need it was suggested as a potential way to increase enrollment. With respect to engagement, participants suggested strategies to limit issues that may arise with scheduling visits. These strategies include scheduling visits during the weekend as well as exploring options for video chatting which would give parents even more access to the program information and services.



Conclusion and Recommendations

MIECHV alumni discussed their perceptions of the Florida home visiting program including the strengths of the program as well as challenges faced. The participants discussed enrollment, retention and engagement, as well as transitioning from the program. Majority of the participants recognized the program as a success. The program provided them with much-needed support, knowledge and training related to child growth and development among others. Many mothers enrolled in the program are single or first-time mothers, hence, the resources and support both material and emotional provided as a part of the program is very beneficial.

"For me, their involvement and kind of participating in the steps that you're taking in your life [...] I'm a mom and going through the experience. They're very helpful; they're very supportive. So, for me, it was helpful in growing into motherhood... Gave me another support system outside of the people that I live with." Yes, the main

"Yes, the main things that I really love, well, all the nurses I had because they were so intelligent, the fact that they understand that I was a new mom and they provided me all the information that I needed. I could call them at any time as well if I liked and also, she provided me with books, that's one thing. She taught me to teach my daughter how to read and interact with colors and everything in her busy life."

Recommendations for increasing enrollment, engagement and retention, and to ensure smooth transition from the program included:

1. Adequate description of program and services provided by the program as well as discussing participants' expectations at enrollment to ensure that there is clarity and limit dropouts due to unmet expectations.
2. Providing home visiting services over the weekends or after business hours.
3. Ensuring consistency in the home visitor once assigned as much as possible, unless requested by the participant.
4. Increasing access to program services and resources, such as video conferencing.
5. Improving training of home visitors to cover broader area of topics and more in-depth parenting information.
6. Consistent scheduling and keeping of appointments by the home visitor.
7. Continued support for participants after transition from the program.

For further information on this report, please contact:

Jennifer Marshall, PhD, MPH

Assistant Professor, Lead Evaluator

University of South Florida, College of Public Health

(813) 396-2672, jmarshal@health.usf.edu

Florida MIECHV Evaluation <http://miechv.health.usf.edu>

This project is supported by the Health Resources and Service Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number D89MC28265, Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsement be inferred by HRSA, HHS, or the U.S. Government.



Using PhotoVoice to Illustrate Engagement and Retention in the Florida Maternal, Infant, and Early Childhood Home Visiting Program

Dogeli Rojas, Ngozichukwuka Agu, Jennifer Delva, Omotola Balogun, Dr. Takudzwa Sayi, Abimbola Michael-Asalu, Dr. Rema Ramakrishnan, Pamela Birriel, Esther Jean-Baptiste, Vasthi Ciceron, Vanessa Sharon, Carlos Parra & Dr. Jennifer Marshall

Executive Summary

The success of a home visiting program is dependent on engagement and retention of enrolled families among other factors. Understanding multiple perspectives around engagement and retention can provide insight into best practices for improving participant engagement and retention. To gain a unique insight into participants' perceptions of engagement and retention, a Photovoice project was implemented. Participants were asked to take pictures that represented 1) their experiences as a parent, 2) meaningful adults in their child's lives, and 3) experiences with their home visitor.

Three participants returned photos and participated in interviews that aimed to understand the significance of the photos. In capturing their experiences as parents, participants took pictures that showed their identity as parents and goals they had for their children. Their identity as parents centered on bonding with their children, promoting their children's happiness, and caring for their children. Participants' goals for their children included enhancing parenting through promoting cultural and religious values.

Pictures also showed meaningful adults in the lives of their children – fathers, grandmothers, and home visitors. Grandmothers were said to provide emotional and instrumental support while fathers were recognized as a source of emotional and informational support. Experiences with their home visitors were showcased through pictures and discussions around the relationship they had with their home visitor as well as the home visitors' provision of instrumental, informational, and appraisal support.

The Photovoice approach highlighted salient factors that are important to participants. Findings from this project showed that the quality of the relationship between the home visitor and client plays a key role in their engagement and retention. Another factor that influenced engagement and retention was that some of the participants did not have a large social support network and relied on the home visitor to provide these supports for them. Recognizing what is important to families and supporting them to achieve those goals could potentially increase their engagement and retention in the program.

Introduction

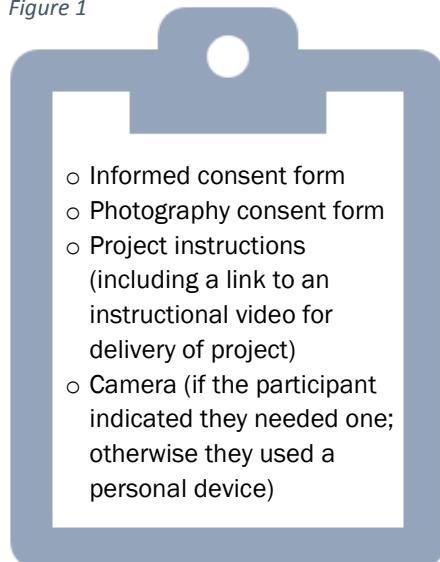
The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program offers evidence-based home visiting services and referrals to support mothers and pregnant women who live in high need communities. An adequate level of connectedness between the home visitors and the participants is required to enable provision of support. Engagement and retention in the program is crucial for enhancing the experiences of participants, perceived benefits of the program, and program effectiveness. The connection between the home visitor and participant as well as an understanding of the needs of participants and their families can foster engagement and retention in the program. Engagement and retention among participants in the Florida MIECHV program has been studied using various methods such as interviews with program staff and Journey Mapping. This report describes findings from a Photovoice project which explored engagement and retention in the home visiting program.

Photovoice is a participatory action research method which utilizes photography and dialogue to deepen understanding of strengths, issues or concerns. Information gathered through Photovoice can be used along with other qualitative and quantitative information to influence policy- and decision-makers. Specific to the Florida MIECHV context, the use of photos served as a means of letting participants tell their own story regarding their experiences as it relates to family, social support systems, and the home visiting program.

Methods

The Photovoice project utilized a combination of photos and interviews to shed light on current participants' personal experiences with parenting, significant adults in the lives of the families involved, and the role of the MIECHV program and home visitor in the family's lives. While usually conducted in person groups, for the purposes of the state evaluation, this project was conducted remotely using home visitors and liaisons. Participant recruitment was done through quota sampling with random ordered lists for each subgroup. The target sample size was 10 participants i.e., seven English-speaking, two Spanish-speaking, and one Creole-speaking with the aim of getting a sample representative of the Florida MIECHV population. Seven participants were initially recruited of which four were English-speaking, two Spanish-speaking, and one Creole-speaking. Of those recruited, three completed the Photovoice project of whom two were Spanish-speaking and one Creole-speaking.

Figure 1



Once participants agreed to participate, their home visitors were contacted and sent a package to deliver to the participant. The contents of the package are listed in Figure 1. Participants were given 2-4 weeks from when they receive the packet, to complete the project and return the necessary paperwork and photos either by email or via their home visitor. Upon receipt of the photos and consent forms, the research team conducted phone interviews to further explore what each photo meant to the participant and why they chose to include it in their submission. All interviews were audio recorded and transcribed verbatim.

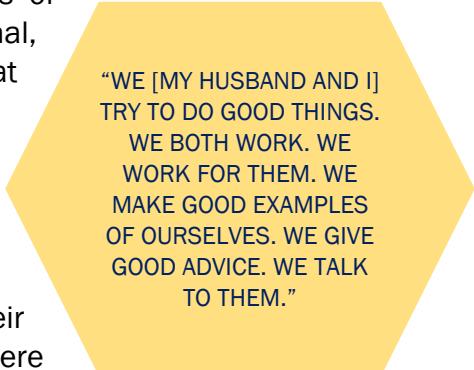
Data analysis began with checking of transcripts for accuracy. After transcripts were checked, two members of the research team went through the transcripts and pictures to identify the photos that participants had selected as well as the contexts of those photos. Pictures and interview data were independently categorized into themes and jointly discussed to come to a consensus.

Results

Respondents expressed that their parenting goals were influenced by their values, culture, and future expectations for their children. The meaningful adults in the lives of the families and children were noted to be important sources of social support in the forms of instrumental, informational, appraisal, and emotional support. All participants stated that the MIECHV program and their home visitors played an important role in their lives; especially in the development of their children.

Experience as a Parent

Participants took photos that captured their experiences as a parent (Pictures 1-6). These pictures were mainly photos of themselves and/or their children performing specific activities or in locations that were significant to them. They explained their identity as parents and their goals for their children when they expanded on what the pictures meant to them. Their identity as parents included discussions around elements of parenting that they believed were important in upbringing. Bonding with children to build relationships, especially in the form of spending time together, was a common element among all parents. Furthermore, pictures and interviews captured ways in which they care for their children (picture 3) and how important their children's happiness was to them (pictures 5 and 6). Goals for their children included teaching them culture as well as enhancing parenting through spirituality. Teaching their children culture during their time together was one way parents taught values and guided their children to a better understanding of their mixed culture i.e., American and their parents' native cultures beyond , that they were growing up in (picture 2). Exploring spirituality and enhancing parenting through emphasizing the role of the church was also mentioned among some parents (pictures 1 and 4). These parents



"WE [MY HUSBAND AND I] TRY TO DO GOOD THINGS. WE BOTH WORK. WE WORK FOR THEM. WE MAKE GOOD EXAMPLES OF OURSELVES. WE GIVE GOOD ADVICE. WE TALK TO THEM."

expressed that the church and its teachings help to prepare their children for future careers, to be humble, to help others, and overall to be good people. In addition, parents measured their own happiness through that of their children. They mentioned that seeing their children happy made them happy, too.

Meaningful Adults in the Child's Life

Photos were taken of grandmothers, fathers, and home visitors who were all regarded as significant figures in the participants' children's lives (pictures 7-9). Significant figures were often defined around the type of support they provided for the participants and their children. For example, grandmothers were identified as great sources of instrumental and emotional support even when they lived in other countries. One participant was unable to provide a picture of her child's grandmother who was out of the country at the time, but named her as a meaningful adult, stating that the grandmother provided financial support

by helping provide shelter for her and her child. Another participant had a picture taken of herself with her children and their grandmother and discussed that the grandmother was able to build a loving and caring relationship with her children in a short amount of time (picture 9).

"[...] to start school. That's what [my home visitor] says she needs now. She jokes that she doesn't even have to go to pre-K. She's like a teacher now. Everything she presents to [my daughter], she does it well."

Home visitors were acknowledged for their important role in the growth and development of the participants' children. Participants indicated that their children showed developmental progress, such as speech and school readiness, with the guidance provided by their home visitors. One participant indicated that they have had the same home visitor for three years and that they now consider the home visitor to be part of their family. Another mentioned that the home visitor has been supportive since the very first day (picture 8).

Fathers were mentioned by two participants. While one father did not want to be photographed, the participant mentioned him as an important figure in the life of her daughters and recognized his participation in spending time together. Another participant discussed the important role that the father plays in the lives of their children; especially because they are the only two adult figures around the child (picture 7). She went on to say that they both work for their children, try to set good examples for them, and try to give them good advice.

"[Home visitor] always brings a form to measure stress and another form to create goals."

Experience with MIECHV/Home Visitor

To represent their experience with their home visitors, participants took pictures of their children, themselves, and their home visitor separately or together (pictures 10-12). Pictures were of participants, the children and the home visitor smiling at the camera and

children playing or engaging in learning activities with their home visitors. All participants indicated that they have good, trusting relationships with their home visitors. Participants mentioned that they feel that they can trust their home visitor and can reach out to them outside of home visits with questions or concerns (picture 10 and 11). Home visitors were recognized as great sources of informational, instrumental, and appraisal support. Participants stated that home visitors provide useful informational material and advice about the growth and development of their children (picture 11). For their children, they provide toys and activities that test development and progress (picture 12). Home visitors provide appraisal support for parents by reassuring them in difficult situations, guiding them in setting and meeting parenting goals, and encouraging them in their personal lives and as a parent. Positivity, respectfulness, and helpfulness were all traits of home visitors that participants discussed contribute to positive relationships. All participants mentioned that home visitors had positive relationships with their children.

"WHEN I FIRST HEARD OF THE PROGRAM MY SON WAS ALMOST THREE [AND] HE WASN'T TALKING AT ALL AND [MY HOME VISITOR] HELPED ME A LOT LIKE [WITH] GETTING HIM INTO SCHOOL. THEN WHEN HE STARTED SCHOOL HE STARTED TO TALK AND TO LEARN."

In addition, all participants acknowledge that the MIECHV program plays a significant role in their lives and the lives of their children. One participant mentioned that she was initially skeptical of entering the program, but later learned a great deal by participating. In some cases, having the same culture enhanced the participants' experience in the program. Participants would recommend the program to others.

"[The program] turned out to be really good for us. I have learned a lot, gained new knowledge. I have learned about how [my daughter's] skills develop at each stage and what she can learn. Her potential and her abilities. Now I understand more about development."

Discussion

Engagement and Retention

The objective of using Photovoice for the MIECHV program evaluation was to identify themes related to engagement and retention. Though participants were not specifically asked about their engagement and retention in the program, the interviews allowed for participants to reflect on their experiences as parents enrolled in the program through lenses which they may not have otherwise explored. Through the interviews we recognized

that the quality of the relationship between the home visitors and parents, and home visitors and children, played a significant role in parents' engagement in discussions and activities. Strong positive relationships between parents and their home visitors gave parents the confidence to trust in their home visitor and reach out to them regarding various topics around parenting. Another influence was the different forms of social support parents got from their home visitors which was helpful in parenting and in their child's development. We've learned that recognizing these parents' commitment to family values, happiness, learning values, and culture will offer insight into rapport building and enhancing engagement and retention among families. Photovoice highlights what is important to families beyond screening and the curricula of the home visiting models implemented with MIECHV support.

Photovoice Process

Utilizing Photovoice to capture factors related to participants' engagement and retention was a way to provide unique insight into family's perspectives on engagement and retention. This process was also advantageous because it is strengths based – focusing on family and program assets and motivations and identifying influences on engagement and retention. There were, however, some challenges in conducting the project remotely as the methodology is often delivered in-person. Difficulties were also encountered during recruitment and retention of Photovoice participants. Despite the small sample size, informative pictures and valuable information was retrieved from participants that may not have emerged through other methods. Home visitors played a crucial role in facilitating the Photovoice process by serving as liaisons between the evaluation team and participants.

For further information on this report, please contact:

Jennifer Marshall, PhD, MPH
Research Assistant Professor
University of South Florida, College of Public Health
Department of Community and Family Health
(813) 396-2672

This project is supported by the Health Resources and Service Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number D89MC28265, Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsement be inferred by HRSA, HHS, or the U.S. Government.



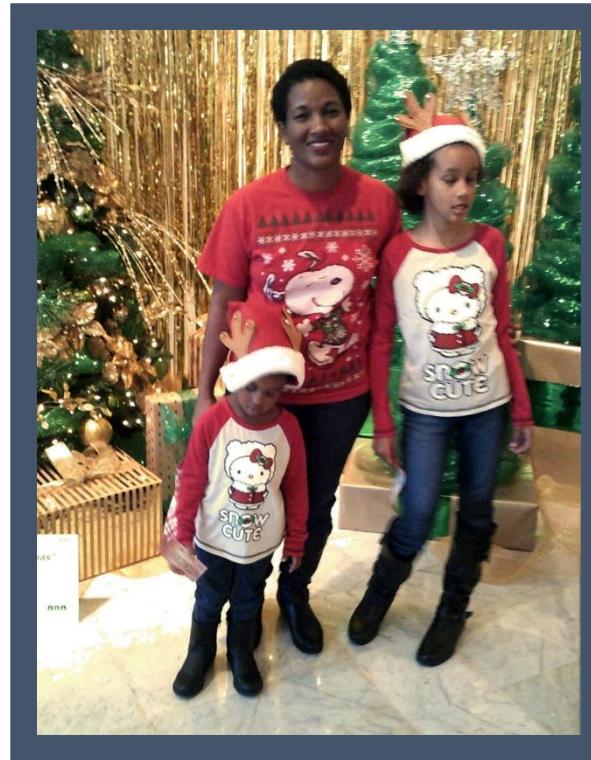
Experience as a Parent



Picture 1.

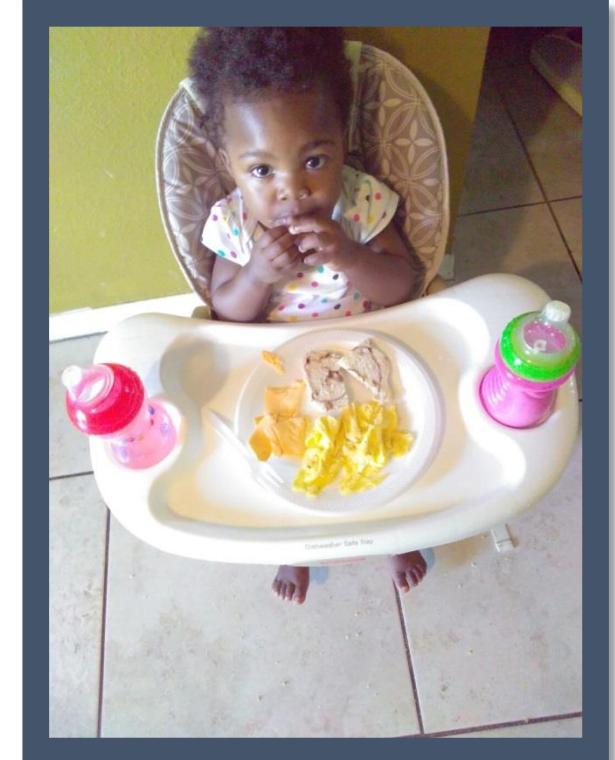
[The church] is a place people are taught these things: to be good, to be humble, to be nice, to be a spiritual person. It's a place where you can disconnect from the outside world and focus on spiritual matters inside a church."

"I want [them] to learn to be human beings, more humble. Because I think if you're humble you can do anything and go anywhere. Because today's material possessions won't mean anything tomorrow. But if you are a good human being, to be humble, to serve others, these are things that will stay with you your whole life. These things are priceless."



Picture 2.

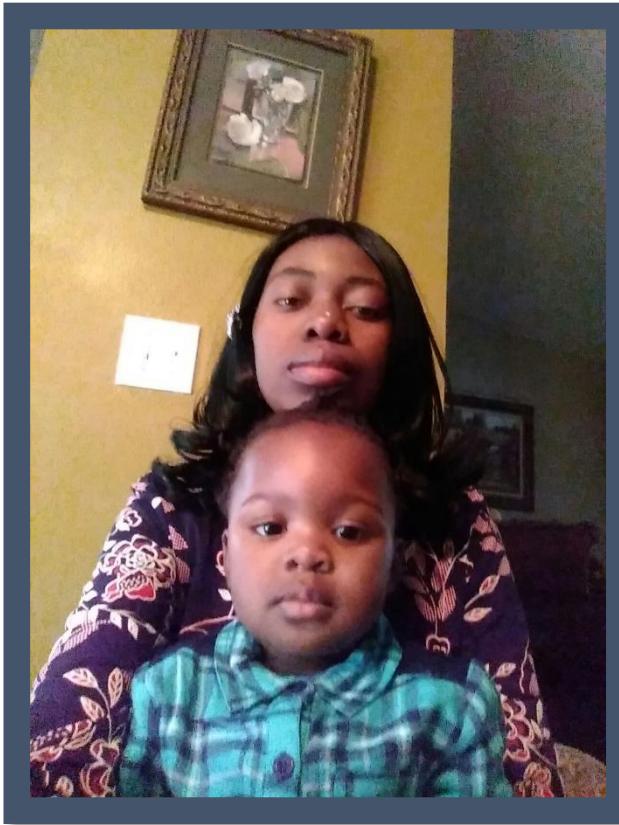
"The Christmas tree [picture]. I am Dominican. And she is being brought up here and I would like her to learn about every season of the year here. I want her to know what it symbolizes and its significance. For them to live their traditions since they are being brought up in this country."



Picture 3.

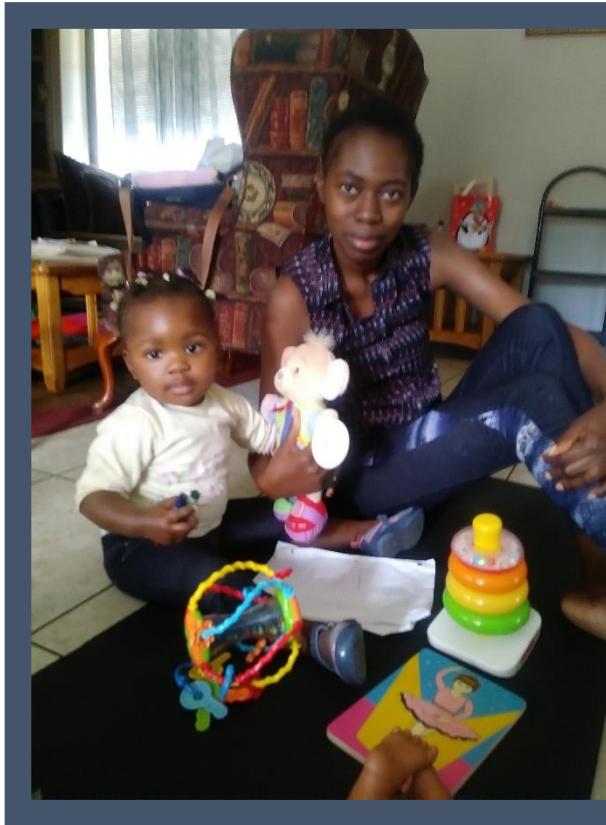
"The fact that you love your child makes you care for her and feeding is one thing that shows your care for your child in love."

Experience as a Parent continued



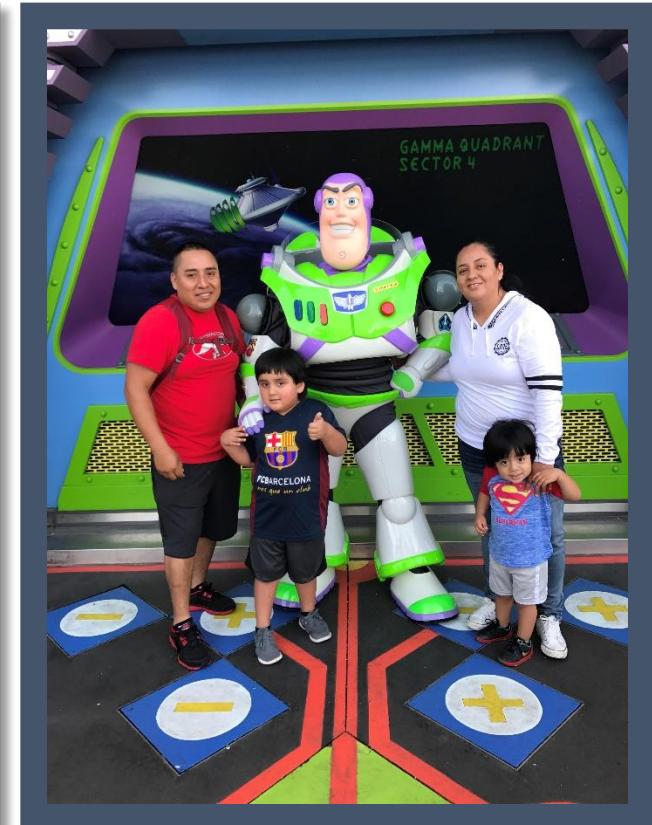
Picture 4.

“Because first of all, [this picture] reminds me that it will be a memory for my child that I used to go to church with her, and then every time I come from church, I always have fun with my child. So, it will be a great memory for my child either when I’m gone or when she’s older and we’re having a good time, it will remind us, both me and my child that when she was just a small child, how we used to have fun and how we still have fun.”



Picture 5.

“This one gives me joy because my child is able to play. She’s not in the hospital. Yes, a lot of children are not able to play. They are not able to play because they are sick. They can’t breathe. This makes me happy every time I see her play that reminds me, that shows me that she is a very happy child. Whenever she’s happy, I’m happy too. Whenever she’s sad, I’m sad too.”



Picture 6.

“Well, I think I’m doing a good job because they are very happy children. I try to give them as much as I can. I try to teach them good things.”

Meaningful Adults in Child's Life



Picture 7.
(Above) "[...] we two [my husband and I] are the only ones in our children's lives because we don't have any other people near us. It's just us two."



Picture 8.

(Left) "Yes, and I was very happy when I found out we [HV and I] were from the same hometown. Secondly, she gives me advice. She always gives me advice and I tell her anything. I tell her anything. Anything that bothers me I tell her and she gives me advice. She always pushes me or encourages me to live. Even though I have problems like I'm not working, she pushes me. She encourages me to get a work. Sometimes, she talks to people about me, people who have jobs. She helps me a lot. She helps me. She does the job that my mom could have done if she was close to me."



Picture 9.

(Left) "She's [my grandmother is] important because, look. For one thing, I never knew either of my grandmothers. I didn't know either grandfather or grandmother. So, for me, it's very important for her to be able to have a relationship with her grandparents, talk to them, know them and experience so many moments with them, especially at the different stages of their lives, and for them to have that experience that I didn't have because I didn't know any of my grandparents. Play with them, share moments, go to a park, go anywhere. That they feel the love of what is a grandmother or grandfather. I didn't have that."

Experience with the MIECHV Program/Home Visitor



Picture 10.

(Above) "My relationship with her [home visitor] is very good. Any time I have a question, I call her and she explains what I need to know or gives me advice as to my best option. She helps me tremendously. I have had a wonderful experience with the [home visitor] that I have, [...]. I have had a really good experience with her."

Picture 11.
(Right) "[Home visitor] is very respectful to me. She's always been interested in Emma's learning the things she brings. She gives me advice about what I can do to help Emma learn more and develop.

Our relationship has been very good. Very instructive and educational for us. She's been very good for us."

(Right) "Of course. I find it very motivating. It's nice to work with someone who isn't just about money, who is very sociable, very nice, very caring, and who does her job with love, with the objective of helping others."



Picture 12.

(Left) First of all, number eight shows my daughter playing and she was looking at the home visitor and she was very happy. First of all, she was playing and she was writing. She was writing. Every time she comes, she gives her toys to play. In that day, she was writing."



(Left) "She's [Daughter is] a great writer. Even though she's still small, but she knows how to write because my home visitor teaches her how to write. Not me, I didn't teach her. [Laughter] She [HV] taught her how to write and that picture shows me that my child was very happy and she had a doll in that picture."

Social Determinants of Health

Evaluation objectives in engagement and retention were to:

- To understand experiences, barriers and facilitators in relation to social factors that affect MIECHV participating families regarding:
 - Immigrant health
 - Social support
 - Adolescence
 - Housing
 - Intimate Partner Violence



Florida Maternal, Infant, & Early Childhood Home Visiting Initiative

Intimate Partner Violence Learning Collaborative Baseline Report August, 2015

Introduction

One of the components of the Florida Maternal Infant and Early Childhood Home Visiting (MIECHV) Initiative is to offer support to families experiencing intimate partner violence (IPV) or those that are at-risk. This process includes screening and detection of ongoing IPV, creating safety plans and providing ongoing support as well as referrals to appropriate agencies. The Florida MIECHV State Continuous Quality Improvement (CQI) Team determined that a more comprehensive approach to IPV is needed and set up a Learning Collaborative modeled after the Institute for Healthcare Improvement Breakthrough Series to fulfill this need. The purpose of this report is to discuss the baseline knowledge and confidence level of home visitors with regards to IPV screening and supporting families experiencing IPV; and to describe the content of the breakout sessions that took place during the first of three Learning Sessions (LS).

Methods

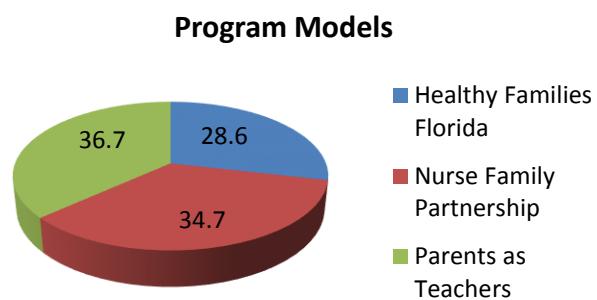
To determine the baseline confidence and knowledge of home visitors in offering support for families experiencing IPV, a brief survey was distributed via email link to Qualtrics online survey software platform to all home visitors working in nine of the 11 Florida MIECHV programs (2 were excluded because of their participation in the national Home Visiting Collaborative Improvement and Innovation Network [HV CollIN]). This very brief survey was developed by the state CQI team and reviewed by an expert panel. The questions collected information on participants' program affiliation, previous training experience, and questions to assess confidence and knowledge pertaining to IPV service delivery.

The Learning Collaborative began with a two-day Learning Session (LS1) for the nine teams.

Specific components that were addressed in LS1 included the definition, prevalence and impact of IPV on survivors and their children. Other components included strategies for improving IPV screening and support services for survivors, measurement through appropriate data collection and reporting, and appropriate referrals. Specific themes that were discussed during LS1 included strategies for interacting with IPV survivors and issues around protecting client information, best practices for IPV screening, identification, safety planning and service coordination. The LS was made up of presentations alternating with group activities to engage participants in active learning. On the second day, discussion groups were held in breakout sessions - one for home visitors and the other for supervisors. These breakout sessions enabled each group to discuss their thoughts about the presentations they had listened to as well as challenges in the field and potential strategies to overcome these challenges.

Baseline Survey Results

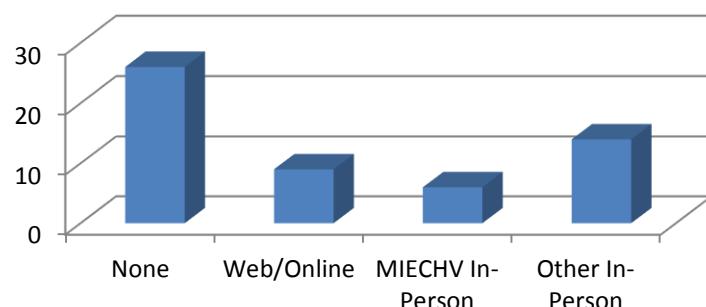
A total of 52 home visitors accessed the survey, and 49 completed the survey in its entirety. Participants were almost evenly distributed in terms of the program model they were affiliated with. Among participants, 18 (36.7 %) were in programs that implemented the Parents as Teachers model, 17 (34.7%) were in Nurse-Family Partnership model programs and 14 (28.6%) were in Healthy Families Florida program models.



Previous Training

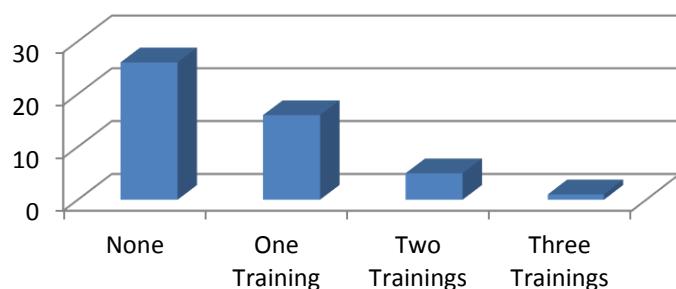
Almost half of the participants, 23 (46.9%), had received prior IPV training at the time the survey was collected. Among participants who had received previous training, nine had received a web/online training, six had received a MIECHV in-person training, while 14 had received an in-person training from another provider [Note: Participants could select more than one option for previous training]. Other sources of in-person training included Department of Children and Families (DCF), Florida Coalition Against Domestic Violence (FCADV), Supporting Families Affected by Domestic Violence (two-day MIECHV training), University of Miami Domestic Violence and Sex Trafficking, and a DV and Sexual Abuse program.

Previous IPV Training Received



The majority of the respondents who had received training (n=16) had participated in one previous training session. Other respondents had been involved in more than one training in the past, with five respondents having participated in two previous training sessions and one respondent having participated in three training sessions in the past.

Number of Previous Trainings



Confidence, Systems Awareness, and Knowledge of Home Visitors in Addressing IPV

There were varying levels of confidence in IPV service delivery among participants. Overall, more than half of the participants reported high levels of confidence with regards to screening (57.1%), knowing what to say and do following disclosure (55.1%) and identifying red flags (59.2%). Almost half (49%) of participants reported that they feel confident creating safety plans in cases of IPV disclosure, while 42.9% felt they were prepared to serve families affected by IPV (Table 1).

Among participants that demonstrated high levels of confidence, home visitors with prior training made up a higher percentage than those without prior training; however, this difference was not statistically significant ($p>.05$), possibly due to the small number of respondents in the sample. Percentage of respondents reporting high levels of confidence for each item ranged from 55.2 - 71.4% (Table 2).

Table 1. Confidence Levels of IPV Service Delivery among Home Visitors

Items measuring confidence level	Agree/Strongly Agree (%)	Disagree /Strongly Disagree/Neutral (%)
I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship	29 (59.2)	20 (40.8)
I feel confident screening participants for IPV	28 (57.1)	21 (42.9)
When a participant tell me he/she has experienced IPV, I feel confident that I know what to say or do	27 (55.1)	22 (44.9)
I feel confident creating a safety plan with participants that disclose IPV	24 (49.0)	25 (51.0)
I feel prepared to serve families affected by IPV	21 (42.9)	28 (57.1)

*All p-values were >0.05

Table 2. Confidence Levels of IPV Service Delivery among HV Stratified by Prior Training

Items measuring confidence level	High Confidence – Strongly Agree/Agree (%)		
	Total (N=49)	HV with prior training (N=23)	HV without prior training (N=26)
I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship	29 (59.2)	16 (55.2)	13 (44.8)
I feel confident screening participants for IPV	28 (57.1)	18 (64.3)	10 (35.7)
When a participant tell me he/she has experienced IPV, I feel confident that I know what to say or do	27 (55.1)	16 (59.3)	11 (40.7)
I feel confident creating a safety plan with participants that disclose IPV	24 (49.0)	16 (66.7)	8 (33.3)
I feel prepared to serve families affected by IPV	21 (42.9)	15 (71.4)	6 (28.6)

* All p-values were >0.05

There were varying levels of system awareness among participants with higher system awareness reported with regards to child abuse. Almost three-quarters (73.5%) of participants agreed that they knew when to make a report to the child abuse hotline for IPV. However, lower levels were reported for other items testing system awareness. Among respondents, 38.8% reported that they knew the name of a staff person at the local DV center that they could call for assistance and only 20.4% reported familiarity with criminal and civil legal options for IPV survivors (Table 3).

Among participants that demonstrated high levels of system awareness, home visitors with prior training also made up a higher percentage than those without prior training; this difference was also not statistically significant ($p>.05$). Percentage of respondents reporting high levels of confidence for each item ranged from 52.8 - 80% (Table 4).

Table 3. Systems Awareness of IPV service Delivery among Home Visitors

Items measuring systems awareness	Agree/Strongly Agree (%)	Disagree /Strongly Disagree/Neutral (%)
I know when to make a report to the child abuse hotline for IPV	36 (73.5)	13 (26.5)
I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant	19 (38.8)	30 (61.2)
I am familiar with the legal options (both criminal and civil) for survivors of IPV	10 (20.4)	39 (79.6)

Table 4. Systems Awareness of IPV Service Delivery among HV Stratified by Prior Training

Items measuring systems awareness	High Confidence – Strongly Agree/Agree (%)		
	Total (N=49)	HV with prior training (N=23)	HV without prior training (N=26)
I know when to make a report to the child abuse hotline for IPV	36 (73.5)	19 (52.8)	17 (47.2)
I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant	19 (38.8)	11 (57.9)	8 (42.1)
I am familiar with the legal options (both criminal and civil) for survivors of IPV	10 (20.4)	8 (80.0)	2 (20.0)

Equal percentages of home visitors reported that their agencies had specific protocols about what to do when a participant discloses IPV, with 51% agreeing while 49% were neutral or disagreed.

There were also varying levels of knowledge among participants at baseline. More than half of the participants answered correctly to the knowledge items that assessed knowledge of types of IPV and factors relating to staying or leaving an abusive relationship. Fewer than half of the respondents however answered correctly on knowledge items that addressed causes of IPV and treatment/prevention methods (Table 5). On items testing knowledge of IPV, there was not a marked difference between home visitors with prior training and those without prior training (Table 6). Knowledge items were scored out of a total of 9. None of the participants

scored 100%. Six participants scored at least 80% and 26 participants scored at least 50%. Again, those with prior training did not appear to have higher total items correct compared to those without prior training (Table 7).

Table 5. Knowledge of IPV Service Delivery among Home Visitors

Knowledge items	Correct (%)	Incorrect (%)
All IPV includes physical violence	39 (79.6)	10 (20.4)
I don't understand why anyone would stay in an abusive relationship	38 (77.6)	11 (22.4)
I only refer to the local DV center if the participant wants to leave the relationship	33 (67.3)	16 (32.7)
If the participant chooses to stay in an abusive relationship, there is nothing I can do	29 (59.2)	20 (40.8)
The primary cause of most IPV is alcohol or drug abuse	23 (46.9)	26 (53.1)
If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline	22 (44.9)	27 (55.1)
A problem with anger is the primary cause of IPV	19 (38.8)	30 (61.2)
Couples counseling is an effective strategy for stopping IPV in families	15 (30.6)	34 (69.4)
Anger management programs are effective in preventing the recurrence of IPV	13 (26.5)	36 (73.5)

*All p-values were >0.05

Table 6. Knowledge of IPV Service Delivery among Home Visitors, Stratified by Prior Training

Knowledge items	Correct Responses (%)		
	Total (N=49)	HV with prior training (N=23)	HV without prior training (N=26)
All IPV includes physical violence	39 (79.6)	20 (51.3)	19 (48.7)
I don't understand why anyone would stay in an abusive relationship	38 (77.6)	18 (47.4)	20 (52.6)
I only refer to the local DV center if the participant wants to leave the relationship	33 (67.3)	18 (54.5)	15 (45.5)
If the participant chooses to stay in an abusive relationship, there is nothing I can do	29 (59.2)	14 (48.3)	15 (51.7)
The primary cause of most IPV is alcohol or drug abuse	23 (46.9)	13 (56.5)	10 (43.5)
If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline	22 (44.9)	11 (50.0)	11 (50.0)
A problem with anger is the primary cause of IPV	19 (38.8)	11 (57.9)	8 (42.1)
Couples counseling is an effective strategy for stopping IPV in families	15 (30.6)	8 (53.3)	7 (46.7)
Anger management programs are effective in preventing the recurrence of IPV	13 (26.5)	7 (53.8)	6 (46.2)

*All p-values were >0.05

Table 7. Total Items Correct for Knowledge of IPV Service Delivery among HV, Stratified by Prior Training

Total Items Correct (out of 9)	Total HV (N=49)	HV with prior training (N=23)	HV without prior training (N=26)
0	3 (6.1)	1 (33.3)	2 (66.7)
1	0 (0.0)	0 (0.0)	0 (0.0)
2	6 (12.2)	2 (33.3)	4 (66.7)
3	7 (14.3)	4 (57.1)	3 (42.9)
4	7 (14.3)	1 (14.3)	6 (85.7)
5	4 (8.2)	2 (50.0)	2 (50.0)
6	10 (20.4)	6 (60.0)	4 (40.0)
7	6 (12.2)	2 (33.3)	4 (66.7)
8	6 (12.2)	5 (83.3)	1 (16.7)
9	0 (0.0)	0 (0.0)	0 (0.0)

Learning Session 1: Sarasota, FL – August 2015

IPV Discussion Breakout Session Summary: MIECHV Supervisors and Administrators

To begin the breakout session the moderator brought up the recurring themes seen on the Post-it notes collected on the previous day of training. “Being successful and working with families who may be in denial or what does that actually mean and how to initiate that trusting relationship” were topics addressed by many attending the training. The staff was then asked what they were doing to take care of themselves which opened up a dialogue on emotional stress. “As nurses, we kind of give ourselves that fixing role and that therapeutic role that you think that you have until something happens that makes you question ‘Have I related to them enough? Have I done the right thing?’” said one respondent. “It is important to use all of the resources available to you, such as the family specialist, and maintain your own health first. Taking care of yourself will allow you to support the staff and encouraging them to take care of themselves as well because again, this can be draining.” The staff then spent time addressing how to encourage and support their home visitors, understanding how stressful and frustrating it can be when they offer referrals and the participants choose not to use them. “I do always make it a point to make sure that they understand that they can only do what they can do. They can only give the information and then it is up to the participant if they’re going to do something.”

The role of the supervisor, as then discussed, is to help the home visitor see the big picture and model a positive attitude towards the changes being put in place: “it has to be modeled from the top-down.” Support for the supervisor is also needed: “I have to understand it in order for me to explain it to my staff.” “We’re on a journey and I’m here on the journey” said one respondent. The change will not be instant but will take place over time and will only be accomplished if it is done together. One program even started implementing rapid cycle testing by conducting “really small tests” that have already shown “some really big improvements” which has encouraged the staff to continue in the process. Team building activities to help boost morale were also discussed to help “lessen the pain” of implementing yet another change. Having to help their staff deal with and accept the changes taking place was another area where support is needed. The home visiting staff is already responsible for so much and adding one more responsibility could be another challenge.

Lastly, the definition of success was a topic that needed to be addressed. Success cannot be measured based on how many women use the resources and education given to them. One person described success as “when the

woman or participant or client is feeling comfortable and confident with her decision and her choice." The co-facilitator defined success as the home visitor providing the information and offering services. While it is important to respect the decisions of the participants, they may or may not feel comfortable with their decisions because of what is at stake. Due to the concern for safety, the decisions may change as the circumstances change. The important piece is that the home visitor has provided resources so that the participants can make informed decisions. The role of the supervisor is to help coach their staff in recognizing IPV and supporting survivors. They must help their staff to become aware of their own biases, in an effort to eliminate judgment. "You have to say this is her choice, her life, you have to respect that." "So when we're connecting someone with a referral regardless of how they respond, whether we know they call or not, the success is that we offer that service, that we offer that referral, that we planted that seed, that we talked to them about domestic violence services so they know that's out there in the community."

Additional Quotes

"For me, it's the supervision and good quality supervision where you're helping them steer through things."

"I think there's another concern in that we don't know the history of all of the people on our teams, on our staff. We don't know who is a child from a battered home. We don't know if the individual is a survivor nor should we expect anyone to make that public. But there's still - as a supervisor, I want to know what to do, how to respond, how to support the nurse."

Moderator: "Just in general, do you all do things to support each other, do you have that built in already?"

Respondent: "Now we're at the point where we're doing well but we recognize that we really need to really celebrate any little thing, when we have an accomplishment because I think so many times, we're just 'Do this, do that. These screens were not completed. We don't have enough clients' and just step back and say we really are moving in a very good direction and we celebrate any accomplishment or when they've done a good job, because they really do great things every day."

Moderator: "How are you going to help your staff have a positive attitude about participating in this learning collaborative on top of everything else that you have to do?"

Respondent: "I think it has to be modeled attitude, it has to be modeled from the top-down, but I also think that we need to be very transparent with stuff and also have those discussions about 'There's a change coming. Some of you will not be comfortable with this. We can talk through this. Some of you will get anxious about this. Some of you will embrace it' and just recognizing that everybody deals with change differently."

"It really starts with us so we have to set the stage. We have to set the tone. We have to be there."

"If I'm having difficulty with it, with lots of years of experience in the nursing field, how am I then going to convey that to my staff? I try very hard to be optimistic. I let them know, 'This is a learning curve for me too. I've not done this before. So we will get through this together as a team. If you're struggling with it, don't struggle. Come to me, let's talk about it. Let's sit down. Let's look at it. If I can't help you, I will reach out to those people who really know how this process works and I will get help for us.'"

"I think for me, success is when the woman or participant or client is feeling comfortable and confident with her decision and her choice... Because it's not our life. It is her life. So whatever she chooses, it's our role to help her sort through to make the best possible decision for her, whatever that is."

"We need to increase the sensitivity of the tools that we use so that we can actually recognize the women who have experienced it first."

"So just everybody being more aware and realize even though you only know what they tell you. You're not going to catch everything but that doesn't make you unsuccessful."

"I had a really big 'Aha' just listening to the powerful stories from our survivors and I'm not sure that any strengthening of the tool or – they just said this topic is so sensitive to a family, they're not going to share with anyone until they have a defining moment and then they're ready."

"So it's not denial. It's their experience. I know an interview from the Caribbean nurse, some Caribbean culture believe that if a man loves you, he's going to hit you. I mean it's actually a saying that he loves you. It's not. So, it's not going to be a denial situation. It's absolutely – it's based on who they are, where they came from, what they saw when they were growing up, their culture, so that denial is this thing about "Okay, they know and they're pretending not."

IPV Discussion Breakout Session Summary: MIECHV Home Visitors

During the home visitors' focus group breakout session, participants discussed multiple aspects of the Learning Session that they believed were thought-provoking. Throughout the hour long discussion several aspects of competently serving families experiencing IPV were discussed. One of the main themes discussed was education. Several home visitors stated that education was an important aspect that needed to be implemented for both home visitors and clients. Other points of discussion included use of screening tools as well as helping participants to navigate within the system.

With varying levels of experience and differing educational, as well as occupational, backgrounds, some of the home visitors reported very little understanding of how to appropriately convey the impact violence in the home has on children. A few home visitors expressed an interest in further training to learn more about this.

It was mentioned that many resources are provided to the mother to cope with experiencing IPV, but quite often there is "...nothing in place for the children." It was also addressed in this quote: "Mostly with domestic violence, they focus so much on the mom that they forget that their children have to live with it long term because as they grow into adulthood... The trauma is still in you. It never goes away." Home visitors believed that a main reason mothers stayed in an abusive relationship was they felt it was important for their child to have a father. Home visitors also stated that appropriately educating women on resources, as well as impact of violence on themselves and the children witnessing the violence would lead to women leaving the relationships. One home visitor stated a participant had already "denied" experiencing IPV. Upon hearing information about the negative impact IPV has on a child, she left her partner. Quoting the participant, the home visitor stated, "I ended up [sic] the relationship with him right away after I heard you saying how much it affects our children, and I've been in this domestic violence relationship for a long time. I'm sorry I lied to you."

To resolve this issue of lack of knowledge on both the part of some of the home visitors and the participants, a suggestion was made that a curriculum be developed or acquired that appropriately addressed healthy and unhealthy relationships, not just IPV, and appropriate resources to provide to participants and their children. This curriculum would permit the conversation to occur in a less startling manner and afford the home visitor the opportunity address the topic in a sensitive and appropriate manner.

Another point discussed was utilizing screening tools for IPV. Many of the home visitors in the focus group placed heavy emphasis on the screening tools used across the programs. The concern was how these tools may not necessarily be the most successful at gathering the necessary information to decipher whether a family has experienced IPV. Some home visitors felt that the stark and "aggressive" nature of the questions, along with the fact the questions so clearly are trying to assess for violence in the home, make it awkward to address within the first few months of interacting with the family. There was also a feeling that participants are unlikely to disclose such personal information.

Two approaches were discussed that other sites use to lessen the intensity of asking such sensitive questions. The first suggestion was ensuring the rapport was developed between the home visitor and mother. This home visitor stated she was able to establish rapport because she saw her families on a weekly basis for the first few months and assured that these questions were asked of every family. One home visitor agreed that rapport was important, but that waiting longer to complete the measure could be a viable option if frequency of visits was less than once a week. Another suggestion made to help with the issue of the required screeners was incorporating the questions into a conversation as opposed to engaging in an interaction that comes off "robotic" and unnatural. Some home visitors said that they were able to do that because of training they received at their respective sites. Others stated they were fearful of not completing every question if they did try to make the questions flow in a conversation as they had not been granted permission, or been provided the training, to do so by their program. One home visitor eloquently stated, "We need to stop focusing so much on the form and give more, be more human and be more empathetic." In being more human, or "real," the participants would then feel more comfortable in sharing private information.

Though not a primary point of discussion, home visitors expressed concern regarding how they work within multi-layer systems. As many of the MIECHV programs occur in various agencies, different requirements exist in addition to those required by MIECHV and the program that is being implemented (i.e., PAT, NFP, Healthy Families). Many home visitors felt frustrated that the agency in which they were housed required they attend meetings they felt were irrelevant or interrupted time with their families. One session participant stated that her colleague missed out on a whole day of work due to meetings and still had to meet with her 25 families within her remaining 30 hour work week. Another point specific to systems navigation was aiding immigrant and undocumented families because leaving a violent partner would lead to social isolation and with no control of whether the participant could stay in the US after leaving said partner. No suggestions were made on how to deal with this particular concern.

Overall, when asked by the moderator to share their experiences and thoughts following the first day of the Learning Session, the home visitors shared their experiences in personally experiencing IPV and being witness to IPV. They also voiced a desire for more training as it relates to their education and the education of their families, as well as ways to help participants to disclose and seek help. While one home visitor stated training in things like motivational interviewing and other strategies was helpful, the moderator mentioned that training in ACEs would be beneficial and potentially what a lot of the breakout session participants were seeking. In all, the home visitors felt that they were collaborators with the participants. "Planting seeds" and hoping that one day the fruits of their labor would burgeon even if they were not witness to it.

Additional Quotes

"I go in establishing a relationship with all my families that I'm here to support you and guide you and provide you information. I'm not here to tell you what to do. I'm not here to tell you how to parent. I'm not here to tell you that you have to have a better relationship or whatever subject it is because it's up to them to do with it what they want."

"We need curriculum that we can address these issues before that even happens, before... None of our curriculum addressed that. I could simply go back and talk about how does arguing affect your children? What if this happened? If we have some curriculum to go by, to start doing this before we even do the heart because we're already talking about it. That may open them up, disclosing something earlier than we have to wait for six months or close. It may open it up right away and we can get them services right away before the child is dangled over something like that. We don't have curriculums. We have handouts. I mean we have little booklets that we could go in but now I got to figure out how I'm going to get away with this if it was the service plan. We have the service plan. We have that on the service plan, but we really don't have the curriculum at the outside. We've been looking for it, I called and asked for those little booklets, how domestic violence affects families but we have to know how to open that up. If I had an easy curriculum that I could introduce to this family before it gets there, it would make it a lot easier."

"Mostly with domestic violence, they focus so much on the mom that they forget that their children have to live with it long term because as they grow into adulthood... The trauma is still in you. It never goes away."

"Kids suffer the most. They do suffer long term."

"I don't think our parents realize the effect and that's what came to me when my mom was sharing with me what was going on. She needs to know the effects that this is going to have on her children if this does not stop. Because we think if you're just arguing all day, okay they're children they're not paying attention because kids keep going. They keep playing, they keep doing everything they're doing so we think it's not bothering them but I want my parents to know that when you talk to them this way, when you guys argue, what is going on? You got to know that something is happening to your child even though your child may be in the other room because this is what she's said."

"So I think the tool is not to get her to disclose. The tool is to give her reasons to rethink what's happening in the violent relationship and plant the seed, right? You plant the seed. It doesn't matter if you ever see it grow. You use the empathy and the kindness and the listening and the caring and you plant the seed and you give the information and, to me, that's the goal of all this and then too bad you don't see the plant but it will be there. We have to have faith that it will be there."

"They [moms] can do the groups. They can do the therapies. They can do those things but we have nothing in place for the children."

"What I'm just concerned about with listening to one of the presentations yesterday, what we want is to protect the children, what we need is to reassure that mother that these kids are not going into foster care. We are so quick to separate the families and put the children in foster care. Yes, I know some parents don't protect the children. They're afraid they don't have the skills or whatever, but we're so quick to separate the family and put them in foster care, come up with the plan. If this lady said yes then you can reassure them that you've got a plan to take them to live with a grandmother, aunt or somewhere, or you need to go to the shelter. 'Your kids are going to the shelter with you. In that shelter, you're going to receive counseling, both parent and children.' Then, I think, parents will be more apt to say, 'Yes, I'm in a situation. Yes, I need help.' But we need some resources to give them too before we go and throw our weight around and saying this and saying that. Just have something in place with them, too."

Next Steps

The Florida MIECHV Program Evaluation Team plans to attend the second and third Learning Sessions in fall 2015 and spring 2016, respectively. Additionally, mid- and post-assessment surveys will be administered in 2016.

Program Evaluation Team Information

Dr. Jennifer Marshall – Principal Investigator, Lead Evaluator

Ngozi Agu – Research Associate

Stephanie Volpe – Research Assistant

Esther Jean-Baptiste – Research Assistant

Pamela Birriel – Project Coordinator

Rema Ramakrishnan – Research Associate, Data Analyst

Paige Alitz – Research Associate

For further information on the Learning Collaborative, please contact:

Allison Parish, MS, EdS

Florida MIECHV Senior Manager

Florida Association of Healthy Start Coalitions, Inc.

(850) 270-9246

For further information on this report, please contact:

Jennifer Marshall, PhD, MPH

Research Assistant Professor

University of South Florida, College of Public Health

Department of Community and Family Health

(813) 396-2672

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



Florida
Maternal
Infant &
Early
Childhood
Home
Visiting
Initiative



The Lawton and Rhea
Chiles Center
for Healthy Mothers and Babies

our
practice
is
our
passion.
University of South Florida
College of Public Health

Florida Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Intimate Partner Violence Screening, Support, and Referral Learning Collaborative

Ngozi Agu, Allison Parish, Judi Vitucci, Abimbola Michael-Asalu, Omotola Balogun, Pamela Birriel, Ruth Sanon, Shana Geary, Rema Ramakrishnan, Esther Jean-Baptiste, and Jennifer Marshall

Executive Summary

The Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative implemented an intimate partner violence (IPV) learning collaborative to fulfill a need for a more comprehensive approach to IPV in order to improve performance on HRSA required benchmarks. This collaborative involved three learning sessions, periodic webinars on specific IPV topics, and program implementation of continuous quality improvement (CQI) methods (plan, do, study, act [PDSA] cycles) to test program improvements. Also, MIECHV staff concurrently participated in monthly site specific data collection regarding screenings, referrals and safety planning during the learning collaborative. The rates of these were observed to increase except that of screening which remained on a plateau. Home visitors' system awareness and knowledge was tested before beginning the collaborative session and again after the second collaborative session. All MIECHV staff participants (supervisors/administrators and home visitors) were grouped into breakout sessions during each of the collaborative sessions to discuss their experiences in participating in the learning collaborative, including successes and challenges. This report describes baseline, midpoint, and post-collaborative levels of confidence, system awareness, and knowledge of home visitors regarding IPV service delivery. It also highlights themes that emerged during the breakout sessions.

At baseline the levels of confidence, system awareness, and knowledge of IPV service delivery varied among participants. Following the second learning session, there was an overall increase in confidence and system awareness of home visitors. Highest increases were noted for home visitors' level of preparedness to serve families affected by IPV; their confidence in knowing how to act when a client discloses IPV experience; their confidence in screening participants; their awareness of the name of a staff person at the local domestic violence center who they could reach out to for help; and knowledge on notifying an IPV survivor prior to making a child abuse report. Levels of confidence and system awareness continued to increase at survey 3, with little change in knowledge scores. In particular, survey 3 respondents reported higher confidence in identifying red flags for IPV, screening, and safety planning. Survey 3 respondents also reported more familiarity with legal options for IPV survivors, knowing when to report IPV, and knowing a staff person at the DV center. The Survey 3 respondents also appeared to have a greater knowledge that IPV includes more than physical abuse, and understanding of why a person may stay in an abusive relationship.

During the first breakout session, supervisors/administrators talked about how to be successful in their supportive roles especially when working with families that are not particularly forthcoming, as well as how and what it means to initiate a trusting relationship and how to redefine success. Home visitors discussed the need for more education, better screening tools and strategies, impact of IPV on children, and increasing awareness of IPV among program staff and participants. The second breakout session involved supervisors/administrators discussing the need for policies on workplace violence, the impact of IPV on staff, the importance of staff support through reflective supervision and organizational supports, and safety in home visiting environments. In addition, discussions around self-care and stress management were the focus of the second breakout session for home visitors. For the third learning session, mixed groups with home visitors, supervisors, and administrators discussed successes (e.g., personal stories, guest presentations, and data training) and challenges of the learning collaborative. Furthermore, strategies used in sharing information from the learning collaborative, as well as challenges and suggestions for improvement were discussed. Lastly, strategies for sustainability including policy development in addition to developing and implementing staff training were highlighted, and the groups discussed next steps to continue to improve IPV service delivery. It is recommended that programs continue to develop and implement policies, procedures, and strategies to improve IPV screening, support, and referral using the knowledge and skills gained from the learning collaborative.

Introduction

Intimate partner violence is an important issue that has several implications for maternal and child health. It has been associated with poor maternal, physical, mental, and sexual health, as well as increased risk for preterm delivery, low birth weight, neonatal death, and reduced breastfeeding rates.¹⁻³ Additionally, children exposed to violence have been shown to have adverse physical, emotional, behavioral, social, and cognitive outcomes including increased physical distress, eating and sleeping problems, post-traumatic stress disorder (PTSD), depression, low self-esteem, academic problems, and increased suicidality.^{4, 5} It is essential to have effective programs that identify and intervene in cases of IPV to reduce the risks of these adverse effects.

One of the components of the Florida MIECHV Initiative is to offer support to families experiencing or at-risk for IPV. This process includes screening and detection of ongoing IPV, creating safety plans, and providing ongoing support, as well as referrals to certified domestic violence centers. The Florida MIECHV benchmarks related to IPV include: 1) Maintain or increase the percent of women screened for domestic violence within 6 months of enrollment; 2) Maintain or increase the percent of women who are referred for domestic violence services within seven days of screening positive for domestic violence; and 3) Maintain or increase the percent of women who have a safety plan within one month of screening positive for domestic violence. The Florida MIECHV State CQI Team determined that a more comprehensive approach to improving performance on IPV-related benchmarks was needed and set up a learning collaborative modeled after the Institute for Healthcare Improvement Breakthrough Series towards this end. The purpose of this report is to discuss changes in levels of knowledge, system awareness, and confidence among Florida MIECHV home visitors regarding IPV screening and supporting families experiencing IPV; describe the content of the three learning sessions; and highlight key themes emerging from the breakout sessions/focus groups with home visitors and supervisors/administrators during these sessions.

Methods

Continuous Quality Improvement (CQI) – MIECHV Site Activities

Each MIECHV site is responsible for developing their unique IPV procedures based on model type, system of care and what works for them. As part of the learning collaborative, each site was expected to use the Model for Improvement (rapid cycle testing using Plan-Do-Study-Act). Below are strategies tested by participating sites to achieve improvement and some of the activities that took place during the learning collaborative.

Broward: Home visitors did not have many positive screens using the Relationship Assessment Tool (RAT) and the MIECHV Domestic Violence Form, but will continue refining and testing their draft IPV policy with more home visitors prior to implementation.

Escambia: IPV screening rates were significantly improved by testing the use of a color coded list of MIECHV due dates, including the HARK. The HARK is a four item questionnaire used to identify women experiencing IPV. This will be used to develop an implementation plan.

Hillsborough: Staff agreed on their final IPV policy and are on the verge of adoption. They plan to change the policy language slightly and adopt it for their system of care based on survey results.

Manatee: Staff found, through multiple cycles, that using their healthy relationship pretest and healthy relationship curriculum prior to administering the RAT screening was a relationship building tool. It encouraged families to talk more extensively about their relationships which may ultimately aid in detecting IPV if it exists. They also learned that families had a better understanding of healthy relationships.

Miami-Dade: Staff focused on using a script to introduce the NFP Relationship Assessment Tools based on positive feedback from the nurse home visitor. They predicted that this would increase positive disclosures.

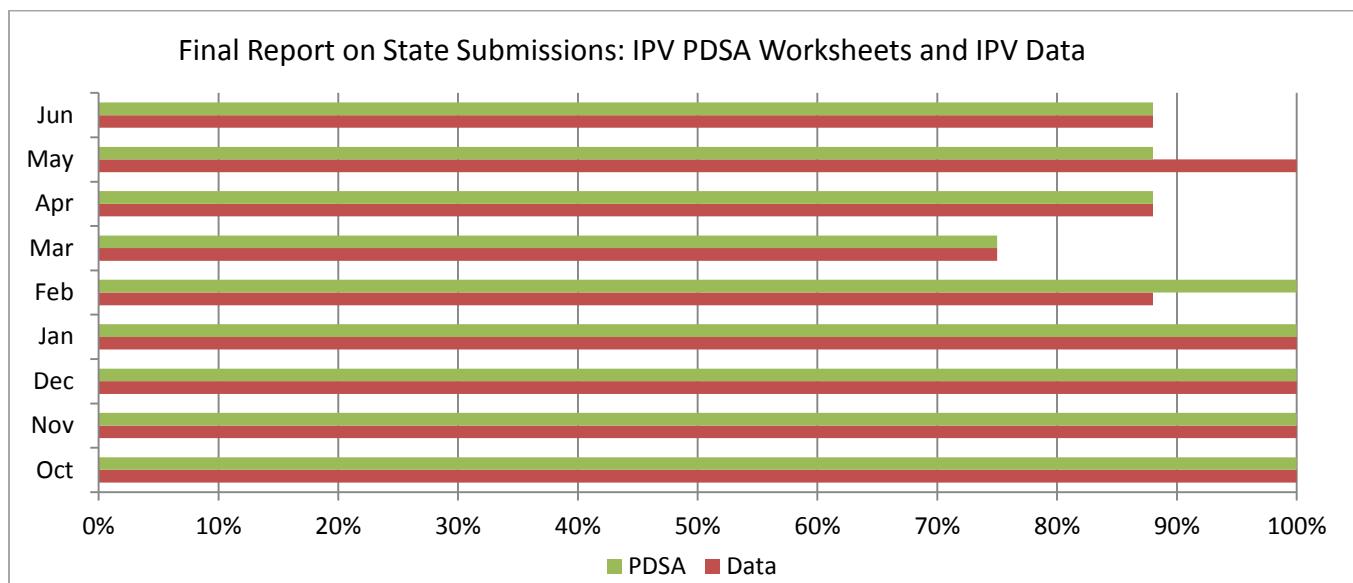
North Central: Staff tested the efficacy of their referral process to the local DV Center by surveying active participants who had a positive screen or IPV disclosure since July 2015. The completed surveys showed that the

current process is working well for most survivors. One significant discovery was a need to specify and strengthen the protocol for referring participants that do not speak English. They plan to implement the new referral process by adding it to their policies.

Orange: Staff received a refresher training and were measured on their comfort level in administering the HARK screen. The refresher training increased their level of comfort with HARK administration and they are planning on implementing the same training for new staff and current staff as needed.

Southwest Florida: Staff completed testing of the segue conversation, the DV Education and Screening Guidelines. As predicted, the standardized DV Education/Screening Guidelines and script increased the comfort levels of home visitors. They tested at multiple sites with multiple home visitors and paid attention to both positive and negative feedback. They are ready to implement the Guidelines and script program-wide.

IPV PDSA reports and data on screening, referral and safety planning rates were submitted to the Florida MIECHV Initiative state staff via Groupsite on a monthly basis. Almost ninety percent of the MIECHV sites consistently submitted their monthly IPV PDSA reports and data respectively by the due date.



Home Visitor Survey - Confidence, System Awareness, and Knowledge in Addressing IPV

A brief survey developed by the state CQI team and reviewed by an expert panel was distributed via email, with a link to the Qualtrics online survey software platform, to all home visitors working in nine of the 11 Florida MIECHV programs. Two programs were excluded because of their participation in the national Home Visiting Collaborative Improvement and Innovation Network [HV Collin] prior to the first learning session. The survey collected baseline information on participants' program affiliation, previous training experience, and questions to assess confidence, system awareness, and knowledge pertaining to IPV service delivery. A similar survey was distributed to all home visitors after the second and third learning sessions to assess changes in their confidence, system awareness, and knowledge regarding IPV service delivery. Descriptive statistics (percentages) were computed for baseline and subsequent confidence, system awareness, and knowledge of survey respondents. Fisher's exact test was used to determine if there were significant differences between individuals (1) who had received prior training versus those who did not and (2) who attended the learning sessions/webinars versus those who did not.

Learning Sessions – Successes, Challenges, and Lessons Learned

The learning collaborative included three in-person learning sessions (LS1, LS2, and LS3) which covered various topics related to IPV. These were 2-day sessions done three to four months apart in August, 2015, November, 2015, and March 2016, respectively. During each of the in-person sessions, breakout sessions were conducted. LS1 and LS2 involved breakout sessions with home visitors in one group and supervisors/administrators in the

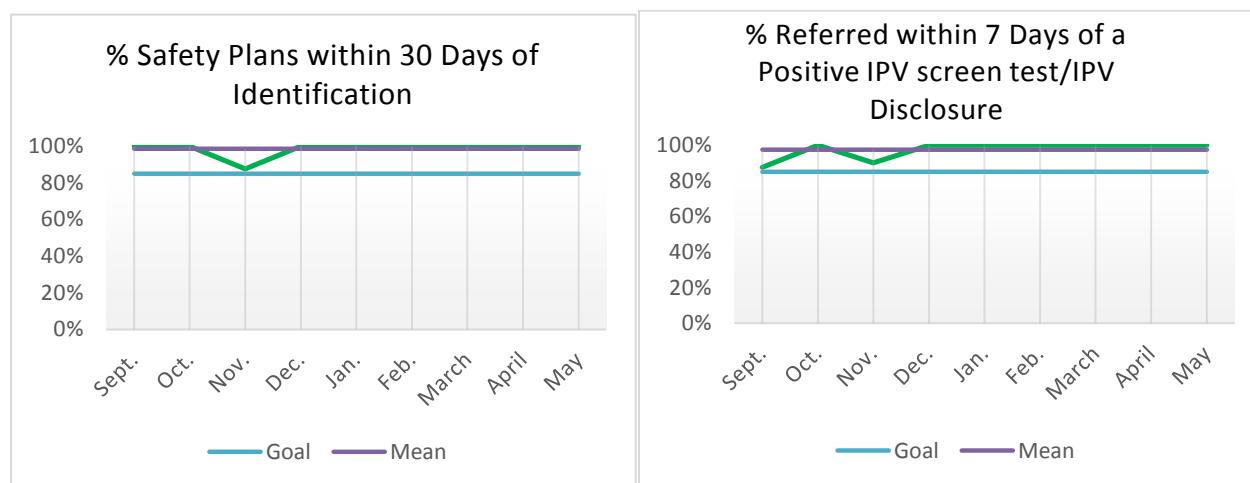
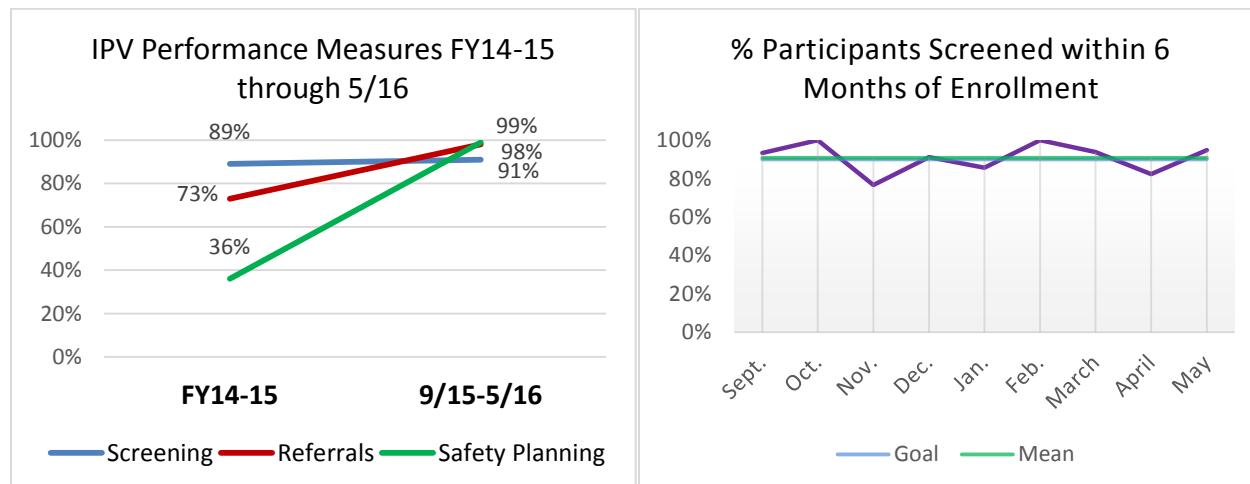
other. LS3 involved mixed breakout sessions with discussions that focused on successes, challenges, and impact of the learning collaborative. These breakout sessions were audio recorded, transcribed, and identified themes summarized.

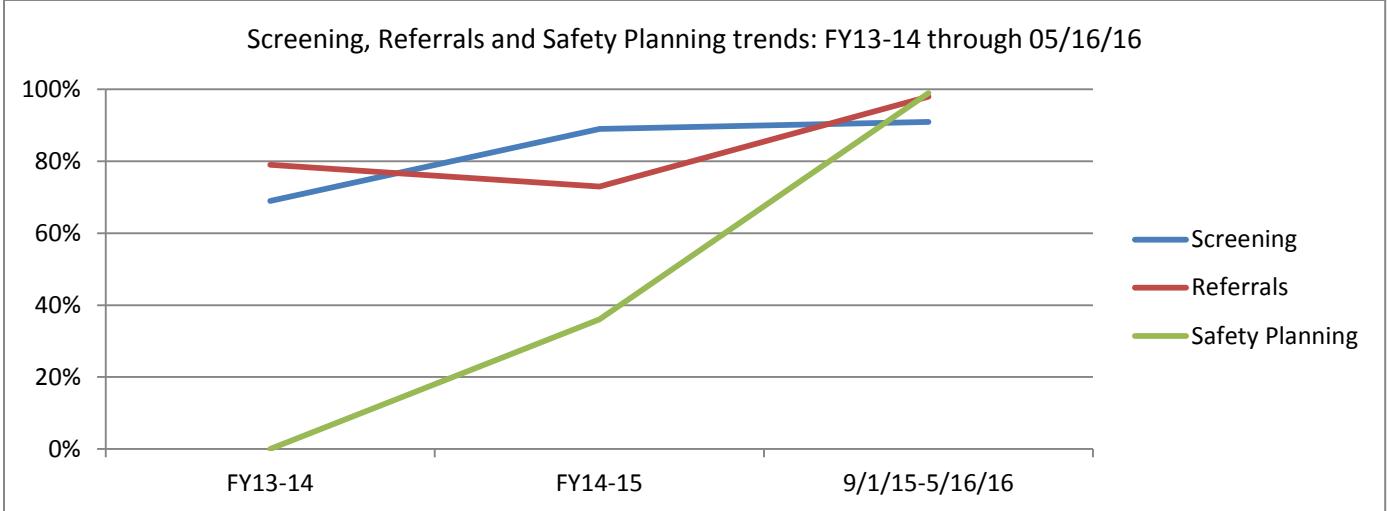
In addition to the learning sessions, home visitors and supervisors/administrators were given opportunities to attend webinars on the following topics:

1. Screening and continuous quality improvement
2. Responding to domestic violence in the African-American community
3. Effects of IPV on children and rapid cycle testing
4. IPV among Latinos and working with Hispanic survivors
5. Female to male violence, batterer intervention programs, and CQI update
6. Guide to DV in civil and criminal system and responses to IPV disclosures

IPV Performance Measures:

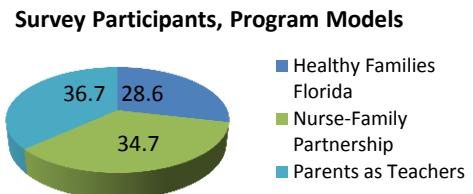
The Florida MIECHV Initiative has different targets set for the different IPV measures (see table 7) and, while some sites still need to work on consistently screening participants within six months of enrollment into the program, the performance goal of 90% screening rate was exceeded with an average (mean) of 91% across all sites. For referrals and safety planning, the Florida MIECHV program achieved 100% since December - well exceeding the 85% goals set for each measure.





Baseline Learning Collaborative Survey Results

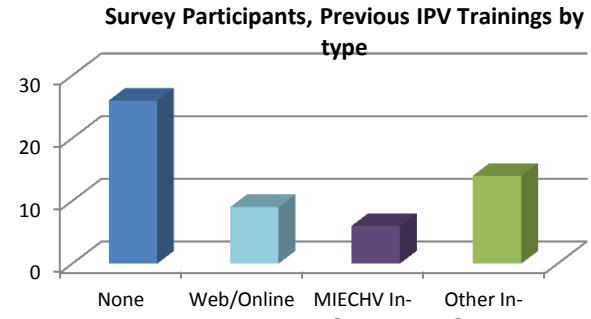
A total of 52 home visitors accessed the survey, and 49 completed the survey in its entirety. Respondents were almost evenly distributed in terms of the program model they were affiliated to. Eighteen home visitors (36.7%) were in programs that implemented the Parents as Teachers model, 17 (34.7%) were in programs based on the Nurse-Family Partnership model, and 14 (28.6%) were in programs that used the Healthy Families Florida model.



IPV Training

At baseline, about 47% (n=23) of the home visitors had received prior IPV training out of which nine had received web/online training, six had received a MIECHV in-person training, while 14 had received an in-person training from another provider [Note: respondents could select more than one option for previous training]. Other sources of in-person training included Department of Children and Families (DCF), Florida Coalition against Domestic Violence (FCADV), Supporting Families Affected by Domestic Violence (two-day MIECHV training), University of Miami Domestic Violence and Sex Trafficking, and a Domestic Violence (DV) and Sexual Abuse program.

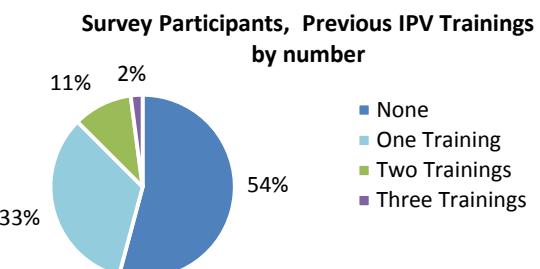
The majority of the respondents who had received training (n=16) had participated in one training session prior to the learning collaborative. Other respondents had been involved in more than one training session, with five respondents having participated in two, and one having participated in three sessions in the past.



Home Visitors' Confidence, System Awareness, and Knowledge in Addressing IPV

Confidence

The levels of confidence in IPV service delivery varied among the home visitors (see Table 1). Overall, more than half of respondents reported high levels of confidence with regards to screening, knowing what to say and do following disclosure, and identifying red flags. Additionally, almost half of the home visitors reported that they feel confident creating safety plans in cases of IPV disclosure, while 42.9% felt they were prepared to serve



families affected by IPV. Furthermore, equal percentages of home visitors reported that their agencies had specific protocols about what to do when a participant discloses IPV, with 51% agreeing while 49% were neutral or disagreed. Among respondents that demonstrated high levels of confidence, those with prior training made up a higher percentage than those without prior training. There were significant differences between home visitors with and without prior training for items related to confidence in screening for IPV, creating a safety plan, and being prepared to serve families affected by IPV (p -value <0.01).

System Awareness

The levels of system awareness also varied among home visitors, with higher levels reported for child abuse (see Table 1). Almost three-fourths of the respondents agreed that they knew when to make a report to the child abuse hotline for IPV, however, lower levels were reported for other items that tested system awareness. About 39% of the respondents reported that they knew the name of a staff person at the local DV center that they could call for assistance, and only 20.4% reported familiarity with criminal and civil legal options for IPV survivors. Among respondents that demonstrated high levels of system awareness, the majority consisted of home visitors with prior training; this difference was, however, significant only for the item testing familiarity with legal options for IPV survivors (p -value=0.02).

Knowledge

Baseline IPV knowledge varied among home visitors (see Table 1). More than half of the respondents correctly answered items that assessed knowledge of types of IPV and factors relating to staying or leaving an abusive relationship. Fewer than half of the respondents, however, correctly answered knowledge items that addressed causes of IPV and treatment or prevention methods. On items testing knowledge of IPV, there were no significant differences between home visitors with and without prior training. Knowledge items were scored out of a total of 9. None of the respondents scored 100%, six scored at least 80%, and 26 at least 50%. Again, those with prior training did not appear to have higher total items correct compared to those without prior training.

Table 1. Home visitors' confidence, system awareness, and knowledge of intimate partner violence (IPV) service delivery stratified by prior training (Survey 1)

	Total Indicated Agree/Strongly Agree (N=49)	HV with prior training (N=23)	HV without prior training (N=26)	P-value
Confidence				
I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship	29 (59.2)	16 (55.2)	13 (44.8)	0.14
I feel confident screening participants for IPV	28 (57.1)	18 (64.3)	10 (35.7)	<0.01
When a participant tells me he/she has experienced IPV, I feel confident that I know what to say or do	27 (55.1)	16 (59.3)	11 (40.7)	0.05
I feel confident creating a safety plan with participants that disclose IPV	24 (49.0)	16 (66.7)	8 (33.3)	<0.01
I feel prepared to serve families affected by IPV	21 (42.9)	15 (71.4)	6 (28.6)	<0.01
System awareness				
I know when to make a report to the child abuse hotline for IPV	36 (73.5)	19 (52.8)	17 (47.2)	0.15
I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant	19 (38.8)	11 (57.9)	8 (42.1)	0.18
I am familiar with the legal options (both criminal and civil) for survivors of IPV	10 (20.4)	8 (80.0)	2 (20.0)	0.02

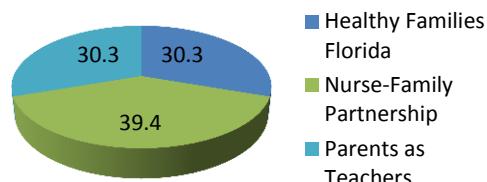
Knowledge	N (%) correct	N (%) correct	N (%) correct	P-value
All IPV includes physical violence	39 (79.6)	20 (51.3)	19 (48.7)	0.20
I don't understand why anyone would stay in an abusive relationship	38 (77.6)	18 (47.4)	20 (52.6)	0.59
I only refer to the local DV center if the participant wants to leave the relationship	33 (67.3)	18 (54.5)	15 (45.5)	0.11
If the participant chooses to stay in an abusive relationship, there is nothing I can do	29 (59.2)	14 (48.3)	15 (51.7)	0.53
The primary cause of most IPV is alcohol or drug abuse	23 (46.9)	13 (56.5)	10 (43.5)	0.16
If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline	22 (44.9)	11 (50.0)	11 (50.0)	0.46
A problem with anger is the primary cause of IPV	19 (38.8)	11 (57.9)	8 (42.1)	0.18
Couples counseling is an effective strategy for stopping IPV in families	15 (30.6)	8 (53.3)	7 (46.7)	0.39
Anger management programs are effective in preventing the recurrence of IPV	13 (26.5)	7 (53.8)	6 (46.2)	0.40

Mid-point and Post-Learning Collaborative Survey Results

Learning Session 2:

A total of 37 home visitors accessed the post-intervention survey, and 33 completed the survey in its entirety. Ten (30.3%) respondents were in programs that implemented the Parents as Teachers model, 13 (39.4%) were from programs that used the Nurse-Family Partnership model, and 10 (30.3%) were from programs based on the Healthy Families Florida model.

Survey Participants, Program Models



Previous IPV Training

Sixteen respondents had attended one or both of the learning sessions. Among these, four (12.5%) and five (15.6%) home visitors had attended LS1 and LS2, respectively, and seven (21.9%) had attended both. Out of 33 home visitors, 11 (33.3%) had not received any other form of training specific to IPV asides from the learning collaborative. More than half of the respondents had participated in three of the four webinars. The webinar on “screening and continuous quality improvement” had been participated in by 19 (57.6%) of the respondents. Similarly, 18 home visitors (54.5%) and 17 home visitors (51.5%) had participated in the webinars “responding to domestic violence in the African-American community” and “effects of IPV on children and rapid cycle testing,” respectively. Almost a third of respondents (12) had participated in the webinar “IPV among Latinos and working with Hispanic survivors.”

Home Visitors' Confidence, System Awareness, and Knowledge in Addressing IPV

Confidence

In this second survey, the home visitors’ generally demonstrated high levels of confidence in IPV service delivery (see Table 2). Overall, more than three-quarters of respondents reported high levels of confidence with regards to screening (85%), knowing what to say and do following disclosure (88%), and identifying red flags (82%). About 76% of the home visitors reported that they feel confident creating safety plans in cases of IPV disclosure, while 85% felt they were prepared to serve families affected by IPV. Twenty-nine (87.9%) of the home visitors surveyed reported that their agencies had specific protocols about what to do when a participant discloses IPV.

System Awareness

The levels of system awareness varied among the respondents with low awareness regarding legal options for IPV (see Table 2). Among respondents, 33.3% reported familiarity with the legal options available for IPV survivors. However, there were high levels of system awareness among other items tested. About 85% of the home visitors agreed that they knew when to make a report to the child abuse hotline for IPV and knew the name of a staff person at their local domestic violence center that they can call if they needed information or assistance for a client (81.8%).

Knowledge

The knowledge of home visitors also varied in the second survey. Less than 50% of respondents had high knowledge regarding the role of anger and services for families affected by IPV. About 49% answered correctly that couples' counseling is *not* an effective strategy for stopping IPV in families, and only 33% answered correctly regarding anger *not* being the primary cause of IPV and anger management *not* being effective in preventing recurrence of IPV. More than 50% of respondents answered correctly for all other knowledge items (see Table 2). Lastly, there was no significant difference in confidence, system awareness, and knowledge of respondents who attended the learning sessions/webinars compared with those who did not (see Table 3).

Table 2. Home visitors with high confidence, system awareness, and knowledge of IPV service delivery stratified by attendance of learning session (Survey 2)

	Total Indicated Agree/Strongly Agree (N=33)	HV who attended LS (N=17)	HV who did not attend LS (N=16)	P-value
Confidence				
I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship	27 (81.8)	14 (51.9)	13 (48.1)	0.64
I feel confident screening participants for IPV	28 (84.8)	13 (46.4)	15 (53.6)	0.14
When a participant tells me he/she has experienced IPV, I feel confident that I know what to say or do	29 (87.9)	16 (55.2)	13 (44.8)	0.28
I feel comfortable creating a safety plan with participants that disclose IPV	25 (75.8)	13 (52.0)	12 (48.0)	0.62
I feel prepared to serve families affected by IPV	28 (84.8)	14 (50.0)	14 (50.0)	0.53
System awareness				
I know when to make a report to the child abuse hotline for IPV	28 (84.8)	14 (50.0)	14 (50.0)	0.53
I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant	27 (81.8)	15 (55.6)	12 (44.4)	0.30
I am familiar with the legal options (both criminal and civil) for survivors of IPV	11 (33.3)	7 (63.6)	4 (36.4)	0.27
Knowledge				
All IPV includes physical violence	29 (87.9)	15 (51.7)	14 (48.3)	0.68
I don't understand why anyone would stay in an abusive relationship	22 (66.7)	11 (50.0)	11 (50.0)	0.55
I only refer to the local DV center if the participant wants to leave the relationship	27 (81.8)	14 (51.9)	13 (48.1)	0.50
If the participant chooses to stay in an abusive relationship, there is nothing I can do	21 (63.6)	11 (52.4)	10 (47.6)	0.59
The primary cause of most IPV is alcohol or drug abuse	18 (54.5)	12 (66.7)	6 (33.3)	0.06
If possible, I would always notify the IPV survivor	25 (75.8)	14 (56.0)	11 (44.0)	0.31

prior to making a report to the child abuse hotline				
A problem with anger is the primary cause of IPV	11 (33.3)	8 (72.7)	3 (27.3)	0.09
Couples counseling is an effective strategy for stopping IPV in families	16 (48.5)	8 (50.0)	8 (50.0)	0.57
Anger management programs are effective in preventing the recurrence of IPV	11 (33.3)	5 (45.5)	6 (54.5)	0.40

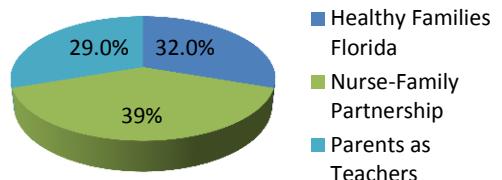
Table 3. Home visitors with high confidence, system awareness, and knowledge of IPV service delivery stratified by attendance of webinars (Survey 2)

	Total Indicated Agree/Strongly Agree (N=33)	HV who attended webinar (N=28)	HV who did not attend webinar (N=5)	P-value
Confidence				
I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship	27 (81.8)	23 (85.2)	4 (14.8)	0.66
I feel confident screening participants for IPV	28 (84.8)	23 (82.1)	5 (17.9)	0.41
When a participant tells me he/she has experienced IPV, I feel confident that I know what to say or do	29 (87.9)	25 (86.2)	4 (13.8)	0.50
I feel comfortable creating a safety plan with participants that disclose IPV	25 (75.8)	21 (84.0)	4 (16.0)	0.65
I feel prepared to serve families affected by IPV	28 (84.8)	24 (85.7)	4 (14.3)	0.59
System awareness				
I know when to make a report to the child abuse hotline for IPV	28 (84.8)	23 (82.1)	5 (17.9)	0.41
I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant	27 (81.8)	23 (85.2)	4 (14.8)	0.66
I am familiar with the legal options (both criminal and civil) for survivors of IPV	11 (33.3)	10 (90.9)	1 (9.1)	0.41
Knowledge				
All IPV includes physical violence	29 (87.9)	24 (82.8)	5 (17.2)	0.50
I don't understand why anyone would stay in an abusive relationship	22 (66.7)	18 (81.8)	4 (18.2)	0.45
I only refer to the local DV center if the participant wants to leave the relationship	27 (81.8)	23 (85.2)	4 (14.8)	0.60
If the participant chooses to stay in an abusive relationship, there is nothing I can do	21 (63.6)	16 (76.2)	5 (23.8)	0.09
The primary cause of most IPV is alcohol or drug abuse	18 (54.5)	14 (77.8)	4 (22.2)	0.23
If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline	25 (75.8)	22 (88.0)	3 (12.0)	0.35
A problem with anger is the primary cause of IPV	11 (33.3)	9 (81.8)	2 (18.2)	0.55
Couples counseling is an effective strategy for stopping IPV in families	16 (48.5)	13 (81.3)	3 (18.8)	0.47
Anger management programs are effective in preventing the recurrence of IPV	11 (33.3)	9 (81.8)	2 (18.2)	0.57

Learning Session 3:

A total of 28 home visitors accessed the third survey and 26 completed most of the items on the survey. Nine (32%) were of the Healthy Families Florida model, eleven (39%) in program implemented as Nurse Family Partnership while eight (29%) were in the Parent as Teachers model.

Survey Participants, Program Models



Previous IPV Training

Among the respondents who had attended the learning sessions, an equal number (9; 33%) had attended LS1 and LS2, ten (37%) had attended the third LS while nine (33%) had not attended any of the sessions. (Note that more than 1 option can be selected for this item). Slightly over a third, (nine home visitors; 35%), had not received training related to IPV outside of the learning collaborative and of the 65% (17 home visitors) who had training outside of the collaborative, six received such online/via a webinar and 7 (41%) through in person training from Florida MIECHV. The webinar most participated in by the home visitors was "responding to domestic violence in the African-American community" (n= 15; 65%) followed by "screening and continuous quality improvement" (14 home visitors; 61%). Thirteen (57%), twelve (52%) and eleven (48%) home visitors participated in "IPV among Latinos and working with Hispanic survivors", "Female to male violence, batterer intervention programs, and CQI update" and "effects of IPV on children and rapid cycle testing," respectively. Other webinars less participated in were "guide to DV in civil and criminal system and responses to IPV disclosures" (8 home visitors; 35%) and "PDSA practice, mid-point HV survey results, and Florida safety cards" (5 home visitors; 22%).

Home Visitors' Confidence, System Awareness, and Knowledge in Addressing IPV

Confidence

A general demonstration of high levels of confidence in IPV service delivery was observed in survey 3 (see table 4). Almost all home visitors demonstrated high levels of confidence with respect to screening (92%), know what to say or do when a participant tells of IPV experience (92%) and in identifying red flags in unhealthy relationships (92%) while over four fifths of them reported high confidence in serving families affected by IPV (84%) and creating a safety plan with participants that disclose IPV (81%).

System Awareness

Similarly, a general high level of system awareness was reported by home visitors in the third distribution of the survey. The lowest awareness was demonstrated in familiarity with legal options for IPV (69%) while almost all HV reported high levels of awareness for items: knowing when to make a report to the child abuse hotline for IPV and knowing the name of a staff person at their local domestic violence center to call if assistance is needed for a participant (96% respectively).

Knowledge

Responses of home visitors to items relating to knowledge showed a wide variability. Only 36% had knowledge that anger management does not prevent the recurrence of IPV while 50% have the knowledge that IPV is *not* primarily caused by problems with anger. About 56% know that the primary cause of IPV is *not* alcohol and drug abuse. About 65% answered correctly that couples' counseling is *not* an effective strategy for stopping IPV in families and can actually make the situation more dangerous for the survivor. All other knowledge items were answered correctly by the home visitors ranging from 76% - 92%. There was no significant difference in confidence, system awareness, or knowledge of respondents who attended the learning sessions/webinars compared with those who did not (see Tables 3, 4) except for knowing when to refer to the local DV center if the participant wants to leave the relationship stratified by attendance of learning sessions (P-Value 0.006, table 4).

Table 4: Home visitors with high confidence, system awareness, and knowledge of IPV service delivery stratified by attendance of learning session (Survey 3)

	Total (%) Agree/Strongly Agree (N=26)	HV who attended LS (%) (N=17)	HV who did not attend LS (%) (N=9)	P-value
Confidence				
I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship	24 (92.3)	16 (66.7)	8 (33.3)	0.58
I feel confident screening participants for IPV	24 (92.3)	15 (62.5)	9 (37.5)	0.42
When a participant tells me he/she has experienced IPV, I feel confident that I know what to say or do	24 (92.3)	17 (70.8)	7 (29.2)	0.11
I feel comfortable creating a safety plan with participants that disclose IPV	21 (80.8)	16 (76.2)	5 (23.8)	0.34
I feel prepared to serve families affected by IPV [#]	21 (84.0)	15 (71.4)	6 (28.6)	0.38
System awareness				
I know when to make a report to the child abuse hotline for IPV	25 (96.2)	16 (64.0)	9 (36.0)	0.65
I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant [#]	24 (96.0)	16 (66.7)	8 (33.3)	0.68
I am familiar with the legal options (both criminal and civil) for survivors of IPV	18 (69.2)	13 (72.2)	5 (27.8)	0.26
Knowledge	N (%) correct	N (%) correct	N (%) correct	P-value
All IPV includes physical violence	24 (92.3)	16 (66.7)	8 (33.3)	0.58
I don't understand why anyone would stay in an abusive relationship	22 (84.6)	15 (68.2)	7 (31.8)	0.43
I only refer to the local DV center if the participant wants to leave the relationship [#]	19 (76.0)	16 (84.2)	3 (15.8)	0.006
If the participant chooses to stay in an abusive relationship, there is nothing I can do	16 (61.5)	12 (75.0)	4 (25.0)	0.19
The primary cause of most IPV is alcohol or drug abuse [#]	14 (56.0)	7 (50.0)	7 (50.0)	0.11
If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline	19 (73.1)	13 (68.4)	6 (31.6)	0.46
A problem with anger is the primary cause of IPV	13 (50.0)	8 (61.5)	5 (38.5)	0.50
Couples counseling is an effective strategy for stopping IPV in families	17 (65.4)	12(70.6)	5 (29.4)	0.37
Anger management programs are effective in preventing the recurrence of IPV [#]	9 (36.0)	7 (77.8)	2 (22.2)	0.37

Key: [#]: Item was not answered by one home visitor

Table 5. Home visitors with high confidence, system awareness, and knowledge of IPV service delivery stratified by attendance of webinars (Survey 3)

	Total (%) Agree/Strongly Agree (N= 26)	HV who attended webinar(s) (%)	HV who did not attend webinar(s) (%)	P-value
Confidence				
I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship	24 (92.3)	21(87.5)	3 (12.5)	0.78
I feel confident screening participants for IPV	24 (92.3)	21 (87.5)	3 (12.5)	0.78
When a participant tells me he/she has experienced IPV, I feel confident that I know what to say or do	24 (92.3)	21 (87.5)	3 (12.5)	0.78
I feel comfortable creating a safety plan with participants that disclose IPV	21 (80.8)	19 (90.5)	2 (9.5)	0.49
I feel prepared to serve families affected by IPV [#]	21 (84.0)	18 (85.7)	3 (14.3)	0.58
System awareness				
I know when to make a report to the child abuse hotline for IPV	25 (96.2)	22 (88.0)	3 (12.0)	0.89
I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant [#]	24 (96.0)	21 (87.5)	3 (12.5)	0.88
I am familiar with the legal options (both criminal and civil) for survivors of IPV	18 (69.2)	16 (88.9)	2 (11.1)	0.69
Knowledge	N (%) correct	N (%) correct	N (%) correct	P-value
All IPV includes physical violence	24 (92.3)	21 (87.5)	3 (12.5)	0.78
I don't understand why anyone would stay in an abusive relationship	22 (84.6)	19 (86.4)	3 (13.6)	0.59
I only refer to the local DV center if the participant wants to leave the relationship [#]	19 (76.0)	17 (89.5)	2 (10.5)	0.58
If the participant chooses to stay in an abusive relationship, there is nothing I can do	16 (61.5)	14 (87.5)	2 (12.5)	0.68
The primary cause of most IPV is alcohol or drug abuse [#]	14 (56.0)	12 (85.7)	2 (14.3)	0.59
If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline	19 (73.1)	16 (84.2)	3 (15.8)	0.37
A problem with anger is the primary cause of IPV	13 (50.0)	12 (92.3)	1 (7.7)	0.50
Couples counseling is an effective strategy for stopping IPV in families	17 (65.4)	16 (94.1)	1 (5.9)	0.27
Anger management programs are effective in preventing the recurrence of IPV [#]	9 (36.0)	9 (100.0)	0 (0.0)	0.24

Key: [#]: Item was not answered by one home visitor

Change in Levels of Confidence, System Awareness, and Knowledge after Learning Collaborative

There was a general increase in confidence, system awareness, and knowledge regarding IPV service delivery. Compared to Survey 1, higher percentages of Survey 2 respondents demonstrated high confidence and high system awareness. In items testing for knowledge, Survey 2 respondents had higher percentages of accurate responses for all but two of the items tested. All items testing for confidence had at least a 20% increase in the percentage of participants who reported high confidence. The highest increases were noted for home visitors in their level of preparedness to serve families affected by IPV (% difference=41.9); their confidence in knowing how to act when a client discloses IPV experience (% difference=32.8); their confidence in screening participants for IPV (% difference=27.7); their awareness of the name of a staff person at the local domestic violence center who they could reach out to for help (% difference=43.0); and knowledge on notifying an IPV survivor prior to making a child abuse report (% difference=30.9). There was a decrease in the percent of accurate responses for survey items “I don't understand why anyone would stay in an abusive relationship” and “A problem with anger is the primary cause of IPV.” All other knowledge items had increased percentage of accurate responses ranging from 4.4% to 30.9% (see Table 6).

A similar general increase in confidence, system awareness and knowledge regarding IPV service delivery albeit minimal, in comparing survey 3 to survey 2. A slight increase in percentage of home visitors demonstrated higher levels of confidence except for item “I feel prepared to serve families affected by IPV”. A 0.8% decrease was observed therein and aside which increase in levels of confidence items were all less than 11%, the highest being confidence in talking to participants about red flags observed (10.5%). All items testing system awareness had at least eleven percent increase over those demonstrated in survey 2. The most improvement in high levels of system awareness was observed in being familiar with the legal options (both criminal and civil) for survivors of IPV (35.9% increase). A variety of percent difference in items measuring knowledge was demonstrated ranging from no increase to less than 20% increase. The highest increase was observed in knowledge of understanding why anyone would stay in an abusive relationship (percentage difference: 17.9); Couples counseling as an effective strategy for stopping IPV in families (percentage difference: 16.9); and “A problem with anger is the primary cause of IPV” (percentage difference: 16.7). A decrease in percent of accurate responses for knowledge items “I only refer to the local DV center if the participant wants to leave the relationship”, “If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline” and “If the participant chooses to stay in an abusive relationship, there is nothing I can do”. All other knowledge items responses ranged from 3% to 4% in percent increase.

Not contrary to expectations, a higher percentage increase in confidence, system awareness and knowledge of IPV service delivery was observed when survey 3 responses were compared to survey 1. All confidence items increased in percent difference ranging between 33% and 41%. Overall, the best increase in percent difference between surveys 3 and 1 was observed in items measuring system awareness: “I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant” (57.2%) and “I am familiar with the legal options (both criminal and civil) for survivors of IPV” (48.8%).

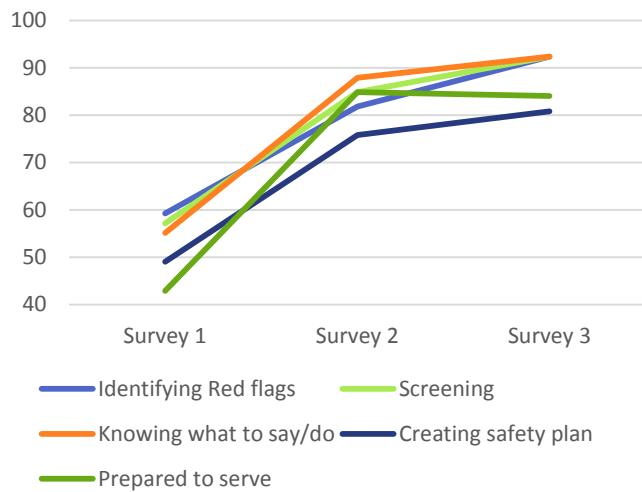
Additionally, an increase on items measuring knowledge was observed, with similar small increases (2-3% difference) for items “If the participant chooses to stay in an abusive relationship, there is nothing I can do”, “The primary cause of most IPV is alcohol or drug abuse” and “If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline”. The highest difference in percent of accurate responses is 34.8% for item “Couples counseling is an effective strategy for stopping IPV in families” and 28.2% for “If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline”.

Table 6. Home visitors' confidence, system awareness, and knowledge of IPV service delivery at baseline and after the second and third learning session

	High levels of confidence, system awareness, and knowledge Indicated Agree/Strongly Agree (%)								
	Pre-test Baseline N=49		Post-test Survey 2 N=33		Post-test Survey 3 N=26		Change Survey 2-1	Change Survey 3-2	Change Survey 3-1
	%	n	%	n	%	n	%	%	%
Confidence	Indicated Agree/Strongly Agree (%)								
I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship	59.2	29	81.8	27	92.3	24	22.6	10.5	33.1
I feel confident screening participants for IPV	57.1	28	84.8	28	92.3	24	27.7	7.5	35.2
When a participant tells me he/she has experienced IPV, I feel confident that I know what to say or do	55.1	27	87.9	29	92.3	24	32.8	4.4	37.2
I feel confident creating a safety plan with participants that disclose IPV	49.0	24	75.8	25	80.8	21	26.8	5.0	31.8
I feel prepared to serve families affected by IPV	42.9	21	84.8	28	84.0	21	41.9	-0.8	41.1
TOTAL	52.6	129/245	80.6	137/165	87.7	114/130			
System awareness	Indicated Agree/Strongly Agree (%)								
I know when to make a report to the child abuse hotline for IPV	73.5	36	84.8	28	96.2	25	11.3	11.4	22.7
I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant	38.8	19	81.8	27	96.0	24	43.0	14.2	57.2
I am familiar with the legal options (both criminal and civil) for survivors of IPV	20.4	10	33.3	11	69.2	18	12.9	35.9	48.8
TOTAL	44.2	65/ 147	66.7	66/99	85.9	67/78			
Knowledge	% who answered item correctly								
All IPV includes physical violence	79.6	39	87.9	29	92.3	24	8.3	4.4	12.7
I don't understand why anyone would stay in an abusive relationship	77.6	38	66.7	22	84.6	22	-10.9	17.9	7.0
I only refer to the local DV center if the participant wants to leave the relationship [#]	67.3	33	81.8	27	76.0	19	14.5	-5.8	8.7
If the participant chooses to stay in an abusive relationship, there is nothing I can do	59.2	29	63.6	21	61.5	16	4.4	-2.1	2.3
The primary cause of most IPV is alcohol or drug abuse [#]	46.9	23	54.5	18	56.0	14	7.6	1.5	9.1
If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline	44.9	22	75.8	25	73.1	19	30.9	-2.7	28.2
A problem with anger is the primary cause of IPV	38.8	19	33.3	11	50.0	13	-5.5	16.7	11.2
Couples counseling is an effective strategy for stopping IPV in families	30.6	15	48.5	16	65.4	17	17.9	16.9	34.8
Anger management programs are effective in preventing the recurrence of IPV [#]	26.5	13	33.3	11	36.0	9	6.8	2.7	9.5
TOTAL	52.4	231/441	60.6	180/297	66.2	153/231			

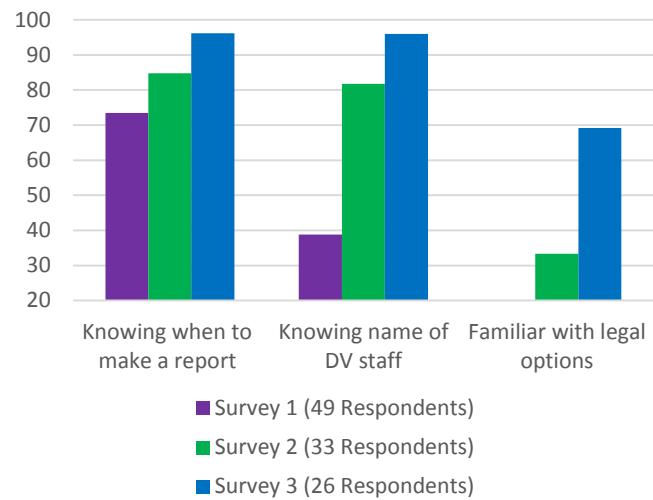
Key: [#]: Item was not answered by one home visitor

Fig 1: Percent Reporting Confidence by Survey



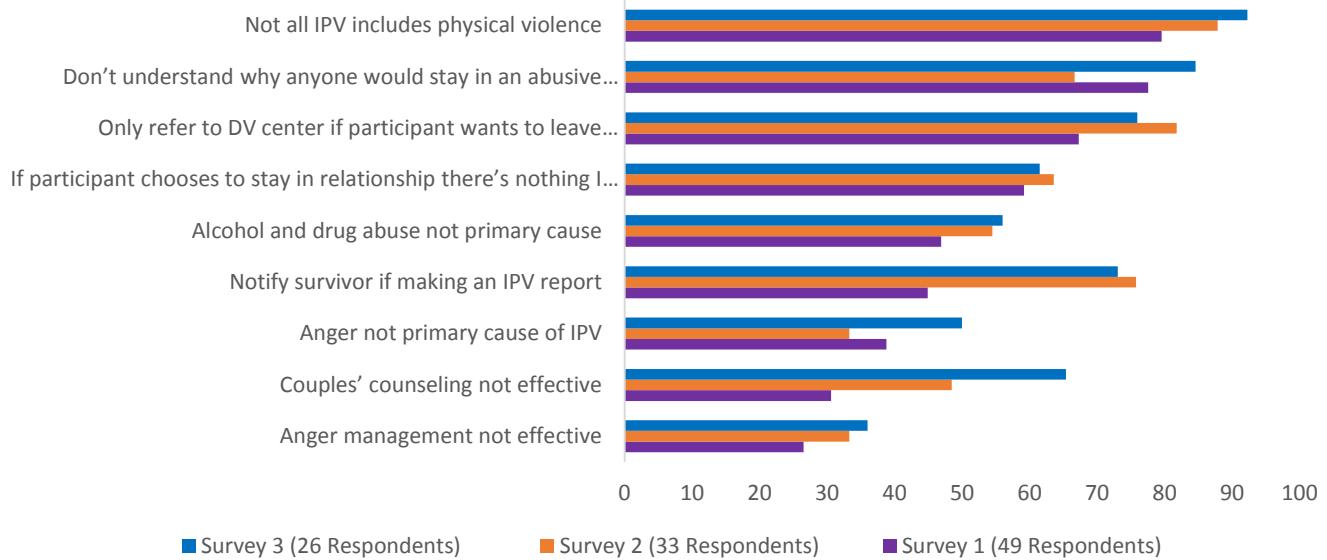
Note: Survey was distributed statewide on three occasions. Results were not individually linked, so respondents to Survey 1, Survey 2 and Survey 3 may differ.

Fig 2: Percent Reporting System Awareness by Survey



Note: Survey was distributed statewide on three occasions. Results were not individually linked, so respondents to Survey 1, Survey 2 and Survey 3 may differ.

Fig 3: Percentage Correct on Knowledge Questions by Survey



Note: Survey was distributed statewide on three occasions. Results were not individually linked, so respondents to Survey 1, Survey 2 and Survey 3 may differ.

Learning Sessions.

Learning Session 1: Sarasota, FL – August 2015

IPV Discussion Breakout Session Summary: MIECHV Supervisors and Administrators

The key themes that emerged from group discussions with MIECHV supervisors and administrators at the first learning session were related to self-care, reflective supervision, and definition of success.

Self-care

The MIECHV supervisors and administrators during their breakout session discussed self-care; the meaning of success, especially when working with families who may be in denial; how to initiate trusting relationships with families; and support for home visitors working with such families recognizing that this can be a source of stress. Different ways in which they performed self-care was discussed, including getting feedback and guidance, as well as using available resources. Ultimately, it was discussed that adequate self-care increases the ability of the administrator/supervisor to provide optimal support for members of the staff.

“...taking care of yourself will allow you to support the staff – and encouraging them to take care of themselves as well because again, this can be draining.”

Reflective supervision

To provide support for home visitors, the value of reflective supervision was discussed. Participants also discussed a need for increased knowledge in knowing what to do for home visitors who had experienced trauma themselves. Being a source of encouragement and helping home visitors realize their limitations in providing help was also discussed as one of the ways to provide support. Supervisors/administrators expressed their need for support, and some of them described instances where they have actively taken steps to understand the information being provided recognizing that it is necessary so they can relay information to the staff. Recognizing that added responsibility can be a challenge for home visiting staff, the group talked about how supervisors can be a source of support as program changes are being implemented. These included modeling a positive attitude with the aim of encouraging staff to adopt this positive attitude, implementing changes in small doses to increase buy-in, making it fun, encouraging everyone to participate, and celebrating successes.

“So you want to make it fun in a way. Change is difficult, so maybe think of different team building activities that you can do during meetings and just make it – kind of lessen the pain a little bit.”

“Now we’re at the point where we’re doing well, but we recognize that we really need to really celebrate any little thing – when we have an accomplishment because I think so many times, we’re just ‘Do this, do that. These screens were not completed. We don’t have enough clients.’ And, just step back and say, we really are moving in a very good direction and we celebrate any accomplishment or when they’ve done a good job, because they really do great things every day.”

“We worked really small tests, and we had some really big improvements. It was all because of the work that they did. They were recognized for that.”

Definition of success

It was decided that **success cannot be measured based on eliciting disclosure/positive screens or how many women use the resources and education given to them**. Success was, however, defined as home visitors being able to recognize red flags and respond with appropriate referrals and having the client comfortable with her decision and choice. The co-facilitator defined success as the home visitor providing information and offering services. While it is important to respect the decisions of the participants, they may or may not feel comfortable

with their decisions because of what is at stake. Due to the concern for safety, the decisions may change as the circumstances change. The important piece is that the home visitor has provided resources so that the participants can make informed decisions. The role of the supervisor is to help coach their staff in recognizing IPV and supporting survivors. They must help their staff to become aware of their own biases, in an effort to eliminate judgment.

"I think for me, success is when the woman or participant or client is feeling comfortable and confident with her decision and her choice."

IPV Discussion Breakout Session Summary: MIECHV Home Visitors

During the home visitors' focus group breakout session, they discussed multiple aspects of the learning session that they believed were thought-provoking. Several aspects of competently serving families experiencing IPV were discussed including education, screening tools, screening strategies and increased awareness of IPV among staff and program participants were discussed.

Lack of knowledge

Several home visitors stated that education was an important aspect that needed to be implemented for both home visitors and clients. With varying levels of experience and differing educational, as well as occupational, backgrounds, some of the home visitors reported very little understanding of how to appropriately convey the impact violence in the home has on children. A few home visitors discussed the lack of resources/help for children who grow up in homes where IPV occurs and expressed an interest in further training to learn more about this. Overall, when asked by the moderator to share their experiences and thoughts following the first day of the learning session, the home visitors shared their experiences in personally experiencing IPV and being witness to IPV. They also voiced a desire for more training as it relates to their education and the education of their families, as well as ways to help participants to disclose and seek help. One home visitor stated training in motivational interviewing and other strategies was helpful. Additionally, the moderator suggested that training on adverse childhood experiences will help increase knowledge of the impact of children's exposure to violence and home visitors agreed with her that this is a priority area.

"Mostly with domestic violence, they focus so much on the mom that they forget that their children have to live with it long term because as they grow into adulthood... The trauma is still in you. It never goes away."

Home visitors believed that the main reason mothers stayed in an abusive relationship was they felt it was important for their child to have a father. Home visitors also stated that appropriately educating women on resources, as well as impact of violence on themselves and the children witnessing the violence would lead to women leaving the relationships. One home visitor stated a participant had already "denied" experiencing IPV, however, on receiving information about the negative impact IPV on children, she left her partner.

"I ended up [sic] the relationship with him right away after I heard you saying how much it affects our children, and I've been in this domestic violence relationship for a long time. I'm sorry I lied to you."

Curriculum

To resolve the issue of lack of knowledge on both the part of some of the home visitors and the participants, a suggestion was made that a curriculum be developed or acquired that appropriately addressed healthy and unhealthy relationships, not just IPV, and appropriate resources to provide to participants and their children. This curriculum would permit the conversation to occur in a less startling manner and afford the home visitor the opportunity to address the topic in a sensitive and appropriate manner.

"We need curriculum that we can address these issues before that even happens... None of our curriculum addressed that. I could simply go back and talk about how does arguing affect your children? What if this

happened? If we have some curriculum to go by, to start doing this before we even do the heart because we're already talking about it. That may open them up, disclosing something earlier than we have to wait for six months or close. It may open it up right away and we can get them services right away before the child is dangled over something like that. We don't have curriculums. We have handouts. I mean we have little booklets that we could go in but now I got to figure out how I'm going to get away with this if it was the service plan. We have the service plan. We have that on the service plan, but we really don't have the curriculum at the outside. We've been looking for it, I called and asked for those little booklets, how domestic violence affects families but we have to know how to open that up. If I had an easy curriculum that I could introduce to this family before it gets there, it would make it a lot easier."

Screening tools

The home visitors expressed concern about how the screening tools for IPV may not necessarily be most sensitive to detecting families who have experienced IPV. Some home visitors felt that the stark and "aggressive" nature of the questions, along with the fact the questions so clearly are trying to assess for violence in the home, make it awkward to address within the first few months of interacting with the family. There was also a feeling that participants are unlikely to disclose such personal information. Two approaches were discussed that other sites use to lessen the intensity of asking such sensitive questions. The first suggestion was ensuring that a rapport was developed between the home visitor and mother. This home visitor stated she was able to establish rapport because she saw her families on a weekly basis for the first few months and assured that these questions were asked of every family. One home visitor agreed that rapport was important, but that waiting longer to complete the measure could be a viable option if frequency of visits was less than once a week. Another suggestion made to help with the issue of the required screeners was incorporating the questions into a conversation as opposed to engaging in an interaction that comes off "robotic" and unnatural. Some home visitors said that they were able to do that because of training they received at their respective sites. Others stated they were fearful of not completing every question if they did try to make the questions flow in a conversation as they had not been granted permission, or been provided the training, to do so by their program.

"We need to stop focusing so much on the form and give more, be more human, and be more empathetic."

Agency and program factors

As many of the MIECHV programs occur in various agencies, different requirements exist in addition to those required by MIECHV and the program that is being implemented (i.e., PAT, NFP, Healthy Families). Many home visitors felt frustrated that the agency in which they were housed required they attend meetings they felt were irrelevant or interrupted time with their families. One session participant stated that her colleague missed out on a whole day of work due to meetings and still had to meet with her 25 families within her remaining 30-hour work week. Another point specific to systems navigation was aiding immigrant and undocumented families because leaving a violent partner would lead to social isolation and with no control of whether the participant could stay in the US after leaving said partner. No suggestions were made on how to deal with this particular concern during the learning session, but staff were later provided with online training that addressed it.

Learning Session 2: Kissimmee, FL – November 2015

IPV Discussion Breakout Session Summary: MIECHV Supervisors and Administrators

The breakout session was specifically targeted at situations where home visitors experience trauma (direct or secondary traumatic stress) – especially relating to IPV – and how supervisors/administrators best support them. They also discussed measures for keeping home visitors safe in that situation and policy level ways in which to address it. The topics that were discussed at this breakout session related to reflection supervision and workplace violence.

Reflective supervision

The first point touched on reflective supervision and how that helps in their supervisory roles. This was referred to as self-care by one of the DV advocates. Supervisors talked about how they utilize reflective supervision. Themes that emerged in terms of effectiveness of reflective supervision included timing and content. In terms of timing, two participants explained that they had weekly meetings with team members to talk about what goes on in the field. In addition to these meetings, there were also some random check-ins with team members to ensure everything was going well. The content of these supervisory efforts were mostly similar. It included being supportive - with their experiences in the field, their emotions and feelings about these experiences and with their caseloads.

"We're just doing a lot of constant checking with that person just to make sure that they're okay with what's – with working with this family, that it's not bringing something up for them, and that's difficult for them to work through."

Workplace violence

The group discussed specific policies that were in place with respect to dealing with workplace violence and disclosures of IPV by their staff/team members. There did not seem to be any specific policies or guidelines for these situations. One participant commented that new policies are only written when a particular situation occurs. Strategies discussed on this topic were: 1) referral to the Employee Assistance Programs for staff members; 2) a personal policy to be non-intrusive and supportive; 3) referral to the home visiting program's mental health specialists; and 4) providing resources for additional help. A participant shared a story about how IPV experience by a team member threatened not just her but also her coworkers, including instances where the perpetrator called and came to the workplace. These incidents led to the development of safety policies for their agency.

"You're only writing policies when you get into that situation."

The group went on to discuss some practical things that can be done by supervisors to help in identifying and addressing instances of workplace violence. These included paying attention, documentation, looking to social workers as sources of information, making appropriate referrals based on issue (mental health, IPV), building a relationship with local DV centers, and educating staff members. One group member described a mandatory workplace training that they receive from a staff member at a DV shelter. A challenge to the issue of addressing workplace violence that emerged was the prevailing assumption that it doesn't occur. Furthermore, the group discussed strategies to increase workplace safety such as checking ID cards of employees. Staying safe while out visiting families was another issue that emerged; a potential solution was taking different routes to get to families' homes.

"Because I think it's still this perception that it only happens to these certain types of women."

"I don't know if [the presenter] said this or not, but that is what stood up in court. It was even more important to her case than the video itself. It was the documentation of her supervisor because that showed that it wasn't just a single event. She had documentation for over a year, and so that showed that this abuse was happening consistently, so it's something as simple as keeping a calendar."

IPV Discussion Breakout Session Summary: MIECHV Home Visitors

The session with the home visitors was primarily a reflective session. It focused on self-care and techniques to relax and cope with stress. Participants were taught several methods of coping with stress (breathing techniques and mindfulness techniques) and also had the opportunity to practice some of the techniques within the group.

The session began by asking home visitors to mention a self-care act that they had used in the past week. Self-care techniques that emerged from the conversations included:

1. Not answering or turning off their phone,
2. Watching their favorite shows on TV or on Netflix (a lot of people used this strategy),
3. Reading,
4. Cutting down or refraining from work during travel or leaving work at work,
5. Taking time off to rest and relax,
6. Listening to music (a lot of people also use this strategy),
7. Going to bed early or getting more sleep in general
8. Catching up on couponing,
9. Talking to a supportive person such as their mother or grandmother,
10. Praying,
11. Establishing boundaries as a preventive approach so they do not need emergency self-care,
12. Painting nails, and
13. Staying at work to escape going back to a stressful home environment.

"One of the things I established a long time ago is boundaries. So I find that the self-care I don't need as much, or it's not as an emergency as it used to be. When I leave work, I leave work and I turn everything off so that I can just focus on the rest of my life."

Following this, the group facilitators discussed the need to identify specific triggers related to IPV. The group considered physical, cognitive, and behavioral cues. Triggers could be as a result of a personal experience, knowing someone that has had the experience or working in that situation (compassion fatigue). Other things that could affect one's perspective of IPV included background experience, beliefs (cultural, religious, etc.).

"Cultural beliefs, religious beliefs that may influence how you see intimate partner violence when you're in a home... what clues will tell you, 'Is my perspective influencing my reaction to this situation?'"

To round up the session, group facilitators discussed specific coping mechanisms with the group. Specific coping strategies included:

1. Movement for at least 10, 15, or 20 minutes per day,
2. Having evening sleep routines (e.g. reading before bed),
3. Slow, deep, rhythmic breathing,
4. Mindful thinking, which improves mental, psychological, emotional, and physical health,
5. Enjoyment of pleasant activities,
6. Writing down string of consciousness, and
7. Setting aside time to think about the things you can't just let go of.

"Exercise. Now, this immediately brings guilt to everybody's mind. Right? You don't have to join a gym, you don't have to get one of those fancy Fitbits. You don't have to buy any kind of special shoes. Just move; for at least 10, ideally 20 minutes a day. Walk your dog. I always turn on dance songs. I just love to dance. Not only am I moving my body but I'm in a very happy place."

"It's always good to have some kind of bedtime routine, right? We do that with our kids. It's like bath, book, bed. But we don't do it ourselves. Part of a routine tells our body, "Okay, it's time to disconnect and go to sleep."

Focus Groups 1 and 2 Summary

The focus group discussion specifically aimed to receive feedback from attendees about the learning collaborative (LC). This discussion covered topics on the successes and challenges of the LC, personal impact that the LC has had on them, strategies used for information sharing during the LC, strategies for sustainability and the next steps. Focus group attendees felt that having the guest speakers during the learning sessions was one of the things that went well for the LC. The personal stories shared by the guest speakers helped them to identify victimization and also be more aware of clients. Another thing that went well was the information shared during the guest presentations. This information built from personal to factual and participants felt that this was useful. Other areas of success included the provision of visual tools on how to appropriately complete necessary programmatic paperwork and training in quantitative data to help program staff understand whether their anecdotal data matched their numbers.

"It is personal, I mean we're not trying to make them dredge up their trauma, but it really does – it does give you insight. You get to ask them questions and you get to remember why you do this kind of work, why you're getting all up in the trauma."

Attendees also discussed the personal impact the collaborative had on them including increased passion and likelihood of advocating for DV screening after establishment of trust with their clients. Other positive impacts included being better able to address data entry and minimize missing data, increased ability to connect with groups/service providers because of information received during the sessions and a positive impact on how data is reviewed at their respective sites.

When discussing challenges with the Learning Collaborative, attendees said that the message they received didn't seem customized for their program, the sessions did not have enough in them for data entry specialists and that there was miscommunication regarding usage of the cards ['Healthy Mom, Healthy Babies' cards]. Other challenges that were mentioned includes paperwork, an overwhelming number of sessions, trying to figure out if to prioritize testing or the task at hand, as well as a lack of clarity on what to be doing at each point in time. Some members of the group suggested that it would be more beneficial to space out the learning sessions and have more practical activities during the sessions.

"I think she brought in a lot of informative material and it was helpful like some things that I wanted to include into my policy but I think they were too general, maybe specific for those particular states that she was in and not customized for our state so that's why it was like, "Okay. This was great, but we don't - we want you to take that information, but don't spread that... so I can kind of see why it would feel like it was, what was the point..."

Furthermore, participants discussed the strategies the travel team had used in sharing information with other members of the team. These strategies included having team meetings to share the stories and information received, discussions as to how to tailor the implementation to fit the team's particular needs, and voting on which methods to use. However, buy-in was said to be a challenge when the information was brought back to team members. Participants also felt that there was a disconnect with regards to information delivery when bringing back information to the rest of the team. A suggestion for a possible solution to this disconnect was that the sessions should be recorded or video-taped if possible.

"So I don't know how you would fix something like that. I mean, maybe some short clips. I know we got the videos, a couple DVDs, maybe when the speakers are here, since they do small stuff like an hour, an hour and a half, some of that might, could be recorded and then we could play it by team meetings and maybe we'd get their passion going a little bit more."

"We shared the story about what happened during a learning collaborative and what we would like to focus on for the next step and how to go about doing it, like as a democracy rather me coming and this is a policy

that we follow, getting feedback like I have a couple of policies, let's look at them and try to merge them into something that would work for us so that way they can buy into what we wanted them to do rather than the CQI team coming in and saying, "Okay. This is what we're going to do now. This is what you should do."

Other suggestions on how to improve sharing of information with other team members were rotating staff participation in the learning sessions, including information/teaching on how to construct the Plan-Do-Study-Act (PDSA) cycle, clarifying procedures, including information on how to present effectively and possibly increasing the time allotment for presentations.

To promote sustainability of lessons learned from the CQI effort, participants said that they put the lessons into a policy. The specific steps they have taken towards sustainability includes steps with the domestic violence centers such as training of call procedure, training the domestic violence staff about the MIECHV program to have a referral program collaboration, and a breastfeeding workshop to create partnerships. To promote their skills with interacting with domestic violence clients, focus group attendees discussed annual training of new hires to orient them to proper procedures, guidelines and services in addition to more in-depth orientation for existing and new staff on domestic violence clients. Attendees also shared that it will be supportive of their work if the MIECHV CQI staff/IPV faculty can advocate for a better screening tool as well as tools for safety planning.

We have annual training for ladies but then and the DV shelters are going to do the training for us. Then, we're doing the – every other year, we'll do a refresher for the sessions, again, through the DV shelters.

Next steps were discussed that included taking things “step by step” and building on new changes, developing a process for change flexibility of going back to make changes, continued testing to revamp change/approach, demonstration of success to increase buy-in (“proof in pudding”, getting ideas from different groups/people and ensuring sustainability. At the end of the session, respondents talked about their appreciation of all the efforts that had been put into the learning collaborative sessions and in providing support to the individual Florida MIECHV programs and staff. One participant said that the introduction of MIECHV into Florida has provided staff with the appropriate quality training that had not existed prior and that the “face of home visiting” has changed for the better.

Table 7: Intimate Partner Violence (IPV) Measures

Measure #	Performance Goal	Measure Name/ Operational Definition	Data Collection Plan	Rationale
1.	By May 31, 2016, at least 90% of women will be screened with an appropriate IPV screening instrument within six months of program enrollment.	<u>% Women Screened with 6 Months of Enrollment</u> Process Measure: # of women screened for IPV within 6 months of enrollment/# women enrolled at least six months and women screened prior to six months	Data collected by: Home visitors Data source: Participants, direct assessment Frequency of data collection: within 6 months of enrollment and as needed Data point: 6 months post-enrollment	All women should be screened for IPV as soon as is appropriate, but no later than six months after enrollment. Unless there are immediate indicators, taking time to develop trust prior to screening is often helpful. A screen should be conducted immediately, if there are indicators of IPV.
2.	By May 31, 2016, at least 85% of women will have a safety plan in progress within 30 days of screening positive or disclosing IPV.	<u>% of eligible women who have safety plan within 30 days of identification</u> Process Measure: # of women who have a safety plan within 30 days of positive screen or disclosure / # women with positive screen or disclosure	Data collected by: Home visitors Data source: Program documentation Frequency of data collection: ongoing Data point: 30 days after positive screen or disclosure	The home visitor must determine what safety planning is needed. Ideally, a DV advocate will take the lead on safety planning, but a trained home visitor should do basic safety planning with participants, if the woman chooses not to speak with a DV advocate.
3.	3. By May 31, 2016, at least	<u>% women referred w/in 7</u>	Data collected by: Home	Once a woman screens

	85% of women will have been referred to a certified DV center or other appropriate IPV service within 7 days of screening positive for IPV or disclosing IPV (if not already receiving appropriate services).	<u>days</u> Process measure: # of women who were referred for IPV services within 7 days of positive screen or disclosure/ # women with positive screen or disclosure	visitors Data source: Program documentation Frequency of data collection: ongoing Data point: 7 days after positive screen or disclosure	positive or discloses IPV, a referral to appropriate services should be made as quickly as possible-within 7 days at the latest-to minimize the risk of harm and infuse supports as soon as possible.
4.	By May 31, 2016, the # of monthly home visits will remain consistent.	<u>Workload Management</u> Balancing measure: Total number of home visits	Data collected by: Home visitors Data source: Program documentation Frequency of data collection: ongoing Data point: At time of monthly report	Participation in the Learning Collaborative could inadvertently affect the ability to complete home visits.
5.	By May 31, 2016, home visitors will report an increase in IPV knowledge from 52 percent at baseline to 75 percent, as measured by the IPV survey.	<u>% of home visitors demonstrating increased IPV knowledge</u> Outcome measure: % of home visitors who demonstrate increased knowledge about IPV	Data collected by: MIECHV evaluator Data source: Survey of home visitors Data points: Prior to first learning session, at the mid-point and at the end	Home visitors who are knowledgeable about IPV will provide better services, including screening, referrals and safety planning.
6.	By May 31, 2016, home visitors will report an increase in system awareness from 44 percent at baseline to 75 percent, as measured by the IPV survey.	<u>% of home visitors demonstrating increased IPV system awareness</u> Outcome measure: % of home visitors who demonstrate increased knowledge about IPV	Data collected by: MIECHV evaluator Data source: Survey of home visitors Data points: Prior to first learning session, at the mid-point and at the end	Home visitors who are aware of systems to support IPV survivors will provide better services, including screening, referrals and safety planning.
7.	By May 31, 2016, home visitors will report an increase in confidence when supporting families experiencing IPV from 53 percent at baseline to 75 percent, as measured by the IPV survey.	<u>% of home visitors demonstrating increased confidence</u> Outcome measure: % of home visitors who self-report increased confidence supporting families experiencing IPV total # of home visitors	Data collected by: MIECHV evaluator Data source: Survey of home visitors Data points: Prior to first learning session, at the mid-point and at the end	Home visitors who are confident supporting families experiencing IPV will provide better services, including screening, referrals and safety planning.

References

1. Sarkar, N. N. (2008). The impact of intimate partner violence on women's reproductive health and pregnancy outcome. *Journal of Obstetrics and Gynecology*, 28(3), 266-271.
2. Shah, P. S., & Shah, J. (2010). Maternal exposure to domestic violence and pregnancy and birth outcomes: A systematic review and meta-analyses. *Journal of Women's Health*, 19(11), 2017-2031.
3. Han, A., & Stewart, D. E. (2014). Maternal and fetal outcomes of intimate partner violence associated with pregnancy in the Latin American and Caribbean region. *International Journal of Gynecology & Obstetrics*, 124(1), 6-11.
4. Carlson, B. E. (2000). Children exposed to intimate partner violence research findings and implications for intervention. *Trauma, Violence, & Abuse*, 1(4), 321-342.
5. Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse & Neglect*, 32(8), 797-810.

CHARACTERISTICS AND EXPERIENCES OF ADOLESCENT PARTICIPANTS IN THE FLORIDA MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM



**Florida MIECHV Program Evaluation
University of South Florida College of Public Health
Chiles Center for Healthy Mothers and Babies**

Abimbola Michael-Asalu, Rema Ramakrishnan, Leandra Olson,
Amber Warren, Pamela Birriel, and Jennifer Marshall

Introduction

This is a summary report of data collected as part of the evaluation of the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. The University of South Florida (USF) MIECHV Program Evaluation Team conducted a cross-sectional, mixed methods analysis to describe characteristics and experiences of adolescent participants served by the Florida MIECHV program.

Pregnant adolescents and their offspring are at higher risk for experiencing health, social, and developmental hazards, such as substance abuse, intimate partner violence, depression, delivery complications, low educational attainment, and repeated pregnancies on the part of the adolescents while their offspring are predisposed to prematurity, poor birth outcomes, failure to thrive, neglect, abuse, and teen pregnancies of their own¹⁻³. The purpose of this study was to 1) compare the characteristics of pregnant adolescents and adolescent mothers served by the Florida MIECHV program to those of non-adolescent participants in the program and 2) examine the experiences of adolescent participants in the program.

Quantitative data were retrieved from the Florida Home Visiting Information System (FLOHVIS). Qualitative data were drawn from a larger dataset of transcripts from telephone interviews conducted with MIECHV participants in 2014 and 2015. The data sets comprised entries collected from participants in all three evidence-based home visiting models implemented in Florida: Parents as Teachers, Nurse-Family Partnership, and Healthy Families America.

- Parents as Teachers is targeted towards educating families using evidence-based curriculum/practices through training and certification of parent educators. The program goals are to increase the knowledge base of child development amongst enrolled parents, thereby improving parenting practices and school readiness. Families are enrolled as teachers beginning with pregnancy and may continue until the child enters kindergarten.
- Nurse-Family Partnership (NFP) is a program conducted by trained nurses aimed at improving the health and well-being of low income and first-time pregnant women. The program is geared towards linking participants to needed health services, reducing alcohol, substance and tobacco abuse, improving parent-child relationships through promotion of mental health, decreasing subsequent unintended pregnancies, and aiding self-sufficiency of mothers. NFP also focuses on school readiness.
- The objectives of Healthy Families America are: development of positive parent-child relationships and parenting behaviors, reducing child abuse incidences, child injuries and consequently emergency department use, increasing children's social-emotional well-being, and improving school readiness. It is designed for parents facing challenges like history of child abuse, domestic violence, mental health issues, and low income. Families are typically enrolled prenatally or within three months of the infant's birth and remain in the program until the child's fifth birthday.

Each of these models are based on human ecology and self-efficacy/self-sufficiency⁴⁻⁶ and have relatively similar data collection and entry system. Home visiting staff are trained on data collection methods to improve data quality and reliability.

Methods

Quantitative

The study population consisted of all females enrolled in the Florida MIECHV program between April 08, 2013 and February 29, 2016. Secondary data analysis was conducted on FLOHVIS data using Statistical Analysis System (SAS 9.4, Cary NC). The variables included in the analyses were: type of home visiting model, race, ethnicity, marital status, education, history of child abuse/neglect and/or abuse/neglect resulting in involvement with child welfare system, current/previous substance abuse problems, intimate partner violence, postnatal depression (measured by the Edinburgh Postnatal Depression Scale), annual household income, perceived parental stress, type of health insurance, and employment status. Descriptive and bivariate statistics were generated for the demographic, socioeconomic, and health behavior variables. For the bivariate analyses, chi-square tests were used for categorical variables and t-tests/Wilcoxon Mann-Whitney tests for continuous variables.

Qualitative

The USF MIECHV program evaluation team conducted in-depth, semi-structured phone interviews with home visiting participants, including adolescents, from 11 programs in Florida to better understand their home visiting experience. From July-September 2014, team members conducted phone interviews with participants from Alachua, Bradford, Duval, Escambia, Pinellas, and Putnam; and from January-March 2015, participants from Broward, Hillsborough, Manatee, Miami-Dade, Orange, and Southwest Florida (i.e., Collier, Hendry, and Lee Counties) were interviewed.

To recruit participants, home visitors distributed flyers to families within the selected MIECHV programs that detailed the purpose of the phone interviews and contact information for the USF MIECHV evaluation team. Interested participants directly contacted the evaluation team to schedule a date and time for their interview. Interviews were conducted via phone, and each participant provided verbal consent to participate. The phone interviews lasted an average of 20 minutes, and all were digitally audio-recorded. Each participant received a \$25 Wal-Mart gift card as compensation for participation.

Participants were asked a series of questions relating to their perceptions of their home visiting experience including: parts of the home visits that are most helpful to them; their relationship with their home visitor; the utilization of home visiting lessons and activities in their daily life; the types of referrals they receive; and access to healthcare and mental health services.

Interviews conducted in English and Spanish were professionally transcribed verbatim and translated to English, if applicable; and Haitian-Creole interviews were transcribed and translated by

bilingual research staff. All recordings and transcripts were simultaneously reviewed to ensure accuracy and qualitative, thematic content analysis was conducted by trained research staff from the evaluation team. The evaluation team further reviewed the interviews conducted with adolescent participants to assess and describe main findings. Self-reported demographic information was also recorded and entered into Qualtrics Survey Software.

Results

Quantitative

The total number of study participants from FLOHVIS was 1,785 which included 246 adolescent females between the ages of 14 and 19. This accounted for 13.8% of total program participants. The Nurse-Family Partnership home visiting program had the highest proportion of adolescents enrolled in their program (66.7%, n=164) compared to the other model types (Healthy Families Florida (21.1%) and Parents as Teachers (12.2%)), of which most are aged 18-19 (n=109). A higher proportion of adolescents who were Black (52.7%) versus White (38.9%) were enrolled in the program compared to an almost equal proportion of non-adolescent participants (47.7% Black, 47.5% White). Ethnic distributions of adolescents were roughly similar to non-adolescents, with slightly higher proportions of Hispanic adolescent participants (28.6% vs. 23.7%). The majority of adolescents (n=239, 98.0%) as well as adults were single (n=1,217, 79.9%).

Overall, women (age \geq 20 years) enrolled in the Florida MIECHV program had low educational status with almost half having less than a high school education (44.0%). As it would be assumed given their age, 100% of those aged 14-17 had a high school/less than a high school/GED education. However, it is notable that 93.8% (n=76) of the 173 adolescents aged 18-19 years had a high school/less than a high school/GED education. Only 6.2% (n=5) of adolescents ages 18-19 had more than high school/GED, compared to 44% of non-adolescents. Nearly a third, 25.6% (n=33) of adolescents were employed (17 full-time), compared to 45.6% of non-adolescents. Four adolescents under age 18 were employed (3 full-time, 1 part-time). Additionally 5.1% (n=12) of adolescents did not have any form of health insurance, including 2.8% (n=2) of adolescents aged 14-17 and 6.1% (n=10) of ages 18 - 19.

Seventeen (7.0%) adolescents reported current or past substance abuse, compared to 22.3% of adult participants. About 13% (n=32) of adolescents reported experiencing a history of child abuse or neglect compared to 25.0% (n=381) of adult participants. Most of the adolescents with a positive self-reported history of child abuse were 18-19 years old (n=24). Analysis of perceived parental stress and postpartum depression scores showed similar values to older participants (mean stress score was 12.2 among adolescents vs. 11.8 for non-adolescents; median depression score was 6.0 among adolescents vs. 5.0 for non-adolescents); however, these score



differences were not statistically significant. Similar results were observed for subgroup analysis of adolescents (median depression scores 5.0 versus 6.0, and median perceived parental stress scores 14.0 versus 11.0 for adolescents aged 14-17 and 18-19, respectively).

As would also be expected given their age, a statistically significant difference (p -value <0.0001) exists when adolescent's income was compared with adult participants enrolled in MIECHV. The median annual household income for adolescents was \$6,000 versus \$12,000 for adults. Similar results were observed for within-adolescent age categories. The median annual household income for adolescents aged 14-17 was \$2,400 while it was \$6,000 for the older adolescents aged 18-19 (p -value 0.03).

The analysis of intimate partner violence (IPV) showed similar results between adolescents and non-adolescents (9.6% versus 10.3%); however, a higher proportion of adolescent aged 18-19 reported experiencing IPV compared to their younger counterparts (11.3% versus 5.5%, p -value 0.22).

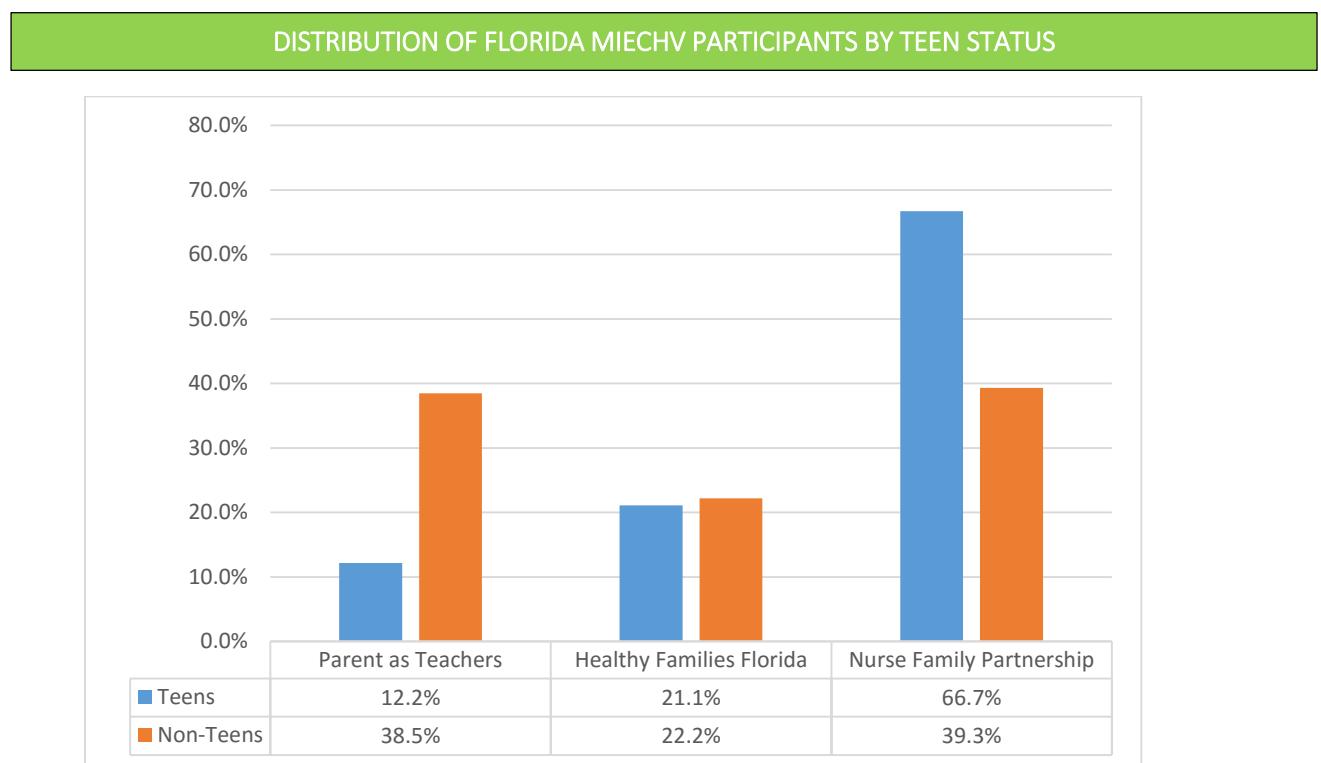


Figure 1 Distribution of Florida MIECHV Participants by Teen Status and Model Type

DISTRIBUTION OF FLORIDA MIECHV PARTICIPANTS BY TEEN STATUS, CONTINUED

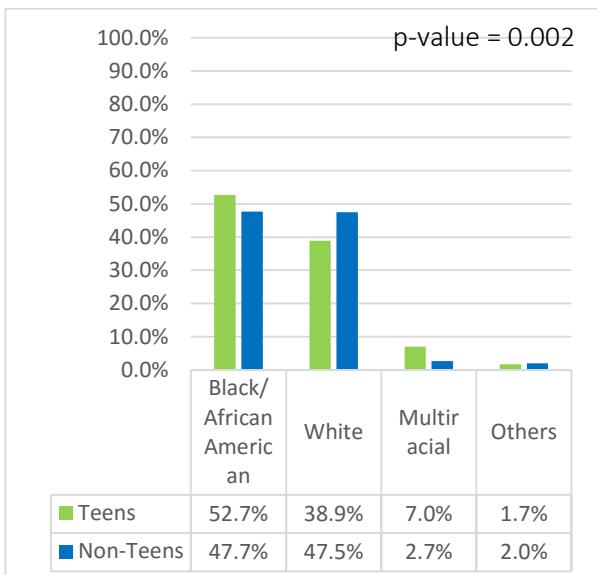


Figure 2 Distribution of Florida MIECHV Participants by Teen Status and Race

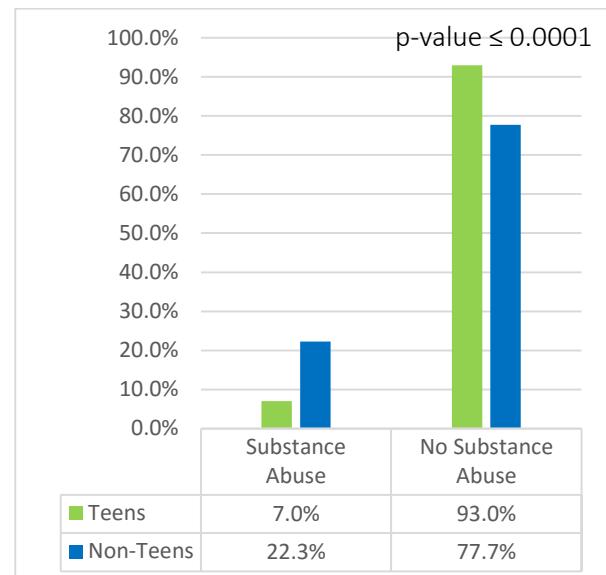


Figure 3 Distribution of Florida MIECHV Participants by Teen Status and Current/Past History of Substance Abuse

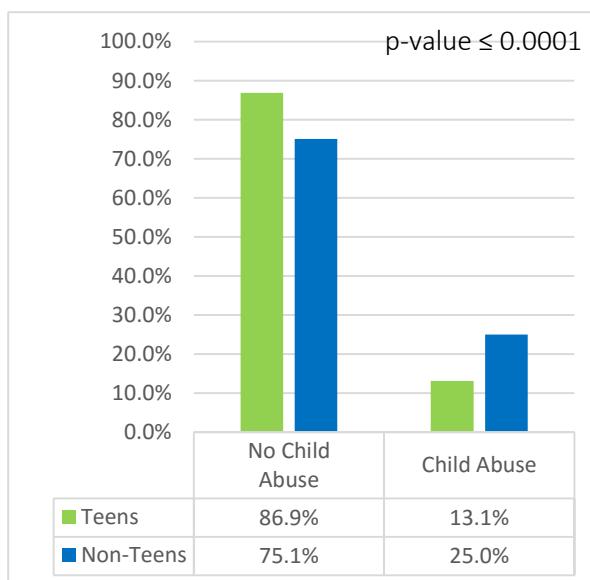


Figure 4 Distribution of Florida MIECHV Participants by Self-reported History of Child Abuse or Neglect

FIGURE 5: DISTRIBUTION OF ADOLESCENTS BY EDUCATIONAL STATUS

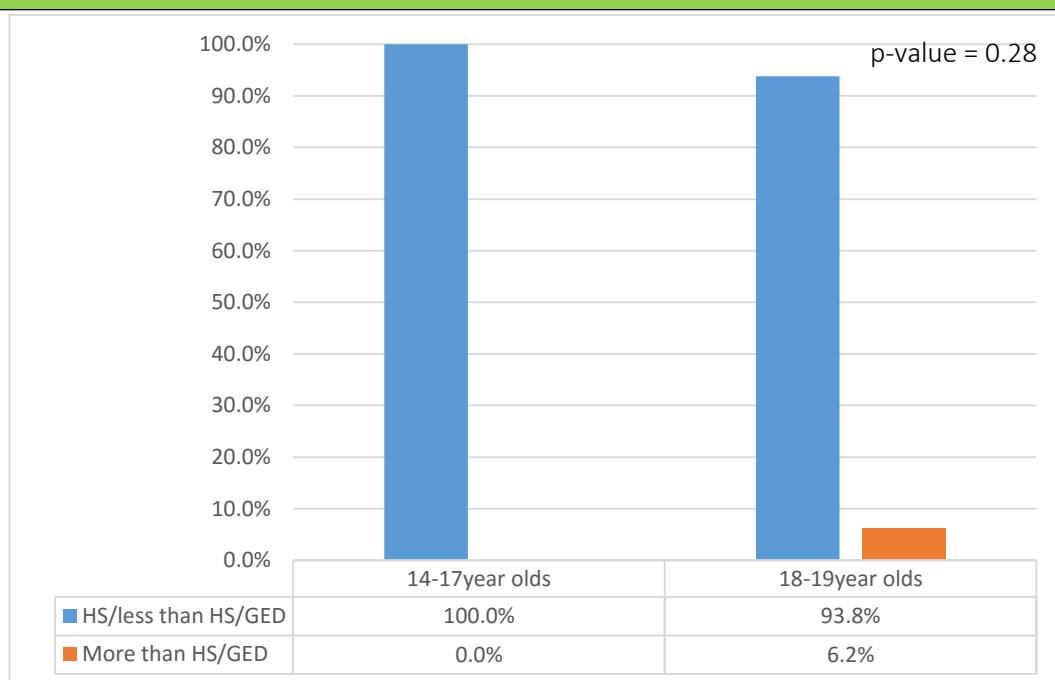


Table 1: Characteristics of Adolescent and Non-adolescent Participants in the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, 2013-2016

MIECHV Participants Characteristics	Adolescents ≤ Age 19 (N=246)	Participants ≥ Age 20 (N=1,539)	
Characteristics	N (%)	N (%)	P-value
MODEL			
Parent As Teachers	30(12.2)	593(38.5)	<0.0001*
Healthy Families Florida	52(21.1)	341(22.2)	
Nurse Family Partnership	164(66.7)	605(39.3)	
RACE			
Black/African American	126(52.7)	718(47.7)	0.002*
White	93(38.9)	715(47.5)	
Multiracial	16(7.0)	41(2.7)	
Other	4(1.7)	30(2.0)	
ETHNICITY			
Hispanic	70(28.6)	362(23.7)	0.10
Non-Hispanic	175(71.4)	1166(76.3)	
MARITAL STATUS			
Married	5(2.1)	307(20.1)	<0.0001*
Single	239(98.0)	1217(79.9)	
SUBSTANCE ABUSE (current or past)			
No	226(93.0)	1,184(77.7)	<0.0001*
Yes	17(7.0)	339(22.3)	
HISTORY OF SELF-REPORTED CHILD ABUSE/NEGLECT			
No	213(86.9)	1,146(75.1)	<0.0001*
Yes	32(13.1)	381(25.0)	

EDUCATION			
High School/Less than HS/GED		94(95.0)	792(56.1)
More than High School/GED		5(5.1)	621(44.0)
INTIMATE PARTNER VIOLENCE			
No		170(90.4)	1,049(89.7)
Yes		18(9.6)	120(10.3)
DEPRESSION SCORES (median, IQR) ^a		6.0(7.0)	5.0(7.0)
INCOME (median, SD) ^a		6,000(12,500)	12,000(14,500)
PERCEIVED STRESS SCORES (mean, SD) ^b		12.2(8.1)	11.8(7.5)
HEALTH INSURANCE			
No Insurance		12(5.1)	203(13.7)
Gov./Public Insurance		218(92.0)	1,175(79.2)
Private Insurance		4(1.7)	93(6.3)
Other Insurance		3(1.3)	12(0.8)
EMPLOYMENT			
Unemployed		96(74.4)	619(54.4)
Part-time		16(12.4)	211(18.5)
Full- time		17(13.2)	308(27.1)

* Statistical significance: $p \leq .05$; ^a Wilcoxon-Mann Whitney test; ^b Independent sample t-test

Abbreviations: SD = standard deviation; IQR = inter-quartile range; HS = high school; GED = General Education Diploma

Results of chi-square tests

Dataset: Florida Home Visiting Information System (FLOHVIS)

Table 2: Characteristics of Adolescents in the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, 2013-2016

MIECHV Adolescents Characteristics	Adolescents aged 14-17 (N=73)	Adolescents aged 18-19 (N=173)	
Characteristics	N (%)	N (%)	P-value
MODEL			
Parents As Teachers	5(6.9)	25(14.5)	0.13
Healthy Families Florida	13(17.8)	39(22.5)	
Nurse Family Partnership	55(75.3)	109(63.0)	
RACE			
Black/African American	35(48.6)	91(54.5)	0.84
White	31(43.1)	62(37.1)	
Multiracial	5(6.9)	11(6.6)	
Other	1(1.4)	3(1.8)	
ETHNICITY			
Hispanic	25(34.7)	45(26.0)	0.17
Non-Hispanic	47(65.3)	128(74.0)	
MARITAL STATUS			
Married	0(0.0)	5(2.9)	0.14
Single	73(100)	166(97.1)	
SUBSTANCE ABUSE (current or past)			
No	69(94.5)	157(92.4)	0.54
Yes	4(5.5)	13(7.7)	

HISTORY OF SELF-REPORTED CHILD ABUSE/NEGLECT			
No	65(89.0)	148(86.1)	0.53
Yes	8(11.0)	24(14.0)	
EDUCATION			
High School/Less than HS/GED	18(100)	76(93.8)	0.28
More than High School/GED	0(0.0)	5(6.2)	
INTIMATE PARTNER VIOLENCE			
No	52(94.6)	118(88.7)	0.22
Yes	3(5.5)	15(11.3)	
DEPRESSION SCORES (median, IQR) ^a	5.0(6.5)	6.0(7.0)	0.84
INCOME(median, IQR) ^a	2,400(10,000)	6,000(14,160)	0.03 [#]
PERCEIVED STRESS SCORES (median, IQR) ^a	14.0(16.0)	11.0(10.0)	0.07
HEALTH INSURANCE			
No Insurance	2(2.8)	10(6.1)	0.22
Gov./Public Insurance	70(97.2)	148(89.7)	
Private Insurance	0(0.0)	4(2.4)	
Other Insurance	0(0.0)	3(1.82)	
EMPLOYMENT			
Unemployed	23(85.2)	73(71.6)	0.26
Part-time	1(3.7)	15(14.7)	
Full- time	3(11.1)	14(13.7)	

* Statistically significant $p \leq .05$; ^a Wilcoxon-Mann Whitney test; ^b Independent sample t-test

Abbreviations: SD = standard deviation; IQR = inter-quartile range; HS = high school; GED = General Education Diploma

Results of chi-square test

Dataset: Florida Home Visiting Information System (FLOHVIS)

Qualitative

There were a total of 103 phone interviews conducted by trained research staff from the USF MIECHV evaluation team with participants from each program. Of those, 15 interviews (five in 2014 and ten in 2015) were with adolescents including one conducted in Spanish and one in Haitian-Creole. Adolescent interview participants received MIECHV home visiting services in Bradford (n=1), Broward (n=1), Duval (n=2), Escambia (n=1), Hillsborough (n=3), Miami-Dade (n=3), Putnam (n=1), and Southwest Florida (n=3). The age of these adolescents ranged from 15-19 years; all were female, almost half (n=6) identified as Black, and a quarter (n=4) as Hispanic. About half (n=8) had not completed high school and a quarter (n=4) stated currently being a student. Almost all (n=13) stated being single (87%), and three of the participants (20%) were still pregnant at the time of the interview. Of the participants who had already given birth (n=12), their child's age ranged from 19 days to 20 months old.

Summaries and key quotes from the in-depth, semi-structured interviews conducted with participants are shared below to add context and detail to the quantitative findings regarding participants' feedback on the home visitor-participant relationship; parenting education and resources; and supporting education and employment. Full reports of all Florida MIECHV program evaluation participant interviews for 2014 and 2015 are available online at <http://health.usf.edu/publichealth/chiles/miechv/state-evaluation>.

Table 3: Characteristics of Adolescent Participants Interviewed by the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Evaluation Team, 2014-2015

MIECHV Adolescents Characteristics	Adolescents ≤ Age 19 (N=15)
Characteristics	N (%)
MODEL	
Parent As Teachers	2(13.3)
Healthy Families Florida	1(6.7)
Nurse Family Partnership	12(80.0)
RACE	
Black/African American	6(40.0)
White	6(40.0)
Multiracial	2(13.3)
Prefer not to answer	1(6.7)
ETHNICITY	
Hispanic	4(26.7)
Non-Hispanic	11(73.3)
MARITAL STATUS	
Married	1(6.7)
Single	13(86.6)
Prefer not to answer	1(6.7)
EDUCATION	
Less than high school/GED	8(53.3)
High school/GED	7(46.7)
More than high school/GED	0(0.0)
EMPLOYMENT	
Unemployed	13(86.7)
Part-time	2(13.3)
Full- time	0(0.0)
NUMBER OF CHILDREN IN HOUSEHOLD	
One child ^a	11(73.3)
Two children	0(0.0)
Three or more children	4(26.7)
ASSISTANCE WITH DAILY CHILDCARE AND ACTIVITIES ^b	
No other adult	3(20.0)
Spouse/partner	1(6.7)
Family member	8(53.3)
Friend	0(0.0)
Other	4(26.7)

^a Current pregnancy was counted as one child in the household

^b Total responses exceed N=15 due to 'select all that apply' option

Abbreviations: GED = General Education Diploma

Home Visitor-Participant Relationship

The home visitor-participant relationship was described in a positive way by the adolescent participants. The participants interviewed described feeling comfortable around their home visitor, whom they found to be funny, nice, helpful, sweet, caring, cool, proactive, and determined. The adolescent participants considered the relationship and interactions with their home visitor to be a big stress-reliever, as well as the best part of the home visiting program. Adolescent participants stated that their home visitor was the best person that they could talk to about any problems or doubts, as their home visitors were available, always open to any questions, and gave the best advice. Others categorized their home visitor as either a very good friend, like a big sister, or a nurse and counselor combined — to the point of becoming attached.

"I have become attached to her because of how helpful she has been."

"I would describe her as... For me she's excellent. I think she's a wonderful person because she's helped me a lot, with any doubts I ask her when she comes I don't have to call anywhere else. She's always ready to help me or the baby with anything we need. If there's anything I need, she takes care of it right away. If she needs to come before the visit date she does. You know."

"She's funny. She makes me laugh. She tells me what to do, like tell me the right things to do. She's cool, pleasing. She wants to help."

"My home visitor is a really good nurse. She's always open to any questions I have to ask her. She's very proactive and she loves to help me. There's nothing that she wouldn't help me with."

"She's so nice, she's so sweet. They maybe need to get her an award. Because I don't think a lot of people come into my house. I'm not a social person but I make exceptions for her. I like her to come around all the time. I wish she comes around all the time, even if there isn't anything to talk about, I tell her I wished she came around."

"It's a good relationship. She helps me out all the time, that's it. It's a good relationship. She helps me out, she's there when I tell her I need help with something like when I need help with my baby – she's there."

"She's really helpful, caring, determined. I can't really say anything bad about her. She's like a very good friend for me as well."

"I actually like meeting with her. She doesn't make you feel uncomfortable, you can talk about anything. She's more like a nurse and a counselor put together like that."

"Overall, I think the home visit helps me the most because I can actually talk to her. It's a big stress reliever. I've got to just talk to her, sit down and talk. We could talk about everything and she gives me the best advice that she's had and all of that. She's just there for me overall. So, I think that's the best part about everything."

"It means a lot to me and my daughter. I really appreciate the program and the help that I get from her. It just means a lot to me."

"She takes her job really seriously which I love her about that. I love how she comes and she makes sure everything is okay and how I'm doing and then we get to the lesson."

"I really like her. I feel comfortable around her. With any problems that I have, she's the best person that I can go to and talk to. She's like a big sister. She's really nice and helpful."

Parenting Education and Resources

Adolescent participants found informational support provided by the home visitor very helpful, more specifically in terms of how to take care of themselves during pregnancy. Other information was important as well, i.e., what to expect during labor; what and how to feed the baby; and how to take care of their newborn's basic needs, from dental care to vaccinations and daycare. The home visitors provided useful parenting education about what to expect and address each month, such as: safe sleeping, comforting when teething, tummy time, and crawling to enable the baby's motor skills. This informational support was vital, especially for these first-time mothers. Instrumental support was also discussed among the adolescent participants. Resources that were mentioned were daycare, food pantries, Goodwill, furniture vouchers, and assistance in finding a car seat, bassinet, and/or crib.

"Well, the nurse brings me all the information I need. She talks to me. Ever since I was pregnant it was about taking care of myself, and about what I should expect to notice each month. We talked about lots of things that were helpful to me."

"Taking care of yourself during pregnancy, taking care of your newborn growth, dental care for the baby... I think we have covered everything in the book."

"Because I'm the only child and I've never really been around babies like that. So, it helped me with learning about how to feed a baby, how to take care of a baby, how to help myself also while I was pregnant and things."

"The home visitation counselor answered all my questions and cleared all my doubts. She brought me a lot of information."

"I've covered everything from what to expect during labor, how to dress the baby, what to feed the baby. I've talked about vaccinations. Most recently we talked about day care for the baby. What to ask the people at day care and how to choose a day care that's good."

"Coming over to talk to me about basic needs that I need for my son, letting me know ahead of time what I'm going to go through."

"My nurse taught me everything that I needed to know about the baby. She taught me a whole bunch of stuff like stuff that I didn't know. Now we're working on my baby's time to teeth so she's teaching me how to hug my baby when she's crying or when she's cranky because the teeth are coming out."

"Safe sleeping, how to control your baby when he or she is crying and you don't know what to do, talking to your baby, teaching them stuff and when they start -right now, we're on the session when they begin to crawl - how to keep stuff off the floor and keep them out of reach of chemicals and choking hazards and stuff and all of that."

"We have tummy time and we make homemade toys we're having him play with and stuff to help him get his motor skills going."

"I would describe it as very helpful and it's a good program when you're new to being a parent and you don't really know much. I feel like she's very helpful. It will help you out a lot. It will teach you a lot of stuff that you really didn't know or you really wouldn't have thought of."

"I went to the Health Department and they gave me a flier that explained what it was so I called because I was interested, because I'm a first time mom and I was a teenager and they teach you some

things that you might not know. So I called then they gave me a call back. Then they scheduled the first meeting and ever since then she's been coming."

"If she didn't come and help me teach him how to crawl and how to... I wouldn't know how to do to because I'm a first time mom. She helps me to know, 'Oh you're supposed to do this.' When I first brought him home, I had crib bumpers in my crib and a whole bunch of toys in there. She told me that it's not supposed to be like that. She said we don't want him to roll over and suffocate and stuff like that. I would never have known that.

That helped me out a lot."

"I was in high school when I got pregnant and I had nothing – I mean, other than a foster home."

"She comes and she bring the papers that either says what the baby should be doing at this month, ways to help him succeed at the things he's supposed to be learning. She brings toys. It's like an interactive kind of thing and then she gives me a lot of helpful information to help with him growing."

"I think because at least if you know that if your baby's dad is not there or you at least don't have anybody there, at least you have a nurse, somebody that you could talk to, could explain to you, could help you get to something that you need help but you are not getting help with. I would recommend my friends, anybody, even a random person."

"She gave me a paper – with a list of places if I want to go to school and stuff like that, stuff to help me if I run out of food at home like food pantries. She told me about Goodwill and a lot of stuff."

"She comes by and she gives me helpful information about how to take care of my infant - about the stages of birth, and she helps me find just like a car seat, bassinet, a crib; any necessities for the baby, she helps me find them at a low price or she helps me get them."

"She gave me a furniture voucher. I needed furniture. I needed a bed. She gave me a furniture voucher and now it got me a bed."

Supporting Education and Employment

Through the MIECHV program, the home visitors enabled adolescent participants to make decisions regarding education and employment for themselves, and daycare and school for their children. The home visitors and adolescent participants created a plan, and the home visitor assisted them to achieve goals, such as finishing school, losing weight, keeping their job, and planning for daycare.

"Anything in life that's revolving around my baby. Anything like stuff with day care and situations like, whether I should keep my job or not..."

"Recently, I had to take an exam for school so my nurse got me some practice questions and she helped me to study."

"She asked me about it whether if I'm planning on putting him in day care. When I told her I got my job. I was like, 'Yes, I was going to try to.' He can now start school also. So she brought me a lot of information about what day cares do this and stuff like that."

"Yes, like whenever - I was 16, I was still in high school. My goal was to finish high school. I've also had a weight loss goal. I've had a goal to go back to school to go to college. I've had a goal to – my job closed down two months after I had my son. My goal was to find more employment."

"What will I do after I have the baby? What career do I want to achieve after the baby? Do I plan on staying in school?"

"She's helped me try to find employment. I needed help with school because I was doing some home schooling and some regular school. If I ever needed help or something and she knew what she was doing and she would help me and stuff like that."

"[She] encouraged me to finish high school, told me that she knew I could do it, not to give up. She kept on encouraging me to keep trying for a job -encouraging me to go back to school and I haven't done it yet."

"Since right now, I'm thinking of starting another job so I'll be working two jobs. My boyfriend works. This is a lot right now so I haven't done it yet."

"I use the community actually, that one. I use that one and it helped pay for my GED classes and, once I get enrolled in a regular job – I get a job - I haven't used that yet, the day care part yet, but it will probably happen soon."

Discussion

The results of this study indicate that a critical aspect of the Florida MIECHV teens is their low educational status. The far-reaching effects of low maternal education cannot be overemphasized. Low educational attainment in mothers increases risk for intellectual and social disadvantage in their children, which can also result in higher rates of antisocial behaviors and mental health problems later in life⁷⁻¹¹. Furthermore, children of teens are at risk of poor developmental outcomes, malnutrition, child neglect and abuse^{12,13}, which can perpetuate a cycle impacting future generations.

Only 7.0% of adolescent participants reported a history of current or past substance use, which is far lower than the non-adolescent participants' reported rate (22.3%). It is also lower than the Florida state rate of adolescent substance use, which is 10.1%¹⁴. However, among adolescents, the rate of substance use was observed to be similar across the age categories (5.5% vs 7.7% for 14-17 years and 18-19 years, respectively). Though analysis on smoking status of adolescents was not possible due to insufficient sample size, literature shows that substance abuse is significantly predicted by tobacco use¹⁵. Additionally, adolescents are more likely to smoke during pregnancy^{7,9,16}. This is important when considering the adolescent population; tobacco and substance abuse among pregnant adolescents not only can harm the

Among Florida MIECHV adolescent participants...

- *66.7% enrolled in Nurse-Family Partnership*
- *About a quarter were employed full- or part-time*
- *5.1% were uninsured*
- *17 out of 246 reported current or past substance abuse*
- *32 out of 246 reported experiencing child abuse/neglect – a lower than expected prevalence*
- *Reported similar levels of stress and depression to non-adolescents participants*
- *A tenth reported history of intimate partner violence*

health and development of the fetus, but it can also affect the health and development of the adolescent mother^{12,13}.

The prevalence of self-reported child abuse/neglect among the adolescent population in this study is low (13.1%), which may be attributed to under-reporting or social desirability bias. Research shows that both sexual and physical abuse are significantly associated with an increased risk of adolescent pregnancy. This association is strongest when these two types of abuse co-occur^{1,17}. Though the prevalence of IPV is low among adolescents enrolled in MIECHV (9.6%), most recent global analysis indicates that about 33% of ever partnered women aged 15 years and above has experienced physical and or sexual intimate partner violence in her lifetime^{18,19}. In the U.S., 30-35% of women report having experienced IPV, with one-fifth of them experiencing IPV for the first time during adolescence^{20,21}. The low prevalence reported may be attributed to under reporting or the tendency for adolescents with a previous history of violence in a relationship to view violent behavior as acceptable in present/future relationships^{22,23}. Understanding IPV in adolescents can be used as a source of information for programs targeted towards reducing it.

Adolescents in the MIECHV program reported positive experiences with their home visitors. They considered home visitors as their friends, confidantes, advisors, and/or counselors who provided informational and instrumental support, and enabled them to create and realize their goals for school, weight loss, employment, and daycare.

Limitations

We could not analyze smoking status and breastfeeding due to insufficient sample size. Additionally, the cross-sectional design makes it difficult to determine the impact that the home visits have on health behaviors or other risk factors. Although the home visitors are trained in data quality assurance, the reliability and timeliness of measurement by individual home visitors cannot be guaranteed. Also, several variables may be under-reported (e.g., history of child abuse, substance use).

Recommendations

The MIECHV program aims to support families experiencing higher risks by providing education, support, and referrals to optimize healthy physical, social, and emotional development. Thus, it should continue to develop and incorporate interventions that meet the particular needs of adolescents. Interventions towards re-integrating the adolescents back into the educational systems should be implemented which will require consideration of employment status, financial supports, and child care needs, to encourage self-efficacy and promote self-sufficiency. Additionally, assisting adolescent MIECHV participants in connecting with primary health care and family planning services will support their continued education. As part of their health promotion curricula, the MIECHV programs should also continue to support adolescent parents in refraining from or engaging in substance use/abuse.

The three home visiting programs funded by Florida MIECHV utilize a number of screening and assessment tools to identify needs, guide intervention and referrals, and to collect accurate data that will help us to understand the population served and the potential outcomes of the program. It is important to recognize that adolescent mothers may be reluctant to report environmental, health, or behavioral risk factors, and one needs to consider strategies to accurately assess and respond to risks and needs identified among these families. Continuing their role as trusted confidantes and counselors, the home visitors can assist the adolescents in the MIECHV program to identify their needs and work with program administrators and supervisors to tailor their visits accordingly.

For more information contact:

Jennifer Marshall, PhD, MPH, CPH

Research Assistant Professor, Lead Evaluator

USF College of Public Health, Department of Community and Family Health

(813) 396-2672

jmarshal@health.usf.edu

www.miechv.health.usf.edu

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



**Florida
Maternal Infant & Early Childhood
Home Visiting Initiative**



HOUSING INSTABILITY AMONG FLORIDA MIECHV PARTICIPANTS

Florida Maternal, Infant, and Early Childhood Home Visiting Program Initiative-
2017



Photo credit to: Change4health.org

UNIVERSITY OF SOUTH FLORIDA, COLLEGE OF PUBLIC HEALTH
Department of Community and Family Health
miechv.health.usf.edu

Omotola Balogun, Kimberly Hailey, Temitope Bello, Ngozichukwuka Agu, and Jennifer Marshall

INTRODUCTION

Home visitors, managers, and administrators support families in the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program by providing health education, social support, and referrals to necessary community agencies. Working in high risk communities, home visitors are tasked with identifying and addressing risk factors associated with poor birth outcomes or issues relating to developmental outcomes. Housing instability among MIECHV families has been recognized as a factor that potentially influences engagement and retention in the MIECHV program and can lead to poor outcomes.

Housing instability can be defined as frequent moves, inability to pay rent, eviction, or homelessness, and it has been associated with negative health outcomes among families who have these experiences (Phinney, Danziger, Pollack, & Seefeldt, 2007; Tsemberis, McHugo, Williams, Hanrahan, & Stefanic, 2007). Several factors can predispose families to housing instability issues. Housing instability is most often influenced by changes in economic conditions; such as a job loss, a decrease in stable income, and an inability to maintain bill payments generally leaving families with no other choice but to find a place to live. These factors that result in housing instability are sometimes difficult to tackle.

The consequences of housing instability not only affects the family as a whole, but has effects on exposed children especially at the initial stages of development and interactions with their parents. The early years in the child's development are very pivotal because it is the period when foundations are laid for emotions, health and general well-being (Christian et al., 2015). The family home has a major environmental influence on a child's development. Families living in unstable conditions are more likely to observe low academic performance and poor behavioral adjustments in their children (Zoil-Guest & Mckenna, 2014). These behavioral problems in children are evident in school and adolescents living in dysfunctional family environments usually exhibit risky behaviors (Mayberry et al., 2014). Housing instability can result in families relocating to very poor neighborhoods which could be detrimental. Studies have found that living in stressful neighborhoods is associated with poor mental health outcomes for children and parents (Kemp, Langer, & Tompson, 2016). Indirect effects of living in these neighborhoods include extremely stressful maternal functioning which affects parenting practices. Some of the parents who are exposed to these neighborhood strains tend to be depressed and experience psychological stress. Depression and psychological stress among parents influences their interaction with their children and ultimately predisposes the child to adverse health outcomes (Mayberry et al., 2014).

The purpose of this study was to understand the effects of housing instability on families, explore the various social factors that influence housing status and the impact of these factors on the family's health. The findings are intended to inform stakeholders of possible factors that impact the quality of home visiting services and the engagement and retention of program participants.

METHODS

Participants' and home visiting staff's perceptions of issues related to housing instability was explored qualitatively. This was a secondary data analysis of already existing qualitative data with researchers analyzing focus group and interviews conducted with Florida MIECHV home

visiting staff and program participants respectively in 2015 and 2016. Overall, secondary data were 124 transcripts transcribed verbatim from audio recordings of 26 staff focus groups and 98 participant interviews. Two members of the research team read through transcripts to identify themes and subthemes. A codebook was thus developed made up of inductive codes using Grounded Theory methodology. The codebook (see Appendix) contained codes for reoccurring socio-economic factors affecting housing, current living conditions, and neighborhood conditions.. Transcripts were uploaded into MAXQDA – an online qualitative data analysis software – and segments of text were coded accordingly. To determine interrater reliability, 6 focus group transcripts were coded between two coders, with an interrater agreement of 88%. Coded segments were exported and thematic analysis performed. Demographic characteristics of participants which were housed in Qualtrics Software on a secure server were also reported.

RESULTS

DEMOGRAPHIC CHARACTERISTICS

A total of XX program participants were interviewed with XX being interviewed in 2015 and XX in 2016. Most participants were between the ages of 20 to 29 years (50% in 2015; 56.4% in 2016). Participants race was mostly Black (56.9% in 2015; 70% in 2016), and majority of them had at least a high school degree (68.8% in 2015; 82.5% in 2016). Focus groups involved XX home visiting staff in 2015 and XX in 2016. In 2015, all home visiting staff who participated in focus groups were female while 2016 included a focus group with one male. For participating home visitors, 49% had been working for less than a year in their position, while only one had less than a year's experience in 2016. Detailed demographics can be found in tables 1 and 2.

Table 1. Demographic characteristics of program participants

Participant Characteristics	2015 interviews (N=XX) N (%)	2016 interviews (N=XX) N (%)
Age (years)		
M,M		
<20	10 (17.2)	4 (10.3)
20-24	18 (31.0)	5 (12.8)
25-29	11 (19.0)	17 (43.6)
30-34	9 (15.5)	6 (15.4)
≥35	9 (15.5)	7 (17.9)
Race		
White	2 (3.45)	11 (27.5)
Black	33 (56.9)	28 (70)
Hispanic	20 (34.5)	0 (0)
Other	1 (1.7)	0 (0)
Education		
Less than high school	19 (32.2)	7 (17.5)
High school graduate	17 (28.8)	13 (32.5)
Some College	15 (25.4)	11 (27.5)
College Degree (Associate/Bachelors)	6 (10.2)	8 (20.0)
Graduate College Degree (Masters/Doctorate)	1 (1.7)	1 (2.5)

Marital Status		
Married	13 (22.4)	10 (25.6)
Separated	2 (3.5)	3 (7.7)
Residing with significant other	4 (6.9)	7 (17.9)
Engaged	2 (3.5)	1 (2.6)
Single	35 (60.3)	17 (43.6)
Employment Status		
Full-time	5 (8.6)	12 (30.0)
Part-time	15 (25.9)	12 (30.0)
Homemaker	18 (31.0)	5 (12.5)
Unemployed-Looking for work	13 (22.4)	8 (20.0)
Unemployed-Disability	1 (1.7)	1 (2.5)
Other	5 (8.6)	2 (5.0)

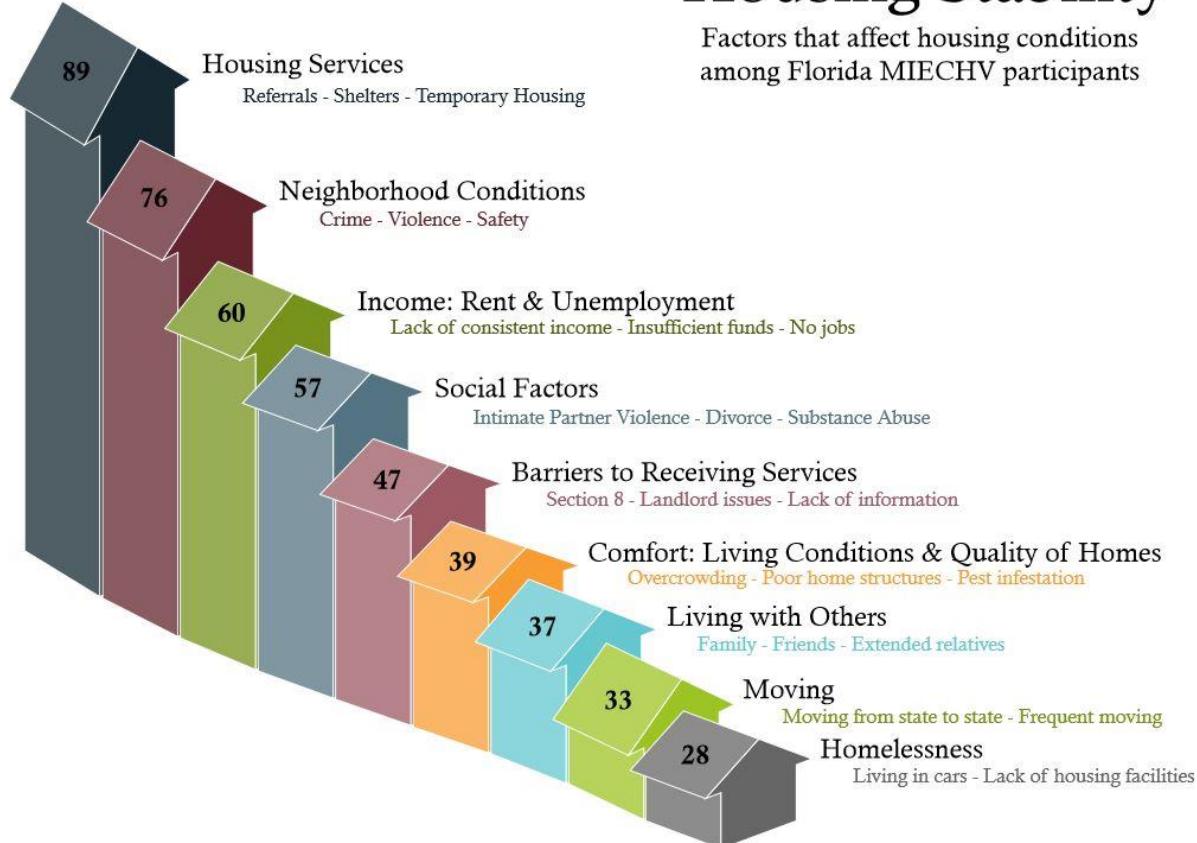
Table 2. Demographic characteristics of home visiting staff

Staff Characteristics	2015 focus groups (N=XX) N (%)	2016 focus groups (N=XX) N (%)
Age (years)		
18-25	3 (6.1)	2 (8.7)
26-35	14 (28.6)	6 (26.1)
>35	32 (65.3)	15 (65.2)
Gender		
Male		1 (4.4)
Female	49 (100. 0)	22 (95.7)
Race		
White	26 (53.1)	15 (65.2)
Black	16 (32.7)	4 (17.4)
Asian	6 (12.2)	1 (4.4)
Other	1 (2.1)	3 (13.0)
Ethnicity		
Hispanic	14 (28.6)	5 (21.7)
Non-Hispanic	34 (69.4)	18 (78.3)
1 (2.1)		
Number of years in profession*		
< 1 year	24 (49.0)	1 (4.3)
1-5 years	17 (34.7)	8 (34.7)
6-10 years	4 (8.2)	4 (17.4)
10+ years	3 (6.1)	9 (39.1)

FOCUS GROUPS AND INTERVIEWS SUMMARY

There were 466 coded segments in the transcripts with the most applied codes being ‘housing services’, ‘neighborhood conditions’, and ‘income’ (figure 1). This implies that these factors are significant housing-related services, concerns, issues, or needs discussed by home visiting staff and/or program participants.

Housing Stability



Housing Services 89 coded segments

Most coded segments were for housing services which referred to services provided by the home visitor that were specifically related to housing. Challenges to housing for which housing services were provided included lack of affordable housing, longer waiting lists for Section 8 housing, and sub-par housing units available in suboptimal neighborhoods. Specific forms of referrals were emphasized by home visitors as being important housing-related services and included referrals to shelters, furniture providers, and organizations that assist with electric and utility bill payments. Providing housing services to participants resulted in positive outcomes such as relieving high levels of stress and mitigating crises.

“By using the resources, you can see their crisis go down. If we’ve given them referral for housing or electric, the tone of the family has changed at the next visit because they’re not in crisis anymore. They’re more relaxed, less stressed. That kind of thing.”



"I would say yes, probably the biggest obstacle even for the nurse home visitors to try to get for the client or assist them in the process of getting, is housing. There's not enough housing. That's the most difficult thing that our nurses face is trying to get our moms on wait list or find shelters or temporary housing. Temporary housing, lost its funding, so most of those temporary transitional housing lost its funding, I should say. Most of those transitional facilities are now becoming shelters, so more emergency type of shelters. So if you have a shorter window that you can stay there than you could if you were in transitional housing. We try to get them food banks and daycare. We're talking early on after the child turns one about programs that can happen next after graduation because we see it as a continuum."

Many program participants were grateful for housing referrals from their home visitor. Housing services provided by home visitors included collecting listings of accessible and affordable housing possibilities, finding resources to assist with electricity bills, and also locating shelters if mothers were experiencing traumatic issues (i.e. divorce/intimate partner violence) and needed immediate services. Home visitors also discussed a need for low income housing programs which is more apparent with the increasing challenges that participants face with housing. Even though home visitors make referrals for shelters and housing, these referrals are not enough to meet the demand. Other housing services provided by home visitors which was not directly related to availability of housing included informational support regarding safety in the home. Participants were commended their home visitors for adding lessons on safety in the home during their home visits. Topics such as fire safety, emergency planning, and poison control were all mentioned as being extremely helpful for ensuring home safety for new mothers and their families.

She is very helpful. We were looking for a place and she got me a list of places for low income and everything. She is extremely helpful for me.

I would say like with the safety topics - I know when we did the extension cord, chemicals, and stuff like that, so I actually went out and bought outlet plugs and make sure that my extension cords and my electrical cords were out of the way, and that with the chemicals that were under the sink I went and bought a latch. So that's something that I had to get used to everyday, but I know that is something that's safe for my daughter.

Neighborhood Conditions 76 coded segments

Neighborhood conditions including factors related to safety and crime or violence in participants' primary residence emerged as the second most used code. Most participants who participated in interviews expressed feeling safe in their neighborhood and were comfortable

enough to walk around their neighborhood in the day and night time. Participants who felt safe in their neighborhood took frequent walks and exercised in the neighborhood with no incidence of harm. Several factors mentioned to determine “safe” neighborhoods were based on proximity to a university, schools, and parks close to their homes. Participants often assumed that the closer they were to a public place of community activity, the higher their perception of safety was- even if the crime rates showed otherwise.

“Well, I’ve been doing it when I was pregnant. I went for a walk almost every day for 30 minutes around 8:00 or 9:00, or 10:00 PM at night. For me, it’s safe. I’ve never heard anybody, or nobody stopped me and asked me what I’m doing at this time on the street, blah, blah, blah, so I mean it’s safe.”

“Yes, because it’s mostly safe – a public school is not far, and we got a university not far like down the block, and it’s like everybody is friendly saying “Hi, how you doing?” You would just get one random stop as you run a light or if you’re down the block, it’s like a lot of you know the neighbors - they have respect for you.”

Although several participants perceived their neighborhoods as safe, many others vividly reported how unsafe the neighborhoods were. One participant even described experiencing so many robberies in her previous neighborhood that it prompted her to relocate to a new county. Some discussed factors that promoted unsafe environments including higher populations of homeless people, overcrowded apartment complexes, and visible substance abusers walking near the areas. Several participants reported robberies, theft, and gun violence as the results of an influx of unwelcomed people moving into the neighborhood. There was a general tone of discomfort in the recognizable changes a neighborhood would experience after new people moved into a neighborhood. Many participants mentioned their neighborhood “used” to be safe, but is no longer. One of the home visitors corroborated this statement by saying she “got scared” when she had to visit clients located in particular areas because of the newfound violent reputation of the area.



“Because there have been robberies. Not in my house, but two or three streets away. There have also been shots fired. It’s not perfectly safe. But here on my block things are quiet. And the neighbors are good and take care of things, but still things are not 100% safe.”

“One, I live - there are too many people who wander through the neighborhood, who you can tell are on drugs... There are, like I said, there are quite a few people who wander through. We’ve had a couple of people who’ve broken into the house next to us, where we’ve had to call the cops on them.”

Income- Rent and Unemployment 60 coded segments

Unemployment is a significant issue for participants in the MIECHV program. Clients who are not working – either being stay-at-home mothers or through the loss of employment, were met

with difficulties in maintaining utility bills and rent. A considerable number of participants reported being evicted from their homes in the past because of a lack of income. The majority of home visitors responded to families lacking funds to maintain households through referrals to organizations that could assist with bill payment. Clients were assisted with job applications, payment assistant services, and forms to complete for housing locator services. Although home visitors mentioned feeling very pleased to assist their clients with rent and employment services, they mentioned that participants were often reluctant to share their issues. After weeks of asking mothers about personal productivity, mothers expressed feeling embarrassed to discuss their income due to a sense of inadequacy in their duties to provide for their families. Although disclosing issues such as affording rent and bills was initially difficult, program participants were grateful that their home visitor could assist with bill payment.

“We got about six families right now in extended stay hotels. Those are \$300.00 a week. If they can come up with \$300.00 a week but coming up with \$600.00 a month is a whole different story. That larger chunk of money at one time, they can get \$300.00 a week or close to it to be able to stay.”

“Yes, because I give a mom like six referrals to help her rent and everybody turned her down. First of all, she didn’t have her proper documents. She didn’t have a social, she didn’t have nothing. The only people in the household that had social listed, dad and the baby, and there’s like six people. So, she didn’t have that so everybody declined her and I’m like oh my God and this was the first time one she worked about the courage to even ask me. Do you know anywhere else that helps? So, that was frustrating.”

Social factors 57 coded segments (Substance abuse 22; Mental health 16; Relationship issues-IPV & divorce 16; Other 3)

A myriad of social factors contributed to housing instability among MIECHV participants. These social factors included mental health issues, relationship issues (i.e. intimate partner violence or divorce), and substance use, among others. Home visitors frequently discussed occurrences of substance use, with Marijuana being the most commonly reported, in the homes of MIECHV participants. Home visitors were able to collectively recognize that several homes have parents who consistently use drugs, which makes it more difficult to maintain finances, interferes with the ability to take care of children, and predisposes families to eviction from their houses.

“They smoke weed, they sell weed, I can’t help it. They’re – so they’re going to live – well they have to live somewhere.”

“We’ve had situations where there has been substance abuse or alcohol that it has impacted the caregiver’s ability to really sense what’s going on. We had a grandfather who had a child on his chest and he was sleeping on the couch, but he was inebriated and he wasn’t aware that the child rolled off of him in between the couch and him, and then the couch back. It’s those kinds of situations.”

Another major factor impacting current housing status was the issue of mental health instability of the mothers. Home visiting staff noted several clients expressing concerns of depression and a

few having clinical diagnoses of schizophrenia. In one focus group, home visiting staff discussed battles with clientele mental health issues as being a major factor influencing the length of retention from these participants.

"We do see a lot of depression. We have families all over in poor housing, low employment levels. They don't have a lot of money. They're below the poverty line. They have the weight of the world on their shoulders and then they have a baby. It's supposed to be a joyous time in their life but they can't afford a crib. They can't afford health – there are so many things to it and they don't see a way out on a lot of them"

We have had several clients that have either been at the ACT Shelter or been in an abusive situation. The father of the baby's now in jail or lots of – yes, we have had several that have had those issues of either been at the shelter or referred them to the shelter and then they end up going somewhere else.

Barriers to Receiving Services 47 coded segments

An emergent theme was barriers to receiving housing services. These barriers included factors that prevented participants from receiving services related to keeping, maintaining, or finding housing. These barriers were clients feeling ashamed to ask for help, believing landlords would remove them from their current housing if they complained of the suboptimal living conditions, or the long waiting lists for housing, shelters, and billing assistance. There are many participants enrolled in MIECHV who have problems with housing and the lack of housing programs further complicates this issue. Many families expressed concern about the lack of affordable housing in safe neighborhoods, and home visitors were also in agreement because they were often unable to find appropriate housing placements for their clients. According to the home visitors, Section 8 housing is "always full" or "they usually have a long waiting list with very short open enrollment periods." Home visitors further discussed that a few participants had felony records or history of mental health issues with resulting inability to find suitable housing. MIECHV staff recognized that families with a history of mental illness or criminal history had even slimmer chances of receiving housing supplements. Suggestions from staff and families were voiced, which emphasized a need to establish with the housing programs and the food hub to ensure priority treatment is given to participants referred from MIECHV.

"Well, the wait lists are long or they've blown it or they can't get on it because of their felony records because a lot of them have felony records and drug charges and/or a lot of the communities, if there's a DV in their record, they're not welcomed into certain communities because they don't want DV"

Felony record, yes. They can't get housing. They can't get jobs, or apartments or anything"

"We connect them with community resources based on what the need is. Sometimes we can meet the need, other times they're on a waiting list. That's all we can do especially with housing. We really need to establish some type of

liaison with housing, with food, HUD, so that hopefully we could start referring in and our clients get priority”

“Well like for example house, we are so bad in housing. We don’t even have like open – how should I say that? Open enrollment periods like it’s always closed. When they are open it’s like for a day and it’s for a certain population. It’s not for like pregnant women or single women - no, it’s for like disabled people or older than 65 people like, you know, it’s very difficult for these clients. I have had clients I had applying Texas for housing because there’s nothing here”

Comfort – Living Conditions and Quality of Homes 39 coded segments

Comfort was mentioned quite often as participants described their current housing situations to interviewers. Again, clients were not prompted to discuss the quality of their homes or their pleasure in where they were living at the moment, yet, many MIECHV participants expressed an unhappiness with their current housing arrangement as well as living conditions that they were forced into or were unable to leave. Several home visitors echoed this concern discussing the poor living conditions of their participants. Overcrowding and unsanitary living environments was of great concern of home visitors. In focus group sessions, home visitors mentioned seeing insects, rodents, mold, and dirt in the same homes as young children or pregnant mothers. With long waiting lists for affordable housing and running out of referrals for housing, bill payment, mattress services, food, and clothing, home visitors were often left to continue visiting families without alternatives. Suboptimal living conditions were identified as a barrier to providing effective home visiting services. Mothers were embarrassed to invite home visitors into their homes for fear of judgement and would decide to rather cancel a home visit. Home visitors also reported the difficulty of promoting safe sleep practices to the families living in these situations. Practicing safe sleep for families living in overcrowded conditions is very difficult because there is usually no space for a crib or other household items are located inside the crib for storage.

“I wish I could have got some help on getting the mattress. It’s all I needed because I was tired of sleeping on a couch for a long time, but there were no resources for that”

“Some of the homes – they’re unclean. I don’t mind the unclean homes because we all have different expectations of what a clean home is and some of these families just don’t have that ability. I do end up getting sick when I go into some of these homes, and I’ve had to end up missing work because I went to a home where it was just very unhealthy, and I end up missing two days of work because of going to that home. That’s their lifestyle”

“Yes. Some of the exceptions - last week I was sitting in a visit - well, I’ve been going in this home for a long time - well not less than a year but there’s not roaches because that would have – but there were some bugs crawling all over the place. One was coming towards my foot and I’m like, “I don’t want it.” It’s not her house. It’s her grandmother’s house. So obviously, they have a bug problem, but it’s not roaches. It’s not fleas. It’s not bed bugs. It’s just some kind

of critter that seems harmless enough, but I didn't want to bring that up because you can't do anything about it. She's living with her grandmother."

Living with Others 37 coded segments

Following difficulties with maintaining housing, MIECH participants resorted to living with relatives and close friends. Living with others greatly impacts their engagement in the program as some clients find it troublesome to have their home visitors in the home of an acquaintance during the visits, and some suggest alternative meeting areas. Some participants live with partners who are opposed to home visits and repeatedly refuse services due to this. However, home visitors reported their willingness to navigate such barriers, by suggesting public meeting places to enable them provide services to these participants.



Home visitors discussed inter-generational families, with many grandmothers living in the homes of their clients. While having additional support is generally helpful, this can impact the home visiting process. Unscheduled guests, cancellation of visits, and distractions due to living with others, can interfere with participant engagement during home visits. In several reported instances, a grandmother or other house guest may contradict the health education messages being provided by the home visitor. Home visitors may feel uncomfortable in this moment and uncertain on the stance of the mother, which may ultimately affect the relationship between home visitor and client.

*"Well, she's still a client that we can capture by phone and then like I said, she's living – she went to the foster home, then she went to her mom's - which she's not supposed to be there at all - and we had a couple of visits there and then it was this trailer and so...
She's on the run."*

"One of the things that I've noticed a lot lately are the families that don't have a support system. If their family lives far away or they don't have any really good friends or relatives close to them, then they struggle with retention. The reason why I say that is because more times than often, they move to be closer to relatives to have that support system that they're lacking away from them. We've been finding that a lot of our families, they move out of area to be with an uncle or a grandma because they just can't do it by themselves."

Moving 33 coded segments

Another common reference to housing was moving from one place to another. Home visitors noted that some participants moved around a lot, making it impossible to keep to their appointment schedules. Factors responsible for moving were poor or unsafe neighborhood conditions, stress, and lack of local family support. A lack of accessible low income housing program was generally attributed to be the primary cause of moving among the participants. Clients were often unable to locate housing in a fundamentally safe neighborhood, and may have

to move completely to another county, city, or state. Because many families are unable to keep up with bills, phones are also turned off, and home visitors are unable to maintain contact with them.

"I had a couple that moved around from place to place so it's really hard to keep locating and they tend to be the ones that change phone numbers on a weekly basis. So that's difficult for retention"

"I think the biggest thing that a lot of them have issues with is housing. Because they're not in – some of them are not in stable environments and they move from place to place. I think I have one client that bounce back and forth like four times to different places."

Relocation of a participant is usually a setback on progress that has been made so far with the home visiting programs because their new locations may not have a similar home visiting program. According to the home visitors, retention of such participants becomes increasingly difficult.

Homelessness 28 coded segments

With the prevailing circumstances of economic hardships, participants sometimes end up homeless. Many supervisors and administrators referred to the issue of homelessness among their participants as affecting the home visiting staff as well. Some families who became homeless sought out housing services by enrolling in Salvation Army shelters and refugee homes. While others who didn't have access to housing services slept in their cars and moved from place to place. Lack of stable housing negatively impacts participants' engagement in the program. Even though home visitors try to provide housing referrals in cases of homelessness, there are stumbling blocks. It is more daunting to provide participants with history of substance abuse and mental health problems with housing services. Most shelters have age as their acceptance limitation, which also make it difficult for some participants to get in.



"You know, because we've had two clients who we know – like one of them was living in her car, the other one was homeless, and we couldn't do anything"

"Yes and it's the same with the mom that she has two kids. She's retained custody of both of those children or reunited with them. Worked very hard, has been providing for them substantially. She just can't find a job because of her felony record. She's right now living in transitional housing..."

CONCLUSION

Issues discussed during the focus groups and interviews highlight opportunities for policy and programmatic interventions. Although neither participants nor staff were asked explicitly about housing services or stability, these issues have consistently been discussed over time. A lot of program participants discussed housing difficulties such as barriers to paying rent, unsafe neighborhoods, or social conditions. Home visitors currently strive to address housing difficulties by providing referrals to participants, however several factors limit participants' ability to seek housing assistance. These factors include fear of backlash from the landlord and embarrassment of their current living situation. It is recommended that the home visiting program should provide resources to enable home visitors actively facilitate conversations about housing with their clients. These conversations should be broached when there is established rapport between the home visitor and participant to prevent discomfort or embarrassment. Once women feel comfortable in their own homes and neighborhoods, home visiting programs will be more effective in improving maternal and child health outcomes.

Immigrant Health through the Lens of Home Visitors, Supervisors, and Administrators: The Florida Maternal, Infant, and Early Childhood Home Visiting Program

Esther Jean-Baptiste, BS,^{1,2}  Paige Alitz, MPH, CPH,¹ Pamela C. Birriel, MPH, CHES,¹  Siobhan Davis, BA,¹ Rema Ramakrishnan, MPH,^{1,2} Leandra Olson, MPH, CPH,¹ and Jennifer Marshall, PhD, MPH, CPH,¹

¹Department of Community and Family Health, College of Public Health, University of South Florida, Tampa, Florida; and ²Department of Epidemiology and Biostatistics, College of Public Health, University of South Florida, Tampa, Florida

Correspondence to:

Esther Jean-Baptiste, Department of Community and Family Health, College of Public Health, University of South Florida, 13201 Bruce B. Downs Boulevard, MDC 56, Tampa, FL 33612. E-mail: estherj1@mail.usf.edu

ABSTRACT **Objective:** The Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program aims to minimize the occurrence of adverse maternal and child health outcomes for mothers deemed at-risk during pregnancy or shortly after childbirth. This study sought to understand the needs of and challenges faced by immigrant families in accessing health care through the perspective of Florida MIECHV home visitors, supervisors, and administrators.

Design and Sample: In this exploratory qualitative study, focus groups were held at each of the Florida MIECHV-funded program sites with a total of 81 MIECHV staff to discuss how the program addresses a range of participant needs. **Measures:** Data were collected through 32 semi-structured focus groups. Transcripts were analyzed using a hybrid approach entailing the development of an *a priori* codebook and thematic analysis. **Results:** Staff from eight of the 11 programs described social and physical isolation and economic hardship faced by immigrant families enrolled in their programs, resulting in barriers to needed health care and social services. **Conclusions:** Home visitors in the Florida MIECHV program served as trusted confidants that helped families navigate social services. Future research should focus on the impact that home visiting has on immigrant health and whether this impact is maintained over time.

Key words: access to health care, barriers, focus groups, immigrants, maternal-child health, program evaluation, qualitative research, underserved populations.

In the United States, immigrants account for nearly 13% of the population, (Baker & Rytina, 2013; Zong & Batalova, 2015). Immigrants, especially those with low English proficiency and low socioeconomic status, face unique challenges which have a bearing on their health and well-being. First- and second-generation immigrant children are more likely to live in

households below the poverty line and reside with at least one parent who is not proficient in English in comparison to native-born children (Mendoza, 2009). Risk factors such as living below the poverty line has been shown to negatively influence cognitive function (Mani, Mullainathan, Shafir, & Zhao, 2013), school achievement, increase emotional and

behavior problems in childhood, (Yoshikawa, Aber, & Beardslee, 2012), and lead to higher rates of adverse health outcomes (Adler & Newman, 2002; McLoyd, 1998). These negative health consequences can include infectious diseases like tuberculosis, human immunodeficiency virus infection, parasitic diseases (Cohen & Murray, 2005; Darr & Conn, 2015), or mental health issues arising from both leaving difficult situations in their home country and learning to adapt to a new environment (Capps et al., 2005).

In spite of these and other health concerns, health care is often inaccessible to immigrants. For example, the Patient Protection and Affordable Care Act renders undocumented immigrants ineligible for comprehensive federal health insurance, and legal immigrants are only eligible for restricted plans (National Immigration Law Center, 2014). Immigrants are often limited to seeking care at community health centers or safety-net hospitals (Lewin & Altman, 2000). While a valuable resource, safety-net hospitals are often underfunded and experience heavy patient loads, along with insufficient numbers of physicians to meet patient demand, especially in rural areas (Redlener, I. & Grant, 2009). Even though most health care facilities are not mandated to report patients to federal immigration authorities, undocumented immigrants still harbor fear of deportation which can manifest into general distrust of formal medical providers leading to delayed care and subsequent worse health outcomes (Heyman, Núñez, & Talavera, 2009).

In addition to barriers associated with health insurance status, an intermingling of linguistic and economic factors increases the likelihood that immigrant families experience physical and social isolation. Immigrant populations often reside in secluded or fragmented urban areas where their legal status is less likely to be discovered (Cristancho, Garces, Peters, & Mueller, 2008). Geographic isolation can lead to reliance on low-wage or dangerous jobs, contributing to poverty and poor health (Kandula, Kersey, & Lurie, 2004). Even with appropriate documentation, lack of English proficiency minimizes the number of desirable employment options for immigrants. While in the past low-pay positions did not require extensive language proficiency, increasingly these positions now

require mastery of English before consideration for employment (Garrett, 2006).

Language proficiency is also an obstacle in receiving appropriate health services. Patients who experience language barriers may be less likely to receive routine medical care, have lower rates of using preventive services, and have an increased risk of non-adherence to prescribed medication regimens (Flores, 2006). Furthermore, immigrants who struggle to understand their physician, and do not have access to a translator, report lower satisfaction with the care received (Boudreax & O'Hea, 2004; Weech-Maldonado, Morales, Spritzer, Elliott, & Hays, 2001; D. W. Baker, Hayes, & Fortier, 1998). As with lack of insurance, the inability to understand the provider and consequent low satisfaction may result in the avoidance of medical services further perpetuating poor health outcomes. In combination, economic instability, lack of language proficiency, and isolation serve as barriers to receiving health care services for immigrants' unique needs.

Home visiting programs offer an individualized approach to address a range of complex health issues among at-risk populations (Wasik, 1993). This approach has demonstrated efficacy in improving family functioning (de la Rosa, Perry, & Johnson, 2008), maternal life course and parenting behaviors (Norr et al., 2003; Olds et al., 2010), and early child development and behavior (Caldera et al., 2007; Norr et al., 2003). Although research on home visiting has burgeoned in the last few decades, it is still lacking in some areas, especially in relation to immigrant populations.

Recognizing the positive maternal and child health outcomes that home visiting programs have achieved, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative was created as part of the Federal Patient Protection and Affordable Care Act of 2010 to expand home visiting in 50 states and 5 territories, resulting in increased numbers of home visiting program participants throughout 26% of rural and urban U.S. counties (U.S. Department of Health and Human Services, 2016a). In 2013–2014, Florida's MIECHV program served 929 participants from 11 programs in 14 communities, including 415 pregnant women and 514 parents/caregivers of young children. Most (74%) of these families had annual household incomes at or below the federal poverty level and

many also qualified for the program based on other socio-demographic risk factors like single and first-time parenthood, adolescent pregnancy/parenthood, illiteracy, mental health or substance abuse problems, and adverse child experiences (Florida Association of Healthy Start Coalitions, 2015).

Although the program does not collect data on immigration status, the racial, ethnic, and linguistic diversity of Florida MIECHV participants reflects that found in the State (U.S. Census Bureau, 2010). However, the MIECHV sample, which draws from low-income communities, has a higher representation of Black women; 48% of MIECHV participants are White, 45% Black, 4% Multiracial, 1% Asian and 2% unknown (compared to the Florida demographics of 77% White, 17% Black, 2.5% Multiracial, 2.4% Asian, and 0.4% American Indian/Alaska Native). Additionally, 21% of Florida MIECHV participants are Hispanic, and 14% speak a language other than English at home (12% Spanish and 2% Other, including Haitian-Creole) (Florida Association of Healthy Start Coalitions, 2015) compared to Florida residents in 2010 which was comprised of 22.5% Hispanic, 27.8% speaking a language other than English at home, and 19.6% foreign born (U.S. Census Bureau, 2010). The Florida MIECHV program uses three evidence-based models that have demonstrated effective implementation with various ethno-racial groups: Healthy Families Florida (Daro & Harding, 1999), Nurse-Family Partnership (Olds, 2006), and Parents as Teachers (Zigler, Pfannenstiel, & Seitz, 2008).

A mixed-methods, multi-component evaluation of Florida MIECHV programs is independently conducted by a research team at a southeastern public university. The present study is an exploratory qualitative analysis of data collected from the Florida MIECHV program which aims to minimize, through prenatal and postnatal home visits, adverse maternal and child health outcomes. During these home visits, home visitors utilize evidence-based programs to provide education, support, and referrals for parents and their families. In general, the study aims to contribute to the current body of knowledge related to immigrant experiences in accessing health care. More specifically, the study primarily aims to understand the needs of and challenges faced by immigrant families in accessing health care through the lens of Florida MIECHV home visitors, supervisors, and administrators.

The MIECHV program evaluation was reviewed and determined exempt by the University Institutional Review Board.

Methods

Design and sample

Semi-structured focus groups conducted on-site between October and December 2014 at each of the Florida MIECHV programs. At each program site, separate focus groups were conducted with current home visitors, supervisors, and administrators; each group was facilitated by a trained evaluation team researcher and an assistant that also served as a note taker.

Measures

First, a focus group guide was used to organize focus group sessions that covered a number of general topics. Questions fell into four domains: strengths of the home visiting program; family and community characteristics in their program service area; the greatest needs of the families served; and factors impacting retention of families in the program. Home visitor group discussions focused on the needs of families served and the home visitors' experiences. The supervisors' focus groups covered family and community challenges along with staff and program strengths and needs. The administrator discussions described the characteristics of the community, populations served, community partnerships, and gaps in meeting the needs of families enrolled in MIECHV. All session participants were encouraged to respond to each question during the focus groups.

Secondary analysis of these focus groups was conducted to code for any discussions that mentioned immigrants or immigrant issues. Eight of these 11 programs mentioned immigrant families as a subgroup they served who faced difficulty in accessing health and social services. As such, a secondary sub-analysis was conducted to examine staff experiences in supporting immigrant families within their respective MIECHV programs.

Analytic strategy

Each session was audio recorded and professionally transcribed verbatim. Notes were also taken during each session to provide additional input, prevent misinterpretation of the data, and as a safeguard against

technology failure. Session transcripts were then reviewed by research staff with audio recordings to ensure accuracy. A thematic analysis approach was utilized where first a subset of 12 randomly selected transcripts were analyzed for emergent themes to develop a preliminary codebook as described by Glauser and Strauss (1967). Preliminary codes included: citizenship/legal status; technology limitations (Internet, phone); transportation; access to services; health care (prenatal care, at-home births, comorbidities, preterm labor, insurance/Medicaid); language barrier; low-income jobs; referrals/basic needs; community involvement/navigating systems; support; reliance on home visitor; client and home visitor relationship; and trust. This codebook was used to complete further analysis of all 32 transcripts by a second coder, allowing for additional sub-codes to emerge regarding immigrant families (mental health, domestic violence, food security). Final thematic analysis was performed as codes were categorized into the five broad themes described in the results. This process included research assistants reviewing the transcribed recordings to identify salient themes and engaging in a comparison of those themes to determine and reach consensus regarding the discrepancies in the coding. Secondary coding occurred independently to ensure a degree of concordance amongst raters using qualitative data analysis software, MAXQDA Version 11 (VERBI GmbH, 1989–2014).

Results

A total of 49 home visitors, 15 supervisors, and 17 program administrators participated in 32 focus groups that were divided by job title across 11 community site visits (See Table 1). The majority of the participants had been employed in their current position for 5 years or less. The majority of participants (92.6%) had a college or graduate level degree, were over 30 years old (85.6%), and came from a variety of professional backgrounds, with the largest percentages in the fields of nursing (28.4%), social work (17.3%), and from multiple disciplines (19.8%). The participants were somewhat racially and ethnically diverse (24.7% Black, 18.5% Hispanic), and 66.7% lived in the communities in which they worked.

When asked about the general needs of the families and communities involved in the home

TABLE 1. Demographic Characteristics of Home Visiting Staff ($N = 81$)

Participant characteristics	<i>n</i> (%)
Position title	
Administrator	17 (21.0)
Supervisor	15 (18.5)
Home visitor	49 (60.5)
Number of years working in current position	
Less than 1 year	34 (42.0)
1–5 years	28 (34.6)
6–10 years	6 (7.4)
More than 10 years	12 (14.8)
Prefer not to answer	1 (1.2)
Education	
Less than high school	0 (0.0)
High school degree	1 (1.2)
Some college	5 (6.2)
College degree (associates/bachelors)	44 (54.3)
Graduate degree (masters/doctoral)	31 (38.3)
Educational background	
Social work	14 (17.3)
Nursing	23 (28.4)
Public health	2 (2.5)
Psychology/counseling	11 (13.5)
Education	7 (8.6)
Multiple disciplines	16 (19.8)
Other ^a	6 (7.4)
Prefer not to answer	2 (2.5)
Age	
20–24	4 (5.0)
25–29	7 (8.6)
30–34	12 (14.8)
35+	58 (71.6)
Race	
White	52 (64.2)
Black	20 (24.7)
Asian	0 (0.0)
Pacific Island/Alaska Native	1 (1.2)
Other	7 (8.7)
Prefer not to answer	1 (1.2)
Ethnicity	
Hispanic	15 (18.5)
Non-Hispanic	65 (80.3)
Prefer not to answer	1 (1.2)
Live in community served by the program	
Yes	54 (66.7)
No	26 (32.1)
Prefer not to answer	1 (1.2)

^aOther includes social justice, business administration, health care administration, criminal justice, international studies, and communication.

visiting program, staff from eight of the 11 programs stated concerns specifically related to immigrant families participating in their programs.

Hispanic and Haitian clients, the specific immigrant populations in the Florida MIECHV program, were perceived to experience unique challenges associated with their socioeconomic and political environment. Through our analysis, these challenges described by MIECHV program staff were organized into five broad themes: social isolation, physical isolation, economic hardship, access to care and services utilization, and mistrust of formal systems. The role of the home visitor in addressing these challenges—through the relationships with the client and through referrals to services/systems navigation—was a common thread throughout the focus group discussions.

Citizenship status for a family member is one fundamental challenge faced by immigrant families, which contributes to social and physical isolation resulting in economic barriers for all family members. With limited English proficiency, transportation, income, and reliable employment, health care services are out of reach for many immigrant

families. As such, program staff identified access to health care as a critical area to aid in achieving optimal health for immigrant families. Home visitors acted as a trusted confidant navigating the political, social, and economic environment alongside immigrant families to better their chances of receiving critical health services (See Figure 1).

Social isolation

Staff reported that many immigrant families faced social isolation due to limited proficiency in English. This language barrier manifested into difficulty in navigating immigration naturalization services, accessing and using a phone, completing necessary forms for insurance coverage, and navigating complicated health service systems. A lack of access to technology (no internet or computer, only one cellular phone carried by the husband who is working) exacerbates the social isolation. A MIECHV program supervisor described the predicament many immigrant families are in:

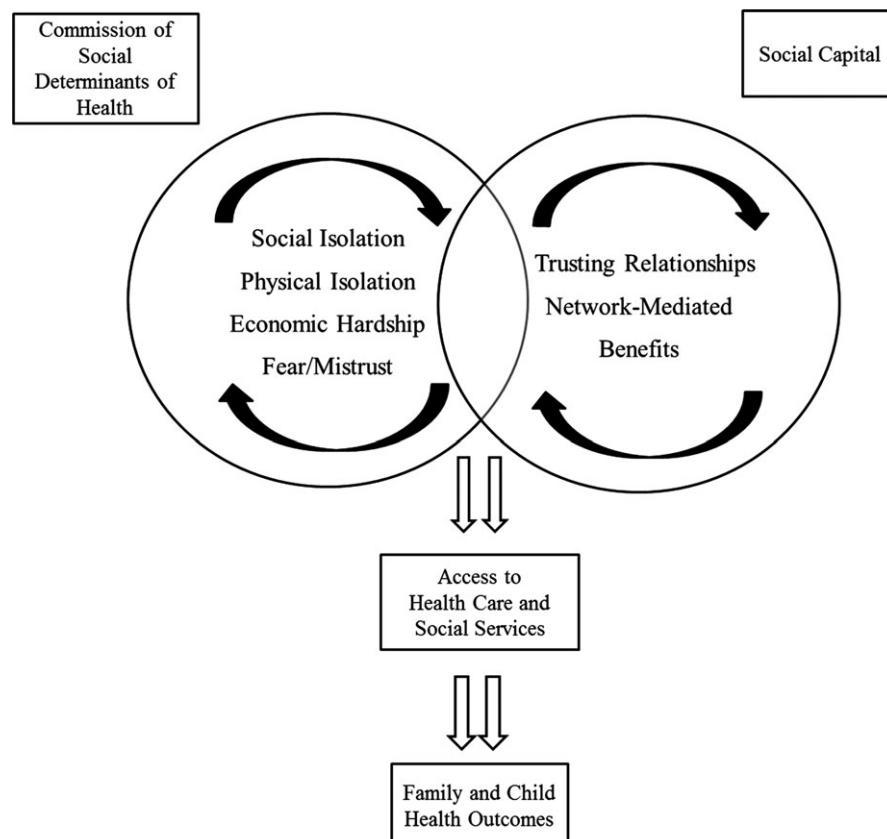


Figure 1. Relationship between Commission of Social Determinants of Health, Social Capital Theory, and Immigrant Health Status

The fact that they're [immigrants] and have no health insurance; they don't go to prenatal care, and they don't go seek services because—I mean, I've tried to navigate the community, and I speak English, and it's impossible. I can't imagine not speaking the language.

MIECHV programs attempt to alleviate the potential health burdens experienced as a result of insufficient health care services by hiring bilingual staff (e.g., Haitian Creole, Spanish) as home visitors. The home visitor is then able to discern which health concerns the family has, seek the appropriate care or insurance coverage if possible, and guide the family to the necessary services rather than the family having to navigate unfamiliar terrain alone. This social isolation can further burden women who are experiencing domestic violence or facing mental health issues.

Physical isolation

MIECHV staff indicated that a number of immigrant families served by the program reside in fragmented urban areas or in dispersed rural communities where public transportation is scarce. Moreover, immigrant families may be in a period of transition, where they move frequently, making it difficult for consistent follow-up by MIECHV home visitors. Economic hardship can also contribute to housing instability. This physical isolation resulted in decreased ability to reach critical health care services and a higher percentage of home births outside of skilled medical support, one home visitor mentioned how program participants would "give birth at home in the tub ... [or] in the kitchen." The same home visitor went on to say birthing in the home "happens every day" because the pregnant mother's situation does not afford them the means to access appropriate medical attention and prenatal care.

The staff also explained how home visitors attempted to reduce physical barriers to health care by acting as advocates, making phone calls on behalf of the families for referral services, and utilizing staff members who are aware of the resources available to the families. In a few MIECHV programs with transportation services, a nurse or home visiting staff member would drive the individual to a health care facility, Medicaid office, and grocery store. Several staff remarked that they find retention and participation rates of immigrant families to be high, because they perceived that families

feel taken care of, attended to, and generally supported by the home visitor. For example, as one home visitor explained:

I even have one mom who asked me, "What day do you want to visit me, so I can ask at work for my day off?" So I can choose the day, and she just asks for that day off. So they are very, very loyal people ... they are so grateful that we are providing this for free that they are willing to do anything to keep [sic] the program and participate in the program.

Economic hardship

Discussions illustrated how the combination of residency status, social barriers, and physical isolation faced by MIECHV immigrant families contribute to economic hardship. All MIECHV programs cater to primarily high-risk populations; immigrants face even further risks due to their vulnerable living circumstances. Without proper documentation or proficiency in English, legitimate jobs are difficult to find. As one home visitor stated of immigrant populations in her community:

They don't have papers, so they can't find good jobs, they don't have health insurance. Everything that they purchase it needs to be in cash...

Even when legal status is established, additional requirements may include high school education, reliable transportation, or a sufficient level of health, which may not be realistic for all families.

The women served in MIECHV are either pregnant, or have recently given birth, making them especially unlikely candidates to find already limited sources of employment. This creates an alarming situation when the women have no outside source of income and lack necessities for themselves and their babies. One home visitor commented on the major needs of her families: "A lot of the time they're having a baby, and they have no crib. They have no money for diapers, they have no money for formula, or they may not have connected to WIC yet."

Access to care and services utilization

As MIECHV staff explained, immigrant families either delay or forego health care services altogether because of their political, social, and economic circumstances even when some health care services are available. A MIECHV administrator

demonstrates how citizenship status impacts access to care:

It's still a challenge though because the services that are available to the people that are ... U.S. citizens are not always available, ... So we are more challenged to meet their needs...

Home visitors connect this lack of access to care to underutilization of prenatal care. Furthermore, a MIECHV supervisor commented on the high prevalence of comorbidities in her clients, usually encompassing one or two chronic diseases, such as diabetes or hypertension, along with sexually transmitted infections. The latter may lead to preterm births in pregnant women. In conjunction with limited or no prenatal care and the inability to seek medical attention, such dire situations leave mothers and their respective baby at risk for complications.

Mistrust of formal systems

Home visitors provide immigrant women with referrals for services they may need based on their personal situations, but a trusting relationship is often integral to how effectively these offered resources are used. Staff reported that some immigrant families in their communities refuse to be enrolled in the home visiting program or do not allow the home visitor to see where they live out of apprehension that the MIECHV program staff will report their whereabouts to authorities. One MIECHV program administrator described how the home visitors adjust their approach when they encounter a woman who is reluctant to participate in the program by meeting instead at a local fast-food restaurant or other location until trust is established. Another home visitor described the building of trust with Hispanic immigrants:

I mean the relationship is, I think, strong ... once they develop a trust in the educator, then they start opening up and start letting to educate [sic] or know what they need or what's going on in their lives. In the very beginning, they're usually reluctant until they build that trust ... Once they know who they can trust and tell me things and it's confidential and that I can help them; then that relationship becomes very strong...

Knowing that the staff member can understand their concerns, their lifestyles, and relate to their struggle in navigating a primarily English system, these women are more likely to openly communicate

their needs with the home visitor. In many ways, the home visitor becomes a trusted confidant to immigrant women who may otherwise feel socially, physically, and economically secluded from society.

Another component of trust is apparent when these women are in need of medical attention. As discussed in previous sections, many immigrants refuse to go to health care clinics for fear of deportation. An established relationship with the home visitor might minimize this fear. This leads not only to trust in the MIECHV program, but may also lead to trust in the broader system of health care. This is crucial in order for women to choose to receive critical health care services offered to them.

Discussion

Thematic analysis of the multi-site Florida MIECHV evaluation staff focus groups revealed that most of the programs served immigrant populations in their communities, including both undocumented and legal family members, posing unique challenges for program implementation. These subpopulations found in MIECHV communities are not surprising given the high concentration of Hispanic and Haitian immigrants in Florida (U.S. Census Bureau, 2010).

Thematic analysis allowed for salient themes to emerge from the qualitative data regarding immigrant families. The study's primary aim was to understand the needs of and challenges faced by immigrant families participating in MIECHV in accessing health services via the lens of Florida MIECHV staff.

This study revealed a number of salient themes present in other studies with similar populations, including social isolation (often related to limited English proficiency); physical isolation (which can be attributed to unstable housing, transitory employment, and living in rural areas with limited transportation); mistrust of formal systems; and economic hardship (Capps, Fix, Ost, Reardon-Anderson, & Passel, 2005). Although the Florida MIECHV program aims to improve coordination and referral of community resources and support (U.S. Department of Health and Human Services, 2016b), these themes invariably contribute to the barriers in access to and utilization of health care services by families (Huang, Yu, & Ledsky, 2006). Previous research has emphasized the perceptions

and experiences of the participants of home visiting programs (Paris, 2008; Paris & Dubus, 2005). This study expands the scientific literature by examining these issues through the lens of the program facilitators (i.e., home visitors) who have built relationships with participants. The dissemination of these experienced challenges could increase awareness of these issues, and promote further development and adaptation of home visiting programs to address them.

The authors contend that the socioeconomic and political climate surrounding immigrant participants contributes to social and physical isolation and economic hardship, further exacerbating barriers to health care access and utilization. Suffering from an unusually high array of morbidities makes the vulnerable MIECHV immigrant population more liable to incur higher medical costs if care is sought (Bodenheimer, Chen, & Bennett, 2009). Delayed treatment for chronic conditions may lead to serious complications, even death, as compared to early diagnosis and treatment of diseases (Eiser, 1993). This relationship ultimately leads to poor health status in underserved immigrant populations. The themes that emerged from these focus group discussions are consistent with the conceptual framework developed by the Commission on the Social Determinants of Health (CSDH) (World Health Organization, 2010). This framework posits that social inequities in the societal structure lead to observed discrepancies in the health status of social minority groups—those in power drive the socioeconomic and political climate of society with influences on such components as public policies, social policies, culture, and societal values. This relationship of power is specifically apparent as it relates to legal governance over immigrants. The development and enactment of such legal judgments not only maintain, but increase, the disparity of the haves and the have-nots that has become apparent in society on both a local and global scale (World Health Organization, 2010).

Often proposed is that societal changes must first occur before closure of the gap in health disparities between socially advantaged and disadvantaged groups. Albeit true, working at a distal level of the ecological system is less likely to instill socioeconomic and political change. It is therefore imperative to address such issues at a proximate level. Home visitors serve as the proximal nexus for

immigrants to navigate the health care system to ensure access and utilization of health care services. In conjunction with a trusting relationship, home visitors are able to navigate the health care system network with their prior experience and professionally developed skills. The relationship with the home visitor can build social capital for program participants who are immigrants, which can offset negative health outcomes influenced by the socioeconomic and political environment. This is captured by the CSDH conceptual framework. The aforementioned relationship between conceptual framework by CSDH and social capital theory (Portes, 1998) as it relates to the results of this study as depicted in Figure 1.

There are limitations in the scope and design of the present study. Focus groups included 11 programs from 14 specific communities, of which eight reported on challenges serving immigrant populations, but the barriers faced by the families discussed in this study may not be generalizable to all immigrants residing in the state of Florida or in the U.S. Furthermore, MIECHV programs cater to high-risk communities and these results may differ from those who are not in similar socioeconomic conditions. We do not know the legal or immigrant status of all family members, their health status upon U.S. arrival, or the level of acculturation or societal integration that could positively or negatively impact MIECHV participants' health.

The evaluations used for the results were based on insights and opinions of home visitors, supervisors, and administrators in health care service programs utilizing Florida MIECHV. Thus, we demonstrated the barriers experienced by immigrants and their families through the lens of other professionals that serve immigrants rather than the immigrants themselves. By using MIECHV personnel, this study may not capture the full scope of problems personally faced by immigrant populations. However, the purpose of this study was to understand, through Florida MIECHV staff's perspectives, the plight of low socioeconomic status immigrants in Florida in obtaining health care. In understanding their plight, this study may shed light on potential mechanisms that professionals may adopt to appropriately interact with and help people with unique circumstances. This study included the perspectives of home visitors, who are intimately familiar with the situations and

challenges encountered by their clients, as well as the perspectives of supervisors and administrators, who are responsible for staffing, training, program design and implementation, as well as community partnerships that are relevant to the needs of families enrolled in the program.

To assess future implications of home visiting programs and the broader impact overall, addressing barriers identified at the distal and intermediate levels discussed in the CSDH framework pave the way for home visitors to provide better services in conjunction with social support and mitigating mistrust experienced by the immigrant population. Future research should directly assess the relationships home visitors have garnered with immigrant populations and how said relationships continue to positively impact health outcomes over time.

Conclusion

It is important to note the socioeconomic and political context in which health disparities occur. While addressing the overarching distal factors at play, we must also consider more proximal issues, and appropriate modes of intervention to aid populations in need. Qualitative research helps to identify the complexities of the lived experience and can inform public health program design and implementation. Home visiting programs are not new, but they have only recently developed into the current approach, which combines evidence-based curriculum and practice with community development and outreach. This study indicated that the MIECHV home visiting intervention approach has demonstrated benefits for immigrant families experiencing numerous hardships in attaining optimal maternal and child health care. Thus, home visiting programs can use the results of this and similar studies to tailor their program designs, staffing, and community partnerships to best meet the needs of immigrant families.

Acknowledgements

The authors express our thanks to Carol Brady, the Project Director of the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative, Florida Association of Healthy Start Coalitions, Inc. for her support of this research.

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

D90MC25705 – Health Resources and Services Administration, U.S. Department of Health and Human Services.

Note

It is important to note that the MIECHV program serves a wide range of pregnant women and families with infants and young children who are experiencing social and economic risks to poor maternal and child health outcomes across the country. The stressors identified in this study - social isolation, physical isolation, economic hardship, access to care and services utilization, and mistrust of formal systems - are not uncommon and certainly not unique to immigrant populations. However, these challenges are exacerbated for individuals who do not have sufficient English proficiency or are part of a community experiencing sociopolitical hardship or oppression. Because of the cultural competence, specialized training, and evidence-based curricula utilized by MIECHV, the program offers a viable approach to connecting women and families to appropriate governmental, health, and social systems and to fostering social connectedness while promoting self-sufficiency.

References

- Adler, N. E., & Newman, K. (2002). Socioeconomic disparities in health: Pathways and policies. *Health Affairs*, 21(2), 60–76. doi:10.1377/hlthaff.21.2.60.
- Baker, B., & Rytina, N. (2013). Estimates of the unauthorized immigrant population residing in the United States: January 2012. *Population Estimates, Office of Immigration Statistics, Department of Homeland Security*, 1–8.
- Baker, D. W., Hayes, R., & Fortier, J. P. (1998). Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. *Medical Care*, 36, 1461–1470.
- Bodenheimer, T., Chen, E., & Bennett, H. D. (2009). Confronting the growing burden of chronic disease: Can the U.S. health care workforce do the job? *Health Affairs*, 28(1), 64–74.
- Boudreaux, E. D., & O’Hea, E. L. (2004). Patient satisfaction in the emergency department: A review of the literature and implications for practice. *The Journal of Emergency Medicine*, 26(1), 13–26.
- Caldera, D., Burrell, L., Rodriguez, K., Crowne, S. S., Rohde, C., & Duggan, A. (2007). Impact of a statewide home visiting program on parenting and on child health and development. *Child Abuse & Neglect*, 31(8), 829–852.
- Capps, R., Fix, M., Ost, J., Reardon-Anderson, J., & Passel, J. S. (2005). *The health and well-being of young children of immigrants*. Washington, DC: The Urban Institute.
- Cohen, T., & Murray, M. (2005). Incident tuberculosis among recent US immigrants and exogenous reinfection. *Emerging Infectious Diseases*, 11(5), 725–728.
- Cristancho, S., Garces, D. M., Peters, K. E., & Mueller, B. C. (2008). Listening to rural Hispanic immigrants in the Midwest: A community-based participatory assessment of major barriers to health care access and use. *Qualitative Health Research*, 18(5), 633–646.

- Daro, D. A., & Harding, K. A. (1999). Healthy Families America: Using research to enhance practice. *The Future of Children*, 9(1), 152–176.
- Darr, J. S., & Conn, D. B. (2015). Importation and transmission of parasitic and other infectious diseases associated with international adoptees and refugees immigrating into the United States of America. *BioMed Research International*, 2015, 1–8. doi:10.1155/2015/763715.
- de la Rosa, I. A., Perry, J., & Johnson, V. (2008). Benefits of increased home-visitation services: Exploring a case management model. *Family & Community Health*, 32(1), 58–75.
- Eiser, C. (1993). *Growing up with a chronic disease: The impact on children and their families*. Philadelphia, PA: Jessica Kingsley Publishers.
- Flores, G. (2006). Language barriers to health care in the United States. *The New England Journal of Medicine*, 355(3), 229–231.
- Florida Association of Healthy Start Coalitions, Inc. (FAHSC). (2015). 2014 State Demographics Report (Florida Maternal Infant & Early Childhood Home Visiting Initiative, Trans.) (pp. 1–5). Available at <http://www.flmichv.com/what-we-do/measuring-results/benchmark-plan/>
- Garrett, K. E. (2006). *Living in America: Challenges facing new immigrants and refugees* (Vol. 13, pp. 1–32). Princeton, NJ: Robert Wood Johnson Foundation.
- Heyman, J. M., Núñez, G. G., & Talavera, V. (2009). Healthcare access and barriers for unauthorized immigrants in El Paso County, Texas. *Family & Community Health*, 32(1), 4–21.
- Huang, Z. J., Yu, S. M., & Ledsky, R. (2006). Health status and health service access and use among children in U.S. immigrant families. *American Journal of Public Health*, 96(4), 634–640.
- Kandula, N. R., Kersey, M., & Lurie, N. (2004). Assuring the health of immigrants: What the leading health indicators tell us. *Annual Review of Public Health*, 25, 357–376.
- Lewin, M. E., & Altman, S. (2000). *America's health care safety net: Intact but endangered*. Washington, DC: National Academies Press.
- Mani, A., Mullainathan, S., Shafir, E., & Zhao, J. (2013). Poverty impedes cognitive function. *Science*, 341(6149), 976–980. doi:10.1126/science.1238041.
- McLoyd, V. C. (1998). Socioeconomic disadvantage and child development. *American Psychologist*, 53(2), 185–204.
- Mendoza, F. S. (2009). Health disparities and children in immigrant families: A research agenda. *Pediatrics*, 124(Suppl. 3), S187–S195.
- National Immigration Law Center. (2014). *Immigrants and the Affordable Care Act (ACA)*. Washington, DC.
- Norr, K. F., Crittenden, K. S., Lehrer, E. L., Reyes, O., Boyd, C. B., Nacion, K. W., et al. (2003). Maternal and infant outcomes at one year for a nurse-health advocate home visiting program serving African Americans and Mexican Americans. *Public Health Nursing*, 20(3), 190–203.
- Olds, D. L. (2006). The Nurse-Family Partnership: An evidence-based preventive intervention. *Infant Mental Health Journal*, 27(1), 5–25.
- Olds, D. L., Kitzman, H. J., Cole, R. E., Hanks, C. A., Arcle, K. J., Anson, E. A., et al. (2010). Enduring effects of prenatal and infancy home visiting by nurses on maternal life course and government spending: Follow-up of a randomized trial among children at age 12 years. *Archives of Pediatrics and Adolescent Medicine*, 164(5), 419–424.
- Paris, R. (2008). "For the dream of being here, one sacrifices...": Voices of immigrant mothers in a home visiting program. *American Journal of Orthopsychiatry*, 78(2), 141–151.
- Paris, R., & Dubus, N. (2005). Staying connected while nurturing an infant: A challenge of new motherhood*. *Family Relations*, 54(1), 72–83.
- Passel, J. S., & Cohn, D. (2014). *Unauthorized immigrant totals rise in 7 states, fall in 14: Decline in those from Mexico fuels most state decreases* (pp. 1–53). Washington, DC: Pew Research Center.
- Portes, A. (1998). Social capital: Its origins and applications in modern sociology. *Annual Review of Sociology*, 24, 1–24.
- Redlener, I., & Grant, R. (2009). America's safety net and health care reform –What lies ahead? *The New England Journal of Medicine*, 361, 2201–2204.
- U.S. Census Bureau. (n.d.). QuickFacts Florida population estimates. (2010). Available at <https://www.census.gov/quickfacts/FL>
- U.S. Department of Health and Human Services. (2016a). *Demonstrating improvement in the Maternal, Infant, and Early Childhood Home Visiting program: A report to congress*.
- U.S. Department of Health and Human Services. (2016b). *Home visiting*. From <http://www.hrsa.gov/about/contact/>
- VERBI GmbH. (1989–2014). *MAXQDA, software for qualitative data analysis*. Berlin, Germany: VERBI Software – Consult – Sozialforschung GmbH.
- Wasik, B. H. (1993). Staffing issues for home visiting programs. *The Future of Children*, 3(3), 140–157.
- World Health Organization. (2010). *A conceptual framework for action on the social determinants of health*. World Health Organization.
- Yoshikawa, H., Aber, J. L., & Beardslee, W. R. (2012). The effects of poverty on the mental, emotional, and behavioral health of children and youth: Implications for prevention. *American Psychologist*, 67(4), 272.
- Zigler, E., Pfannenstiel, J. C., & Seitz, V. (2008). The Parents as Teachers program and school success: A replication and extension. *The Journal of Primary Prevention*, 29(2), 103–120.
- Zong, J., & Batalova, J. (2016). *Frequently requested statistics on immigrants and immigration in the United States*. Migration Policy Institute - Online Journal.

WIDENING THE SCOPE OF SOCIAL SUPPORT: THE FLORIDA MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM

JENNIFER MARSHALL AND PAMELA C. BIRRIEL 

University of South Florida

ELIZABETH BAKER

Des Moines University

LEANDRA OLSON, NGOZICHUKWUAGA AGU, AND LIANNE F. ESTEFAN

University of South Florida

ABSTRACT: The Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program is designed to support pregnant women and families in developing skills and utilizing resources necessary to promote their children's physical, social, and emotional development. Little evaluation attention has focused on large-scale, public policy driven home-visiting programs. Social support provision is a critical component of a successful home-visiting program; therefore, there is a need to better understand participants' perceptions of social support provided to them in this context. Forty-five home-visiting participants from five Florida MIECHV programs completed semistructured telephone interviews. Participants discussed their experiences with the MIECHV program, including descriptions of their interactions with home visitors. Content analysis revealed that participants experienced multilayered social support from home-visiting staff. Families needed and received substantial emotional, instrumental, informational, and appraisal support at the individual level. This support was embedded within and strengthened by the strategies and activities of the home-visiting model of service provision. Results highlight the powerful opportunity home visiting offers as a method of service delivery within the larger system of care to increase social support in families experiencing high risk for negative maternal and child health outcomes. Implications for policy and practice are discussed.

Keywords: high-risk families, home visiting, qualitative analysis, social support

RESUMEN: El programa Materno Infantil y de la Temprana Niñez de Visitas a Casa de la Florida (MIECHV) está diseñado para apoyar a mujeres embarazadas y familias en cómo desarrollar habilidades y utilizar recursos necesarios para promover el desarrollo físico, síquico, social y emocional de sus niños. Poca atención evaluativa se ha enfocado en programas de visita a casa a gran escala y manejados a nivel de la política gubernamental. La provisión de apoyo social es un componente crítico de un exitoso programa de visitas a casa; por tanto, hay una necesidad de comprender mejor las percepciones de los participantes acerca del apoyo social que se les provee en este contexto. Cuarenta y cinco participantes de las visitas a casa de cinco programas MIECHV de Florida tomaron parte en entrevistas telefónicas semiestructuradas. Los participantes discutieron sus experiencias con el programa MIECHV, incluyendo descripciones de sus interacciones con quienes les visitaban a casa. Los análisis de contenido revelaron que los participantes recibieron del personal de visitas a casa un apoyo social a varios niveles. Las familias necesitaban y recibieron un apoyo emocional, instrumental, informativo y evaluativo considerable al nivel individual. Este apoyo ocurrió dentro de y fue fortalecido por las estrategias y actividades del modelo de visitas a casa de provisión de servicio. Los resultados resaltan la poderosa oportunidad que la visita a casa ofrece como un método de prestación de servicios dentro del más amplio sistema de cuidado con el fin de incrementar el apoyo social a las familias que experimentan alto riesgo de resultados negativos de salud materna e infantil. Se discuten las implicaciones para la política y la práctica.

Palabras claves: familias de alto riesgo, visitas a casa, análisis cualitativo, apoyo social

We declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article. The Florida Maternal, Infant, and Early Childhood Home Visiting program evaluation study was submitted to the Institutional Review Board at the University of South Florida and was found to be exempt due to its status as a program evaluation. This project was supported through subcontract with the Florida Maternal, Infant, Early Childhood Home Visiting Initiative, Florida Association of Healthy Start Coalitions, which is funded by the Health Resources and Services Administration Grant D90MC25705. We thank Carol Brady, the Project Director of the Florida Maternal, Infant, and Early Childhood Home Visiting Initiative, Florida Association of Healthy Start Coalitions, Inc., for her support of this research.

[Correction added on August 09, 2018, after first online publication: A correction has been made to affiliations of the authors.]

Direct correspondence to: Jennifer Marshall, Department of Community and Family Health, College of Public Health, 13201 Bruce B. Downs Boulevard, MDC 56, University of South Florida, Tampa, FL 33612; e-mail: jmarshal@health.usf.edu.

RÉSUMÉ: Le programme floridien (Etats-Unis) de visites à domicile maternelles, aux nourrissons et à la petite enfance (Florida Maternal, Infant, and Early Childhood Home Visiting program, abrégé en anglais MIECHV) est conçu afin de soutenir les femmes enceintes et leurs familles dans le développement de compétences et dans l'utilisation de ressources nécessaires à promouvoir le développement physique, social et émotionnel de leurs enfants. Une faible attention à l'évaluation a porté sur les programmes de visites à domicile créés dans le cadre d'une politique publique et à grande échelle. La prestation de soutien social est une composante critique d'un programme de visites à domicile réussi. Par conséquent il est nécessaire de mieux comprendre les perceptions des participantes du soutien social qui leur est offert dans ce contexte. Quarante-cinq participantes aux visites à domicile de cinq programmes MIECHV de Floride ont passé des entretiens téléphoniques semi-structurés. Les participantes ont discuté de leurs expériences avec le programme MIECHV, y compris des descriptions de leurs interactions avec les visiteuses / visiteurs à domicile. L'analyse du contenu a révélé que les participantes avaient expérimenté un soutien social à couches multiples des employés de visites à domicile. Les familles avaient besoin et ont reçu un soutien émotionnel, instrumental, informationnel, et évaluatif important au niveau individuel. Ce soutien était intégré et renforcé par les stratégies et les activités de la prestation du modèle de service de visite à domicile. Les résultats mettent en évidence la chance importante que la visite à domicile offre en tant que méthode de prestation de services au sein du plus grand système de soins afin d'augmenter le soutien social aux familles faisant l'expérience d'un risque élevé de résultats maternels et de la santé de l'enfant négatifs. Les implications pour la politique de santé et la pratique sont discutées.

Mots clés: familles à haut risque, visite à domicile, analyse qualitative, soutien social

ZUSAMMENFASSUNG: Das „Florida Maternal, Infant, and Early Childhood Home Visiting“-Programm (MIECHV-Programm) wurde entwickelt, um schwangere Frauen und Familien bei der Entwicklung von Fähigkeiten und der Nutzung von Ressourcen zu unterstützen, die notwendig sind, um die körperliche, soziale und emotionale Entwicklung ihrer Kinder zu fördern. Bislang wurde wenig Aufmerksamkeit auf die Evaluation von groß angelegten, von der öffentlichen Politik angetriebenen Hausbesuchsprogrammen gerichtet. Die Bereitstellung sozialer Unterstützung ist ein wichtiger Bestandteil eines erfolgreichen Hausbesuchsprogramms; daher ist es notwendig, die Wahrnehmungen der Teilnehmer in Bezug auf soziale Unterstützung in diesem Zusammenhang besser zu verstehen. Fünfundvierzig Hausbesuchsprogramm-Teilnehmer aus fünf MIECHV-Programmen in Florida absolvierten halb-strukturierte Telefoninterviews. Die Teilnehmer diskutierten ihre Erfahrungen mit dem MIECHV-Programm, einschließlich der Beschreibungen ihrer Interaktionen mit den Hausbesuchern. Die Inhaltsanalyse ergab, dass die Teilnehmer eine vielschichtige soziale Unterstützung durch die Hausbesucher erfahren hatten. Die Familien benötigten und erhielten umfangreiche emotionale, instrumentelle, informative und einschätzende Unterstützung auf individueller Ebene. Diese Unterstützung wurde eingebettet in und verstärkt durch die Strategien und Aktivitäten des Hausbesuchsmodells. Die Ergebnisse verdeutlichen die große Chance, die Hausbesuche als Methode zur Erbringung von Dienstleistungen innerhalb eines größeren Betreuungssystems bieten, um die soziale Unterstützung in Familien mit hohem Risiko für negative Auswirkungen auf die mütterliche und kindliche Gesundheit zu erhöhen. Implikationen für Politik und Praxis werden diskutiert.

Stichwörter: Risikofamilien, Hausbesuche, qualitative Analyse, soziale Unterstützung

抄録: フロリダ母親・乳幼児家庭訪問 (MIECHV) プログラムは、妊婦や家族が子どもの身体的・社会的・情緒的発達を促進するために必要な技能を発達させ、資源を活用するために企画された。これまで大規模な公共政策により推進される家庭訪問プログラムとしての評価にはほとんど焦点を当ててこなかった。社会的支援の提供は、家庭訪問プログラムの成功に重要な要素である; それ故この文脈において提供される社会的支援に対する参加者の認識をより良く理解することがニーズとしてある。5つのフロリダ MIECHV プログラムから45人の家庭訪問プログラム参加者に半構造化電話インタビューを行った。参加者は、MIECHV プログラムについて、家庭訪問員とどんな交流を持ったかを具体的に話すことを含め、自分の体験を話し合った。内容分析の結果、参加者が家庭相談員から多層的な社会的支援を体験していることが明らかになった。家族は個別レベルで必要な情緒的、実際的、情報的、評価の支援を十分に与えられていた。この支援は家庭訪問によるサービス提供モデルのやり方と活動の基本を強化したものである。本研究結果は、家庭訪問がチャンスの機会を強力にもたらすサービス提供法であることを明らかにした。ネガティブな健康のリスクの高い母子を体験している家族への社会的支援を増強するため、より大きなケアの体制におけるサービス提供法として、強調している。政策と実践の意義を考察する。

キーワード: ハイリスク家族, 家庭訪問, 定性分析, 社会的支援

摘要: 佛羅里達州母親、嬰兒和兒童早期家庭訪問 (MIECHV) 計劃，旨在幫助孕婦和家庭發展技能，並利用必要的資源，促進其子女的身體、社交和情感發展。很少評估專注在大規模的公共政策驅動的家庭訪問計劃上。社會支助是成功的家訪計劃的重要組成部分；因此，有必要更了解參與者在這種背景下對提供的社會支持之看法。來自五個佛羅里達州 MIECHV 項目的45名家訪參與者，完成半結構化電話訪談。參與者討論他們在 MIECHV 計劃中的經歷，包括他們與家訪者互動的描述。內容分析顯示，參與者經歷了來自家訪員工的多層次社會支持。參與家庭需要並在個人層面上獲得大量的情感、工具、信息和評估的支持。這種支持嵌入在家訪服務模式的策略和活動中，並在家訪中得到加強。研究結果突出家庭訪問提供的強大機會，作為在更大的醫療系統內提供服務的方法，以增加對母親和兒童負面健康結果高風險家庭的社會支持。作者討論研究對政策和實踐的意義。

關鍵詞: 高危家庭, 家訪, 定性分析, 社會支持

ملخص: يهدف برنامج فلوريدا للأمهات والرضع والطفولة المبكرة (MIECHV) إلى دعم النساء الحوامل والأسر في تطوير المهارات واستخدام الموارد الالزمة لتعزيز نمو أطفالهن البدني والاجتماعي والعاطفي. وقد ترتكز القليل من الاهتمام على تقديم برامج الزيارات المنزلية الواسعة النطاق والمدفوعة بالسياسة العامة. وبشكل توفر الدعم الاجتماعي عضرا حاسما في نجاح برنامج الزيارات المنزلية؛ ولذلك ، هناك حاجة إلى فهم أفضل لتصورات المشاركون للدعم الاجتماعي المقدم لهم في هذا السياق. ساهم 45 مشاركا في خمسة برامج للزيارات المنزلية (MIECHV) في فلوريدا في بيانات الدراسة حيث استكملوا مقابلات هادفة شبه منتظمة. وناقش المشاركون تجاربهم مع برنامج MIECHV ، بما في ذلك وصف تفاعلاتهم مع الزوار المنزليين. وكشف تحليل المحتوى أن المشاركون شهدوا دعما اجتماعيا متعدد المستويات من الموظفين الزائرين في المنازل. وتحتاج الأسر إلى دعم كبير وفعال عاطفيا وإعلاميا وتثبيطا على المستوى الفردي. وقد أدمج هذا الدعم في الاستراتيجيات والأنشطة التي وضعها نموذج تقديم الخدمات الخاص بالزيارات المنزلية. وتبين النتائج أهمية زيارة المنازل كوسيلة لتقديم الخدمات في إطار نظام الرعاية على النطاق الأوسع لزيادة الدعم الاجتماعي في الأسر التي تواجه مخاطرات عالية فيما يتعلق بالنتائج السلبية لصحة الأم والطفل. وتناقش الدراسة التطبيقات العملية للنتائج على السياسة والممارسة.

الكلمات الرئيسية: عائلات عالية المخاطر ، زيارة منزلية ، تحليل وصفي ، دعم اجتماعي

* * *

Overall, Florida ranks poorly on several key indicators of maternal and child health, with higher rates of low birth weight babies; infant, child, and adolescent mortality; and a higher percentage of children in poverty and in single-parent families as compared to the national average (Florida KIDS COUNT, 2011; Martin, Hamilton, Osterman, Curtin, & Mathews, 2015). One strategy to address these disparities is to implement home-visitation programs in which nurses, early childhood professionals, and/or parent educators provide support, education, and resource linkages to high-risk families. The comprehensive and personalized supports provided through home-visiting programs have the potential to impact the well-being of families at highest risk for poor maternal and child health outcomes in ways that other service-delivery mechanisms may not (Olds, Kitzman, Knudtson, Anson, Smith, & Cole, 2014).

THE FLORIDA MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program is a nationwide, federally funded program that expands access to home visiting and responds to the diverse needs of children and families living in at-risk communities through evidence-based home-visiting programs (Health Resources & Services Administration, 2016). While home-visiting programs have been in existence for decades, the MIECHV program offers an added value by expanding the number of families served and counties where home visiting is offered, particularly those in high-risk communities; ensuring fidelity to evidence-based models; and contributing to collective impact in communities by requiring programs to adopt shared benchmarks in each state to address a wide range of important issues faced by enrolled families (Health Resources & Services Administration & Centers for Medicare and Medicaid Services, 2016; Office of Planning, Research, & Evaluation, 2015). All MIECHV programs reported outcomes in six benchmark areas: maternal and newborn health outcomes (including nutrition, health, and mental health); child injuries, child abuse, neglect, or maltreatment and reduction of emergency department visits; school readiness and achievement; crime or domestic violence; family economic self-sufficiency; and coordination and

referrals for other community resources and supports. The Florida MIECHV program began serving families in 14 of 29 identified high-need communities in 2013. Five programs across six counties were initially funded, with further expansion later that year. The home-visiting models funded within Florida MIECHV include Nurse–Family Partnership (NFP; Olds, 2006), Healthy Families Florida (HFF; Healthy Families Florida, 2012), and Parents As Teachers (PAT; Parents as Teachers, 2011). All three contain some elements of support in their program designs, in the forms of screening/assessment; case management; and family support, counseling, and parent/caregiver skills training (Health Services & Resources Administration & Centers for Medicare and Medicaid Services, 2016; Office of Planning, Research, & Evaluation, 2015).

The intent of MIECHV is to provide the highest quality home-visiting services to families living in the highest need communities in Florida. For example, in its first year, Florida MIECHV served 929 pregnant women, and mothers and fathers of young children, most of whom were single parents (76%) and living below poverty level (72%), with a proportion experiencing substance-abuse history (22%), current/past involvement in the child welfare system (25%), and adolescent motherhood (under age 21, 18%) (Florida MIECHV, 2014). MIECHV participants are racially and ethnically diverse, comprised of 25% Hispanic/Latino, 47% Black/African American, and 7% multiracial, with 15% of the households speaking a language other than English (Florida MIECHV, 2014). Thus, MIECHV programs hire staff with required qualifications and training for the service-delivery model and who are culturally, linguistically, and ethnically compatible with the populations they serve. In Florida, home-visitor qualifications are based on program model. The NFP requires that nurse home visitors and nursing supervisors are registered professional nurses with a minimum of a bachelor's degree in nursing and prefers that supervisors have a master's degree in nursing. The program also requires nurse home visitors, nursing supervisors, nurse consultants, site administrators, program managers, and state leaders to complete a series of introductory education sessions offered by the NFP National Service Office. Nurse supervisors, nurse consultants, site administrators, program managers, and state leaders must participate in an annual education session to update their skills and knowledge. PAT requires parent educators to have a minimum of a high-school

diploma or GED; 2 years of previous supervised work experience with young children and/or parents; and participate in a 3-day foundational training, continuing professional development, and annual recertification (Eckenrode et al., 2010; Parents as Teachers, 2017). The Healthy Families America (HFA) National Office requires that direct service staff (family support and parent survey staff) have a minimum of a high-school diploma along with a 4-day core training and additional “wraparound training” (Healthy Families America, 2015). It also requires that staff are selected based on their personal characteristics, including their experience working with or providing services to children and families; ability to establish trusting relationships; acceptance of individual differences; experience working with culturally diverse communities (that are present among the site’s target population); knowledge of infant and child development; ability to maintain boundaries between personal and professional life; and their reflexive capacity (U.S. Department of Health & Human Services: Administration for Children & Families, n.d.). The HFA National Office also requires all staff to complete mandatory HFA training. Regardless of program model, MIECHV home visitors’ caseloads are limited to 25 families, with a minimum of two visits to be completed per month to promote relationship-building and to ensure sufficient dosage for the program to have an impact. The NFP, HFF, and PAT models follow evidence-based curricula designed to build rapport with participants, assess their needs, offer referrals, and provide education tailored to their stage of pregnancy or child’s age through weekly, bimonthly, or monthly sessions (OPRE, 2015). In addition to model-specific requirements, Florida MIECHV staff participate in additional training delivered via professional development trainings, an online learning management system and training portal, and a state conference (Florida MIECHV, n.d.-a).

As part of the ongoing Florida MIECHV program evaluation, various needs of enrolled families and the strategies that home-visiting programs use to address those needs via evidence-based models are examined; further details on the various support strategies are available in Appendix A. Specifically, this exploratory study examined families’ perceptions of the MIECHV services and supports provided by their home visitor within a social support framework.

SOCIAL SUPPORT

Shumaker and Brownell (1984) defined social support as “an exchange of resources between two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient” (p. 13). Resources exchanged can include tangible items, information, or emotional support. Key ingredients of successful home-visitation programs are the provision of social support that connects families to community services that can provide long-term assistance and having a sensitive home visitor who promotes engagement of families (Thompson, 2015). One framework describes four subtypes of social support: instrumental, informational, appraisal, and emotional (Gottlieb & Bergen, 2010; Heaney & Israel, 2008). While instrumental support involves di-

rect provision of tangible assistance (e.g., transportation, goods and services, etc.), informational support includes advice, suggestions, and information offered from one person to another to help address problems (Heaney & Israel, 2008). Appraisal support assists an individual in his or her own self-evaluation process by providing “constructive feedback and affirmation” (Heaney & Israel, 2008, p. 190). Finally, emotional support includes empathy, love, trust, and caring that one individual can offer another (Heaney & Israel, 2008). Changes in specific types of support are hypothesized to be related to improvements in the MIECHV benchmark domains. For example, improvements in service coordination and referral information for other community resources likely would improve the perception of informational and instrumental support a home visitor provides.

Home-visiting programs provide critical social support for families living in high-risk situations, including mothers who are low-income, young, pregnant for the first time, or are of ethnic minority or immigrant status, along with parents who are at higher risk of child maltreatment or lacking strong informal support networks (Avellar & Supplee, 2013; Jack, DiCenso, & Lohfeld, 2005; Jean-Baptiste et al., 2017; Landy et al., 2012; Paris, 2008). These are among the risk factors that are identified through a statewide risk screen that is conducted in Florida for every pregnant woman and new mother to streamline referrals to home-visiting programs (Hardt et al., 2013). Home-visiting support enhances parent knowledge, skills, and self-efficacy (Caldera et al., 2007; Landy et al., 2012; Paris, 2008); reduces social isolation (Paris & Dubus, 2005); improves the home learning environment (Caldera et al., 2007); and increases the parent’s utilization of other supportive services (Caldera et al., 2007). A model showing how the subtypes of social support and home-visitor strategies can improve child and family outcomes is presented in Figure 1. As shown in the figure, home visitors provide (a) informational support by assessing families’ needs using screening tools and motivational interviewing; provide appraisal support to promote family goal-setting and reflective parenting, (b) instrumental support by offering referrals to additional services, and (c) emotional support to enhance parent coping and stress management. These activities occur within the context of a supportive relationship, with the goal of achieving improvements in important maternal and child health benchmark areas.

SIGNIFICANCE

Although home-visiting programs have many potential benefits, program diversity makes it difficult to determine the degree to which these programs are effective in improving maternal and child health outcomes. Peacock, Konrad, Watson, Nickel, and Muhanjrine (2013) found that while overall it is difficult to demonstrate outcomes of home-visiting programs in populations with multiple risks and stressors, programs are most successful when the home visitor can first identify a family’s most pressing needs—posing the question of “Where to begin?” (p. 11)—and connect families to additional resources. They also noted positive outcomes in areas such as prevention of child abuse, improved child development, reduced

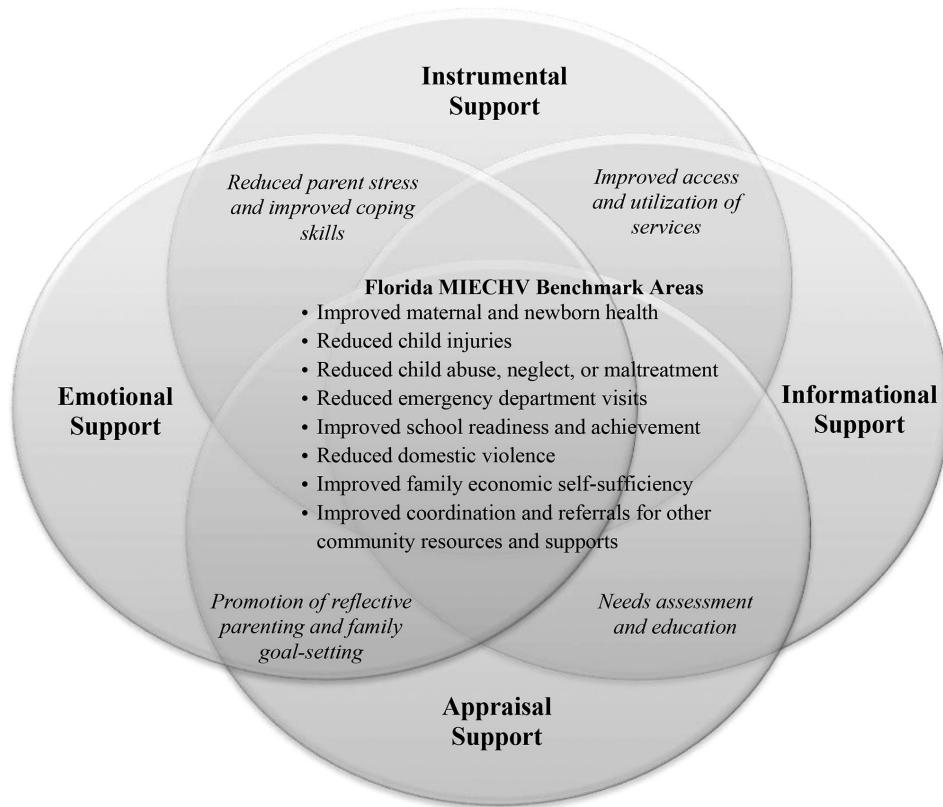


FIGURE 1. Social support framework applied to the Florida MIECHV benchmark areas.

incidence of low birth weight and health problems, and increased incidence of appropriate weight gain (Peacock, et al., 2013). As such, in addition to benchmark/outcomes reporting, home-visiting program evaluations may include a process evaluation that examines both needs assessment and service delivery (information, support, and referrals) from the individual perspectives of home visitors and their clients. For example, using the Helping Relationship Inventory, Korfomacher, Green, Spellmann, and Thornburg (2007) closely examined the home visitor-client relationship over time and its connection to client participation and satisfaction in Early Head Start. There remains a need for further research evaluating large-scale, public policy driven home-visiting programs (Korfomacher & Roggman, 2016; McDonald, Moore, & Goldfeld, 2012). Our study focuses on service delivery in the statewide, federally funded Florida MIECHV program. As shown in Figure 2, the national, state, and local infrastructure of Florida MIECHV builds networks of resources to support the home-visitors' work described in Figure 1; the benchmarks provide guidance on specific areas of need to focus on, essentially determinants of maternal and child health (Health Services & Resources Administration & Centers for Medicare and Medicaid Services, 2016; Office of Planning, Research, & Evaluation, 2015). Thus, within the three evidence-based home-visiting models comprising Florida MIECHV, we examine various supports provided within the context of the home visitor-participant relationship, as described by the participants themselves (see Figure 1; Appendix A).

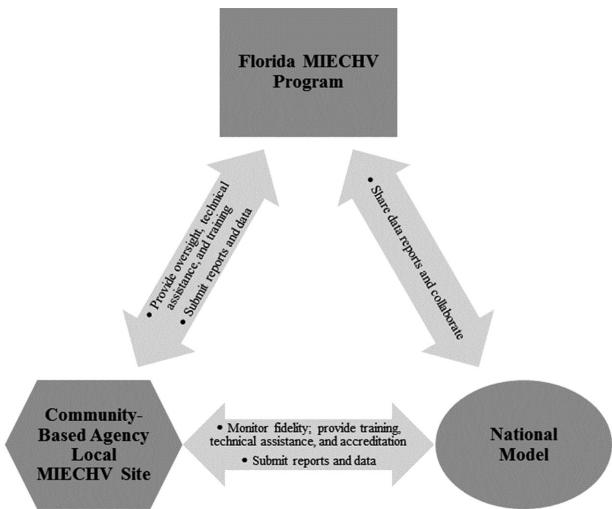


FIGURE 2. National, state, and local collaboration plan.

METHOD

Participants

The MIECHV program evaluation was submitted to the Institutional Review Board at the University of South Florida and was found to be exempt due to its status as a program evaluation. This article reports on interview data collected as part of the larger

Florida MIECHV program evaluation with clients participating in the five initially funded programs. The sampling frame included all families enrolled in those five programs at the time of the study, with convenience quota sampling of at least 5 participants from each program.

Recruitment

To recruit participants, home visitors from each program distributed flyers in English and Spanish to their clients. Flyers included information on the study and contact information for the evaluation team. Eligible participants were those identified as the primary caregiver of a child enrolled in the MIECHV program (one adult per household) and who could speak and understand English or Spanish, the two languages predominately spoken by MIECHV participants. To enroll, clients called or texted the evaluation team to schedule an interview at their convenience. Clients from the five programs were recruited until a quota of 7 to 10 per site was reached and until theoretical saturation was achieved.

Data Collection

Telephone interviews were conducted with 45 clients in English ($n = 43$) or Spanish ($n = 2$). Before each interview, participants provided verbal consent and were informed that they could withdraw from the interview at any time. Interviews lasted approximately 20 min and were digitally recorded and professionally transcribed verbatim. Interviews conducted in Spanish were professionally translated and transcribed in English.

Before data collection began, the interview guide was reviewed by an expert panel of maternal and child health professionals and MIECHV program administrators and then pilot-tested with home-visiting clients. Following these activities, changes were made to the format and content of the interview guide. Interviews were semistructured to allow participants to openly describe their overall experiences with the program, with additional prompts to collect detail on service needs and referrals, aspects of the home visits perceived as most and least helpful, and the participant–home visitor relationship. Participants also provided sociodemographic information. A \$25 gift card was mailed to each study participant following the interview.

Analysis

Transcripts were reviewed by evaluation staff to ensure accuracy, then imported into ATLAS.ti Qualitative Data Analysis Software, Version 7.5 (2015), which facilitates organization and coding of qualitative data. Content analysis was conducted using *a priori* codes based on the four subtypes of social support (i.e., appraisal, emotional, informational, and instrumental support) (Heaney & Israel, 2008). Emergent codes that fit the definition of a subtype of social support were placed in that category. For example, codes that referred to educational materials, educational activities, and information/instructions to clients by home visitors were categorized

as informational support (see Appendix B). To determine inter-rater reliability, the lead analyst coded all transcripts, and a second analyst coded every fifth transcript ($n = 9$). Agreement between raters was 78.35% ($\kappa = 0.74$). Self-reported demographic information was entered into Qualtrics Survey Software (2015) and stored on a secure server. Descriptive statistics were calculated within Qualtrics.

RESULTS

The study population ($N = 45$, see Table 1) reflected the overall population of Florida MIECHV program participants (Florida MIECHV, 2014), with the exception that a greater proportion of our study participants were postpartum/parenting (vs. pregnant) than that of the Florida MIECHV population because they were selected from a stratified sample. The majority were female (96%), single (71%), under the age of 25 (53%), and unemployed (42%), and had a high-school education or less (48%). Eleven percent of participants were currently pregnant, and the majority had children in the household who were under 12 months old (64%).

Overall, participants described a wide range of needs that their home visitor helped to address, including basic needs (e.g., housing, transportation, etc.), food access (e.g., food stamps, the Special Supplemental Nutrition Program for Women, Infants, and Children, etc.), and child-related issues (e.g., childcare, child support, etc.). In addition, participants identified access to health-related services for all members of the family (e.g., health insurance, dental care, family planning, breastfeeding support, smoking cessation, mental health counseling, etc.) as critical needs. Responses are expanded upon next, organized by social support subtype, which are illustrated by quotes from participant interviews.

Instrumental Support

Participants' responses on the types of referrals received, services utilization, and ease of accessing services highlighted instrumental support provided by MIECHV home visitors. Most home visitors provided the families with a general list of community resources and identified specific family needs through formal needs assessments and informal conversations. Participants described many basic needs; referrals for childcare, clothing, furniture, and transportation were most frequently given, in addition to financial assistance (e.g., rent and utilities), food, housing, and employment. In times of need, home visitors provided items such as diapers and formula directly to families. One participant described how the home visitor addressed her family's basic needs:

Most of [her knowledge], she has off the top of her head, and it is really awesome that what she does, and she is really attentive to make sure that she goes and lists it up. If it's something that I need more immediately, she will actually text me or call me with the information on where to find it, to help me locate the information that is really important, whereas on less important things, like by the next visit, she already has pamphlets that she printed out for me. (Mother of 5-month-old infant, age 27)

TABLE 1. Individual and Household Characteristics of Interview Participants from the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Evaluation

Characteristic	Study Participants		Florida MIECHV ^a
	(N = 45)	%	
Age (years)			
<20	5	11	18
20–24	19	42	33
25–29	13	29	25
≥30	8	18	24
Race/Ethnicity			
White	17	38	48
Black	19	42	45
Hispanic	6	13	21
Other	3	7	8
Education			
<High School	10	22	34
High-School Graduate	16	36	24
Some College	12	27	27
College Degree (Associate/Bachelors)	7	16	5
Employment Status			
Full-Time	6	13	20
Part-Time	7	16	18
Homemaker	9	20	
Unemployed	19	42	60
Full-Time Student	4	9	
Marital Status			
Engaged or Married	11	24	16
Separated	1	2	2
Residing With Significant Other	1	2	
Single	32	71	76
Pregnancy Status			
Pregnant	5	11	45
Parenting	40	89	
No. of Children in Household ^b			
1 Child	30	67	n.a. ^d
2 Children	11	24	
≥3 Children	4	9	
Age of Index Child ^b (months)			
<12	34	76	n.a. ^d
12–24	11	24	
Assistance With Daily Childcare and Activities ^c			
No Other Adult	17	38	n.a. ^d
Spouse/Partner	9	20	
Family Member	16	36	
Friend	1	2	
Other	5	11	

^aFlorida MIECHV demographic information may have different categories from the categories in the study.

^bCurrent pregnancy was counted as 1 child <12 months in the household.

^cTotal responses exceed N = 45 due to “select all that apply” option.

^dFlorida MIECHV demographic information in these categories is not available.

Participants also reported receiving referrals for childcare services; social groups; faith-based organizations; childbirth, breastfeeding, safety, and child development classes; and health services such as family-planning and counseling. Home visitors motivated clients to utilize the services available to them:

She kind of pushed me to apply for it and pushed me to go to the breastfeeding class and probably without her help I wouldn’t have it done, honestly, on my own. (Expectant mother, 8-months pregnant, age 36)

However, over one third of participants reported not using any referrals, reporting that they did not need the service at the time.

Informational Support

Participants described home-visit activities that reflected the informational or educational nature of the program. Clients generally received informational support through educational lessons, advice, educational materials (e.g., books, pamphlets), and activities or games covering topics such as prenatal care, childbirth, child development, and parenting techniques (e.g., discipline, home safety, nutrition, parent-child interaction):

[My home visitor and I] go over everything . . . Parenting, developmental skills . . . basically anything you can think of parenting-wise that you can do with your child, she’ll help you with. (Mother of 12-month-old infant, age 29)

Appraisal Support

Participants described how the home-visitor’s assistance and facilitation of goal-setting, their reflection on the pregnancy and parenting experience, and the nature of a supportive, reflective relationship as indicative of appraisal support. For example, it was common for home visitors to assist clients in setting goals regarding the stages of pregnancy and child development as well as other personal and family goals:

. . . [My home visitor and I] sat down and I [started] going through the paperwork and setting the goal that I wanted. It was goals that I want for the baby, goals that I want for myself, goals that I want as a family. Actually, it’s helping me stay on track with those goals that I have set . . . So, that’s what I’ve enjoyed the most, the goal-setting. (Expectant mother, 7-months pregnant, age 38)

Informational support such as advice and suggestions was frequently applied to stimulate reflective-parenting and goal-setting techniques among clients. At times, home visitors were referred to as “life-coaches,” as they encouraged clients, checked in on progress, and provided affirmation and feedback regarding their goals:

. . . One of our goals is to become self-sufficient all the way around the board and [my home visitor is] making that possible. Anything I need help with, she’s there . . . If it’s there, she lets me know, “Hey, I can get it. You

got to work with me, set goals for yourself. I can assist you in achieving them." She lets me know—"I can't do it for you, but I can assist you." (Mother of 5-month-old infant, age 20)

Although home visitors encouraged goal setting, they also set clear expectations that clients take the initiative to make achievements themselves, thus building self-efficacy through reflective appraisal support rather than through direct intervention, which allowed the client to own her successes and experience personal agency.

Emotional Support

Participants also discussed emotional support received from their home visitor, emphasizing a close, personal relationship with the home visitor. Although relationships remained professional, participants felt that the home visitor showed genuine concern and interest in their family:

[My home visitor] is very knowledgeable about what she does. She is very interested, I would say, and invested in me and my daughter to make sure that I stay on the right track and continue doing the right thing to be able to provide the best that I can for my daughter. (Mother of 9-month-old infant, age 36)

Many participants described their relationship with the home visitor as comfortable and trusting, and felt that they could relate to their home visitor in a judgment-free environment. One participant shared her experience with starting the home-visiting program:

When I first got into the program, I was skeptical because it's a person coming into my home. So, it wasn't really like a cup of tea, but when [my home visitor and I] got to know each other, and we got to talking and stuff like—we relate to each other. She doesn't even look at me like I was just someone that's in distress right now and needs help. She was right there with me through the whole process. She made me comfortable. (Mother of 5-month-old infant, age 20)

Participants often thought of their home visitor as a friend, mentor, role model, or mother figure. As such, they felt a strong bond and connection with their home visitor, allowing for an open, confiding relationship to form:

... When [my home visitor] came here and I met her and we were—we connected with each other. That's why I stayed with the program because she makes me feel comfortable always.... She always made me feel like—she made me feel like she's a mother actually. She made me feel like she'll always be there for us if we need her. (Mother of 5-month-old infant, age 20)

Emotional support played such a key role in the client–home visitor relationship that transitioning to a new home visitor or out of the program was identified as a concern by participants:

I don't know if I necessarily want to open my doors back up to another worker and discuss some of the things that I was so open with her about....

If I don't feel the same connection, I might not stay with the program. (Mother of 5-month-old infant, age 20)

One participant's response to the question "What does the home-visiting program mean to you?" illustrates how these supportive components improve family well-being:

To me, it honestly means, to me it kind of equals a better relationship with my children, a better calm in my house, a better home space, happy environment. (Mother of 5-month-old infant, age 27)

DISCUSSION

The MIECHV Initiative has a strong vision for supporting families who face multiple stressors and risks for poor maternal and child outcomes, and specific home-visiting models also build in various forms of social support into their program designs (see Figures 1 and 2). It is critical for program evaluators to consider how these aspects of the program are received from the perspectives of the participants. It is clear from the study that families who participate in the Florida MIECHV program need and receive instrumental, informational, appraisal, and emotional support from home-visiting staff. We know from a systems perspective that the support is provided through planned activities that are purposeful in terms of program design and home-visitors' implementation of the model; we found in this study that these supports are perceived as comfortable and natural by participants within the context of the caring relationships that are developed. Study participants could articulate the practical utility of the instrumental and informational support received and the less tangible impacts of the emotional and appraisal supports that contribute to their engagement with the home visitor, as well as positive relationships with their children.

For the program to be effective, support must be individualized to and aligned with the family's needs (DeMay, 2003; Gomby, Culross, & Behrman, 1999). As a majority of the participants are single mothers, the instrumental support that home visitors provide can be essential for day-to-day living in challenging communities with few financial resources. Home visitors provided a lifeline for resources to access basic goods (e.g., food, shelter, etc.) for some participants. Home visiting has been found to address economic self-sufficiency and mitigate the effects of poverty through referrals to community services (Minkovitz, O'Neill, & Duggan, 2016). However, given the high percentage of MIECHV participants experiencing poverty and other stressors, it was surprising that over one third reported not needing instrumental support by way of service referrals. It may be that those participants truly did not need additional services, were already connected to services, did not know what services were available, or chose not to disclose a need for services. Regardless, this phenomenon warrants further exploration.

Informational and appraisal supports helped parents learn and reflect on their parenting and personal development and to gain information to help them improve life skills, health behaviors, and child-rearing. The two-generation approach—supporting the

individual as a parent while also assisting with personal well-being and professional development used in home visiting—is unique and vital. The two-generation model requires a clear role conceptualization and methodological approach; a wide range of skills, knowledge, and access to a variety of resources; and partnership development with the parent (Korfmacher et al., 2008).

As observed in our study, parents may need additional supports or services but may not know about the resources, may be hesitant to ask for them, experience cultural taboos or stigma related to seeking help, and often encounter barriers to accessing services. Evidence-based home-visiting programs are designed to identify and address the need for multiple services via trained and skilled relationship-based providers. Consistent with other research (Cline, 2014; Landy et al., 2012), our participants reported that emotional support was an important aspect of the MIECHV program. In fact, because of the trust established in the home-visiting relationship, home visitors were often described by families not only as a formal service provider (e.g., social worker or nurse) but also as a life coach and a friend (Cline, 2014; Landy et al., 2012). This also supports the premise that provision of emotional support through being sensitive to participants can help promote engagement of families, which is a key ingredient for program success (Thompson, 2015).

Strengths and Limitations

This study utilized a social support framework to understand the perceptions of the supportive relationship between a home visitor and client from the client's perspective. However, this study has some limitations. Home visitors were used as the point of contact to send out recruitment flyers to participants. While the staff was instructed to provide a flyer to every family enrolled in the program, there was potential for selection bias in the recruitment process. Mailing out flyers to clients may have controlled for this potential bias. However, utilizing home visitors in the recruitment process is more likely to have led to a higher response rate, as receiving information about the study from a trusted source may increase willingness to participate in the study. Table 1 shows how study respondents compare demographically to Florida MIECHV participants; a slightly higher proportion of study respondents were ages 20 to 29, Black, high-school graduates, and married/engaged.

Implications for Practice

Social support is a useful theoretical framework for guiding training for home visitors in areas such as relationship- and trust-building, active listening and motivational interviewing, health and parenting education, care coordination, and familiarity with resources that can benefit participants. Trust is established when a participant perceives that the home visitor can relate to her experiences through shared background or perspective and when the relationship is based on respect, empowerment, and shared decision-making (Jack et al., 2005; Paris, 2008; Paris & Dubus, 2005).

Establishing trust may take time (McNaughton, 2000), but does appear to increase program engagement and retention (Gomby et al., 1999; Paris, 2008). Participants in our study described initial reluctance to connect with the home visitor and to developing trust throughout their relationship, and voiced concerns about losing that relationship when assigned another home visitor or when the program ended. As such, program administrators should seriously consider the impact on participating when reassigning home visitors and should plan for transitions when the program ends. McCurdy (2001) found that neither individualized, home-based services nor group, center-based services enhanced the support systems of mothers outside of the program, although concrete social support, network size, and/or community involvement improved because of home visitation. Thus, enhancing participants' social support networks outside of the program should be a goal of MIECHV to ensure that the benefits of increased social support continue beyond program enrollment (McCurdy, 2001; McNaughton, 2000).

Home visiting can positively impact lifestyle behaviors, mental health, coping skills, support systems, stress- and anger-management skills, and the supportive relationship is the foundation for positive change (Ferguson & Vanderpool, 2013). Because the Florida MIECHV program is operated by the Association of Healthy Start Coalitions, the program goals and focus areas are informed by the data collected through the universally collected maternal and infant risk screens (Florida MIECHV, n.d.-b), infant mortality data, and other assessments conducted by coalitions and their partners.

However, a substantial need for basic resources remains in many high-risk communities. While MIECHV programs include methods to assess and address families' diverse and complex needs, home visitors also should assess and support the family's social support networks beyond the program. Furthermore, programs should set up systems for tracking referrals, connection and enrollment in referred programs, and utilization of additional services. Follow-up surveys with families can identify the outcomes of referrals (Marshall & Raffaele-Mendez, 2014, and data systems can be designed to track referral outcomes program-wide. Beginning in 2014, Florida MIECHV programs began working closely with regional Healthy Start Coalitions to improve their coordinated intake and referral systems through Learning Collaboratives, with the goal being that families are referred to home-visiting programs as well as other services from pregnancy and birth and that provider networks (including home visiting as a cornerstone of family support) are strengthened to facilitate referral, connection to services, and enrollment in supportive programs (Florida MIECHV, n.d.-c). These coalitions are exploring data systems, including universally accessible apps, to track referral outcomes.

CONCLUSION

This study describes the powerful opportunity that home visiting offers as a method of service delivery within the larger system of care to increase social support in families experiencing high

risk for negative maternal and child health outcomes. Assessment, provision, and enhancement of social supports for MIECHV participants guided by MIECHV foci and tailored to families' needs may lead to more focused and effective services, and may ultimately improve child and family well-being during and beyond enrollment in the MIECHV program.

REFERENCES

- ATLAS.ti Qualitative Data Analysis, Version 7.5. [Computer software]. (2015). Berlin, Germany: Scientific Software Development. Available from <http://atlasti.com/>
- Avellar, S.A., & Supplee, L.H. (2013). Effectiveness of home visiting in improving child health and reducing child maltreatment. *Pediatrics*, 132(Suppl. 2), S90–S99. <https://doi.org/10.1542/peds.2013-1021G>
- Caldera, D., Burrell, L., Rodriguez, K., Crowne, S.S., Rohde, C., & Duggan, A. (2007). Impact of a statewide home visiting program on parenting and on child health and development. *Child Abuse & Neglect*, 31(8), 829–852. <https://doi.org/10.1016/j.chabu.2007.02.008>
- Cline, E.M. (2014). Exploring trust in the provider-patient DYAD: Capturing the mother's voice in her own words. Retrieved July 31, 2019, from <http://scholarworks.montana.edu/xmlui/handle/1/3395>
- DeMay, D.A. (2003). The experience of being a client in an Alaska public health nursing home visitation program. *Public Health Nursing*, 20(3), 228–236. <https://doi.org/10.1046/j.0737-1209.20310.x>
- Eckenrode, J., Campa, M., Luckey, D.W., Henderson, C.R., Cole, R., Kitzman, H. et al. (2010). Long-term effects of prenatal and infancy nurse home visitation on the life course of youths: 19 year follow-up of a randomized trial. *Archives of Pediatrics & Adolescent Medicine*, 164(1), 9–16.
- Ferguson, J.M., & Vanderpool, R.C. (2013). Impact of a Kentucky maternal, infant, and early childhood home-visitation program on parental risk factors. *Journal of Child and Family Studies*, 22(4), 551–558. <https://doi.org/10.1007/s10826-012-9610-4>
- Florida KIDS COUNT. (2011). 2011 KIDS COUNT data book: A Florida comparison. Retrieved July 31, 2018, from http://floridakidscount.fmhi.usf.edu/_assets/docs/pubs/2011KidsCountComparison.pdf
- Florida Maternal, Infant, and Early Childhood Home Visiting. (Florida MIECHV, n.d.-b). Collective impact. Retrieved from <http://flmiechv.com/what-we-do/collective-impact-capacity-building/>
- Florida Maternal, Infant, and Early Childhood Home Visiting (Florida MIECHV). (n.d.-a). Professional development. Retrieved July 31, 2019, from <http://www.flmiechv.com/what-we-do/professional-development/>
- Florida Maternal, Infant, and Early Childhood Home Visiting (Florida MIECHV). (n.d.-c). Coordinated intake & referral learning collaborative. Retrieved July 31, 2018, from <http://www.flmiechv.com/coordinated-intake-referral-learning-collaborative/>
- Florida Maternal, Infant, and Early Childhood Home Visiting (Florida MIECHV). (2014). 2013–2014 State Demographics Report. Retrieved July 31, 2018, from <https://www.flmiechv.com/what-we-do/measuring-results/benchmark-plan/>
- Gomby, D.S., Culross, P.L., & Behrman, R.E. (1999). Home visiting: Recent program evaluations: Analysis and recommendations. *The Future of Children*, 9(1), 4–26. <https://doi.org/10.2307/1602719>
- Gottlieb, B.H., & Bergen, A.E. (2010). Social support concepts and measures. *Journal of Psychosomatic Research*, 69(5), 511–520. <https://doi.org/10.1016/j.jpsychores.2009.10.001>
- Hardt, N.S., Eliazar, J., Burt, M., Das, R., Winter, W.P., Saliba, H., & Roth, J. (2013). Use of a prenatal risk screen to predict maternal traumatic pregnancy-associated death: Program and policy implications. *Women's Health Issues*, 23(3), e187–e193. <https://doi.org/10.1016/j.whi.2013.02.002>
- Health Resources and Services Administration. (2016). The Maternal, Infant, and Early Childhood Home Visiting program: Partnering with parents to help children succeed [Program brief]. Retrieved July 31, 2018, from <https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/programbrief.pdf>
- Health Resources and Services Administration & Centers for Medicare and Medicaid Services. (2016). Coverage of maternal, infant, and early childhood home visiting services. Retrieved July 31, 2018, from <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-02-16.pdf>
- Healthy Families America. (2015). Keeping HFA excellent: Training for HFA sites. Retrieved July 31, 2018, from <http://www.healthyfamiliesamerica.org/core-training/>
- Healthy Families Florida. (2012). Healthy Families Florida model. Retrieved July 31, 2018, from <http://www.healthyfamiliesfla.org/pdfs/HFFLogicModel.pdf>
- Heaney, C.A., & Israel, B.A. (2008). Social networks and social support. In K. Glanz, B.K. Rimer, & K. Viswanath (Eds.), *Health behavior and health education: Theory, research, and practice* (4th ed., pp. 189–210). San Francisco: Jossey-Bass.
- Jack, S.M., DiCenso, A., & Lohfeld, L. (2005). A theory of maternal engagement with public health nurses and family visitors. *Journal of Advanced Nursing*, 49(2), 182–190. <https://doi.org/10.1111/j.1365-2648.2004.03278.x>
- Jean-Baptiste, E., Alitz, P., Birriel, P.C., Davis, S., Ramakrishnan, R., Olson, L., & Marshall, J. (2017). Immigrant health through the lens of home visitors, supervisors, and administrators: The Florida Maternal, Infant, and Early Childhood Home Visiting program. *Public Health Nursing*, 34(6), 531–540. <https://doi.org/10.1111/phn.12315>
- Korfsmacher, J., Green, B., Spellmann, M., & Thornburg, K.R. (2007). The helping relationship and program participation in early childhood home visiting. *Infant Mental Health Journal*, 28(5), 459–480.
- Korfsmacher, J., Green, B., Staerkel, F., Peterson, C., Cook, G., Roggman, L. et al. (2008). Parent involvement in early childhood home visiting. *Child & Youth Care Forum*, 37(4), 171–196. <https://doi.org/10.1007/s10566-008-9057-3>
- Korfsmacher, J., & Roggman, L. (2016). Home visiting to enhance child development in the context of violence: Possibilities and limitations. In L. Roggman & N. Cardia (Eds.), *Home visitation programs: Preventing violence and promoting healthy early child development* (pp. 15–34). Cham, Switzerland: Springer International.
- Landy, C.K., Jack, S.M., Wahoush, O., Sheehan, D., MacMillan, H.L., & the NFP Hamilton Research Team. (2012). Mothers' experiences

- in the Nurse-Family Partnership program: A qualitative case study. *BMC Nursing*, 11(15). <https://doi.org/10.1186/1472-6955-11-15>
- Marshall, J., & Mendez, L.M.R. (2014). Following up on community-based developmental screening: Do young children get the services they need? *Infants & Young Children*, 27(4), 276–291.
- Martin, J.A., Hamilton, B.E., Osterman, M.J.K., Curtin, S.C., & Mathews, T.J. (2015). Births: Final data for 2013—Supplemental Tables. *National Vital Statistics Reports*, 64(1). Hyattsville, MD: Division of Vital Statistics. Retrieved July 31, 2018, from http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01_tables.pdf
- McCurdy, K. (2001). Can home visitation enhance maternal social support? *American Journal of Community Psychology*, 29(1), 97–112. <https://doi.org/10.1023/A:1005201530070>
- McDonald, M., Moore, T., & Goldfeld, S. (2012). Sustained home visiting for vulnerable families and children: A literature review of effective programs. Royal Children's Hospital's Centre for Community Child Health and the Murdoch Children's Research Institute.
- McNaughton, D.B. (2000). A synthesis of qualitative home visiting research. *Public Health Nursing*, 17(6), 405–414. <https://doi.org/10.1046/j.1525-1446.2000.00405.x>
- Minkovitz, C.S., O'Neill, K.M., & Duggan, A.K. (2016). Home visiting: A service strategy to reduce poverty and mitigate its consequences. *Academic Pediatrics*, 16(3), S105–S111. <https://doi.org/10.1016/j.acap.2016.01.005>
- Office of Planning, Research, & Evaluation (OPRE). (2015). The Mother and Infant Home Visiting Program Evaluation: Early Findings on the Maternal, Infant, and Early Childhood Home Visiting Program. A Report to Congress. OPRE Report No. 2015-11. Retrieved July 31, 2018, from http://www.acf.hhs.gov/sites/default/files/opre/mihope_report_to_congress_final_1.pdf
- Olds, D.L. (2006). The nurse–family partnership: An evidence-based preventive intervention. *Infant Mental Health Journal*, 27(1), 5–25. <https://doi.org/10.1002/imhj.20077>
- Olds, D.L., Kitzman, H., Knudtson, M.D., Anson, E., Smith, J.A., & Cole, R. (2014). Effect of home visiting by nurses on maternal and child mortality: Results of a 2-decade follow-up of a randomized clinical trial. *JAMA Pediatrics*, 168(9), 800–806.
- Parents as Teachers. (2011). Parents as Teachers logic model. Retrieved July 31, 2018, from <https://parentsasteachers.org/logic-model>
- Parents as Teachers. (2017). Essential requirements. Retrieved from <https://parentsasteachers.org/essential-requirements/>
- Paris, R. (2008). “For the dream of being here, one sacrifices . . .”: Voices of immigrant mothers in a home visiting program. *American Journal of Orthopsychiatry*, 78(2), 141–151. <https://doi.org/10.1037/0002-9432.78.2.141>
- Paris, R., & Dubus, N. (2005). Staying connected while nurturing an infant: A challenge of new motherhood. *Family Relations*, 54(1), 72–83. <https://doi.org/10.1111/j.0197-6664.2005.00007.x>
- Peacock, S., Konrad, S., Watson, E., Nickel, D., & Muhajarine, N. (2013). Effectiveness of home visiting programs on child outcomes: A systematic review. *BMC Public Health*, 13(1), 1. <https://doi.org/10.1186/1471-2458-13-17>
- Qualtrics: Online Survey Software & Insight Platform [Computer software]. (2015). Provo, UT. Available from <http://www.qualtrics.com/>
- Shumaker, S.A., & Brownell, A. (1984). Toward a theory of social support: Closing conceptual gaps. *Journal of Social Issues*, 40(4), 11–36. <https://doi.org/10.1111/j.1540-4560.1984.tb01105.x>
- Thompson, R.A. (2015). Social support and child protection: Lessons learned and learning. *Child Abuse & Neglect*, 41, 19–29. <https://doi.org/10.1016/j.chab.2014.06.011>
- U.S. Department of Health & Human Services: Administration for Children & Families. Home Visiting Evidence of Effectiveness (HOMEVEE). (n.d.). Implementing Healthy Families America (HFA). Retrieved July 31, 2018, from <https://homvee.acf.hhs.gov/Implementation/3/Healthy-Families-America-HFA-sup—sup-/10/1>

APPENDIX A***Program Models, Theoretical Background, and Link to Social Support***

Model	Theories	Type of Support(s) Provided by Program Activities
Nurse–Family Partnership	Human Ecology Self-Efficacy Human Attachment	<p>APPRAISAL SUPPORT</p> <ol style="list-style-type: none"> 1. Nurse home visitor helps client envision how she would like life to be for herself and her child, promoting pregnancy planning, education, and employment as a means of accomplishing client's goals. 2. Nurse home visitor works with client to envision how she wants to care for her child using the guidelines and program materials to promote her ability to accurately read and respond to her infant's cues; to promote infant's trust and attachment, child's language skills, behavioral regulation, and emotional, physical, and cognitive development. 3. In collaboration with her client, the nurse home visitor promotes engaging other appropriate individuals in the client's family and social networks, promoting healthy relationships and nurturance of the child. <p>INSTRUMENTAL SUPPORT</p> <ol style="list-style-type: none"> 1. Nurse home visitor provides service coordination based on each client's identified needs, referring to available community services, as needed. 2. Nurse home visitor assesses and promotes positive infant and toddler health, screens development, and works with parents and community providers to obtain supportive services.
Parents as Teachers	Human Ecology Family Systems Developmental Parenting Attribution Theory Empowerment Self-Efficacy	<p>INFORMATIONAL SUPPORT</p> <ol style="list-style-type: none"> 1. Parent educators share research-based information and utilize evidence-based practices by partnering, facilitating, and reflecting with families. <p>INSTRUMENTAL SUPPORT</p> <ol style="list-style-type: none"> 1. Parent educators use the PAT foundation curriculum in culturally sensitive ways to deliver services that emphasize parent–child interaction (parenting behaviors, child development, parent–child activities), development-centered parenting (link between child development and parenting, developmental topics), and family well-being (family strengths, capabilities, and skills, protective factors; resourcing).
Healthy Families Florida (Based on Healthy Families America)	Attachment Theory Ecological Perspective Constructivist Views of Child Maltreatment	<p>INFORMATIONAL SUPPORT</p> <ol style="list-style-type: none"> 1. Collaborate with and empower families to set and achieve goals that lead toward greater self-sufficiency 2. Educate and model positive parent–child relationships, including developmentally appropriate discipline and guidance techniques <p>INSTRUMENTAL SUPPORT</p> <ol style="list-style-type: none"> 1. Provide referrals for substance abuse, domestic violence, mental health, and other issues needed 2. Screen children for developmental delays (physical, cognitive, and emotional) and provide referrals when needed

APPENDIX B

Types of Social Support and Relationship to Qualitative Codes

Type of Support	Definition	Code	Description of Code	Representative/Example Quotes
Instrumental Support	Direct Provision of Needed Tangible Assistance	Direct Services	Reference to the Home Visitor Providing Direct Services	"If I ever get low on diapers and I don't have the money, I can call or text her and let her know that I don't have any and then [unintelligible]. If I have enough to last until the next visit, she'll bring me diapers or something. If I need them the next day, she'll make a special trip to my house and bring them."
	Access Barriers	Barriers to Accessing Services		"No. We don't have a vehicle so if I go anywhere, it's really hard to go on the bus. I have three to four kids at my house most of the time so it's kind of hard to get on the bus with all the kids."
	Referral Type	Types of Referrals Clients Received		"Yes. I see a counselor through Healthy Start now."
	Referral Process	Description of How Client Received Referrals		"No, but the counselor, she helped me out a lot. She's given me a paper to—we were having problems with our teeth, me and my fiancé. She gave me information for a dentist that I can get a hold of. She has helped me find out about programs I didn't know about like the backpack giveaway or school supplies and stuff like that. She's been helpful with giving me information also."
	Referral Use	Reference to Whether Clients Used or Did Not Use Referrals Received		"I have used the Women's Center to get some clothes and diapers for my son. There's a couple of churches too."
Informational Support	Advice, Suggestions, and Information Offered From One Person to Another To Help Address Problems	Materials	Reference to Specific Educational Materials Used During or Brought to the Home Visit	"Well, she'll come and they—generally like wherever I am like when I was pregnant, where I was like during my pregnancy, they gave me information about what to expect in how big my baby was—where he is—what part of him is developing and those types of things. Now, she'll bring information about where you should see development, like developing-wise."
	Activities	Specific Educational Activities That Are Conducted as Part of the Home-Visiting Program's Curriculum; Also May Include Health Assessments of Baby or Client		"With the activities, like this month's activity was something called touchy socks where you would go and get clean, two socks and put different things in it with different textures like cotton balls or dried beans or crinkled paper, and you tie the two socks up and you let her—of course supervised. I let her play with it—because there's paper, she could put it in her mouth, just to make sure none of the insides come out. Then it explains how it helps her senses, how it helps her mind, and gives her the motivation to explore more."
	Topics	Specific Information or Instructions That Are Covered as Part of the Home-Visiting Program's Curriculum		"We talk about the milestones that she's going to be going through and activities to try with her."
Appraisal Support	Assisting an Individual in Their Own Self-Evaluation Process by Providing "Constructive Feedback and Affirmation"	Description	Characteristics of Home Visitors	"I like that they're very personal, like she gets to know our family and comes in and I can just talk to her and I can say whatever, a kid's name and she's not like, 'Oh, who are you?'"
	Relationship	Description of Relationship Between Home Visitor and Client and/or Family		"It's like a distant friend. We don't talk every day but I know that she has her own life so it's not like we're in each other's lives but she's there whenever—if I need to talk to her or if there's something I need and if she's available or can help, she will. So I don't know how to put a title on that because it's not an everyday relationship but it's some kind of something."
	Goal-Setting	Future Goals Set for Mom or Baby by Home Visitor and/or Client		"She gives me tips as far as my goals. She helps me reach my goals and as far as my son goes, so she's really like a life coach."
Emotional Support	Empathy, Love, Trust, and Caring That One Individual Can Offer Another	Emotion	Reference to Emotional Support Provided by Home Visitors	"Encouraged me to finish high school, told me that she knew I could do it, not to give up. She kept on encouraging me to keep trying for a job. She still—encouraging me to go back to school and I haven't done it yet."

The Evaluation Team

Our evaluation team is ever evolving. Here is our team throughout the years...



**Dr. Jennifer Marshall, Lead Evaluator
MIECHV Evaluation Coordinators**

Kimberly Hailey
Leeandra Olson
Marshara Fross
Ngozichukwuka Agu

Dogeli Rojas
Dr. Elizabeth Baker
Esther Jean-Baptiste
Oluwatosin Ajisope

Dr. Pamela Birriel
Dr. Rema Ramakrishnan, Data Analyst
Vanessa Sharon

Abimbola Michael-Asalu
Adriana Campos
Amanda McMahon
Amber Warren
Amita Patil
Barbara Dorjulus
Bola Yusuf
Carlene Geffrard
Carolyn Heeraman
Cedrick Ade
Chantell Robinson
Cynthia Horwitz

Research Assistant/Associates
Davies Toluhi
Destiny Singleton
Igbagbosanmi Orediein
Jasmine Ulysse
Jennifer Carter
Jennifer Delva
Jordan Stofan
Kaylin Martin
Loreal Dolar
Oluyemisi Amoda
Oluyemisi Aderomilehin
Omotola Balogun

Paige Alitz
Priyashi Manani
Ruth Sanon
Suen Morgan
Shruti Kaushik
Stephanie Volpe
Dr. Takudzwa Sayi
Tara Foti
Temitope Bello
Tochukwu Obioha
Vasthi Ciceron
Vidya Chandran

Faculty

Dr. Lianne Estefan, Lead Evaluator Year 1
Dr. Lana Yampolskaya, Data Linkage
Dr. Connie Walker, Data Linkage

Dr. Bill Sappenfield, Data Linkage
Dr. Marti Coulter, MCH and Family Violence
Dr. Deborah Cragun, Implementation Science

Dr. Vicki Phares, Mental Health
Dr. Alison Salloum, Mental Health
Dr. Cheri Eisert, Health Economics

Site Contact List

Escambia
Healthy Families Expansion
Ounce of Prevention Fund of Florida/90Works
Jennifer Ohlsen, johlsen@ounce.org
www.ounce.org

Duval/Baker/Clay
Nurse-Family Partnership
Northeast Florida Healthy Start Coalition, Inc.
Faye Johnson, fjohnson@nefhsc.org
www.nefhealthystart.org

Alachua/Bradford/Putnam/Columbia/Hamilton
Parents as Teachers
Healthy Start of North Central Florida, Inc.
Fay Davis, fdavis@wellflorida.org
www.healthystartncf.org

Orange
Healthy Families Expansion
Orlando Health, Inc.
Anna Wilson, anna.wilson@orlandohealth.org
www.orlandohealth.com/arnoldpalmerhospital/howardphillipscenter

Hillsborough
Nurse-Family Partnership
Healthy Start Coalition of Hillsborough County, Inc.
Brenda Breslow, Bbreslow@hstart.org
www.healthystartcoalition.org

Pinellas
Parents As Teachers+
Healthy Start Coalition of Pinellas, Inc.
Linda Thielmann, lthielmann@healthystartpinellas.org
www.healthystartpinellas.org

Manatee/Sarasota/Desoto/Hardee
Parents As Teachers
Step Up Suncoast
Carol Hunt, cahunt@stepupsuncoast.org
Anna Cismesia, acismesia@stepupsuncoast.org
Maria Cruz-Morgan, mmorgan@stepupsuncoast.org
www.stepupsuncoast.org

Lee/Hendry/Collier
Nurse-Family Partnership
Healthy Start Coalition of SWFL
Valarie Bostic, valarie@healthystartswfl.com
www.healthystartswf.com

Broward
Nurse-Family Partnership
Broward Regional Health Planning Council, Inc.
Manoucheka Chery, mchery@BRHPC.ORG
www.brhpc.org

Miami-Dade
Nurse-Family Partnership
Health Choice Network of Florida, Inc.
Adriana Hurley, aphurley@hcnetwork.org
www.hcnetwork.org

Highlands
Nurse-Family Partnership
Healthy Start Coalition of Hardee, Highlands & Polk
Charlene Edwards, cedwards@healthystarthhp.org
www.healthystarthhp.org

Polk
Nurse-Family Partnership
Early Learning Coalition of Polk
Gregg Heinkel, greggheinkel@elcpolk.org
www.elcpolk.org

Gadsden/Jackson
Nurse-Family Partnership
Gadsden County Healthy Start Coalition
Joy Anderson, joy.anderson@gadsdencountyhsc.org
www.gadsdencountyhsc.org

Bay
Parents As Teachers
Bay, Franklin, Gulf Healthy Start Coalition
Sharon Owens, healthystart@comcast.net
www.healthystartbfg.com

Okeechobee/Martin (Indiantown)
Parents As Teachers
Okeechobee County Healthy Start Coalition
Kay Begin, hscikb@embarqmail.com

Palm Beach (Belle Glade)
Parents As Teachers
Lutheran Services Florida
Children & Head Start Services
Josefina Fletcher, josefina.fletcher@lsfnet.org
www.lsfnet.org

Marion
Parents as Teachers
WellFlorida Council, Inc.
Julie Moderie, jmoderie@wellflorida.org
www.wellflorida.org

